Primary Care in the Fraser Health region

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Primary Care in the Fraser Health region

QUICK FACTS

- The Fraser Health region encompasses 20 communities from Burnaby in the North, to White Rock in the South, and Boston Bar in the East.
- Fraser Health is the fastest growing health region in Canada, with a patient population of approximately 1.5 million.
- 37% of its population is living with multiple chronic conditions, and use 80% of health resources.
- Approx 30% of people are ‘unattached’ – don’t have a regular family doctor.
- 1435+ GPs and specialists practice in the region.
- 12 Fraser Health Nurse Practitioners work in Primary and Aboriginal Health Care.
- The primary care professional network also includes public health staff, community nurses, midwives, pharmacists, mental health professionals, clinical counsellors, physiotherapists and others.
- Home and community care workers, mental health and addictions professionals, dietitians, specialists, other professionals and non-governmental organizations work in the primary care setting.

Strategic Partners

- Ministry of Health Services
- General Practice Services Committee (GPSC)
- BCMA
- Family Physicians / Divisions of Family Practice
- Patient Voices Network / Impact BC
- FH Community-based services, including Home Health and Mental Health and Addictions
- Non-government Community partners
- Municipalities

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Primary Care is increasingly recognized as the pivotal point of care where health outcomes can be positively affected.

- Family physicians are the cornerstone of primary health care, and constitute its largest workforce.
- Evidence points out the critical importance of primary care in overall health care system sustainability.
- Pressures on primary care providers are greater than ever due to an aging and growing population. For this reason, GPs, community-based health care providers, the health authority, and General Practice Services Committee are working together to strengthen a supportive, integrated network of collaborative, primary and community care.
- Several funded initiatives are available to GPs and Divisions of Family Practice to support practice enhancements, patient care, attachment and other primary care work.

PRIMARY HEALTH CARE TEAM: BACKGROUND

The primary care leadership and project team working in Fraser Health exists to enable providers to optimize the health of patients they care for. The team works closely with physicians and specialists, and community-based providers to:

- Plan new programs or systems
- Organize optional, compensated education opportunities for providers to learn about new innovations and practices.
- Liaise with governments at all levels to support new programs and innovations.
- Acquire funding for new programs.
- Research innovations and systems, and share best practices and innovations from other jurisdictions.

The Primary Health Care team in Fraser Health was established in 2003 to support primary care renewal. The portfolio was made permanent in 2005 as a result of federal funding and a provincial commitment to more vigorously support physicians and their patients. Today the Primary Health Care program in Fraser Health has expanded to further support providers and patients with complex and chronic conditions, through the provision of practice support programs and the collaborative development of integrated primary and community care networks.

Leading the Primary Health Care Development team is:

Barbara Korabek, Vice President
Dr. John Hamilton, Medical Director,
Georgia Bekiou, Director
Lisa Samms-Maxwell, Manager
Teresa Armstrong, Manager

Diane Miller, Executive Director
Dr. Brenda Hefford, Physician Executive Lead
Lisa Dwyer, Manager
Joan Rabillard, Manager

Plus, a team of Primary Care Project Coordinators, who work closely with GPs and practice managers.

For more information, please visit:
www.fraserhealth.ca
www.gpscbc.ca
www.Impactbc.ca
Integrated Health Networks

Expanding capacity for GPs and other providers in an integrated primary and community care system

GPs can more readily respond to increasing numbers of patients with chronic or complex conditions, with the establishment of new integrated health networks.

In an integrated health network, a patient (and family) is considered a partner with their GP. An interdisciplinary team wraps around the patient and GP to provide comprehensive care coordination and services as health needs become more complex.

What is its purpose?

An integrated health network is designed to support GPs and patients who are living with complex, chronic health conditions and those at increased risk of poor health outcomes.

An IHN is built around a person’s relationship with a family physician and an extended health care team – linking patients and their GPs in a geographic area with existing health authority and community resources.

Key resources are brought together to form an integrated team, customized to meet the specific needs of patients. Collectively, clinical and community partners work together in a collaborative way, to improve the health of each individual as much as possible.

As a partner, a patient (and their caregiver) is the key priority and recipient of services. An IHN is designed around the needs of the patient, and aims to improve the quality and safety of care, while encouraging healthy individual behaviour, including self-care and lifestyle choices.

An integrated health network is not a place, but a system, with many delivery points.

How does it work?

Instead of working independently to address each condition in isolation, health providers agree to work together across the spectrum of services to share and coordinate care. They proactively plan for a person’s range of health needs over the long term.

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The Most Responsible Provider – usually the family doctor – directs overall care. He or she may connect a patient with one or more partners, such as care coordinator, home health provider, mental health specialist, or pharmacist, to name a few.

