Facilitating the Dialogue:
What is the Role of the Faculty of Medicine in Primary Health Care in First Nations, Metis and Inuit Communities
Planning Session – March 14, 2013

Summary Report
Acknowledgements

The ‘Facilitating the Dialogue: What is the Role of the Faculty of Medicine in Primary Health Care in First Nations, Metis and Inuit Communities’ Summary Report and Facilitated Planning Session was prepared / conducted by AMR Planning and Consulting.
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Executive Summary

The University of Manitoba has a substantive role in shaping the delivery of primary health care services in Manitoba. As the education entity responsible for the training of all allied health, dental, nursing and medical health care professionals, it is imperative that we recognize and understand the primary health care needs of our urban, rural and northern Manitobans. In addition, the University, through the Department of Community Health Sciences in the Faculty of Medicine, has had several decades of responsibility for providing direct health service to several First Nations, Metis and Inuit communities through the service and coordination efforts of the J.A. Hildes Northern Medical Unit.

The Planning Session was held to identify perspectives on the role of the Faculty of Medicine in Primary Health Care. Engagement of key stakeholders provided an overview of the vision for, and current activity in, primary health care within our province. The current practice in service delivery for First Nations, Metis and Inuit communities was explored, and the focus on inter-professional practice and the role of the education system in participating in, or leading these efforts for comprehensive primary health care model development was discussed.

The potential components required for consideration in the development of a framework for the university’s role in primary health care in First Nations, Metis and Inuit communities follows on page 5.

Components of A Framework for Equitable and Effective Primary Health Care in First Nations, Metis and Inuit Communities

Components of a potential framework for the University’s role in the development of equitable and effective primary health care in First Nations, Metis and Inuit communities. The components reflect information and ideas shared by both participants and presenters.

Purpose

To partner with communities, various levels of government, service providers, and other stakeholders to develop, implement and sustain a model for equitable and effective primary health care model for First Nations, Inuit and Métis communities

Goals

To improve health outcomes for First Nations, Metis and Inuit community members.
To improve the delivery of primary health care services in First Nations, Metis and Inuit communities

Areas for Action

Authentic Engagement
- Use community-driven methods and participatory approaches to identify and successfully implement authentic community engagement that will establish strategies to respond to community needs.
- Value and learn from Indigenous knowledge, including successes in care for the health and wellness of their people

Quality of Care
- Develop a more comprehensive definition of PHC that addresses determinants of health and heals for Indigenous peoples
- Embed cultural safety in both University policy and curriculum, and offer ongoing access to cultural awareness and competency training to health care professionals and incorporating Indigenous ways of understanding, caring for and practicing health and wellness into curriculum and practice.

Sustainability
- Establish committees, working groups and other mechanisms with membership from key stakeholders to support joint planning, knowledge sharing, and coordinated services
- Develop future health care learners, with initiatives that target First Nations, Metis and Inuit people
- Prioritize inter-professional education as a way to support quality of care while making the most of available resources, and incorporate it into teaching and learning for health disciplines

Principles

1. Commitment to authentic engagement and mutually empowered relationships with First Nations, Metis and Inuit communities, acknowledging the diversity within and across First Nations, Inuit and Métis peoples.
2. Focus on sustainability of the primary health care model for First Nations, Metis and Inuit communities
3. Provision of patient-centered care that is responsive to patient-identified needs
4. Delivery of primary health care services that are community driven and responsive to community-identified needs
5. Commitment to support the cultural safety of clients, service providers, and other stakeholders
Introduction

On March 14, 2013, the Office of the Associate Dean, First Nations, Metis and Inuit Health, Faculty of Medicine, University of Manitoba, hosted a planning session that explored the University’s role in primary health care in First Nations, Metis and Inuit communities. Invitees included representatives of First Nations, Metis and Inuit governments and organizations, First Nations and Inuit Health Branch, provincial government departments, regional health authorities, community health sciences, and the University of Manitoba.

The main objectives of the planning session were to:

- Provide stakeholders with an overview of current primary health care models in Manitoba;
- Define key actions that the University of Manitoba, Faculty of Medicine might take to participate in the development of a model for primary health care for First Nations, Metis and Inuit communities; and
- Provide an opportunity for networking, team building, and interaction amongst key stakeholders in primary health care delivery in Manitoba.

The agenda designed for the planning session supported these objectives:

- Panel presentations provided an overview of current areas of responsibility in the delivery of primary health care, including funding models, service delivery models, and referral networks;
- Working in small groups, using a “knowledge café” process, participants identified areas where the University can take a proactive role in promoting or advocating for change in order to improve the delivery of primary health care services in First Nations, Metis and Inuit communities; and
- Throughout the day, activities supported participant interaction, providing them with ongoing opportunities to share their experiences, interests, accomplishments and insights, and to work together to develop input for the framework.

In opening remarks, Dr. Catherine Cook (Associate Dean, First Nations, Metis and Inuit Health, Faculty of Medicine, University of Manitoba) observed that recognition of the need for an appropriate model for primary health care for First Nations, Metis and Inuit people has been identified as an increasing priority in our province. The Faculty of Medicine’s recent curriculum renewal established Indigenous health as a focus throughout the program. The World Health Organization’s *Towards Unity for Health* project (Boelen, 2000) offers a model that brings together health communities, health managers, policy makers, health professionals and academic institutions as health partners to deliver a sustainable health system that is based on the needs of the people it serves.

