COMMUNITY HEALTH CENTRES

Advancing *Primary Health Care* to Improve the Health and Wellbeing of British Columbians

BCACHC
British Columbia Association of Community Health Centres

Position Paper and Recommendations

April 2017

ABOUT BCACHC

First established in 2015, the British Columbia Association of Community Health Centres (BCACHC) was formally incorporated as a not-for-profit society in 2017. BCACHC works with the province's Community Health Centres to improve health and healthcare for individuals, families and communities throughout British Columbia.

BCACHC advocates increased investment in Community Health Centres throughout the province as a cost-effective way to improve access to high-quality, patient-centred and community-oriented primary health care. In carrying forward its mission, BCACHC collaborates actively with provincial partners, Community Health Centre associations in other provinces, and the Canadian Association of Community Health Centres.

CONTACT

Grey Showler
Director of Health and Support Services, Victoria Cool Aid Society
President, British Columbia Association of Community Health Centres

713 Johnson Street, 2nd Floor
Victoria, BC V8W 2G2
board@bcachc.org

www.bcachc.org
@BCACHC

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: Operationalizing *Primary Health Care*

As multi-sector health and social service organizations, Community Health Centres (CHCs) play an essential role in helping the Government of British Columbia and its various ministries achieve many top priorities for British Columbia residents. Among these, are core healthcare system priorities outlined by the B.C. Ministry of Health in *Setting Priorities for the B.C. Health System,* including:

- Providing patient-centred care;
- Implementing targeted and effective primary prevention and health promotion through a coordinated delivery system;
- Implementing a provincial system of primary and community care built around inter-professional teams and functions.[1]

Within the healthcare system, the B.C. Ministry of Health is now pursuing these priorities through plans to establish Primary Care Homes (PCHs)[2] and Patient Medical Homes (PMHs)[3] throughout the province.

The descriptions of PCHs and PMHs provided by the B.C. Ministry of Health and the General Practice Services Committee inspire hope that there is political will in our province to modernize frontline services and to invest in more than just fee-for-service, solo practitioner medical models of primary care. If the potential of this shift is truly to be realized, the B.C. Ministry of Health must embrace and invest in a "primary health care" approach, not just primary care.

The distinction between ***primary care*** and ***primary health care*** is not merely one of language. Primary care refers to firstline, clinical care services; in other words, the "narrower concept of 'family doctor-type' services delivered to individuals".[4] These primary care services can be delivered by a single practitioner, such as a family physician, or by a team of providers.

In contrast to this, *primary health care* refers to the broader coordination and integration of interventions that are necessary to actually improve health, of which *primary care* is one component. The World Health Organization cites five goals for primary health care: reducing exclusion and social disparities in health; organizing health services around people's needs and expectations; integrating health into all sectors; pursuing collaborative models of policy dialogue; and increasing stakeholder participation.[5]

---

[1] B.C. Ministry of Health (February 2014). *Setting Priorities for the B.C. Health System*

[2] B.C. Ministry of Health (February 2016). *Ministry of Health Strategic Initiatives; Priority 1 – Establish Primary Care Homes*. A Primary Care Home (PCH) will provide integrated and comprehensive primary care services to meet the primary care needs of a geographical community providing patients with appropriate and timely access to an inter-professional team of primary care full service family physicians and/or nurse practitioners as well as other primary care health professionals (e.g. primary care nurses and medical office assistants; health authority primary care/public health/community nurses; co-located allied health professionals)…. Key services provided by the PCH as part of comprehensive, longitudinal patient-centred primary care will include: Health promotion and illness prevention services; Primary care for minor or episodic illnesses; Primary reproductive care; Chronic disease management; Mental health and substance use (MHSU) services; Coordination and access to rehabilitation; Support for hospital care and care provided in-home and in long-term care facilities; and Support for the terminally ill."

[3] General Practice Services Committee (2017). Accessed at: http://www.gpscbc.ca/what-we-do/primary-care-bc. GPSC has established four goals for PMHs in B.C.: Increase access to appropriate, comprehensive, quality primary health care for each community; Improve support for patients, particularly vulnerable patients, through enhanced and simplified linkages between providers; Contribute to building a more effective, efficient, and sustainable health care system in order to increase capacity and meet future patient needs; Retain and attract family doctors and teams to work together in healthy and vibrant work environments.

