

Ontario's Community Health Centres

Addressing the great health divide



A solution for the provincial government
and Local Health Integration Networks

“Community Health Centres go where others fear to tread. I have great admiration for them... I think it’s a marvellous idea. It really works for the community, for people to be able to come to one place in their community and access a whole range of services. One of the things that we’ve managed to do is build up a lot of wonderful organizations, but they’re all located in different places so it’s very hard for people to navigate. Now that they’re all in one place, people can come here, feel at home, feel comfortable, get the health services they need and also the social services. I think it’s very, very exciting.”



Remarks made by The Honourable Deb Matthews, Ontario’s Minister of Health and Long-Term Care, at the opening of The Hub, a new satellite of Scarborough Centre for Healthy Communities on January 19, 2010.

Communities where access to Ontario's Community Health Centres has expanded

... as a result of the 2004-2005 announcement (SHOWN BY LHIN)



Good news for Primary Health Care: thousands more people can now access services and programs delivered by Ontario's Community Health Centres (CHCs).

In urban centres, in rural Ontario and throughout the north, the 49 new centres and satellites announced by the current government back in 2004 and 2005 are delivering significant and positive results.

This report chronicles these results, detailing the effectiveness of these new CHCs in improving the health of individuals, families and entire communities. It also offers guidance to the provincial government, as well as Local Health Integration Networks (LHINs) on how Ontario's Community Health Centres, along with their sister Aboriginal Health Access Centres, can help solve a huge health challenge in our province – the great health divide.

This great health divide is largely driven by poverty and Ontario's CHCs and AHACs have proven their effectiveness in closing it. However, as things now stand, only 3.7 per cent of Ontarians have access to their vital services.

To expand this access by 2020 we've set a goal to double the number of Ontarians served by CHCs and AHACs to one million people. The provincial government and the LHINs can reach this goal in two ways. They can invest strategically in existing centres and they can also create new centres.

Planning and implementation will take a lot of work but will yield many benefits: healthier people, healthier communities and a more sustainable healthcare system.

Benefits of more Ontarians accessing Community Health Centres



A community kitchen at Country Roads CHC.

Since CHCs were first formed 40 years ago, they have been one of the great success stories of Ontario's health system. By combining primary healthcare services with a wide range of other health promotion and community development services under one roof, CHCs offer a unique and comprehensive model of Primary Health Care.

For this reason, early in its mandate, the current Liberal government decided to increase access to CHCs. Funding for 21 new centres and 28 satellites was announced. The decision means that upon full implementation, 175,000 more Ontarians will access CHC services and programs.

Smart policy-making

The provincial government's decision to increase investment in Ontario's CHC network was smart policy-making that looked to the future. CHCs, together with ten sister Aboriginal Health Access Centres (AHACS), are the only primary health care models in Ontario specifically mandated to focus on the social determinants of health – the wide variety of social, economic, environmental and cultural factors that shape our well-being.

Seamless accessible programs and services

CHC and AHAC interprofessional teams design programs and services based on the knowledge that health isn't just something to be accessed at a doctors' office, the hospital, or the pharmacy. It's something that starts in our families and homes, in our schools and workplaces, in our playgrounds and parks, in the air we breathe and the water we drink. This knowledge guides a complete, coordinated and comprehensive approach to service delivery.

All of the new centres and satellites offer:

- convenient access to a wide range of services;
- care that is customized to client and community needs and
- programs that address the root causes of illness and injury.

As did all CHCs across the province, the new centres and satellites conducted extensive community engagement processes to identify populations most vulnerable to illness. This means services are connecting with those who need them most.

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

George Smitherman, at that time Minister of Health and Long-Term Care for Ontario, speaking in 2005.

New centres respond to Ontario's health challenges

New Community Health Centres and satellites announced by the provincial government in 2004 and 2005 are already addressing some of Ontario's most urgent healthcare needs and challenges.



Increasing access to those who face barriers in the GTA

VAUGHAN COMMUNITY HEALTH CENTRE

A health promotion group for older adults at Vaughan CHC.

The Challenge: Like many parts of the outlying Greater Toronto Area, Vaughan's population is growing rapidly. But many people do not have adequate access to health services. In the region, many newcomers to Canada face difficulties finding health providers who understand or are willing to deal with the issues they face.

