

What will it take to make **Canada** the best  
in the world at meeting the healthcare needs  
of marginalized populations?



## The Frontline Health Dialogues

Report from the Vancouver Dialogue  
June 11<sup>th</sup> and 12<sup>th</sup>, 2008

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# **The Frontline Health Dialogues: Finding common purpose, common passion and common experience**

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## Acknowledgements

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Note: the images in this report are drawn from the Frontline Health Story Project, an ongoing initiative to capture stories, voices and images from the frontlines of health in Canada. To view a complete gallery of photos and stories, please visit [www.frontlinehealth.ca](http://www.frontlinehealth.ca).

This report is the product of the Frontline Health program, a program developed by AstraZeneca Canada that aims to increase the capacity to serve those people who are beyond the reach of Canada's mainstream healthcare system.

# Introduction



Photographer: Christopher Grabowski

Downtown Eastside, Vancouver, British Columbia

On June 12th, 2008, a group of 20 doctors, nurses, social workers, academics, policymakers and non-profit leaders from British Columbia came together to probe the question: *What will it take to make Canada the best in the world at meeting the healthcare needs of marginalized populations?* The Vancouver dialogue was part of a groundbreaking series of dialogues happening across Canada. These dialogues are organized and hosted by the Frontline Health program, a long-term commitment by AstraZeneca Canada to advance the capacity to serve

those beyond the reach of Canada's mainstream healthcare system.

The Frontline Health dialogues are the only formal discussions of their kind in Canada. The first dialogue of the series, held in Ottawa in June 2007, looked at the frontlines of health from a national perspective. The report from that session in Ottawa was used as a springboard for Vancouver; but, instead of thinking at the national-level, Vancouver participants focused on the challenges and innovations of the frontlines of health in British Columbia.

As introductions began and participants went around the room, giving some background on themselves and their work, connections started to occur. They realized they shared many commonalities and were energized by the opportunity to connect with people they seldom get a chance to see or, in many cases, had not even met yet. The mutual sense of purpose, of the important need to improve the health and healthcare of marginalized populations, was profound.

*“The opportunity that this dialogue creates is important. We need a little bit of enforced time in our busy schedules to actually connect with people from very different frontlines, to see the commonality despite our very different regional places and practices.”<sup>1</sup>*

Face-to-face dialogue among frontline practitioners is rare. Vancouver dialogue participants, like all frontline healthcare practitioners, often work at arm’s length from formal healthcare networks and associations and without the support and resources of traditional educational practice and professional development. But that is starting to change. Frontline health is emerging as a more recognized area of practice and there is a growing awareness of and appreciation for the work of these practitioners. The progress being made by the Frontline Health program is helping to drive this change.

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*...connect with people from very different frontlines, to see the commonality...*

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Around the table, dialogue participants freely referred to themselves as frontline practitioners, working on the frontlines of health. The frontlines exist wherever there are people who are unserved or

underserved by the mainstream healthcare system. They include the most remote, fly-in communities of BC to the growing Okanagan valley to the busy streets of Vancouver’s downtown eastside.

Vancouver participants shared their work and insights. They included a distributed medicine program focused on remote, rural and northern health; a tele-dispensing solution that fills prescriptions for homeless patients onsite, at community centres; a stroke recovery program that connects stroke survivors with mentors, even in extremely remote communities; and a safe injection site that aims to reduce overdose deaths on the downtown eastside.

The Vancouver dialogue followed the thematic structure that was established at the first dialogue in Ottawa and focused the discussion around three areas: building a community of practice around frontline health; engaging and educating the next generation of frontline health practitioners; and finding approaches to increasing public awareness and influencing policy.

Building on the key messages that came out of the Ottawa roundtable, participants contributed some new approaches that came up repeatedly throughout their discussion.

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<sup>1</sup> Quotes used throughout this report have been taken from recorded transcripts of the dialogue session. Wherever possible, attributions have been given.



Photographer: David Campion

Victoria Youth Clinic, Victoria, British Columbia

- a) Integrating across disciplines and regions and between institutions and entities is a critical part of breaking down barriers to providing quality and equality of care.
- b) Drawing from the assets that exist within the community and within the practitioners' broader sphere of influence is a more successful approach than focusing on the deficits.
- c) Gaining an understanding of the values and culture of today's healthcare consumers and tomorrow's healthcare practitioners is one way to better engage, interest and influence them.

*"It's always inspiring to be in a room with like-minded people and to be able to put things out in a safe place. It feeds the soul and creates opportunities for me to think 'hmm, good idea' or 'wow, so somebody else is facing the same kinds of issues I am.'"*

Vancouver participants took up the call to action issued by the first roundtable discussion in Ottawa: all Canadians, whether they live in the most remote corners of the country or on the busiest city streets, deserve quality care. *"Health for all is good for all"* was the consensus of the Ottawa participants. In Vancouver, they agreed and believe the dialogue process *"may be onto something."*

Participants emphasized the isolation of frontline work and the incredible value in connecting practitioners and thought-leaders together.

# Starting the Dialogue



Photographer: Christopher Grabowski

Dr. Trevor Corneil, Downtown Eastside, Vancouver, British Columbia

British Columbia is a compelling place for a regionally focused dialogue on frontline healthcare. Geographically, the province is very diverse. There are many remote, northern and aboriginal communities, some of which are very isolated. These northern towns create great wealth for the province, but that wealth isn't always invested locally. As one participant noted, *"our economy is driven by industry from the north yet most of our healthcare services and providers are in the south."*

BC's urban centres also face some tough challenges. HIV rates on Vancouver's downtown eastside are equivalent to those of the Third World. In Victoria, *"people*

*couldn't go downtown anymore and not see somebody sitting on the street shooting up, or acting out because of drugs and so on."* And mid-sized towns, like Kelowna, are struggling with growing homeless populations.

In this environment, academics and practitioners have started to interconnect to find solutions. In fact, some of the first supporters of the Frontline Health program, people who really drove its development, were from BC. These early adopters formed the steering committee for the Vancouver dialogue and their work became a catalyst for the discussion.

## The Steering Committee

The members of the steering committee have many years of knowledge and experience in the area of frontline healthcare. They are thought-leaders, dedicating themselves to finding new and creative ways to care for those beyond the reach of the mainstream healthcare system.

Dr. Joanna Bates, a family physician turned academic, pioneered the establishment of UBC's distributed

medical education program for rural and remote medicine. Based in Prince George, the program partners with the University of Northern British Columbia, the University of Victoria and the local community and has engaged a loyal public following in the north whose involvement and support for the medical program now impacts people all over the province.

Kim Daly (RN) was one member of a team who built a unique, multi-disciplinary clinic for street youth in Victoria. Today, the approaches used by Kim and her peers are taught to others through a series of e-learning modules she and a colleague helped develop with the support of the Frontline Health program.

Dr. Trevor Corneil is an inner-city primary care physician on Vancouver's downtown eastside. His modus operandi is to find populations who have difficulty accessing healthcare services, what he calls the invisible minorities, and build the relationships and programs to provide them with the care they need. One of the programs he's helped develop is a prenatal clinic for women living with addiction.

