Healthcare Excellence Canada

Excellence en santé Canada

Alliance for Healthier Communities
Alliance pour des communautés en santé

Promising practices to strengthen primary care in northern, rural and remote communities

If you are looking for strategies being used in other northern, rural and remote communities in Canada to improve access to safe, high-quality, team-based primary care, then this promising practice will be of interest to you.

About Healthcare Excellence Canada

Healthcare Excellence Canada (HEC) works with partners to spread innovation, build capability, and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaborations with patients, essential care partners and people working in healthcare, we turn proven innovations into lasting improvements in all dimensions of healthcare excellence.

HEC focuses on improving care of older adults, bringing care closer to home, and supporting pandemic recovery and resilience – with quality and safety embedded across all our efforts. We are committed to fostering inclusive, culturally safe, and equitable care through engagement with different groups, including patients and essential care partners, First Nations, Métis and Inuit, healthcare workers and more.

Launched in 2021, HEC brings together the Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement. We are an independent, not-for-profit organization funded primarily by Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

150 Kent Street, Suite 200
Ottawa, Ontario, K1P 0E4, Canada
1-866-421-6933 | info@hec-esc.ca

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The Community Health Centre (CHC) Model in Ontario

What is the promising practice?

Of the more than 100 CHCs in Ontario, 21 CHC sites (located within nine CHCs) primarily serve communities that are northern, and serve rural and remote communities.

The CHC approach to care is based on the Model of Health and Wellbeing (MHWB). The MHWB highlights the need for and importance of a systematic and upstream approach to primary healthcare to better support and address the barriers to health that impact people and communities.

CHCs share five core attributes:

1) provide team-based interprofessional primary care
2) integrate the provision of a diverse array of health and social services
3) are community-centred
4) address the social determinants of health
5) commit to health equity and social justice.[1]

CHCs are community governed, multi-sectoral and are incorporated as a not-for-profit. Staff include a multi-disciplinary team of salary-based primary care providers that include physicians, nurse practitioners, registered nurses, registered practical nurses, allied health professionals (for example physiotherapists, chiropractors, social workers and dietitians), health promotors and community health workers. Many of the social services are supported by the CHC's health promoters and community health workers, who support their communities by providing the knowledge and tools to take control over their health (for example education programs, screening, advocacy, and other activities and programs). CHC staff raise awareness for and promote the work of CHCs through work and community partnerships, recognizing that the health of communities is critical for overall health and wellness.

Client Pathways

Each centre has its own policies and procedures as it relates to new clients as well as internal and external referrals, but all are meant to improve access to care for people who experience barriers including social, linguistic, geographic and systemic barriers. Centre de santé Univi Health Centre, for example, is committed to improving access to healthcare for clients without a primary care provider. Community members who are registered on Health Care Connect can be

contacted, and the centre recruits new clients through flyers, local newsletters and social media. Once a community member registers as a client of the centre, they can and are referred to primary care and internal and external social programs.

All CHCs are open to community members as well as the clients being provided clinical care. This means that people within the community served can access social services even if they're not a registered client of the clinic and culturally diverse staff and programs help ensure diverse linguistic and cultural needs are met.

Evaluation and impact

Example outcomes include:

- Increased availability and access to timely, quality healthcare services for clients in rural, remote and First Nations, and Francophone communities reducing their risk, time and expense traveling for medical appointments. Univi Health Centre recently acquired funding for palliative care nursing and secured a physician who specializes in palliative care. This has helped reduce delay of care for palliative care clients in the area and enabled this service to be delivered within a person's community. Where necessary, CHC staff have also supported providing in-home care to those clients who may be homebound or have mobility limitations.
- In 2021, Mary Berglund CHC (located in Ignace, in Northwestern Ontario – 3 hours west of Thunder Bay and 1.5 hours east of Dryden) surveyed their clients and 86 percent reported getting an appointment on the day they wanted; and 88 percent rated their overall experience as very good, or excellent.
- In 2022, 97 percent of Univi Health Centre CHC clients surveyed reported that they were either always or often involved in decisions about their care and treatment; 95 percent reported they always or often had enough time to discuss their health issues.
    - Visits to an emergency department (ED) can be used as an indicator of access to primary care services in the community.[2] A number of studies have found that CHCs reduce the number of ED visits and hospitalizations among community members.[2]
    - A study by Glazier et al. (2012) compared primary care models, such as CHCs, family health groups, family health networks, family health organizations and more. Results suggested that the CHCs client population in rural areas were more complex and despite this complexity had lower observed ED visit rates than

expected.[2] CHCs also had the lowest ratio of observed and expected mean ED visits per person for Ontario residents compared to other primary care models in rural settings.[2]

