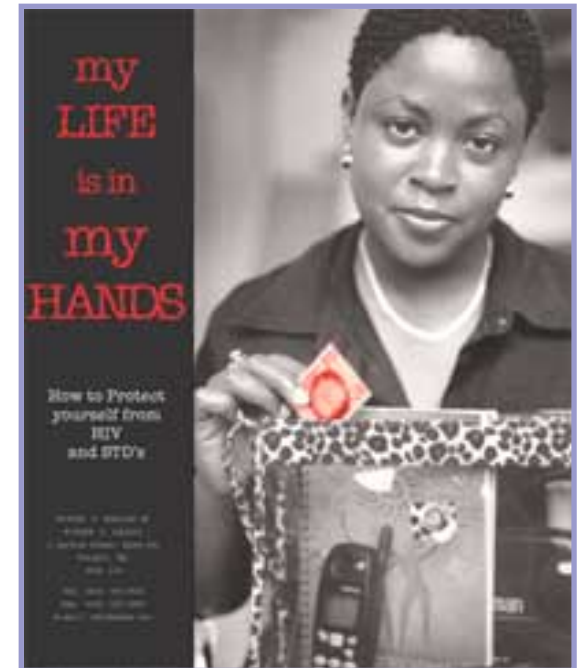


Waterloo Wellington LHIN: November 19, 2007 CHC Annual Planning Presentation 2008-09



- **Bill Davidson, Executive Director, Langs Farm Village Association**
- **Stephen Gross, Interim Executive Director, Kitchener Downtown Community Health Centre**
- **Denise Squire, Executive Director, Woolwich Community Health Centre**





Outline of Presentation

- General Background on CHCs
- Who We Are and Who We Serve in terms of:
 - Initiatives Supporting LHIN Health System Priorities:
 - Access, Sustainability, Effectiveness, Population Health
 - Initiatives Supporting LHIN Focus Areas:
 - Services for Seniors, Mental Health and Addictions, Chronic Disease Prevention and Management, e-Health
- Current Pressures
- Integrated Solutions
- Partners

