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Welcome

Message from the Regional Program Directors

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.

- **Jeanette Edwards** - Regional Director, Primary Health Care and Chronic Disease
- **Margaret Kozlowski** - Director, Primary Health Care Community
- **Dr. Sheldon Permack** - Medical Director, Primary Health Care
- **Christian Becker** - Director, Primary Health Care Administration & Process Improvement
- **Dr. Jose Francois** - Medical Director, Family Medicine

Contact the WRHA Primary Health Care Program

This orientation manual was 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](http://www.wrha.mb.ca) is a public source of information. Valuable information on this site includes (and is not limited to):

- WRHA Mission Vision and Values
- WRHA Organizational Structure
- WRHA Organizational Priorities
- WRHA Board of Directors
- WRHA Strategic Plan
- WRHA Policies

The Internet site also offers health information for the public and staff, in a directory titled Health Services A-Z. There is also an online [Health Services Directory](http://www.wrha.mb.ca) which is a searchable listing of health services, programs, and organizations in the Winnipeg Health Region. You will find a description of all health services in Winnipeg at this site as well as a mapping feature. This data base is part of the CONTACT community
listings which includes not for profit services available throughout Manitoba.

The Internet site also offers a Family Physician Website and is maintained and updated by the Primary Health Care Program. The website is an important part of the WRHA’s communication with all family physicians, but especially those who work in private practice within Winnipeg.

Detailed information about the WRHA and its corporate and human resources policies is 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 a good idea to check it daily if possible. It is also 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 has a listing of Operating Guidelines, Practice Guidelines, Care Maps and other resources.

**PRIMARY HEALTH CARE**

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**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).

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**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

The integrated Primary Health Care Program has seen the merger of 4 programs over time while preserving the integrity of each.

- **Community Development** (public engagement, community capacity building, chronic disease, population health (cross links with the PPH program), regional services)
- **Primary Care** (direct primary care operations, funded agencies)
- **Community Seniors Services** (regional seniors services/initiatives, funded services, HART teams)
- **Family Medicine** (academic programs, inpatient services)

With the national and provincial commitment to Primary Care Renewal, the WRHA recognized the need to add a focus on work with the Fee-for-Service family physicians. Given the scope of this work, a regional director position was added to focus on this work and linked to the program team.

**Regional Program Oversight:**
- Primary Care clinics (6), Family Medicine Teaching clinics (3), Community Health Agencies - Type 1 (13) and Family Medicine inpatient services (290 beds across for hospital sites)
- Community Development (community facilitators and funded sites)
- Support Services to Seniors (48 sites, Healthy Aging Resource Teams)
- Fee-For-Service family physician collaboration

**Centralized Service Delivery consists of:**
- Antenatal Home Care Program
- Midwifery Services
- Quick Care Clinics

**Regional Initiatives that cross the system and sectors:**
- Language Access Interpreter Services)
- Volunteer Services
- Chronic Disease Collaborative
- Funded sites (Examples include: Cardiac Rehab, Oral Health (Healthy Smile Happy Child), Specialized Services for Children and Youth (SSCY), Provincial Health Contact Centre (PHCC), WISH student run clinic

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**Staffing Overview**

**Regional Primary Health Care Program Staff**
- Regional Director Primary Health Care and Chronic Disease - Jeanette Edwards
- Director, Primary Health Care Community - Margaret Kozlowski
Primary Health Care Program Staff

- Program Specialist, Business Operations and Quality Improvement - Kevin Mozdzen
- Program Specialist, Clinical - Jo-Anne Kilgour
- Program Specialist, Clinical (In-Patient Services) – Audra Kolesar
- Manager, Antenatal Home Care - Darlene Girard
- Manager, Midwifery Services – Kelly Klick
- Manager, Local Health Involvement Groups - Colleen Schneider
- Specialist, Community Development & Seniors - Madeline Kohut
- Facilitator, Support Services to Seniors - Kathy Henderson
- Manager, Volunteer Services - Suzie Matenchuk
- Manager, Language Access Interpreter Services – Allana Carlyle
- Manager, Chronic Disease Collaborative - Michelle Meade
- Manager, Quick Care Clinics – Frankie Scribe
- Manager, Primary Care Renewal & Primary Care Connector – Anita Jenin
- Program Specialist, My Health Teams – Allison Murphy

Primary Health Care Programs and Services

Primary Health Care programs and services include:
- **Community Development**
- Local Health Involvement Groups
- Volunteer Services
- Support Services to Seniors
- Language Access Services
- Chronic Disease Collaborative
- Health Services Directory

Centralized programs and services include:
- **Antenatal Home Care**
- Midwifery Services
- Quick Care Clinics

Each program and service will now be described immediately below in detail.

**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**
   - Enable staff to contribute to a healthy positive working environment and reduce identified organizational or structural barriers to support accountability for these efforts.  
   - The organization’s values and beliefs will need to 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.  
   - The program collaborates with organizations in the community area with their community development activities.  
   - The program supports and consults 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/Developers in your community area, visit the Community Development website on INSITE

Local Health Involvement Groups

The Community Health Advisory Councils have been providing advice and their unique community perspectives on significant health issues to the WRHA Board for 12 years. As a result of changes to the Regional Health Authorities Act in 2013, they have become Local Health Involvement Groups (LHIGs). The role and membership of these advisory groups has not been impacted except that LHIG members will be play a greater role in determining what topics are explored.