[4] Muldoon, Hogg and Levitt. "Primary Care and Primary Health Care: What is the Difference?" *Canadian Journal of Public Health*, Sept/Oct 2006

[5] World Health Organization (2008). *The World Health Report 2008 - primary Health Care (Now More Than Ever)*

With broad goals such as these, primary health care is not exclusively the responsibility of the healthcare system. However, the healthcare system's responsibility is to ensure that primary care services are embedded within structures and organizations that are funded and mandated to operationalize primary health care. These organizations bridge those primary care services with services and programs in other sectors (housing, income security and others).

Community Health Centres (CHCs) are where primary health care is most effectively operationalized within the tapestry of health and social services provided to Canadians. CHCs deliver timely and accessible *primary care* services through interprofessional teams comprised of family physicians, nurse practitioners, nurses, dietitians, social workers, physiotherapists, dentists and other care providers.

But CHCs do more still.

They integrate these primary care services with health promotion and illness prevention programs, and they deliver additional services and programs that address local factors that affect people's health – what are called the "social determinants of health".

Sir Michael Marmot has called social determinants of health the "causes of causes of illness". For many individuals and families these "causes of causes" may be poverty, inadequate housing, food insecurity, social isolation, language barriers, and other social factors. In some rural and northern communities additional causes include factors such as lack of transportation, barriers caused by vast geographical distances, and the overall lack of services available to residents due to small population sizes. CHCs fill these gaps through direct services and programs, and by providing a strong and stable organizational base from which necessary additional services can be "home grown" through strategic partnerships and local social enterprise.

In delivering this integrated *primary health care* approach, CHCs also engage members of the community to make sure that services, programs and priorities are grounded in the actual needs and priorities of the people being served. This ensures that services and programs are not delivered from the top down, based exclusively on healthcare provider preferences.

CHCs involve members of the community through community-based boards of directors, through community advisory committees, through patient satisfaction and feedback surveys, through community forums and through other mechanisms. Not only does this ongoing community engagement result in more responsive services, it also enables services and programs to evolve over time as communities themselves evolve.

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 (2010). "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.

In addition to their general role in improving health and access to appropriate primary health care for the diverse communities they serve, CHCs have tremendous potential to provide high-value solutions to a number of current priorities that must be addressed in British Columbia. Among these are the need to:

- Reduce the burden/cost to the health system from avoidable use of hospital emergency rooms (ER);
- Improve accessibility and comprehensiveness of health and social services in rural B.C.;
- Enhance the accessibility and effectiveness of mental health and addictions programs.

Reducing avoidable hospital ER visits

Significant research throughout North America has demonstrated the impact of CHCs in reducing avoidable hospital ER visits and costs. In 2012, the single largest comparison of primary care models to date in Canada found that "when adjusted for patient complexity, Community Health Centres exceed expectations in reducing hospital emergency room visits, while other models of primary care are found not to meet expectations in reducing ER visits."[6]

The comprehensive, team-based care approach of CHCs is a key factor for success. It allows greater capacity to address complex care issues and to ensure appropriate screening and follow-up with patients by diverse care providers and health programs staff. The fact that CHCs are also multi-sector organizations that not only provide care but also address day-to-day challenges such as poverty, food insecurity, precarious housing and other social determinants of health means that clients of CHCs are less likely to end up in hospital ERs due to the deeper social causes of illness.

In Calgary, the housing program at CUPS Calgary, a local CHC, reduced the number of visits to the ER by 27% for 71 high-use clients[7]. And, an overall evaluation of CUPS Calgary indicated a $19 social return on investment for every dollar invested in the CHC.

In Edmonton, research from Boyle McCauley Health Centre found that the CHC's wound care clinic helped prevent 76% of individuals accessing the clinic from requiring urgent care at the hospital ER. Another 16% of clients accessing the clinic reported that without the clinic they would not have sought care, which would ultimately have resulted in them accessing more costly acute care in the future.[8]

Evidence from Canada is further supported by major, national research from the United States where the country's vast network of over 1200 CHCs has shown that:

- CHCs prevent 25% more emergency department visits than other models of primary care and save the U.S. health system more annually compared to fee-for service medicine[9]; and
- CHCs act as local economic engines, generating roughly $20 billion in new economic activity annually[10].

---

[6] Glazier RH et al (2012) *Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Department Use, 2008/09 to 2009/10*. Institute for Clinical Evaluative Sciences. Toronto.

[7] CUPS Calgary (2015). *Community Impact Report 2015*. Accessed at: http://cupscalgary.com/wp-content/uploads/2015/07/CUPS-Community-Impact-Report-July-242015.pdf p.10

[8] Snopkowski M et al (2012). *Use of an Inner City Wound Care Service.* Accessed at: http://www.bmhc.net/pdfs/Mischa%20Snopkowski%20wound%20care%20Poster%20.pdf

[9] U.S. National Association of Community Health Centres (2011). *Community Health Centers: The Local Prescription for Better Quality and Lower Costs*. Washington, DC.