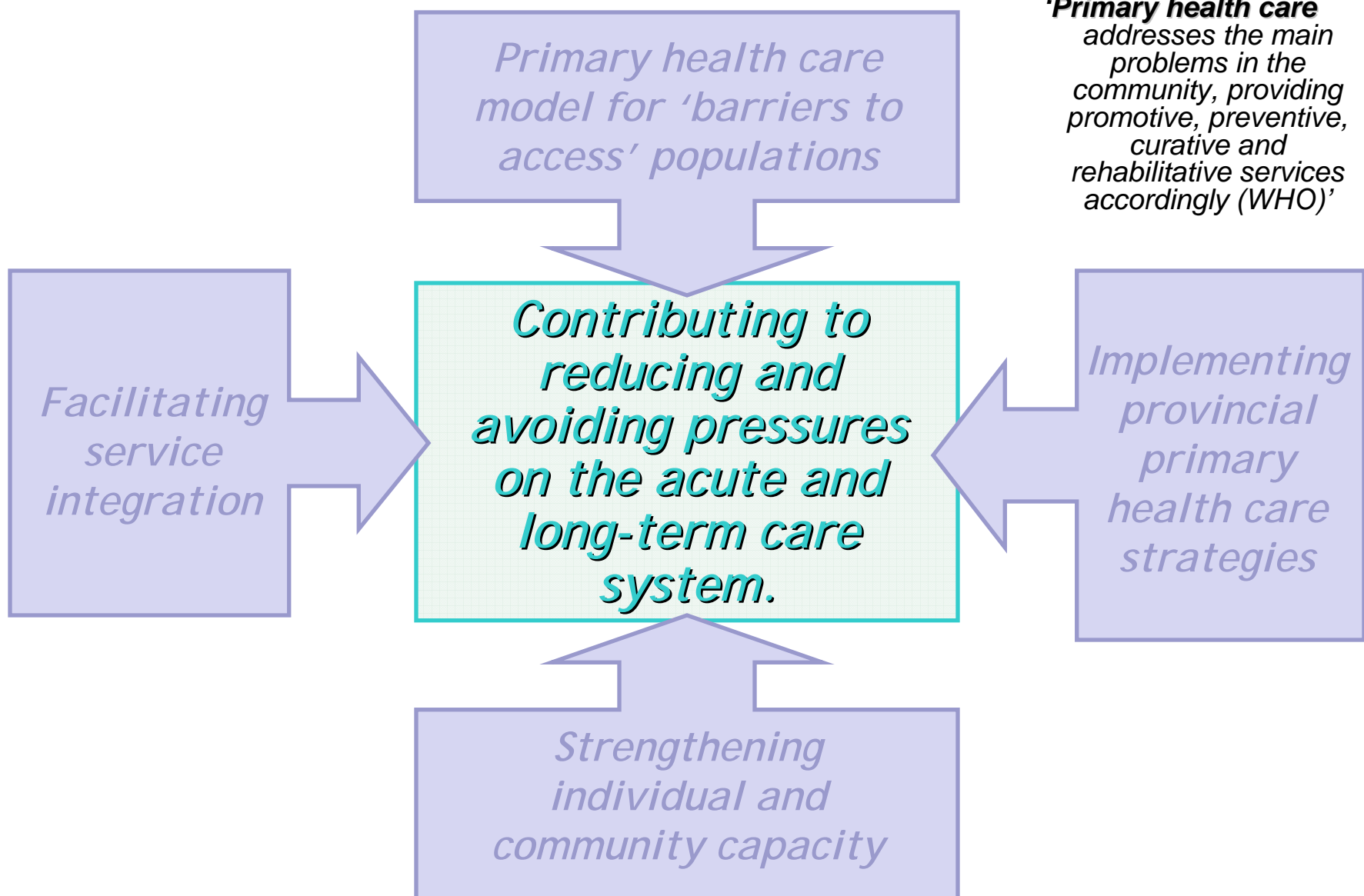


What is a Community Health Centre?

- 54 Community Health Centres (CHCs) and 10 satellite CHCs across Ontario, with 22 new CHCs and 17 new satellites starting up between 2005-06 and 2007-08
- CHCs have provided primary health care in Ontario for 30+ years
- CHCs are accredited, non-profit organizations governed by a volunteer Board of Directors, that provide:
 - Primary health care
 - Health promotion, illness prevention and community development

Using interdisciplinary teams of health providers: physicians, nurse practitioners, nurses, social workers, dietitians, health promoters, and others who are employed and paid by salary rather than through fee-for-service

General Background on Community Health Centres (CHCs)



