



Ontario's Community
Health Centres

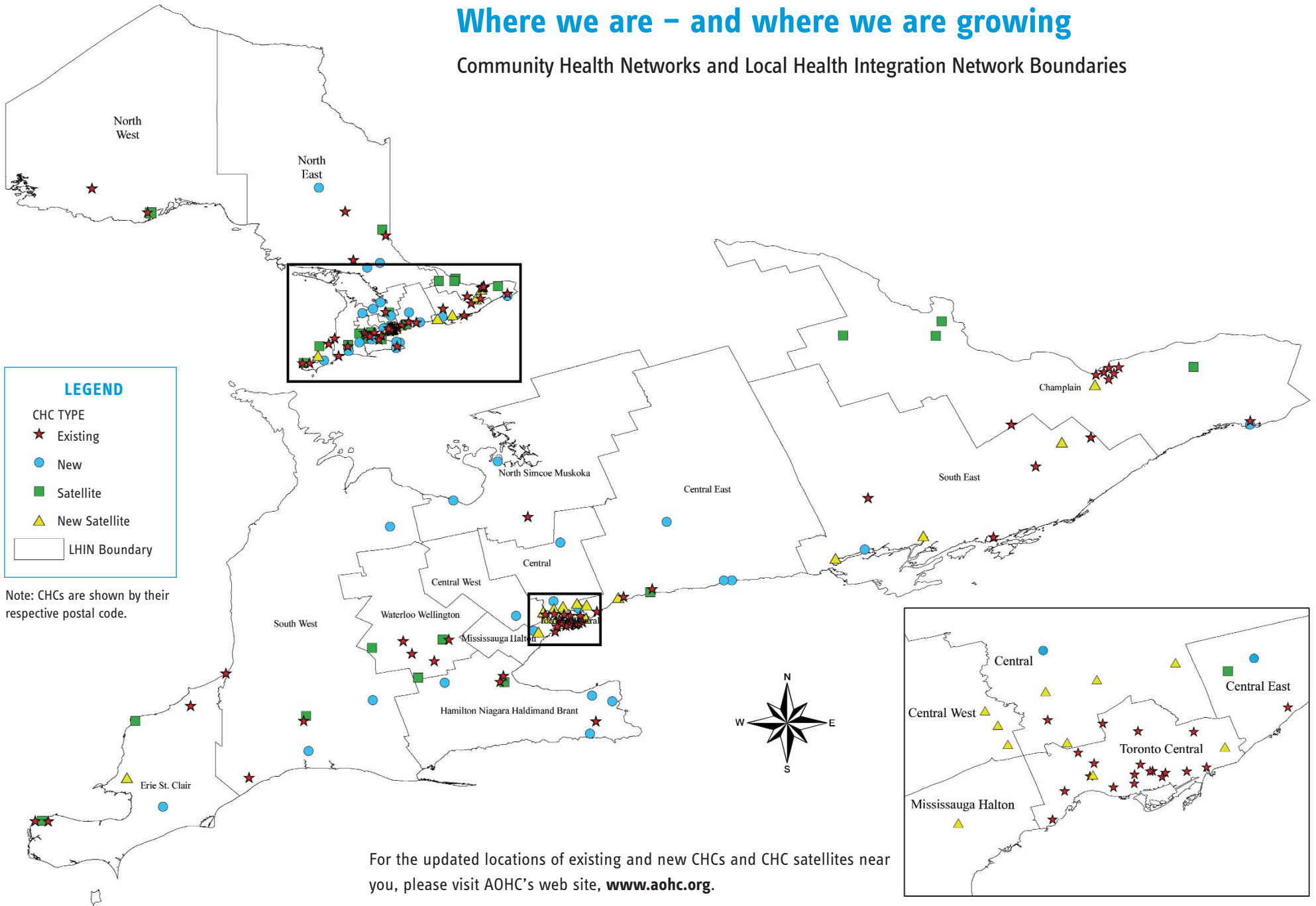
Every One Matters.

**Who We Are
and What We Do.**

March 2008

Where we are – and where we are growing

Community Health Networks and Local Health Integration Network Boundaries



For the updated locations of existing and new CHCs and CHC satellites near you, please visit AOHC's web site, www.aohc.org.



VINCENZO PIETROPAOLO

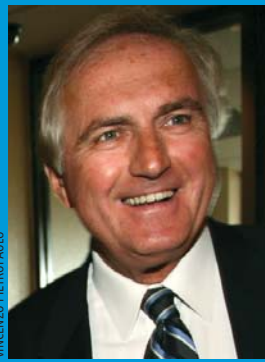
GEORGE SMITHERMAN

“I’m tremendously proud of the work CHCs are doing across the province and the primary care services they provide to more than 300,000 Ontarians ... the community capacity building that

directly and indirectly benefits us all. We want to see more of that, from our existing CHCs, from new CHCs and from new Satellite CHCs.”

“The reason we’re expanding CHCs so dramatically is simple: they work. They’re one of the most effective tools we have to address health issues – and by health issues, we don’t just mean treating people when they’re sick, we mean the entire range of factors that contribute to healthy lives and healthy communities.”

*George Smitherman,
Minister of Health and Long-Term
Care (MOHLTC) announcing
new CHCs and satellite CHCs
on November 10, 2005.*



VINCENZO PIETROPAOLO

ROY ROMANOW

“Day in and day out, Community Health Centres are already at the forefront. By shattering silos and modelling interdisciplinary practice, by showing leadership on genuine community collaboration and responsiveness, by

ensuring that it is people, from the ground up, who must be involved in shaping the future of health care, and putting a population health approach at the forefront of your thinking, you are leading the charge for positive transformation of medicare.”

*Roy Romanow speaking
at the annual conference of
the Association of Ontario
Health Centres, June 2007.*

Transforming medicare



Table of contents

Telling our story: every one matters	4
What exactly are Ontario's Community Health Centres?	6
Eight attributes of Ontario's CHCs	7
Where are Ontario's CHCs?	8
Ontario's CHCs on the move	9
Who do Ontario's CHCs serve?	12
Complexity of health care needs	14
What makes Ontario's CHCs stand out most?	15
Prioritizing health promotion and illness prevention	17
Delivering culturally competent care	19
Building communities' capacity to keep healthy	22
Prevention and management of chronic disease	25
Partnerships in Ontario's CHCs	29
Service integration	32
Engaging communities	34
Value and accountability	36
How are Ontario's CHCs accountable?	38
CHC sector strategy map, June 2006	39
Accountability agreements	40
Accreditation	41
Moving forward: e-health and clinical information systems	42
Maximizing our potential	43

Charts

Chart 1: CHCs by LHIN	9
Chart 2: Priority populations of CHCs by LHIN	10
Chart 3: Total active clients in each LHIN	12
Chart 4: Non-insured or homeless clients	13
Chart 5: Annual family income of clients	13
Chart 6: Number of providers seen per visit by clients	14
Chart 7: External and internal referrals	15
Chart 8: Care from interdisciplinary teams	16
Chart 9: Languages in which services are delivered	19
Chart 10: Clients from around the globe	20
Chart 11: Partners	29
Chart 12: Source of revenues	37
Chart 13: Use of funds	37

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Telling our story: every one matters.

Ontario's Community Health Centres (CHCs) are doubling in numbers – an exciting development because CHCs provide a model of care that offers huge promise and potential for all Ontarians. The expansion is also a very important development because Ontario's Community Health Centres are an especially effective model of care for Ontarians who have traditionally had difficulty accessing primary health care.

Our services and programming reflect our vision, a vision for Ontario in which every one matters.

- Every individual Ontarian matters and deserves access to high-quality health care;
- Every Ontarian community matters – and every community would benefit from the kinds of services and programming Ontario's Community Health Centres provide;
- Every Ontarian who needs a Community Health Centre – but cannot access one – matters.

To give Ontario's decision makers a better idea of how they can make optimal use of the Community Health Centre model of care, CHCs are embarking on regular reporting to answer fundamental questions about the

work we do delivering primary health care. This is the first in this series of our reports.

We have been able to gather the kind of cross-sectoral data contained in this foundational report because Ontario's Community Health Centres use the same methods to track information. In this first report the Ministry of Health and Long-Term Care (MOHLTC) and Local Health Integration Networks (LHINs) will find:

- Population profiles showing how (CHCs) serve those who have traditionally faced barriers accessing health care;
- Data revealing the wide variety of health professionals who work in Ontario's Community Health Centres; and
- Evidence showing the extent to which CHCs already work in partnership with other health and social service organizations that deliver care.

In addition to quantitative data, this report offers qualitative information, including short descriptions of innovations that we want to spread more widely through our network.

Methodology

The types of data and information contained in this report are used by Ontario's Community Health Centres to make optimal decisions about productive use and allocation of resources. In preparing this report, the Association of Ontario Health Centres (AOHC) used a standardized survey of Ontario's 54 existing CHCs and their operational satellite CHCs. Future reports will include data on new CHCs and Satellite CHCs as they emerge. Currently all but two CHCs in Ontario use the same clinical information system.

To gather information, AOHC first distributed data-extraction queries to Ontario's CHCs to ensure response consistency in the data extracted. We then asked centres to validate the information for the sub-set of data that was selected for this report. Finally, an AOHC Working Group reviewed and analyzed the results for another level of validation.

The data represent the 2006/07 fiscal year, and wherever a point-in-time value is presented, the reference date is March 31, 2007. In those cases where the data represent a subset of Centres, it is noted within the report.

AOHC intends to repeat this process regularly and hopes to work closely with both MOHLTC and LHINs to produce data and evidence that are relevant to current planning processes and improved outcomes for Ontarians.



Simone Hammond, President
AOHC Board of Directors



Adrianna Tetley
Executive Director, AOHC



What exactly are Ontario's Community Health Centres?

Ontario's Community Health Centres are part of the original vision for medicare, what Tommy Douglas and other founders called the second stage of medicare. The first stage of medicare removed financial barriers through the creation of a publicly funded insurance system to cover costs for doctors and hospitals.

The second stage of medicare, of which Ontario Community Health Centres are a part, is all about breaking down other kinds of barriers to good health. Douglas described it simply as “keeping people well,” rather than “just patching them up when they get sick.” (For more on the second stage of medicare please visit www.aohc.org)

Keeping people well, and keeping communities well, is exactly what Ontario's Community Health Centres are all about. Under one roof, Ontario's CHC clients receive clinical care from doctors, nurse practitioners, nurses, dietitians, social workers and other kinds of clinical health providers. They work as a team to make sure the client gets the right care, at the right time, delivered by the most appropriate provider. Health promoters, community workers and others respond to health problems triggered by social, environmental or economic problems with customized services and community programs.

Because Ontario's CHCs partner with other social service sectors and harness the expertise of local commu-

nity members, CHCs are especially effective in providing care to those populations that have, for whatever reason, traditionally faced difficulties in accessing and benefiting from health care.

CHC services are specifically structured to eliminate system-wide barriers to access such as poverty, geographic isolation, ethno- and culture-centrism, racism, heterosexism, language discrimination, ableism and other harmful forms of social exclusion. These, we know, can lead to increased burdens or risks of ill health.

One of our most effective tools is what we call community initiatives (CIs). These are sets of activities that strengthen and, in many cases, transform the entire community by addressing factors affecting individual, family and collective health. Some examples of these are provided on pages 22 and 23 of this report.

Diversity is key. Each of Ontario's Community Health Centres is unique. Sizes and budgets, programs and services vary greatly. Because our differences reflect the great diversity of the communities we serve, we have learned to customize our programs and services to meet the specific needs and preferences of the clients we serve. But, despite great diversity, every CHC applies a common model of care that holds much promise and potential for primary health care throughout Ontario.