The Success: In its first year of operation, the Vaughan Community Health Centre (VCHC) served more than 2,500 clients through its clinical and social services – an amazing five times the target set by the Central Local Health Integration Network. When it reaches full capacity it will serve 3,500 clients who will benefit from over 30 partnerships the centre has established with other health and social service agencies.

“At the Vaughan Community Health Centre our focus is on keeping people well,” says Executive Director Isabel Araya. Interprofessional teams design programs and services to meet the needs of three groups: youth, seniors, and people with mental health or addiction issues.

M.E.A.L. (Mindful Eating and Active Learning), developed in cooperation with the York Region Canadian Mental Health Association, offers Type 2 diabetes education and self-management lessons for members of the Italian community experiencing mental health issues and Type II diabetes.

A free **Yoga program**, offered in partnership with the Elspeth Heyworth Centre for Women, provides a chance to be physically active, maintain a routine and learn about cardiovascular health, strength training, stretching and mental wellness.

Other programs include **On a Healthy Track**, a drop-in program for seniors that promotes wellness, and **Urban Kitchen**, which provides youth with an opportunity to meet new friends, learn about different cultures and gain valuable life skills while preparing delicious meals. The VCHC strongly believes in client feedback and has achieved a 99% satisfaction level.

The Challenge: Like most parts of rural Ontario, the Smiths Falls area is underserved when it comes to access to health services. Residents have to travel long distances for care, which is particularly hard on people with low incomes or those with disabilities.

The Success: Smiths Falls Community Health Centre (SFCHC) was launched as a satellite of the Merrickville District Community Health and Services Centre in 2006. It is committed to breaking down a wide variety of barriers to better health in the rapidly growing community. It currently serves 2,100 clients and at full capacity this will increase to 2,500.

The centre has adopted a special focus on people with developmental disabilities, a decision the community-led board made two years ago when the province closed down a local institution and residents moved into group homes. Key components of the program include a community nursing program as well as a dental suite.

Other programs are directed at a wide range of other populations and focus on health promotion and illness prevention. These include: the **Get With It Program (Walking In The Halls)**, a local high school-based program with between 50 and 160 persons walking for exercise; the **Good Food Box Program**, which improves healthy eating by providing fruits and vegetables at lower cost; and **Community Gardens**.

Like all CHCs, Smiths Falls CHC is very proactive, forging partnerships with other health and social service agencies to provide more seamless, convenient and connected services. It is now working with the town of Smiths Falls, the local hospital and five other health and social service agencies to pursue the community's dream of creating a **Health Village** within one neighbourhood campus. "Very soon we hope," says Executive Director Peter McKenna.

CENTRE DE SANTÉ COMMUNAUTAIRE DE KAPUSKASING ET RÉGION

Supporting compliance with the *French Language Services Act*

The Challenge: When people have health concerns, it's best if they can talk to their health provider in their first language. Yet, thousands of Francophones living in Ontario cannot access health services in their mother tongue, even though for many parts of the province, the French Language Services Act asserts this as a right.

The Success: Nine CHCs have identified meeting the healthcare needs of Francophones as a top priority; four were part of the 2004-2005 expanded access announcement. In Kapuskasing, the delivery of services in French has made a major positive difference. "When clients can speak to their health providers in their mother tongue it's so much easier to be open and frank about health issues," says Yves Barbeau, Executive Director of the Centre de santé communautaire de Kapuskasing et région. "That leads to better trust, better understanding, better outcomes."

The Centre, which at full capacity will serve 2,000 clients, works hard to promote a strong sense of community spirit, participating in special events such as Franco-Ontarian St. Jean Baptiste day and those for seniors. "With a better sense of belonging comes better health," says Barbeau. "I remember an old lady telling me that coming to that celebration day made her feel better than all the pills she was taking!"

The Centre also has a focus on chronic disease prevention and management – 16% of its clients have Type 2 diabetes. **The Diabetic Follow-up Program** carefully monitors participants' status and monthly group education sessions are offered in combination with quarterly follow-up exams.

For seniors and people with physical or mental disabilities, the Centre's health promoters have organized a **Knitting Group** that helps create blankets for cancer patients.



Black Creek CHC works with youth to build their capacity for a healthy future.