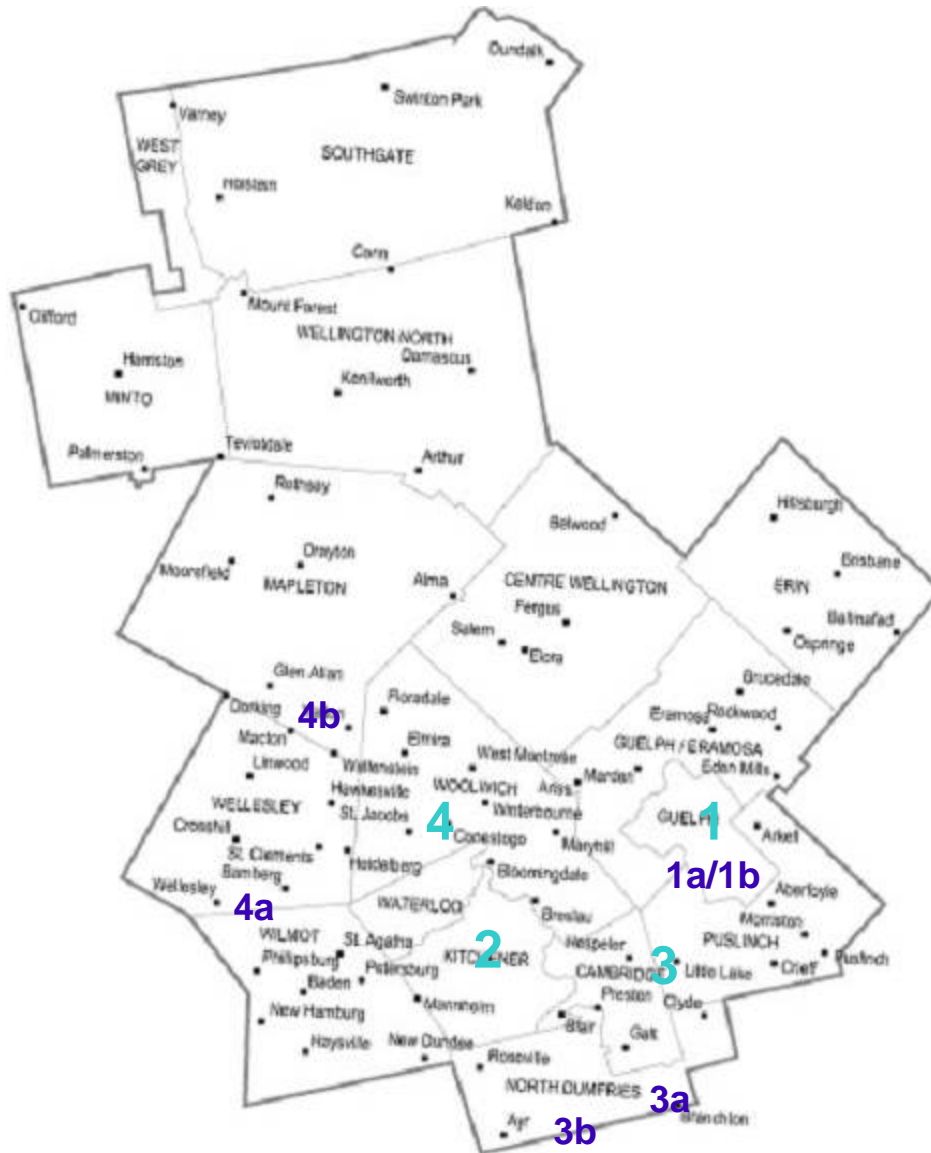


General Background on Community Health Centres (CHCs)

Guiding Principles of the CHC Model:

- Priority given to populations who encounter a diverse range of ‘barriers to access’, and individuals at greater risk of developing health problems
- Client-centred, interdisciplinary services
- Determinants of health focus
- Building and sustaining community capacity through community governance, engagement and local decision-making
- Commitment to the full continuum of primary health services (*disease prevention, health promotion, early intervention and management of chronic diseases*)
- Sectoral and cross-sectoral service planning and coordination to complement, and not duplicate services.
- Contributing to a healthy, safe, just and supportive community for all

Community Health Centres (CHCs) in WWLHIN: Community-centered primary health care



CHCs in WWLHIN – serving defined geographical catchment areas:

- 1 - Guelph CHC
 - 1a (Satellite in Shelldale)
 - 1b (Early Years Centre in Stone Road Mall)
- 2 - Kitchener Downtown CHC
- 3 - Langs Farm CHC (Cambridge)
 - 3a (Satellite in North Dumfries)
 - 3b (Nurse Practitioner Office in Ayr)
- 4 - Woolwich CHC (St. Jacobs)
 - 4a (Satellite in Wellesley)
 - 4b (Nurse Practitioner Office in Linwood)



CHC-Specific Background: Kitchener Downtown

- Staffing: 26 full and part time staff
- Volunteers: 130 volunteers
- Primary Health Care Clients served: 3000 registered clients and 800 served at 3 outreach sites
- Priority Populations: New Canadians, Aboriginal community, Isolated Seniors, Youth, Families in the downtown. Included in many of these groups are people with mental health and/or addiction issues



CHC-Specific Background: Langs Farm Village Association CHC

- Staffing: 45 full and part time staff (23 FTE's for the Langs CHC, 6.7 FTE's North Dumfries satellite, other MOHLTC sources for NPs and diabetes with the balance of positions multi-funded)
- Volunteers: 204 volunteers, 17 Board Members
- Primary Health Care Clients served: 4800 registered patients, over 9,000 active patients/participants in 06/07
- Priority Populations: Langs Farm community (socio-economic) and Preston area of Cambridge (youth, families & seniors). North Dumfries Satellite CHC (Ayr, Roseville, Plattsville, Washington, Drumbo, Canning, New Dundee, Branchton and Clyde).