The eight attributes of Ontario's Community Health Centres

Comprehensive

CHCs provide comprehensive, co-ordinated, primary health care encompassing primary care, illness prevention and health promotion, in one-to-one service, personal-development groups and community-level interventions.

Accessible

CHCs are designed to improve access to appropriate health care services through the optimal location and design of facilities, carefully planned programs and 24-hour on-call services. CHCs have expertise in ensuring access for people who encounter a diverse range of social, cultural or geographic barriers or who are at risk of developing health problems. This would include, for example, the provision of service by staff with cultural knowledge and language skills suited to the community.

Client- and community-centred

CHCs are continuously adapting and refining their ability to reach and to serve their clients and communities. CHCs base their planning on population health needs and develop best practices for serving those needs. CHCs strive to provide client-centred care.

Interdisciplinary

CHCs build interdisciplinary teams working in collaborative practice. In these teams, salaried professionals work together in a co-ordinated approach to address the health needs of their clients. Depending on the actual programs and services offered, CHC interdisciplinary teams may include physicians, nurses, nurse practitioners, dietitians, physiotherapists, occupational therapists, social workers, health promoters, community development workers, administrative staff and others.

Integrated

CHCs develop strong connections with both formal-health-system partners and community partners to ensure the integration of CHC services with the delivery of other health and social services. Integration improves client care through the provision of timely services, appropriate referrals and the delivery of seamless care. Integration also leads to system efficiencies and effectiveness.

Community-governed

CHCs are not-for-profit organizations, governed by community boards. Community boards and committees provide a mechanism for centres to be responsive to the needs of their respective communities, and for

communities to develop a sense of ownership of “their” centres. Boards also build important relationships of trust in the community.

Inclusive of the social determinants of health

The health of individuals and populations is affected by social factors. CHCs strive for improvements in the social support and conditions that affect the long-term health of their clients and community, through participation in multi-sector partnerships and the development of healthy public policy within a population health framework.

Grounded in a community-development approach

CHC services and programs are tailored to local needs, and they build on community assets and skills. CHCs enhance the existing community infrastructure, supporting the delivery of a range of community-based services and other responses to community health concerns. Both the direct service and the infrastructure-enhancement aspects of CHCs increase the capacity of communities to improve community and individual health outcomes.

Where are Ontario's Community Health Centres located and growing?

Facts about CHCs

Budgets range from \$1.8 million to \$12 million. Sizes range from 12 to 130 full-time-equivalent staff.

The average number of clients per centre is 5,550.

The smallest centre serves 2,042 clients.

The largest centre serves 12,046.

One satellite CHC has three sites located in three different communities.

Community Health Centres are located in 13 of the 14 LHIN districts. Altogether there are 43 urban and 11 rural and northern CHCs in Ontario. When the new CHCs open, these numbers will increase to 52 urban and 23 rural and northern CHCs, a clear acknowledgment by the provincial government that Ontario's Community Health Centres play a vital role in both ongoing rural and urban development strategies.

Thanks to the recent expansion, by 2009 a total of 110 Ontario communities will enjoy the benefits of CHCs, their satellites and smaller CHC sites. Altogether, 21 new CHCs and 28 new satellite CHCs are scheduled to open. A few have already opened. Most of the growth for new CHCs is in southwestern Ontario, where 13 of the 21 (62 per cent) new CHCs will open. Eleven of the 18 (69 per cent) new satellite CHCs announced in November 2005 will be located in Metropolitan Toronto. Soon there will be CHC services and programs running in all neighbourhoods identified as high-priority by the City of Toronto and United Way.

Growth in Toronto reflects the acknowledged expertise and contributions of the city's 22 existing CHCs that have proven key in providing services and programming to at-risk youth and other populations that have traditionally had difficulties accessing services.

Although the Mississauga Halton LHIN does not yet have any fully operational CHCs, the first satellite CHC in that LHIN is scheduled to open in early 2008. However, many more CHCs are needed in the heavily populated areas surrounding the Greater Toronto Area, which contain diverse communities that would benefit greatly from CHC services and programming. And there are other large parts of Ontario that also do not yet have access to CHC services. For instance, people who live in large rural and isolated areas often face geographical access barriers, so in the coming years more CHCs will be required to meet their needs as well.

Thanks to the recent expansion, by 2009 a total of 110 Ontario communities will enjoy the benefits of CHCs.

Ontario's Community Health Centres on the move

During their 30-year history, Ontario's Community Health Centres have grown from a series of small pilot projects into a dynamic and vibrant network.

They first came on the scene after the federal government established the Community Health Centre Project task group in 1971. The project, chaired by Dr. John Hastings, was initiated for three reasons:

- concern that the growth in spending on health services was accelerating;
- a growing belief that there needed to be a shift in emphasis from hospital in-patient care to other forms of care, including CHCs; and
- a growing belief that CHCs were an effective way to respond to problems in the way existing health services were provided.

The 1972 report, *The Community Health Centre in Canada*, recommended the development of a significant number of Community Health Centres in a fully integrated health services system.

As a result, the Ontario Ministry of Health established the CHC program as a pilot, funding 10 CHCs in Toronto and Ottawa. These CHCs served predominantly poor, ethnically diverse, urban communities. By 2004, the network grew to 54 centres, with CHCs established

in urban, rural and northern settings serving identified priority populations. Priority populations include those who have difficulty gaining access to primary health services: rural and/or northern isolated com-

munities and populations with a higher risk of developing health problems than the general population, such as immigrants, refugees, homeless people, at-risk-youth, seniors and the poor.

Chart 1: CHCs by LHIN

LHIN	Number of CHCs Operational	Number of CHC Satellites Operational	Number of New CHCs Planned	Number of New CHC Satellites Planned
Erie St. Clair	4	2	1	1
South West	2	1	3	0
Waterloo Wellington	4	3	0	0
Hamilton Niagara Haldimand Brant	3	0	4	0
Central West	1	0	1	3
Mississauga Halton	0	0	0	1
Toronto Central	18	0	0	2
Central	1	0	1	4
Central East	3	2	4	1
South East	5	1	1	2
Champlain	7	2	1	1
North Simcoe Muskoka	1	0	2	0
North East	3	0	3	1
North West	2	1	0	0
Total	54	12	21	16

Chart 2: Priority populations of CHCs by LHIN

	ESC	SW	WW	HNHB	CW	TC	C	CE	SE	CH	NSM	NE	NW
Aboriginals	•		•			•		•				•	•
Addictions / Mental Health	•	•		•		•	•	•	•	•	•		
Children & Youth		•	•	•		•	•	•	•	•	•	•	•
Chronic Disease		•		•		•	•	•		•	•		
Disabled			•							•			
Families	•		•	•		•	•	•	•	•	•		
Francophones				•		•				•		•	
GLBT						•		•		•			
HIV/AIDS/Hep C				•		•				•			
Homeless / Street Involved			•	•		•		•	•	•		•	•
Immigrants & Ethnocultural Communities		•	•	•	•	•	•	•		•	•		
Isolated			•	•		•	•	•	•		•	•	
Local Catchment Area	•			•		•	•	•	•	•	•		
Low Income & Unemployed		•	•	•		•	•	•	•	•	•	•	•
Non-Insured				•		•	•	•		•	•		
Rural	•	•	•	•					•	•	•		
Seniors	•	•	•	•		•	•	•	•	•	•	•	•
Sex Trade Workers				•		•				•		•	•
Single Parents			•	•		•	•	•		•	•		•

The number of clients receiving primary health-care services at CHCs will almost double with the opening of 21 new CHCs and 28 new CHC satellites.

In 2004 and 2005, the Ontario Ministry of Health and Long-Term Care announced the first significant growth for CHCs in more than 20 years. During the next few years the number of clients receiving primary health care services at CHCs will almost double with the opening of 21 new CHCs and 28 new CHC satellites.

However, Ontario's network of CHCs is still incomplete. Whereas in Quebec, CLSCs (Centres locaux de services communautaires) are located in every part of the province, this is not the case in Ontario.

To address this weakness, the Association of Ontario Health Centres is calling on the MOHLTC and the LHINs to develop a primary health care strategy that ensures every Ontarian who needs access to a Community Health Centre is able to get it. To initiate this strategy, AOHC is asking that at least 20 new CHCs or satellite CHCs and AHACs be established annually over the next four years.

NorWest Mobile Unit



Reaching out to isolated communities

Of all Ontario's Community Health Centres, the **NorWest Community Health Centres** has the largest catchment area: 24,567 hectares, approximately the size of the entire province of New Brunswick. Located in the North West LHIN, the NorWest CHCs operate a CHC from its base in Thunder Bay and has two additional point-of-service sites in the communities of Longlac (three hours northeast) and Armstrong (three hours north).

Its newest CHC satellite is an innovative mobile unit that

travels around the vast catchment area with a nurse practitioner, an RN foot-care nurse and a community health worker. Clients receive primary health care like Pap smears, physicals and the identification and monitoring of chronic illnesses. The unit is also a platform for health-promotion programs on healthy eating, effective parenting and alcohol and substance-abuse prevention. More isolated communities will have access to this kind of service once the network of Ontario CHCs is complete.

Who do Ontario Community Health Centres serve?

In 2006/07, Ontario Community Health Centres had over 250,000 active clients (see Chart 3). This figure includes those registered as clients and those who had received care or service within the previous three years. However, this figure understates the total number of people actually served by CHCs. Excluded are those who participate in group programs that do not require individual registration, as well as those who benefit from the range of community initiatives (CIs) undertaken by CHCs.

In some measures, CHC demographics are similar to many other primary care organizations in that just under 14 per cent of clients are over 65 years of age and approximately 58 per cent of clients are female. However, the demographic profile of Ontario's CHC clients is much more diverse than that of many other health care providers and organizations.

Each CHC identifies priority populations (see Chart 2 on page 10). Seven CHCs focus exclusively on the Francophone population; two serve Aboriginal communities; two focus exclusively on youth; one focuses on care for black, African, Caribbean, Hispanic and southeast Asian women; one has a priority population

of immigrants and refugees; and one has a priority population of disabled adults.

Over 11 per cent of CHC clients are homeless or have no health insurance. This percentage increases to an average of 12.5 per cent for urban CHCs (see Chart 4 on next page).

Because CHC clients come from 209 different countries, Ontario's CHCs have responded by providing services in more than 56 languages. In three centres alone services are offered in more than 40 languages.

Chart 5 on the next page shows a breakdown of self-reported household income. Forty-four per cent of CHC clients did not report income to their CHC. Nevertheless, for those 56 per cent of clients who have reported a family income, data indicate a very high proportion of low- and lower-income households. Across Ontario the median income of families with children is \$54,000. Of the 56 per cent of CHC clients reporting family income, nearly 100 per cent live on an income below the median family income level for Ontario as a whole.