Joanna, Kim and Trevor committed their time and expertise to shape the agenda and put together the invitation list. Nancy Hall was asked to facilitate. Well-known among local frontline practitioners for her work in the BC healthcare sector, Nancy contributed enthusiastically at the planning sessions and chaired the day's

discussion. With the support of the Frontline Health program, invitations were distributed, travel was arranged and the dialogue session took place.

### **Dialogue Structure**

The dialogue was organized into three parts based on themes that came out of the Ottawa roundtable. These themes continue to be relevant to regions across Canada and act as a baseline for activities and developments from dialogue to dialogue:

- a) Part One: Building a community of practice
- b) Part Two: Supporting and encouraging the next generation
- c) Part Three: Facilitating public policy and building public awareness

The dialogue took place over two days, starting on the evening of June 11th with introductions and continuing throughout the day of June 12th. As with other kinds of convening, people introduced themselves. Some knew one another but many new linkages were made. Some worked in remote or northern communities and others in the inner city. But despite their different practices, there was a quick recognition of congruence of challenge and opportunity for learning. Everyone is very busy. It is a fact of frontline life. Giving their time on June 12th is a stirring acknowledgment that an opportunity like this has great value, to broaden perspectives, share insights and recognize mutual goals.

# Part One: Building a community of practice

Frontline work is challenging and isolating. Practitioners are overworked and under-supported. Their resources are stretched thin. There are no formal associations or networks to connect practitioners so that they can share ideas and very little research exists on the field to help inform their practice. In fact, the Frontline Health dialogue series is one of the only chances for frontline practitioners to get together and talk about what they do.

Once the dialogue began, participants immediately seized the opportunity to tell their stories and put questions to others around the table. Their discussion demonstrates the inherent value in the idea of building a community of practice around frontline health; the value of solidarity and recognition of shared purpose; the value of building “professional social capital”, bridging channels and capturing ideas, innovations and information.

*“I get calls from various spots like Winnipeg and Ontario and Halifax [about] what’s going on and we’re having the same issue...”*

Developing a community of practice around frontline health is a strategic priority of the Frontline Health program. Around the table in Vancouver, participants explored the reasons why, the motivations for and the ways to establish a community of practice. There were some breakthroughs as the discussion prompted participants to look at their work in a different light and see opportunities for taking their ideas into new communities for the benefit of new populations. Participants talked about actions; practical projects that would help develop and begin to flesh-out a community of practice around frontline health: hold a ***national conference***; conduct a ***review of gray literature***; focus on ***French to English*** translations; begin to catalogue frontline health programs, organizations and practitioners in a ***national database***.

As one participant said, *“it would be great to have a network together to start to develop and learn from each other.”*

## **Finding commonality**

Finding common purpose is one of the key reasons why a community of

practice on frontline health is needed. There was a very strong sense in the room that the participants belonged together, that there were critical ideas and insights to be shared despite the fact that there was often a significant difference in the types of communities they were serving and the places they were working. Some commonalities emerged repeatedly throughout the day: participants work on the margins; they see their patients as their partners; and they are committed to changing the system for the long-term.

#### **Working on the margins**

One strong trait shared by all participants is quite simple: they all work on the margins of the mainstream healthcare system. The patients they serve have incredibly complex health issues; they are “*orphaned patients in the system.*” Factors such as mental illness, homelessness, addiction, and / or extreme poverty have a direct influence on their patients’ health and have to be considered. In many cases, doctors, nurses, social workers, addictions counsellors, public health and mental health professionals are all involved with caring for one individual.

To deal with this complexity, participants have turned to something different from conventional treatment models. They have engaged the broader community, to educate them and gain their support to fight the root causes — like hunger, poverty and homelessness — of their patient’s health issues.

*“The stuff about some pills is all relatively simple; it’s the other stuff that’s much more complicated: poverty, abuse and all the other things. Whenever the [mainstream system] comes to deal with these [frontline] problems it just doesn’t know what it is doing.”* Everyone agreed: a simple trip to the clinic and a prescription is not always the answer.

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*The stuff about some pills is all relatively simple; it’s the other stuff that’s much more complicated...*

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As they talked, it became clear that many participants use similar approaches to help them navigate these complex issues.

#### **Seeing your patient as a partner**

Seeing their patients as their partners was a common theme in the discussion. Participants had considerable commonality of experience and believed that there was a lot more that could be done in this area. From stroke patients to incarcerated youth to former prisoners, there was a strong sense from the practitioners serving them, of the value of involving patients in their own healthcare.

*“When you start working with people and they start to move from that*

*dependence to independence, and start to be able to advocate for themselves... they become almost more of a healthcare partner with the provider. That's a huge difference for the provider as well as the person that they are working with because right away they start to have some interest... and they are paying attention to the advice that they are being given."*

Empowering the patient is one way participants help their patients take responsibility for their own health and get them on the path to wellness. Through the discussion, participants started to realize they were doing the same kinds of things. A number of them had developed peer education and mentorship programs to engage patients.

Terry Howard, coordinator of the Prison Outreach Program for the BC Persons

with Aids Society, spoke about his experience with a peer education program that was developed by a prison doctor within the women's prison system in BC. Women were invited to pick a topic related to health issues and develop a twenty minute PowerPoint presentation for their peers. They were given access to do factual research. At the end of the process, there were more than 60 presentations and the results were extraordinary: *"It went beyond just mere health and knowledge translation. The change in the attitude of those women, the decline in any kind of behaviour problems that were going on there, the way that the women actually took care of each other and the health promotion that went on."* The women gained a confidence that was empowering, making them partners in their own healthcare rather than dependents on the system.

## The Homeless Soccer League

Rhonda Alvarez, Program Coordinator, Healing Spirit Lodge, is a tireless advocate for Vancouver's homeless population. She's always thinking outside the box. Her newest project shows how sport can be used as a powerful tool against homelessness. She's the driving force behind the Vancouver Dreamcatchers, Canada's first homeless soccer team. The team has already faced off against local MLA's and looks forward to the chance to compete in the Homeless World Cup in Australia. Rhonda tells her story:

*I started working on this awesome project in 2006. It's a soccer league for the homeless and its part of a global program that uses sport and wellness to change a homeless person's outlook on life. There wasn't any funding in the beginning but I thought it was such a great idea that I donated 30 hours a week to get it going. The players had to meet certain criteria and be committed to working on their wellness. I got a hold of every service agency that worked in the downtown east side and tried to really recruit. Within a few months, we had our team. Soon, there were 18 guys coming out to practice and we had the opportunity to help identify their health needs and work with them. We started to see a real improvement in their self confidence. They felt like somebody really cared about them and supported them and that motivated them to have a better life than the one they have on the streets.*

*'What's the answer to homelessness' is a big question. But I think one of the answers is social inclusion; the soccer league allows people to become a part of something that gives them a sense of belonging. Statistics show that 94% of the players who get involved with this project have a new motivation for life. Seventy-three percent changed their lives forever by coming off drugs or alcohol and moving into homes and going into training. We've certainly seen that here in Vancouver. Within a year of starting the program, six of our players are off the streets and a number of them are in training or back at school.*

The prison example triggered another participant to share her work with stroke survivors. To help minimize the sense of isolation felt by stroke survivors, Stroke Recovery Association of BC has developed a mentor network of stroke survivors who reach out in communities across the province to help stroke victims through their recovery.