**How do providers and patients benefit?**

An integrated health network has many benefits for patients, providers and the system:

- Improves health for people with chronic, co-morbid, or complex conditions, mental health issues and the frail elderly.
- Sustains, continuous, coordinated care, with an attachment to a primary care provider, optimizes overall health.
- Improves a patient’s experience and satisfaction as they access services in the system, with more continuity of care, less run-around and stronger relationships with care providers.
- Increases a patient’s / client’s confidence and sense of control as they gain knowledge and tactics to manage their own health and develop healthy lifestyle choices.
  - For GPs and other providers, the network expands capacity for chronic /complex care beyond practices and into the community, and eases the load on individual providers.
  - For GPs and other providers, improves professional satisfaction as it saves time, reduces duplication and improves feedback with fewer communication gaps.
  - Enables primary care providers to actively work together with the broader community to foster healthier lifestyles, improve population health, and create a healthier community.
  - Reduces costs for the health care system as a whole, better management of disease, prevention of hospital visits, and more effective use of primary care, community care, and regional resources.

**When and where is this being implemented?**

Early integrated health networks were tested in several communities in 2007. A second phase of Integrated health networks starts in Chilliwack and White Rock/South Surrey in Fall, 2010.

The second phase of Integrated Health Networks will establish a foundation based on GP partnerships with Home Health (care management in GP offices) and Mental Health and Addictions services.

IHNs will be established by 2012 in additional Fraser Health communities where there are Divisions of Family Practice, in partnership with clinical and community resources. The goal in five years is to have IHNs established in all communities.

Each IHN will be evaluated as it develops and refined for its effectiveness.

**Opportunities for GPs to participate**

GPs and Divisions in Fraser Health communities are invited to participate in the design and implementation of the integrated health networks. (Contact below.)

**Contact information**

Lisa Dwyer
Lisa.dwyer@fraserhealth.ca
604-517-8620
DIVISIONS OF FAMILY PRACTICE

What is a Division of Family Practice?
A Division of Family Practice is an association of family physicians with common health care goals who practice in the same geographic area of BC. Each local division is established as a society.

Divisions of Family Practice work in partnership with their Health Authority (HA), the GPSC and the Ministry of Health Services (MOHS). Together, they work to identify gaps that exist in patient care in a Division’s community and to develop solutions for their particular issues.

How and why did the Division model get developed?
Divisions of Family Practice are a physician-driven initiative designed and supported by the General Practice Services Committee (GPSC), to bring together groups of family physicians (FPs) for the purposes of:

- increasing influence on health care delivery within their community
- increasing professional support and networking for physicians

Feedback from Professional Quality Improvement activities in 2005/2006 indicated that as a result of erosion of hospital-based communities of practice, FPs had low morale and work satisfaction due to feeling isolated with no support in their communities. In addition, capacity was shrinking for GPs to manage increasing numbers of complex, aging patients, and unattached patients in their communities. Among other benefits, the Division model addresses this issue.

Divisions of Family Practice work together with the Health Authority within the structure of a Collaborative Services Committee (CSC), to plan and carry out primary health care initiatives in each community.

As of September 2010, Divisions have been established in most communities in the Fraser Health region.

Why are the benefits of participating in a Division of Family Practice?
Participating in a Division in results in a number of potential benefits (depending on the community):

- enhanced provision of full spectrum primary care as a collective responsibility
- greater impact on the organization of local/regional health services around your practice
- improved linkages with health authority and specialist services
- increased ability to advocate for the needs of patients and for yourself and your colleagues
- on-going support from peer networks as well as physician health and wellness programs
- shared efforts for recruitment, retention and locums
- more support from colleagues and partners in caring for complex patients
- support and services to care for unattached patients
- reliable assistance with duties historically falling to call groups, e.g. scheduling, meeting organization
- strong support for developing and implementing innovative service models

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How does a Division of Family Practice work?

To form a Division, a group of community-based practicing family physicians must currently be discussing common issues impacting patient care in their community, and be interested in working as partners with the Health Authority and GPSC in addressing these issues.

The partners then collectively develop and sign a Document of Intent (DOI) with the GPSC, their local Health Authority, and the MoHS Medical Services Division (the partners) that will outline how each partner will support the Division of Family Practice and each other.

Although there are some basic, common elements to all Divisions, others – such as family physician involvement in the local hospital – are determined by a Division’s members to reflect local priorities. As Divisions mature, they may take on additional responsibilities that could include:

- ensuring comprehensive primary health care for community residents
- facilitating administration for Division members
- facilitating integrated care with specialists
- exploring integration with mental health and addiction services, palliative care and residential services as well as with community organizations

How are Divisions funded?

Annual funding for basic facilities and the operation of each Division is provided by the GPSC and is calculated based upon the number of physicians in the Division. These funds can also be used to cover physician attendance at planning meetings. Additional funding for special clinical programs, attachment, or other patient care initiatives may be available separately from the Ministry of Health Services (MoHS) and/or from the HAs, as agreed upon by the Division partners.

Where can I get more information?