Chart 3: Total active clients in each LHIN

LHIN	Active Clients
Erie St. Clair	14,331
South West	6,158
Waterloo Wellington	18,614
Hamilton Niagara Haldimand Brant	27,531
Central West	5,628
Mississauga Halton	-
Toronto Central	75,422
Central	5,000
Central East	14,461
South East	14,714
Champlain	54,305
North Simcoe Muskoka	6,000
North East	4,062
North West	6,733
Total	252,959

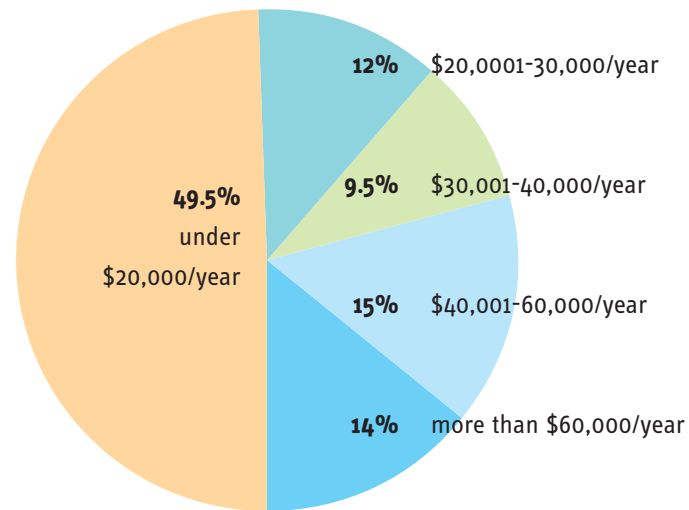
The demographic profile of Ontario’s CHC clients is much more diverse than that of many other health care providers and organizations.

Chart 4: Non-insured and homeless clients, based on data from 37 centres

LHIN	Total of Non-Insured Clients	Total of Homeless Clients
Erie St. Clair	108	*
South West	11	940
Waterloo Wellington	583	356
Hamilton Niagara Haldimand Brant	227	*
Central West	1,199	*
Mississauga Halton	-	-
Toronto Central	9,001	3,390
Central	1,500	*
Central East	1,272	701
South East	67	28
Champlain	4,406	2,779
North Simcoe Muskoka	90	*
North East	1	59
North West	1	*

* Data not available.

Chart 5: Annual family income of Ontario’s CHC clients

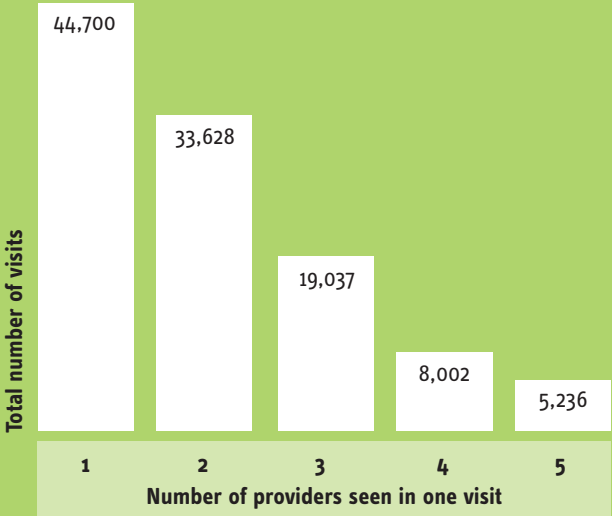


Complexity of health care needs

Many CHC clients have complex health care needs. This is reflected in the number of health care providers a client may see in one visit.

In 2006/07, over 8,000 CHC clients saw more than four health care providers during a single visit; almost 20,000 clients saw more than three health care providers; and almost 35,000 saw more than two.

Chart 6: Number of providers seen per visit by CHC clients.



Emergency care for refugees

The efforts of **Access Alliance Multicultural Health and Community Services** in downtown Toronto spotlight how swift, decisive action by primary-health care agencies have a high impact when newcomers with serious health problems suddenly arrive in a community.

Five waves of Karen refugees from the Thai-Burmese border arrived in Toronto during one month in the summer of 2006. They had been granted emergency refugee status by the federal government. Local welcoming agencies had to address a host of individual and public health issues, such as pulmonary tuberculosis, typhoid, cellulitis and head lice.

Access Alliance quickly partnered with COSTI Immigrant Services to ensure that all the new arrivals received an emergency screening and chest X-ray within 24 hours of their arrival. Within 10 days Access Alliance staff also took full medical histories and conducted physical examinations.

Access Alliance knew that support for the Karen refugees had to extend beyond basic clinical care. For all 68 refugees, the Centre offered skills-building programs to assist them with their health problems and help them adapt to their new Canadian environment.

What makes Ontario's Community Health Centres stand out most?

Long history providing interdisciplinary care

Ontario's CHCs have over 30 years of experience in developing and improving teams that work in collaborative practice. Our providers know that interdisciplinary teams are necessary to address complex clinical care challenges and the social determinants of health.

The wisdom of using interdisciplinary teams has become more apparent over the years. CHCs were the first primary health care model to welcome nurse practitioners on to their teams. Currently more than 200 nurses, 150 nurse practitioners and 190 physicians work in our 54 CHCs. Although virtually all CHCs have physicians, nurse practitioners and nurses, Chart 8 on the next page illustrates how CHC interdisciplinary teams also include members with many other kinds of skills and expertise. In all cases team membership is based on the specific needs of the clients and communities being served.

Timely referrals

Many of our clients have complex health conditions and need to see multiple providers. In 2006/07, 37 CHCs made over 200,000 referrals either internally to other health care providers on the team or to external health care providers (see Chart 7 on this page).

Chart 7: External and internal referrals across 37 CHCs in 2006/07

	External Referral	Internal Referral	Total
Alternative / Complementary Therapist	1,181	158	1,339
Child Worker / Teacher	88	102	190
Chiropodist / Podiatrist	284	3,021	3,305
Chiropractor	103	351	454
Community Health Worker / Health Promoter / Outreach Worker	96	2,021	2,117
Counsellor / Social Worker	2,074	10,360	12,434
Cultural Interpreter	4	61	65
Dentist	481	59	540
Dietitian / Nutritionist	175	5,267	5,442
Home Care Worker	132	33	165
Legal Services	534	112	646
Midwife	151	2	153
Nurse	434	10,978	11,412
Nurse Practitioner	383	15,814	16,197
Other	47,473	4,276	51,749
Physical / Occupational / Recreation Therapist	4,814	982	5,796
Physician / Surgeon / Specialist	53,102	43,037	96,139
Physiotherapist	366	-	366
Psychometrist	9	3	12
Service Access Coordinator	8	233	241
Speech & Language / Audiologist	930	26	956
Traditional Healer	-	199	199
Grand Total	112,822	97,095	209,917

Chart 8: **Clients in CHCs receive care from interdisciplinary teams that extends well beyond physicians and nurses.**

	Number of Client Encounters (06/07)
Counsellor / Social Worker	27,048
Community Health Worker / Health Promoter / Outreach	16,969
Chiropodist / Podiatrist	15,596
Dietitian / Nutritionist	14,869
Physical / Occupational / Recreation Therapist	2,479
Child Worker / Teacher	1,079
Service Access Coordinator	1,013
Traditional Healer	1,000
Dentist	938
Cultural Interpreter	800
Alternative / Complementary Therapist	724
Speech & Language / Audiologist	559
Chiropractor	447

A toolkit to build better teams

To maximize the benefits of interdisciplinary teams, the AOHC has produced a workshop and accompanying toolkit called Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres.

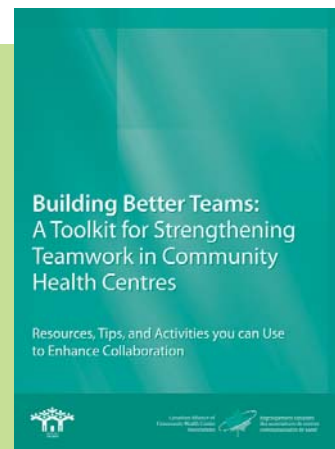
Both resources are a result of extensive quantitative and qualitative research with 13 of Ontario's Community Health Centres. Funding was provided by the Primary Health Care Transition Fund of Health Canada and the Ministry of Health and Long-Term Care. The toolkit addresses the eight basic competencies identified for effective teamwork.

- | | |
|---------------------------|----------------------------|
| Team vision | Team values |
| Communication | Collaboration |
| Decision-making | Conflict management |
| Effective meetings | Everyday leadership |

Each module summarizes the related evidence and provides tools and activities that will help team members to develop the knowledge and skills needed to work effectively in interdisciplinary primary health care teams.

AOHC is now working with new CHCs and Community Family Health Teams (CFHTs) to develop additional tools for new teams.

Workshops and toolkits are available in English and French. For more information or to order copies please go to the Association of Ontario Health Centres' web site at www.aohc.org or call 416-236-2539.



Prioritizing health promotion and illness prevention

Ontario's Community Health Centres prioritize health promotion and illness prevention, making it a point to integrate it throughout all services and programming. Like many other primary health care providers, Community Health Centres focus on encouraging clients and program participants to improve their lifestyle to enhance their health. But Ontario Community Health Centres know that to promote health and prevent illness most effectively, a much more comprehensive and complete approach is required than simply focusing on lifestyle changes.

Many studies have shown conclusively that income inequality, child poverty and the lack of individual empowerment result in adverse health outcomes. Similarly, inadequate housing and unemployment, racism and other kinds of oppression have negative impacts on health.

In developing our health-promotion and illness-prevention programs and services, Ontario's Community Health Centres take all these social determinants of health into account. Our activities are closely aligned

with principles laid out in the Ottawa Charter for Health Promotion, which identifies five areas for action:

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services

And throughout our health-promotion and illness-prevention services and programs, we focus both on individuals' health and on overall community health.

To this end, we deliver programs and services in a variety of different ways that maximize positive impact.

- Like many other primary health care providers, we work with clients and program participants one on one.
- But very often we find we can achieve even greater benefits when clients receive information about how to stay healthy in group settings where they can share experiences and learn from one other.

- To address the root causes of illness and injury, almost all Ontario's Community Health Centres also mount community-wide initiatives, usually in partnership with other community and/or health service providers. Here are some examples of how these community initiatives work.

Helping community members to stop smoking

The **Merrickville District Community Health Centre** (MDCHC) Tobacco Strategy focuses on protection, prevention and cessation, incorporating education, support and involvement of both the individual and the community. With the local public health unit and local Heart Health Coalition, MDCHC worked with a local foundry to develop a tobacco strategy. The centre uses the "ask, advise, assist" client protocol and invites smokers to attend cessation sessions provided by a qualified tobacco treatment specialist. CHCs throughout Ontario have recently been identified and funded as key partners in the government's multi-step Smoke Free Ontario Strategy.

Almost all CHC programs, services and community initiatives are conducted in partnership with other community and/or health-service providers.

Encouraging teen sexual health

Grade 9 students are taking more control over their sexual health, thanks to the **Windsor Teen Health Centre's** leadership in this multi-partner Adolescent Sexual Health Program. Dare 2 B Strong tackles urgent social and health concerns, including sexually transmitted infections (STIs), HIV, family planning, teen pregnancy, birth control, violence in relationships and the effects of drugs and alcohol.

Nutritional guidance for low-income families

In southwestern Ontario's **West Lambton Community Health Centre**, a community initiative targets low-income families in partnership with a local food bank. *Cooking on a Shoestring* is a four-week cooking series on healthy, low-cost, simple recipes, and a fifth-week grocery store tour. Food is enjoyed in group settings with friendly educational discussions about healthy eating, including fat content and serving sizes. In **North Lambton Community Health Centre** an intercultural Women's Wellness Series created in partnership with Kettle and Stony Point Health Services builds on the strengths of both organizations. A host of interdisciplinary programs are provided, including "well women evenings," where health promoters, primary care providers and community health workers offer services, such as Pap screenings and other educational and health-promotion activities.



West Lambton CHC provides a four-week cooking series on healthy, low-cost, simple recipes, and a fifth-week grocery store tour.