There are six Local Health Involvement Groups representing areas across the Winnipeg health region:
- St. James-Assiniboia / Assiniboine South
- River East / Transcona (includes East St. Paul)
- Seven Oaks / Inkster (includes West St. Paul)
- St. Boniface / St. Vital
- Downtown / Point Douglas
- River Heights / Fort Garry

The Role of the LHIGs

These Groups are advisory to the Board of Winnipeg Regional Health Authority (WRHA) and provide an on-going opportunity for community members to share their thoughts about and provide suggestions to address important issues that impact the health of Winnipeg communities. Between September and May, members meet to explore at least two topics. The WRHA Board, with input from members of the LHIGs, chooses topics to
explore. Discussion from the meetings is included in reports that are presented to the Board and members of senior management and then made available to the public.

**Membership of the LHIGs**
Local Health Involvement Groups are advisory groups made up of community and board members from health organizations - like hospitals, personal care homes, and community health agencies. Each LHIG has between 11 and 15 members who are appointed by the WRHA Board. Non-voting members include a WRHA Board member and a WRHA staff person that is able to provide information and answer questions about health and social services that are delivered in their community area.

Additional information about Local Health Involvement Groups can be found on their website

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**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.

**WRHA Guiding Principles for Volunteer Involvement**

- Volunteers assist WRHA staff in providing quality services to clients and communities by sharing their skills and talents.
- Volunteer engagement at the WRHA supports meaningful public participation.
- The WRHA Volunteer Program works collaboratively and cooperatively with staff, volunteers and other organizations, thus ensuring that services are not duplicated.
- The WRHA is committed to building capacity in the community and achieving service excellence.
- Volunteering is a learning experience for both the volunteer and WRHA staff.

**WRHA Volunteer Services and Its Volunteers**

- Complement and enhance the provision of health services
- Provide opportunities for citizen participation
• Encourage public involvement and awareness of WRHA services
• Support communication between the WRHA and Winnipeg residents
• Support community development
• Support collaborative community action by both the community at large and
• Individual citizens
• Bring new ideas, skills, insights, energy and fresh perspectives

A number of tools and resources are available to staff when working with volunteers. These can be found on the Volunteer Services website.

Support Services to Seniors

Support Services to Seniors offer community-based programs for seniors that promote health and well-being and assist seniors to continue to live in the community. These services are offered throughout the Winnipeg health region by a variety of community agencies.

The Support Services to Seniors
• Promotes a range of coordinated, accessible and affordable, community-based services that focus on promoting health, independence and well-being for older person;
• Determines the needs of seniors in the community and tailor services to address those needs;
• Empowers people to improve their health while taking an active role in the formation and execution of services they need and want;
• Reduces and/or delays the need for more invasive intervention (e.g. institutional care); and
• Strengthens support and leadership from volunteers that work to further strengthen Services to Seniors.

Congregate Meal Programs offer seniors the opportunity to enjoy well-balanced affordable meals in a social setting. Hot nutritious meals are offered to seniors three to five days per week in a group setting, such as an apartment block or senior centre. Seniors are encouraged to participate in planning, cooking meals, setting tables and helping with clean up.

Community Resource Councils
Community Resource Councils are not-for-profit organizations, which help develop services and programs for older people based on identified needs. Services vary from community to community however some common services are:
• Escorted transportation, which allows seniors to get to medical appointments, bank, store, etc.
• Yard and home maintenance referrals, including a registry of fee-for-service workers who provide housekeeping, meal preparation, yard work, snow
removal, minor electrical and plumbing services.

- ERIK (Emergency Response Information Kit) promotes awareness and preparedness for individuals encountering an emergency situation. The kit is a standardized package of health related information that is placed on the refrigerator so that paramedics and first responder’s personnel have access to up to date information in emergency medical situations.
- "Daily Hello" is a daily phone call to individuals to ensure well-being. If concerns are identified, appropriate actions are initiated.
- Information and referrals for community and government services such as pension information, mobility aids, adult day programs, senior centres, housing, grocery delivery services, health care services and health education.
- Presentations on a variety of topics such as housing for seniors, living wills, senior’s safety etc.

Senior Centres
Senior Centres are a community focal point where older adults, as individuals and in groups, come together for services and programs. The Centres offer accessible and affordable services and programs such as:

- fitness and exercise programs;
- leadership development;
- health promotion;
- illness prevention;
- advocacy, legal advice;
- nutrition and education;
- social and recreation programming

They also provide information and referrals, counseling and volunteer opportunities.

Tenant Resource Programs
Designed for individuals living in elderly persons housing complexes. Tenant resource programs can help residents find services to help with their daily needs. The tenant resource coordinator develops and coordinates a service plan for the tenants of the building and/or for a collection of housing complexes.

