British Columbia Federation of Community Health Centres

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ACHIEVING SUSTAINABILITY AND THE TRIPLE AIM IN HEALTHCARE FOR BRITISH COLUMBIA

Leveraging the Critical Role of Community Health Centres

Submission to the British Columbia Legislative Select Standing Committee on Health

December 2014

EXECUTIVE SUMMARY

The British Columbia Federation of Community Health Centres (BCFCHC) is the voice for Community Health Centres (CHCs) and community-oriented, interdisciplinary primary health care throughout British Columbia.

We are providing recommendations to the British Columbia Legislative Select Standing Committee on Health in response to the Committee's call for written submissions on the sustainability of the province's health system. Community Health Centres play an important role in addressing the four areas of concern raised by the Committee:

- Improving health and health services in rural communities, including overcoming barriers to recruitment and retention of health providers;
- Creating a cost-effective health system built around interdisciplinary and community-based care;
- Supporting effective care and support for seniors and others nearing end of life; and
- Enhancing addictions care and conditions for effective recovery.

At the same time, Community Health Centres are optimally-structured and positioned to help the Government of British Columbia achieve the "Triple Aim in Healthcare", as recommended by the globally-recognized Institute for Healthcare Improvement (IHI). The triple aim entails building health systems that:

1. Improve the patient experience of care (including quality and satisfaction);
2. Improve the health of populations; and
3. Reduce the per capita cost of health care.

An expansion of CHCs throughout the province would enable the Government of British Columbia to update our outdated primary health care "system"; to achieve significant progress related to all four areas of concern raised by the Standing Committee; to catalyze community economic and social development; and to advance the triple aim in healthcare for our province. As such we are recommending four key action steps:

1. Immediately scale-up access to primary health care by committing to adequate, core budgets for all existing Community Health Centres throughout British Columbia.

2. Undertake a policy reform process to correct the adverse impact of current physician compensation processes on effective interdisciplinary, team-based care and continuity of care.

3. Provide policy direction to the province's Regional Health Authorities supporting routine collaboration by RHA-led Community Health Centres with all other CHCs in British Columbia, to advance knowledge-exchange, quality improvement and scale-up of service innovations.

4. Commit to a five-year plan to establish 75 new Community Health Centres throughout the province and dedicate $150 million in one-time infrastructure and start-up funding. Commit to funding at least 50% of these new CHCs as community-governed not-for-profit or cooperative organizations.

WHAT ARE COMMUNITY HEALTH CENTRES?

Community Health Centres (CHCs) have been in operation across Canada since 1926, when the first CHC in Canada, Mount Carmel Clinic, was established in Winnipeg. Since then, CHCs have flourished to varying degrees across the country and are now found in all thirteen provinces and territories.

In 1972, an extensive pan-Canadian research study, commissioned by the Canadian Ministry of Health and Welfare and chaired by Dr. John E.F. Hastings, recommended that Community Health Centres be established and funded across Canada, and as non-profit corporations within fully-integrated health systems.[1]

Community Health Centres are comprehensive, integrated primary health care organizations that bring healthcare providers like family physicians, nurse practitioners, nurses, dietitians, therapists and others out of isolation to work together in collaborative, interdisciplinary teams. Patients receive the right type of care, from the right provider(s), at the right time. This not only results in high-quality care, but also makes best use of our scarce healthcare resources and helps to overcome gaps in access to particular care providers such as family physicians.

This expertise in interdisciplinary care moves our provincial health systems in the right direction. The Founding President of the Canadian Academy of Health Sciences, Dr. Paul Armstrong, has stated: "We talk about five million Canadians not having access to a family doctor, but they should have access to an integrated healthcare team where the first point of care would not necessarily be a physician."[2]

The added value of Community Health Centres is that, in addition to high-quality interdisciplinary care, they go beyond just "care". CHCs integrate interdisciplinary care teams with health promotion programs, social supports, and community programs that emphasize illness-prevention, wellbeing and local socio-economic development.