THE BLACK CREEK COMMUNITY HEALTH CENTRE

Ensuring a healthy start for youth in urban Ontario

The Challenge: Jane/Finch is an urban area in Toronto with high rates of poverty, an unemployment rate of 23-26%, a growing number of immigrants, a large number of youth-at-risk and a very high drop out rate. The United Way has identified it as a high-priority neighbourhood.

The Success: The Black Creek Community Health Centre (BCCHC) provides comprehensive and coordinated health care services with a special focus on working together with community members to improve their capacity for better health. The Centre's new satellite located in Yorkgate Mall, which currently serves 2,500 clients and will increase to 3,000 at full capacity, focuses heavily on youth and addresses an array of issues including sexual health, substance use, education, employment readiness and social skills.

One of the secrets to the new satellite's effectiveness is engaging youth in designing and delivering the programs.

These efforts include the **Financial Literacy Program (FLIP)** which teaches youth how to make important financial decisions – budgeting, employment, financing education, personal banking, credit and debt – and encourages them to teach and support others in the community. A key goal is to get new immigrant youth into university.

Other programs include **Phenomenal Women**, a lunch program where young women can learn sexual health and healthy sexuality and **Modern Times**, a theatre program for young women 13-20 years old.

Like most other Community Health Centres throughout the province, the Yorkgate satellite prioritizes chronic disease prevention and management. For example, **Live, Learn and Share** is a diabetes peer support group project for the Caribbean community that empowers and enables people with diabetes to manage their disease.



Research shows Ontario's Community Health Centres deliver superior care

An interprofessional team at Rexdale CHC.

Not only do Ontario's Community Health Centres address some of the most urgent healthcare challenges, a growing body of evidence is also starting to show that CHCs' mandate to address the social determinants of health is producing excellent outcomes.

A good example is chronic disease. CHCs take a comprehensive approach that addresses both medical and non-medical issues and this pays off for those receiving services.

What the research shows: The Élisabeth Bruyère Research Institute conducted a series of studies as part of an extensive overview comparing four different models of primary care delivery in Ontario. The research concluded that "Chronic disease management was superior in CHCs."

The same research project also found superior performance in other areas of healthcare delivery. It reported, for example, that CHCs do a better job of orienting their services to the needs of the communities they serve.



Participants in a healthy food program at Vaughan CHC.

Compared to other models, CHCs were found to be twice as likely to:

- 1 Assess and/or determine what programs and services are needed by the communities.
- 2 Reach out to the populations in the communities.
- 3 Monitor and evaluate the effectiveness of the services and programs they offer.

“Chronic disease management was superior in CHCs.”

The great health divide

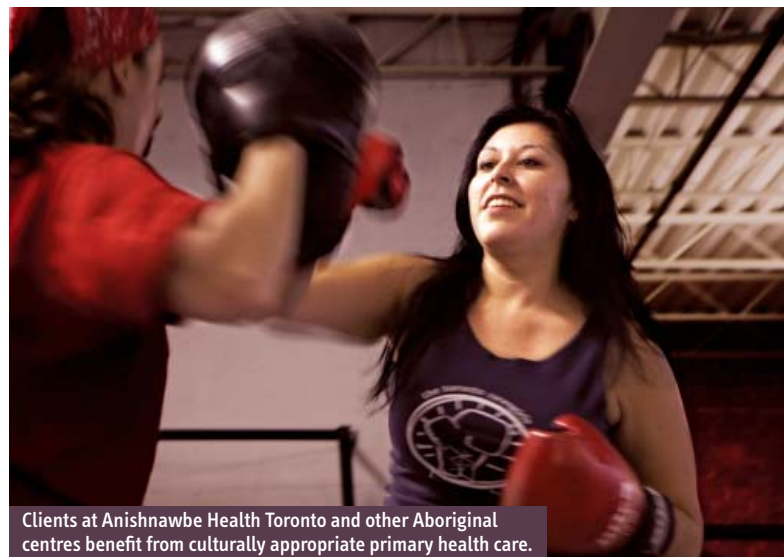
When all of the new centres and satellites announced by the current government are operating at full capacity, approximately 493,800 Ontarians will be served by CHCs and Aboriginal Health Access Centres (AHACs). The ten Ontario AHACs along with two Aboriginal-focused CHCs are the key vehicles through which culturally-appropriate primary health care is extended to Aboriginal communities.