Examples include:

- Grocery shopping, Transportation, Errands, Advocacy, Information and referrals, Electronic surveillance check, Friendly visiting, Income tax, House cleaning, Translation, Filling out forms, Health clinics

Senior Serving Organizations
WRHA has service purchase agreements with 46 funded agencies in Support Services to Seniors.

Examples include:

- Meals on Wheels of Winnipeg, Creative Retirement Manitoba, Rupert’s Land Caregiver Services, Manitoba Association Senior Centres, CNIB, Medication Line,
Advancing Continuing Care
Advancing Continuing Care is a plan to balance services and resources within the Long Term Care sector of the Winnipeg Region. The strategy supports the concept of "Aging in Place." Aging in Place is designed to preserve the ability of Manitobans to remain in their communities for as long as possible. It includes creation of affordable community housing with support options as an alternative to Personal Care Home (PCH) placement and extended lengths of stay in hospital.

Supports to Seniors in Group Living
Includes enhanced support services provided to seniors in existing community congregate settings. This model supports health promotion and independence with a goal of aging in place. There is no additional charge to residents for this service. Target population: Individuals (primarily seniors) who do not require 24-hour support and supervision.

Sponsors include:
- Metropolitan Kiwanis Courts
- Lindenwood Manor
- Donwood Manor
- Good Neighbors Senior Centre (4 sites)
- Transcona (Park Manor and Columbus Villa)

Healthy Aging Resource Teams
Healthy Aging Resource Teams (HART) work in the community to promote health, increase awareness about injury and illness prevention, provide primary care and management of chronic diseases for adults age 55+. These teams are a direct operation of the WRHA. Healthy Aging Resource Teams consist of two health care professionals such as a nurse, occupational therapist or dietitian. Together, they provide health services and community support for older adults.

Healthy Aging Resource Team locations include:

**River East/Transcona**
720 Henderson Highway
Winnipeg, MB R2K 0Z5
Phone: (204) 940-2114

**St. James/Assiniboia/Assiniboine South**
203 Duffield Avenue
Winnipeg, MB R3J 0L3
Phone: (204) 940-3261
For all tools and community resources visit the **Support Services to Seniors** website.

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**Language Access Interpreter Services**

WRHA Language Access provides the services of qualified trained interpreters 24/7/365, either in-person, by phone or via MB-Telehealth for non-Aboriginal, spoken languages. These evidence-informed services are critical to reducing barriers between service providers and patients/clients who do not share a common language. They enhance the WRHA’s commitment to provide high quality safe care to every person regardless of ethnicity, race or culture.

WRHA Language Access Interpreter Services are provided at no cost to all government funded health services, e.g. WRHA-funded facilities, programs and services, Cancer Care Manitoba, WRHA funded dental services, and for fee-for-service physician appointments.

Services are also available on a cost-recovery basis to health authorities and government departments (provincial and federal). A variety of other organizations can also access these services.

In-person interpreter services are provided in over thirty (30) languages by a team of 70-75 trained and qualified WRHA Language Access casual employees. Immediate over-the-phone interpreter services are also available in approximately 200 languages through an external contracted service provider.

WRHA Regional Policy 10.40.210 was approved July 2013 and contains specific information regarding **Interpreter Services – Language Access**.

For general information visit the **Language Access Interpreter Services** website on WRHA INSITE.

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**Chronic Disease Collaborative**

The WRHA Chronic Disease Collaborative role is to identify, support and facilitate system redesign opportunities to create a client centered seamless and integrated approach to chronic disease prevention and management, as well as optimizing the use of existing resources/initiatives.
**Chronic Disease Collaborative Goal**
The goals of the Chronic Disease Collaborative are to:
1. Identify opportunities for system redesign that close gaps and create a more coordinated approach to the delivery of chronic disease prevention, care and management in the WRHA;
2. Expand and improve self-management supports;
3. Address needs and consider health determinants for chronic disease prevention, care and management through intersectoral collaboration.

**Principles**
The following principles guide the work of the Collaborative:
1. The strongest system improvements will occur when all stakeholders (e.g. patients, families, communities, providers, administrators, funders) have been consulted and their views respectfully considered.
2. Effective system design will demonstrate coordination, comprehensiveness and integration of services that incorporates the perspective of the “whole person”, and includes environmental, societal and economic determinants of health.
3. Self-management (i.e. ownership and responsibility of individuals to participate in the development and accomplishment of their wellness and health care plans) and person centered approaches will be promoted as fundamental components of effective health systems.
4. The strategic directions and priorities of the WRHA and its relevant programs will guide Collaborative work priorities (e.g., population and public health, mental health, primary care/family medicine, primary health care, medicine).
5. Stronger linkages between private primary care providers and the community, long term care and acute care sectors must be forged if effective chronic disease prevention, care and management are to occur.
6. The health care sector should be a strong voice for effective public policies that address chronic disease risk factors and health inequities; and
7. Compelling evidence must exist or be generated through innovative evaluation and research or demonstration projects to support any design prop.

For more information visit the [Chronic Disease Collaborative](#) website on WRHA INSITE.

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**Health Links and Health Services Directory**

**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) **Health Services Directory Online**
For online information about health services, programs and organizations in the Winnipeg Health Region, search the Health Services Directory.