Visit the GPSC Divisions of Family Practice website at: www.bcma.org/divisions-family-practice.

Contact information

Dr. Brenda Hefford
brenda.hefford@fraserhealth.ca
604-807-7496
Practice Support Program

Creating a more rewarding, flexible family practice with leading-edge tactics & tools

"I’ve been able to take on a number of new patients with the new way we’re running the practice. It’s better care. It allows me to capitalize on some of that higher-volume, lower-acuity medicine. My patients enjoy coming to see me, so if I’m having a good day, my patients are having a good day."

– Dr. Alex Bartel, Chilliwack

GPs and MOAs are invited to participate in compensated, physician-led sessions to learn about new techniques that increase efficiencies and enhance the capacity of a practice. When applied, these approaches can help to create a more satisfying experience for providers and patients.

What is its purpose?
The PSP program is designed to assist practices to:
- Integrate new ideas and processes into clinical practices and practice management.
- Help improve access and best care for patients.
- Make working conditions more manageable and fulfilling.

How does it work?
The province-wide program developed by the BCMA and GPSC and delivered by each health authority, provides family physicians and medical office assistants with incentives, training and technical support. It includes:
- Learning modules and materials designed for application in primary care clinical practices.
- Compensation for family physicians and medical office assistants (MOAs) to attend.
- Project coordinators to support implementation in the practice.
- Ongoing practice support for family physicians and their clinical staff.

Each Learning Session is 3.5 hours long and co-facilitated by a GP lead who is involved in program development and delivery. Each Module encompasses 3 to 8 Learning Sessions. Modules and program materials reference best practices and leading-edge approaches to clinical practice operations, including:

- Office efficiency
- Chronic Disease Management (CDM)
- Mental Health Management

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How do providers, practices and patients benefit?

Participating GPs and MOAs are experiencing:

- Increased efficiency.
- Space in the schedule to accept new patients.
- Greater provider and patient satisfaction.
- More effective partnerships with patients.

They are also observing ‘happier,’ more satisfied patients, with:

- Improved coordination of care between their family physician and other health services.
- Increased access for patients to see the family physician in a timely fashion, including the same day.
- Care that meets evidence-based clinical guidelines.

When and where is this happening?

Nearly 500 health professionals (one out of five GPs) in the Fraser Health region have participated in PSP modules since it was introduced in 2007. Learning Sessions will continue for GPs in the region.

Opportunities for GPs to participate

All learning modules are optional and voluntary - involvement with the Practice Support Program is entirely at the discretion of each physician or practice.

Modules start at various times throughout the year, and all GPs across Fraser Health are welcome to attend.

PSP meets the accreditation criteria of the College of Family Physicians of Canada.

Additional information and resources:

Program information: [www.impactbc.ca/practicesupport](http://www.impactbc.ca/practicesupport)

PSP in the Fraser Health region: [www.fraserhealth.ca/services/primarycare](http://www.fraserhealth.ca/services/primarycare)

Contact information

Jennifer Tierney, PSP Project Coordinator
psp@fraserhealth.ca
604.519.8585
PSP Specialist (PSP-SP)

Improving Access, Efficiency and Capacity in Specialty Practices

Previously available only to General Practitioners and their MOAs, the PSP’s learning modules are specifically designed to support specialists and their office staff (PSP-SP) to enhance practice efficiency.

What is its purpose?
The goal of PSP-SP is to support specialist practices across the province to test and implement changes intended to decrease waiting time. The modules are designed to assist specialists to build more efficient processes, and implement new delivery mechanisms to improve specialist capacity and enhance patient experiences.

How does it work?
PSP-SP utilizes three separate strategies to achieve its goal:

   - **Advanced Access**: Implementing innovative scheduling processes to decrease patient wait times.
   - **Office Efficiency**: Patient experience of office flow; specialist use of new billing codes.
   - **Group Medical Visits**: Structured group medical appointments provided to a group of patients sharing similar health concerns, thereby, leading to improved provider efficiency, patient experience and improved health outcomes.

Modules are tailored to specialist practices to ensure that the needs of each practice are met on an individual basis.

When and where is this being implemented?
Since June 2010, the PSP support team has visited seven specialist practices, who were among those who expressed interest.

Opportunities for Specialists to participate
Interested specialists are encouraged to contact PSP-SP.

Contact information
Kathy Riyazi: Project Coordinator
kathy.riyazi@fraserhealth.ca
604.519.8554
Patient as Partner Program
Enhancing provider and patient collaboration in everyday practice

*Studies show that when health care providers, patients and families work in partnership, the quality and safety of care increases, costs decrease, and satisfaction for both parties improves. A patient or family member's experience is a key factor in affecting outcomes.*

– Institute for Family Centered Care

What is its purpose?
The aim of the Patient as Partner program is to improve the quality and experience of care for physicians, patients and families. Its strategies help to increase a patient’s health literacy and confidence as a participating partner in managing their own health.