[10] US Department of Health and Human Services (June 20, 2012). "Health care law expands community health centers, serves more patients". Accessed at: http://www.hhs.gov/news/press/2012pres/06/20120620a.html

Improve accessibility and comprehensiveness of health and social services in rural communities

Expanding access to Community Health Centres (CHCs) in rural communities is a critical step to overcoming longstanding challenges related to recruitment and retention of health professionals, as well as continuity of patient care and support. Over a decade ago, the Canadian Ministerial Advisory Council on Rural Health warned that, across Canada, "health care restructuring has centralized, reduced or eliminated hospital-based services without community-based services being enhanced.[11]" The fundamental concerns and recommendations expressed by the Advisory Council in 2002 are just as relevant today.

To improve health in rural communities, the Council urged that we must provide integrated health services that "put rural health in rural hands"; we must take a broader determinants of health approach, working across sectors; we must strengthen health promotion; we must build local infrastructure and help to foster community-led capacity-building; we must support sustainable health human resources strategies; and we must improve rural health research.

Community Health Centres provide a critical solution to all of these areas for action by providing a community hub from which comprehensive services and supports can be planned, coordinated and sustained.

As integrated organizations, CHCs take administrative responsibility for recruitment and retention of physicians, nurse practitioners, nurses and other professionals. This enables effective planning over the long-term so that communities are not left orphaned as a result of individual practitioner decisions. In addition to this administrative role, the team-based, interdisciplinary model of care means that CHCs are able to optimize limited supplies of diverse practitioners in rural communities. They do so by:

a. Providing a fertile and continuous practice environment for cadres of practitioners, such as nurse practitioners, who are otherwise left without stable primary care practice opportunities;
b. Distributing care and follow-up responsibilities across the team of providers so that the most appropriate care is provided by the most appropriate provider(s), and at the right time;
c. Maximizing impact of all providers by supporting practitioners to work to the full scope of their training and regulation.

Ontario's extensive Community Health Centre network has described effectively how CHCs are improving access and continuity of care in rural and northern Ontario communities:

> The likelihood of recruiting health care professionals increases substantially for northern and rural communities that have a CHC. When health providers considering a new position in a rural or northern community know they are going to be part of an interdisciplinary team whose members support each other managing a high demand for their services, they are more likely to commit to a practice. In addition, a strategically located CHC can play a vital role in easing shortages of health professionals system wide. If people know they can access continuity of care in a CHC, pressure eases in over-crowded hospital emergency rooms.[12]

[11] Ministerial Advisory Council on Rural Health (2002). *Rural Health in Rural Hands: Strategic Directions for Rural, Remote, Northern and Aboriginal Communities.*

[12] Association of Ontario Health Centres (2011). *Ontario's Community Health Centres: increasing access to care in northern and rural Ontario.* Accessed at: http://www.cachc.ca/wp-content/uploads/downloads/2014/12/Fact-Sheet-CHCs-for-Northern-and-Rural-communities.pdf

In addition to improving recruitment and retention of healthcare providers, CHCs in rural communities are also able to harness their organizational capacity to deliver programs that overcome geographical and other barriers to care and support. This includes mobile care units that bring care from the CHC hub to local communities in their vicinity; conducting home visits; providing group programs for isolated seniors; and many other innovative services.

An excellent example of this innovation is found in northwest Ontario, where NorWest Community Health Centres' mobile unit provides set-schedule services to eight small communities of fewer than 1000 people, each located over 100 km away from the CHC's base in Thunder Bay. The mobile unit also brings care and support to Thunder Bay's homeless shelter. All of these services are provided through an interdisciplinary care team with all providers paid by salary.[13]

The population health focus and determinants of health approach taken by CHCs also enables them to strengthen local partnerships across housing, education, employment and other sectors. Using health as the gateway for action, the active role of CHCs in local rural communities means that fewer individuals and families fall between cracks in various systems. Robust programs and partnerships at the CHC help families overcome barriers to health wherever they are faced. In other words, every door becomes the right door to effective care and support.