*“Mentorship is empowering. It transforms a person from being a victim to being a community leader and partner within the recovery process.”*

Participants agreed that turning patients into partners and empowering them with the knowledge to improve their own health is a powerful tool for change.

Speaking with great passion, Dr. Elizabeth Saewyc provided proof from a health promotion program she is involved with that engages incarcerated youth :

*“One of our clear signs of fabulous success within the Burnaby Custody Centre was when we were trying to recruit within a pod for [one of our programs] and one of the kids is like, ‘Oh no, what’s the point. We’re just going to get together and complain and nothing will ever happen.’ And another kid was able to immediately turn around and go, ‘Uh uh, we were part of [the process]... and look they’ve already changed things, so this does make a difference, you can speak out and you will be heard.’”*

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*We deliver services to the frontlines for a reason, we want to create change.*

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#### **Developing long-term solutions**

As participants talked about their projects and shared their ideas, another common trait emerged. They are changemakers, they want to create solutions for frontline populations that are long-term. *“We deliver services to the frontlines for a reason, we want to create change.”*

One participant described the awakening she had when trying to care for street youth from St. Paul’s outpatient department: *“We were upset about the quality of care to marginalized street youth... and a group of us said we’re doing crummy medicine here. This system isn’t working for us. We’re not seeing our patients as people and we need a different venue.”* So they changed things and created a clinic that marginalized populations would be comfortable using. The result was the Three Bridges Clinic in Vancouver.

Andrew Hughes, Health Service Director, Primary Health & Community Care for Central Okanagan Interior Health spoke about a community triage approach to improve the health and wellbeing of the homeless in Kelowna. Partners in Community Collaboration

(PICC) holds weekly meetings where frontline service providers, such as outreach workers, local shelter workers and healthcare practitioners, meet in a room for one hour to manage cases. *“We go around the room and we triage an individual through the process so that we can connect them with their needs whether its income assistance, seeing physicians etc.”* PICC set a goal for themselves in 2007: take 51 people off the street.<sup>2</sup> They more than exceeded that: 138 people were taken off the street that year. Furthermore, when Andrew tracked these people over the course of the year, he saw a significant decrease in emergency room visitations which can be calculated into real cost savings for the health authority.

Andrew’s numbers got the participants talking. Why did he feel this project was such a success? He believes it comes down to two things: client care and peer-to-peer accountability. PICC established a culture within the Kelowna community that made the healthcare of its homeless population a priority. *“We had developed this peer-to-peer accountability that increased the level of actual service delivery. Everybody was working together and accountable to each other. We had created a continuity of care that made a pretty remarkable difference for our clients. They started to get better.”*

### **Solidarity in community**

There is a great deal of value in the solidarity that a community of practice

provides. The dialogue is an example of how reinforcing it can be when a group of like-minded people get together for just a day to talk: *“When you are working constantly with your head down it’s so great to hear everyone’s stories and to hear what everyone else is doing. I know I’m a dreamer and I have lots of ideas, but sometimes it’s hard within our systems to make them happen but when you come to a place like this it makes you realize things are possible.”*

### **Building bridges**

Over and over again, throughout the dialogue, many practical examples of problem solving, breakthroughs and innovations surfaced that are just not getting shared. This is a compelling reason for building a community of practice around frontline health. The concepts of peer researchers and mentors, of community triage and clinics designed specifically for marginalized populations have already been introduced. Throughout this report, more examples of the participants’ work will be introduced. Here are a few vivid examples that show the opportunity and need for a community of practice around frontline health.

Linda Lane Devlin started her work in addiction services on Vancouver’s downtown eastside. She moved out of Vancouver’s urban health authority and into the position of Executive Director of the Stroke Recovery Association of BC. Linda’s focus is now provincial, not urban, and includes remote communities

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<sup>2</sup> One person a week with the exception of the Christmas week.

that completely lack healthcare services. Despite these differences, she's still using the same kind of approach as when she was counselling addicts on the downtown eastside. *"What really helps [frontline patients] recover faster whether they are stroke victims or suffering from addiction is that we, as [practitioners] must trust that the people who have the challenge are the ones who are going to help us understand what we have to do."* She has successfully shown how the common experiences of frontline practitioners can actually be used to bridge channels. Enabling this information exchange, making it easy for practitioners to compare notes across the rural/remote/urban landscape and cut through the silos of patient populations is critical.

Dr. Joanna Bates has been an active change maker in the field of frontline healthcare for more than 20 years. She has helped create unique programs to improve the capacity to care for marginalized populations. Early on in the dialogue, Joanna had an "aha" moment, realizing that an interprofessional elective program on rural health for UBC medical students could be used as a template for creating a similar program focused on urban and inner city medicine. She challenged the group: *"How could we use our frontline [experience and resources] to create some network that engages students? They could talk to Terry about prisoner's health and Mark at the*

*Portland Hotel Society and then come back as a group to talk to Wayne about policy issues."*

Once again, a channel is bridged because of a realization that came through dialogue, proving the power of networking and the necessity of a community of practice around frontline health.

One of the most stirring examples of the potential of building networks came from Dr. Gail Knudson, Medical Director, Vancouver Coastal Health Transgender Health program. What she has been able to accomplish in less than a year is perhaps the clearest demonstration of the appetite for a community of practice and the opportunity that it represents.

Gail was an early partner of the Frontline Health program. She wanted to connect with other people who do what she does: *"We have no formal networks of Canadian health care providers for transgender populations. It's a challenge because [the transgender community] lives in pockets, usually in large cities across the country. How do we connect people? If one person is moving from BC to Alberta, well who would they connect with?"*

One day, Gail met with the people from the Frontline Health program at her office at Vancouver General Hospital. They asked her what she wanted to do.

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*Having this network... has really made a big change in the practice.*

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*“I said that I would like to create this network that goes across the country, and they said okay, so away we went.”* The rapid growth and the robustness of the network shows what happens when there is a catalyst like the Frontline Health program. There were 22 people at the first meeting Gail organized in mid-2007. By June of 2008, there were more than 100 people who had become members of the newly incorporated Canadian Professional Association of Transgender Health (CPATH) and had attended its first inaugural meeting in Toronto.

The incredible growth of this network reveals a deep truth about the frontlines. There are disconnected practitioners everywhere and they have a profound need for a “go to” place. CPATH has made a huge difference for Gail and others practicing in the field of transgender health: *“having this network and having communication, having people who are experts and being able to talk with them freely has really made a big change in the practice that we have been able to do for our patients and in our confidence and in our education.”*

**Actionable items: building communities of practice**

Participants unanimously agreed: a community of practice around frontline health is needed. The idea of what a community of practice represents was brought to light vividly through the discussion around peer mentorship and the establishment of CPATH.

