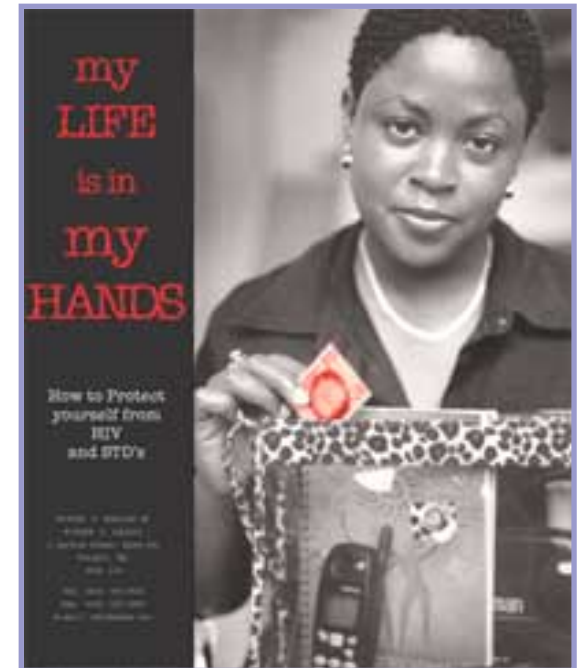


Waterloo Wellington LHIN: November 19, 2007 CHC Annual Planning Presentation 2008-09



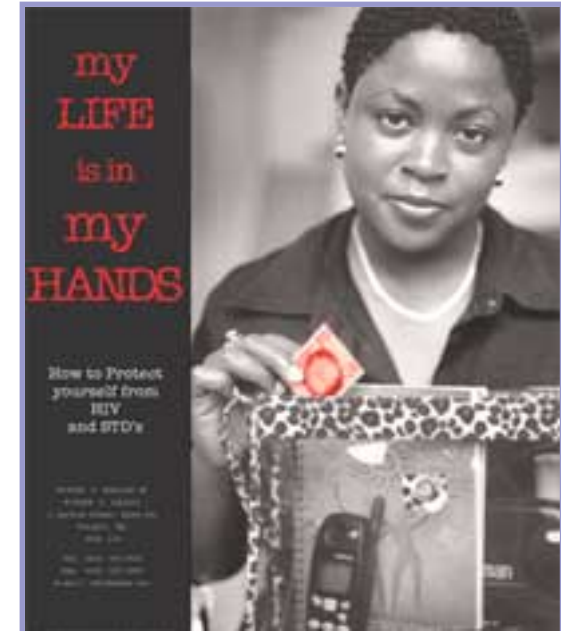
- **Bill Davidson, Executive Director, Langs Farm Village Association**
- **Stephen Gross, Interim Executive Director, Kitchener Downtown Community Health Centre**
- **Denise Squire, Executive Director, Woolwich Community Health Centre**



Waterloo Wellington LHIN: November 20, 2007 CHC Annual Planning Presentation 2008-09



**Michael Barkley, Interim
Executive Director, Guelph
Community Health Centre
(Konnie Peet -- Executive
Director on Leave until
February 4, 2008)**





