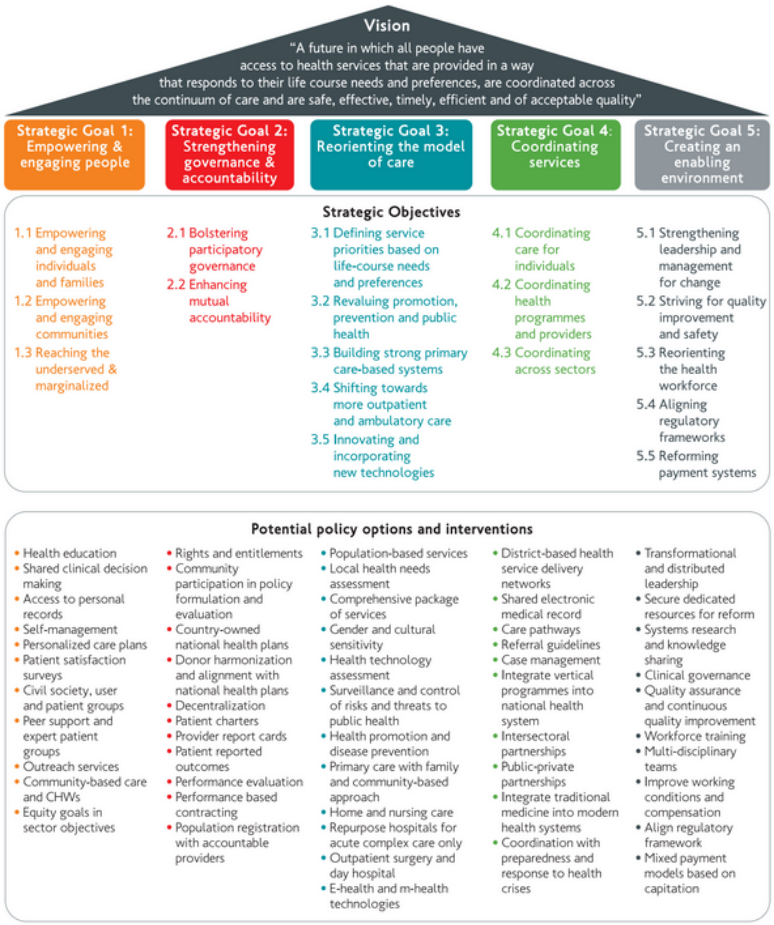
Case Study of an Integrated People-Centred Health Service: Community Health Centres

Summary:
Without a trusted primary care relationship, people often struggle to investigate symptoms and receive a timely diagnosis followed by needed treatment and support. Poor determinants of health compound this situation for many. Integrated primary health care teams that address medical and social needs through co-design with patients and communities are a solution that deliver Quadruple Aim outcomes. Community Health Centres (CHCs) are one such model.

WHO global strategy on integrated people-centred health services: an overview [1]



Challenges:
As people cycle among primary care providers, emergency rooms and allied health professionals because they are experiencing symptoms and are trying to be investigated for a diagnosis, delays of months or years occur as people seek validation of their symptoms and subsequent referrals. Delays are further compounded by unnecessary re-work due to referrals which fall through the cracks, necessitating that a person cycle back to the referring doctor for a re-referral.

For many people, the visit to the family physician to discuss concerning symptoms is not an affirming one. People report that their physicians tend to minimize or dismiss their symptoms leaving them without answers or, in some cases, an inaccurate diagnosis accompanied by inappropriate prescribing of medications. Some people went on to visit an allied health professional to seek answers only to find the usual course of action was to be sent back to the family physician with intermittent presentation at the emergency room as symptoms worsened.[2]

1. World Health Organization (2015). "Figure: WHO global strategy on integrated people-centred health services: an overview." WHO global strategy on integrated people-centred health services 2016-2026: Executive Summary, 7.
2. Sahay, T. et al Optimizing Diagnosis in Canadian Cancer Care. All.Can Canada, February 2022.