While serving almost half a million clients may sound impressive – and in many ways it is – we have barely scratched the surface of need. Only 3.7% of the over 13 million people living in Ontario can access the services and programs of a CHC or AHAC.

Given the effectiveness of the CHC model, it is clear that all communities in Ontario would benefit from increased access to Community Health Centre services and programs. But how should the government and LHINs start setting priorities for ongoing expanded access? Our answer is simple. Start by taking a close look at the great health divide.

The great health divide separates poor from prosperous, new immigrants and racialized groups from long-time residents and European descendants, Francophones from Anglophones, and Aboriginal Peoples from non-Aboriginal populations. It also isolates and disadvantages many populations, such as lesbian, gay, bisexual and transgendered, from accessing the care they need.

Many of these populations live in poverty. And all experts agree, poverty is the most important determinant of health. As the Honourable Roy Romanow said in launching the Canadian Index of Wellbeing's *First Report: How are Canadians Really doing?*, "The stark reality is that household income continues to be the best predictor of future health status. The formula is straightforward: more income equals better health, less income equals worse health. This is true in all age groups and for both women and men."



Clients at Anishnawbe Health Toronto and other Aboriginal centres benefit from culturally appropriate primary health care.

Consider these facts:

- **Ontarians who live in northern regions** lose more years to premature death than the national average.¹
- **Immigrant women** find it more difficult than Canadian-born women to access the resources they need to stay healthy.²
- **Aboriginal Peoples** have, on average, lower life expectancies and higher rates of serious chronic diseases such as diabetes, heart disease, cancer and asthma.³
- **Francophones** rate their overall health lower than the rest of Ontarians. They have a higher rate of heart disease and are less likely to visit a healthcare facility.⁴
- **South Asians**, the largest racialized group in Ontario, have diabetes rates of 11-14%, compared to 5-6% for non-racialized Ontarians.⁵
- **Lesbian, gay, bisexual and transgendered people** have larger health risks, mainly because of social marginalization and the stress of coping with prejudice and discrimination.⁶

1 The Chief Public Health Officer's Report on the State of Public Health in Canada, 2008, Public Health Agency of Canada

2, 3 Ibid

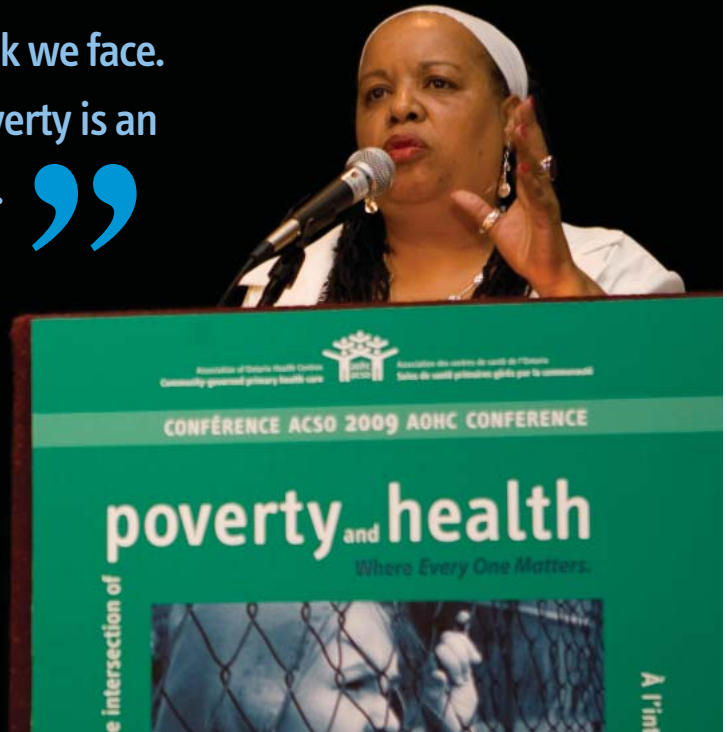
4 Second Report on the Health of Francophones in Ontario (IFO and PHRED) 2005

5 *A Diagnosis for Equity: An Initial Analysis of South Asian Health Inequalities in Ontario*, Council of Agencies Serving South Asians (CASSA) 2010

6 Rainbow Health Ontario website, www.rainbowhealthontario.ca/home.cfm

“Poverty is the biggest health risk we face. Poverty is a political choice. Poverty is an unacceptable human condition.”