A community of practice connects participants who share many similarities, despite the very different communities in which they practice. It provides an opportunity to share ideas and present a united face for the newly emerging field of frontline healthcare. The group identified several actions that could be undertaken to support the development of communities of practice.

- **A national conference** would generate public awareness and stimulate a national discussion of the field of frontline health.
- **A review of gray literature**<sup>3</sup> would help practitioners research topics and stay current.
- **French to English translations** would give Anglophone practitioners access to a range of new materials.
- **A national database** of frontline health programs, organizations and practitioners would help organize a community of practice. Such a database could include an online method for registering programs, a searchable directory and a launch campaign to promote uptake and utilization within the community.

<sup>3</sup> Gray literature is a term used variably by the intelligence community, librarians, and medical and research professionals to refer to a body of materials that cannot be found easily through conventional channels such as publishers, “but which is frequently original and usually recent.” Source: [www.wikipedia.org](http://www.wikipedia.org) in August 2008.

## Part Two: The next generation

Frontline health is starting to emerge as a more recognized and accepted field of practice. It's still in its infancy and in comparison to the mainstream system, there are far fewer active practitioners. So it's understandable that participants expressed genuine concern about who would follow in their footsteps. They are so busy focusing on their work that it's difficult to pull back and put some time towards planning for the future and thinking about how to reach out to the next generation of frontline practitioners.

Despite this, participants were characteristically positive: *"I think we can transform a younger generation and create more change than you know."* In BC, there are some great programs that reach out to engage youth in frontline health. Looking around the table, many participants were the product of what

Dr. Joanna Bates calls "the subversive activity of education." They graduated from programs like the Family Practice Residency Program through UBC which focuses on inner city medicine and was created because people realized there was a great need for it. They are involved, either as mentors or participants, in programs like CHIUS (Community Health Initiative of University Students) that put healthcare students into frontline health clinics.

Change is starting to happen as a result of the work being done by frontline practitioners and through the efforts of the Frontline Health program. For Vancouver participants, building sustainable academic programs and understanding the changing shift in values of the next generation were at the core of the discussion. So was a desire to find some way to work within the

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*I think we can transform a younger generation and create more change than you know.*

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fairly inflexible structure of the current medical system. They suggested several key actions like building an **interprofessional training program** for inner-city medicine, **connecting mentors with students**, and collecting opportunities for students to **gain firsthand experience** of frontline work.

### **Building sustainable programs**

Several participants in the room hail from the academic world. Practitioners turned academics, they shared some striking examples of how redesigning curriculum to target frontline health has changed the way their traditional educational systems work.

had an uprising that put the state of rural /remote/northern healthcare into the spotlight. Something had to be done to build the capacity of BC's healthcare system across the province in a sustainable way.

Four years later, the tangible benefits of that uprising were striking. UBC partnered with University of Northern BC (UNBC) to create a distance campus in Prince George that educates medical students for the duration of their medical program in collaboration with local physicians and other healthcare workers. The training provided focuses on rural and remote northern care.

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*...shifted a lot of the conversation about what medical schools are doing across Canada and brought forward a social accountability framework.*

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*“People across Canada said to us ‘Are you crazy? This is an underserved community; there aren’t any doctors; who is going to teach?’”* Typical of most frontline health solutions, Joanna and her team had to think outside the box. Most of the content is taught by video-conferencing due to the lack of onsite faculty and community practitioner resources. UBC has also altered its admission process to assess candidates’ rural, remote, northern and/or aboriginal experience in addition to their academic merit. In fact, *“many of our interviewers for applicants to medicine are now mayors from small northern towns, people like that.”*

Dr. Joanna Bates spoke about the fact that in 2000, Prince George was listed as one of the worst places to get sick in British Columbia. *“There was a profound lack of services and practitioners, so much so that people were being flown out of the province for care.”* The community of Prince George

Making frontline medicine a focus through the establishment of this program has become a legitimate aim and an important mission of UBC's

medical school. They take pride in it. *“I get to say to other medical schools who are proud of their cardiovascular research scientists, ‘so what exactly are you doing for your northern areas,’ which has sort of shifted a lot of the conversation about what medical schools are doing across Canada and brought forward a social accountability framework.”*

One thing Joanna didn’t expect was the intense support and engagement of the Prince George community. They recognized the benefit of having a medical program in their city and understood how it would improve their own healthcare locally. As a result, the community got engaged and helped drive the change that was happening in their city. Local physicians purchased a 3-bedroom house for the free use of visiting residents and faculty. Prince George residents responded en masse to calls for volunteers, even when the opportunity wasn’t all that pleasant: *“We use volunteer patients when our first year med students [learn] to do clinical exams...You can imagine it is not the nicest thing in the world to have 30 pelvic exams by new medical students. We put a little tiny ad in the Prince George Citizen for volunteer patients; 500 people volunteered.”*

The support of Prince George and surrounding communities impacts the health of British Columbians more than they might know: today, UBC’s body donor program is driven almost entirely by donations from the North. *“The local*

*engagement is remarkable. I mean, even the taxi drivers who picked me up at the airport knew all about the program and would tell me ‘oh, you should hear about it.’”*

Social change often begins on the margins. Prince George is not the only underserved community with a distributed medical education program. There are now six across Canada. The UNBC project has also been presented in the United States as an example for building capacity in underserved areas.

Joanna has partnered with the Frontline Health program to develop a collaborative project *“that will provide evidence of the impact these programs are having on physician recruitment and retention and on shifting the admissions process of the medical school to look at northern and rural students. It also looks at the impact on the community as a whole in terms of how the community feels about themselves because they now have a medical school, a medical program.”*

### **Shifting values and expectations**

Participants showed their philosophical sides as they talked about the shifting values and expectations of the younger generation. What do they think about the frontlines of health? How do you reach out to today’s youth and interest them in frontline work?

There was a mixture of worry and optimism among participants.

*“We are facing some pretty big challenges in the way society seems to accept homeless on the street and other things like that.”* What does this portend for the future? One participant believes it’s a reflection of a younger generation who passively accepts the way things are; they learn to work within the system rather than challenge it. Dr. Garey Mazowita, Chair, Department of Community and Family Medicine at St. Paul’s gives an example: he’s been involved with the College of Family Physicians’ exam for the last 25 years and has seen major changes in the oral exams. Four years ago, students would not be able to finish their exam in the 15 minute allotted time. Today, most students are finished within 12 minutes. *“Medical students today are modeled and mentored to work within our fee-for-service system where it’s all about through-put.”* This approach wouldn’t work in the field of frontline healthcare. Incorporating sensitivity and cultural training into the curriculum and offering frontline experiences is one way to show students alternatives to the mainstream.