As it relates to social determinants of health, above-average-income Canadians have greater access to healthcare than below-average income Canadians. There was a 9 percent difference between above- and below-average-income Canadians regarding whether their regular doctor spent enough time with them to explain things. There was a 19 percent difference in having cost-related access problems with medical care in the past year and an 8 percent difference in being able to obtain after-hours care.[3]

Solution:
Community Health Centres (CHCs) deliver integrated primary care and social services within communities who experience systemic barriers to care. CHCs address and provide support to underserved populations by coordinating efforts related to social determinants of health. According to a 2020 rapid synthesis,[4] CHCs have the following features:

Providing team-based interprofessional primary care

Three primary studies described interprofessional teams as a key feature to a CHC model. Team-based interprofessional primary care can involve clients, providers, allied health professionals, patient navigators and others who connect health and social services. Seven primary studies reported on different aspects related to the collaborative relationships within team-based care. Two primary studies described that a CHC model fosters a supportive and trusting environment for patient-provider relationships…One study explained that system navigators were an integral part of a primary care team as they can respond to both health and social care needs. The study reported reduced emergency department visits, in-patient stays, and length of stay due to the integration of system navigators.

Integrating the provision of a diverse array of health and social services

CHCs provide and link clients with a diverse array of health and social services within the community, such as health promotion programs and disease prevention. An older medium-quality systematic review that focused on quality improvement initiatives among CHCs described a diverse array of screening, immunization, smoking cessation programs and services specific to chronic conditions (such as diabetes and asthma) as examples of primary healthcare services and programs in CHCs. Two primary studies based in Ontario emphasized standardization of data and definitions, the ability to produce digital coordinated care plans, and incorporation of data management coordinators within CHCs as examples of components that increased the efficiency and effectiveness of primary care delivery and the integration of other services. Specifically, one study described the EMR data-sharing partnership between Alliance for Healthier Communities and the Canadian Institute for Health Information.

3. Raphael, D., Bryant, T., Mikkonen, J. and Raphael, A. (2020). Social Determinants of Health: The Canadian Facts. Oshawa: Ontario Tech University Faculty of Health Sciences and Toronto: York University School of Health Policy and Management.
4. All of the info on CHCs comes from the following source: Bhuiya AR, Scallan E, Alam S, Sharma K, Wilson MG. Rapid synthesis: Identifying the features and impacts of community health centres. Hamilton: McMaster Health Forum, 23 October 2020.

The authors reported that there was a better understanding of a patient's continuum of care (acute and primary care). In a recent study on the implementation of social prescribing in CHCs, the authors reported that providing patient-centred care, having dedicated staff and senior organizational commitment, incorporating a learning health system approach to data collection and utilization, and incorporating innovation were factors that led to the success of the program.

Being community centred

CHCs build partnerships and are governed by elected community members with the aim to identify specific care needs within a community. Limited studies within the literature described the governance structure of CHCs. However, in a 2010 primary study that focused on comparing models of primary care in Ontario, the authors reported that community governance (elected community members on the board of directors) was an integral component in the acceptance of a CHC model of care within the community.

A 2019 study identified that CHCs incorporate nine of the 11 fundamental core dimensions of primary care: 1) applying a population-health approach; 2) integrating interdisciplinary teams; 3) providing care in a group practice setting; 4) coordinating with other sectors; 5) maintaining individual patient records and assessing utilization patterns and outcomes through available data infrastructure; 6) accepting alternative payment mechanisms (salaried payments for physicians and other team members, and population-adjusted global budgets for organizations); 7) engaging community (lay boards and community outreach); 8) measuring performance and quality improvement; and 9) involving community governance.

In 1999, I had moved to Canada and was for a while without OHIP coverage. I didn't need a lot of medical care but when I did, I registered with our local Community Health Centre (CHC) because that was the only place I could get care without a health card. My partner had just returned from a few years living abroad and her family doctor had closed her practice, so she too registered with the CHC.