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

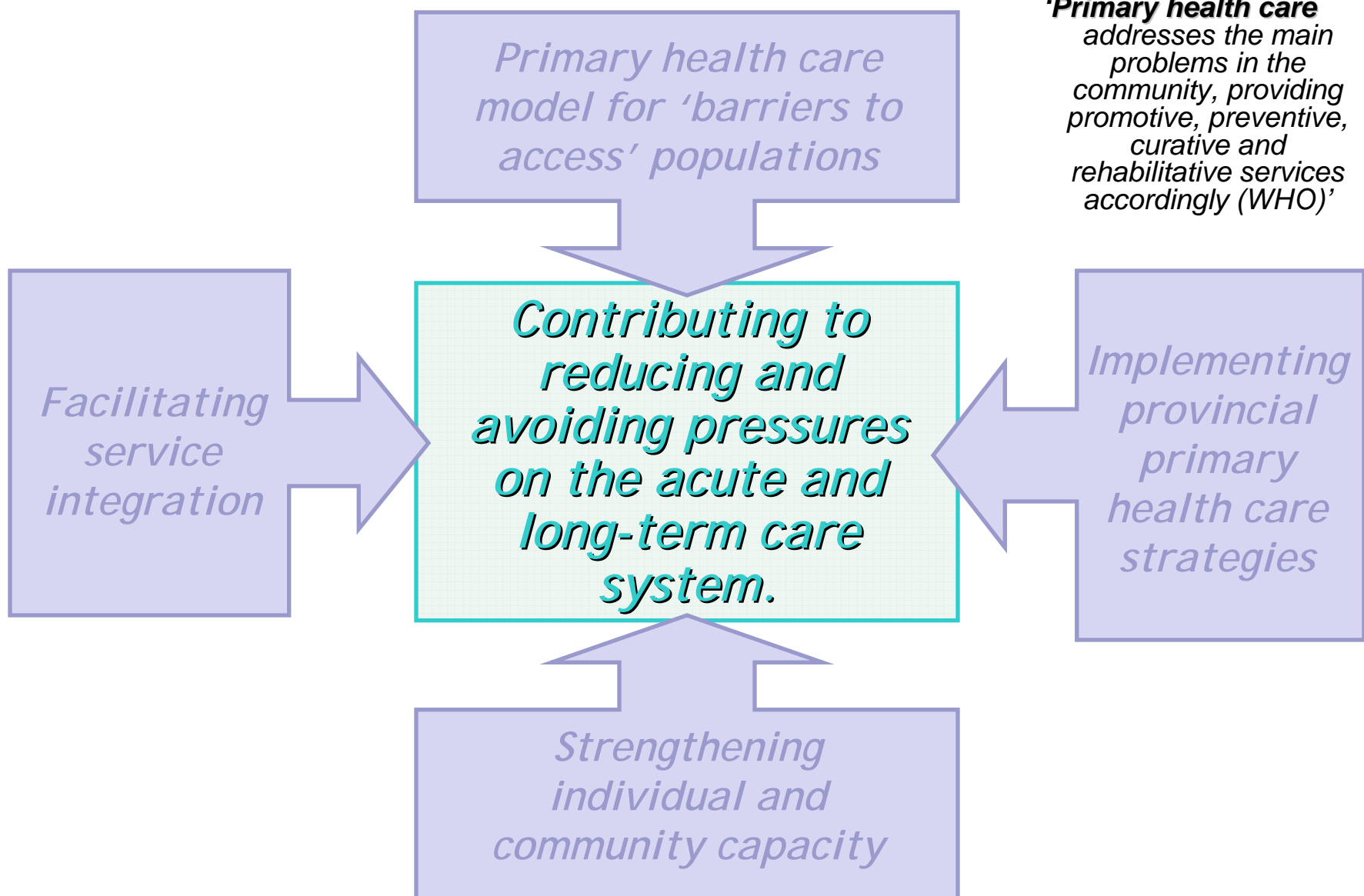


What is a Community Health Centre?

- 54 Community Health Centres (CHCs) and 10 satellite CHCs across Ontario, with 22 new CHCs and 17 new satellites starting up between 2005-08
- 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 multi-disciplinary 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 capitation or fee-for-service

General Background on Community Health Centres (CHCs)