Delivering culturally competent care

“What we understand as sickness begins in our spirit. It then affects the mind, then the emotions and finally the body.

“Equality and freedom from discrimination are key determinants of health. If you are part of a culture that is not recognized, respected, or is actively devalued, you can expect barriers to access and worse health outcomes. In addition, emotional and mental health issues – such as low, or no self-esteem, self-hatred, stress and others – often manifest physically. At its core, cultural competency recognizes that we are more than a single body part and that in order to achieve true health and the best health outcomes, a holistic, multi-disciplined approach is essential. Culture is an inseparable component of who we are.”

Anishnawbe Health Toronto

Given Ontario’s increasing diversity, many of Ontario’s CHCs make it a priority to deliver culturally competent health care and carefully adapt their delivery approach to the needs and preferences of the communities they serve. This focus on client-centred care takes many

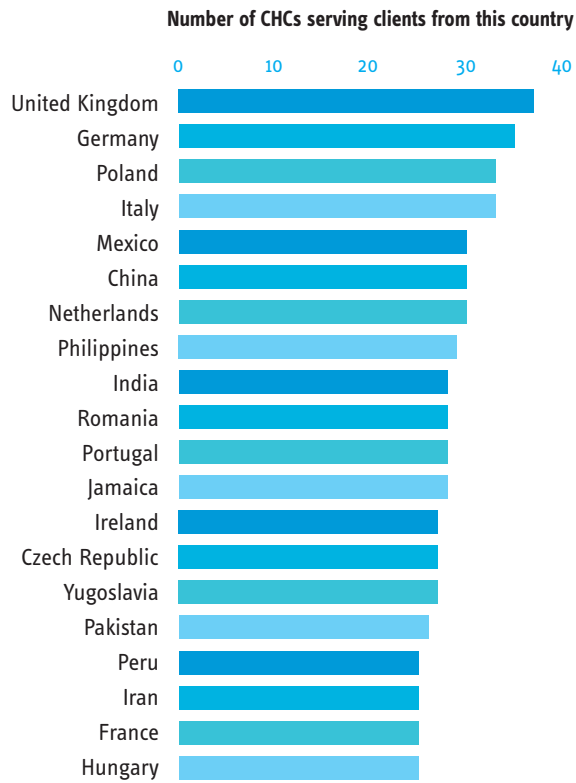
forms, including delivering services in many different languages. Chart 9 shows the high number of languages Ontario’s CHCs use to deliver programs and services. Chart 10 on the next page shows our clients’ countries of origin. Ontario’s CHCs constantly consult with clients to explore how they can customize programs and services in ways that are likely to have the greatest impact.

Chart 9: Clients in CHCs receive services in 56 languages. The top 15 other than English and French are shown here.



- English
- French
- Spanish
- Chinese
- Vietnamese
- Portuguese
- Arabic
- Somali
- Urdu
- Russian
- Persian
- Ukrainian
- Polish
- German
- Italian
- Turkish
- Tamil
- Hindi
- bengali
- Amharic
- Khmer (Cambodian)
- Serbo-Croatian
- Korean
- Hungarian
- Ojibway
- Croatian
- Hindi
- Kurdish
- Swahili
- Serbian
- Punjabi
- Czech
- Tagalog(Philipino)
- Tigrigna
- Romanian
- Tagalog (Pilipino)
- Creole
- Japanese
- Telugu
- Gujarati
- Bulgarian
- Armenian
- Thai
- Greek
- Oji-Cree
- Pashto
- Hebrew
- Finnish
- Twi
- Algonquin
- Arabic
- Byelorussian
- macedonian
- Sinhalese
- Inuktitut (Eskimo)

Chart 10: CHCs serve clients from around the globe. The top 20 countries (outside Canada and the US) are shown here.



Responding to religious and spiritual diversity

Regent Park Community Health Centre has adapted its services to respond better to Muslim clients when they are fasting during the holy month of Ramadan. Potential health complications include altered nutritional levels, prescription medication issues and mental and emotional health issues stemming from the intensity of the month’s devotions.

To gauge better the extent of these issues and to foster a relationship of trust and partnership, the centre conducted extensive interviews with health providers and clients.

Physicians, nurses and other providers have also worked with community and religious leaders to develop guidelines for better care and treatment. They also actively encourage clients to “have the conversation about fasting” with their health care providers. This is supported through educational materials endorsed by religious leaders and distributed at the local mosque.

Delivering culturally customized programming and services

Hamilton Urban Core Community Health Centre ensures that Somali Migdan and Roma families have access to high-quality primary health care and other social support. Large numbers of Somali Migdan and Roma people arrived in Hamilton several years ago. They faced cultural barriers to integrating into the community and navigating the complex education, employment and social service systems. At the same time, the newcomers’ settlement difficulties were compounded by a serious shortage of health providers in Hamilton willing to work with refugee clients. Still, Hamilton Urban Core CHC welcomed the refugees as clients by offering customized programs and services. The project provided immediate support to community members, as well as mid- and longer-term measures for building sustainable community capacity.

The CHC’s cultural competencies were informed by information and perspectives gathered in focus groups attended by the new community members.

- United Kingdom
- Germany
- Poland
- Italy
- Mexico
- China
- Netherlands
- Philippines
- India
- Romania
- Portugal
- Jamaica
- Ireland
- Czech Republic
- Yugoslavia
- Pakistan
- Peru
- Iran
- France
- Hungary
- Trinidad and Tobago
- El Salvador
- Guyana
- Colombia
- South Africa
- Ukraine
- Turkey
- Greece
- Russian Federation
- Nigeria
- Vietnam
- Japan
- Venezuela
- Afghanistan
- Somalia
- Ethiopia
- Chile
- Sri Lanka
- Egypt
- Argentina
- Barbados
- Bangladesh
- Guatemala
- Ghana
- Lebanon
- Australia
- Brazil
- Hong Kong
- Cuba
- Sudan
- Costa Rica
- Nicaragua
- Congo
- South Korea
- Austria
- North Korea
- St. Vincent and the Grenadines
- Bulgaria
- Bosnia and Herzegovina
- Zimbabwe
- Uganda
- Iraq
- Kenya
- Israel
- Switzerland
- Ecuador
- Honduras
- Croatia
- Uruguay
- Spain
- Grenada

Centre de santé communautaire de Sudbury staff reached out to young Franco-Ontarians through the arts.



VINCENZO PIETROPALIO

As a result of the community initiative, strong leadership has emerged in both the Somali Migdan and Roma communities. Training and skills have increased, employment levels are on the rise and 90 per cent of newborns have been received into their new Canadian home through the Centre's midwifery partnership.

Reconnecting youth with their heritage

Franco-Ontarian youth frequently fear losing their Francophone identity and being disconnected from their roots, rich traditions, and sometimes even the French language. This threat to identity creates stresses that can have a serious impact upon health in many ways, including increasing the likelihood of smoking.

At the **Centre de santé communautaire de Sudbury** (CSCS), staff help young people to address the root cause of the stress by reaching out through the arts.

Fifty young Francophones participate in the program, which connects students in high school and post-secondary institutions to their rich French heritage. More than 8,000 students have joined in the St. Jean Baptiste musical shows as organizers, per-

formers or enthusiastic audience members. The young people also organize a homeless supper and, on Ste. Catherine's Day, conduct a mass collection of personal-care products for people living on the street.

Other Centre activities include writing and photography contests in local schools, theatrical improvisation, community lunches and leadership workshops. And yearly Franco-Ontarian Flag Day celebrations which mark 350 years of French culture in Ontario. The youth programming reminds young Franco-Ontarians that their roots run deep and that they are part of a vital and connected community. And it also familiarizes young Francophones with other local Francophone agencies and services.

Building communities' capacity to stay healthy

As mentioned earlier, a hallmark of Ontario's Community Health Centres are what we call community initiatives – activities specifically designed to improve community development and increase the communities' capacity to keep themselves healthy.

Community initiatives are often dramatic change makers because they tackle the root causes of problems that are harming people's health. And they engage community members in developing solutions.

Community initiatives are flexible, and they use whatever approaches work, employing advocacy, community organizing, political action and other group strategies.

Here is a sample of these initiatives:

Improving neighbourhood safety and tackling crime

To help neighbourhoods help themselves, **South East Ottawa Centre for a Healthy Community** has developed a highly innovative initiative called *No Community Left Behind*. The initiative is designed to prevent crime and address social determinants of health in South East Ottawa through a collaborative approach and integration of services.

Since July 2005, Centre staff have been collaborating

with a wide range of community-development specialists, community-policing professionals and neighbourhood activists to address factors that lead to crime, victimization, fear for safety and social exclusion. Intergenerational tension and fears of vandalism and loitering have been reduced with a youth centre, a skating park, weekly movie and sports nights, dances and other programming initiated and directed by young people themselves.

The program has been so successful it is now spreading to neighborhoods throughout the Ottawa area.

For more information please visit www.nocommunityleftbehind.ca.

Pathways to education: tackling education as a key determinant of health

Ensuring that young people get to school, graduate, and move on to post-secondary programs are the core objectives of *Pathways to Education*, an award-winning initiative developed at **Regent Park Community Health Centre**. The program uses a multi-layered approach to achieve plummeting dropout rates and a 60 per cent reduction in the number of students who are considered to be “academically at-risk.”

The results:

- The five-year graduation rate has soared to over 75 per cent.
- There is now a 90 per cent acceptance rate for four-year graduates who have applied to colleges and universities.
- More than twice the proportion of Regent Park youth will now attend post-secondary institutions.

Some of the program's keys to success:

- Mobilizing parents to play an active role in the education of their children.
- Offering practical solutions such as bus tickets tied to attendance and bursaries held in trust until high school graduation.

In November 2007 the Ministry of Health and Long-Term Care announced an expansion of this program to Greater Toronto Area Community Health Centres in Rexdale and Lawrence Heights.

Creating healthy communities for youth

Spurred on by a business survey that identified loitering and vandalism in Tweed's small downtown core as a major issue of concern, the community developed programs to promote and nurture safe social environ-

Healthier transportation = Healthier community



This innovative east-end Toronto community initiative (CI) was triggered by poor air quality, dangerously high levels of sulphur dioxide, lead and carbon monoxide; and the desire of residents to tackle health and environmental problems at the local level.

With support and leadership from **South Riverdale**

CHC, it blossomed into much more. Today, a thriving east-west bicycle commuter route to downtown Toronto is a tribute to the power of community initiatives to foster profound change; a bike repair drop-in for underhoused and homeless people is in full swing at the CHC; and the promotion of “active” transportation to support physical health is a high-profile daily reality.

that the Cambodian community was fractured, isolated and disengaged, the centre took further action to launch a community initiative.

With a grant from the Trillium Foundation, the centre in collaboration with local community members established a community working group with representatives from the leadership of the entire Cambodian community that now meets regularly to resolve community issues.

Creating affordable services and employment


In Ottawa, *Centretown Laundry Co-op* has created a self-service laundry to improve health and well-being in the local community. The laundry co-op, the first of its kind in Canada, if not in North America, has been developed by and for people who are struggling on low incomes. With the support of **Centretown Community Health Centre**, families no longer have to choose between giving their children school lunches or clean clothes.

It has 300 members who now run their affordable and accessible laundry. Business clients such as medical clinics, gyms, and others express their delight at the quality of the work provided at market rates. The *Centretown Laundry Co-op* is a collaboration of community members and paid staff.

ments, tolerance and mutual respect between young people and their community. Community members turned to **Gateway Community Health Centre**, which in turn sought Human Resources and Social Development funding for a youth events co-ordinator. This led to the formation of a Youth Action Committee and weekly meetings to address local concerns. In April 2007 the Youth Action Committee was recognized as a committee of City Council.

