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Welcome

Welcome Message!

Welcome to the Winnipeg Regional Health Authority (WRHA) and Primary Health Care Program. As a primary care provider, you are an important part of a multidisciplinary primary care team whose aim is to deliver services to clients to improve their health and the health of their families. The program is also committed to supporting healthy communities and meaningful engagement of patients and the public.

You are important to the process of delivering integrated community-based services, and we look forward to having you on our team.

Contact the WRHA Primary Health Care Program

This orientation manual is designed to provide you with key information on the principles and objectives of the WRHA Primary Health Care Program. It is also a practical guide that points new providers to resources that are commonly used by team members.

If you require further information about the Program, please contact Kevin Mozdzen, Primary Health Care Program Specialist at kmozdzen@wrha.mb.ca.

WRHA Information

The WRHA internet site www.wrha.mb.ca is a public source of information. Valuable information on this site includes (but not limited to):

- Healing our Health System
- About the Region
- Hospital & Facilities
- Community Health
- Long Term Care
- Programs
- Indigenous Health
- Quality & Patient Safety
- Research
- Health Information

The Internet site also helps link users to health information for the public and staff through an online database called 211 Manitoba. 211 Manitoba is a searchable online database of government, health, and social services that are available across the province. The service helps Manitobans who are looking to find the right community or social resource but don’t know where to start. 211 Manitoba also makes it easy for service providers and first responders to direct others to the right resource. Services are grouped together into
categories that include food and clothing, housing and homelessness, health, mental health, employment, newcomers, children and parenting, and youth.

Detailed information about the WRHA and its corporate and human resources policies is also available through the WRHA Intranet site which is accessible only through workplace computer terminals. The Intranet site (often referred to as INSITE) contains information and forms from Departments, such as Human Resources, Finance and Community Programs. Some of the most up-to-date information is on the Intranet, so it is the best place to start if you are searching for background information, paid hour adjustment forms, or information on employment opportunities.

Members of the Primary Care Team will also find the Intranet a useful source in the day-to-day operations of the clinic. The Intranet pharmacy link offers pharmaceutical information through the WRHA Formulary as well as the Micromedex Drug Index. The Intranet also supplies a link to the Library Services from the University of Manitoba. The Primary Health Care Program maintains a listing of current Operating Guidelines, Practice Guidelines and other resources for reference by staff as required.
Launched in June 2018, a new integrated service brought together Palliative, Primary Health Care and Home Care models of service to offer coordinated clinical and service-level planning and delivery. This integration has been implemented in several jurisdictions in Canada with a vision to build a person-centred supportive health network around a person’s attachment to their Primary Care Home Clinic.

Through a common leadership/administrative structure, the integrated model strives to better meet the needs of patients/clients through coordinated clinical and service-level planning and delivery and to complement existing primary care models in the WRHA.

As the needs of each of our patient/client populations shifts and people continue to age in place in their homes and communities, this care provision model will continue to support those individuals in remaining at home for as long as independently possible. The goals of the integrated service include offering:

- Seamless and coordinated services offered between Home Care and Home Clinics.
- Efficient and effective client transitions across the care continuum.
- Enhanced collaboration between care providers from different areas of the health system enabling joint care planning and decision making.
- Overall improved responsiveness and collaboration of the integrated team which will improve client and provider satisfaction.

For the purpose of this orientation, content will focus on the Primary Health Care portion of our integrated service.

Definition of Health

The Winnipeg Regional Health Authority uses the World Health Organization (1948) definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization).

Principles of Primary Health Care

Although the name of the program team reflects key service elements, it functions based on the principles of Primary Health Care.

- Primary health care is integrated and inter-sectoral.
- Primary health care emphasizes health promotion.
- Primary health care views the individual as a whole being.
- Primary health care addresses the main health problems within a community from the community perspective.
• Primary health care relies on a diversity of trained workers functioning as an interprofessional team.

### Primary Health Care Program Overview

The Primary Health Care Program is currently comprised of:

- **Community Primary Care:**
  - WRHA Primary Care Direct Operated Clinics (9)
  - Funded Community Health Agencies – Type-1 (13)

- **Community Development:**
  - Community Facilitators (12)
  - Healthy Aging Resource Teams (3)
  - Volunteer Services (Corporate and Community)

- **Centralized and Regional Programs/Services:**
  - Antenatal Home Care Program
  - Midwifery Services

- **Regional Primary Care Renewal:**
  - My Health Teams (6)
  - Interprofessional Team Demonstration Initiative (ITDI) (25 Clinicians)
  - Family Doctor Finder
  - Walk-In Connected Care Clinics (5)

### The Organization of the Primary Health Care Program

Primary Health Care is comprised of programs and services that cross the system and sectors including Community and Regional. These programs and services will now be described immediately below in detail.

### Regional Program

The Regional Program Team, with primary care offices located on 5th floor, 496 Hargrave Street consists of members who each hold key responsibilities for setting strategic directions of the Program and carrying out the primary health care vision and objectives of the WRHA within Primary Care. The staff provides support to the Program Team.

The Primary Health Care Program Team provides leadership and expertise in a number of areas such as strategic planning; quality and evaluation; information management; and medical and clinical practice issues. The Program team is consistently active in four major areas:

1. **Program Specific Regional Strategic Planning:** The Program Team plays a key role in developing strategic plans, operational plans, human resource planning, financial management of Program and in coordinating research initiatives.
2. **Program Specific Quality**: The Program team provides leadership and expertise in quality improvement and program evaluation.

3. **Program Specific Information Management and data analysis**: The Program team provides leadership in developing information management plans, collecting data, monitoring and analyzing, and report writing.

4. **Program Specific Practice Standards and Support**: The Program team provides clinical leadership and resource to sites and staff, and facilitates the implementation of standards and guidelines across the sites.

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**WRHA Primary Care Direct Operated Clinics**

Each WRHA Primary Care Direct Operated Clinic provides comprehensive and continuous care, which address physical, psychological, and social factors. Services are provided by an interdisciplinary team, which may include Physicians, Nurse Practitioners, Physician Assistants, Nurses, Midwives, Dietitians, Outreach Workers and Mental Health Shared Care Counselors.

In addition to providing primary care, Physicians and other health care professionals work as a team in the supervision and education of resident physicians from Canadian or foreign medical schools who are training to become family physicians. As a teaching facility, each clinic is associated with the Rady Faculty of Health Sciences at the University of Manitoba. Residents have an opportunity and responsibility to:

- Participate in delivery of the full range of health services to patients
- Be involved in health promotion, health monitoring, acute and chronic problem management and rehabilitation through regularly scheduled clinical time
- Work closely with an assigned preceptor as well as with other health care professionals in providing patient care

The WRHA is responsible for primary care clinics located within the following Service Delivery Sites:

- Access River East
- Access Transcona
- Access Downtown; also includes:
  - BridgeCare Clinic
  - Northern Connection Medical Centre
- Access Winnipeg West
- Access Fort Garry
- Aikins Community Health Centre
- Kildonan Medical Centre
While the WRHA Primary Care Program is responsible for a large number of clinics and projects, more than 80% of family medical clinics in the city do not come under WRHA jurisdiction; this emphasizes the need for WRHA partnership with fee for service physicians.