- Results from the sector's Practice Profile (2021) showed a low percentage of CHC clients in the ED that presented with specific conditions that could have been better managed elsewhere (under six percent for both Univi Health Centre and Mary Berglund CHC). This suggests that CHCs support the reduction of non-urgent ED visits.
- A number of studies (not limited to northern, rural or remote settings) found that CHC clients have lower spending costs for primary care, ambulatory care and EDs.[1] Glazier et al. (2012) concluded that CHCs are providing care to populations who face significant barriers and who tend be sicker but use the emergency room less than expected. Preliminary data is demonstrating that due to the complexity and hospital utilization (upstream costs) this model is saving health system dollars; more research is required to better understand the benefits.[3]
- CHCs have shown improved outcomes of care. Bhuiya et al. (2020) synthesized evidence (not limited to northern, rural and remote settings) and found that CHC clients:
    - reported positive experiences and enhanced satisfaction with the care received[4, 5, 6]
    - had improved uptake of screening programs for cancer and diabetes[7]
    - received higher quality of care provided based on the payment structure of CHCs compared to fee for service practices[8]
    - received a combination of individual and group-based care and education for diabetes, which demonstrated positive health outcomes among clients
    - benefited from superior chronic disease management compared to other primary care models in Ontario[9]
    - Training and resources are provided to ensure staff have the skills necessary to provide quality care to their clients. Univi Health Centre supports a large population of Francophone speaking clients and has made a commitment to offer clients services in the language they prefer. They have hiring policies as well as training to support the continued provision of high-quality Francophone services. Mary Berglund CHC reports that they receive and plan many cultural training sessions throughout the year, above what is required.
- CHCs have been found to improve disease-management programs through increased

accessibility of care, inter-agency partnerships, awareness of social determinants of health, training and education, and incorporating virtual-care technology.[1]

What do the providers who deliver the CHC model think?

- *"*The CHC model is effective because it is "all encompassing" and accessible … CHC supports addressing and looking at the whole person and working 'with' the client where they are at." (Univi Health Centre participant, 2023)
- "By supporting both their social, mental and spiritual health, this reduces the need for urgent care and reduces the frequency of primary care visits." (Univi Health Centre participants, 2023)

What do clients, care partners, family and community members think of this approach?

- "As a patient, I am given the time to spend with my nurse practitioner. I can spend the time understanding my health concerns." (client of Centre de santé Univi Health Centre, 2022)
- "I feel so lucky to have the doctors, the nurses and physio. This whole clinic could teach other places a thing or two about treating clients with dignity and respect." (client of Mary Berglund CHC, 2021)

Key success factors that support sustainability

- The interdisciplinary team providing and coordinating care and social services from a single location within their community ensures better support for the health and social needs of the client.
- Social determinants of health and health equity are a central feature of both client care and evaluation. For example, due in part to the salaried funding model, the interdisciplinary team of providers takes the time to prioritize building trusting relationships with clients to better understand health and social needs and how they can be met in the community. This is facilitated through the collection of sociodemographic data to monitor and improve equitable access to services within the community.
- Partnership and collaboration with local community organizations, community members and clients, including social service providers, help identify community needs and

informs advocacy efforts for funding to fill gaps in services and supports throughout the community. CHC's rely on feedback from clients and community members to identify gaps and needs within the community. This information is gathered formally through needs assessments and community consultation, and informally through communication with clients and program participants.

- Integration of health promotion and social programs are a big part of reducing frequency of primary care visits, reducing the need for urgent care and ensuring that all needs and concerns are addressed.
- Ongoing evaluation, with support from the Alliance for Healthier Communities is an important part of planning, decision-making, advocacy and collaboration to continue to improve the service and supports.
    - Data is collected via the electronic medical record (EMR), including all encounters with all clients who receive services through the CHC.
    - Performance agreements have been established between Ontario Health and CHCs to help ensure the provision of excellent care to communities and to support the centre to set and meet projected targets within a target corridor as established by the Ministry of Health (MOH). Ontario Health has Service Accountability Agreements in place with each CHC funded and these agreements support the centres. In addition, reporting standards were established to ensure consistent data reporting within and between sectors. Each centre is required to develop a Quality Improvement Plan that addresses priority indicators and also common indicators developed within the sector.
    - CHCs also received accreditation through the Canadian Centre for Accreditation that supports continued improvement of the quality and efficiency of the programs and services offered.