A few months after I arrived in Canada, I spotted a small freckle on my earlobe and noticed that it had increased in size. I felt uneasy about it and made an appointment with the Nurse Practitioner at the CHC. She was wonderful, kind and a very talented healthcare provider who immediately recognised what it was (although she didn't tell me that at the time) and arranged a biopsy. It turned out to be a melanoma, luckily caught very early on. I was quickly referred to a specialist and the melanoma was removed through day surgery and no other treatment was needed. I have always been very aware that my life could have been very, very different (and potentially a lot shorter) if not for the excellent skill of that Nurse Practitioner and the care that I received through the CHC.

We moved to another city for four years and during that time had to make do with a patchwork of walk-in clinics because it was impossible to find a family doctor who was accepting patients and there was no CHC close to us. It was a shock for us but it is a sad reality that so many people must make do with suboptimal healthcare. During that time, we had some challenging and stressful healthcare conditions to deal with in our family and we really missed the CHC care we had been used to. I have continued to prefer receiving care at CHCs over the past 23 years, not just for myself but for my whole family. We all value the culture and ethos of the CHC model. I have found that the staff are warm and welcoming, knowledgeable, patient, and helpful. I love that there are so many medical and other services all under one roof. The CHC model of care provides wraparound support, prevention as well as treatment and recognises the full context of the patient's life.

Addressing the social determinants of health

CHCs support clients through an integrated approach to help address the social determinants of health (e.g., access to housing, food security, education, language barriers). A 2014 primary study that examined 11 CHCs in Ontario described successes and challenges related to implementing community initiatives that address upstream determinants of health. The majority of the CHCs were limited in staffing, where it is often one staff member with a diverse skillset to coordinate efforts and oversee management of community initiatives. Successful components to implementing community initiatives involve: 1) support from senior management; 2) sustainable funding sources; and 3) engagement with multiple partners (government, public-health units, educational institutions, advocacy groups, community). The study reported a range of successes such as increased education opportunities and employment among clients, and increased awareness among providers and policymakers of issues related to social determinants of health within their community.

Committing to health equity and social justice

A community-focused approach can facilitate the opportunity to address health inequities and advocate for systemic changes to reduce health disparities within the community.

Over the years, my family has received a broad range of care services from CHCs: prenatal care, new moms' support group, infant and children's developmental care and support, vaccinations, minor medical procedures, mental health care, physiotherapy, foot care, specialist referrals, tests and screening, regular, ongoing healthcare, advice, and support

During the pandemic, my teenage son, T., seemed to manage well with virtual classes. He had a good circle of friends and good relationships with teachers that kept him motivated and engaged. The move to university that ended up being online all year, with no such social supports, was pretty much a disaster. T. struggled with crippling anxiety that began to affect his day-to-day functioning. This led us to urgently seek mental health care services for him.

What we quickly found out was that mental health services, particularly for youth, are scarce and access is extremely challenging because waiting lists are one-and-a-half to two years, even for basic services (and this includes private therapy that can cost $200+ an hour, a cost that many people cannot afford).

In the meantime, our child was suffering enormous distress. Unless he posed an immediate danger to himself or others or could be helped with general self-help apps and websites, there seemed to be no help available for years. He fell into this brutal middle ground where, unless the issues are severe enough to be hospitalized, there is an appalling dearth of supports and services that are readily available. After weeks of reaching absolute dead ends looking for services, we sought advice from our family doctor at our Community Health Centre. This was a turning point.

The family doctor immediately recognized the severity of the issues and made referrals to longer term supports (still with long wait times). The doctor also connected us with a youth psychiatrist who was able to offer diagnostic services and medication. Although neither the family doctor nor the psychiatrist can offer ongoing therapy, the family doctor committed to being available for T. whenever he needed support. She also works closely with the psychiatrist to support him. Knowing that this safety net was in place, made all the difference.