It is in this context that we begin the dialogue on the development of a primary health care model for First Nations, Metis and Inuit communities.
Overview of Primary Health Care in Manitoba

The planning session included two panel presentations that offered information and concepts that participants could draw on in their discussions of a framework for primary health care in First Nations, Metis and Inuit communities.

1.0 Primary Health Care in Manitoba:

The morning series included presentations that reflect the primary health care models and developments in primary health care practice in Manitoba. Presenters highlighted efforts at the level of Manitoba Health, the Winnipeg Regional Health Authority, First Nations and Inuit Health Branch, and the University of Manitoba research projects. The presentations on Primary Health Care are summarized below.

Primary Health Care in First Nations, Métis and Inuit Communities (Terry Goertzen, ADM, Executive Director, Population Health Branch, Ministry of Health).

Manitoba Health seeks to meet the health needs of individuals, families and their communities by leading a sustainable, publicly administered health system that promotes wellbeing and provides the right care in the right place at the right time. MB Health has established improved service delivery as a priority, and set the goal of leading advances in health service delivery for First Nations, Metis and Inuit Manitobans, through policy and programs that focus on prevention, primary health care, and education. Services funded by MB Health include physician services (on- and off-reserve) and tertiary and specialty care services (off-reserve, but accessible to all Manitoba residents), and the department also manages and operates nursing stations in three (3) of the 63 First Nations in the province.

Under its current Primary Care Strategy, MB Health is establishing Primary Care Networks, with the goal of ensuring that all Manitobans will be able to access a family physician by 2015. The strategy has supported the development of the Northern Primary Care Pathway Plan, rolled out in four northern communities, including the Northlands Dene First Nation and the Metis community of Wabowden. The plan is expected to provide quality and safety, patient-centered care, and collaborative practice teams within and across geography and jurisdiction. A collaborative governance structure (with representatives from each community and partner organizations) has been established. The “Family Doc for All” strategy focuses on health human resources and scopes of practice, new remuneration models, new collaborative practice team-based models and networks of care, information technology and systems, performance monitoring, evaluation and quality improvement, and patient-centered self-management services.
Significant challenges are generated by the limited jurisdictional mandates of the various levels of government (federal, provincial and First Nations) who deliver health services to First Nations people living on-reserve. With limited integration and coordination among the systems, and no formal overarching governance structure in place that can address bureaucratic barriers, First Nations people are left with gaps in services. MB Health recognizes the need for a made-in-Manitoba approach that responds to the unique Treaty, geographic, organizational, cultural and other contextual realities.

Winnipeg Regional Health Authority (Jeanette Edwards, Regional Director, Primary Health Care and Chronic Disease, WRHA).

The Winnipeg Regional Health Authority (WRHA) provides integrated, community-based services – and where possible, provides them in the neighborhoods where people live. WRHA’s activities are consistent with its holistic approach to the health and wellness of the population it serves, and commitment to enhance access. These include:

- Winnipeg Integrated Services (WIS): WRHA partners with provincial departments to provide integrated and holistic health and social services, a project that is helping to address social determinants of health
- Primary Care Clinics, including ACCESS centers (associated with the WIS project) and Community Health Centers, as well as Family Medicine Teaching Clinics, operated in partnership with the University of Manitoba
- Quick Care Clinics: Walk-in nurse-managed clinics, operated in partnership with Manitoba Health
- Community development: Broad range of strategies focused on organizational capacity building, inter-sectorial networking and local area development
- Community Health Advisory Council and other public engagement activities
- Support services to seniors, which offers fifty community-based programs
- Language Access, with 70 interpreters, enabling service delivery in more than 100 languages, including local Indigenous languages
- Chronic Disease Collaborative, focused on inter-sectorial prevention, care, and management of chronic disease.

Significant accomplishments at WRHA have included the implementation of electronic medical records, which enable seamless communication across systems, increased inter-professional collaboration, and the Northern Connections Medical Clinic, which supports family medicine residents in northern Manitoba. Challenges for WRHA relate to the fact that Winnipeg is home to a relatively large and diverse population. Key challenges include the need for more timely access to services, access to specialty services, and, with the implementation of personal care networks, the need to enhance links between specialists and patients’ primary care home.
Additionally, WRHA recognizes that the most vulnerable and/or stressed sectors in the population are the least likely to have a primary care home.

First Nations and Inuit Health Branch (Dr. Pam Smith, FNIHB and Wendy Ducharme, FNIHB).

First Nations and Inuit Health Branch supports the delivery of public health and health promotion services on-reserve and in Inuit communities, provides drug, dental and ancillary health services to First Nations and Inuit people regardless of residence, and provides primary care services on-reserve in remote and isolated regions. In First Nations in the south of Manitoba, FNIHB supports promotion and prevention services delivered at health centres, with primary health care services typically accessed off-reserve through regional health authorities. In the north, FNIHB supported nursing stations are on-reserve community members’ main point of contact with the health system, with additional services available through partnerships with University Medicine and Nursing departments. The nursing-based model of collaborative care and inter-professional practice (including invaluable and typically non-credentialed community health workers) used in the north is now being implemented elsewhere.