As a result of this "upstream" approach, numerous Canadian research studies have found that CHCs are highly effective and cost-effective, achieving better overall outcomes than other models of primary care. For example:

- Community Health Centres offer significantly more comprehensive services (74%) than other primary care models (61-63%; $P < 0.005$) like Fee-for-Service practice and "clinical care only" teams[3];

- 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[4];

- Community Health Centres provide superior chronic disease management. Clinicians in CHCs

[1] Ministry of National Health and Welfare (1972). *Report of the Community Health Centre Project to the Conference of Health Ministers*. Available at: http://www.cachc.ca/an-idea-ahead-of-its-time-hastings-report-1972/

[2] Health Council of Canada (2009). *Teams in Action: Primary Health Care Teams for Canadians*. p. 18

[3] Russell G et al G (2010). "Getting it all done. Organizational factors linked with comprehensive primary care". Family Practice. 27(5): 535-541.

[4] 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*. Toronto: Institute for Clinical Evaluative Sciences

find it easier than those in other models to promote high-quality care through longer consultations and interprofessional collaboration. This superior care has been correlated with the presence of a nurse-practitioner. It is also associated with lower patient-family to physician ratios and smaller full-time-equivalent family physician groupings[5];

- Patients of Community Health Centres report higher satisfaction scores across multiple domains of analysis including "accessibility", "prevention and health promotion", "patient and family-centredness" and "chronic disease management" compared to patients of other models of primary care[6].

Further evidence from the United States, where there are over 1300 CHCs funded by the federal government and serving nearly 30 million Americans, demonstrates that:

- Community Health Centres prevent 25% more emergency department visits than other models of primary care[7];

- Community Health Centres save the U.S. health system more annually compared to fee-for-service medicine[8];

- Community Health Centres act as local economic engines, generating roughly $20 billion in new economic activity annually[9].

The integrated primary health care approach of CHCs – with emphasis on individual, family and community health as well as prevention of "downstream" and long-term health system costs – means that CHCs are high-impact contributors to the Healthcare Triple Aim.

[5] Russell G et al (2010). "Managing Chronic Disease in Ontario Primary Care: The Impact of Organizational Factors". *Annals of Family Medicine*. 7(4):309-318.
[6] Conference Board of Canada (2014). *Final Report: An External Evaluation of the Family Health Team (FHT) Initiative.*
[7] U.S. National Association of Community Health Centres (2011). *Community Health Centers: The Local Prescription for Better Quality and Lower Costs*. Washington, DC.
[8] Ibid
[9] US Department of Health and Human Services (June 20, 2012). "Health care law expands community health centers, serves more patients". Available at: http://www.hhs.gov/news/press/2012pres/06/20120620a.html

COMMUNITY HEALTH CENTRES IN BRITISH COLUMBIA

While British Columbia has a larger number of Community Health Centres than one might suspect, it remains difficult to determine the exact number. The main reason for this is that there is an overall lack of systemic planning, coordination and funding for CHCs within our provincial health system. Ministry of Health and Regional Health Authorities act largely in silos with respect to community-based primary health care and, as a result, there is a patchwork of CHCs across jurisdictions within the province.

Within this patchwork of CHCs, there is significant variation in type and scope of CHCs from one location to the next. There are also major inequities in policy support and funding when comparing some CHCs to others. As a result of this patchwork, our province is missing an important opportunity to achieve greater coherence in primary health care; to improve access to care; to improve the overall cost-effectiveness of our health system; and to spark community-based economic and social development.

In its *2013 Canadian Community Health Centres Organizational Survey*, the Canadian Association of Community Health Centres identified 64 Community Health Centres throughout British Columbia.[10] A previous study conducted in 2009, by Professor Laurie Goldsmith from Simon Fraser University, identified 78 Community Health Centre organizations in British Columbia.[11] The most recent cataloguing of CHCs, in late 2014 – conducted jointly by the British Columbia Federation of Community Health Centres and Canadian Association of Community Health Centres – has now identified over 100 CHCs throughout the province.[12]

Though the exact number of Community Health Centres in our province may be difficult to pinpoint, all CHCs in British Columbia and across Canada fall into three main categories:

1. Independent not-for-profit corporations or cooperatives that have organizational funding relationships with the Ministry of Health and/or Regional Health Authorities. These organizations are governed by independent Boards of Directors.
    - EXAMPLES: REACH CHC (Vancouver) Mid-Main CHC (Vancouver); Vic Cool Aid CHC (Victoria); Island Sexual Health (Victoria); Maxxine Wright Community Health Centre (Surrey)

2. Independent not-for-profit corporations or cooperatives that foster a CHC-type environment by coordinating individually-contracted healthcare providers, volunteers and complementary services within a shared space and organization. These organizations are also governed by independent Boards of Directors.
    - EXAMPLES: Galiano Island Health Centre (Galiano Island); Umbrella Multicultural Health Cooperative (New Westminster); Victoria Community Health Cooperative (Victoria); Sanctuary Health (Vancouver); Catherine White Holman Wellness Centre (Vancouver); Pender Harbour Health Centre (Madeira Park)

[10] Canadian Association of Community Health Centres (2013). 2013 Canadian Community Health Centres Organizational Survey. Available at: http://www.cachc.ca/2013-chc-org-survey

[11] Goldsmith L (2009). "Key organizational and delivery features of community health centres in BC" Paper presented at the 2009 Annual Canadian Association for Health Services and Policy Research Conference, Calgary, AB, May 11-14, 2009.

[12] Map of British Columbia Community Health Centres (2014): http://www.bcfchc.ca/findchcs

3. Community health centres that are operated directly by Regional Health Authorities. These organizations are governed by the structures governing the RHAs.
    - EXAMPLES: Raven Song CHC (Vancouver); Kamloops Downtown Health Centre (Kamloops); Oliver Health Centre (Oliver); Kelowna Outreach Urban Health Centre (Kelowna); South Cariboo Health Centre (100 Mile House)

In spirit and vision, CHCs across all three of these categories reflect the core attributes of the "Community Health Centre model": interdisciplinary teams; integration of primary care with health promotion and community development; a population health approach, with attention to the broader social determinants of health; and processes for engaging community members in shaping various dimensions of the services provided by the health centre.

In practice, however, many obstacles impede the majority of CHCs from reaching their potential and optimizing care and support for British Columbians. Key among these obstacles are:

- The lack of core funding arrangements for many CHCs, whether directly with the Ministry of Health or with a Regional Health Authority;

- The insufficiency of core funding arrangements where they do exist, covering only select portions of the comprehensive services offered by CHCs;

- The lack of robust, mutual accountability agreements;

- The adverse impact of direct payment requirements for physicians – both Fee-for-Service and Alternate Payment Programs – on the ability to effectively plan services, and to nurture interdisciplinary care teams;

- The lack of policy guidance and support for RHA-managed CHCs to participate in collaboration, knowledge-exchange and collective planning with CHCs from other RHA jurisdictions and independently-governed CHCs.

These barriers to effective planning, service delivery, and coordination constitute major missed opportunities for the province. The good news is that much of this could be remedied through a renewal of the government's primary health care vision and policies, along with a small investment of resources to support underfunded CHCs in leveraging their untapped capacity. This would enable rapid scale-up of access and scope of primary health care services for British Columbians.

COMMUNITY HEALTH CENTRES PROVIDE SOLUTIONS TO THE SELECT COMMITTEE ON HEALTH'S FOUR PRIORITY ISSUES OF CONCERN

ISSUE #1: How can we improve health and health care services in rural British Columbia? In particular, what long-term solutions can address the challenges of recruitment and retention of health care professionals in rural British Columbia?

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.[13]" 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. The Council also cautioned that we must pay particular attention to the distinctive approaches and leadership of Aboriginal communities in rural settings in order to ensure that health services for rural Aboriginal communities are culturally-safe, inclusive, and appropriate.

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.

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

Ontario's extensive Community Health Centre network has described 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.[14]

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 example of this innovation is found in northwest Ontario, where NorWest Community Health Centres' mobile unit provides set-schedule services, through an interdisciplinary care team, 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.[15]

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.