Regarding access/intake to WRHA Primary Care services, persons who reside in the community area within which the Service Delivery Site is located are eligible to use the primary care services provided in that community area. Eligibility and appropriate community area is usually determined by the first three digits of the client’s postal code. Access is further outlined in the Primary Care Operating Guideline #1 titled, Patient Access and Transfers. New clients are accepted as capacity permits.

At their first encounter, clients typically meet with the Primary Care Nurse for an intake appointment, and are orientated to the appropriate site and program. The client is then connected to the most appropriate team member or resource. Clients are generally connected with one Primary Care provider (usually a Physician or Nurse Practitioner) but over the course of their care, they may receive care from other members of the Primary Care team.

**Access River East**  (975 Henderson Highway)

Access River East provides a single point of access to primary health care and social services for citizens of the River East community area including parts of East St Paul. The clinic provides a range of services including Primary Care, Elmwood Teen Clinic, Midwifery, Pediatric Speech & Language Therapy, Audiology, Dietary, Diabetic Education, Psychiatry and Shared Care Mental Health.

The Primary Care Clinic consists of an interdisciplinary team made up of Physicians, Nurse Practitioners, Primary Care Nurses, Primary Care Assistants, Shared Care Counselor, Dietitian, Speech Language Pathologist, Audiologist, Laboratory Technologist and Midwives.

**Access Transcona**  (845 Regent Avenue West)

Access Transcona provides a single point of access to primary health care and social services for citizens of the Transcona community area. The clinic provides a range of services including Primary Care, Respiratory Spirometry, Dietary, Diabetic Education, Psychiatry and Shared Care Mental Health.

The Primary Care Clinic consists of an interdisciplinary team made up of Physicians, Nurse Practitioners, Primary Care Nurses, Primary Care Assistants, Dietitian, Shared Care Counselor and Speech Language Pathologist.

**Access Downtown**  (640 Main Street)

Access Downtown, situated in the heart of downtown, serves a population that experiences
more barriers in accessing health and social services and has poorer overall health and social outcomes than their counterparts other parts of Winnipeg. There is a high concentration of new Immigrants, literacy levels and work force participation rate are among the lowest in the region.

Primary Care services consists of an interdisciplinary team of Physicians, Nurse Practitioners, Primary Care Nurses, Community Health Worker, Social Worker, Dietitian, Shared Care Counselor, Speech Language Pathologist, Lab Technician and Primary Care Assistants. In addition to Primary Care they provide Nutrition Education, Counseling, Shared Care Mental Health, Sexual Health Education, Tuberculosis Clinic, Midwifery, Dental Services (with U of M) and Community Health Workers who assist in linking its clients to alternate agencies and services in the area.

Other clinics and services managed by Access Downtown include:

- **BridgeCare Clinic (425 Elgin Avenue)** provides a single point of access to primary care services for newly arrived immigrants and refugees. The Clinic also provides assistance in linking these individuals to other resources as required. The care team includes Physicians, Nurse Practitioner, Primary Care Nurse, Lab Technician and Primary Care Assistants.

- **Northern Connection Medical Centre (425 Elgin Avenue)** provides primary care and other medical services for northern and remote residents who are temporarily in Winnipeg, while at the same time helping train medical residents to become family physicians who will work in northern and remote locations. In addition, the centre also serves as the home base for some of the Winnipeg Health Region physicians who work with the University of Manitoba's Northern Medical Unit flying into northern communities to provide care. The care team includes Physicians, Primary Care Nurses, Shared Care Counselor, Dietitian, Pharmacist, Lab Technician, Social Worker, Occupational Therapist, Physiotherapist and Primary Care Assistants.

- **Health Services on Elgin (425 Elgin Avenue)** provides support from Nursing, Rehabilitation Services, Nutrition Counseling, Social Support/Relief and Hygiene Support. Its role is to assist older adults in the inner city area, who are identified as 'A Risk', to cope with their infirmities and environment thus improving/attaining quality of life, preventing acute admissions where possible and preventing or deferring institutionalization in long term care facilities. Health Services on Elgin also works towards increasing health awareness and assists to access existent health and social resources and services.

**Aikins Community Health Centre**  (601 Aikins Street)

Aikins Community Health Centre provides primary care services to citizens living in the Point Douglas community area. It serves a population which fares worse for most health outcomes and health determinants for the Winnipeg Health Region. In general, lower levels of socio-economic status, social support and social environments result in a
population with below average health status.

The primary care team at Aikins is comprised of Physicians, Nurse Practitioner, Physician Assistant, Primary Care Nurses, Shared Care Counselor and Primary Care Assistants.

**Access Winnipeg West**  (280 Booth Drive)

Access Winnipeg West (AWW) provides a single point of access to health and social services for citizens of the St. James – Assiniboia and Assiniboine South community areas. It is located on the same campus as Grace Hospital and efforts of both sites are integrated under the Winnipeg West Integrated Health and Social Services leadership structure.

AWW includes a Primary Care Clinic with services offered by an interdisciplinary team that includes Physicians, Nurse Practitioners, Nurses, Midwives, Pharmacist, Dietitian, Shared Care Counselor, Occupational Therapy, Physiotherapy and Psychology.

AWW also operates a Walk-In Connected Care Clinic (WICC) staffed by Nurse Practitioners and Nurses. WICCs are open to the public and designed to meet unexpected primary health care needs thereby addressing unnecessary visits to the emergency room. WICCs promote and support continuity of care by linking with primary care providers and assisting in finding a provider through Family Doctor Finder when a patient doesn’t have a primary care home.

Other programs at AWW include: Public Health Services; Mental Health Services; PACT Team; Child and Adult Speech Language Pathology; Audiology; Employment and Income and Assistance Services; Employment support for people with Disabilities and MarketAbilities program; Children’s and Community Living Disability Services; Child and Family Services; and Home Care Services. The access centre also includes a new early learning and child care service child-care centre with 80 spaces.

**Access Fort Garry**   (135 Plaza Drive)

Access Fort Garry (AFG) provides a single point of access to health and social services for citizens of the Fort Garry community area. AFG is integrated with the River Heights community area along with the Victoria Hospital under the South Winnipeg Integrated Health and Social Services leadership structure.

AFG includes a Primary Care Clinic with services offered by an interdisciplinary team that includes Physicians, Nurse Practitioners, Physician Assistants, Nurses, a Pharmacist, a Dietitian, Shared Care Counselor, a Psychologist and Psychiatrists.

AFG also operates a Walk-In Connected Care Clinic (WICC) staffed by Nurse Practitioners and Nurses. WICCs are open to the public and designed to meet unexpected primary health care needs thereby addressing unnecessary visits to the emergency room. WICCs promote and support continuity of care by linking with primary care providers and assisting in finding a provider through Family Doctor Finder when a patient doesn’t have a primary care home.
care home.