The University of Manitoba:

Centre for Aboriginal Health Education (Dr. Barry Lavallee, Director).

The University of Manitoba’s Centre for Aboriginal Health Education (CAHE) provides supports to First Nations, Metis and Inuit students in health professional programs. While equitable primary health care services can help address some of the ongoing impacts of colonization and racism on the health and wellness of First Nations, Metis and Inuit peoples and communities, more change is needed. Dr. Lavallee noted that providing cultural competency training to providers will enhance their ability to provide culturally safe care, but it is also important that, as individuals, providers develop their own internal resources, and understand and work to undo the impacts that racism might have on the care they deliver.

Diffusion of Personal Health Information Services: Self-Determining and Empowering Practices for Manitoba Inuit (Dr. Alan Katz, Professor, Departments of Community Health Sciences and Family Medicine and Associate Director, Research, Manitoba Centre for Health Policy).

Dr. Katz’s entered his position with considerable knowledge about primary health care, but relatively little knowledge about First Nations, Metis and Inuit peoples. As he learns more, he has come to understand the link between First Nations, Metis and Inuit peoples’ wellness and the wellness of their communities, linked, in turn, to accountability and governance within those communities. First Nations, Metis and Inuit people in Manitoba access services in a system that
is fragmented, particularly with respect to jurisdictional responsibilities. Much of the discussion about primary care focuses on successes in urban centers, rather than in rural areas, where health outcomes are generally less positive, indicating a need for better PHC systems. Research, which generates new knowledge, can help create needed change, but equally valuable ‘old’ knowledge (traditional understandings of health and wellness) that can contribute to change can be found in First Nations, Metis and Inuit communities. A role for the University then is to learn from First Nations, Metis and Inuit peoples.

2.0 Current Realities in Primary Health Care:

The panel presentations in the afternoon focused on the current realities in primary health care delivery. They included several of the current models and issues, including those at the University of Manitoba through the Section of First Nations, Metis and Inuit Health J. A. Hildes Northern Medical Unit and the Family Medicine Residency Program, recruitment and retention issues from Manitoba Health and primary health care approaches at the Southern Regional Health Authority and the Northern Regional Health Authority. The presentations are summarized below:

The J.A. Hildes Northern Medical Unit: Current Realities in Primary Health Care  (Melanie MacKinnon, Senior Director, Programs & Administration, Section of First Nations, Metis and Inuit Health, Community Health Sciences).

The Northern Medical Unit (NMU) provides health care services to remote communities in northern Manitoba (family physician services, medical specialists, retinal screening, advanced foot care, and renal dialysis) and Nunavut (medical specialists and medical rehabilitation). NMU also provides services in education (student placements, residencies, and other services) and research (student research, collaborative research with internal and external partners, evaluations and organizational reviews, and patient-centered research). NMU’s vision affirms Indigenous self-determination and its mission statement includes a commitment to work collaboratively with First Nations, Metis and Inuit peoples, communities and leadership. NMU has set strategic goals that reiterate this commitment, and acknowledge the importance of valuing, respecting, engaging with, being accountable to, and supporting the capacity development of its community and government partners. Actions that NMU have taken to achieve these goals include the recruitment and retention of talented staff and health care providers, the provision of culturally safe programming and providers, engaging community in health planning and decision making, and developing and sustaining relationships with patients, providers, and partners. NMU’s relational network includes Indigenous and Northern partners (from patients through health managers and departments through leadership), federal, provincial and territorial government departments, faculty and university partners, and students, health providers and professionals. NMU brings a holistic approach to primary health care, emphasizing holistic wellbeing, recognizing that control over health lies with individuals,
families, communities and nations, focusing on health through equity and self-determination, developing culturally safe multidisciplinary teams that include traditional healers and community paraprofessionals, and drawing on inter-jurisdictional and multi-sectorial collaboration.

Challenges for NMU have included:

- The funding formula is 15 years old, and primary funding limited to physicians and medical specialists
- Required to redesign primary care model to improve access, but because multiple partners and community are involved in planning, this is a slow process
- Resources to support community engagement in health planning are limited
- Balancing relationships and autonomy of multiple partners
- Process of negotiating and signing formal agreements and funding instruments with communities
- Organizational change management as paradigm shifts and Indigenous behaviours, attitudes, and knowledge are included in care models.

Significant successes have included:

- Stabilization of programs and services
- Low vacancy rates for both physicians and overall staff, and successful recruitment of Indigenous leadership
- Renewed interest in NMU from communities, students, and health professionals
- Working toward renewed funding relationships with provincial and federal partners.

Next steps for NMU will involve organizational restructuring, development of an Inter-professional Primary Care Model, continued focused recruitment and retention activities, and quality assurance and improvement.

The Northern and Remote Family Medicine Residency Program (Dr. Joanna Lynch, Associate Program Director, Northern Remote Family Medicine Residency Program, University of Manitoba, and Medical Director, Northern Connection Medical Centre).