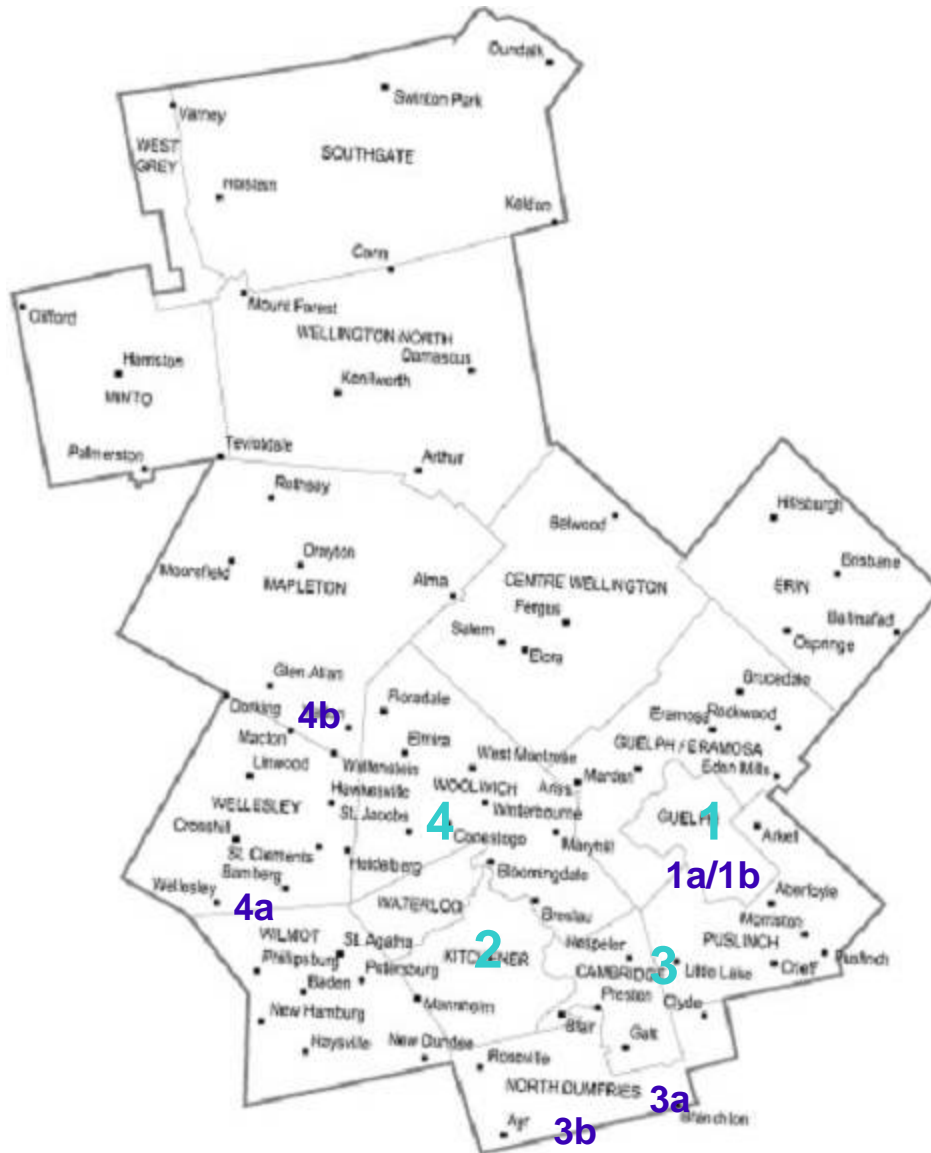


General Background on Community Health Centres (CHCs)

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: Guelph

Guelph CHC Vision

- The Guelph CHC will be a valued leader in a community supportive of those with barriers to well being

Priority Groups

- Children, prenatal to 6 yrs & their families
- New Immigrants
- Homeless/under-housed & downtown vulnerable adults
- Individuals with barriers to good health



CHC-Specific Background: Guelph

- Staffing: 71 full and part time staff, 36 FTEs
- Volunteers: 200 volunteers, 5,358 contributed hours
- Primary health care and health promotion group clients 6,037 active
 - Current use of long term medication
 - Visit for preventative immunizations
 - Request for administrative procedures
 - Depression
 - Well adult
 - Hypertension
 - Medical prescription
 - Needing parental support / education
 - Abnormal lab tests
 - Anxiety / feeling depressed



CHC-Specific Background: Guelph

- Early Years clients: 8049 children, 6828 parents/caregivers; child visits 26,946, parent visits 20381; workshop participation 661
- Multi-funded: LHIN (for CHC& Homeless Program), Ministry of Health (NPs, midwifery TPA), community / foundation grants (local food systems, Parent Child Place)



CHC-Specific Background: Guelph

Types of Services Provided:

- Primary Health Care
- Social Work Services (e.g. counseling, EY groups)
- Dietitian and Nutrition Services
- Early Years
- Healthy Child Screening
- Lactation Support
- Pre- Post-Natal Programs
- Food Access
- Physical Activity programs (Pre- Post-Natal)
- Parenting Programs
- Health Promotion
- Cultural / Language Interpreter Service
- Adult Programs (ID Clinic, Welcome In Drop-in)
- Transfer Payment Agency for 2 Guelph Midwifery Practices
- Student placements for dietitians, NPs, physicians, social workers, ECE



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

Primary Care: Access to free interpreters through our language / cultural interpreter program (60 interpreters / 39 languages); limited funds to assist clients in paying for medication; funds to pay for non-insured client lab, diagnostic and specialist services; transportation for clients, staff positions who provide individual support, advocacy and some systems navigation (health, social services, government services); physician availability 24/7/365; psychiatry shared care model development; ID Clinic

Outreach Services: Development of Shelldale, 45 different points of service for various primary care and early years services; Stone Road Mall Early Years satellite; teen parent programs; garden fresh box outreach delivery system; school based programs; exploring strategies to improve youth access