Some participants see great opportunity in a new generation of youth who want to make a difference. Ric Young, an advisor to the Frontline Health program and specialist in social change referenced a relatively recent phenomenon among students entering business schools and MBA programs. These students have a marked interest in social issues and many of them are driven to make a difference rather than a

fortune. These students expect social justice and responsibility to be part of their curriculum and they seek out positions at companies that are socially responsible. *“[Youth today] are really interested in the relationship of people to community. And they don’t see fixing the world just by fixing people but by understanding the sort of complex system that community is. So I think there is an opportunity to really engage the next generation of doctors and harness their desire to make a difference.”* Ric pointed to volunteer programs for healthcare students, like CHIUS, that are in place at universities across Canada and are evidence that this sense of social justice extends to young people pursuing medical training.

Dr. Vicki Smye, from the UBC School of Nursing, has been working to integrate some social introspection into her curriculum. *“We live these unexamined lives in terms of how we approach people and how we build relationships with people.”* Vicki encourages students to consider social situations as part of their approach to healthcare and patient diagnosis. This has been extended to include graduate programs, recognizing that it is just as important to educate the people who are already working in the system.

Moving to small group teaching has also been shifting health profession education, added another participant and teacher, because it puts a person’s values squarely into the learning



Photographer: Christopher Grabowski

Downtown Eastside, Vancouver, British Columbia

environment. Her medical students spend a lot of time in small groups, and in those groups they *“can’t ignore who they are and who the people around them are.”* They learn how different cultures accommodate and manage marginalized groups of people. *“It colours who they are and how they practice.”*

Renewing curriculum is one way to address the shifting values and expectations of today’s students as well as the frontline patients they will one day care for. There were several participants from UBC in the room who spoke about the work UBC is doing around curriculum renewal. *“We did a series of meetings and focus groups with aboriginal students who were in our medical program and we found that they were really disturbed by the messaging within the program.”* This has led to

changes in communication and messaging within their curriculum.

UBC’s distributed medicine education program has introduced rural and remote perspectives into their curriculum. Students from campuses in Victoria, Vancouver and Prince George are taught via video-conference by instructors who hail from each of the three sites. At least one third of the sessions are taught by faculty from the north. *“The [northern-based faculty] might not talk about the family physicians’ role in the same way that the urban specialist would. So the students who are in classrooms across the province interacting with this teacher all get the same message. The message is that medical care in BC is not urban care. Medical care is care to people whoever, wherever they are.”*

## The influence of the current healthcare system

The current healthcare system wields great influence on the behaviour and beliefs of the next generation of students. *“I can remember a time when a physician could spend an hour with a patient, build a relationship and establish trust.”* Those days are gone. Today’s system is structured to encourage through-put. *“It has reduced doctor’s visits to 10 minutes and has moved the doctor’s office from the storefront to the third floor.”* Medical students are trained to practice within this system.

Placing students in practicums at community health centres, where *“there is a different philosophy, there is a different funding system and where the enthusiasm of the staff is very evident”* is one way to give them a different perspective on healthcare. It opens their eyes to alternative approaches that are far more connected to the community. It also introduces students to the realities that exist for people on the frontlines.

CHIUS (Community Health Initiatives by University Students) has been really successful at providing students with the option to gain some experience within a frontline community. CHIUS is a student-led volunteer program from UBC *“that encompasses nine health care disciplines. [Volunteers] go down to the Three Bridges Community Centre and it gives them a chance to maybe understand better that it’s not just about writing the script, it’s not that ten minutes, it’s about*

*spending time and understanding the patient. [CHIUS] has actually changed some of the students’ decisions about where they want to practice.”*

## Actionable items: the next generation

Encouraging the next generation of practitioners to take up the field of frontline practice is an important part of making Canada the best in the world at meeting the healthcare needs of its vulnerable populations. The group identified several actions that could be undertaken to attract, recruit and retain the next generation of frontline practitioners.

- **Develop an interprofessional elective for inner-city frontline health** that is a complement to the elective UBC has created for rural health. Students from across disciplines could come together as a group and gain experience from a range of inner-city, frontline health providers.
- **Create mentoring networks** that can connect new practitioners with those active in the field.
- **Incorporate sensitivity and cultural training** into curriculum.
- **Engage youth** in the process, collect their ideas.
- **Maintain a database of opportunities** for clerkships, residencies, preceptorships and rotations on the frontlines of health.

## Part Three: Facilitating public policy, building public awareness

Creating real change for marginalized populations requires policy work and public awareness campaigns. The story of the frontlines needs to be told because more often than not, it is a story of innovation and opportunity. It shows the great deal of good work that is being done and, in many cases, how this work is actually saving money rather than costing money.

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*...you need to be political about this stuff.*

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Participants at the Vancouver roundtable have had some success with putting frontline health on the agenda of municipal politics and generating community support and awareness of the issues. As a result, they had some interesting insights around approaches and lessons learned. Perhaps one of the strongest messages they send is that *“you need to be political about this stuff.”* Working together at the service delivery level is critical and so is

establishing local governance. Participants firmly believe there is also a need for public accountability.

Through the discussion, participants identified a number of actions they could take to aid policy work and public relations around frontline health. A big part was to **build the business case** and develop the value proposition for policy change. This could be built into a **position paper on frontline health**. **Promoting the stories** of good works and **establishing an online resource** on frontline health is also important.

### **Being political about frontline healthcare**

Perhaps one of the best-known and most avant-garde frontline healthcare projects is Vancouver’s safe injection site, Insite. Insite has received both accolades and criticism for its approach to curbing overdose deaths among injection drug users.<sup>4</sup> The project is an interesting study about *“being political”* on frontline issues. It took careful planning, daily lobbying and considerable organization from a large number of

<sup>4</sup> At the time of the Vancouver roundtable, opponents to Insite were lobbying to have it shut down. This lobby was unsuccessful because of existing policy that gives Insite the legal right to operate. An appeal of this policy that protects Insite is expected.

people to get from the original idea to implementation.

The safe injection site is managed by the Portland Hotel Society Community Services (PHS). Mark Townsend, Executive Director of PHS, spoke about the process: at an early stage, “we made a very difficult decision to focus on lobbying for just one issue: curbing overdose death. The fact is people were dying from overdose every day.” Once committed to this focus, the journey was mapped out. Communications were written with the intent to convert the Mayor and gain his support. “You have to get someone who is prepared politically to go to the wall and basically lose his job as Mayor because of his commitment to real change.”

emphasized: “It takes the ability to reach out to a vast army of people who will take it on as their own thing to build that movement to create the change.”

Changing public opinion on frontline issues is not easy. Sometimes it gets uncomfortable. As Mark summarized: “It requires a lot of money, a lot of time and a lot of effort... knowing the journey that you’re on and being very sure what your paradigm is and being able to kind of fan out across the various elements that you need to bring into play to win.”

There was a strong sense in the room that it would be completely irresponsible to simply let things be. The agenda around frontline health has to move forward.