The goal of the University of Manitoba’s Northern and Remote Family Medicine Residency Program (NR) is to creatively and sustainably address the ongoing issue of medical human resource shortages throughout remote and northern regions of Manitoba. The program was developed through a partnership between Manitoba Health, the provincial government, the University, and WRHA, and has received funding support from Health Canada. The program features a first year family medicine completed at a clinic in Winnipeg’s inner city; majority of family medicine training completed in a northern setting in the second year; a Return of Service
(ROS) agreement with MB Health; and curriculum focused on the needs of northern populations. Although the program is relatively new, it is already having positive impacts:

- With respect to primary care provision in First Nation communities, bringing residents and other learners into community helps keep in-community practitioners up-to-date and reduces burnout for those practitioners. Additionally, the ROS component of the program infuses new graduates in communities, and can increase the stability of community medical teams and enhance continuity of care for patients.
- Residents are expected to engage in community and the program creates opportunities for community-based research. Research projects associated with the NR program include a current study on the use of Tele Health for inter-professional CPD rounds; repatriating birth to Norway House; patient surveys to assess their satisfaction with involvement with medical learners; and antibiotic use in children.

The program’s Winnipeg clinic, the Northern Connection Medical Centre (NCMC), focuses on services to displaced northern patients and their families in need of primary care. Services, which are provided by physicians who work part-time for the Northern Medical Unit, include admissions to SBGH and full obstetric service. NCMC staff also includes primary care nurses, a community liaison worker, and psychiatric, PT/OT, pharmacy, and dietary professionals. The Centre is helping to improve communication between home community and tertiary care institutions. For example, in the case of one elderly patient who, over a short period of time, had been repeatedly flown down from a northern community to SBGH ER, support from the program facilitated diagnosis and treatment of C. difficile, followed by a stay in a medical boarding home in Winnipeg while the family arranged thorough cleaning of his residence in his home community. Follow-up at NCMC led to additional diagnoses of TB and cancer, and the patient’s appropriate treatment of these conditions.

Recruitment and Retention – Current Realities and Emerging Opportunities  (Michele Matthae-Hunter, Director, Physician Resource Coordination Office, Health Workforce Strategies, Manitoba Health).

Historically, health workforce planning in Manitoba has occurred in silos (addressing issues by discipline, i.e., physicians, nursing, allied health, etc.) with pockets of connectivity. More recently, planning has refocused on support for team-based approaches to care and working to full scope of practice, and provincial solutions. The Physician Resource Coordination Office (PRCO) was established in 2005 as a one-stop shop to coordinate and facilitate physician resource planning. Its initial strategies focused on improving IMG assessment/training processes, repatriating Canadian physicians, and improving incentives and flexibility to meet short, medium and long-term need(s). More recent activities have focused on developing resources for rural and northern locations, and include the Northern Remote Family Medicine Residency program’s ROS incentives, as well as support for resettlement in northern locations,
and the use of Physician Assistants. The program supports Aboriginal Medical scholarships at the University, with recipients beginning return service as early as 2014.

Health Workforce Manitoba is a new approach to health human resources planning in the province. It brings together all stakeholders’ recruitment and retention efforts under a single umbrella, and enables the province to leverage opportunities for employers to connect with potential recruits and support the matching process. The province continues to seek input that can inform the strategy from a variety of tables. Current activities include direct engagement with family medicine, Physician Assistants (PAs), Nurse Practitioners (PNs), and midwives inside and outside the province, a re-launch of the Manitoba Locum Tenens Program, and development of a dashboard of workforce information to support planning. The province has also brought stakeholders (employers, educational bodies, regulatory bodies and others) together to explore a “deliberate approach” to northern health provider recruitment and retention, with the goal of taking tangible approaches to improve conditions that will promote recruitment and retention in that region. Health Workforce recognizes that there is no one-size-fits-all solution and welcomes input on what will work.

Southern Health: Initiatives to Impact Change for Individuals & Communities (Kathy McPhail, Chief Executive Officer, Southern Health-Santé Sud).

Southern Health, formed in 2012 with the merger of Regional Health Authority-Central (RHA Central) and South Eastman RHA, serves a region with a large Aboriginal population. Southern Health is building on two important strategies undertaken by the previous RHA’s: an Aboriginal workforce initiative, and activities to decrease cultural conflict experienced by First Nations and Métis people when accessing healthcare services.

Southern Health’s Aboriginal Support Worker Program (which began at RHA Central) focuses on adapting the health system to better meet the needs of Aboriginal people, modifying health system components that generate cultural conflict, and supporting First Nation and Métis people’s successful navigation in the health system, in order to access services that meet their self-defined needs. The Aboriginal Support Workers have addressed issues relating to cultural beliefs and cultural competency, linguistic barriers, degree of trust in the system, and jurisdictional responsibilities. Southern Health has also worked to enhance cultural diversity in healthcare by offering educational activities that give staff a better understanding of the impacts of historical experiences (such as residential school) on present-day realities for Aboriginal people. Southern Health also offers traditional healing practices to its clients.

Southern Health’s Aboriginal Human Resources Recruitment and Retention Strategy has been undertaken in partnership with the Aboriginal community, and includes a commitment to increase representation of Aboriginal people in all job classifications and levels so that the workforce will represent Southern Health’s client profile, regional labour force, and the population it serves. Southern Health works to increase youth awareness of opportunities in the
health care sector (through career pathing, mentorship, internships, and student employment and volunteer activities).