Other programs at AFG include: Winnipeg Child and Family Services, Children’s disABILITY Services, Community Living disABILITY Services, Community Mental Health, Employment and Income Assistance, marketAbilities, Home Care, Home Care Nursing, Population and Public Health, Pediatric Speech Language Pathology, Audiology and Community Living Psychiatry Services. Community partners at AFG include: Family Dynamics - Neighborhood Immigrant Settlement Worker, Fort Garry Senior Resource Council, South Winnipeg Family Information Centre and St. Norbert/Fort Garry Healthy Child Coalition.

**Kildonan Medical Centre** (2300 McPhillips Street)

Kildonan Medical Centre (linked with Seven Oaks General Hospital) provides comprehensive primary care, while serving as a training site for Family Medicine residents, medical students, and students from a variety of health care disciplines. Care is provided under the supervision of physicians and other health care providers who hold faculty appointments with the University of Manitoba. Services include obstetrical care, well-baby and well-child care, shared mental health care, chronic disease management, and skin and wound care. Both clinics provide inpatient care to their patients ensuring excellent continuity of care. The clinics operate under a unique governance model where decision-making is shared between the hospitals with which these clinics are associated, the University of Manitoba, and the WRHA.

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**Funded Community Health Agencies**

Many community services are also provided by community governed organizations funded through the WRHA. Funds are provided via Service Purchase Agreements whereby financial accountability and performance deliverables are negotiated by relevant program teams to ensure regional consistency and quality. In this case, the community program is responsible for the development and management of these agreements.

**Aboriginal Health and Wellness Centre of Winnipeg** (215 – 181 Higgins Street)

The mandate of the Aboriginal Health and Wellness Centre of Winnipeg is to provide primary care, social and cultural support programs to the urban Aboriginal community that will enhance their overall health and well-being. All programs are based upon traditional values and perspectives, where services and programs provided are a part of a continuum of resources made available to identify and support the aspirations, needs and goals of individuals, families, and community through access to both Traditional and non-Traditional (Western) resources.

Current Primary Care services include episodic diagnosis of acute illness/exacerbations; screening and prevention; chronic disease management; primary health care for those with addictions; diabetes care; sexually transmitted blood borne infections; immunizations; reproductive & sexual health; an onsite lab; student-learning opportunities; and a cultural
advisor/elder.

For further information visit www.ahwc.ca

**Centre de santé Saint Boniface**  (170 Goulet Street)

The mission of Centre de Santé is to offer primary health services and programs to the Winnipeg francophone population with accessibility to the Anglophone population residing in the Saint-Boniface community. While services are offered in both official languages, Centre de Sante’s work environment is French.

Centre de Santé also operates a Walk-In Connected Care Clinic (WICC) staffed by Nurse Practitioners and Nurses. WICCs are open to the public and designed to meet unexpected primary health care needs thereby addressing unnecessary visits to the emergency room. WICCs promote and support continuity of care by linking with primary care providers and assisting in finding a provider through Family Doctor Finder when a patient doesn’t have a primary care home.

The Centre is a “one-stop” community health centre where you can access a wide range of health services through an interdisciplinary team: primary care clinic, preventive health care, mental health services, nutritional consultation, counseling/advocacy, health education, and community development.

For further information visit www.centredesante.mb.ca

**Hope Centre Health Care**  (240 Powers Street)

Hope Centre provides comprehensive, continuous, and episodic care which addresses the physical, emotional, spiritual, and social factors of its patients. An interdisciplinary team of professionals provides services by offering the following:

- Family medicine for all ages, pregnancy test, prenatal and postnatal care, STD, HIV/AIDS testing, diabetes management and education including foot care
- Other services, which are direct client operations, include counseling families, couples, and individual clients, which include a wide variety of issues such as, family violence, sexual abuse, depression & anxiety, marriage and family conflict, alcohol/drug dependency
- Also provided to clients, are a number of programs that include community development. Support groups include: craft, gardening, easy moves exercises, diabetes cooking, healthy eating, diabetes educational session, children’s program, healthy start mom & me, and support groups as needed for both men and women

**Klinic Community Health Centre**  (870 Portage Avenue)

Klinic provides comprehensive community health services to assist with medical, social and emotional needs. Primary Health Care services are offered to our geographic population and populations of need. The services are provided by Physicians, Nurse
Practitioners, Nurses, Social Workers, Dietitians, Laboratory Technologists and others. Klinic will help clients make choices about their health and address the needs of the individual.

Services include the following: Primary Health Care Clinic (includes Chronic Disease Management, Primary Care for individuals with substance abuse, refugee health, HIV, Hepatitis C, Latent TB, STI and Reproductive Health); Transgender Health Care; Community Development and Health Education, Drop-in Counseling Program; Community Services Program; Crisis and Trauma Counseling Program; 24 Hour Crisis Line; Evolve (Domestic Abuse Counseling); Sexual Assault Crisis Program; Sage House outreach; Suicide Bereavement Groups; Take Back the Night; Teen Klinic; Teen Talk; and Volunteer Program. We also support clients with addictions through opioid replacement therapy (suboxone or methadone).

For further information visit www.klinic.mb.ca

**Main Street Project (MSP) (75 Martha Street)**

Main Street Project (MSP) provides a safe place of respite, shelter and support, with dignity and without judgment to individuals in the community experiencing homelessness, chronic and acute illness, addiction and mental health issues. MSP advocates for a more inclusive society and assist marginalized individuals in making real choices in their lives and holds a vision that every individual has a safe place to be, and an opportunity to make real choices.

WRHA funded services and programs coordinated by MSP include:

- **Emergency and Social Services**
  - Drop-in shelter and crisis services are designed to ensure emergency respite is available to those in distress without appointment. MSP offers safe, respectful and non-judgmental services to those who are homeless, displaced, experiencing mental health issues or struggling with addictions. Community members may walk in, be referred by other agencies, or may be identified by the Street Patrol and directed to MSP for shelter and other essentials.
  - Individuals use MSP services and connect for basic, daily needs such as a bowl soup or cup of coffee, basic nutrition, access to showers, clean clothing, access to phones, mail delivery, transportation, access to Case Workers, resource information and housing referrals or medical support through WFPS paramedics.

- **Medical Withdrawal Management Services** – A 30 bed men’s medical detoxification facility providing supervised managed withdrawal from the toxic effects of substance abuse.
  - Helps clients create attainable goals including stabilization and decreased risk, accessing longer treatment programs, managing stressful life issues and processing previous traumatic events. Provides 24-hour support in a safe and stable environment at no cost.
o Staff do regular check-ins with clients regarding their plans, goals and physical, emotional and spiritual well-being and create individualized withdrawal management care plans to support and guide individual recovery – whether it is reducing the harm they may experience from their drug of choice or continuing treatment if abstinence is their goal.

- Mainstay Transitional Housing Program – A supported transitional living environment that provides its residents with a safe place to live while they work to change their lives. Mainstay is staffed 24/7 and provides assistance, continuity and a sense of security to its up to 34 community members in 28 rooms.
  o Residents have access to community programming such as weekly Sharing Circles, Alcoholics Anonymous, recreational activities and monthly meetings. They also have opportunities to participate in volunteering such as kitchen help, outdoor maintenance crews and other placements in the community.
  o Using both harm-reduction and Housing First philosophies, staff actively engage with each individual’s transition plans and goals throughout the duration of their stay.
  o Community members often move on to safe accommodations, long-term supported housing, substance abuse treatment programs or other appropriate accommodations.