Reaching out to isolated communities

When fire destroyed a grocery store and its upstairs apartment in downtown Ottawa, the tragedy not only took the lives of five members of the same family but also destroyed the only Cambodian grocery store in the area. **Somerset West Community Health Centre** quickly became involved in supporting the family. When it saw



Ontario's Community Health Centres support seniors in maintaining their independence and keeping as healthy as possible. Prevention, early detection and management of chronic conditions are key.

Prevention and management of chronic disease

Ontario Community Health Centres are positioned to play a key role in the prevention and management of chronic disease (CDPM).

Interdisciplinary teams provide a wide range of skills and expertise to manage the complexity that chronic disease often presents. The holistic approach to health and wellness works well in preventing and managing chronic diseases, where in most cases solutions are most likely to emerge when health providers are able to get as complete a picture as possible from the client about factors affecting their health.

Strong community engagement practices and partnering skills enable Ontario's Community Health Centres to mount wide-ranging programs that address not just a clients' medical situation, but also social factors that may cause or worsen chronic disease conditions.

Activities vary from centre to centre and target an array of clinical conditions, such as diabetes, asthma and mental health. Intervention ranges from clinical care to support for a client's self-management to education and support through group programs and activities. Many centres also run special programs for seniors who often are dealing with the interplay of a number of chronic conditions all at the same time.

To continue improving CDPM best practices in Ontario's Community Health Centres, the CHC network recently created a Chronic Disease Working Group. The group's first task is to conduct a survey of chronic disease programs across their network to understand better how specific populations are using services and how programs are integrated into other chronic disease or health care activities within the CHC's community.

In the months and years to come, the working group will be a valuable tool enabling Ontario's CHCs to share best-practice ideas throughout their network.

Shortening waiting lists

The *Regional Diabetes Education Program* of **Langs Farm Village Association** (CHC) has shortened hospital waiting lists by 25 per cent and has speeded up access for CHC patients waiting for diabetes education classes to no more than two weeks. The innovative program has also improved documentation and referral processes. "With two local hospitals, three CHCs and satellite CHCs and the Canadian Diabetes Association we are taking the lead in this model of care. We have not only increased the level of education and quality of treatment individuals receive from community

providers, but we have also improved access to services across the whole continuum," says Rosemary Dal Bello, Health Service Manager at Langs Farm Village Association.

Diabetes strategies for diverse ethno-cultural communities

The *Latin American Diabetes Program (LADP)* at the **London InterCommunity CHC** is an award-winning formula for diabetes care that shows how much success can be achieved when primary health care providers adopt a holistic and comprehensive approach to preventing and managing chronic disease.

The program was developed for London's Latin-American population to improve diabetes awareness and outcomes and help them live healthier, more active lives. Diabetes is a significant challenge in Latin-American populations. In the United States, where the correlation between race, ethnicity and health status is measured more effectively, one in every four Latin-American adults over age 45 has diabetes.

In Canada, people originally from Latin America make up Canada's fourth-largest immigrant group; 80 per

London InterCommunity CHC's award-winning formula for diabetes care and support turns the clinical model upside down.

cent live in Ontario, many in the city of London. The CHC's *LADP* works with this population in partnership with other diabetes-service providers. It increases awareness of diabetes among Hispanic community members and provides access to essential diabetes services and self-care skill development. Some of the barriers that currently limit access for Latin Americans are difficulties with English, lack of money and low self-care capacity.

Working with community partners, the program has developed and delivers six programs: an adult Saturday screening program; an intensive risk-management and risk-prevention program; a children's diabetes risk-assessment program; a children's intensive risk-management program; a diabetes complication-prevention program; and a diabetes specialist satellite clinic. All facets of the program are supported by an interdisciplinary health care team which includes a nurse practitioner, an endocrinology expert, phlebotomists, a social worker, volunteer community workers and a psychologist.

Clients, community members and health care providers are all empowered through the use of dynamic communications tools. Training packages are also part of the process, including a pre-event work plan and check list, a screening algorithm, a take-home risk-profile form and post-screening follow-up lists.

In addition to on-site programs, the CHC maintains key partnerships with the Hispanic community, diabetes-service providers and a number of intersectoral groups to target the broader determinants of health, like employment, physical activity, affordable food and diabetes self-care supplies that affect the life of diabetes clients and their families.

During the past six years, the program has garnered national and international praise as a leader in multi-cultural diabetes care. Its many accolades include the 2002 Peter F. Drucker award for Canadian non-profit innovation and, in 2007, recognition for excellence in chronic disease prevention and management by the Health Council of Canada.

For more information visit www.lihc.on.ca.

Comprehensive service delivery

Toronto's **Stonegate CHC** is an example of an Ontario CHC offering comprehensive service delivery with respect to chronic disease prevention and management.

Services and programs are delivered in three different ways:

- Individual counselling, accessible resources (like medication samples or glucometers) and community education are used where appropriate.
- Group activities, such as asthma fitness camps and seniors' wellness programs, are designed for at-risk or age-specific populations.
- The influence of community outreach programs extends beyond the four walls of the centre.

Encouraging clients and program participants to manage their own conditions is integrated through all services and programs. Physical-fitness activities are always folded into the mix to improve function and self-esteem among those diagnosed with chronic disease.

Self management of chronic disease empowers individuals and reduces morbidity, mortality and cost to the healthcare system.

Stonegate is particularly responsive to those who face economic, language and social barriers that interfere with their health and independence. That's why the centre offers housing support, personal counselling, employment and education assistance, interpreter services, and child care and transportation aid.

Diabetes: Stonegate partners with seven CHCs, Etobicoke community support organizations that serve seniors, and three hospitals in west Toronto. The program has been accessible in the broad west-end community for five years, serving about 4,000 people with diabetes. In addition, a diabetes nurse educator and registered dietitian offer individual counselling and group programs once a week. Stonegate measures outcomes by tracking individual information, such as weight and activity; group information is evaluated by monitoring how applied learning changes behaviour.

Asthma and chronic obstructive pulmonary disease: Stonegate also supports clients in developing action plans to manage their asthma themselves, the leading cause of hospitalization for children living in Ontario. The centre piloted two research projects funded by the Ministry of Health and Long-Term Care.



Ontario's CHCs have access to award-winning food guides and programs.

In the *Asthma Primary Care Research Project*, the asthma co-ordinator provides overall program management for three other west Toronto CHC's. Asthma fitness camps for children have improved outcomes for participants and enhanced their social skills. The project has proved that an increase in asthma self-management decreases visits to specialists and emergency rooms and saves money for the health care system. It has evolved into a province-wide program of individual, family and community education.

The second project, the *Chronic Obstructive Pulmonary Disease (COPD) Research Project* is validating a COPD screening tool and learning if COPD is under-diagnosed and affecting primary care practice in the province.

Osteoporosis: Stonegate's Osteoporosis program is geared to improving knowledge and self-management through education modules, physical activity programs and annual community outreach to specific target populations.

Cancer prevention: Primary care services and smoking cessation for cancer and COPD prevention are offered. A unified interdisciplinary team of certified smoking-cessation, clinical and health-promotion staff provide individual and group counselling and support. Specific events for high-risk youth are held twice a year.

Hypertension: Primary care and health-promotion staff provide preventative biannual wellness programs for seniors, including strategy modules for self-care of hypertension. Where appropriate, the centre provides resources such as home blood-pressure-monitoring units.

Chronic Disease: Meeting the Challenge in the Second Stage of Medicare

Completing the Second Stage of Medicare is all about breaking down barriers that prevent Canadians from being healthy.

Policymakers now recognize that the prevalence of chronic diseases is one of the most serious obstacles in achieving this end.

AOHC's upcoming conference brings together experts from across Canada and frontline health care providers to ask:

How can frontline health care providers ensure ongoing improvement in the quality of care they deliver?

How can our health care system deliver more complete and comprehensive Chronic

Disease Prevention and Management services and programs?

How can community outreach and community development programming be incorporated into more traditional clinical methods of preventing and managing chronic diseases?

Join us in June 2008 to explore and answer these and other important questions. Mark your calendars now! And for more information visit: www.aohc.org.

AOHC CONFERENCE 2008
WESTIN HOTEL, OTTAWA
JUNE 12th-13th

Partnerships in Ontario’s community health centres

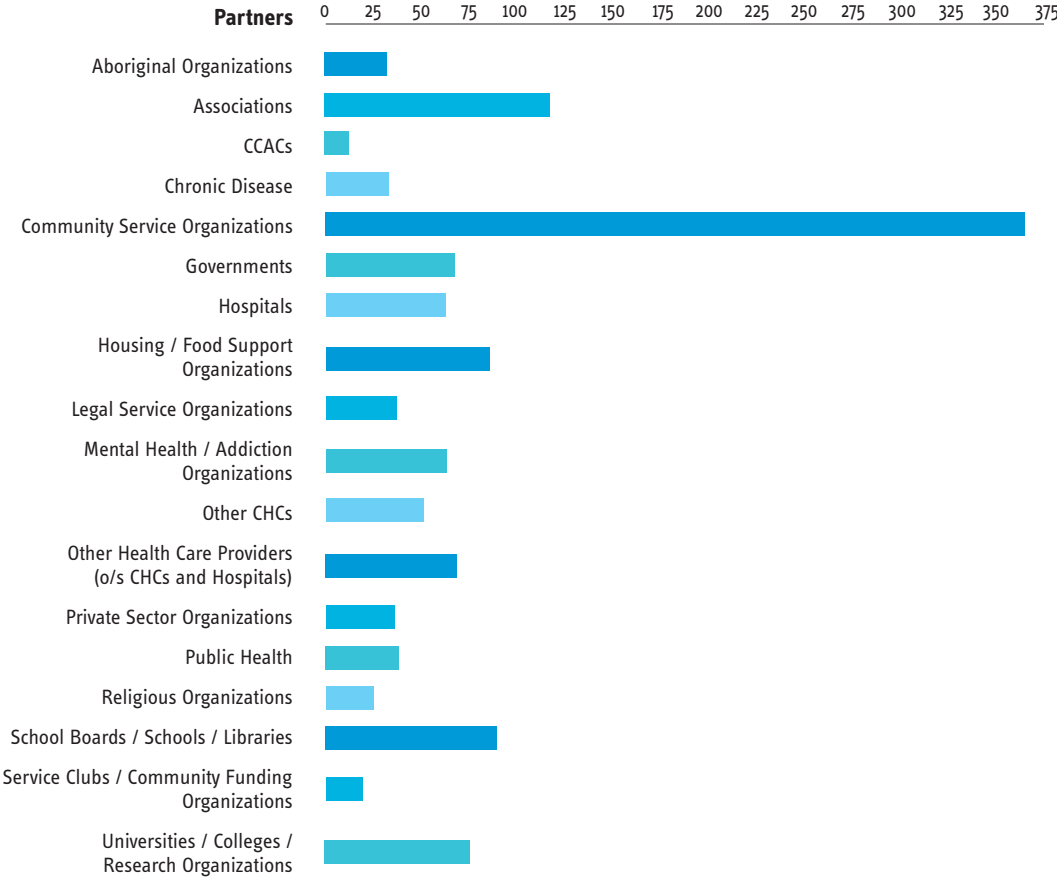
Partnering is a core attribute of the CHC model and an essential component of the CHC accreditation process called Building Healthy Organizations (BHO). When LHINs began asking their health service provider partners to develop broader and more robust partnerships, CHCs could easily say this work had long been under way. BHO defines partners as “organizations that CHCs work closely with to jointly operate programs and services or work on joint planning or advocacy initiatives to benefit their communities.” CHCs undergoing BHO accreditation – offered through the independent accreditation body Community Organizational Health Inc. (COHI) – are measured on their success in building and sustaining partnerships according to this definition. Community partners are asked to complete anonymous report cards on behalf of their CHC counterparts.