**Northern Health Region: Model for Primary Health Care (Rusty Beardy, Vice President, Aboriginal Services Northern Health Region and Jo-Anne Lutz, Director, Primary Care Clinics).**

The Northern Health Region is currently in the implementation phase of Primary Care Pathway (PCP) Project. The PCP objectives are to: attach each individual in the region to a Primary Care Home; support each individual to walk her/his health pathway, from prevention to self-management of chronic conditions; provide mechanisms for health providers to strategically manage and partner with the patient, work with Community Care Circles, and work together to monitor patient’s progress on their pathway; and measure and evaluate the effectiveness of PCP in improving health outcomes and health status. The Primary Care Home is defined as the place where a patient accesses primary health care services for coordination of services by the PHC team and support for self-management. The Primary Care Pathway (or network) supports a patient’s journey toward optimal health. The Primary Health Care Team is understood to include, at its core, the patient and their family, physicians, nurse practitioners, nurses and community health representatives, and radiates from there to include other supports for health and wellness (including specialists, public health activities, diagnostics, homecare, EMS, services delivered through Tribal Councils, and traditional healers), community support, and local and regional leadership and funders.

Key services of the PCP include patients’ automatic and active enrolment to a PCH, pathway referral and common care plan, and self-management. Leadership within the PCP plan is provided through partnerships within and between regional and community primary care circles, project leadership, and service delivery and implementation plan working groups. The plan is being rolled out in stages: in 2013, enrolment in a PCH, pathway referral and Pathway (Common) Care Plans will be rolled out in four test communities; in Year 2, another six communities will be added to the project, and the Self-Management Program will be introduced; in each of Years 3 and 4, an additional six new communities will join the project.

To date, strengths of the program have included collaboration with regional partners to develop and implement the PCP Plan, the identification of the four test communities, and completion of service mapping. Challenges encountered to date have related to geography and jurisdictional issues, particularly with respect to sharing service and other information, working together as partners, maximizing all service partners for service delivery, and managing referrals.
3.0 Observations from participants:

After each panel, participants were invited to respond to the presentations. Key comments and observations included:

- Indigenous knowledge about health and wellness is valuable. If we want to access it, it will not be enough to try to ‘fit’ community into our structures. We need to find ways to work with Elders, healers, and other community people who support health and wellness. Some First Nations have established Community Health Plans that are highly integrated and enable connection with these people.
- The planning and delivery of health services are driven primarily by funding, but currently available funding is not adequate to meet the distinct and unusual needs of First Nations, Metis and Inuit people.
  - We need to assess whether we are using existing resources effectively and efficiently, examine how we measure results, determine whether we are as productive as we could be, and look for opportunities to do things differently.
  - To ensure that we put our investments where they are needed, we need to be able to make the argument for doing that. Developing indicators and data to show this is a good use of resources.
  - In Manitoba, we use a lot of money (approximately $100 million) for medical transportation. That in itself is a strong argument for the development of different approaches.
- We are the system. If we deny someone access to services because of jurisdictional issues, we are participating in systemic racism. It is difficult to define systemic racism, but its impacts are around us. High rates of poverty in Indigenous communities do not exist because Indigenous people are ‘deficient’ – they are a result of systematized inequality and systemic racism. If we want to change health outcomes, we must address systemic racism and other ‘upstream’ issues.
- Bureaucratic systems can be a toxic environment. There’s a disconnect between the ‘good spirits’ working in these systems, who are often frustrated by systemic racism and other toxic aspects of these systems.
Knowledge Cafés

Knowledge Cafés are a process that provides small groups with a process for open and creative conversation on a selected topic, through which they can build collective knowledge, share ideas and insights, and foster a deeper understanding of the subjects or topics they are discussing. At the planning session, a Knowledge Café followed each of the panel presentations. Each Knowledge Café featured three work stations, each exploring a specific question related to the topic being explored in the café. Panel presenters with expertise in the topic were present at each station, along with a facilitator to support and guide the group discussion. Participants organized into three equally sized groups that each began the activity at a different work station. The groups were allowed fifteen minutes to discuss and respond to the question presented at that station, and then moved to the next station. Over a 45 minute period, each group was able to visit each station and contribute to and refine the collective knowledge gathered in response to the question posed at the station. At the end of the Knowledge Café, participants reassembled as a large group, and a representative from each station provided a brief report on what had been learned at each station.

A summary of the collective knowledge gathered at each station is presented below.

1.0 Understanding the Current Primary Health Care Model in Manitoba

In the three stations set up for the first knowledge café, participants explored the current primary health care model in Manitoba. The questions associated with each station are presented below, followed by a summary of the collective knowledge developed at the station.

1.1 Key components for the development and delivery of PHC in First Nations, Metis and Inuit communities

Participants were asked to consider:

What are the key components in the successful development and delivery of equitable and effective primary health care models in First Nations, Metis and Inuit communities?