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**Antenatal Home Care Program**

The Antenatal Home Care Program 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.

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**Midwifery Services**

Midwives currently have offices in five primary care sites in the WRHA: Access River East, Access Downtown, Access Winnipeg West, Mount Carmel Clinic and Women’s Health Clinic (Birth Centre). They 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.

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**Quick Care Clinics**

**McGregor Quick Care Clinic:** 2-363 McGregor Street  
**St Mary’s Quick Care Clinic:** 17 St Mary’s Road  
**Dakota Quick Care Clinic:** 620 Dakota Street  
**Vermillion Quick Care Clinic:** 115 Vermillion Road  
**Jefferson Quick Care Clinic:** 101-930 Jefferson Avenue  
**Portage West Quick Care Clinic:** 3250 Portage Avenue West

Quick Care Clinics (QCC) exist to meet the unexpected health care needs of individuals during times when most other clinics are closed. These clinics, staffed by Registered Nurses and Nurse Practitioners, diagnose and treat minor health issues which in turn may eliminate the need for a trip to an emergency room or having to wait for regular clinic hours.
QCCs provide walk-in services as well as by appointment during evenings and weekends. Anyone can visit a QCC, though they’re not a replacement for regular visits with a health care provider. QCCs are designed to help Manitobans access health care they need, when their regular provider may be closed or at a time that is more convenient to them. Information about a visit to a QCC can be shared with the patient’s regular health care provider so as to keep medical records accurate and up-to-date. If a patient does not have a regular health care provider when they visit one of these clinics, staff can assist in locating one.

Examples of health issues that could be treated at a QCC may include:

- bumps, bruises or sprains;
- rashes, eczema, infected cuts or minor sores;
- sore throat, earache, colds and flu, cough, hay fever or nose bleeds;
- immunizations;
- sore eyes with redness or infection;
- stomach pain, diarrhea and vomiting, urinary infections or indigestion;
- headache, back pain or neck pain;
- birth control or breast feeding issues

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, as stated in the Government of Manitoba’s commitment that all Manitobans will have access to a family doctor by 2015.
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, nurses, midwives, nurse practitioners, 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.

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**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.

The WRHA Community Primary Care Council establishes and reviews program priorities and ensures that the set priorities are met through a number of initiatives across service areas and aligns with provincial priorities. In 2010, this team created the Building a Primary Care System in the Winnipeg Health Region: An Action Plan. This vision document has been adopted by the Region as the vision for primary care system development and establishes guiding principles and a road map for the work of the Program.

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**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)

What have we done?
• Enhanced Family Doctor Finder Program soft launch (October 2013)
• The Primary Health Care Program developed and implemented an Operating Guideline to enroll patients at WRHA directly operated sites
• Informed and supported the development of provincial strategy
• Enrollment and Clinical Information Sharing Steering Committee
• As EMR optimization continues, core patients are now identified and EMR use and processes are optimized to demonstrate primary care quality targets, with an initial focus on chronic disease informed by the provincial primary care indicators
• Worked with network partners and IPT in FFS partners and government to develop plans to expand capacity and access to primary care home through interprofessional teams and other mechanisms.
• Enhanced capacity in St. James/Assiniboine S through part-time NP community clinic in collaboration with the Grace Hospital
• Expanded capacity in the Inkster area through the establishment of Bluebird clinic (satellite of Access NorWest)
• Development of 2 Access Centres; NorWest 2013 and Winnipeg West 2014

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

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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, PCH)
- 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

**What have we done?**
- Physician engagement
- Participated as a key stakeholder in the Care Link “After Hours Call” initiative and evaluation to determine its potential application to the development of a regional system to support after hours primary care call in Winnipeg; ongoing improvements being investigated with partners
- Developed Decision making structures to support Networks as a partnership
- Developed agreement on management infrastructure for My Health Team’s (MyHT)
- Completed plan and budget for 6 MyHTs in Winnipeg
- In partnership with Mental Health program, developed vision and stepped model for MH in primary care in response to patient need in community
- Summarized existing surveillance information to create community area chronic disease profiles (by paired community areas), circulated to fee-for-service physicians
- In partnership with Home Care program – assisted in the development of Hospital Home Teams
- Completed an operational process review of WRHA sites
- Engaged Community Health Agencies (Service Organizations)
- Established PCN priority targets for Year I
- Implemented Quick Care in six sites and developed program monitoring processes to ensure alignment with QCC objectives and to inform planning of future QCC and Networks
- Implementation and evaluation of IPT in FFS in alignment with PCN’s
- Further developed Chronic Disease prevention and management strategies in Primary Care; Chronic Disease Collaborative is now in place
- Aligned health priorities within community area with FFS practice priorities to develop first PCN activity
- Developed Operating Agreement and shared accountability amongst partners

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

Manitoba EHealth and information technology are enablers of a patient-centered
sustainable primary care system and enables the key components of system development (primary care home, primary care networks and ‘virtual wards’). 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 in all WRHA primary care direct operations and funded sites
- Use of the EMR in fee-for-service primary care offices
- 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 PHCC 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