To date, 54 CHCs have developed over 1,275 partnerships, an average of 24 partners per CHC. Over the years, CHCs have developed expertise which ensures that their partnerships succeed. Chart 11 indicates the many different types of organizations with which CHCs partner. Almost every example cited in this report has involved a partner with which the CHC delivers integrated services to clients and the community.

Here are four examples of successful CHC partnership activities – with public health agencies, seniors’ groups, homeless groups and residents of Northern Ontario.

Through their accreditation process Ontario’s Community Health Centres are measured by their success in building and sustaining partnerships.

Chart 11: Partners of CHCs across Ontario



Over the years, CHCs have developed expertise in ensuring that partnerships succeed.



The *Breastfeeding Buddies Program* matches mothers, one-to-one, by phone and in person.

Public health

Ontario's CHCs see huge potential in partnering with local public health agencies and have already done so in numerous situations:

To improve dental care

In east Toronto, **South Riverdale CHC** and Toronto Public Health have launched a dental-care program for adults in need. Toronto Public Health provides the qualified dental professionals, and South Riverdale (which is not funded through Ontario's public health system for dental services) provides the location. The dental partnership has also expanded into advocacy activities, with both agencies working together to call on the provincial government to incorporate dental care into the public health-insurance system.

To provide needle exchange programs

Over the past 10 years, the **South Riverdale Community Health Centre** and Toronto Public Health have collaborated to support east Toronto's long-neglected I/V drug

user community. Toronto Public Health clients now have safe injection kits through a needle-exchange program. Together, the agencies are serving over 1,000 clients per year.

To support new mothers

The **Kitchener Downtown Community Health Centre** and Region of Waterloo Public Health are working together, to offer peer-based programs to encourage and support breastfeeding. The *Breastfeeding Buddies Program* matches mothers, one-to-one, by phone and in person. Volunteer "buddies" give free prenatal classes and do outreach at local festivals and fairs.

The results:

- De-medicalized and normalized breastfeeding.
- Enhanced child development through the documented benefits of breastfeeding.
- Reduced costs to the health system through the use of volunteer health supports.
- Contribution to local employment. Many breastfeeding buddies have become doulas, nurses, fitness instructors and other health professionals.

In 2006-07, 54 CHCs were part of 1,275 partnerships.

Other kinds of partnerships

To support seniors living at home

Anne Johnston Health Station in Toronto has partnered with Baycrest Centre for Geriatric Care to develop tele-health capability. Through the partnership, frail, isolated seniors and older adults with physical disabilities now have computers and web-cams in their homes and are helped to access on-line facilitated peer support groups. They also join weekly on-line live group sessions facilitated by a staff person from Anne Johnston Health Station and Baycrest. The peer-facilitated model lets them communicate with each other, use e-mail and have Internet access. As well, the CHC provides isolated seniors who live in subsidized housing with nursing and social work services, thanks to working partnerships with Senior Peoples Resources in North Toronto (SPRINT), Toronto CCAC and Toronto Housing.

To address the needs of the homeless

Through the *O Ta Ti Baen* program (meaning “Earned with a good heart”), the Babishkhan Unit

at **Anishnawbe Health Toronto** has created successful partnerships through the United Way to support people who are working towards a life away from homelessness. Community agency partners include Native Men’s Residence of Toronto, Council Fire Native Cultural Centre, Native Canadian Centre of Toronto, Native Women’s Resource Centre and Two Spirited People of the First Nation. In return for performing services at community-placement partner agencies, participants earn credits which they can apply towards their housing, clothing and other personal needs. Some graduates of this program are now working as Traditional Helpers to the medicine people in the community.

To provide care to youth in Northern Ontario

NorWest Community Health Centres has fine-tuned its administrative approach to provide primary care services in a vast rural and urban catchment area. In fact, this organization of three centres and multiple service points serves 47 per cent of Ontario’s total land mass. Part of NorWest’s mammoth organizing feat is being undertaken by a nurse practitioner on site at William Creighton Youth Services. The nurse practitioner pro-

vides four to five hours a week of health assessments for youth in custody, sparing them the indignity of going to hospital emergency departments with a guard. It also provides four-day fetal alcohol syndrome disorder training for FASD Resource Persons, school boards, probation and policing officers and child protection agencies. NorWest CHCs’ huge co-ordinating effort has also included development of a half-day urgent-care instruction program, conducted by a nurse practitioner, a nurse and a community health worker. The CHCs also provide food, volunteer support and hot lunches for children, in partnership with the Thunder Bay Housing Authority in 80 housing complexes weekly.

The Thunder Bay-based CHC staff also travel 260 km to Armstrong for a few hours each month to deliver outreach programs.

In the area of HIV/AIDS prevention and care, NorWest CHCs offer physician-led primary care at AIDS Thunder Bay, and they have taken the lead on an Aboriginal HIV/AIDS network, co-facilitating *Caring for Our Own* workshops for service providers who have clients with HIV/AIDS.

Service integration

Ontario's CHCs are committed to a more integrated and responsive health system. The goal of all CHCs is to continuously connect and work more closely with one another and with other groups and organizations both in and outside the health system.

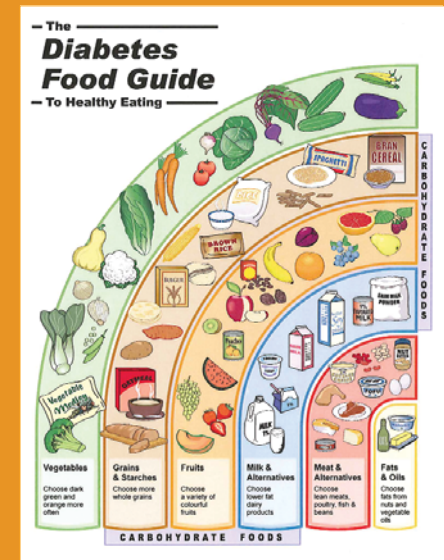
CHCs share resources and staff members such as data management co-ordinators, health promoters and dietitians. Different CHCs also take the lead in different partnership projects. One centre, for example, may lead on diabetes programming while others focus on arthritis; working as a network, they build and support each other, through best practice and program leadership.

For instance, since 1998, a community-based program for type 2 diabetes education has operated in Ottawa out of **Centretown Community Health Centre**. The Diabetes Network serves all of the community health and resource centres across the city, co-ordinating services among community members, hospital-based programs, public health, CCAC, the Canadian Diabetes Association and, more recently, local family health teams. Staff members are expected to achieve Certified Diabetes Educator status. They also provide feedback to referring physicians. A key component of program delivery is to lower the barriers to access, whether

based on language, age, culture, physical ability, transportation or other factors.

People who come to the education sessions are referred by family practitioners both within and outside CHCs. In fact, approximately 90 per cent of client referrals come from non-CHC physicians, or via self-referral. From April 1, 2007, to June 30, 2007, the program served 592 new clients in groups and individually, in addition to offering almost 800 follow-up visits. Services are available in 11 different languages.

A year ago, the *Community Diabetes Education Program* began offering insulin initiation, through physician referral, to clients who need to improve their blood glucose levels. Physicians report that it saves them time and reduces their reluctance to start patients on insulin. Preliminary results suggest dramatic reductions in A1c blood glucose levels. The close collaboration with consulting community endocrinologists provides a solid basis for high-quality work by the RN and RD teams, including in-service education to physician groups. Between April and June 2007, 75 individuals were supported as they started on insulin. In addition, a dietitian designed an award-winning diabetes food guide that is now available across Canada in many languages.



Sharing language and interpretation capacity

Access Alliance Multicultural Health and Community Services in Toronto recruits, screens and trains bilingual people at its Interpretive Service. The CHC then dispatches them to health care organizations on a fee-for-service basis. This work is proving invaluable to Ontario's CHCs. Although many hospitals have in-

house interpreters, they do not always have every language and may need to purchase additional services. Access Alliance Interpretive Service is centralized and can respond quickly. The service also offers orientation sessions for health care providers on working with interpreters and training for bilingual staff and volunteers on the responsibilities of interpreters.

Training to build cultural competence

Six CHCs in Ottawa, in collaboration with eight Ottawa resource centres, have mounted an integrated training program to improve cultural competence in delivering services and programs for people who are gay, lesbian, bisexual or transexual (GLBT).

The *Enhancing GLBT (Gay, Lesbian, Bisexual and Transexual) Cultural Competence Project* promotes changes in behaviour, attitudes, policies and practices. The result is safe and welcoming services for community members and their families.



Engaging communities

Ontario’s CHCs want their clients to be engaged meaningfully in decisions about health and health care in their communities. This is because case studies and research reviews suggest that meaningful community engagement, with community members actually involved in decision making, improves health and health care.

The University of Alberta Centre for Health Promotion Studies recently reported that CHCs “embody all of the principles of current government reform initiatives in health care and more broadly in effective civic engagement.”

The overall community-engagement approach is to enable clients first to understand, and then to get more involved in, decisions about the kind of care that can be available to them. It can occur in a variety of ways, and as mentioned above, is most valuable and effective when it involves community members in actual decision making, rather than merely providing input and feedback.

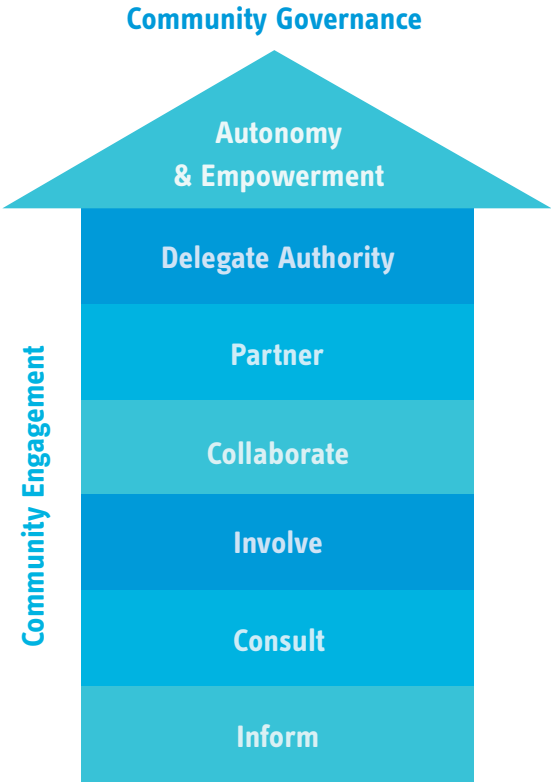
Community governance, as practised in Ontario’s CHCs, is now recognized as one of the highest forms and most effective means of community engagement. And

there are also many other ways CHCs encourage engagement, such as through the facilitation of leadership development, community organizing, health advocacy and political action.

In fact, the Building Health Organizations (BHO) accreditation process in which Ontario CHCs participate requires the use of community-engagement processes to improve programming. All CHC boards of directors are required to be composed of an array of members from the community.

Local leadership from the ground up

Since the late 1980s, the **London InterCommunity Health Centre’s** *Women of the World Project (WOW)* has been increasing community capacity, overcoming social isolation and building local leadership from the ground up. The project has trained scores of local immigrant women to navigate the health and social system. Graduates often go on to do additional training in order to become volunteer peer support workers. Many volunteers have, in turn, been able to translate their experience into well-paying employment with community agencies.