The Patient as Partner strategy is guided by three provincial charters:

- **Charter 1 (Personal Health Care):** Aim to enhance the collaborative relationship for individual health care between patients (and their families and caregivers) and health care professionals so that patients can achieve better health and patients have a better experience at a reasonable cost.
  - Patients are supported to plan and manage their health.
  - Health care professionals also supported to work with patients in ways that patients find meaningful.

- **Charter 2 (Primary Care Measures):** Aim to continuously include the diversity of patient and family voice, choice and representation in deciding how primary health care is planned, organized and provided in British Columbia.
  - This is based on collaborative relationships and include all levels from policy through to the practice level.
  - Patients and families are asked to help design and evaluate the way care is delivered at the planning stage.
  - Health care systems are involving patients in primary health care where patients and families are trained and supported to participate in primary health care transformation.

- **Charter 3 (Community Action Measures):** Aim to support growing and meaningful partnerships between Primary Health Care, community, patients and their families. Health care systems support increasing the involvement of the community in health care service delivery and decision-making.
  - This is based on a collaborative relationship among individual British Columbians, health care professionals and community partners.
How do providers and patients benefit?
Participants gain knowledge and tactics to increase collaboration between GPs, patients and families, with the aim of improving the experience of care and clinical outcomes.

- Patients are guided and educated to manage their health, prevent future illness, and learn self-care methods.
- Providers can gain more efficient patient management and increased practice efficiency.
- The approach supports a shift from reactive to more proactive and preventive care, which in turn reduces pressures on family physicians and other providers practicing elsewhere in the system.
- Patients and their families will benefit from stronger choice, voice and role in health care design and delivery.

Additional information and resources
Institute for Family Centered Care: [www.familycenteredcare.org](http://www.familycenteredcare.org)

Patient as Partner Information & Publications: [www.impactbc.ca/PatientsasPartners](http://www.impactbc.ca/PatientsasPartners)

Programs for providers in the Fraser Health region: [www.fraserhealth.ca/services/primarycare](http://www.fraserhealth.ca/services/primarycare)

Contact information

Fraser Health:

**Jami Brown**
Leader, Healthy Living/Healthy Community Strategies
Jami.brown@fraserhealth.ca
(604) 539-2900 Ext 743067

Ministry of Health Services:

**Kelly McQuillen**
Director, Patients as Partners
Integrated Primary and Community Care
Kelly.McQuillen@gov.bc.ca
250-952-2635
My Health Plan  
The shareable care plan

myHEALTHPlan is an innovative proof-of-concept project that shares patient health information on-line, electronically among a patient, their physician, and their allied health care providers.

How does it work?

- New electronic care plan templates for family physicians and web portal for patients and allied health care providers
- Easy for a patient and their primary care provider to create a personalized electronic care plan
- Amalgamates multiple plans for a patient who has more than one chronic condition.
- A patient and their allied health care providers at the local chronic care centre can view or print the plan via access through a secure web portal.
- The plan does not replace, but augments a practice’s Electronic Medical Record.
- The technology also connects Meditech with participating family physician offices to transmit admission and discharge data from Peace Arch Hospital directly into Electronic Medical Records
- myHEALTHPlan is part of myHEALTHSystem, an initiative to establish one consolidated electronic health information system in Fraser Health.

Patients have access to:

- A personalized action plan that tracks prevention and self management goals and progress.
- A patient resource library.
- Privacy protection and patient consent.

How does it support patients and providers?

- Gives patients access to information they need to self-manage, including links to approved electronic health resources.
- Helps allied health care providers provide care that is coordinated and consistent with the health goals of the patient and their primary care provider.
- Embeds clinical decision-support tools and care alerts for physicians.

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What are its benefits?

- For providers, myHEALTHPlan enables more coordinated patient management and follow-up. It reduces duplication and saves time, leading to greater efficiencies and satisfaction for GPs and providers.
- myHEALTHPlan enables patients to partner with providers to plan and manage care, and to set and meet targets. It provides tools and knowledge to help patients prevent and self-manage conditions, with the aim of improving their health outcomes.

Intended outcomes:
- Improve patient health outcomes.
- Enhance the experience and satisfaction of patients and their care providers.
- Streamline care, saving time for both providers and patients.

When and where is this being implemented?

- Fall 2010 demonstration in White Rock South Surrey
- 25 health care providers and 500 patients
- Focus on four chronic conditions: Diabetes, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure and Hypertension.

Opportunities for GPs to participate

During the demonstration, myHEALTHPlan will be assessed for its effectiveness, for potential expansion beyond the pilot practices. Meanwhile, interested GPs are encouraged to put forward feedback, suggestions or questions, to help ensure the work meets the needs of providers.

Contact information

Joan Rabillard, Manager, Primary Health Care
myhealthplan@fraserhealth.ca
604-519-8557
Measurement and Evaluation

Tracking the effectiveness of programs for providers and patients

A dedicated team of evaluation experts measures progress regularly to ensure that GPs and patients are benefiting from Primary Care programs and funding.