- The Bell Hotel – An evidence-based Housing First approach that demonstrates that securing appropriate housing is the first and most essential step in achieving independence for individuals who were previously chronically homeless. MSP partnerships with the Bell Hotel include Centre Venture, Winnipeg Housing Rehabilitation Corporation and WRHA.
  o Delivers health, eviction prevention, Harm Reduction, life skills, capacity building, counseling, goal-setting and advocacy services through the lens of independence and tenant-defined success.

Other services and programs coordinated by MSP include: Essential Market/Food Bank; Intoxicated Person Detention Area/Protective Care; Women’s Detoxification Facility; Transition Services; Project Breakaway; and Homeless Outreach Team Mentors.

For further information visit www.mainstreetproject.ca

MFL Occupational Health Centre (102 – 275 Broadway)

The MFL Occupational Health Centre (MFL-OHC) is a non-profit community health centre whose purpose is to provide services to workers, employers, and joint health and safety committees to improve workplace health and safety conditions and eliminate hazards. MFL-OHC has a provincial mandate and service is delivered through a multi-disciplinary team consisting of: Physicians with expertise in occupational health; Occupational Health Nurses, Social Workers, Ergonomist and Resource Coordinator.

Services include medical services; prevention; education and outreach; workplace services;
resource centre; and a cross cultural community development train the trainer program.

For further information visit [www.mflohc.mb.ca](http://www.mflohc.mb.ca)

**Mount Carmel Clinic**  (886 Main Street)

Mount Carmel Clinic is a community health centre located in Winnipeg’s North End. It is the oldest community health clinic in Canada and has been serving Winnipeg’s North End residents for over 90 years. Mount Carmel Clinic considers all the social determinants of health and continuously strives to work together with individuals, families and communities to enhance lifelong health and well-being. It delivers the service through a multi-disciplinary team consisting of Physicians, Primary Care Nurses, Counselors, Pharmacist, Midwives, Laboratory Technician, Oral Health Practitioners and more.

Services include Primary Care; Teen Clinics; Foot Care; Hepatitis C program; Pharmacy; Laboratory and X-ray; Dental; Midwifery; Counseling; Assertive Community Treatment (ACT); Sage House; Mothering Project; Child Care; Indigenous Wellness and Multicultural Wellness program.

For further information visit [www.mountcarmel.ca](http://www.mountcarmel.ca)

**Nine Circles Community Health Centre**  (705 Broadway)

Nine Circles is a non-profit community health centre in West Broadway that serves a variety of community populations. Nine Circles offers STI testing to the public as well as delivers primary care to key populations that would benefit from HIV care, other STBBI care and opioid adjunct therapy. In addition, Nine Circles offers social work support, allied care and linkages to community resources. The organization’s goals are:

- To provide client-centered care that reduces the rate of infection for STIs including HIV
- To improve quality of life for those living with and affected by HIV; and
- To reduce the stigma and discrimination associated with sexual health resulting in the overall improved health of our community.

Services include: STI Testing; Primary Care; Primary Care with HIV care and treatment; Opioid Adjunct Therapy; group programming; mental health support and counseling; outreach and advocacy; health promotion and education; risk assessment and reduction planning; PHA food bank; and Sex Friendly Manitoba Online platform.

For further information visit [www.ninecircles.ca](http://www.ninecircles.ca)

**NorWest Co-op Community Health Centre**  (785 Keewatin Street)

The NorWest Co-op Community Health Centre focuses on engaging community members in the Inkster area in co-operative health and wellness. The main building is located at 785 Keewatin Street, with a satellite clinic (Bluebird Clinic) at 100-97 Keewatin Street, along
with several other service locations throughout the community such as the Community Food Centre and Youth Hub (103-61 Tyndall Ave), resources centres (1880 Alexander Ave, 312 Blake Street, 7-35 Gilbert Avenue), and daycare (105 Lucas Ave).

NorWest delivers community-based services and programs through a multi-disciplinary team including Physicians, Nurse Practitioners, Primary Care Nurses, Physiotherapists, Occupational Therapists, Dieticians, Counselors, Health Promoters, Clinical Pharmacist, Kinesiologist and a Psychologist.

Some of the services and programs offered at NorWest include:

- Primary Health Care, Walk-In Connected Care Clinic (WICC), and Allied Health Services with the My Health Team including home visits and outreach
- Chronic Disease Management and Healthy Lifestyle counseling including: Diabetes Education & Support, Foot Care, Commit to Quit, Healthy Eating and cooking classes for all ages
- Prenatal Care, Reproductive Health, Pregnancy Counseling, and Well-Baby Clinics
- InSight Mentor Program for pregnant women and new mothers with substance abuse problems and FAS Mentor Programs
- Children and Youth services including: Early Learning Childcare Centre, Bright Start play program, Teen Clinic, Gilbert Park Going Places, and Youth Hub
- Indigenous Health including Aboriginal social work and counseling
- Mental Health and Counseling services including the Mental Health Team, Parent & Child Counseling, Family Violence Counseling and A Woman’s Place (no-cost legal services for women abused by intimate partners’)
- Community Development programs including: Community Resource Centres, Hans Kai, and Inkster Parent Child Coalition
- Newcomer services including: Neighbourhood Immigrant Settlement and Immigrant Women’s Counseling
- Community Food Centre and affordable fresh grocery markets
- Intervention and Outreach Team (IOT)

For further information visit [www.norwestcoop.ca](http://www.norwestcoop.ca)

**Rehabilitation Centre for Children (RCC) (1155 Notre Dame Avenue)**

The Rehabilitation Centre for Children (RCC) supports children and youth in Manitoba and surrounding areas (including Nunavut and Northwest Ontario) in achieving their goals and participating in their communities. RCC is located in the Specialized Services for Children and Youth (SSCY) Centre.

RCC provides services to children with physical and developmental challenges. Children from birth to eighteen (twenty-one if still in school) are eligible for services from the Centre. RCC receives its funding from the WRHA, Manitoba Health, the Department of Families, a number of Manitoba School Divisions, and the Children’s Rehabilitation Foundation.
Sexuality Education Resource Centre (SERC)  (200-226 Osborne Street)

SERC is a community-based, non-profit, pro-choice, provincial organization providing a wide range of sexual and reproductive health services to Manitobans. SERC offers sexual and reproductive outreach, advocacy and education to populations of need, with particular emphasis on youth, immigrant/refugee, mainstream, and Aboriginal community members. Services are provided through general education and outreach, information and referral, training and consultation for service providers and educators, print resource development and translation services for ethno-cultural minority communities, information and referral services through the multi-media Facts of Life program, formal research in addition to program and resource evaluation, and resource distribution including lending through their Winnipeg and Brandon resource centers.