CHC-Specific Background: Woolwich

- Staffing: 42 full and part time staff
- Volunteers: 100
- Primary Health Care Clients served: 5600 registered clients, plus 960 additional for allied health services and group programs, with continuing (but slow!) intake for all sites, programs and services
- Priority Populations:
 1. Families with Young Children (0-6),
 2. Seniors and their Caregivers
 3. Rural & Farm Families (includes four conservative Anabaptist cultural groups: Old Order Mennonites, David Martin Mennonites, Old Order Amish, and Low-German Speaking/ “Old Colony” Mennonites)
 4. Youth (14-19) [Priority population only for Wellesley catchment]
- Multi-funded: LHIN (for CHC), Ministry of Health (diabetes, NPs, midwifery TPA), Health Canada (prenatal nutrition), community/foundation grants (specialized fitness, local food systems)



Initiatives Supporting LHIN Health System Priorities: Improve Accessibility to Health Services

KDCHC

Primary care: Access to free interpreters, limited \$ to assist clients in paying for medication, Advanced Access appointment scheduling system; limited \$ to provide transportation for clients, Community Health Worker provides individual support, advocacy and some systems navigation (health, social services, government services)

Outreach primary care: Nurse practitioner, Chiropodist, ID services offered at St. John's Kitchen, Nurse practitioner at Mary's Place and Anselma House: flu shot clinics at outreach and to isolated seniors

Community Group/ Initiatives: Cost of ID replacement for homeless/at risk populations covered by KDCHC; community development and capacity building initiatives with priority populations assist clients to identify own assets and build skills to better support/care for self; produce New Canadian guide to health services

Partnerships: Developing relationships with Grand River Hospital, CCAC; ongoing relationship with CMHA, Waterloo Regional Homes for Mental Health, successfully lobbied Region of Waterloo to provide funds for those on OW to replace lost ID



Initiatives Supporting LHIN Health System Priorities: Improve Accessibility to Health Services

Langs CHC

Primary Care: two sites (Langs and North Dumfries), urgent/same day appointments, flu shot clinics, weekly clinic at the Bridges, serve Argus Residence for Young People, Haven House, Association for Community Living, discretionary policy for Cambridge

Community Group/ Initiatives: Neighbourhood-based model reduces barriers to access and improves timeliness of services and increases availability to appropriate services. Range of programs and services including Social Work Services Dietitian and Nutrition Services.

Partnerships: Arthritis Society, School of Optometry, Literacy Group of Waterloo Region, Kids Ability (speech and language), Lutherwood, Cambridge Career Connections, Pharmacy on site. Other partnerships with Cambridge Midwifery Practice, Public Health, local schools, Social Planning Council, other neighbourhood based organizations



Initiatives Supporting LHIN Health System Priorities: Improve Accessibility to Health Services

WCHC

Primary care: multiple sites across three rural townships, broad range of health care providers, extended hours and 24/7 on-call, provider visits in home and LTC facilities, services to non-insured (including support for diagnostic and specialist services), urgent/same day access, systems navigation (health, social services, government services)

Community Group/ Initiatives: outreach/ 'bring programs to people', transportation/ 'bring people to programs', translation, programs offered day, evening and weekends (depending on program)

Partnerships: Public Health, Arthritis Society, Community Care Concepts, St. Marys/PRIISME program, CAPC Outreach Worker, Alzheimer's Society, Family Violence Worker/Wilmot FRC, School of Optometry, KidsAbility – partners come to WCHC sites to provide services to rural communities



Initiatives Supporting LHIN Health System Priorities: Build Community Capacity to Achieve a Sustainable Health System

KDCHC

- Working from a social determinants of health perspective, many of the initiatives listed on other slides focus our work on improving individual and community health through action on improving community conditions such as poverty, housing etc; building relationships with other agencies to assist in better access, easier flow of support for clients

LFCHC

- 12 community partners on site improves access and enhances community capacity
- Electronic Medical Records as of Feb 07
- Peer Worker Program

WCHC

- Range of partnerships, within and beyond health care sector, to address broad determinants of health and support community capacity building in rural communities (e.g., Public Health, Community Care Concepts, Woolwich Community Services, Wilmot Family Resource Centre, local schools, day care, CAPC Outreach Workers, LTC facilities, St. Jacobs Family Support Centre, etc.)