Key Statements:

1. Use community-driven methods and participatory approaches to identify and successfully implement authentic community engagement, including the development of feedback mechanisms that inform practitioners, researchers, policy makers, and community leadership.
   • Ask communities what they need and how you can meet that need, then work in ways that are consistent with what you have learned
   • Value the time needed to build relationships
• Identify new models for how we can gather information from communities.
• Identify community champions
• Train K-12 educators about public health as a way to increase community engagement

2. Implement a fundamental shift in philosophical principles at the university itself (involving both medical faculties and other social science disciplines) to ensure that cultural safety is embedded in both policy and curriculum.
• Integrate practice, teaching and policy to meet the needs of equitable health care delivery models. The framework from which we teach should meet the needs of the communities
• Build capacity within faculty by shifting thinking, and emphasizing cultural safety as a goal of faculty development activities
• Cultural safety should be seen as a means to address power disparities that exist between patient and provider
• Need to think beyond medicine, and, in our education of health professionals, shift the focus from treating disease to keeping people well.

3. Recognize Indigenous health providers (including traditional healers) as a vital component of the primary health care ecology, support a reciprocal relationship between stakeholders, and turn the existing hierarchy with the health system to place the patient at the top of the model.
• Recognize Indigenous ways of understanding, caring for and practicing health, wellness.
  o Support the recognition of traditional medicine and knowledge within health care models and practices
  o Respect clients’ beliefs and trust that they will help support wellness

Observations:

We need to understand the diversity that exists between and within First Nations, Metis and Inuit peoples.

1.2 Relationships and partnerships to support equitable and effective PHC models

Participants were asked to consider:

In Manitoba, are there any existing or potential relationships or partnerships that can help support equitable and effective primary health care models in First Nations, Metis and Inuit communities?

Key Statements:

1. Engage, build relationships, and partner with First Nations, Metis and Inuit communities as early as possible in the process of planning new primary health care models and improving services and access for community members
• Formalize mechanism to talk to patients families and communities
• Ask how we can work together to improve the delivery of health care services
• Acknowledge distinct needs of First Nations, Metis and Inuit communities
• Work with communities to map services
• Help lead activities that will empower the community, e.g. sports activities
• Undertake pipeline work to develop future health care learners: connect youth in communities with representatives of University programs; allocate funding for First Nations, Metis and Inuit learners
• Strengthen collaborative interdisciplinary learning in communities. Create opportunities for learners (from health disciplines and from other disciplines, such as agriculture, social work, kinesiology, sports, education, etc.) to spend more time in First Nations, Metis and Inuit communities

2. Engage, build relationships, and partner with other stakeholders for joint planning
• Focus on getting right people (e.g., provincial and federal governments, AMC, MMF, RHAs, primary health care providers, specialist health care providers) into room at right time
• Ask how we can work together to improve the delivery of health care services
• Form a group or association (with First Nations, Metis and Inuit representation) that can undertake joint planning and coordinate services; ensure that services are not duplicated but enhanced
• Explore opportunities to contribute (e.g., research) to Intergovernmental Committee on First Nations Health
• Expand use of video conferencing and e-networks to connect with key partners and stakeholders
• Look to successful PCH models, e.g., model developed by NW Ontario University

Observations:

Personal relationships are very important

• Important asset when negotiating jurisdictional issues and bureaucratic challenges
• Supports the process of building trust in communities or with other stakeholders

1.3 Actions to increase awareness and understanding of best practices and research to support models

Participants were asked to consider:

What actions can the University take to increase awareness and understanding of best practices and other information or findings that may contribute to the development of equitable and effective primary health care models in First Nations, Metis and Inuit communities?
Key Statements:

1. Knowledge is a two-way street. The University needs to become a better receiver of Indigenous knowledge, so that it can become more literate (at emotional, spiritual, physical and mental levels) about Indigenous knowledge and ways of being
   - Knowledge is exchange. We need to learn from the successes that Indigenous people and communities have had in supporting wellness. Indigenous peoples have long drawn on knowledge (much of it shared through oral traditions) that kept us healthy. How can the University help us access this knowledge?
   - Indigenous learners can be sources of new knowledge for the University
   - Look to successful models in Indigenous communities, such as those developed through the US Department of Health and Human Services’ NUCA program
   - The University should take responsibility to increase the cultural competency of society as a whole, and to help people undo their ‘unlearning’ about Indigenous peoples.

2. Focus on building and strengthening trust and relationships with communities
   - A sustainable primary health care model for First Nations, Metis and Inuit communities will put the needs and wellbeing of communities ahead of those of university and government.
   - The community has been missing from the process of developing a sustainable PHC model
   - Increase Indigenous peoples’ participation in the health workforce, highlighting the gifts within First Nations, Metis and Inuit communities, with a strong focus on practical and useful knowledge.

3. Improve education and training of primary care providers
   - Address attitudes of physicians and other health care providers so that they are more capable of accommodating what community members need
   - Advance person-centered care
   - Work together rather than in silos. Strengthen professionals’ skills and capacity for communication and shared services, and use technology to facilitate linkages within the PHC system.
   - More inter-professional education
   - The broad scope of nursing should be a model for all practice.