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*I think it’s a challenge to everybody who is delivering services to get together and do business perhaps in a different way.*

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PHS worked to convince many people from across the province to buy-in to the idea. They managed a self-help group for drug users called **Grand Dieu** and “amplified” their message to the public. They funded a film called **Fix** that came out prior to the civic election. Mark

### **Working together to deliver services**

One of the hurdles that needs to be overcome in order to facilitate policy change is better integration among frontline service organizations. There are a vast number of community groups in BC that provide services to frontline populations but there is also a profound lack of integration and coordination among them. “To me that’s the big task. I think it’s a challenge to everybody who is delivering services to get together and do business perhaps in a different way”. Participants discussed some ideas, both within their communities and at the policy level, on how they could work together to take a different approach to delivering services.



Albert Street, Nanaimo, British Columbia

Participants agreed that finding funding to keep their programs going is a constant effort. There isn't much private money available and the needs of frontline projects often do not fit the inflexible and ever-changing requirements of government grants. *"What's happened because of this idea that there are too many organizations providing similar services... is that **now** in order to get the funds, we have to actually partner with another organization."*

Coordinating the "ask" has been used successfully by AIDS and Cancer advocacy groups. *"When you bring together all the organizations, like from the downtown east side [of Vancouver], to create a plan and go as one voice, you are more likely to be heard and get support."*

Some of the Victoria-based participants shared how they have been able to get a handle on this issue of duplication of services and competition for funding. Downtown Victoria service providers meet on a regular basis to address issues and share information. Irene Haigh-Gidora from the CoolAid Health Centre in Victoria: *"It's worked to our advantage to look at some of our downtown homeless issues and work as a community instead of fighting around the issue and [competing] for the same dollars. We still have huge problems with homelessness and drugs and alcohol and so on, but we're looking at them in an atmosphere of agencies being able to work closely together."*

Kelowna is another smaller community that has worked to bring together organizations to address frontline issues in its downtown core. Andrew Hughes talked about the Partners for a Healthy Downtown (PHD) program. Representatives from the municipality, law enforcement, local business and community organizations get together and *"use their assets to find ways to maintain a safe and happy community."*

Andrew believes the business community is an untapped resource for addressing systemic frontline issues such as homelessness; but, you need to know how to work with them. *"In order to engage business, you need creative profit; you need to think like them."* He is exploring ways to make low-income housing attractive to property investors

by changing tax laws. *“We’ve got to create a system that makes it attractive for business to develop affordable housing. Drop city taxes, make it tax free housing, so the investors are motivated to build.”*

### **Establishing local governance over healthcare**

BC is one of a number of provinces that has regionalized its health authorities. Many participants feel the system isn’t doing what it was supposed to do: *“the whole idea about regionalization of [healthcare] services and decentralization was it would create local governance, it hasn’t really done that.”* Participants couldn’t say, definitively, why it hasn’t worked. One participant who relocated to BC from another province was stunned to find that *“there was one Board of Directors for a huge diverse region and that they were all basically appointed by the government and they weren’t necessarily representative of communities that they serve.”* In the smaller areas, having one health authority and one board of directors might work but in a more urban setting, *“[regionalization] really hasn’t gone far enough. We need local community health organizations with local boards and with a population responsibility.”*

Having local representation in the health authorities is a critical part of making sure that the healthcare concerns of local communities are voiced. Put community members on health boards.

As one participant related, *“community representatives were bang on as to how the system failed them and how we can move forward. The challenge is to take away the emotion and be able to work within their strengths and within their, you know their core issues.”*

The Victoria taskforce on homelessness is one example of a municipally led initiative that levered a significant change in the health authorities’ attention to an issue. Irene Haigh-Gidora spoke about how her local community got together because they didn’t want to see people shooting up on the sidewalks anymore. *“I think there is much more support now for a concept of a safe injection site in Victoria because people see the reality of not doing anything about it.”*

### **The power of an informed public**

One of the biggest challenges for participants is that the frontlines are misunderstood by the general public. Media stories are often negative because, in the opinion of participants *“that is what sells newspapers.”* In fact, the Frontline Health program is one of the only vehicles that is actively collecting and publishing the stories of innovations from the frontlines of health.

Dr. Jennifer Lee, a physician with the Victoria Youth Clinic, spends a lot of her time trying to change people’s perceptions about marginalized populations. Telling half the story, the

bad half, just isn't accurate. What is worse is that it also perpetuates the negative perception that frontline issues are intractable and should therefore not be funded. This has a bottom-line effect on her organization and her ability to help street youth. *"People are not seeing the strengths, the possibilities, the programs that are working; the exciting things that are happening [on the frontlines]. We need to change their perspectives and create that will to fund things."* Jennifer believes it's incredibly important to get the messages out that things are working so that people will invest the money needed to keep programs like hers going.

When people are educated about the needs of frontline populations and the work of frontline service providers they lend their support and become more accountable. Sometimes public accountability is harnessed through active lobbying and media use, such as with the campaign to establish Insite. Sometimes it's a result of changing social conditions: *"[The Victoria] public's eyes were opened only because they couldn't go downtown anymore and not see somebody acting out because of drugs or the growing numbers of homelessness."* In either case, the public became an important voice in effecting change on a frontline issue.

Unfortunately, the public is often uninformed about frontline healthcare. *"You talk about the taxpayer, nobody owns those people that are on the streets*

*but everybody is paying for them."* The cost of not doing anything about frontline issues, such as homelessness, has a greater impact on taxpayers than they know. This is an argument that isn't being made by practitioners because they don't have the time to make it.

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*People are not seeing the strengths, the possibilities, the programs that are working; the exciting things that are happening [on the frontlines].*

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Participants have tracked the difference it would make if you look at the cost of doing nothing. Andrew Hughes from Kelowna: *"I tracked one individual just because I was curious. It cost us \$108,000 to house him last year because he spent four months in the hospital...we could have housed him for approximately \$23,000 in our most expensive hotel."*

Similarly, Mark Townsend from the Portland Hotel Society did some tracking of his own: *"We put in money to feed one set of our residents three meals a day to see what effect it would have...and it was very complicated too because there are no kitchens [in the*

rooms]. The results were statistically significant: everyone's weight went up, and the 911 calls went to almost nothing because people were feeling quite mellow."

One participant pointed to how these ideas around the cost of doing nothing have been used with great effectiveness in Calgary. The project was led by a group of CEO's who mapped out what it cost to do nothing with frontline populations. The result was the creation of a new form of governance that included the municipality, the health authority, the private sector, and the community. "It was a new form of accountability and a very measured form of accountability." Finding a way

to follow Calgary's lead could be one way to engage the public in the issues of frontline health and gain their support to effect some real change.