What is the purpose of evaluation?

Fraser Health Primary Health Care evaluations have the following principal objectives:

- To assess program impact and determine the degree to which program objectives are met.
- To provide quantitative and qualitative information for making project enhancements.
- To relate internal program dynamics to program output and outcome.

Evaluation can also ensure that lessons can be learned regardless of whether outcomes are positive or negative.

How does it work?

A manager and two evaluation leaders, supported by project coordinators, work with physicians and planners to implement evaluation strategies for all Primary Health Care development programs. This includes establishing evidence-based metrics, and ensuring that patient and GP informed consent processes are in place.

From time to time, GPs and practices participating in primary care programs are asked to participate in evaluation processes and to provide information for evaluation purposes, but always on a voluntary basis.

The unit also collaborates with the Ministry of Health Services, other health authorities and non-governmental organizations to evaluate joint initiatives such as:

- Integrated Health Networks
- The Practice Support Program

The introduction of a new electronic Sharable Care Plan (now in the testing stage) will further improve the availability and quality of information for program evaluation and knowledge management (e.g. outcomes-oriented Diabetes, CHF, and hypertension reports).

How does evaluation assist providers and patients?

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Evaluation is a critical component of a sustainable primary health care system. Data collection, measurement and analysis helps project teams track and refine programs to maximize their effectiveness.

For providers and the system, the evaluation process:
- Provides evidence-based feedback.
- Increases efficiency and effectiveness of programs.
- Makes visible the return on investment in terms of provider time and costs, system costs, and individual and population health outcomes.

For patients, evaluation drives process and programs improvements, and ultimately:
- Improves quality of care and health outcomes.
- Improves quality of life, health and well-being.
- Improves the coordination of care delivery.

**Program Contact**
Lisa Dwyer, Manager, Primary Health Care
Lisa.dwyer@fraserhealth.ca
604-517-8620
Community-based Fraser Health services

Connecting providers with specialty health services for shared care

“Together with community services we are able to provide an all-inclusive program to keep patients at home and safe. We know our patients are in great hands and really looked after. The communication and coordination back and forth is fantastic. This is a great example what it looks like to provide better, more comprehensive care.”

– Dr. Glenn Anderson, GP, White Rock Medical (Referencing collaborative care with Elder Health services)

Primary Care providers who are treating patients with numerous health-related needs can refer them to wide range of specialty services available throughout the Fraser region.

What is their purpose?

GPs can refer patients for assessments or services to a number of programs delivered in the community, while maintaining the Most Responsible Physician role of directing care. These include:

- Programs and services for patients with mental health and addictions issues:
  - Support for depression, low mood, cognitive behavioral therapy, and other mental health and/or addictions issues.

- Support in the home for individuals who are living with a chronic medical condition, a life-limiting condition, or are having a difficult time on their own; or for people who need post-hospital care.
  - Extensive services in the home include home support for everyday living; home care nursing; wound care; IV therapy; and physiotherapy.

- Specialized health care services for seniors:
  - Specialized seniors clinics; programs for frail elderly with complex conditions; fall and injury prevention; disease management; medication management.

- Specialized services for people living with one or more chronic diseases:
  - Diabetes Centres (for insulin starts, prevention and self-management education); Cardiac rehabilitation programs; respiratory rehabilitation / COPD management; extensive renal programs and services.

- Services and support for new Canadians (immigrants and refugees)
  - Primary care clinics in Surrey and Burnaby for new immigrants and refugees, with multidisciplinary health care providers, and links to community and social supports.

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Public Health services and support for GPs
  - Immunization programs; smoking cessation support; HIV and AIDS awareness programs; influenza serums.

How do providers and patients benefit?

- Collaborative, ‘shared care’ can assist GPs to address a patient’s range of health issues. It also eases some of the pressures experienced by primary care providers in managing care for more complex patients.

- A comprehensive, team approach improves the overall quality of care, and improves the health and well being of many patients.

Opportunities for GPs to participate

Services are available to providers and patients in all communities in the Fraser Health region. GPs may refer directly to any of the community programs. (See attachment for a list of many of these programs.)

Services:

- Mental Health and Addictions – services, programs and facilities are provided in all communities in the region.

- Home Health – supporting independence with services provided in the home, in clinics, and in community settings, on a short-term or long-term basis.

- Seniors Health – Many services are available across the region

- Specialized Geriatric Clinics – Integrated care for seniors living with complex conditions in Surrey, Abbotsford and Mission.

- Chronic Disease Management Services – These include Chronic Disease Clinics, along with diabetes education centres and cardiac rehabilitation programs, respiratory rehabilitation and comprehensive renal services.

- New Canadian Clinics – these meet the specialized needs of new immigrants and refugees, including linking individuals to social supports.

