THE COMMUNITY HEALTH CENTRE SOLUTION

Supporting Nova Scotia's Original "Health Homes" to Improve Health and Healthcare for Nova Scotians

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ABOUT NSACHC

The Nova Scotia Association of Community Health Centres (NSACHC) works with the province's Community Health Centres (CHCs) to improve the health and wellbeing of Nova Scotians and their communities. We work collaboratively with local, provincial and national partners, including the Canadian Association of Community Health Centres and other provincial CHC associations.

For over 40 years, Community Health Centres have been "Health Homes" for many residents of Nova Scotia, delivering collaborative care through teams of diverse healthcare professionals including family physicians, nurse practitioners, nurses, occupational therapists, social workers and other providers.

The NSACHC believes strongly that Community Health Centres are an ideal model of primary health care for Nova Scotians and are essential to fulfilling the Nova Scotia Government's vision of Health Homes and collaborative care. CHCs are particularly effective at meeting the complex needs of individuals, families and communities that face greater-than-average barriers to health.

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What are Community Health Centres?

Definition: Community Health Centres (CHCs) are multi-sector healthcare and social service organizations that deliver integrated, people-centred services and programs that reflect the needs and priorities of the diverse communities they serve. A Community Health Centre is any not-for-profit corporation or co-operative which adheres to all five of the following domains:

1. Provides inter-professional primary care
2. Integrates services/programs in primary care, health promotion, and community wellbeing
3. Is community-governed and community-centred
4. Actively addresses the social determinants of health
5. Demonstrates commitment to health equity and social justice

CHCs: Better Care, Better Health, Stronger Health System for all

Community Health Centres (CHCs) play an essential role in helping the Nova Scotia Government achieve many of its core priorities for Nova Scotians. This includes realizing the shared vision of "Healthy People, Healthy Communities - for Generations" promoted by the Nova Scotia Department of Health and Wellness (NSDHW) and Nova Scotia Health Authority (NSHA) and the NSHA's new strategic vision for collaborative care and "Health Homes".

CHCs are team-based, multi-sector healthcare and social service organizations. They provide timely and appropriate primary care through collaborative teams of family physicians, nurse practitioners, nurses, therapists, social workers and other care providers. CHCs bring care providers together to make sure that individuals and families receive the right care and support, at the right time, by the most appropriate care provider. Not only does this improve patient experience and outcomes, it improves the cost-effectiveness of the health system for everyone.

However, CHCs do not *only* provide clinical care. They wrap care and support around patient needs, and they actively address social barriers to health for individuals, families and communities at large.

These social barriers are commonly called the "social determinants of health" and they are the causes of causes of illness. Commitment to addressing social determinants of health is embedded in the CHC model and approach.

For some individuals and families these social barriers may be poverty, inadequate housing, food insecurity, language barriers, and other forms of social isolation. In some communities – rural and northern communities, for instance – these barriers include lack of transportation, wide geographical distances, and the overall lack of services available to residents. Wherever they are located, CHCs respond to local needs by providing a stable organizational base that ensures continuity of services and makes sure that services adapt with the local community.

The integrated primary care, health promotion and community/social services approach taken by CHCs builds "supportive environments to promote health" (a core strategic priority of the NSDHW).

In carrying forward their programs and services, CHCs actively engage members of the community to make sure that services, programs and priorities are grounded in the evolving needs and priorities of the people being served. This includes community-based boards of directors, patient satisfaction and feedback surveys, community forums and other mechanisms. CHCs put people and community *back* into healthcare and social services, providing a shining example of what it means to work "with Nova Scotians to create a healthier future" (a core strategic direction of the NSHA).

CHCs offer significantly more comprehensive services (74%) than other primary care models (61-63%) like Fee-for-Service practice and "clinical care only" teams.

Russell G et al (2010a). "Getting it all done. Organizational factors linked with comprehensive primary care". *Family Practice*. 27(5): 535-541.

Clients of CHCs report higher satisfaction scores across multiple domains of analysis including accessibility, prevention and health promotion, client and family-centredness and chronic disease management compared to clients of other models of primary care.

Conference Board of Canada (2014). *Final Report: An External Evaluation of the Family Health Team (FHT) Initiative*.