Unfortunately, there is a poverty of research on innovative rural healthcare in Canada. However, robust research from the United States clearly demonstrates the major impact that CHCs have in reducing barriers to care and improving health outcomes in rural communities. An impressive one out of every seven residents of the United States receives primary care from a CHC. When compared against other primary care models in rural America:

- Rural CHC patients experience lower rates of low birth weight than patients of other providers in rural communities[16];
- Female patients of rural CHCs are significantly more likely to receive Pap smears compared to rural women nationally[17];

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

[15] 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

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

[17] Ibid

- Even after adjusting for population density, rural counties with CHCs exhibit 25% fewer uninsured Emergency Department visits than non-CHC rural counties[18].

These CHCs also act as local economic engines for rural communities throughout the United States, yielding more than $5 billion annually in economic returns through the purchase of goods and services and by generating employment[19].

Rural CHCs in the U.S. have also proven highly-effective in delivering appropriate care and support for migrant and seasonal farmworkers[20], an issue that receives inadequate attention in British Columbia and across Canada. An innovative example of how CHCs in Ontario are also making inroads in effective care and support for migrant farmworkers recently gained national attention in Canada. The Grand River CHC offers "a weekly clinic in Simcoe that shuttles migrant farmworkers to regular care — and helps reduce visits to the hospital emergency department.[21]"

ISSUE #2: How can we create a cost-effective system of primary and community care built around interdisciplinary teams?

Community Health Centres wrote the book on interdisciplinary care and have been providing this type of service model to Canadians since the first CHC was established in 1926, in Winnipeg. In 2007, as part of the national Primary Healthcare Transition Fund, the Canadian Association of Community Health Centres and Association of Ontario Health Centres jointly produced *Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres.*[22]

Pursuing the Community Health Centre model for more British Columbians would mean scaling up a proven model of interdisciplinary care – one where responsibilities for care are spread across a team of providers; where all providers are supported to practice to the full scope of their training; and where all of the above results in timely and cost-effective care.

Decades of experience at CHCs in building effective, interdisciplinary care teams teaches us that attempting to build primary healthcare teams via a physician-centric approach is neither appropriate nor cost-effective. As quoted above, the Canadian Academy of Health Sciences has stated that, "we talk about five million Canadians not having access to a family doctor, but they should have access to an integrated healthcare team where the first point of care would not necessarily be a physician."[23]

Therefore, while the Government of British Columbia must certainly work to increase the number of family physicians practicing in the province, strategies such as "a GP for me" are inherently flawed.

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[18] Ibid

[19] Ibid

[20] U.S. National Association of Community Health Centers (2012). *The Role of Health Centers in Caring for Farmworkers.* Available at: http://www.nachc.com/client//FarmworkersFS12.pdf

[21] Toronto Star. December 14, 2014. "Simcoe clinic in a grocery store breaks barriers for migrant farm workers." Available at: http://www.thestar.com/news/immigration/2014/12/14/simcoe_clinic_in_a_grocery_store_breaks_barriers_for_migrant_farm_workers.html

[22] Association of Ontario Health Centres and Canadian Association of Community Health Centres (2007). *Building Better Teams: A Toolkit for Strengthening Teamwork in Community Health Centres; Resources, Tips, and Activities you can Use to Enhance Collaboration*. Available at: http://www.cachc.ca/wp-content/uploads/downloads/2012/03/AOHC_Building-Better-Healthcare-Teams_toolkit.pdf

[23] Health Council of Canada (2009). Op cite.

Physician-centric approaches such as this perpetuate a number of systemic problems including the lack of team-based supports for physicians; destructive power dynamics within care teams; and the public's perception that, ultimately, only physicians provide appropriate care.

In addition to achieving effective interdisciplinary care, pursuing team-based care through CHCs is the best way to support practice choice for family physicians. A growing population of family physicians is justifiably frustrated with fee-for-service medicine, both in terms of its impediments to quality care and its impact on quality of practice/life. Family practice within a CHC setting provides a broad range of practice supports and quality-of-life supports that contribute to a higher quality of practice and helps to prevent practitioner burnout.[24]

It is also noteworthy that in addition to providing care through teams of family physicians, nurse practitioners, nurses, therapists and counsellors, CHCs are also innovating in the integration of health professionals that have traditionally been excluded from primary health care. Mid-Main CHC, in Vancouver, for example introduced one of the first clinical pharmacists into primary care team practice across Canada. The positive impact on both quality of patient care and quality of pharmacy practice has been significant.[25]

ISSUE #3: What best practices can be implemented to improve end-of-life care?