- Public Health Services – 21 Public Health offices.

SEE LISTINGS ON NEXT PAGES FOR CONTACT INFORMATION FOR THESE SERVICES

NOTE: A list of all health services in the region are now accessible at the 811 HealthLink BC Directory. Visit www.healthlinkbc.ca or dial 8-1-1.
Community-based Fraser Health services

SPECIALIZED SERVICES AND CLINICS

**CHRONIC DISEASE CLINICS**

**White Rock - South Surrey**  
iConnect Health Centre  
15455 Vine Avenue,  
White Rock, BC V4B 2T3  
Phone: 604-541-7162  
Fax: 604-538-9809

**New Westminster**  
iConnect Health Centre  
(at Victoria Heights)  
230 Ross Drive,  
New Westminster, BC  
Phone: 604-523-8800

**Surrey**  
iConnect Health Centre  
Diabetes Services  
13750-96 Ave,  
Surrey, B.C., V3V 1Z2  
Phone: 604-585-5697  
Fax: 604-585-5628

**NEW CANADIAN CLINICS**

**NEW CANADIAN CLINIC, BURNABY**  
7423 Edmonds St  
Burnaby, BC V3N 1B1  
Tel: 604-528-5077

**NEW CANADIAN CLINIC, SURREY**  
#1113 - 7330-137 St  
Surrey, BC V3W 1A3  
Tel: 604-953-5033

**SENIORS SPECIALIZED CLINICS**

**SENIORS FIRST HEALTH CLINIC**  
Surrey and North Delta  
Gateway ScotiaBank Tower  
1300 – 13401 – 108th Avenue  
Surrey BC V3T 5T3  
Phone: 604-953-4919 Fax: 604-953-4953

**SENIORS CLINIC**  
Abbotsford and Mission  
Abbotsford Regional Hospital  
Abbotsford, BC V2S 3P1  
Phone: 604-851-3056 Fax: 604-557-2086

**SPECIALIZED GERIATRIC CLINICS**

**NEW WESTMINSTER SPECIALIZED GERIATRIC CLINIC**  
230 Ross Drive  
New Westminster, BC V3L 0B2  
Tel: 604-528-5031  
Fax: 604-528-5030

**ELDERHEALTH SPECIALIZED GERIATRIC CLINIC – WHITE ROCK**  
Peace Arch Hospital  
Berkeley Pavilion  
15476 Vine Avenue  
White Rock, BC V4B 2R4  
Tel: 604-535-4577  
Fax: 604-535-4587
DIABETES EDUCATION SERVICES

Abbotsford Regional Hospital (ARH) Diabetes Education Centre
Sumas Level 2
32900 Marshall Rd.
Abbotsford, BC V2S 0C2
Phone: 604-851-4700 Extension 646238
Fax: 604-851-4782

Chilliwack General Hospital and Fraser Canyon Hospital Diabetes Education Centre
45600 Menholm Road
Chilliwack, BC V2P 1P7
Phone: 604-702-4766
Fax: 604-702-2880

Mission Memorial Hospital Diabetes Education Centre
7324 Hurd Street
Mission, BC V2V 3H5
Phone: 604-814-5145
Fax: 604-814-5108

Diabetes Outreach serving remote communities and First Nations
Phone: 604-706-4766 to book

Burnaby Risk Reduction Centre Diabetes Management Program
3935 Kincaid Street
Burnaby, B.C., V5G 2X6
Phone: 604-412-6139
Fax: 604-412-6233

Eagle Ridge Hospital Diabetes Centre
475 Guildford Way,
Port Moody, BC V3H 3W9
Phone: 604-469-3112
Fax: 604-469-5101

New Westminster iConnect Health Centre
(at Victoria Heights)
230 Ross Drive,
New Westminster, BC
Phone: 604-523-8800

Ridge Meadows Diabetes Centre
400 - 22470 Dewdney Trunk Road
Maple Ridge, BC V2X 5Z6
Phone: 604-476-7056
Fax: 604-476-7077

Royal Columbian Hospital - Diabetes In Pregnancy Clinic
330 East Columbia Street
New Westminster, BC
V3L 3W7
Phone: 604-520-4473
Send all referrals to the offices of Dr. J. Lee and Dr. J. Klinke
Phone: 604-520-1135
Fax: 604-520-1132

Delta Hospital Diabetes Education Centre
5800 Mountain View Blvd.
Delta, B.C. V4K 3V6
Phone: 604-946-1121 Loc. 278
Fax: 604-952-7352

Langley Memorial Hospital Diabetes Education Centre
22051 Fraser Hwy
Langley, BC V3A 4H4
Phone: 604-533-6407
Fax: 604-533-6449

Surrey iConnect Health Centre
Diabetes Services
13750-96 Ave.
Surrey, B.C., V3V 1Z2
Phone: 604-585-5697
Fax: 604-585-5628