### **Making the case for systems change**

Moving the needle on systems-wide change in Canadian healthcare seems daunting but participants felt strongly that it needs to happen to really make a difference for the health of their patients. Developing a position paper is one idea. "The hard work of crafting a case can be a powerful lever for change." They talked about what to include in the position paper: evidence of the success of new approaches to healthcare; the implications for not

## **Tele-dispensing: a different kind of vending machine**

Andrew Hughes, Primary Healthcare Lead for the Central Okanagan, talks quickly. His creative approach to caring for the health of Kelowna's growing homeless population has produced a Canadian-first: the establishment of a remote telepharmacy dispensing machine right inside his clinic. Andrew explains how this all came about:

*I bring doctors into my clinic and when they finish their consultation with one of our homeless patients, the first thing they do is write a prescription. That prescription walks out with a person who has no money; it might as well be a dirty cup on the street because the patient can't fill it. We needed to find the barrier that stops them from getting their meds.*

*Obviously, the biggest barrier is financial. A homeless person needs to get the money to get the 'script filled. At the clinic, we can find a one-time solution by using our emergency support fund, getting them connected to income assistance or getting them onto a government plan so they can have coverage but that takes at least a 24 hours. What about next time? My patient has already left the clinic without his meds.*

*We needed to create the capacity within the clinic to dispense the medications immediately. So we partnered with a company to become one of the first in Canada to have a remote telepharmacy dispensing machine onsite.*

*Now, the doctors coming to my clinic e-mail or fax a prescription to an off-site pharmacist who then provides remote authorization for my onsite vending machine to dispense medication. Essentially, it's a vending machine in our clinic but instead of pushing E4 and out pops your potato chips, out pops your seven day supply of Keflex®. The machine also connects back with the pharmacist using a webcam so the patient can ask questions if he wants to. The triangle of having — from the doctor to the patient to the pharmacist — is there.*

*Today a person can walk out the door with their antibiotics and we know we've increased their medication management and given them the chance to improve their health.*

doing anything; the policy response that would move things forward.

*“The work that is being done on the frontlines is unbelievable and inspiring and it’s important to bring this to the attention of the rest of the country because of the opportunity to influence a systems change. I think that a big change is possible. Ultimately, it’s not just a question of strengthening service for people on the frontlines [of health]; it’s also about the innovation found on the frontlines of health and huge lessons that are transferable to the mainstream health care system.”*

#### **Actionable items: influencing public policy and perception**

Influencing public policy and perception is all about communication and information sharing. The discussion uncovered examples of innovation and success that will shine a light on the field of frontline healthcare.

The following are some of the action items suggested by the group:

- **Draft a position paper**, in a collaborative manner, that gives shape to the field of frontline healthcare by sharing success stories and driving policy change.
- **Build the business case and value proposition** for funding frontline health initiatives.
- **Provide toolkits for media and advocacy work** to frontline practitioners and providers
- **Develop a frontline health newsletter** that provides progress reports, creates a sense of possibility and shares stories from, not just of, the frontlines.
- **Collect online resources and references** and make them available to practitioners for advocacy work.

# Conclusion



Photographer: Christopher Grabowski

*Downtown Eastside, Vancouver, British Columbia*

What will it take to make Canada the best in the world at meeting the healthcare needs of marginalized populations? It will take the continued efforts of frontline practitioners and thought-leaders, like the ones around the table in Vancouver, to develop innovative solutions and challenge the mainstream system. And it will take dialogues, such as this one, to get the message out to the masses.

Building on the first national roundtable on frontline health in Canada, the Vancouver dialogue keeps the

momentum going. From the mile-high perspective offered by the national group, Vancouver participants were able to add some essential and focusing themes to the discussion:

- a) Go forward with a shared voice, realize the power of integrating services and coordinating efforts to lobby for change, obtain funding and identify and prioritize local needs.
- b) Use what you've got on hand, the assets of your community, to move projects forward.
- c) Know your audience, their values and culture, to develop recruitment and training programs that are relevant and responsive.

Whether talking about building a community of practice, training the next generation of frontline practitioners or influencing public policy and perception, these themes are relevant. They will add richness and dimension to future dialogues.

Frontline healthcare is still an emerging field in Canada, but it is gaining more

recognition and more support. There is a shared determination among the Vancouver participants, and frontline practitioners and thought-leaders from across the country, to make healthcare accessible to all Canadians. *“We need to break down barriers so that every door truly is the right door for our clients.”* They will continue to push boundaries

and build programs that completely retool how healthcare is delivered. And they will continue to look beyond the treatment to the more systemic issues that are marginalizing populations. Perhaps the most exciting thing about the field of frontline healthcare is that it isn't just about treatment, it's about social change.

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*We need to break down barriers so that every door truly is the right door for our clients.*

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# Appendix A: The people around the table

## Participant List

<p><b>Rhonda Alvarez</b> Program Coordinator Helping Spirit Lodge</p>	<p><i>“I am a frontline grassroots worker and I deal with people who are homeless and at risk of homelessness. My passion is to really making a difference in the homeless community to make their quality of life better.”</i></p>
<p><b>Dr. Joanna Bates</b> Senior Association Dean, Education UBC Faculty of Medicine</p>	<p><i>“I am a family physician. I worked for years out of St. Paul’s Hospital in downtown Vancouver and for the last 20 years I have been doing health professions education on faculty at UBC.”</i></p>
<p><b>Dr. John Carsley</b> Medical Health Officer Vancouver Coastal Health Authority</p>	<p><i>“One of the most important things for me through this dialogue is to hear what other people are doing, their models, what they have gained and what they have learned.”</i></p>
<p><b>Dr. Trevor Corneil</b> Medical Director – Primary Health Care Urban Vancouver Coastal Health Authority Three Bridges Clinic</p>	<p><i>“I’m an inner city primary care physician and my modus operandi is to find populations who have difficulty accessing healthcare and then finding ways to provide support and care to these communities. Right now, I’m doing a lot of work with the transgender health community.”</i></p>
<p><b>Ms. Linda Lane Devlin</b> Executive Director Stroke Recovery BC</p>	<p><i>“My career has taken me from working in addiction services in Vancouver’s downtown eastside to working with stroke survivors. I am passionate about peer-based programming and am currently working on a peer mentorship program within the stroke survivor community.”</i></p>
<p><b>Ms. Anne Drost</b> CoolAid Health Centre</p>	<p><i>“I used to be a street nurse and worked with marginalized people on reserves up north and in the inner city. Now, I’m a nurse at CoolAid Health Centre in Victoria. We serve people who suffer from addictions and mental health problems.”</i></p>
<p><b>Ms. Irene Haigh-Gidora</b> CoolAid Health Centre</p>	<p><i>“My passion is in integrated community health. I was involved with developing the CoolAid Health Centre and various community centres when I was working in Manitoba.”</i></p>
<p><b>Mr. Terry Howard</b> Coordinator, Prison Outreach Program BC Persons with Aids Society Building Community Society</p>	<p><i>“I coordinate a prison outreach program for the person’s with AIDS society but I’m also here to represent the new Building Community Society. I’ll be working with marginalized populations and doing a needs assessment and then a gap analysis for those people on services.”</i></p>
<p><b>Mr. Andrew Hughes</b> Health Service Director Primary Health &amp; Community Care Okanagan Interior Health</p>	<p><i>“My background is social work and right now my area of responsibility includes the Outreach Urban Health Clinic in downtown Kelowna which is an interprofessional team that services disenfranchised clientele in the Central Okanagan area.”</i></p>
<p><b>Ms. Wendy Johnstone</b> Solutions for Seniors Eldercare Planning</p>	<p><i>“I’m a gerontologist and I help people who want to plan care for their elderly parents, making sure we can link seniors back into the community so they can have a fulfilled life for as long as possible.”</i></p>
<p><b>Dr. Gail Knudson</b> Vancouver Coastal Health Authority President, Canadian Professional Association of Transgender Health (CPATH)</p>	<p><i>“I am a psychiatrist and I work in both Vancouver and Victoria in the area of transgender health sexual medicine. I also teach at UBC.”</i></p>