We are still on the long wait lists for ongoing care but having these supports in place for now has helped him (and all of us) remain functional. The CHC model offers connected, integrated care, and gave us a lifeline in a truly bleak and dark time for our family.

Mother of 2, Living in Toronto, Ontario

Two primary studies described equity in the context of providing culturally competent care and services to specific populations within the community (such as people identifying as LGBTQ+, Indigenous peoples, people who use substances, new immigrants, rural communities, francophones, and youth).

In Ontario, populations using CHC services include individuals from lower-income neighbourhoods, newcomers, those receiving social assistance, people with severe mental and physical health conditions, and those with higher levels of morbidity and comorbidity. In a study examining CHCs across Toronto, advocacy was reported to be an essential component of CHCs and was largely driven by organizational commitments to health equity. Challenges of community health centres advocacy include funding constraints, competing service-delivery priorities, lack of resources and non-profit restrictions.

Quadruple Aim[5] Achievements

Enhanced patient experience

There was consistent evidence that CHCs enhance patient experience with a number of studies describing positive client experiences and increased satisfaction regarding the delivery of care within this setting... It is worth noting that establishing a positive rapport and patient-provider relationship can have a substantial impact on this part of the quadruple aim metric, with one study noting that regular communication between both parties resulted in increased positive patient experience outcomes.

Improved health outcomes

A core focus of CHCs is on addressing health outcomes related to inequities due to systemic barriers such as poor access to healthcare and other social supports. In acute care settings, six primary studies found that accessing care at a CHC can reduce the number of emergency department visits and hospitalizations among community members. Further, two systematic reviews and four studies found that CHCs increase engagement with screening programs, including cancer screening, pap tests and mammograms. Additionally, a 2020 study in Ontario reported overall improvements to mental health, self-management and interconnectedness and belonging after implementing social prescribing within CHCs. CHCs have also been found to positively contribute to cardiovascular disease prevention and the management of chronic conditions such as diabetes, in part due to recognition of the social determinants of health, and efforts to collaborate with allied health professionals and communities which provide access to more comprehensive care.

5. In 2007, the Institute for Healthcare Improvement developed the Triple Aim (improving population health, enhancing the care experience, and reducing per capita cost), which has since expanded to the Quadruple Aim and Quintuple Aim, incorporating joy at work/enhancing provider experience and equity, as additional strategic priorities.

Manageable costs

There was consistent evidence among the documents identified when describing costs and cost-effectiveness of CHCs. One single study and a report on the use of CHCs among Medicare beneficiaries in the U.S. detailed lower costs of care and higher reported savings for CHCs when compared to other care settings... Additionally, there was consensus among a number of primary studies that investigated patient expenditure on health services that CHC clients typically have lower spending costs in a variety of healthcare settings, including primary care, ambulatory care, inpatient care and emergency departments. With regards to cost of these services within CHCs, a U.S. audit study reported that uninsured patients often have lower appointment costs at Federally Qualified Health Centers (i.e. CHCs) than at non-Federally Qualified Health Centers.

Positive provider experience

One primary study found that many CHC staff experience a positive work environment, while four primary studies reported an emphasis on a shared vision of advocacy and equity. The environment cultivated by many CHCs was identified as contributing to a collaborative energy among team members, which contributes to the delivery of community-focused care. Healthcare providers found social prescribing useful for enabling deeper integration between clinical care, interprofessional teams and social support. It is important to note that the experience of employment at CHCs is heterogenous, and the literature identified ways in which different types of staff members experience care provision. For instance, one primary study found that nurse practitioners and family physicians perceive less fairness when it came to decisions from administration related to the services and programs in CHCs. These providers may have greater job satisfaction and improved stress-related outcomes when they perceive fairness within CHC governance.

References:

World Health Organization (2015). "Figure: WHO global strategy on integrated people-centred health services: an overview." WHO global strategy on integrated people-centred health services 2016-2026: Executive Summary, 7.

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