Community Health Centres provide health services across the spectrum of life, including end of life care. Primary health care providers at CHCs work closely with specialized palliative services to support clients and their families through to their death by providing medical care, education, coordinating access to specialized care and equipment, and access to determinants of health like food and shelter.

Community Health Centres play an especially critical role in providing palliative care for people living in poverty who, as their health decreases, are less able to access housing, medical attention, nutritional supports, and often lack the informal supports provided by family and friends at end of life. CHCs work with community partners to help ensure access to food, shelter, medical and spiritual care so that clients experience death with comfort and dignity.

Community Health Centres in British Columbia are developing innovative, cost-effective programs to support palliative care for some of the most impoverished and complex populations in the province. For example, healthcare providers at Cool Aid CHC in Victoria, BC, work closely with community partners and health authority programs to provide palliative services to populations dealing with homelessness, severe mental illness and chronic substance use disorders. CHCs develop trusting and respectful relationships with clients that allow for service provision and coordination at the end of life for people who may otherwise face barriers to accessing palliative care or are unable to access care at all.

Expanding access to CHCs would offer an opportunity for marginalized populations to experience death with dignity and comfort. This would also fill a significant gap in current palliative services, which are

[24] For excellent accounts of physician practice benefits in CHCs, see *Community Health Centres: Family Medicine at its Best*. Available at: https://www.youtube.com/watch?v=g02TURzm1iM

[25] British Columbia Federation of Community Health Centres (2013). *Beyond Dispensing: The Voice of a Pharmacist Working as a Member of an Interdisciplinary Primary Health Care Team*. October 7, 2013. Available at: http://www.bcfchc.ca/beyond-dispensing-the-voice-of-a-pharmacist-working-as-a-member-of-an-interdisciplinary-primary-health-care-team

challenged to provide care at end of life for people living with multiple barriers of poverty, substance use and mental illness.

ISSUE #4: How can we enhance the effectiveness of addiction recovery 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 addictions and the potential for recovery. Furthermore, 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 addictions.

A major obstacle to overcome in improving addiction recovery throughout British Columbia is moving an integrated approach to addictions and recovery beyond the walls of the Ministry of Health, and into integrated, inter-sectoral environments. Primary health care is central.

Community Health Centres offer an integrated 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. Individual family physicians and "clinical care only" teams are challenged in providing a continuity of support to individuals recovering from addictions due to the many disconnects between them, as clinical providers, and the broader circle of supports needed by individuals. These include housing, education counseling, skills development, peer support, and other social supports.

CHCs provide the wraparound care and support that supports clinical providers, case managers, program staff and partners from other agencies to collaborate in supporting an individual's recovery.

It is also important to recognize that when placed under the direction of Aboriginal communities, CHCs across Canada have demonstrated tremendous potential to prevent addiction among Aboriginal community members and to improve the likelihood that Aboriginal community members dealing with addictions will navigate a path to recovery. Leading examples include Vancouver Native Health Society[26]; Anishnawbe Health Toronto[27]; Wabano Centre for Aboriginal Health (Ottawa)[28]; and Aboriginal Health and Wellness Centre (Winnipeg)[29].

Culture is key to this success. The holistic approach to treatment and recovery common to Aboriginal CHCs aligns with Medicine Wheel teachings that to fully heal, we must treat body, mind, emotions, and spirit together. By providing a culturally-safe environment, and supporting individuals to re-discover cultural practices and culturally-specific methods of dealing with root causes of addiction, Aboriginal CHCs empower individuals and families to move beyond the inter-generational influences that have ravaged First Nations, Metis and Inuit communities.