White Rock - South Surrey iConnect Health Centre
15455 Vine Avenue,
White Rock, BC V4B 2T3
Phone: 604-541-7162
Fax: 604-538-9809
## HOME HEALTH OFFICES

<table>
<thead>
<tr>
<th>Office Name</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbotsford Home Health</td>
<td>Unit 103 – 34194 Marshall Rd. Abbotsford, BC V2S 5E4</td>
<td>604-556-5000</td>
<td>604-556-5010</td>
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<tr>
<td>Agassiz Home Health</td>
<td>7243 Pioneer Avenue Agassiz, BC V0M 1A0</td>
<td>604-793-7160</td>
<td>604-796-8587</td>
</tr>
<tr>
<td>Burnaby Home Health</td>
<td>400 – 4946 Canada Way Burnaby, BC V5G 4H7</td>
<td>604-918-7447</td>
<td>604-918-7631</td>
</tr>
<tr>
<td>Chilliwack Home Health</td>
<td>45470 Menholm Road Chilliwack, BC V2P 1M2</td>
<td>604-702-4800</td>
<td>604-702-4801</td>
</tr>
<tr>
<td>Hope Home Health</td>
<td>1275A 7th Avenue Hope, BC V0X 1L4</td>
<td>604-860-7747</td>
<td>604-860-7742</td>
</tr>
<tr>
<td>Langley Home Health</td>
<td>#101 – 20651 56th Avenue Langley, BC V3A 3Y9</td>
<td>604-532-6500</td>
<td>604-532-9642</td>
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<tr>
<td>Maple Ridge Home Health</td>
<td>Suite 400 – 11762 Laity Street Maple Ridge, BC V2X 5A3</td>
<td>604-476-7100</td>
<td>604-476-7126</td>
</tr>
<tr>
<td>Mission Home Health</td>
<td>32618 Logan Avenue Mission, BC V2V 6C7</td>
<td>604-814-5520</td>
<td>604-814-5517</td>
</tr>
<tr>
<td>New West Home Health</td>
<td>57 – 6th Street New Westminster, BC V3L 2Z3</td>
<td>604-777-6700</td>
<td>604-777-6762</td>
</tr>
<tr>
<td>South Delta Home Health</td>
<td>4470 Clarence Taylor Crescent Delta, BC V4K 3W3</td>
<td>604-952-3552</td>
<td>604-946-6953</td>
</tr>
<tr>
<td>Tri-Cities Home Health</td>
<td>#6 – 2601 Lougheed Hwy Coquitlam, BC V3C 4J2</td>
<td>604-777-7300</td>
<td>604-777-7302</td>
</tr>
<tr>
<td>White Rock Home Health</td>
<td>15476 Vine Street White Rock, BC V4B 5M2</td>
<td>604-541-6800</td>
<td>604-541-6872</td>
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</table>
## MENTAL HEALTH OFFICES

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Phone</th>
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<tbody>
<tr>
<td><strong>Abbotsford</strong></td>
<td>Abbotsford Mental Health Centre</td>
<td>604-870-7800</td>
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<tr>
<td></td>
<td>11-32700 Dahlstrom Ave., Abbotsford V2T 4V6</td>
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<tr>
<td><strong>Burnaby</strong></td>
<td>Burnaby Central Mental Health Centre</td>
<td>604-453-1900</td>
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<tr>
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<td>3935 Kincaid St, Burnaby V5G 2X6</td>
<td></td>
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<tr>
<td><strong>Burnaby</strong></td>
<td>Burnaby North Mental Health Centre</td>
<td>604-777-6870</td>
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<tr>
<td></td>
<td>206-3900 East Hastings St, Burnaby V5C 6C1</td>
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<tr>
<td><strong>Burnaby</strong></td>
<td>Burnaby South Mental Health Centre</td>
<td>604-702-4860</td>
</tr>
<tr>
<td></td>
<td>320-7155 Kingsway, Burnaby V5E 2V1</td>
<td></td>
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<tr>
<td><strong>Chilliwack</strong></td>
<td>Chilliwack Mental Health Centre</td>
<td>604-702-4860</td>
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<tr>
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<td>45470 Menholm Rd, Chilliwack V2P 1M2</td>
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<tr>
<td><strong>Delta</strong></td>
<td>Delta Mental Health Centre - North</td>
<td>604-704-7626</td>
</tr>
<tr>
<td></td>
<td>129-6345 120th St, Delta V4E 2A6</td>
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<tr>
<td><strong>Delta</strong></td>
<td>Delta Mental Health Centre - South</td>
<td>604-748-7626</td>
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<tr>
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<td>15-1835 56 St, Delta V4L 2L8</td>
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<tr>
<td><strong>Fraser Valley</strong></td>
<td>Fraser Valley/West Coast Mental Health Support Teams</td>
<td>604-777-7450</td>
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<tr>
<td></td>
<td>207 - 2248 Elgin Ave, Port Coquitlam V3C 2B2</td>
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<tr>
<td><strong>Hope</strong></td>
<td>Hope Mental Health Centre</td>
<td>604-860-7733</td>
</tr>
<tr>
<td></td>
<td>1275A 7th Ave, Hope V0X 1L4</td>
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<tr>
<td><strong>Langley</strong></td>
<td>Langley Mental Health Centre</td>
<td>604-541-6844</td>
</tr>
<tr>
<td></td>
<td>305-20300 Fraser Highway, Langley V3A 4E6</td>
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<tr>
<td><strong>Mission</strong></td>
<td>Mission Mental Health Centre</td>
<td>604-814-5600</td>
</tr>
<tr>
<td></td>
<td>101-33070 5th Ave, Mission V2V 1V5</td>
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<tr>
<td><strong>New Westminster</strong></td>
<td>New Westminster Mental Health Centre</td>
<td>604-777-6800</td>
</tr>
<tr>
<td></td>
<td>2nd Floor 403 Sixth St, New Westminster V3L 3B1</td>
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<tr>
<td><strong>Surrey</strong></td>
<td>Surrey Mental Health &amp; Addictions</td>
<td>604-953-4900</td>
</tr>
<tr>
<td></td>
<td>#1100 13401 108th Ave, Surrey</td>
<td></td>
</tr>
<tr>
<td><strong>Tri-Cities</strong></td>
<td>Tri-Cities Mental Health Centre</td>
<td>604-777-8400</td>
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<tr>
<td></td>
<td>1 - 2232 Elgin Ave, Port Coquitlam V3C 2B2</td>
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<tr>
<td><strong>White Rock</strong></td>
<td>White Rock/South Surrey Mental Health &amp; Addictions</td>
<td>604-458-7500</td>
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<tr>
<td></td>
<td>Peace Arch Hospital, Russell Unit, 15521</td>
<td></td>
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<tr>
<td></td>
<td>Russell Ave, White Rock V4B 2R4</td>
<td></td>
</tr>
</tbody>
</table>
PUBLIC HEALTH OFFICES