CHCs provide superior chronic disease management. Clinicians in CHCs find it easier to promote high-quality care through longer consultations and interprofessional collaboration.

Russell G et al (2010b). "Managing Chronic Disease in Ontario Primary Care: The Impact of Organizational Factors". *Annals of Family Medicine*. 7(4):309-318

CHCs foster environments in which community members and staff feel empowered to participate in decision making. CHC decision making leads to improved programs and services and the range of programs and services meets the needs of the community.

Church J et al. (2006) *Citizen Participation Partnership Project*. University of Alberta Centre for Health Promotion Studies.

Addressing the Policy and Funding Gap for Nova Scotia's Original Health Homes

Nova Scotians have long felt that the status quo of primary care in Nova Scotia has been out of step with best practice and the real day-to-day needs of individuals and families throughout the province. Therefore, the NSACHC and CHCs throughout the province have been encouraged to see the NSDHW and the NSHA begin to more formally align their vision for primary care with the model of *primary health care* promoted by the World Health Organization.

The province's recent shift toward collaborative care and commitment to establishing "Health Homes" throughout Nova Scotia aligns with the integrated model and approach that CHCs have been delivering in Nova Scotia for over 40 years and across Canada for over 90 years. The NSACHC and Nova Scotia's CHCs look forward to collaborating closely with NSDHW and NSHA to fully realize the benefit of Health Homes, bringing Nova Scotians more timely and responsive health care and a more integrated approach to health and wellbeing. As Nova Scotia's original Health Homes, the province's CHCs have many lessons to share and provide a solid foundation for growth of Health Homes.

Nova Scotia Vision for Health Homes

Primary health care services that will reflect the following attributes:

1. person- and family-centered;
2. timely access;
3. every person has a most responsible provider;
4. comprehensive scope of services carried out by teams or networks of providers;
5. continuity and coordination of relationships and information;
6. ideal sites for training and research;
7. electronic medical (health) records;
8. commitment to continuous quality improvement and safety;
9. strong support by governance structures, practice management, the public, etc.;
10. continuous, coordinated and comprehensive care across a person's life-span from birth to death;
11. population health approach where care teams engage with individuals and families in primary care, wellness and chronic disease management across integrated settings in a community cluster and network;
12. working in collaboration with other Health Homes.

At the same time, CHCs in Nova Scotia face systemic inequities that must be addressed. These include long-standing gaps in provincial policy and funding for CHCs. If they are not remedied, they pose a major impediment for the Nova Scotia Government in fulfilling its commitment to Health Homes.

CHCs throughout Nova Scotia have operated in varying degrees of financial crisis for many years. At core, this can be traced to the fact that the Nova Scotia Government has not developed a provincial policy framework for CHCs. During the 2011 election, the Liberal Party of Nova Scotia committed to working with the NSACHC (then the NSFCHC) to develop a provincial policy framework for CHCs. However, this commitment has not yet been fulfilled.[1]

As a result of the policy gap in which CHCs are situated, CHCs throughout Nova Scotia continue to experience severe neglect. Research from 2016 shows that no CHCs in Nova Scotia currently receive a core, annualized funding budget from the provincial government for their integrated primary care, health promotion, community health, and social services – the combined factors that make them "Health Homes". CHCs in Nova Scotia that *do* receive some small pockets of provincial funding, receive siloed amounts for a few individual healthcare providers, typically physicians only.[2]

The funding crisis faced by Nova Scotia CHCs is reaching a breaking point. In 2016, the Rawdon Hills Community Health Centre, a local centre built from the ground up by members of the community, was

[1] See "Nova Scotia political parties reveal commitments to addressing second-class funding of CHCs": http://www.nsfchc.ca/nova-scotia-political-parties-reveal-commitments-to-addressing-second-class-status-of-critical-health-services

[2] Canadian Association of Community Health Centres (2016). *The 2016 Canadian Community Health Centres Survey*. Accessed at: http://www.cachc.ca/2016survey

forced to cease operations after years of unsuccessful appeals to the provincial government for operational funding. It is a fate that other CHCs throughout Nova Scotia also may face in the future if the provincial government does not commit to core operational funding.