Again, major evidence from the United States also underscores the particular benefits of CHCs to rural communities throughout the country:

- Even after adjusting for population density, rural counties with CHCs exhibit 25% fewer Emergency Room visits than non-CHC rural counties;
- Rural CHC patients experience lower rates of low birth weight than patients of other providers in rural communities;
- Female patients of rural CHCs are significantly more likely to receive Pap smears compared to rural women nationally;
- Rural CHCs generate $5 billion annually in economic returns through the purchase of goods and services and by generating employment.[14]

Enhancing accessibility and effectiveness of mental health and addictions programs

The BC Ministry of Health's Communicable Disease Prevention, Harm Reduction and Mental Health Promotion (CHM) branch explicitly recognizes the impact of social determinants of health on mental health and addictions, and the potential for recovery. The branch's integration of mental health, addictions, harm reduction and communicable disease prevention programming into an integrated administrative branch is tacit, if not explicit recognition of the complex intersections connected to mental health, addictions and recovery.

A major obstacle to overcome in improving mental health and addictions care throughout British Columbia is moving this integrated approach beyond the walls of the Ministry of Health, and into integrated, inter-

[13] For more information on the NorWest CHCs' mobile unit visit http://www.norwestchc.org/mobile_unit.htm and http://www.cachc.ca/wp-content/uploads/downloads/2013/10/NorWest-CHCs-Pres-Mobile-Health-Unit_Sept-2013.pdf

[14] U.S. National Association of Community Health Centers (2013). Removing Barriers to Care: Community Health Centers in Rural Areas. Accessed at: http://www.nachc.com/client/documents/Rural_FS_1013.pdf

sectoral environments. The opioid crisis that has gripped our province in recent years has further underscored the need for a systemic, primary health care approach to addressing mental health and addictions in B.C. A commitment by the federal government for mental health provides important new opportunities to finally make progress.

Community Health Centres offer an integrated, multi-sector approach that places individuals and families at the centre of a circle of care and support. In addition to clinical care and support, the programs and partnerships offered through CHCs prevent individuals from falling through cracks once their immediate encounter with a clinical provider has ended. Some excellent examples of this integrated approach to mental health and addictions care, embedded in multi-sector CHCs, are already found in B.C. The following three B.C. CHCs provide templates for how this approach may be expanded:

- Atira Women's Resource Society (Vancouver, Burnaby, White Rock and Surrey)
- PHS Community Services Society (Vancouver)
- Victoria Cool Aid Society (Victoria)

Although each of these CHCs must contend with siloed funding from multiple ministries and perennial challenges related to the lack of policy and core funding for CHCs, each has managed to integrate primary care, health promotion and a wide range of housing, employment, food security and other social services into an organizational whole which improves accessibility and impact of mental health and addictions care.

By contrast, individual family physicians and "clinical care only" teams are challenged in providing effective care and support to individuals living with addictions and complex mental health issues. Payment models for individual providers – especially fee-for-service – provide disincentives to appropriate care; and clinical care teams alone are not embedded in a primary health care environment where clients have access to the broader circle of supports they need like housing, employment counseling, food support and other services that are essential to improving mental health and the opportunity for recovery from addiction.

Addressing the Policy and Funding Gap for Community Health Centres in B.C.

The B.C. Ministry of Health's strategic initiative to implement PCHs and PMHs is a positive step forward, particularly in fostering a shift in "primary care" toward interprofessional, team-based care. However, the vision for PCHs and PMHs will fall short if it does not include policy support and funding for the places in which primary health care is best operationalized: Community Health Centres.

This should include investment in new CHCs to serve communities that do not currently have access to appropriate primary health care, and it must also include investment to correct major inequities faced by existing CHCs throughout British Columbia. These inequities include long-standing gaps in provincial policy and funding for CHCs that have resulted in varying degrees of financial crisis for many years.

Research from 2016[15] shows that only 8% of CHCs in British Columbia receive core, annual operational funding from the B.C. Government for their integrated primary care, health promotion, community health, and social services. Some other CHCs in B.C. receive small pockets of provincial funding, but this funding is very siloed and typically covers only individual healthcare provider contracts.

In March 2017, the British Columbia Legislature's Select Standing Committee on Health reported its findings[16] from extensive hearings throughout the province on the B.C. healthcare system. On multiple occasions, the bi-partisan committee identified the strategic value and impact of CHCs and identified the need for increased investment in CHCs throughout B.C.

The Committee noted: "Submissions outlined the demonstrated positive outcomes of Community Health Centres, such as the ease of access to interdisciplinary teams, centralization of interrelated services, and the cost savings of sharing a facility and administrative supports. Increased capital funding for this purpose could improve interdisciplinary care for British Columbians."