For further information visit www.serc.mb.ca

Women’s Health Clinic  (Unit A-419 Graham Avenue)

Women’s Health Clinic (WHC) is a feminist, pro-choice community health centre providing health services and resources on women’s health issues especially in the areas of sexual and reproductive health. Services offered in the medical program include, but are not limited to: sexually transmitted infections (STI) testing and treatment, birth control starts and follow up, provision of safer sex supplies, unplanned pregnancy and abortion counseling, menopause and other one-time consults, general and teen counseling, and drop-in teen clinics at our Graham location and Vincent Massey Collegiate. An interdisciplinary team of providers including Physicians, Nurse Practitioners, Nurses, Counselors, Social Worker, Dietitians and Volunteer Counselors provide health and counseling/education services. Other programs offered at WHC include the Mother’s Program, Health Education, the Provincial Eating Disorder Program, general and teen counseling, and the Therapeutic Abortion Program offered at our satellite clinic.

A free standing Birth Centre opened in 2011. The Birth Centre is a designated bilingual site offering midwife provided prenatal, intrapartum and post-partum care and is an alternative to home or hospital for midwife assisted births. Health education, mothering support and various groups by WHC Mother’s Program are offered from the Birth Centre. The Birth Centre is a partnership between the WRHA and Women’s Health Clinic.

For further information visit www.womenshealthclinic.org

Centre Youville Centre

(Unit 6 - 845 Dakota Street)

Youville Community Health Centre is a non-profit community-based, health resource in the community of St Vital. Youville Centre provides a place where individuals and families can work on their health concerns with health professionals or with other people who
have similar experiences. Services are provided by an interdisciplinary team of fully qualified health care professionals including Dietitians, Community Health Nurses, a Counselor, Community Development Coordinator, Certified Health Educators, Student and Volunteer Coordinator and Outreach Worker.

Youville Centre is Community Nurse Resource Centre offering a wide range of primary health care services ranging from chronic disease management and prevention, individualized health and emotional counseling, group health education, support groups and primary care clinics (including drop-in services “Ask a Nurse” and Teen Clinic).

(33 Marion Street)

Youville Diabetes Centre (YDC) provides diabetes education/management for clients with Type 1, Type 2 on prescribed medication or insulin and to women with pre-existing diabetes who are pregnant or who have developed Gestational diabetes (GDM). YDC focuses on complex diabetes cases which includes all diabetes technology (insulin pumps, CGM’s). This site offers a specialized Young Adult Program (YAP) for 16-25 year olds with Type 1 diabetes that are seen by an endocrinologist and educators.

Certified Diabetes Educators, Nurses, Dietitians and a Counselor work in collaboration with clients and their referring health care providers. Incoming referrals are triaged by a Diabetes Educator and individual or group appointments are scheduled which create opportunities for personalized problem-solving, education and care regarding lifestyle, medication management (oral, injectable, insulin pump/continuous glucose monitoring) and risk reduction for acute and chronic complications. Phone triage and follow up also provides extensive and ongoing health professional contact.

As mental health is an integral part of diabetes self-management, counseling services utilizing the cognitive behavioral approach are accessible to all YDC clients. Craving Change™, an interactive program to modify eating behaviors, and participatory cooking classes, are part of the lifestyle education provided. Foot care needs may be addressed, for a fee, by the nursing and podiatry care services. Leadership, education and resources are also provided to multidisciplinary health care providers and students attending post-secondary institutions.

For further information visit www.youville.ca

Community Development

By developing a conceptual framework for Community Development and model for public participation within the Winnipeg Regional Health Authority, it becomes essential to guide and support community development activities at all levels of the organization and in communities. The WRHA Community Development framework includes:

1) Organizational Capacity Development
• By enabling staff to contribute to a healthy positive working environment and reduce identified organizational or structural barriers to support accountability for these efforts.
• By ensuring an organization’s values and beliefs demonstrate leadership, and a shared understanding about what community development is, how it contributes to health, and how it fits within the spectrum of services provided by the organization.
• By collaborating with organizations in the community area with their community development activities.
• By supporting and consulting with community area staff and program specialists in their work particularly as it relates to community development within the community area.

2) Inter-sectoral Networking and Inter-sectoral Collaboration
Inter-sectoral Collaboration is essential in supporting healthy communities and addressing health determinants. Program activities include:
• Identifying and participating with existing inter-sectoral, interagency and resident networks.
• Enabling services to share ideas and experiences, to learn from one another and enable more effective community action.
• Where networks are not in place, identifying potential neighborhood partners facilitates the development and maintenance of effective networks.
• Facilitating resident participation in networks that include agency and resident membership.

3) Locality Development
Locality development focuses on working with communities. For any community development strategy to be effective it must include the provision of, and access to, resources (human resources, support, finances etc.) targeted to facilitate grassroots work and local action. Local action can occur within communities sharing a common interest or within geographic communities.

This work often aims to build on shared experiences of people’s lives in order to develop new solutions to community-defined problems. Hence, a process must be developed with local communities to define their strengths, problems and strategies for change. Community development is long-term work, building trust and mutual respect among community members and professionals for which the WRHA is one player of many.

The Role of Community Facilitators
In order to enable community capacity building and public engagement in building healthy communities, the Winnipeg Health Region supports “Community Facilitators” in each of the 12 community areas. These Community Facilitators provide leadership to
community by incorporating community development principles in their everyday work and help WRHA, service agencies, local non-profit organizations, various levels of government and residents work together to achieve our common goal of keeping people healthy and improving access to care.

The community facilitators support their community areas by:

1) Strengthening community capacity
2) Building partnerships
3) Improving access to information
4) Enhancing health systems

To locate Community Facilitators in your community area, visit the Community Development webpage on INSITE.

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Healthy Aging Resource Teams

Healthy Aging Resource Teams (HART) consist of two health care professionals such as a Nurse, Social Worker, Occupational Therapist or Dietitian. Together, they provide health services and community support for older adults living in the River East/Transcona, St. James/Assiniboia Assiniboine South and Downtown/Point Douglas community areas. By connecting with My Health Team resources, these teams are able to maximize capacity to support older adults in remaining in independent community living environments.

The goals of HART:

- To support older adults to achieve and maintain health and wellness.
- To enhance client experience and increase positive health and wellness outcomes and prevent the need for acute and costly health interventions and supports.
- To enhance the connection between Primary Care, Community Development and primary and secondary prevention.

HART is responsible for the development and implementation of health promotion programs and services to address the health needs and priorities of the older adult (55+) population. HART works in partnership with older adults, caregivers and their families, community groups, other health care and service providers to provide services and health education programs that maintain and promote the health of the older adult population living in the community. HART is integrated with My Health Team thereby ensuring enhanced connection with primary care services. This collaboration further supports secondary prevention for those older adults who are at risk and can benefit from early intervention and connection with community resources. HART uses a client/family centered approach when providing care.

For additional resources visit the Support Services to Seniors webpage on INSITE.
Volunteer Services

The Winnipeg Health Region values the contributions made by the community to the health care system. Volunteers play an important role in supporting WRHA’s values of meaningful community participation and improved health and well-being of individuals, families and communities. WRHA volunteers help strengthen and build a healthier community!

The WRHA Volunteer Services program provides support to the following areas:

- Community Health Programs
- Centralized Services
- Corporate Programs
- Pan Am Clinic
- Breast Health Centre

All other sites within the Winnipeg region have their own Volunteer Departments and requests for service or applications to volunteer must be made directly to the site.