**What have we done?**
- Completed the implementation of the EMR in all WRHA primary care direct operations and funded sites, office
- Supported the use of the iEHR by all primary care providers
- Actively participated in the review and evaluation of the use of technology in supporting primary care (e.g., provincial health contact centre, Care Link after hours call)
- Supported primary care providers in accessing and using information to not only deliver primary care services but also, in planning proactively as population characteristics change
- Promoted ongoing electronic documentation adoption in ER
- Supported clinical Information Sharing Working Group- Episodic Visits (Mb Health/WRHA/Fee for Service physicians)
- Work with the UoFM and other partners in implementing the Poverty and Primary Care tools within the EMR
- Support QHR’s Inter-instance data sharing solutions
- Work with provincial groups to explore the development of electronic mechanisms to ensure linkages between network providers and patients’ primary care provider/home MB health and MB eHealth
- Assisted in e-health EMR adoption survey of practices without EMR
• Developed the WRHA Clinical Advisory Group

**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

**What have we done?**
- Developed Primary Health Care plan for the Role of Hospitals initiative in partnership with Emergency, Long-Term Care and other Programs
- Completed analysis of CTAS 4’s and 5’s (suitable for primary care) across the region; undertook an extensive knowledge exchange process with many WRHA stakeholders
- Supported the development of the Hospital Home Team model and evaluation framework to support transitions for complex patients from hospital to community
- Partnered with Mental Health Program and sites to develop mechanisms for discharging in-patients to primary care upon discharge
- Developed and Implemented model for PA’s in hospital supporting Family Medicine – supporting networks and community practices
- Linkages with Specialty Care
- In collaboration with the Mental Health program, supported the development of a stepped care approach to MH in Primary Care (includes Shared Care)
- Engaged the WRHA Chronic Disease Collaborative on system redesign issues, beginning with diabetes
- Fostered partnerships across system and Program to ensure patients without primary care providers are attached to primary care homes
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 in-patient family medicine sites and within 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

What have we done?
- Completed Interprofessional Team Demonstration Initiative (ITDI) development of tool kit and evaluation framework (provincial)
- Supported interprofessional collaboration in teams
- In partnership with MB Health, University of Manitoba Faculty of Medicine, and WRHA, PA implementation and evaluation in primary care settings (provincial)
- CD Collaborative has worked with Manitoba RHAs and community-based services and teams to support CD self-management
- Developing processes to ensure providers are supported to work at full scope of practice and within interprofessional teams through education opportunities and team practice supports in primary care
- Actively participate in regional interprofessional education opportunities
- Strengthened collaboration with the Department of Family Medicine to provide and strengthen network of teaching opportunities within the primary care system (e.g. placement of over 100 pre clerkship students in primary care sites)
- Supported interprofessional team development within WRHA Primary Care sites
- Developing Chronic Disease teams/expertise in each of the community areas to support primary care networks
- Enhanced Shared Care opportunities in collaboration with the Mental Health program
- Identified population needs; developed chronic disease population profiles for each of the 12 community areas.
- Supported practice facilitation/Care connect implementation
- Implemented and evaluated of PA’s in Primary Care in alignment with PCN’s
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

What have we done?

- Completed full analysis of CTAS 4/5; necessary in further exploring primary care renewal actions
- Completed process review of direct operations sites with focus on site activities and regional efficiencies (e.g. signature, panel size initial targets)
- Successfully participated in the WRHA Accreditation process
- Dedicated some resource to data analysis; supported through successful recruitment of graduate students
- In collaboration with national research team, submitted a Partnership in Health System Improvement Proposal to CIHR, to support evaluation and research of Physician Assistants in primary care settings (will find out if successful in June 2014)
- Provided broad input on Primary Care Networks through existing relationships between WRHA and family physicians, PIN Clinics, Shared Care and clinics participating in the ITDI to ensure early involvement for input into development of PCN
- Completed broad engagement of all family physicians within the WHR through 6 Town halls in 2011, with Senior Leadership chairing and in attendance
- Contacted over 140 practices to discuss My Health Teams and individual meetings to over 50 practices throughout Winnipeg
- Established 6 geographic based collaborative planning tables between RHA and Family physicians (2012-2014) with representatives from clinics, hospitals, Community Health Centres, Docs Manitoba, and Health Agencies in attendance
- Formalized 6 My Health Teams - operating agreement signed and funding received
The Organization of the Primary Health Care Program

The 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 the “Program Strategic Plan” and “Framework for Action,” 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.

WRHA Direct Operated Clinics

The Primary Care Clinic provides comprehensive, continuous and episodic 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 counselors.

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

- Access River East
- Access Transcona
- Access Downtown (including BridgeCare Clinic)
- Access Winnipeg West
- Corydon Primary Care Clinic
- Aikins Street Community Health 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 six digit 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 meet with the Primary Care Nurse for an intake appointment, and are orientated to the appropriate site and program. She/he then connects the client 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.