4. Our definition of primary health care services should be more comprehensive, address the determinants of health, and encompass all that impacts health and healing for Indigenous peoples
   - Need to be contextualized by the real-life needs, understandings and ways of First Nations, Metis and Inuit peoples
   - Narrative medicine might be one tool that can help improve PHC
   - Explore courageously and ask ourselves who benefits from our current focus on acute care.
2.0 The University’s Role in an Equitable and Effective PHC Care System

In the second Knowledge Café, participants explored the University’s role in an equitable and effective primary health care system for First Nations, Metis and Inuit communities. The questions associated with each station are presented below, followed by a summary of the collective knowledge developed at the station.

2.1 University’s role and actions to support development and delivery of equitable and effective PHC

Participants were asked to consider:

What role can the university play or what actions can it take to support collaboration with stakeholders in the development and delivery of equitable and effective primary health care services in First Nations, Metis and Inuit communities?

Key Statements:

1. The University can act as a catalyst to bring together stakeholders in order to facilitate dialogue.
   • Establish a community working group to facilitate community involvement to bring first hand needs to the conversations that take place
   • Knowledge sharing:
     o Use Tele Health connections to facilitate knowledge sharing with broad audiences

2. Broaden the definition of primary health care to include health protection and promotion as a way to support increased collaboration across disciplines, including both health disciplines and other helping professions (such as nutrition, kinesiology, dentistry, physical education, etc.).
   • Champion the concept of health promotion as a means to support increased collaboration
   • Engage foundations to support health promotion initiatives

3. Have systems in place that will enable increased collaboration between knowledge holders (such as the Northern Medical Unit, regional health authorities, Amdocs, and others) on the use of Tele Health and other new service delivery methods in the provision of primary health care.
   • Incorporate Tele Health further into curriculum, to encourage use by all health stakeholders
   • Use Tele Health more widely as an alternative to delivering care through conventional medical encounters
**Observations:**

What is the university prepared to do to increase collaborative partnerships with first responders and others within the circle of primary care?

The university should increase use of technology to attract and interest students in health careers in the communities they serve.

**2.2 University’s role and actions to address learning needs of health care professionals**

Participants were asked to consider:

What role can the university play or what actions can it take to support identification of health care professionals’ learning needs (with respect to the delivery of equitable and effective primary health care services for First Nations, Metis and Inuit people), and the development and delivery of education and training that addresses those needs?

**Key Statements:**

1. Currently, there are no processes in place at the University to identify (and then prioritize) learning needs.
2. University needs to gather input on learning needs from:
   - **Patients**
     - Patient satisfaction surveys that gather both qualitative (including patient stories) and quantitative information
   - **Communities**
     - Ask community what their needs are; identifying a community that will buy-in to a pilot project will help generate interest in other communities
   - **RHAs**
     - RHAs can help University understand learning needs associated with the everyday professional lives of practitioners. For example, practitioners should be prepared to deal with racism in ways that protect well-being of the patient, the practitioner, and the organization.
3. Key areas for practitioners’ learning needs include:
   - Cultural awareness, cultural competency, and cultural safety: This should be a component of mandatory curriculum for all health professionals working in Canada. A spectrum of training in this area should be available continuously to health professionals. Mandatory training should include training that will equip participants to recognize and understand micro-aggression, and to recognize any biases they might have, and understand the impacts these may have on their experiences with Aboriginal peoples.
• First Nations, Metis and Inuit peoples: Practitioners need to learn about and understand the general history (including treaties, and Indian Residential School experiences) and its impacts on present day experiences of First Nations, Metis and Inuit peoples.
• Critical thinking and self-awareness, to enable practitioners to understand/unpack issues like ‘othering’ and the need for equitable services for people regardless of their race, culture, sex, gender identity, sexual identity, or class.

4. Use technology such as Tele Health and other virtual media to expand opportunities for learning and teaching.
5. Information Sharing:
   a. To draw on networks to identify teaching/learning opportunities, e.g., expand email contact lists to gather and share information about conferences, events or innovations
   b. To expand access to libraries and other facilities

2.3 University’s role and actions to champion inter-professional education models

Participants were asked to consider:

What role can the university play or what actions can it take to support and champion inter-professional education models?

Key Statements:

1. Prioritize it and set it as an expectation
   • Identify and share ways in which it can be a valuable model
     o Shared responsibility for care, where appropriate
     o When the number of available physicians is limited, other professional can assume an enhanced role
     o Identify champions
   • Develop goals and objectives for inter-professional practice
     o Consult with people who have experience with inter-professional models, representatives of multiple disciplines, and with communities we serve
   • Introduce an integrated systems approach and allied professional training to education:
     o If inter-professional education begins early, it can change practice
     o Take advantage of changes to curriculum. For example, the development of the Health Sciences cluster and new Student Health Services opens new opportunities for students to do practicums and work in a multi-disciplinary environment.
     o Group learning (beginning in undergraduate studies and throughout programs) on shared competencies, such as cultural sensitivity in patient interviewing and other aspects of cultural competency and safety, ethics and values clarification, and statistics. These areas could be taught by interdisciplinary teams
2. Address the hidden curriculum in Faculty of Medicine and other health professional programs:
   - Does the culture of the Faculty of Medicine and other disciplines affirm and support respect, integrity, and other values that support inter-professional education?
   - The structure of medical education programs is restrictive
   - The culture can be brutal – encourages students to work hard and not treat people well
   - Students are vulnerable because their careers depend on the system
   - As professionals, that is the culture we ‘grew up’ in. We often emerge as independent, high achieving professionals who are territorial about our turf.