Denise Brooks, former president of AOHC, speaking at “Intersection of Poverty and Health” Conference in June 2009



The details tell the story

- Poverty is strongly linked with chronic illness, acute illness, injuries and many adverse health outcomes.¹
- People with low incomes are four times more likely to report poor or fair health as people with high incomes.²
- Women with low incomes are more than four times more likely to suffer from diabetes than their high-income counterparts.³
- In many cases, chronic diseases are “poverty diseases”. Every \$1,000 increase in income for the lowest 20% of earners in Canada leads to nearly 10,000 fewer chronic conditions and 6,600 fewer disability days every two weeks.⁴
- The lowest income groups across Canada use the healthcare system twice as much as higher income Canadians.⁵

For all these reasons, future investments in Primary Health Care must target the needs of low-income Ontarians. This is what CHCs are already doing.

A study conducted by the Institute for Clinical Evaluative Sciences and Ontario’s Community Health Centres to be released later this year will comprehensively outline how CHCs are leaders in expanding access to low-income Ontarians. A 2009 interim report focused on six CHCs⁶ throughout the province and compared their client base with those of Ontario’s Family Health Teams (FHTs), as well as four other primary care models. (Family Health Groups, Family Health Networks, Family Health Organizations and Primary Care Groups.) One of the most noticeable differences between CHCs and FHTs, as well as the other models, was the proportion of people served living in poverty.

1 ‘Why poverty makes us sick’, ‘Identifying poverty in your practice and community’, ‘Strategies for physicians to mitigate the health effects of poverty’, Ontario Medical Review, May 2008; ‘The Many faces of poverty’, ‘Poverty reduction: policy options and perspectives’, Ontario Medical Review, June 2008

2,3,4 Ibid

5 Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, Reducing Health Disparities – Roles of the Health Sector: Discussion Paper (Ottawa, Ont.: Public Health Agency of Canada, 2004).

6 The six CHCs participating in the study were Kingston, Sandy Hill (Ottawa), CSC du Grand Sudbury, London InterCommunity, Youth Centre (Ajax) and Woolwich.

Community Health Centres serve a higher number of low-income Ontarians.

- At the London InterCommunity Health Centre, approximately 80% of clients have incomes in the lowest and second lowest income quintile.
- At the Kingston Community Health Centres, approximately 65% of clients have incomes in the lowest and second lowest income quintile.

In other primary care models, low-income Ontarians represent on average less than 40% of the total numbers served.

Community Health Centres see a higher number of people on welfare (Ontario Works).

- At the London InterCommunity Health Centre, almost 25% of clients are on welfare.
- At the Kingston Community Health Centres, 15% of clients are on welfare.

In other primary care models, clients on welfare represent on average less than 2% of the total numbers served.

Community Health Centres see a higher number of people on Ontario Disability Support Program.

- At the London InterCommunity Health Centre, almost 30% of clients are on ODSP.
- At the Kingston Community Health Centres, 22% of clients are on ODSP.

In other primary care models, clients on ODSP represent on average less than 2% of the total numbers served.

In March 2011, Ontario's CHCs will release the same kind of comparative data with respect to all CHCs in Ontario.



Creating a plan for expanded access

Earlier this year, the Association of Ontario Health Centres (AOHC), which represents Ontario's Community Health Centres and Aboriginal Health Access Centres, decided to start mapping out a plan for the expanded access to both CHCs and AHACs.

We engaged Steps to Equity, an independent social epidemiology and health equity research and consulting service, to identify the areas where the need for expanded access to CHC programs is high.

The project was led by Dianne Patychuk, a social epidemiologist with more than 25 years of experience. The study looked at the 141 subLHINs (the planning areas within each Local Health Integration Network) and used Statistics Canada data from the 2006 census to map the province according to the highest rates of:

- poverty
- rurality
- racialized
- disability
- new immigrants
- Francophones
- Aboriginals

The study found that:

- 36 subLHINs have **high poverty rates** (i.e. greater than the 15.2% provincial average);
- 39 subLHINs have at least 50% **rural populations**, at least 6 of which have high poverty rates;
- 19 subLHINs have at least 30% **racialized populations** and all of these sub-LHINS have high poverty rates;
- 10 subLHINs have at least 10% **new immigrant populations**, all have high poverty rates and are in the GTA;
- 15 subLHINs have at least 25% of the population who are **Francophones**; and
- at least 5 subLHINS have a minimum of 25% of the population who self-identified as **Aboriginal**.