[26] Vancouver Native Health Society: http://www.vnhs.net
[27] Anishnawbe Health Toronto: http://www.aht.ca
[28] Wabano Centre for Aboriginal Health: http://www.wabano.com
[29] Aboriginal Health and Wellness Centre: http://www.ahwc.ca

OUR RECOMMENDATIONS

By supporting existing Community Health Centres and establishing new CHCs throughout British Columbia, the provincial government will be updating our outdated primary health care "system". It will also enable the provincial government to achieve significant progress related to all four areas of concern raised by the Standing Committee; to catalyze community economic and social development; and to advance the triple aim in healthcare for our province. As such we are recommending four key action steps:

1. **Immediately scale-up access to Community Health Centres by committing to adequate, core budgets for all existing CHCs throughout British Columbia.**

Whether via capitation or global budgeting, it is essential to provide all CHCs in the province with adequate core operating budgets. These budgets should be attached to robust, mutual accountability agreements outlining service expectations and other terms of agreement.

A provincial review of not-for-profit and cooperative CHCs, as well as CHCs operated directly by regional health authorities would clearly reveal the many gaps that CHC organizations throughout the province face in meeting demand for services.

Addressing these gaps would enable the Government of British Columbia to harvest a "low-hanging fruit" by leveraging untapped capacity that already exists within these organizations. This would immediately improve access to care for British Columbians; it would reduce pressures on other more costly health and social services; and it would catalyze local economic development.

The British Columbia Federation of Community Health Centres is prepared to collaborate with representatives from the Ministry of Health to help identify gaps at CHCs throughout the province. This could include comparative study of core-funded CHCs in other jurisdictions. Collaboration from the Canadian Association of Community Health Centres and stakeholders in other provinces could be secured to facilitate this process.

2. **Undertake a policy reform process to correct the adverse impact of current physician compensation processes on effective interdisciplinary, team-based care and continuity of care.**

As currently configured, the direct contractual relationship between physicians and the Ministry of Health and Regional Health Authorities compromises patient care; it undermines interdisciplinary care; and it undermines the ability of health organizations like Community Health Centres to effectively plan services. The Auditor General of British Columbia recently found that:

> Government is not ensuring that physician services are achieving value for money. Government is unable to demonstrate that physician services are high-quality and cannot demonstrate that compensation for physician services is offering the best value. Furthermore, there are systemic barriers that are hampering Government's ability to achieve value for money with physician services.[30]

The two dominant modes of physician payment in British Columbia, Fee-for-Service (FFS) and Alternate

[30] Auditor General of British Columbia (2014). *Oversight of Physician Services*. February 2014.

Payment Program (APP), pose particular barriers to effective care, as they are currently configured. Fee-for-Service payment (FFS) payment of physicians puts a perverse payment incentive in between physicians and their patients. As one leading BC family physician has noted:

> Doctors like myself are paid well in British Columbia, but we are paid by an antiquated compensation model called fee-for-service, which basically reduces medical visits to a series of billable scenarios. In family practice this is not cost-effective, and often leads to "turnstile medicine," because we can only bill the government for one ailment at a time…The fee-for-service model is expensive, because it incentivizes illness care rather than prevention. It is also expensive for patients, who bear the burden of having to come back again and again for various issues.[31]

Not only does FFS undermine patient care, it is poisonous to interdisciplinary care teams. Experience with FFS payment of team-based physicians shows that, in many instances, because there is a payment code attached to a particular procedure, family physicians are inclined to perform those procedures even if they are better suited to other care team members. In other instances, family physicians receive payment for a procedure even if another member of the team *actually* performed the procedure, because payment for the procedure must be flowed directly to a physician and not the care team or health centre organization.

As a result of these barriers, FFS constitutes a "poison pill" for interdisciplinary care teams, perpetuating undesirable silos within the healthcare team. This includes destructive power dynamics and resentments and rifts within the team.

Since FFS forces family physicians to focus on just clinical services, and at high volumes and quick turnaround times, this also disincentivizes the participation of physicians in referral practices and organization-wide initiatives that focus on health promotion and population-level activities. Ironically, this runs counter to recommendations from and growing trends within the Canadian medical community. The Canadian Medical Association, Canadian Doctors for Medicare and a wide-range of provincial medical associations are now strongly advocating the role of physicians in addressing the broader determinants of health affecting individuals, families and communities – work that is fundamentally undermined by FFS.

