Interprofessional Team-Based Care for Chronic Complex Illness Canada: a Case Study

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Burden of Chronic Conditions in Canada

- 40% of Canadians report having one CC
- Over 2 million caregivers
- 10.1% GDP spent on health care and this is rising
- Productivity loss

Canada's Performance

- Access to care is poor compared to other OECD countries
- Rates of obesity are high

- In Ontario, people with a CC have 70 points of contact per year with the health care system!

Primary Health Care

Good primary health care

is based on

interdisciplinary teamwork,

with care available to all,

24 hours a day, seven days a week.

(Romanow Report 2002)

2003 Health Ministers' Accord

By 2011 50% of Canadians will have access to primary care teams

2003 – 2010

- **Primary HealthCare Transition Fund** with $800 million over 6 years on stimulus projects many involving interprofessional care team delivery models
- **Interprofessional Education for Collaborative Patient Centred Practice Initiative** with $20 million over 5 years
- **Primary Care Reform** in all F/P/T jurisdictions creating new ways of practice

Nfld &Lab	Primary Health Care Teams	27% pop
PEI	Family Health Centres	25% pop
Nova Scotia	Primary Care Teams	10% FPs
New Brunswick	Community health Centres	7% pop
Quebec	Groupe de Medecins de Famille	Target 300
Ontario	Family Health Teams	16% pop

Manitoba	Physician Integrated Networks	9 FPs
Saskatchewan	Primary Care Teams	29% pop
Alberta	Primary Care Networks	60% FPs
BC	Integrated Health Networks	25% pop
Nunavut	Teams are model	
NWT	Integrated Service Delivery Model	
Yukon	Chronic Conditions Support Program	

Further Investments

- Information Management Systems
- Performance Management and Research
- Infrastructure for Practice Re-Design
  - Funding models
  - Team development
  - Self-management
- Education

Acknowledgement

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