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**Family Medicine Teaching Clinics**

Within the Family Medicine there are three Family Medicine teaching clinics:
- Family Medical Center (St Boniface General Hospital)
- Kildonan Medical Center (Seven Oaks General Hospital)
- Northern Connection Medical Center (Health Sciences Centre)

These clinics were developed specifically as training sites for the Family Medicine residents enrolled in the University Of Manitoba Faculty Of Medicine. Northern Connection Medical Center serves as the primary teaching site for residents in the Northern/Remote stream of the residency program.

Family Medicine supports patients and their families throughout their lifespan and across the continuum of care and is therefore a vital part of both the larger primary health care and acute care systems. Within the scope of the WRHA Primary Health Care Program team, those activities associated with inpatient care and academic teaching are designated as “Family Medicine”.

In addition to providing primary care, family physicians and Family Medicine residents provide inpatient care at St. Boniface, Victoria, Concordia and Seven Oaks General Hospitals. Family Medicine supports family physicians and midwives in the provision of low-risk obstetrical services including intrapartum care at St. Boniface General Hospital, Health Sciences Centre and the Birth Centre. Family Medicine residents learn to provide full scope family medicine practice, based out of family medicine teaching clinics.
My Health Teams are about teams of care providers (whether located in the same offices or virtually connected online) that work with the patient to make sure they get the care they need, when they need it.

My Health Teams are built around strong partnerships. Teams of care providers work together to plan and deliver services for a geographic area or specific community or population. My Health Teams are less about physical space, and more about leveraging and building on existing services and enhancing them so that consumers are offered more coordinated and comprehensive care. Most of all, My Health Teams are about providing excellent service to Manitobans that meets community needs. Once well-established, all My Health Teams will provide a common set of services to their communities.

Inter-professional My Health Teams develop services to ensure people are more informed and involved in planning their own care. Other goals of My Health Teams include:

1. Improving access to primary care for all Manitobans
2. Demonstrating quality and safety in Primary Care
3. Increasing the focus on the patient and patient-centered primary care
4. Connecting care providers within and across geographic boundaries to provide seamless transitions in care
5. Enhancing efficiency in primary care and supporting sustainability of the health system

Family Doctor Finder Program

The Family Doctor Finder Program will assist any Manitoban currently without a family physician and wanting one, to find one. Interested individuals can register with the program by phoning 204-786-7111 or registering online via the Family Doctor Finder Online Registration.

When an individual registers with the Family Doctor Finder they will be asked to provide some basic information, as well as their preference for location and type of provider (family doctor, nurse practitioner). Upon successful registration the individual will be given a registration number.

Primary Care Connectors are specialized staff located in each of the health regions. Their job is to connect people who need a family doctor with a regular primary care provider. Once registered with the program, the regional Primary Care Connector will work with the individual to find a primary care provider who meets their needs, in a location that works for them. The length of time for a connection with a primary care
provider may vary, depending on the availability of providers in the requested area and/or demand for this service.

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<th>Primary Care Service Locations &amp; Descriptions</th>
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**Access River East**  975 Henderson Hwy

Access River East (ARE) was the first access center to open in the Winnipeg Health Region. Access centers were designed to provide a single point of access to health and social services for citizens. It provides primary health care services to the citizens of the River east community area including East St Paul. This includes Primary Care Medicine, Elmwood Teen Clinic, Pediatric Speech and Language Therapy, Audiology, Dietary, Diabetic Education and Shared Care Mental Health.

The team is made up of Physicians, Nurse Practitioners, Primary Care Nurses, Shared Care Counselors, Dietician, Audiologist, Laboratory Technologist, and Midwives.

**Access Transcona**  845 Regent Ave West

Access Transcona (AT) was the second access center opened in the WRHA. AT provides service to citizens of the Transcona community area. The clinic provides a range of services including Primary Care, Teen Clinic, Respiratory-Spirometry and Diabetic education. The clinic has a close relationship with the local hospital, accepting patients who are without providers.

The Primary Care Clinic services consist of a multidisciplinary team of Physicians, Nurse Practitioners, Primary Care Nurses, Dietitian, Shared Care Counselor, Speech and Language Pathologist.

**Access Downtown**

**BridgeCare Clinic**  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 a multidisciplinary team of Physicians, Nurse Practitioners, Primary Care Nurses, Social Workers, Dietitian, Shared Care Counselor, and Lab Technician. In addition to Primary Care medicine they provide Nutrition education, Counseling, Shared Care Mental Health, Sexual Health education, Tuberculosis clinic, Midwifery, Dental Services (with U of M) and Outreach Services which assists in linking its clients to alternate agencies and services in the area.
BridgeCare Clinic provides Primary Care services to newly arrived immigrants and refugees. The Clinic also provides assistance in linking individuals to other resources.

Health Services on Elgin (HSE) is located on the second floor of Elgin and 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. HSE also works towards increasing health awareness and assists to access existent health and social resources and services.

**Access Winnipeg West** 280 Booth Drive

In April 2014, Access Winnipeg West (AWW) was the fourth Access Centre to open in the Winnipeg Health Region. Access Winnipeg West was designed to provide 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.