“ Our CHC is making an incredible difference in our isolated, rural community. We wish we could provide services to the entire population instead of to half of it. We are the only healthcare provider in the region and the needs are enormous. ”

Jacqueline Gauthier, Executive Director,
Sudbury East CHC

Populations to prioritize in planning expanded access to CHCs and AHACs

(based on 2006 Census Data)

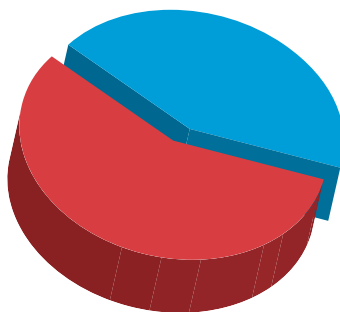
Category	% of Ontario Population	Number of People ¹
Poverty ²	15.2	1,848,363
Racialized groups	22.8	2,772,545
New Immigrants ³	4.8	579,630
Francophones	4.8	578,460
Aboriginal populations	3.4	413,450
Rural populations	14.9	1,811,882
People with activity limitations/disabilities ⁴	18.0	2,188,851

¹ Any one person may fall into one or more categories ² Definition of poverty is the same used in the Government of Ontario Poverty Reduction Strategy, i.e. After Tax Low Income Measures (LIMs) ³ Arrived in Canada within the last 5 years

⁴ Under 65 years of age

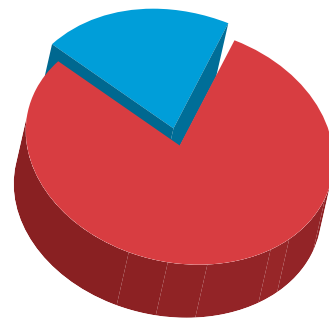
Many Ontarians most in need do not have access to CHC and AHAC services

At the time of the 2006 census, the number of people living in poverty alone – setting aside the other risk factors – was a staggering 1.85 million, or 15.2% of the provincial population. The number with access to CHCs and AHACs, even after full expansion, will only be 493,800. Yet many CHCs are already at full capacity while others are approaching it.



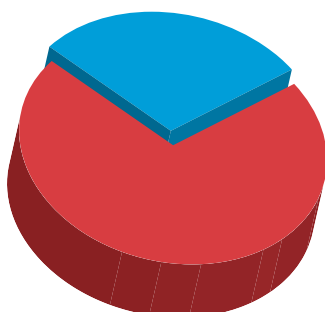
Toronto Central 57.1% gap

In Toronto Central there are 217,690 people living in poverty, but only 93,480 have access to a CHC or satellite. **Gap of 124,210.**



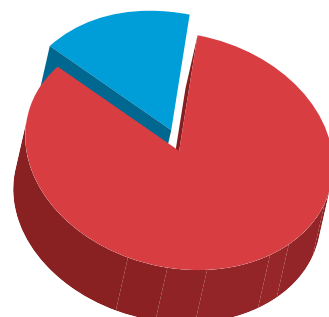
Hamilton Urban Core 79.5% gap

In the Hamilton Urban Core there are 28,080 people living in poverty, but only 5,756 have access to a CHC or satellite. **Gap of 22,325.**



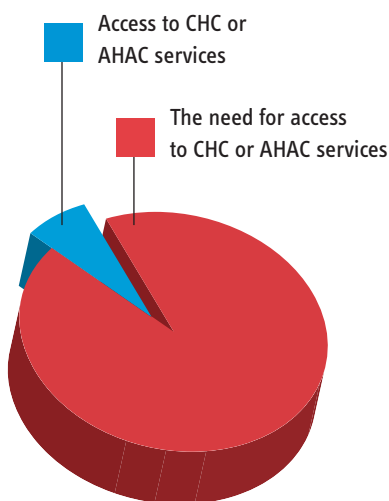
St. Catharines 70.9% gap

In the region surrounding and including the City of St. Catharines there are 20,630 people living in poverty, but only 6,000 will have access to a CHC or satellite. **Gap of 14,630.**