Despite the lack of core funding from the Government of Nova Scotia, CHCs have filled major service gaps faced by communities throughout the province. They have also injected millions of dollars into the province's health system: many CHCs are housed in buildings that were financed entirely by members of the local community through fundraising, and all CHCs in Nova Scotia continue to support their operations, to a significant degree, through fundraising and grant applications.

It is tragic and unjust that the very tangible investments being made by communities throughout Nova Scotia to finance their own health centres and to share the burden of funding health services is not being met with commensurate support by the Government of Nova Scotia. These services are guaranteed in principle by our universal Medicare system. It is time for CHCs throughout Nova Scotia to receive a fair, annualized operating budget from the provincial government for the services they provide as Health Homes. *Appendix 1* provides a closer look at what core, annualized funding of a CHC looks like.

NSACHC Recommendations

Nova Scotia's CHCs have only begun to scratch the surface of their potential. As properly-funded Health Homes, CHCs have the potential to further improve healthcare for Nova Scotians and to improve the cost-effectiveness of our province's healthcare and other social service systems. CHCs remain committed to working with the Government of Nova Scotia to achieve its objectives with Health Homes and its broader vision of "Healthy People, Healthy Communities – for Generations".

The Nova Scotia Association of Community Health Centres (NSACHC) looks forward to working closely with the Government of Nova Scotia and its departments to achieve fairness for CHCs and the Nova Scotians they serve. Toward this end, the NSACHC recommends the following four actions to the Government of Nova Scotia, with associated timelines:

1. In 2017-18, establish a one-time stabilization fund of $4 million to be distributed equitably among Nova Scotia's existing CHCs. These funds will enable CHCs to address high-priority operational gaps during this transition year and enable them to actively contribute to the province's strategic discussions and planning for expansion of Health Homes.

2. In 2017-18, establish a primary health care partnership table, with representation from NSACHC and other relevant associations/groups, to advance the province's planning of primary health care, including necessary steps to ensure that all Nova Scotians have access to the most appropriate type of Health Home.

3. By 2018-19, establish a provincial policy framework and implement core, annualized provincial funding for CHCs. Annualized global funding budgets should be provided to each existing CHC in Nova Scotia to support the package of team-based primary care, health promotion and community/social services that they deliver as Health Homes (See *Appendix 1* for examples). This funding should be accompanied by mutual accountability agreements between CHCs and the Nova Scotia Health Authority.

4. By 2020, invest in 10 new community-governed Community Health Centres throughout Nova Scotia to provide more Nova Scotians access to Health Homes through the integrated CHC model.

APPENDIX 1: Core, annualized funding of Community Health Centres

Community Health Centres in Manitoba, Ontario, Saskatchewan and other jurisdictions provide important examples of what core, annualized funding of CHCs should look like. CHCs receive a core, annualized funding envelope from their provincial Ministry of Health (via regional health authorities) to deliver an integrated basket of primary care, health promotion and community/social services.

Ontario is arguably the best example, given the broad base of CHCs across different types and sizes of communities. In Ontario, core funding for CHCs is also coupled with robust mutual accountability agreements between the CHC and its regional health authority (LHIN). These agreements outline service priorities, deliverables and other features.

Across Ontario, there are over 100 Community Health Centres that all receive an annual, core operating budget from the provincial government. This funding is very often supplemented by project-specific funding that comes from the Ministry of Health, other provincial ministries, regional health authorities, federal government, United Way and other sources. Below are two examples of what core, annualized funding looks like.

Case Study 1: Chatham-Kent Community Health Centres (CKCHCs)
CKCHCs is a multi-site Community Health Centre in Chatham-Kent, Ontario, a municipality in southwestern Ontario spread across a land mass of 2,458 sq/km and with a total population of approximately 101,000. The municipality contains 13 small towns, and five hamlets. 43,000 people out of the total population reside in the largest single town: Chatham.

CKCHCs is a Health Home to over 3500 clients who access team-based primary care, health promotion and community/social services at CKCHCs' four service sites in Chatham (main site), Wallaceburg, Pain Court, and Walpole Island First Nation.