Initiatives Supporting LHIN Health System Priorities: Enhance System Effectiveness

KDCHC

- Internal Professional development to improve service delivery: Chart audits; BPD education, PBL learning modules, best practice policy on narcotics prescribing
- Access to free interpreters
- New strategic plan: ongoing commitment to identify barriers to access for priority populations, look at new outreach opportunities; new community initiatives to address social determinant of health through community mobilization and action

LFCHC

- Recent co-located with Family and Children's Services and Catholic Family Counselling Centre to improve co-ordination and integration
- Logic Models and Evaluation Processes

WCHC

- Best Practices, established (Diabetes) and developing (Weight Management/Obesity)
- "One-stop" service availability, coordination and integration of CHC services and programs (range of providers, illness prevention/health promotion programs), with non-CHC funded programs and services: on-site partners (previously listed) and tenants (pharmacy, dentist, chiropractors, acupuncturist, naturopaths, massage therapist, midwives)



Initiatives Supporting LHIN Health System Priorities: Improve the Health of the Population

KDCHC

- Outreach sites, Chronic Disease Self Management groups, Community Diabetes Education Program, Breastfeeding Buddies program (partnership with Public Health), Community Initiative-Community Health Helpers (support own ethno cultural communities to learn about and access health/social services)

LFCHC

- Social determinants of health focus with Early Years, Youth & Teen Services (e.g. youth drop-in centre, 7th Inning, mentoring), Parenting Programs, Adult Programs (e.g. Retired and Ready, Women's Group, Outreach/Income Support), Resource Centre (e.g. computer access, employment counselling, housing support)

WCHC

- Specialized exercise programs (age/condition-specific); smoking cessation, health education programs (cholesterol, high blood pressure, men's health, medications management, etc.), prenatal nutrition program, children's farm safety education in rural schools (including parochial), Diabetes Fair, Youth Council programs; use of client/community advisory groups



Initiatives Supporting LHIN Health System Focus Areas: Services for Seniors

KDCHC

- Seniors Advisory group hosts information seminars for isolated seniors on various health issues, beginning to develop peer outreach program to provide isolated seniors with support in learning about/accessing services; development of drop-in gatherings for seniors less comfortable in attending “traditional mainstream” services

LFCHC

- Monthly seniors program; Retired, Ready and Roving Group in partnership with Allan Reuter Seniors Centre and Fairview Mennonite Home; large population of seniors accessing primary care services

WCHC

- Monthly health education program (with social component) for seniors, caregiver support groups, range of seniors exercise programs (some peer-led), Seniors (Adult) Health Fair, Seniors Networking Group.



Initiatives Supporting LHIN Health System Focus Areas: Mental Health and Addictions

KDCHC

- Harm Reduction Network, Sex Trade Workers Network, Housing and Homelessness Umbrella Group; ongoing relationship with Grand River Hospital Psychiatric and Mental Health Programs, CMHA, Waterloo Regional Homes for Mental Health, ACCKWA; internal strategy group and community advisory group currently developing strategies for improved care and service delivery

LFCHC

- Partnerships with Community Mental Health Clinic and 7th Inning Education Program, CASH, Social Work Services (e.g. case management, counselling).

WCHC

- Primarily focused on social work/counsellors, physicians, nurse practitioners working with individuals, couples, families; specific focus on caregivers of those who are terminally ill or have chronic, debilitating illness, through mutual support and bereavement groups; specific focus on farm women/farm couples, with social and educational events



Initiatives Supporting LHIN Health System Focus Areas: Chronic Disease Prevention and Management

Waterloo Region Diabetes Education Program

Vision:

- A community where adults living with pre diabetes and type 2 diabetes are supported with an accessible system of education and care to help them successfully manage their disease and achieve optimal health.

Partners:

- Cambridge Memorial Hospital
- Grand River Hospital
- Kitchener Downtown Community Health Centre
- Langs Farm Village Association Community Health Centre
- Woolwich Community Health Centre
- Canadian Diabetes Association
- Community Care Access Centre
- Region of Waterloo Public Health



Initiatives Supporting LHIN Health System Focus Areas: Chronic Disease Prevention and Management

Waterloo Region Diabetes Education Program

Goal:

- To increase access and reduce wait times for adults newly diagnosed with Pre diabetes and Type 2 diabetes – low to moderate risk.