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

- Developing infrastructure capacity for e-health solutions
- Diabetes service delivery using a systems approach – partnership steering group – one delivery agent
- Working for equitable salaries in CHCs
- Participation in local and regional initiatives to build capacity:
 - Canada Prenatal Nutrition Project - Partner
 - Buy Local – Garden Fresh Box Initiative - Leader
 - Alternative Education - Partner
 - Guelph Services Coordination Group - Partner
 - Physician Recruitment Initiatives – Participant
 - Shelldale Centre – Participant on committees and management of site
 - Substance Abuse Strategy Committee – Partner
 - Outreach Workers Committee – Participant
 - Regional Diabetes Strategy – Partner
 - Wellington Children’s Partner’s – Partner (psychiatry resources for Guelph and Wellington County)
 - Best Start initiative - Participant
 - Quality Child Care Initiative - Lead



Initiatives Supporting LHIN Health System Priorities: Enhance System Effectiveness

- Supporting professional development to improve service delivery: Regular chart audits, all providers, use best practices for chronic disease such as diabetes and hypertension
- Access to free interpreters
- Partnerships with other health care agencies to improve continuity of care and communication: CCAC, Downtown Board of Management, United Way, School Boards, WDG Public Health, Wellington County Social Services, Ontario Works to strengthen and improve co-ordination and integration
- Logic Models and Evaluation Processes in place
- Fully Accredited
- Development of e-health solutions



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

- Outreach sites
- Chronic Disease Self Management groups
- Community Diabetes Education Program (under development)
- Breastfeeding Support programs
- Newcomers support programs
- Specialized exercise programs (age/condition-specific)
- Health Education programs (cholesterol, high blood pressure, men's health, medications management, etc.)
- Prenatal nutrition programs
- Diabetes education and treatment
- Little Chefs (cook and play, ages 3-6 + parent/caregiver)



Initiatives Supporting LHIN Health System Focus Areas:
Services for Seniors

While the Guelph CHC does have seniors as primary care clients (582 @ 55+) this population group has not been identified as a priority population, therefore there are no specific programs/initiatives targeting this group.



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

- Post-partum depression support group
- Direct clinical care at Welcome In drop-in (downtown vulnerable adults)
- Short-term case management services
- ID Clinic
- Clinical counseling services
- Substance abuse strategy coordinator collaboration for City of Guelph / County of Wellington
- Child and adolescent psychiatry collaboration with Family Health Teams and Trellis
- Social Workers participate in the Growing and Parenting (GAP) program
- Shelldale parenting and self esteem groups
- Needle exchange
- Provide Primary Health Care to Stonehenge clients during treatment



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

Guelph / Wellington 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:

- Guelph General Hospital
- Canadian Diabetes Association
- Community Care Access Centre
- Guelph Family Health Team
- North Wellington Health Care



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

Guelph / Wellington 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

- Chronic Disease Self Management groups
- Stress/ meditation groups
- Issue specific chart audits
- Regional Diabetes Program participant
- On-site diabetes clinic for GCHC clients



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
- Desire to work closely 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

- General population growth
- Newcomer population growth
- More complex physical and mental health issues presenting



Current Pressures

Key System Challenge:

- Population growth is our greatest challenge. Demand for services for vulnerable members of our community and changes in demographics are requiring changing patterns of service. The inflexibility built into the funding structure and the lack of commitment to the populations we serve is a key issue for the Centre. This is also complicated with our inability to remain competitive and recruit physicians since our compensation structure is significantly disadvantaged compared to other primary care models.

How Addressed:

- Development of the cultural and language interpretation service has helped provide better services; a desire to address youth issues downtown and working towards a better collaboration with other service providers to look for solutions; expanding our outreach services to reach more people where they live; community initiatives to improve social conditions, partnerships as indicated in other slides; development of ID clinics

Potential Integrated Solutions for future:

- Increased knowledge in the community/health services about the issues facing vulnerable populations; strengthen existing partnerships/relationships (especially with Family Health Teams); Continue to advocate for poverty reduction, affordable housing; increased minimum wage, access to benefits for working poor; education/support for new Canadians attempting to integrate and navigate the system

Who to engage/collaborate with in these solutions:

- Hospitals, Family Health Teams, CCAC, Mental Health and Addictions Services, Community service agencies, levels of government; community residents



Discussion Questions

- The Determinants of Health have a significant impact on the physical and mental health of community residents. A significant number of people in our community do not have adequate, affordable housing and food, have barriers to adequate education, suffer from insufficient income support and lack of well paying jobs. This population may, therefore, experience a long term reduction in their mental and physical health. What actions can be taken at a system wide level (health and other systems) to raise these concerns and develop specific action plans to address these barriers to wellbeing.
- Are there integration opportunities that will improve access for the most vulnerable in our community? What are the barriers in the system that prevent vulnerable people from obtaining services they need? Can we envision new opportunities to improve access? Can we identify current initiatives that are working well?