Among others, the bi-partisan Committee made the following final recommendations to the B.C. Government:

- Implement a range of team-based, scalable and customizable interdisciplinary primary and community care models based on communities' needs, including the integration of health and social services, where appropriate. (*Rec 18*)

- Implement a Community Health Centre model of care, comprised of co-located interdisciplinary teams, including a physician or nurse practitioner, and other health care providers. (*Rec 19*)

- Develop and implement alternative flexible funding and compensation structures for health care providers, including nurse practitioners, in order to encourage the adoption of innovative primary and community care models. (*Rec 26*)

- Provide adequate operational and capital funding for new and existing Community Health Centres throughout the province. (*Rec 27*)

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

[16] B.C. Legislative Select Standing Committee on Health (2017). *Looking Forward: Improving Rural Health Care, Primary Care, and Addiction Recovery Programs*. Accessed at: https://www.leg.bc.ca/cmt/health

Numerous findings by the Legislative Committee underscore the major challenges faced by existing CHCs throughout the province as well as the immense potential of CHCs to dramatically improve health and healthcare for B.C. residents.

Despite the major challenges CHCs face, including the lack of operational funding from the B.C. Government, CHCs have succeeded in filling major service gaps faced by communities throughout the province. They have also injected millions of dollars into the province's health and social service system: many CHCs are housed in buildings that were financed entirely by members of the local community through fundraising, and all CHCs in B.C. continue to support their operations, to a large degree, through local fundraising and grant applications.

It is time to recognize the very tangible investments being made by communities throughout British Columbia to finance their own Community Health Centre and to share a disproportional burden of funding health services without commensurate support from the B.C. Government. It is time for CHCs throughout the province to receive a fair, annualized operating budget from the provincial government for the important services and programs they provide to B.C. residents.

Appendix 1 of this document provides a closer look at what core, annualized funding of a CHC looks like.

On April 3, 2017, the B.C. Government announced its intention to invest $90 million in new funding over three years on integrated team-based primary care services throughout B.C.[17] The BCACHC welcomes these new investments and believes strongly that sizeable portions of this new funding must be dedicated to addressing the major funding gaps at the province's existing CHCs, as well as to supporting establishment of new CHCs in communities that do not have access to appropriate primary health care.

[17] B.C. Ministry of Health (2017). "New funding to help create team-based primary care services throughout B.C." Accessed at: https://news.gov.bc.ca/releases/2017HLTH0074-001006

BCACHC Recommendations

Our province's CHCs have only begun to scratch the surface of their potential. The fair, equitable and appropriate core funding of these organizations and investment in new CHCs would further improve health and healthcare for British Columbians and bring increased sustainability to our province's healthcare and other social services. The B.C. Government's April 2017 announcement of $90 million in new funding for integrated, team-based primary care can go a long way toward addressing the major funding gaps experienced by the province's CHCs.

The time for commitment and action is now. To help the Government of British Columbia achieve its goals for B.C. residents, the BCACHC recommends the following four actions, with associated timelines:

1. In 2017-18, establish a one-time emergency fund of $6 million to be distributed among British Columbia's existing CHCs. These funds will enable CHCs to address high priority operational gaps during this transition year and enable them to meaningfully participate in provincial strategic planning.

2. In 2017-18, establish a primary health care partnership table, with representation from BCACHC and other relevant associations/groups, to advance the province's planning of primary health care, including necessary steps to ensure that all British Columbians have access to CHCs and other forms of Primary Care Homes and Patient Medical Homes, where needed.

3. By 2018-19, implement an annualized global funding model for existing CHCs in British Columbia that encompasses the package of team-based primary care, health promotion, community development initiatives and social services that they deliver. This funding model should be developed in cooperation with BCACHC and British Columbia's CHCs, and we recommend that it be accompanied by mutual accountability agreements. *Appendix 1* provides a closer look at what core, annualized funding of a CHC looks like.

4. By 2020, invest in 20 new community-governed Community Health Centres throughout British Columbia to provide more British Columbians access to appropriate primary health care when and where needed.

We look forward to working closely with the Government of British Columbia to make these important and achievable measures a reality over the months and years ahead.

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 can and 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 core 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 and what BCACHC recommends as a template for core, annualized operational funding of CHCs in British Columbia.

Case Study 1: Chatham-Kent Community Health Centres

Chatham-Kent Community Health Centres (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 provides services 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.

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 420 sq/km and has a population of roughly 383,000. This makes it slightly smaller than Surrey, BC.

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 who are all paid by salary and are spread across the CHC'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 visit: www.lihc.on.ca