Desired Results:

- Increased accessible care provided in the community
- Decreased hospital wait times for more complex care patients
- Improved system effectiveness and sustainability
- Flexible programming to meet the needs of our diverse populations



Initiatives Supporting LHIN Health System Focus Areas: Chronic Disease Prevention and Management

Waterloo Region Diabetes Education Program

Outcomes:

- More than 400 individuals have accessed diabetes education through the program
- Waiting lists for individuals with pre-diabetes and type 2 diabetes are being positively impacted allowing local hospitals to develop other services and see high risk individuals
- Orientation opportunities and education tools are being provided to local diabetes educators from other organizations, e.g. FHT

Ongoing Challenge:

- Recruitment of staff continues



Initiatives Supporting LHIN Health System Focus Areas: Chronic Disease Prevention and Management

KDCHC

- Regional Diabetes Program, serving Kitchener-Waterloo, Chronic Disease Self Management groups, Stress/ meditation groups, Living on a Survival Budget program, Issue specific chart audits

LFCHC

- Regional Diabetes program, serving Cambridge and North Dumfries, Healthy Me programs at Langs and North Dumfries (in partnership with FHT), Fitness program, Walking Club

WCHC

- Regional Diabetes program, serving Woolwich, Wellesley and Wilmot Townships; Stanford CDPM program; stress management programs; weight management programs



Initiatives Supporting LHIN Health System Focus Areas: e-Health

- All CHCs using same EHR system (currently Purkinje) for appointment scheduling and data collection driven by provincial evaluation system for CHCs, for past 10 years.
- Each at various stages of using Purkinje modules for electronic charting, labs and prescriptions
- Preliminary connections with WWLHIN eHealth Council
- Optimistic that current Ministry-driven CHC eHealth and Information Systems work will dovetail with local eHealth work led by LHIN.



Current Pressures

Internal Pressures – similar to many other HSPs, related to how CHCs are permitted to use existing resources, which influences capacity to respond to external pressures:

- Health Human Resources: Lack of competitiveness relative to salaries and benefits
- Single-year budget approvals
- Limited budget flexibility

External Pressures – Community needs/demands exceed resources

- Population growth in communities served
- Aging population



Current Pressures: KDCHC

Key System Challenge:

- Clients with significant barriers to accessing health and other community/government services. Barriers include: policies/procedures geared for the “mainstream populations” but not easily adaptable to others; perceptions of/attitudes towards different “population types”; lack of knowledge or skill to engage and navigate the system; systems and expectations that are foreign and confusing to those from different cultures; limited ability to access services (eg working poor affording medications or being able to take time off to attend appointments, poor housing conditions that restrict or eliminate services in the home); lost or lack of health card

How Addressed:

- Community initiatives to improve social conditions (eg. advocate for increase in minimum wage), partnerships as indicated in other slides; educating internally and externally regarding issues facing clients; internal Community Health Worker position who supports/advocates; KDCHC ID program; initial conversations with Grand River Emergency department to assist homeless/at risk population accessing a OHIP number

Potential Integrated Solutions for future:

- Increased knowledge in the community/health services about the issues facing vulnerable populations; develop specific partnerships/relationships; advocacy for poverty reduction, affordable housing; increased minimum wage, access to benefits for working poor; education/support for new Canadians re the system;

Who to engage/collaborate with in these solutions:

- Health and community service agencies, levels of government; community members



Current Pressures: LFCHC

- Key System Challenge/how addressed in past:
 - North Dumfries Township access to primary care services coming to Cambridge
 - Growing needs of Cambridge population
- Potential Integrated Solutions for future:
 - establishment of North Dumfries CHC satellite
 - Expansion of boundaries and priority populations
- Who to engage/collaborate with in these solutions:
 - Variety of community partners interested in being on site in ND
 - Future satellite in Cambridge?



Current Pressures: WCHC

Key System Challenge:

- Limited range of available health/human services in rural Townships (underserved for more than just primary health care!)

How addressed in past:

- Expansion of CHC services over time to broaden range of services we can provide 'in-house', and development of partnerships with urban-based agencies that have regional mandate to bring services to rural areas

Potential Integrated Solutions for future:

- New partnerships and enhanced existing ones, particularly related to mental health and addictions

Who to engage/collaborate with in these solutions:

- Hospitals, mental health agencies, specialists



Discussion Questions

For KDCHC:

- Adequate access to the determinant of health plays a significant role in people's mental health and overall wellness. Given that a significant minority of the population in our community do not have adequate access to these determinants and as a result may experience a long term reduction in their mental and physical health, what actions can be taken at a systems wide level (health system and other systems) to raise these concerns and develop specific action plans to address these barriers.

For LFCHC:

- What opportunities exist to further our work with vulnerable populations including seniors, youth at risk and the homeless and secure funding that is given to larger cities?

For WCHC:

- What are the options for new/enhanced partnerships, to bring urban-based services with Region-wide mandates, out to the rural Townships?