Access Winnipeg West includes a new Primary Care Clinic that is currently working with the Family Doctor Finders (204-786-7111) to actively connect new patients without a family provider with a health care provider. The primary care services are offered by an interdisciplinary team that includes Physicians, Nurse Practitioners, Nurses, Midwives, Pharmacist, Dietitian, and Shared Care Counselor. Additional efforts are underway to include other resources/supports including Occupational Therapy, Physiotherapy, Psychology, Psychiatry and Laboratory services.

Other programs at Access Winnipeg West 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.

**Corydon Primary Care** 1001 Corydon Avenue

Corydon Primary Care provides Primary Care services to the River Heights, Osborne Village and Riverview community areas. Delivery of primary health care is through a collaborative care model. This means that our primary care team includes Physicians, Nurse Practitioners, Primary Care Nurses, Shared Care Counselor, Psychiatry, and Dietitian who work together to address health care needs. Corydon also operates a Teen Clinic at a local school and share a Mental Health Counselor with a neighboring private practice (Tuxedo Medical).
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 Aikins team members are comprised of Physicians, Nurse Practitioner, Physician Assistant, Primary Care Nurses, Shared Care Counselor, and Dietitian.

Kildonan Medical Center  2300 McPhillips Street (within Seven Oaks Hospital)
Family Medical Center  400 Taché Avenue
Northern Connections Medical Center  425 Elgin – Lower Level

The three Family Medicine Teaching Clinics provide comprehensive primary care, while serving as principal training sites 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. All three 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 region.

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.

Mount Carmel Clinic  886 Main Street

The Mount Carmel Clinic is a non-profit secular community health centre whose purpose is to create and promote healthy inner city communities. It provides primary health care services mainly to those living in the Point Douglas or North Winnipeg community areas. It delivers the service through a multi-disciplinary team consisting of Physicians, Primary Care Nurses, Counselors, Pharmacist, Midwives, Laboratory Technician, and Oral Health Practitioners.
Services include primary care; teen clinics; foot care; pharmacy; laboratory and x-ray (on site), dental, midwifery, counseling, Sage House and a multicultural wellness program.

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

Also known as Access NorWest, the NorWest Co-op Community Health Centre is community operated and provides primary health care to citizens in the Inkster community area. Service is provided through a multi-disciplinary team of Physicians, Primary Care Nurses, Pharmacist, and Counselors.

Services include family medical care; Early Learning and Child Care Centre; family violence counseling; FAS Mentor Program; Foot Care; chronic disease management; Community Development; prenatal care; reproductive health and pregnancy counseling; mental health; Aboriginal social work/counseling; immigrant women’s counseling; no-cost legal services for women abused by intimate partners; home visits/outreach; nutrition and lifestyle counseling; Well baby Clinic; Teen Clinic and family support.

**Centre de santé Saint Boniface** 170 Goulet

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 our services are offered in both official languages, Centre de Sante’s work environment is French. It is also our Board of Director’s language of operation.

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.

**Klinik Community Health Centre** 870 Portage Avenue

Klinik 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, nurses, nurse practitioners, social workers, dietitians, medical assistants, laboratory technologists, and others. Klinik 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, TB, STI, reproductive health); Community Development and Health Education, Community 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; Volunteer Program

**Nine Circles Community Health Centre** 705 Broadway

Nine Circles is a community based, non-profit centre that promotes sexual and personal health through primary care, social support and HIV/STI prevention, testing & treatment. 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: Primary Care and treatment for HIV, Hepatitis C and other STBBIs; HIV and STI testing; group programming; mental health support and counseling; outreach and advocacy; health promotion and education; risk assessment and reduction planning; PHA food bank; Sexual Health Information Line.

**Centre Youville Centre** St. Vital: Unit 6 - 845 Dakota

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, physician, community development coordinator, certified health educators, support staff, a student and volunteer coordinator and an outreach worker.

Youville Centre is Community Nurse Resource Centre co-located with WRHA Public Health and Community Mental Health and offers 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). Examples include: asthma education and training; diabetes education and management; foot care; Healthy Baby Programs including non-traditional prenatal classes; Mothers & Daughters In Touch; nutrition counseling and programs, emotional/spiritual mental health services; Seniors Programs; Taking Steps Bereavement Group; Volunteer Program. It also offers a community Internet community centre.

**Youville Diabetes Centre** St. Boniface: 33 Marion St.

Youville Diabetes Centre (YDC) is a Winnipeg-regional community-based accredited centre of excellence dedicated to providing integrated diabetes education, care and support to people affected by type 1 or type 2 diabetes, and women with diabetes pre-pregnancy or gestational diabetes who have complex issues. Young adults with type 1 diabetes 18-25 years are part of a Young Adult Program (YAP), which includes monthly on-site
endocrinology access.

Certified diabetes educators, including 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.

**Women’s Health Clinic** 3rd floor, Unit A 419 Graham Ave.

Women’s Health Clinic 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, unplanned pregnancy and abortion counseling, menopause and mental health counseling, pelvic pain consults and drop-in teen clinics at our Graham location and Vincent Massey collegiate. An interdisciplinary team of practitioners including physicians, nurse practitioners, primary care nurses, medical assistants, counselors, a social worker, dieticians 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.

**MFL Occupational Health Centre** 102 – 275 Broadway Avenue

The MFL Occupational Health Centre (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. 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.