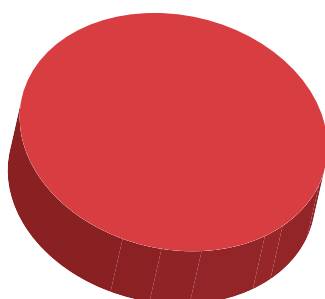
Parry Sound/Nipissing 83.5% gap

In the districts of Parry Sound and Nipissing there are 18,140 people living in poverty but only 3000 will have access to a CHC or satellite. **Gap of 15,140.**



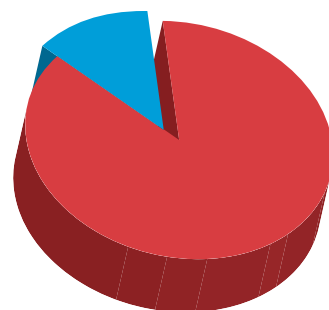
905 urban belt 92.7% gap

In the rapidly growing 905 urban belt surrounding Toronto, there are 503,800 people living in poverty, but only 36,582 have access to a CHC or satellite. **Gap of 467,218.**



Francophone 100% gap

In the Mississauga Halton LHIN and the Central West LHIN the total number of Francophones is in excess of 32,000 but there are no CHC or satellites to meet their needs. **Gap of 32,000.**



Aboriginal 85.9% gap

In Ontario there are 413,450 Aboriginal Peoples but only 52,638 have access to an AHAC or Aboriginal-focused CHC. **Gap of 355,342.**

Access to CHC or AHAC services

The need for access to CHC or AHAC services

Closing the Divide

By whatever yardstick you use – expert research, client survey or anecdotal evidence – CHCs and AHACs have proven to be a leading model for delivering primary health care in Ontario. The unique advantage of these two models is that they are the only models in Ontario specifically mandated to address the social determinants of health.

In 2004 and 2005, the McGuinty government’s decision to expand CHCs significantly increased the number of Ontarians who could access CHCs and AHACs. The time has come to start planning again for more Ontarians to have access to CHCs and AHACs, especially in those parts of the province where there are significant populations with highest needs.

Our long-term goal is for Ontario’s Community Health Centres and Aboriginal Health Access Centres:

To serve 15.2% of Ontarians – with a focus on the populations with the most need, including those living in poverty, new immigrants/refugees, racialized groups, Aboriginal Peoples, Francophones, those living in rural and remote areas without services, those with complex chronic care needs, people with physical and mental disabilities/limitations and lesbian, gay, bisexual and transgendered Ontarians.

This goal is both modest and ambitious. Modest because, according to the Government’s Poverty Reduction Strategy, 15.2% represents only the percentage of Ontarians living in poverty in 2006.

Ambitious, because reaching the 15.2 per cent goal will require major efforts from the current government – as well as future provincial governments – over the course of several mandates.

The short term target: To double the number of Ontarians served by Ontario’s Community Health Centres and Aboriginal Health Access Centres to 1 million by 2020.



Recognizing the time needed for both planning and implementation, we have set a short term target: To double the number of Ontarians served by Ontario’s Community Health Centres and Aboriginal Health Access Centres to 1 million by 2020.

The 15.2 per cent goal can be reached in two ways:

- By investing in existing CHCs and AHACs so they can serve more clients
- By expanding the number of CHCs and AHACs throughout Ontario.



We ask the current Government of Ontario, as well as future governments and the LHINs, to adopt our goal and work with us in developing a plan to achieve it.

The plan would include specific annual targets for expanding access to each of the following groups:

- People living in poverty
- New immigrants and refugees
- Racialized groups
- Rural and remote populations
- Francophone populations
- Aboriginal populations
- People with chronic complex care needs
- Lesbian, gay, bisexual and transgendered Ontarians
- People with physical and mental disabilities/limitations

Working together we can achieve this goal. And when the potential of Ontario's CHCs and AHACs is fully maximized, the outcome will be healthier people and healthier communities throughout Ontario as well as a stronger, more sustainable healthcare system.

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To find out more about Ontario's Community Health Centres visit
www.ontariochc.ca