As a Health Home, CKCHCs receives an annualized, global budget of $7.4 million from the Ontario Ministry of Health and Long-Term Care via the Erie St Clair Local Health Integration Network (the regional health authority in which CKCHCs in located). Within this budget, all clinical care providers, program staff and administrative staff are paid by salary (including family physicians) and they work collaboratively to deliver CKCHCs' diverse array of integrated services and programs.

Through the $7.4 million annual budget, CKCHCs currently retains the following clinical and health promotion team members, who are spread across the CHC's four service sites:

Family Physicians (5.0 FTE)
Nurse Practitioners (9.0 FTE)
Physician Assistant (1.0 FTE)
Registered Nurses (4.93 FTE)
Registered Practical Nurses (3.5 FTE)
Medical Receptionists (8.43 FTE)
Social Workers (3.0 FTE)
Registered Dietitians (2.0 FTE)
Physiotherapists (1.5 FTE)
Occupational Therapist (1.0 FTE)
Registered Respiratory Therapist (1.0 FTE)
Occupational / Physio Therapy Assistant (0.6 FTE)

Medical Receptionists (8.43 FTE)
Kinesiologist (0.86 FTE)
Chiropodist (0.9 FTE)
Health Promoters (2.0 FTE)
Addictions Counsellor (1.0 FTE)
Youth Programs Coordinator (1.0 FTE)
Child and Youth Worker (1.1 FTE)
Traditional Healer Community Outreach Worker (0.6 FTE)
Low German Mennonite Community Outreach Worker (0.75 FTE)
Low German Childcare workers (0.4 FTE)

In addition to routine primary care, delivered through a collaborative team of providers, CKCHCs has targeted clinical services in areas such as mental health and addictions care, cardiac rehabilitation, Hepatitis C prevention and care, and diabetes care. These are complemented by a wide array of health promotion programs and community/social services for the general population and specific priority population groups (eg, youth aged 13-21, Indigenous peoples, seasonal workers, and other groups). For more information visit: http://ckchc.ca.

Case Study 2: London InterCommunity Health Centre (LIHC)

LIHC is a Community Health Centre located in London, Ontario, a municipality in southern Ontario that covers an area of 2,665 sq/km and has a population of approximately 383,000. This makes it slightly larger than the Halifax urban area, which has a population of ~316,000 (out of the Halifax Regional Municipality's total population of ~403,000).

LIHC serves 6,467 clients who access the CHC's diverse programs and services, including team-based primary care, diabetes education program, poverty and homeless outreach programs, anonymous HIV testing, youth outreach programs, harm reduction and mental health programs, and immigrant and ethno-cultural programs.

In 2016, LIHC received an annual core operating budget of $8,361,148 from its regional health authority, the South West Local Health Integration Network. In addition to this core funding, LIHC receives close to another $1M each year from other provincial government ministries and the local United Way, as follows: Ontario Ministry of Health and Long-Term Care's AIDS Bureau ($124,403) and Hep C Secretariat ($464,013); Ontario Ministry of Children and Youth Services ($340,300); United Way of London and Middlesex ($64,000).

LIHC's total annual operating budget of $9,353,864 (from all sources) enables the following client-facing service providers, spread across the centre's two sites:

Physicians (6.5 FTE)
Community Outreach Workers (9.2 FTE)
Nurse Practitioners (7.6 FTE)
Youth Outreach Workers (5.5 FTE)
Registered Nurses (8.0 FTE)
Seniors Wrap Around Facilitators (7.0 FTE)
Registered Practical Nurses (1.0 FTE)
Systems Navigators (2.0 FTE)
Medical Receptionists (7.5 FTE)
Peer Coaches (2.0 FTE)
Social Workers (5.0 FTE)
Counsellors, HIV/AIDS Testing (2.0 FTE)
Registered Dieticians (2.5 FTE)
Physio Therapy Assistant (1.0 FTE)

Team-based primary care is complemented by a wide range of health promotion programs and community and social services aimed at populations who face barriers to care, including people facing poverty and homelessness, people who inject drugs, transgendered people, and immigrant and ethno-cultural communities. For more information, please visit: www.lihc.on.ca.

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