All CHC boards of directors are required to include an array of members from the community.

Local knowledge in health research

Changing the way health policy research is conducted to ensure it reflects top priorities and needs is one other way that Ontario's CHCs are enabling community members to get more involved in decisions about their health and health care. Toronto's Access Alliance, Regent Park and Black Creek Community Health Centres are undertaking a community-based research (CBR) project in which community members and local agencies play an active role.

Four health research topics are currently being explored. The goal is to gather evidence to support policy makers in decision making. Although the project is still in its early stages, the co-ordinators report that they have gathered highly relevant and crucial evidence that might have been missed had community members not been involved. Not simply the subjects of research, community members are actively involved as engaged collaborators and agents for change.



The greater the community engagement in decisions about health and health care, the better the outcomes.

Value and accountability

Ontario's Community Health Centres have always had balanced budgets

- In 2006/07, Ontario's Community Health Centres and their satellites had revenue totalling some \$250 million. Of this, approximately 85 per cent originated from the Ministry of Health and Long-Term Care with an additional 5 per cent from other Ontario ministries.
- The CHCs supplemented the Ontario government funding by over \$25 million, which was 10 per cent of their total budgets.
- CHCs spend 66 per cent of their budgets on program staff and benefits, 30 per cent on operations and 4 per cent on one-time costs. The management team executive director, administration support and medical receptionists are included in the 30 per cent that CHCs allocate to operations.
- The CHC accountability agreement signed with the MOHLTC in 2006/07 includes a provision for CHCs to maintain balanced budgets and return any year-end surplus funds.

Solving recruitment and retention problems

Retention and recruitment of staff is crucial to enhancing and maintaining services at CHCs. For CHCs to continue to provide quality services, they must employ qualified staff members that are paid adequately for their work. Currently, CHCs face challenges recruiting and retaining staff because of the higher salaries and benefits in other health care organizations.

MOHLTC is committed to ensuring that nurse practitioners and physicians are being fairly and equitably funded in all primary care models. It is essential that this commitment be fulfilled in order to achieve equity and competitiveness and to ensure continuity of care for CHC clients.

However, CHCs face challenges in recruiting staff for other positions as well. Inadequate funding for benefits is one difficulty. Out of the salary and benefit envelope, CHCs must spend 75 per cent on salaries and 5 per cent on staffing relief, leaving only 20 per cent for benefits. Twenty per cent falls short of the real cost of benefits and, in most cases, does not allow for pension provisions. This is a major barrier to recruiting and retaining

professionals, who can obtain strong benefit packages and pensions at institutions such as hospitals.

As the LHINs move towards building partnerships and programs across health-service-provider organizations, lower salaries and less generous benefits and pensions will be barriers. A recent case in point: the MOHLTC and LHIN wanted to transfer a hospital-run diabetes program to a local CHC. A major stumbling block was a \$20,000 difference in salary for dietitians, added to the fact that the CHC could not offer a pension to staff, meaning that hospital staff would need to give up their hospital pension in order to transfer into the new program delivery model.

To address this problem, Ontario's CHCs are seeking a funding formula that allows for CHC compensation packages (salaries and benefits) to be:

- consistent across the CHC sector;
- equitable in relation to other primary care models; and
- competitive with other health-service-provider organizations.

CHCs spend 66 per cent of their budgets on program staff and benefits, 30% on operations and 4% on one-time costs.

Chart 12: Sources of revenue

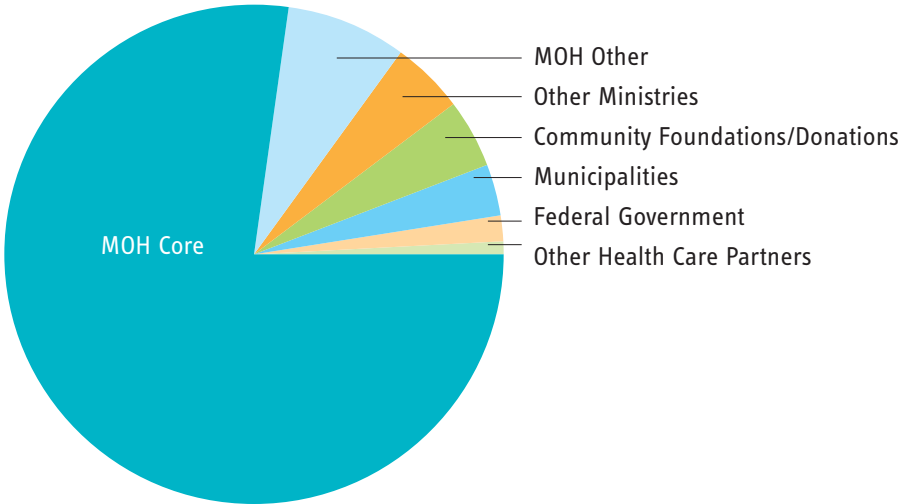
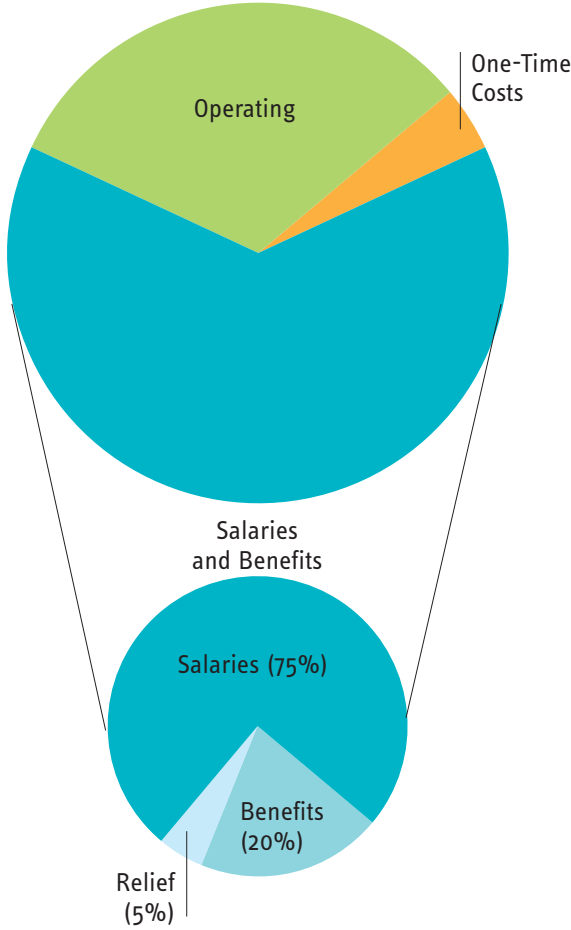


Chart 13: Use of funds



How are Ontario's Community Health Centres accountable?

Ontario's Community Health Centres are accountable to their communities and funders in the many ways described earlier in this report. They serve communities through their engagement and governance practices and the funders through their balanced budgets and program-delivery agreements. The CHC model of care is also aligned with current MOHLTC and LHIN strategies in the following four major ways:

- alignment with primary care model
- development of the CHC Strategy Map
- CHC Accountability Agreement
- Building Healthier Organizations Accreditation process

Alignment with MOHLTC and LHIN strategies

CHCs are a harmonized model of primary health care. They have

- interdisciplinary teams working in collaborative practice;
- extended hours;
- common service-delivery requirements;
- client registration or enrolment;
- 24/7 access through Telephone Health Advisory Service; and
- preventive-care and comprehensive-care incentives.

Alignment with MOHLTC and LHIN strategy maps

The CHC sector strategy map is aligned with the MOHLTC and the LHIN strategy maps. The CHC sector developed its strategy map in 2005/06 and adopted it collectively in June 2006.

CHCs are now looking forward to working closely with the LHINs and the primary care branch of the MOHLTC to develop indicators to measure outcomes associated with the CHC strategy map, which is also aligned with the LHINs and the MOHLTC.

CHC sector strategy map, June 2006

CHC sector mission

Focusing on the social determinants of health, we provide accessible, community-governed, interdisciplinary primary health care services, including health promotion, illness prevention and treatment, chronic-disease management and individual and community capacity building.

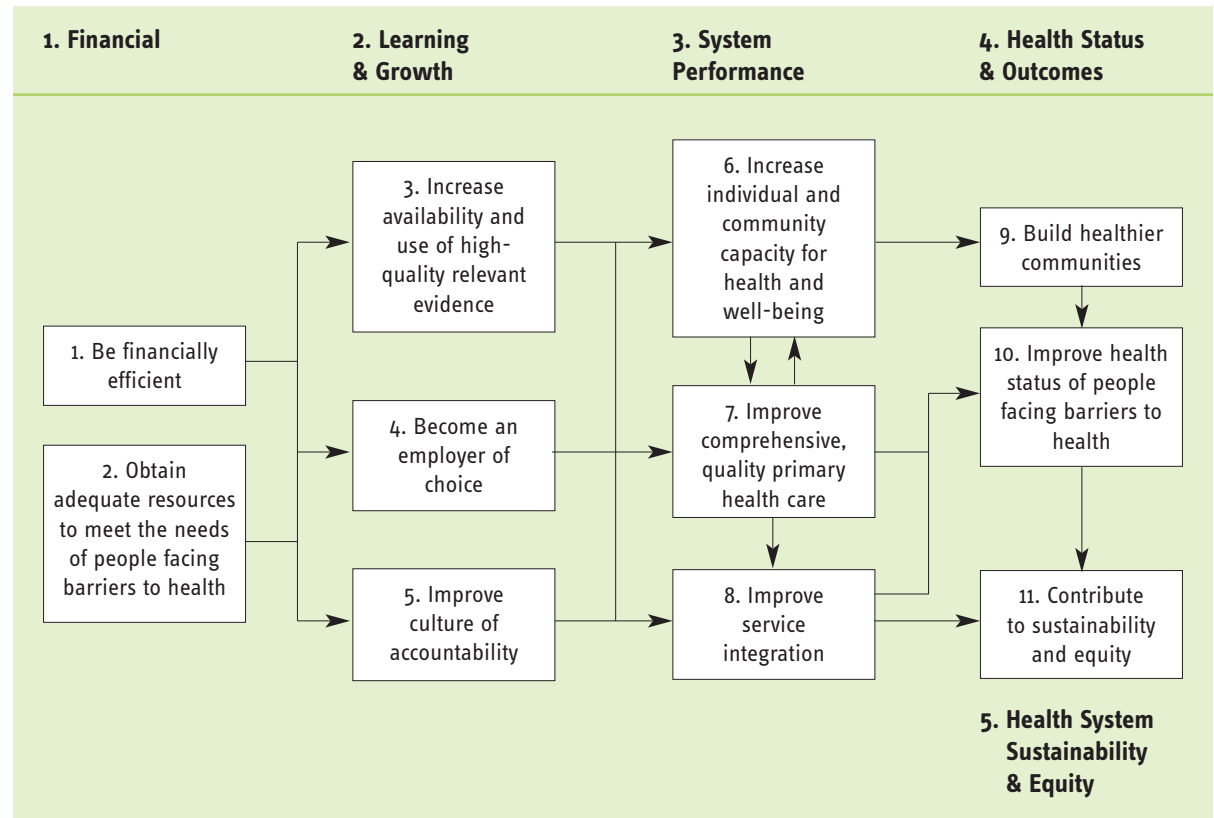
CHC sector vision

All Ontarians facing barriers to health* have access to quality primary health care within an integrated system of care.