## Appendix A: The people around the table – continued

### Participant List

<b>Dr. Jennifer Lee</b> Victoria Youth Clinic	<i>“I am family physician and my passion is youth. I work closely with a team of cool people establishing a multi-disciplinary clinic in Victoria that enables access to healthcare for street youth.”</i>
<b>Dr. Maureen Mayhew</b> Vancouver Coastal Health Bridge Clinic	<i>“I’ve been a primary healthcare physician for the last 20 years. I’ve worked in many parts of the world. My passion is international health and refugee health.”</i>
<b>Dr. Garey Mazowita</b> Head, Department of Community & Family Medicine, Providence Health Care St. Paul’s Hospital	<i>“I’ve been working in this field for many years, first in Manitoba and now here in Vancouver and I find the changes taking place today utterly fascinating. I’m really interested in the next generation of care providers and in understanding their values and what they are going to bring to the table.”</i>
<b>Ms. Katherine Mooney, RN</b> Community Health Services Pine Free Clinic	<i>“I’ve been working with marginalized populations since I was a nursing student. You could say it’s been my career job and my definitely my passion.”</i>
<b>Mr Warren O’Brian</b> BC Ministry of Health	<i>“I work in the population and public health area and we look at health prevention and harm reduction. We look at how we can bring the principles of population health to bear for vulnerable populations.”</i>
<b>Ms. Lyana Patrick</b> Program Assistant Division of Aboriginal People’s Health UBC Department of Family Practice	<i>“My background is in family communications and one of the things that led me to medicine was a great desire to contribute to improving the healthcare for indigenous people. Right now, I am developing an on-line course specifically on residential school for health professional students so we can see the links, the historical links to our contemporary health issues and concerns.”</i>
<b>Dr. Elizabeth Saewyc</b> UBC School of Nursing	<i>“I am a public health nurse by background but my passion and program of research is youth health, especially marginalized populations and primarily issues of sexual violence and mental health and substance use.”</i>
<b>Dr. Todd Sakakibara</b> Vancouver Coastal Health Three Bridges Clinic	<i>“I am family doctor at the Three Bridges Clinic and I am really interested in marginalized pops such as people with HIV or addictions and the gay, lesbian and transgendered community.”</i>
<b>Dr. Vicki Smye</b> UBC School of Nursing	<i>“I am on faculty at the UBC School of Nursing and my program of research is inequities in access to mental health and addictions care, mostly focusing in aboriginal populations and women.”</i>
<b>Mr. Mark Townsend</b> Executive Director, Portland Hotel Society Manager, Insite	<i>“I founded the Portland Hotel Society a long time ago to drive change on Vancouver’s downtown eastside. It’s a long process but it’s something that has to be done. To ignore the problems there would be irresponsible.”</i>

# Appendix B: About the Frontline Health Program

The **Frontline Health** program is AstraZeneca Canada's long-term commitment to help improve Canada's capacity to serve those Canadians who face barriers to healthcare. It was inspired by AstraZeneca's belief that every Canadian, whether living on the street or 100 kilometres from the nearest hospital, has the right to quality care.

The **Frontline Health** program works with community-based stakeholders to:

- Pursue research and innovation that will advance capacity to serve marginalized populations.
- Build knowledge sharing networks among practitioners to help foster communities of practice on the frontlines.
- Support university programs that will help attract and develop the next generation of frontline health professionals.
- Share and celebrate stories of dedicated practitioners and successful innovations to raise the public and policy profile of frontline health.

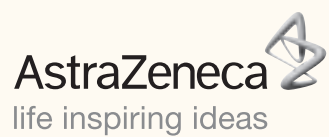
For more complete information on the Frontline Health program, please visit [www.frontlinehealth.ca](http://www.frontlinehealth.ca).

# Appendix C: The frontlines of health

The frontlines of health exist wherever there are people who cannot or will not access the mainstream healthcare system. This includes populations that are geographically, socially, economically and/or culturally isolated. Many factors discourage a person from accessing care. Their town may no longer have an emergency room or a needed medical service — like ophthalmology or dialysis. A person may face constraints that make them unable to get out for care. These could be physical constraints that affect a growing number of senior citizens who spend a great deal of their time alone; or time and situational constraints, like those facing immigrant women with responsibilities to work through the day and care for their families in the evenings. The social stigma attached to a person's lifestyle — whether they chose their path or not — may deter them from seeking care. This includes the homeless, people with substance abuse issues, transgender individuals, street youth and others. Staff in mainstream systems, like emergency rooms and clinics, are often not trained to treat these individuals. For instance, the pain treatment you might give for a patient admitted with a broken arm would not reduce the pain of an addict admitted with a broken arm.

Canada and its healthcare system is challenged to provide equal care to a richly diverse and geographically scattered population. Remote outposts, suburban bedroom communities, inner city streets. The frontlines of health exist everywhere. More than 9 million people, 30% of our populations, live in rural populations, beyond the reach of mainstream services that typically exist in urban centres. Yet only 18% of family doctors and nurses have chosen rural practice. More than 100,000 Canadians live in absolute homelessness. The HIV rate of injection drug users in Vancouver's downtown eastside is one of the highest in the world, equal to that in Swaziland. Suicide rates among street youth are 100 times higher than the national average.

While these statistics may seem insurmountable, there is a determined group of people — practitioners, researchers, nonprofit leaders, policy-makers — who work tirelessly to make healthcare more available to frontline populations. They work in street clinics, community health centres, inner city hospitals, mobile outreach units, solo rural practices and remote outposts, striving to make a difference where the needs are greatest and the system is stretched most thin. The solutions they develop are innovative and should serve as learning opportunities for others working in both mainstream and frontline healthcare.



#### About AstraZeneca

AstraZeneca is a leading global pharmaceutical company with an extensive product portfolio spanning six major therapeutic areas: gastrointestinal, cardiovascular, infection, neuroscience, oncology, and respiratory. AstraZeneca's Canadian headquarters and packaging facilities are located in Mississauga, Ontario, with a state-of-the-art drug discovery centre based in Montreal, Quebec.

AstraZeneca Canada supports communities as part of its commitment to improving the health and quality of life of Canadians. Its Frontline Health program aims to improve the capacity of Canada's healthcare system to meet the needs of unserved and underserved populations.

For more information, visit the company's website at [www.astrazeneca.ca](http://www.astrazeneca.ca) or the Frontline Health program at [www.frontlinehealth.ca](http://www.frontlinehealth.ca).

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