Abbotsford
104-34194 Marshall Road
Abbotsford, BC V2S 5E4
Tel: (604) 864-3400 Fax: (604) 864-3410

Agassiz
Box 104, 7243 Pioneer Ave.
Agassiz, BC V0M 1A0
Tel: (604) 793-7160 Fax: (604) 793-7161

Burnaby
300-4946 Canada Way
Burnaby, BC V5G 4H7
Tel: (604) 918-7605 Fax: (604) 918-7630

Chilliwack
45470 Menholm Road
Chilliwack, BC V2P 1M2
Tel: (604) 702-4900 Fax: (604) 702-4901

Cloverdale
Suite #205 – 17700 56th Ave
Cloverdale, BC V3S 1C7
Tel: (604) 575-5100 Fax: (604) 574-3738

Delta - North
11245-84 Avenue, Delta, BC V4C 2L9
Tel: (604) 507-5400 Fax: (604) 507-4617

Delta - South
4470 Clarence Taylor Crescent
Delta, BC V4K 3W3
Tel: (604) 952-3550 Fax: (604) 946-6953

Hope
Box 176, 444 Park Street
Hope, BC V0X 1L0
Tel: (604) 860-7630 Fax: (604) 869-2332

Langley
20389 Fraser Highway
Langley, BC V3A 7N2
Tel: (604) 539-2900

Maple Ridge
400-22470 Dewdney Trunk Road
Maple Ridge, BC V2X 5Z6
Tel: (604) 476-7000 Fax: (604) 476-7077

Mission
32618 Logan Ave.
Mission, BC V2V 6C7
Tel: (604) 814-5500 Fax: (604) 814-5517

New Westminster
537 Carnarvon Street
New Westminster, BC V3L 5B3
Tel: (604) 777-6740 Fax: (604) 525-0878

Port Coquitlam
2266 Wilson Ave
Port Coquitlam, BC V3C 1Z5
Tel: 604-777-8700

Surrey
Maxxine Wright Community Health Centre
13729 92 Avenue, Surrey, BC V3V 1H9
Tel: (604) 587-3835

Surrey – Guildford
100-10233 153 Street
Surrey, BC V3R 0Z7
Tel: (604) 587-4750 Fax: (604) 587-4777

Surrey – Newton
200-7337 137 Street
Surrey, BC V3W 1A4
Tel: (604) 592-2000 Fax: (604) 501-4814

Surrey – North
220-10362 King George Highway
Surrey, BC V3T 2W5
Tel: (604) 587-7900 Fax: (604) 582-4811

Tri-Cities
200-2005 Newport Drive
Port Moody, BC V3H 5C9
Tel: (604) 949-7200 Fax: (604) 941-2409

White Rock
15476 Vine Avenue
White Rock, BC V4B 5M2
Tel: (604) 542-4000 Fax: (604) 542-4009