** Barriers to health includes those facing barriers to access, chronic disease and those affected by the determinants of health.*

Key strategic result

To build individual and community capacity and to prevent and reduce health disparities, CHCs are accountable and responsive partners within the health care system.



Accountability agreements

CHCs have negotiated their first accountability agreements with the Ministry of Health and Long-Term Care (MOHLTC); these took effect in 2006/07. This accountability agreement has been transferred to the LHINs for the years 2007/08 and 2008/09. A new accountability agreement will be negotiated with the LHINs for 2009/10.

The philosophical and policy basis for the agreement was the accountability framework document collaboratively developed by MOHLTC and the CHC sector through a Joint Accountability Negotiating Committee (JANC). The accountability framework identifies four domains of accountability:

1. client outcomes
2. service integration
3. organizational health
4. strengthening of community capacity

The Accountability Agreement for the CHC Sector for 2006/07 contains the six indicators presented in this table.

Domain	Indicator	Category
Client outcomes	Number of primary care direct service hours (physician and/or NP) offered outside weekdays from 9 am to 5 pm	Performance
	Percentage of female clients aged 18 to 69 who have had a Pap test within the last three years at the CHC	Performance
	Number of service events per year per physician	Performance
Service integration	Percentage of clients with a particular chronic disease diagnosis (asthma, diabetes, obesity, osteoarthritis, hypertension, depression, anxiety, schizophrenia), who have received service within the past two years from two or more CHC funded health providers other than a physician	Developmental
Organizational health	CHC participates in a recognized accreditation process	Performance
Strengthening community capacity	Percentage and number of community initiatives' sub-activities that involve developing knowledge, leadership and civic skills in the community	Developmental

Accreditation

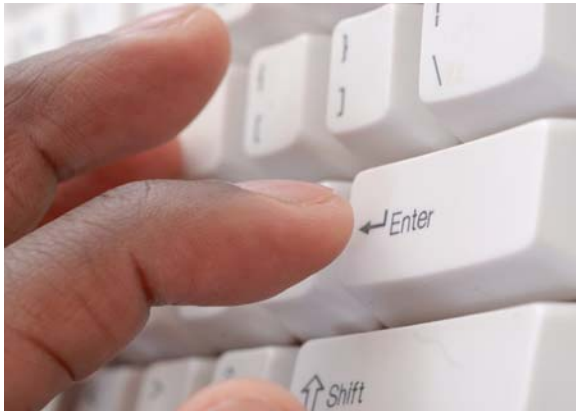
All of Ontario's Community Health Centres participate in the Building Healthier Organizations (BHO) accreditation process administered by Community Organizational Health Inc. (COHI). BHO was initiated in the mid-1990s in response to an identified need for an accreditation process that reflected aspects of the CHC philosophy, such as community ownership and primary health care, and the importance of having a healthy organization. Neither was included in the only other accreditation tool available at the time.

BHO was first designed to promote learning and quality improvement. A significantly revised BHO, launched in 2005, incorporates recommendations from an independent evaluation, a review of 12 other accreditation processes and feedback from participating organizations.

This new BHO brings with it Standards of Best Practice and Standards of Mandatory Practice, which are aimed at building capacity in all critical realms of not-for-profit service organization operations. As well, the new BHO provides assurances that participating organizations meet legislated requirements and are actively managing risk.

BHO review teams are comprised of peers from participating organizations and a COHI team leader. Peer reviewers share their experience and knowledge and take useful ideas back to their own organizations. The BHO process is unique in bringing 10 years of experience to the assessment and ongoing improvement of practice in areas of community involvement and ownership, primary health care, and health promotion for community governed, non-profit health organizations.

Moving forward: e-health and clinical information systems



CHCs recognize the importance of information technology in improving the care and services they deliver.

Ontario's Community Health Centres recognize the importance of information technology in improving the care and services they deliver. For this reason, the sector has partnered with the MOHLTC to create a CHC e-health strategy that is fully aligned with Ontario's e-health vision and primary care directions.

This strategy recognizes that CHCs, as the only primary care component of the health system fully within the responsibility of LHINs, need to be aligned with LHIN e-health activities and to ensure that primary health care issues and criteria are addressed effectively.

Specifically, the strategy calls for a common provincial Clinical Management System (CMS) for all CHCs in Ontario that

- is interoperable and is integrated with other provincial and local e-health solutions;
- supports service delivery through interdisciplinary primary health care teams;
- increases the ability of CHCs to deliver safe, high-quality, evidence-based care; and
- takes advantage of the experience of working together as a sector.

There is a long history of applying information management and information technology solutions

within Ontario CHCs. For example, 75 per cent of Ontario's CHCs are connected to the Smart Systems for Health (SSHA) network, and there are plans to reach 100 per cent. While CHCs are at varying points in the transition to electronic records, of the 54 centres, 52 are using a common CMS application.

A number have adopted lab and/or drug-order entry, and five centres are well along the journey to full electronic medical records.

By playing a leadership role in the adoption of next-generation clinical information and e-health systems, CHCs will also continue to enhance their reporting capabilities to allow them to support new clinical expectations (e.g. evidence-based care, best practices in CDPM) and the accountability requirements of both the LHINs and the Ministry.



Maximizing our potential

The information contained in this report offers just a quick snapshot of the depth and breadth of services and programming provided by Ontario's Community Health Centres. In future reports we intend to provide much more detailed information relevant to quality of care and performance measurements.

By offering a detailed picture of our work, we intend to give Ontario decision makers the information they need to make optimal use of the Community Health Centre model of care. We believe that when the potential of this model is fully maximized, the outcome will be healthier Ontarians, healthier communities, a stronger health care system and an excellent return on investment for Ontario's taxpayers.

Chronic Disease: Meeting the Challenge in the Second Stage of Medicare

Completing the Second Stage of Medicare is all about breaking down barriers that prevent Canadians from being healthy.

Policymakers now recognize that the prevalence of chronic diseases is one of the most serious obstacles in achieving this end.

AOHC's upcoming conference brings together experts from across Canada and frontline health care providers to ask:

How can frontline health care providers ensure ongoing improvement in the quality of care they deliver?

How can our health care system deliver more complete and comprehensive Chronic Disease Prevention and Management services and programs?

How can community outreach and community development programming be incorporated into more traditional clinical methods of preventing and managing chronic diseases?

Join us in June 2008 to explore and answer these and other important questions. Mark your calendars now! And for more information visit: www.aohc.org.

**AOHC CONFERENCE 2008
WESTIN HOTEL, OTTAWA
JUNE 12th-13th**

A toolkit to build better teams

To maximize the benefits of interdisciplinary teams, the AOHC has produced a workshop and accompanying toolkit called **Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres.**



Building Better Teams:
A Toolkit for Strengthening
Teamwork in Community
Health Centres

Resources, Tips, and Activities you can Use
to Enhance Collaboration

Both resources are a result of extensive quantitative and qualitative research with 13 of Ontario's Community Health Centres. Funding was provided by the Primary Health Care Transition Fund of Health Canada and the Ministry of Health and Long-Term Care. The toolkit addresses the eight basic competencies identified for effective teamwork.

Team vision

Communication

Decision-making

Effective meetings

Team values

Collaboration

Conflict management

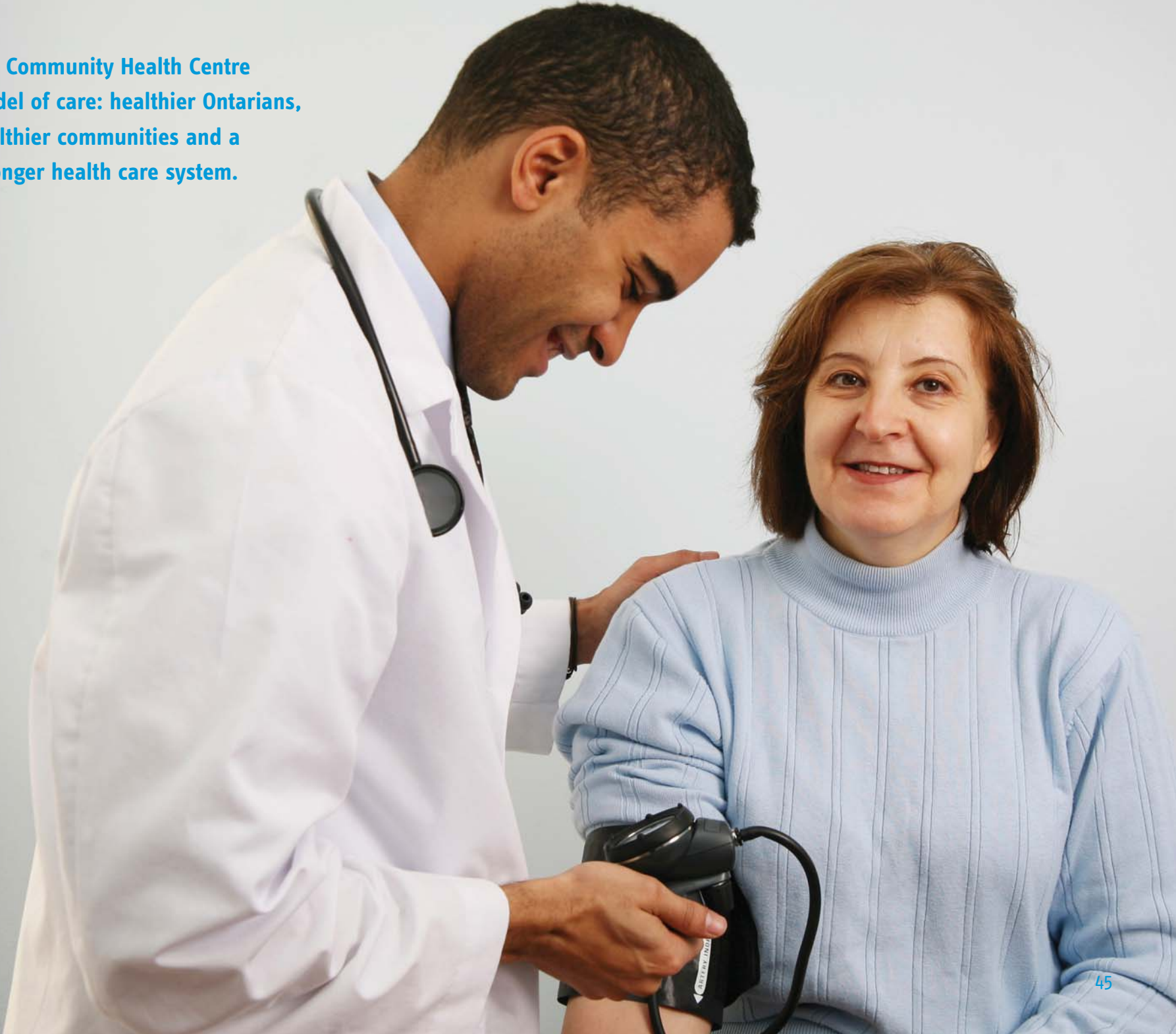
Everyday leadership

Each module summarizes the related evidence and provides tools and activities that will help team members to develop the knowledge and skills needed to work effectively in interdisciplinary primary health care teams.

AOHC is now working with new CHCs and Community Family Health Teams (CFHTs) to develop additional tools for new teams.

Workshops and toolkits are available in English and French. For more information or to order copies please go to the Association of Ontario Health Centres' web site at www.aohc.org or call 416-236-2539.

**The Community Health Centre
model of care: healthier Ontarians,
healthier communities and a
stronger health care system.**





Ontario's Community
Health Centres

Every One Matters.

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