Alternate Payment Program (APP) contracts with physicians, as they are currently configured, also undermine interdisciplinary primary health care. The negotiation of APPs directly with physicians place primary health care organizations, like CHCs, at the mercy of individual practitioner decisions. BC's Auditor General has found that "aspects of work culture are impeding constructive engagement with physicians and current legislation is not adequately supporting entities overseeing physician services.[32]"

Healthcare organizations engaging physicians on APP, including CHCs, have no resident authority to plan for succession, and when a physician decides to leave the organization (physician transiency being common across the health system), the organization is forced to identify another physician who is both an appropriate fit and who carries with him/her an APP arrangement.

There is, however, a simple alternative. Flowing APP agreements directly to Community Health Centres – protected within a separate envelope inside a core operating budget – would better enable CHCs to

[31] Dr. Vanessa Brcic (2014). "Why it pays to practice poor medicine in BC". *The Tyee*. February 21, 2014. Available at: http://thetyee.ca/Blogs/TheHook/2014/02/21/Fee-For-Service/

[32] Auditor General of British Columbia (2014). Op cite.

ensure continuous care and to recruit physicians that are appropriately-suited to the mission of the organization.

Currently, FFS and APP constitute the lion's share of funding for family physicians in British Columbia. We do not expect a complete about-turn overnight. We recommend instead that where there is a commitment by the Government of British Columbia to increasing access to interdisciplinary care, there be commensurate commitment to policies that support effective team-based care, especially for organizations like CHCs. This aligns closely with the BC Auditor General's recommendation to the Government of British Columbia to "rebuild physician compensation models so they align with the delivery of high-quality, cost-effective physician services.[33]"

Barriers to interdisciplinary care posed by FFS and APP can be remedied through policy reform, while still providing exceptional practice and compensation opportunities for family physicians in our province.

Other jurisdictions have demonstrated that it is both possible and beneficial to guarantee physician services within interdisciplinary teams by negotiating and protecting the physician compensation envelope within a primary health care organization's core budget. The goal in doing so is to duly compensate physicians for their services, while at the same time assuring appropriate patient roster sizes for the interdisciplinary team – of which the physician is a member – as part of an accountability agreement and reporting processes. These would be negotiated between British Columbia's CHCs and either the Ministry of Health or local RHA.

The Multi-sector Service Accountability Agreements (MSAA) negotiated between Ontario's Local Health Integration Networks and Ontario's CHCs provide a good example of how this might be accomplished in British Columbia.

3. Provide policy direction to the province's Regional Health Authorities supporting routine collaboration by RHA-led Community Health Centres with all other CHCs in British Columbia to advance knowledge-exchange, quality improvement and scale-up of local innovations.

As a provincial association, the BCFCHC routinely observes the many economies of scale, practice innovations, and other benefits that could be achieved if the province's Community Health Centres were better supported to learn from and collaborate with each other.

Our association and our federal counterpart, the Canadian Association of Community Health Centres (CACHC), believe firmly that RHA-operated CHCs can and must be active partners in developing strong and collaborative CHC networks built around a commitment to the triple aim in healthcare. Currently, RHA-operated CHCs operate in a highly-isolated manner from other CHCs and are not supported to participate in knowledge-exchange, practice innovation and scale-up activities within either the BCFCHC or CACHC.

Not only is this a missed opportunity for quality improvement in healthcare for British Columbians, it constitutes an inequitable double-standard within the health system. Hospitals, long-term care facilities,

[33] Ibid

individual physicians and nurses, and other sectors within the health system are not denied authorization to participate in such activities via their sector-specific or profession-specific associations. In fact, they are often mandated and financially-supported to do so.

As a result they are allowed to benefit from operational quality improvement, and practitioners are supported to establish and maintain peer development and educational relationships that bring improvements to their provision of services to British Columbians. Community Health Centres and the diverse healthcare providers practicing within CHCs are currently prevented from doing the same. This double-standard is a fundamental inequity, and it ultimately disadvantages patients receiving care and support from the province's 100-plus CHCs.