Opportunities for spread

- The CHC model is based on the MHWB, which has been successfully adapted to fit the needs of various unique northern, rural and remote communities within Ontario. The principles within the MHWB are broad in nature, to allow a community to adapt the model to the unique needs of their community.
- Staff from northern Ontario CHCs would be willing to explore partnerships with other communities in Canada to provide support in adapting the MHWB to meet the needs of

their communities and providers.

- The Canadian Association of Community Health Centres' mission is to support CHCs to work collaboratively. Through communities of practice, the CHCs can advance health equity and wellbeing for all communities.
- CHCs in the north support their communities by including them in planning and priority setting. CHCs have adapted existing programs to meet the unique needs of their communities. These examples could be helpful for other organizations in northern rural, and remote communities in Canada.

Facilitators of spread

- Recruitment and retention of staff to these more rural and remote communities remains a challenge. Many of the more remote communities are supported by locum physicians and nurse practitioners.
- The CHC's organizational commitment to equity and community-focused approach is met with funding constraints, competing service-delivery priorities, lack of resources and non-profit restrictions.[10]

Cost

Ontario CHCs receive most of their funding from the MOH through Ontario Health. Additional funding is provided in-kind through other provincial ministries, local partnerships, local municipal government, external grants, provincial grants and other corporate funders. The additional funding is often time-limited and may support longer term projects or initiatives.

Of the nine northern based CHCs in Ontario, the average funding received from the MOH or Ontario Health and other funders for fiscal year 2021-22 was $4.75 million. The majority (between 70 to 86 percent) of this funding is used for compensation expenses (human resources) and the remainder covers expenses for supplies, equipment, building and grounds expenses, etc. The average number of individuals served between the nine northern sites in fiscal 2021-22 was more than 4,000 (ranging from 975 to 15,102).

For more information

To learn more about Ontario-based CHCs, contact:

- Stephanie Bale, Quality Improvement and Performance Lead, Univi HealthCentre: stephanie.bale@univi.ca
- Dr. Jennifer Rayner, Director of Research and Evaluation, Alliance for HealthierCommunities: Jennifer.rayner@allianceon.org

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[1] Bhuiya AR, Scallan E, Alam S, Sharma K, Wilson MG. Rapid synthesis: Identifying the features and impacts of community health centres. Hamilton: McMaster Health Forum, 23 October 2020.

[2] Glazier RH, Zagorski BM, Rayner J. (2012). Comparison of primary care models in Ontario by demographics, case mix and emergency department use 2008/09 to 2009/10. https://www.ices.on.ca/Publications/Atlases-and-Reports/2012/Comparison-of-Primary-Care-Models.

[3] Provincial Health Services Authority (2011). Towards reducing health inequities: a health system approach to chronic disease prevention. A discussion paper. Vancouver, BC: Population & Public Health, Provincial Health Services Authority.

[4] National Association of Community Health Centers. Community Health Center Chartbook. January 2020. Washington, DC: National Association of Community Health Centers; 2020.

[5] Shi L, Lebrun-Harris L, Parasuraman S, Zhu J, Ngo-Metzger Q. The quality of primary care experienced by health center patients. *Journal of the American Board of Family Medicine* 2013; 26(6): 768-77.

[6] Shi L, Lebrun-Harris L, Daly C, et al. Reducing disparities in access to primary care and patient satisfaction with care: The role of health centers. J*ournal of Health Care for the Poor and Underserved* 2013; 24(1): 56-66.

[7] Han H, McKenna S, Nkimbeng M, et al. A systematic review of community health center based interventions for people with diabetes. *Journal of Community Health* 2019; 44(6): 1253-80.

[8] Liddy C, Singh J, Hogg W, Dahrouge S, Taljaard M. (2011). Comparison of primary care models in the prevention of cardiovascular disease – a cross sectional study. *BMC Family Practice*, 12: 114.

[9] Russell G, Dahrouge S, Tuna M, Hogg W, Geneau R, Gebremichael G. (2010). Getting it all done: organizational factors linked with comprehensive primary care. *Family Practice*, Vol. 27, 5: 535-541.

[10] Cheff, R. (2017). Making room for health equity: The role of community health centres in advocacy. Toronto, ON: Wellesley Institute.