For additional resources visit the Volunteer Services webpage on INSITE.

Antenatal Home Care

Antenatal Home Care provides a safe alternative to hospital care for women residing in Winnipeg and experiencing a variety of complications of pregnancy. Women are referred to the program by their physician and are cared for in their home on a seven-day-a-week basis by a team of specially trained nurses. Women participate in monitoring their own health status in addition to daily in-person or telephone assessments with the nurses.

For additional resources visit the Antenatal Home Care Program webpage on INSITE.

Midwifery Services

Midwives currently have offices in five primary care sites including Access River East, Access Downtown, Access Winnipeg West, Mount Carmel Clinic and Women’s Health Clinic (Birth Centre). These sites provide primary prenatal, labour and birth and postpartum care to women with low obstetrical risk. Midwives have hospital admitting privileges and attend births with women in hospital or, for those women who meet the criteria for out-of-hospital birth, in the client’s home.

A Midwifery Birth Centre operated by the Women’s Health Clinic through a service purchase agreement with the WRHA opened in 2011 and provides a variety of services in addition to an alternative to home birth for midwifery clients. Midwives provide postpartum and newborn care for their clients for approximately six weeks following birth.
Regional Primary Care Renewal

The WRHA is committed to coordinated and integrated primary care services through the involvement of all stakeholders. Although the patient’s first contact with the health system is often in primary care, they may also be referred to specialists, hospitals, home care services, or other services as the need arises. Good communication and coordinated and integrated care between primary care and the rest of the health care system is imperative for quality, safe patient care.

The Primary Health Care Program actively supports health system re-design and patient flow activities. Ensuring a strong and responsive Primary Care system means most people who visit primary care sites do not need to go further into the health care system because they are able to have their immediate health issues and preventive practice/screening needs dealt with in primary care.

There are four Key Pillars to Primary Care Renewal in the Winnipeg Health Region:

1. **Family Doctor Finder (FDF)**

   The WRHA Family Doctor Finder Program is a way to match patients without a regular family physician/nurse practitioner, to a home clinic for their health care needs, based on their identified individual health care needs. To access the service, patients may register online or call 204-786-7111. The FDF program provides education and information on various available resources and services currently existing within the WRHA. Additionally, FDF reaches out to existing and new family doctors/nurse practitioners in Winnipeg, creating linkage for physicians to connect to patients and provincial/regional resources. This relationship building has actively engaged physicians in participating in other primary care renewal activities, including the Interprofessional Team Demonstration Initiative (ITDI) and My Health Teams (MyHT).

   For additional resources visit the [Family Doctor Finder](https://www.insite.ca) webpage on the [Manitoba Health, Seniors and Active Living site](https://www.insite.ca).

2. **Interprofessional Team Demonstration Initiative (ITDI)**

   The Interprofessional Team Demonstration Initiative aims to increase access to primary care by establishing collaborative interprofessional teams within fee-for-service family doctor clinics. The ITDI has been a provincial initiative since spring 2013. Fee-for-service family doctor clinics applied to participate through an Expression of Interest. Following an Agreement, accepted clinics...
work with the WRHA to identify what type of provider (generally a physician assistant or a primary care nurse) can be added to their clinic to best assist in promoting interprofessional practice to meet patient population needs and improve access.

For additional resources visit the Interprofessional Team Demonstration Initiative - Toolkit.

3. My Health Teams (MyHT)

My Health Teams are formal partnerships with fee-for-service family doctors, as well as WRHA alternate funded Primary Care Clinics, Access Centres and Community Health Agencies. MyHTs are about providing enhanced health services to communities and are designed around community needs to allow access to a broader range of primary care services.

Winnipeg has 6 MyHTs that are geographically based networks of primary care providers that work collaboratively with a small number of interprofessional clinicians (Chronic Disease Management Clinicians, Pharmacist, Occupational Therapist, and Physiotherapist) that they share to help improve access to quality primary care. Through greater collaboration and larger scale, MyHTs are better positioned to provide enhanced primary care to the populations they serve.

For additional resources visit the My Health Teams webpage on the Manitoba Health, Seniors and Active Living site.

4. Walk-In Connected Care Clinics (WICC)

Walk-In Connect Care Clinics, staffed by Nurse Practitioners and Registered Nurses, are designed to meet unexpected primary health care needs thereby addressing unnecessary visits to the emergency room. WICCs promote and support continuity of care by linking with primary care providers and assisting in finding a provider through Family Doctor Finder when a patient doesn’t have a primary care home.

WICCs are open 7 days a week, providing evening care during the week and daytime hours on weekends. There are 5 WICCs located in Winnipeg as follows:

- **WICC McGregor**: 2-363 McGregor Street
- **WICC Access Winnipeg West**: 280 Booth Drive
- **WICC Access Fort Garry**: 135 Plaza Drive
- **WICC Access Norwest**: 785 Keewatin Street
- **WICC Centre de Sante-Saint Boniface**: 170 Goulet Street

For additional resources visit the Walk-In Connected Care Clinics
webpage on INSITE or myrightcare.ca webpage for other available healthcare options.
Understanding the WRHA Primary Health Care Program

Definition of Primary Care

Primary care is defined as the provision of integrated, accessible health care services by clinicians who are:

1. Addressing a large majority of personal health care needs,
2. Developing a sustainable partnership with patients, and
3. Practicing in the context of family and community.

Primary care has become one of the leading health system priorities across the country and within the WRHA, and is being increasingly recognized as the foundation of the health system. The Province of Manitoba continues to make strategic investments in order to provide better care and develop a sustainable health care system. This is driven by Primary Care Renewal Strategies and the need to enhance the patient experience through increased access to Primary Care.

Primary Care is a person’s first point of contact with the health system. It includes health services that are located in the community and delivered by health professionals such as Family Physicians, Nurse Practitioners, Nurses, Midwives, Physician Assistants, or Dietitians. Most people who visit primary care sites do not need to go further into the health care system because they are able to have their immediate health issue(s) dealt with in primary care. Others make their first contact with the health care system in primary care, but they are referred to acute care facilities (hospitals), home care services, or other specialists or programs from the point of first contact in primary care.

Goals and Objectives of Primary Care

The priorities of Primary Care are informed by the WRHA’s vision for primary health care, with emphasis on improving access, demonstrating quality and accountability, and ensuring Primary Health Care principles are supported. To accomplish these, the Program is working to support the development of a coordinated primary care system within Winnipeg in partnership and collaboration with the public, community areas, funded agencies, primary care providers, and family physicians (including engaging private practice physicians) and other stakeholders.
Building Blocks of Primary Care

The Building a Primary Care System is organized around six building blocks, described below, and is known around the region as the “Building Blocks” vision. The “Building Blocks” provide a road map to guide the Primary Health Care Program’s strategic vision of supporting the development of a primary care system within the Winnipeg Health Region. Without a strong primary care system, a fully integrated health care delivery system that recognizes and responds to patient needs cannot be realized. The Program team is committed to the evolution of a region wide ‘primary care system’ that builds upon new ideas and innovation initiatives, which support system integration, and approaches the work based on population health principles.