Providing policy support to British Columbia's RHA-operated CHCs, as well as a modicum of financial support to all CHCs in the province, geared to collective knowledge-exchange and quality improvement activities, would eliminate this double-standard in our province. This, in turn, would translate into access and quality improvements in care for residents of the province, and a more sustainable health system for all.

4. **Commit to a five-year plan to establish 75 new Community Health Centres throughout the province and dedicate $150 million in one-time infrastructure and start-up funding for this purpose. Commit to funding at least 50% of these new CHCs as community-governed not-for-profit or cooperative organizations.**

A tremendous amount of progress can be achieved in British Columbia simply by leveraging the untapped potential of existing CHCs. However, there is also a great need to expand access to CHCs beyond communities that can be served by the roster of existing CHCs. British Columbia should commit to catching up with other leading jurisdictions that are updating their primary health care infrastructure and expanding access to Community Health Centres.

Our recommendation in this respect is to again begin by leveraging latent capacity, this time within the broader "community health sector". We recommend that the province conduct a community needs assessment to identify communities most in need of the comprehensive services offered through a CHC, and to issue a call for proposals from existing community support agencies within those communities.

BCFCHC believes strongly that many community support agencies would be eager to evolve into Community Health Centres in order to expand the scope of services and supports available to the individuals and groups they already serve. These agencies not only are already delivering several components of primary health care (e.g., counselling, health promotion, capacity-building), but also have organizational infrastructure that can be leveraged to bring the fuller "primary clinical care" package into effect more quickly. Retrofitting of existing spaces, negotiation of new spacing leases, and some new brick-and-mortar construction could be accommodated through a one-time capital outlay.

There is added virtue in this approach. These community health and social support organizations have already established relationships of trust with the communities they serve. This would enable them to achieve high impact, especially with vulnerable communities and complex-care individuals, many of whom are known to fall through gaps in the health system and to be high and repeat consumers of emergency department and other healthcare and social services.

In supporting new CHCs throughout the province, we believe that it is critical for the province to invest in CHCs that are governed by members of the communities they serve. Participation in governance by members of the community is important to ensuring appropriateness of services and to building important relationships of trust and buy-in, especially in communities facing higher-than-average barriers to health and development. Research on CHCs across Canada has found that "CHCs provide a wide range of opportunities for citizen participation not found in most parts of the health care system. Opportunities range from consultation to direct decision making.[34]"

The same research found that among community-governed CHCs, "participants felt that citizen participation in CHC decision making had led to improved programs and services and that the range of programs and services met the needs of the community.[35]"

Research from the United States[36], where all 1300-plus CHCs are governed by independent, community-based, and patient-majority boards of directors, found that:

- Community participation in health care decision making makes health care providers more responsive to community-defined needs.[37]

- Patient participation on governing boards ensures greater board focus on the scope of the care delivered, and results in higher quality care, lower cost services, and better procedures for patient complaints.[38]

- Community Health Centres with patient-majority boards are better able to respond to the needs of the diverse communities since many of their board members are of diverse ethnic/minority groups.[39]

BCFCHC remains committed to working with and supporting continuous quality improvement among all CHCs in the province, including RHA-operated CHCs. At the same time, we believe that expanding the number of community-governed CHCs in British Columbia is essential to optimize impact in many communities, as well as to build critical mass among community-governed CHCs in the province. Achieving critical mass will help catalyze further quality improvement, collaborative practice and innovation among community-governed CHCs with respect to the particular processes through which community-governed CHCs plan, organize and operationalize services and programs.

[34] Church J, et al (2006). *Citizen Participation Partnership Project Report*. Centre for Health Promotion Studies, School of Public Health University of Alberta. Available at: http://www.cachc.ca/wp-content/uploads/downloads/2014/12/Citizen-Participation-Research-Project-2006.pdf

[35] Ibid

[36] National Association of Community Health Centers (2007). *The Importance of Community Governance*. Available at: http://www.nachc.com/client/documents/Governing_Board_12_17.pdf

[37] Crampton P, et al (2005) "Does Community-Governed Nonprofit Primary Care Improve Access to Services?" *International Journal of Health Services* 35(3): 465-78.

[38] Ibid

[39] Ibid