**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

**Aboriginal Health and Wellness Centre**  Suite 215 – 181 Higgins Street

The mandate of the Aboriginal Health and Wellness Centre is to provide primary care and social 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 thus the 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; teaching; and a cultural advisor/elder.

**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.

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

The Main Street Project’s mission is to provide a safe, respectful and accessible place for individuals at risk in the community, to advocate for a more inclusive society, and to assist marginalized persons to make real choices. The Main Street Project works with individuals in the City of Winnipeg who are in need and unable to function due to substance use, physical or mental health issues, abuse and/or homelessness. The agency’s role is to assist such individuals through their periods of crisis and support them to make the best possible choices in the short and longer term.

WRHA funded services and programs coordinated by Main Street Project include:

- Crisis Intervention and Drop-in Services - Is the first point of contact for the majority of clients and is also the coordination centre for all Crisis Services including the transportation component, requests for information about the range of MSP resources, and admission requirements for the Chemical Detoxification Unit
- Chemical Detoxification Unit (CDU) – A 25 bed non-medical detoxification facility providing supervised withdrawal from the toxic effects of substance abuse
- Mainstay Transitional Housing Program – A 34 bed facility that provides supervised transitional housing for men and women who are unable to function in the community, or who wish to stabilize their lifestyles to achieve greater independence. Most of the residents have a history of substance use, mental health issues, or a co-occurring disorder, and many are homeless or hard to house.

Other services and programs coordinated include: Gap Services; Emergency Shelter Services; Intoxicated Person Detention Area; Transition Services; Opportunity Ahead; Project Breakaway; and Homeless Outreach Team Mentors.

**Rehabilitation Centre for Children (RCC)**  633 Wellington Crescent

The Rehabilitation Centre for Children, Inc. (RCC) is a community-based health care facility providing programs and services to children and youth with special needs and their families in Manitoba and surrounding areas in Canada. The Centre provides support and services to children at the RCC in Winnipeg, as well as through our rural clinics and outreach programs delivering service in homes, schools and day cares throughout Manitoba. Children and youth from birth to the age of eighteen (twenty-one if still in school) are eligible for the services of the Centre. Services areas include Out-Patient Clinics, Rehabilitation Engineering, and Rehabilitation Therapies.
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 para-professionals 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 and Specialized Services
- 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 Family Medicine-Primary 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 or Manager of Facilities and Support Services.

**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 Midwifery Manager with joint accountability to the site Team Manager.

**Antenatal Home Care Public Health Nurse**
The Antenatal Home Care Program 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 Winnipeg Regional Health Authority (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 or Family Medicine – Primary Care Program 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 Agencies 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, Quick Care Clinic, Family Medicine Teaching Clinic, and Community Health Agency. Representation from the Antenatal Home Care Program, the Midwifery Services, and Chronic Disease Collaborative is also included. This group is chaired by the Regional Director, Primary Health Care & Chronic Disease and meets bi-monthly.

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 area: 1) system competency, 2) responsiveness, 3) client and community focus, and 4) 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, quality of life audit, chart documentation audit, peer review, 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**

Incidences 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 metrics, Vacancies, Hand Hygiene auditing, and Quality of Care (Comparative Analytic Reports) for all Physicians, Nurse Practitioners, and Physician Assistants working within the WRHA Direct Operated Clinics. Plans are underway to also measure these metrics at the Family Medicine Teaching Clinics and Community Health Agencies offering Primary Care. Other metrics planned to be tracked and maintained on the Dashboard include Direct Contacts, Cost per Visit, Access for Urgent Care, and Patient Satisfaction.
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.

### WRHA Direct and Community Operated Primary Care Services Grid

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<tr>
<th>SERVICES</th>
<th>ARE</th>
<th>AT</th>
<th>AWW</th>
<th>Condon</th>
<th>Aikins</th>
<th>AD (HAC)</th>
<th>AHWC</th>
<th>Centre de Santé</th>
<th>Hope</th>
<th>Klinic</th>
<th>MSP</th>
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### Regional Primary Care Service Sites

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<td>Access Downtown</td>
<td>640 Main Street</td>
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<td>Aboriginal Health and Wellness Centre</td>
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<td>Corydon Primary Care Clinic</td>
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<td>785 Keewatin Street</td>
<td>204-938-5900</td>
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<td>100-97 Keewatin Street</td>
<td>204-938-5830</td>
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<td>QCC Dakota</td>
<td>Dakota Quick Care Clinic</td>
<td>620 Dakota</td>
<td>204-940-2211</td>
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<td>St Mary’s Quick Care Clinic</td>
<td>17 St Mary’s Road</td>
<td>204-940-4332</td>
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<td>204-940-8508</td>
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<td>3250 Portage Avenue West</td>
<td>204-940-8453</td>
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<td>Youville - St. Vital</td>
<td>Centre Youville Centre</td>
<td>6 – 845 Dakota Street</td>
<td>204-255-4840</td>
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<td>Youville - St. Boniface</td>
<td>Youville Diabetes Centre</td>
<td>33 Marion</td>
<td>204-233-0262</td>
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