Building Block #1 - Develop Primary Care Home Processes

A primary care home can be referred to as a patient-centered medical home that has four key features:

- Accessibility for first contact care for each new problem or health need
- Long-term person-focused care (longitudinally)
- Comprehensiveness of care, in the sense that care is provided for all health needs except those that are too uncommon for the primary care practitioner to maintain competence when dealing with them
- Coordination of care in instances in which patients do have to go elsewhere

What are the objectives?

- Ensure all Winnipeggers have the option of identifying a primary care home
- A primary care ‘system’ that supports the enrollment of individuals with a primary care practice/team
- Demonstrate quality primary care in Winnipeg with an initial focus on chronic disease management and complex care

What does this mean for patients?

- Continuous and comprehensive primary care
- Appropriate access (right provider at the right time)

Building Block #2 - Develop Networks of Primary Care Providers

A primary care network (referred to as My Health Team) is a geographically distributed network of care providers providing a continuum of services to patients in a coordinated fashion and across time. The providers within the network extend beyond medical health professionals at a single clinic site to include health educators, hospitals, home care agencies and community-based groups.

What are the objectives?

- Timely appropriate access to the right provider providing the right care at the right time in the right setting
- Enhanced access to primary care (extended hours, after hours call)
- Support equity of access to primary care
- Support continuity of care across the continuum (including in-hospital, home care, Personal Care Home)
- Improve chronic disease management and complex care
- Improve coordination and quality of ante, intra and post-partum care
- Support healthy primary provider work life (including physicians)

**What does this mean to patients?**
- Accessible quality primary care

**Building Block #3** - Information Systems and Technology

Digital Health and information technology are enablers of a patient-centered sustainable primary care system and enables the key components of system development. Electronic health records can provide patient health information across multiple settings. This sharing of information is essential in supporting continuous and comprehensive client centered primary care.

**What are the objectives?**
- EMR implementation
- Enhanced comprehensive and continuous care primary care practice through the sharing of relevant information and use of evidence informed tools for primary care
- Effective communication of linked primary care providers within a network to each other
- Expanded and enhanced after hours primary care services; linked after hours Provincial Health Contact Centre supports to the primary care providers’ EMR
- Enhance the access and use of health information by all primary care providers

**What does this mean for patients?**
- Enhanced continuity of care, support of a primary care home
- Demonstrated quality primary care
- Comprehensive primary care
- Improved access to primary care
- Improved patient safety; Reduction in the potential for medication errors and duplication of services

**Building Block #4** - Improved System Integration across the Continuum

As the Primary Care ‘system’ evolves, it is imperative that this ‘system’ aligns with other health sectors such as acute care and long term care. In addition, services linkages within the community care system including home care, community mental health and public health are also essential. These linkages are critical in order to avoid duplication of services and to provide client centered continuity of care.
**What are the objectives?**
- A developed ‘primary care system’ within the context of the health system
- Primary care as the foundation of the health system
- Shared Care fully implemented with an initial focus on chronic disease management and complex care
- A responsive consultative approach between community care, acute care and long term care sectors

**What does this mean for patients?**
- Continuity of care across the continuum
- Open and transparent accountability for quality and service delivery

**Building Block #5 - Support the Development of a Skilled Workforce and Interprofessional Practice**

The Primary Health Care Program believes that attention is needed to develop supports for interprofessional team education and development within WRHA primary care and MyHTs. Further, the program team is committed to ensuring that all members of interprofessional teams work within full scope of practice in primary care.

**What are the objectives?**
- Opportunities for interprofessional education in all WRHA primary care sites and networks
- That interprofessional teams are in place to support Winnipeg MyHTs

**What does this mean to patients?**
- Quality primary care services (right provider at the right time in the right place)
- Broad range of expertise and knowledge to employ different strategies for addressing complex health concerns

**Building Block #6 - Evaluation and Quality Improvement**

The Building Blocks for primary care system change require close attention to evaluation of the implementation processes and outcomes in relation to health system performance, quality improvement and patient perspectives. Furthermore, as evaluation findings are discussed and monitored, quality improvement processes will need to be developed and adopted based on the local evidence.

**What are the objectives?**
- Evidence-informed building blocks development
- Building blocks performance measures are identified and monitored by the Program and appropriate stakeholders
- The implementation of system re-design initiatives are evaluated in light of the overall vision and for improvement purposes
- An effective, efficient and evidence-informed primary care system is fully developed in the Winnipeg health region
Clinical Tools for Primary Care

The Primary Care Team: Position Descriptions

Primary Health Care providers work as a multidisciplinary team. They also work with individual clients, their family members, other relevant agencies, and a range of paraprofessionals and non-professionals in providing care.

The WRHA Primary Care Program has developed specific position descriptions for the following positions:

- Primary Care Physician
- Nurse Practitioner
- Physician Assistant
- Primary Care Nurse
- Primary Care Assistant
- Primary Care Dietitian
- Midwife
- Antenatal Home Care Public Health Nurse
- Team Manager - Primary Care
- Site Medical Leader

Primary Care Physician
The Primary Care Physician will provide medical services consistent with the principles of primary health care, including the provision of comprehensive, accessible services within an interdisciplinary practice. The Primary Care Physician refers clients to other team members for education and follow-up, to specialists or specialty programs. The Primary Care Physician also provides delegation leadership support for the Nurse Practitioner and the Primary Care Nurse, and consultation support to these team members. The Primary Care Physician is jointly accountable to the Site Medical Leader, Community Area Director and Medical Director of Primary Health Care.

Nurse Practitioner
The Nurse Practitioner (NP) has completed advanced education and clinical training in primary health care, and is a member of an integrated, multi-disciplinary community area team. The NP is a leader in the provision of comprehensive health care with the emphasis on health promotion, disease prevention, clinical intervention/treatment, urgent care and chronic disease management on an individual, family or group basis. Working as a team member with primary care physicians, the NP can accept responsibility for the delegated clinical function to improve access to services for clients requiring health assessments, periodic health surveillance and health maintenance, monitoring, and management of stable chronic conditions and health promotion and/or education for individuals, families, and groups. The Nurse Practitioner reports to the Team Manager or Delegate.
Physician Assistant
Physician Assistants (PA) are academically prepared and highly skilled health care professionals who provide a broad range of medical services. PAs are physician extenders and not independent practitioners; they work with a degree of autonomy, negotiated and agreed on by the supervising physician(s) and the PA. PAs can work in any clinical setting to extend physician services. PAs complement existing services and aid in improving patient access to health care. A relationship with a supervising physician is essential to the role of the PA. The PA’s scope of practice is determined on an individual basis and formally outlined in a practice contract or agreement between the supervising physician(s), the PA and often the facility or service where the PA will work. Activities may include conducting patient interviews, histories and physical examinations; performing selected diagnostic and therapeutic interventions or procedures; and counseling patients on preventive health care.