Additional observations:

What are the objectives of interdisciplinary teaching and learning? Why would the university be interested?

   - Help practitioners understand each other’s scope of practice
   - Shared competencies across practices
   - Resource scarcity (making the most of available resources)
   - Are there other reasons? Do inter-professional education models improve health outcomes? That is where the focus should be
   - If we put resources into inter-professional education, must make sure that it is making a difference – not just in terms of financial outcomes, but in terms of outcomes that relate to the quality of the care experience and quality of life.

Additional observations:

The term ‘inter-professional’ is exclusionary, i.e., implicitly, it excludes family, community, and other key players in health.
Conclusions:

The planning session was well attended and participants were eager to enter in to a dialogue on primary health care in First Nations, Metis and Inuit communities.

In identifying the key components of an equitable and effective primary health care model, participants indicated that participatory approaches and community driven methods were most likely to achieve success and would need to be a holistic approach that included looking at the broader determinants of health and leadership in those systems to collaborate on development of an effective model. Taking time to build relationships with communities and with other stakeholders was considered vital. Knowledge sharing as a two way process would support the development of trusting relationships, improve education and training of health care providers and build a more comprehensive definition of primary health care for communities.

The University could function as a catalyst in bringing stakeholders together and could support and engage in increased collaboration between knowledge holders and service delivery models the University could also participant in supporting the delivery to training and education that meets the learning needs of health care practitioners specific to First Nations, Metis and Inuit health as well as in the area of cultural safety and cultural competency. Inter-professional education is a valuable education model and would support the primary health care needs and could incorporate cultural competency training. Understanding scope of practice and the need to focus on patient centered care is a positive outcome of primary health care and collaborative practice.
Next Steps

As noted by Dr. Catherine Cook (Associate Dean, First Nations, Metis and Inuit Health), the planning session provided an opportunity to share perspectives on the role of the Faculty of Medicine in Primary Health Care in First Nations, Metis and Inuit Communities. The anticipated outcome from the planning session was to produce a document that the Faculty will draw on as they consider new models for primary health care.
References


Appendix A: A definition and overview of Primary Health Care

The following definition and overview of Primary Health Care is derived as an excerpt from Wikipedia and summarizes the key decisions, goals and principles of a Primary Health Care approach.


Primary Health Care is defined as: “essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community. It is through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination”.

PHC is an approach to health beyond the traditional health care system that focuses on health equity-producing social policy. PHC includes all areas that play a role in health, such as access to health services, environment and lifestyle.

This ideal model of health care was adopted in the declaration of the International Conference on Primary Health Care held in Alma Ata, Kazakhstan in 1978 (known as the “Alma Ata Declaration”), and became a core concept of the World Health Organization’s goal of Health for all. The Alma-Ata Conference mobilized a “Primary Health Care movement” of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook to tackle the “politically, socially and economically unacceptable” health inequalities in all countries.

The ultimate goal of primary health care is better health for all. The WHO has identified five key elements to achieving that goal:

- Reducing exclusion and social disparities in health (universal coverage reforms);
- Organizing health services around people’s needs and expectations (service delivery reforms);
- Integrating health into all sectors (public policy reforms);
- Pursuing collaborative models of policy dialogue (leadership reforms); and
- Increasing stakeholder participation.

Behind these elements lies a series of basic principles identified in the Alma Ata Declaration that should be formulated in national policies in order to launch and sustain PHC as part of a comprehensive health system and in coordination with other sectors.

- Equitable distribution of health care – according to this principle, primary care and other services to meet the main health problems in a community must be provided equally to all individuals irrespective of their gender, age, caste, color, urban/rural location and social class.
• Community participation – in order to make the fullest use of local, national and other available resources. Community participation was considered sustainable due to its grass roots nature and emphasis on self-sufficiency, as opposed to targeted (or vertical) approaches dependant on international development assistance.

• Health workforce development – comprehensive health care relies on adequate number and distribution of trained physicians, nurses, allied health professionals, community health workers and others working as a health care and supported at the local and referral levels.

• Use of appropriate technology – medical technology should be provided that is accessible, affordable, feasible and culturally acceptable to the community. Examples of appropriate technology include refrigerators for vaccine cold storage. Less appropriate could include, in many settings, body scanners or heart-lung machines, which benefit only a small minority concentrated in urban areas. They are generally not accessible to the poor, but draw a large share of resources.

• Multi-sectional approach – recognition that health cannot be improved by intervention within just the formal health sector; other sectors are equally important in promoting the health and self-reliance of communities. These sectors include, at least: agriculture (food security); education; communication (concerning prevailing health problems and the methods of preventing and controlling them); housing; public works (ensuring an adequate supply of safe water and basic sanitation); rural development; industry; community organizations (including local governments, voluntary organizations, etc.)

In sum, PHC recognizes that health care is not a short-lived intervention, but an ongoing process of improving people’s lives and alleviating the underlying socioeconomic conditions that contribute to poor health. The principles link health and development, advocating political interventions, rather than passive acceptance of economic conditions.