Primary Care Nurse
Consistent with the principles of primary health care, the primary care nurse provides access to first level basic health care within the scope of nursing practice for individuals, families, groups and communities. As a member of an interdisciplinary community area team, the Primary Care Nurse provides comprehensive health care with an emphasis on healthy living, illness prevention (primary and secondary), health education, chronic disease management, clinical intervention, and palliation. Develops and implements a health plan with clients and evaluates success in meeting this plan. Provides ongoing service coordination and links clients with resources. The Primary Care Nurse reports to the Team Manager or Delegate.

Primary Care Assistant (PCA)
As a member of an integrated, inter-disciplinary Primary Care team, the Primary Care Assistant will provide support to the Physicians, Nurse Practitioners, Physician Assistants and Primary Care Nurses, in order to facilitate access to Primary Health Care. In order to support the work of these providers, the PCA assists with a number of tasks including clinic flow, lab support, provision of information to clients, and processing referrals. The PCA reports to the Primary Care Team Manager.

Primary Care Dietitian
The Primary Care Dietitian provides leadership in nutrition-related care with clients and their families to manage change in order to promote health, improve control of pre-existing problems or to avoid complications of those problems. The Primary Care Dietitian will also provide leadership in the area of nutrition therapy within the interdisciplinary team, by collaborating with other members in identifying and adhering to established standards of care for patients with diabetes and other health conditions. The Dietitian reports to the Team Manager.

Midwife
The main function of the midwife is to be the primary care provider to women during the childbearing year within a multidisciplinary team, and in a variety of settings such as in the client’s home, in community clinics, and in hospitals. All midwifery services provided...
are delivered in accordance with the Midwifery Model of Practice and the Standards of the College of Midwives of Manitoba. The priority populations to be targeted for midwifery services within the WRHA include women and communities who currently do not receive adequate perinatal health care and are socio-economically disadvantaged clients. The midwives report centrally to the Director Midwifery Services with joint accountability to the site Team Manager.

**Antenatal Home Care Public Health Nurse**
The Antenatal Home Care Program (ANHC) is a community based, safe alternative to hospital care for women experiencing one of the following complications of pregnancy: High Blood Pressure, Preterm Labor, Premature Preterm Rupture of Membranes (PPROM) or Diabetes. Woman must reside in an area (or have temporary accommodation in) serviced by the WRHA as well as be under the care of a family physician, midwife or obstetrician who has admitting privileges to a hospital that provides antepartum care.

The ANHC is delivered by public health nurses who visit daily and provide assessment, coordinate weekly lab work and fetal assessment appointments, provide teaching regarding the high risk condition and prenatal education, provide emotional support and referral to community resources as appropriate.

**Team Manager – Primary Care**
The Team Manager is responsible for effective integrated case management and service delivery to teams and will report to the Community Area Director. The Team Manager provides support and leadership to staff through the ongoing integration and change process. The manager establishes and fosters a common vision among team members for the area and services provided, supervise the team through open communication and management of workload levels within the team, identify broad community issues and service needs, and ensure an inter-sectoral approach.

**Site Medical Leader**
The Site Medical Manager provides leadership for the planning, organization and quality of medical care provided to clients at the site. In addition to the management role, the Medical Manager participates as a member of the medical staff in the delivery of primary care medical services.

**Operational and Practice Guidelines**
Primary Care Operational Guidelines are available at:
http://home.wrha.mb.ca/prog/primarycare/guidelines_operational.php

Primary Care Practice Guidelines are available at:
http://home.wrha.mb.ca/prog/primarycare/guidelines.php
Primary Care Quality and Decision Support

Quality and decision support refers to the efforts of WRHA programs and sites to promote and achieve high quality care and service provide key information to facilitate effective knowledge management and evidence based decision making, and to work towards coordinating the delivery of health information services. Quality and decision support initiatives within the primary care program are:

**Primary Care Quality Teams**
Each WRHA directly operated site and accredited Community Health Agency have site quality teams. Accreditation is a peer review process that is conducted every four years by Accreditation Canada. The site quality teams are made up of representatives from each service area at the site. These teams are mandated to develop quality plans and to identify priority areas.

There is also a Regional Primary Health Care Quality Team consisting of one representative from each WRHA directly operated site and Community Health Agency. Representation from Antenatal Home Care, Midwifery Services and MB Health (Primary Care Branch) is also included. This group meets quarterly or as needed.

**Quality Improvement Roadmap/Performance Reporting**
The Primary Care Program sites use the Quality Improvement Roadmap to report on quality improvement initiatives. These reports are on four dimension of the program or service areas:
- System competency
- Responsiveness
- Client and community focus
- Work life

**Quality Audit Process**
Quality audit is a systematic process and/or tool to measure and analyze performance in clinical and support service areas against established standards. Examples include accreditation, critical occurrence reviews, questionnaires, client satisfaction surveys, critical results audit, performance conversation audit, medication storage audit, spirometry audit, hand hygiene audit, and equipment audit. The audit cycle is a continuous process that involves monitoring practice/process, setting standards, implementing change and evaluating the change for effectiveness.

**Incidence and Occurrence Reporting**
Incidence and occurrences are reported on using RL6 software to assist the program and services in reviewing reasons for errors or mistakes and facilitating improvements in the system to prevent recurrences.

**Primary Care Dashboard**
The goal of the Primary Care Process Review undertaken in 2013 was to establish a process of linking strategy to operations through the development of a Dashboard, a
communication tool highlighting clinical performance based on key metrics. Objectives included:

- Identify key measures related to regional and provincial priorities
- Determine target ranges for key measure
- Identify data sources and frequency requirements
- Develop Standard Operating Procedures for data collection and analysis
- Identify a sustainability plan to ensure target achievement is tracked regularly

The Primary Care Dashboard currently reports on active Panel Size, Third Next Available (Long/Short), No-Show, Vacancies, Hand Hygiene auditing, Out the Door in 24 (OTD24), and Quality of Care (Primary Care Report for Home Clinic) for all Physicians, Nurse Practitioners, and Physician Assistants working within the WRHA Direct Operated Clinics.

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**How to Find Health Services in Winnipeg?**

Ways to Find Health Services in Winnipeg:

1) **Health Links - Info Santé**
   For answers to your health related questions call Health Links - Info Santé at 204-788-8200 or toll free at 1-888-315-9257. Registered nurses are available to answer your questions 24 hours a day, 7 days a week.

2) **211 Manitoba**
   For online information about health services, programs and organizations in the Winnipeg Health Region, search the database at 211 Manitoba.

3) **Healing our Health System**
   When you're sick or injured, what you really want and need is the right care at the right time in the right place. Depending on the scope and nature of your health issue, you might find an effective solution right around the corner, or even on the other end of the phone. Visit the "Knowing where to go will improve your care" guide for easy reference.
Regional Primary Health Care Services Grid

The Regional Primary Health Care Service Grid is a quick reference guide to the services available at primary health care sites in the WRHA. The grid also lists services by the service title used in the Purchase Service Agreement that the WRHA has with Community Health Agencies.

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*Youville (St.Vital) Primary Care is a nurse run clinic*

**SERC – Reproductive Health Services are all educational, none clinical**

***McGregor WICC is a free standing building located at 2-363 McGregor Street but is supported by physicians working out of Aikins Community Health Centre***
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