Ontario's Community Health Centres

Les centres de santé communautaire en Ontario

Community Health Centre Guidelines

November 2013

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1. Introduction

The Community Health Centre Guidelines complements the Multi-Sector Accountability Agreement (MSAA) between the Community Health Centres (CHCs) and the Local Health Integration Networks (LHINs, as well as the Community Financial Policy (2013) and the the Community Health Centre Requirements (2013); and the Model of Health and Wellbeing (2013).

This guideline is for information purposes only and are specific to Ontario CHCs.

2. About Community Health Centres

2.1 The Beginning

The concept of CHCs is not new, Mount Carmel Health Centre in Winnipeg was Canada's first CHC opening in 1926.

The introduction of the Hospital Insurance and Diagnostic Services Act of 1957 and the Medicare Act in 1966 changed the way health care was organized, delivered and funded.

In 1971 the Federal Government commissioned the Community Health Centre Project task group chaired by Dr. John Hastings. The 1972 report *The Community Health Centres in Canada* recommended the development of a "significant number of community health centres in a fully integrated health services program".

In the 1970s, the Ontario Ministry of Health established the CHCF Programs as a pilot, funding ten CHCs in Toronto and Ottawa. These CHCs served predominantly poor, ethnically diverse and urban communities.

In 1975, there was no distinction between Community Health Centres (CHCs), Health Centres and Community Health Service Organizations (CHSOs). At that time, all centres were considered experimental pilot projects and the Ministry of Health funding was based on that premise. All centres were funded through capitation payment mechanisms. However, centres that were not considered financially viable were given a program budget with the intent to convert into capitation as soon as a centre achieved financial viability. The latter, now operating as CHCs, stayed with the program budget as the preferred way to fund the type of programs, operation and philosophy by which these centres delivered their programs and services.

2.2 Period of Growth

In 1982, then Minister of Health, Larry Grossman, announced that CHCs and CHSOs were no longer "experimental pilot projects" but would be a part of mainstream healthcare services. Targets were set for annual growth rates so that the CHC and CHSO component of the system would grow across the province.

Under then Health Minister Murray Elston and Elinor Caplan, health centres began to thrive. In 1987, Premier David Peterson announced the government's intent to double within five years the number of Ontario residents receiving primary health care through alternative funding arrangements.

By November 30, 1989, 93.75% of the Premier's target had been achieved. Back in 1985 there were 11 CHCs in operation serving approximately 29,000 people. By March 31, 1990, 32 CHCs were serving a population of 110,000.

2.3 Period of Transition

In 1994, Ontario's Auditor General posed questions about the CHC program in Ontario. It was decided that the province would freeze funding for the creation of new centres until CHCs were able to collect and submit data to demonstrate their purpose and effectiveness as a provincial program. Concurrently, AOHC worked with member centres on evaluation assessments which produced five key themes on which the current Evaluation Framework was collecting data. The five themes were: 1) Increased accessibility; 2) Emphasis on wellness and prevention; 3) Coordination and integration; 4) Holistic, client-centred approach, and; 5) Increasing individual and community ownership/responsibility for health.

Early in 1999, satellites were funded in Chelmsford and Hanmer (Centre de santé communautaire de Sudbury) and Armstrong Health Clinic (Ogden-East End CHC).

In May 1999, Minister of Health Elizabeth Witmer announced a lifting of the funding freeze. Soon after, two new CHCs and one satellite were announced, the Kitchener Downtown Community Health Centre, Grand Bend and Area Rural Community Primary Health Care Centre and Crysler, a satellite to Centre de santé communautaire de l'Estrie (Cornwall).

By 2001, there was a network of 56 CHCs with a budget of $100.7 mllion. CHCs were in urban and rural settings serving identified priority populations, including those who have difficulty gaining access to primary health services such as rural and/or northern isolated communities and populations with higher risk of developing health problems including immigrants, people who are homeless, seniors, people in poverty and street youth.

In 2001, the MOHLTC conducted a Strategic Review of the CHC Program. The review recognized that CHCs play a strategic role in primary care reform for populations with barriers to access to care based on key strengths including: interdisciplinary care, flexible service approaches that respond to population health needs, programs that build community capacity to address broader health determinants, accountability to communities served through community board governance and accreditation; partnership with other community stakeholders in needs assesssment, as well as design, delivery and evaluation of services and an infrastructure that supports integration of primary care with the delivery of other health and social services.

In June 2008 the CHC Model of Care was adopted by the CHC EDs Network and incorporated into Schedule D of the 2009-11 MSAA and the 2011-14 MSAA.

In May 2013, the CHC EDs Network adopted a refreshed Model of Health and Wellbeing (see Appendix A)
A CHC Results Based Logic Model (RBLM) is under development to align with the revised Model of Health and Wellbeing. The RBLM describes comprehensively the work that CHCs do, is a communications tool that demonstrates the CHCs contribution to the ultimate sector outcomes, and helps the sector to maintain a strategic focus on those activities and outputs that can influence the successful attainment of system goals.

2.4 A Bright Future

In April 2004 and November 2005, the MOHLTC recognized the CHCs critical role within the health system and announced the largest ever expansion of the CHC program in the province's history by announcing a total of 22 new CHCs and 27 new CHC satellites.

As of 2013, there are 76 CHC corporations in the Province. When all the 2004/05 announced centres are fully operational, CHCs will serve approximately 4% of the Ontario population.

2.5 Legislative Authority Governing CHCs

Section 7 of the Ministry of Health and Long-Term Care Act (1990)[1] gives the Minister of Health and Long-Term Care the authority to make agreements with municipalities, persons or corporations for the provision of hospitals and health facilities, services and personnel. This is the Ministry's authority for funding CHCs.

[1] http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m26_e.htm

In 2006, the Local Health Systems Integration Act[2] was passed in Ontario. This resulted in the establishment of 14 Local Health Integration Networks (LHINs). While the funding and oversight of CHCs was transferred from the MOHLTC to the LHINs, the MOHLTC's involvement continues through its role as steward of the Ontario health system.

CHCs need to take into account the strategic priorities of both the MOHLTC and their LHIN. LHIN priorities are set on a 3-year planning basis, and are outlined in their Integrated Health Servicess Plan.

Because CHCs have a variety of types of staffing, programs and services (different from CHC to CHC), the list of legislation governing CHCs is not only lengthy but does not pertain to every CHC. *The following is a list of a portion of the acts/legislation that affects all CHCs:*

- The Ministry of Health and Long-Term Care Act
- Broader Public Sector Accountability Act (2010)
- Accessibility for Ontarians with Disabilities Act
- Local Health System Integration Act (2006)
- Business Corporations Act
- Not-for-Profit Corporations Act (2010)
- Canada Corporations Act
- Personal Health Information Protection Act
- Employment Standards Act

The Excellent Care for All Act became a law in June 2010.Its guiding principles include:

- The patient is at the centre of the health care system.
- Decisions about patient care are based on the best evidence and standards.
- The health care system is focused on the quality of care and the best use of resources.
- The main goal of the health care system is to get better and better at what it does.
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Effective April 2013, CHCs were required to submit Quality Improvement Plans to Health Quality Ontario (HQO) on an annual basis.

2.6 The CHC as a Non-profit Corporation

CHCs are registered non-profit corporations ("without share capital") under the Ontario *Not-for-Profit Corporations Act (2010)* governed by a community Board of Directors. To ensure strength, effectiveness and efficiency as primary healthcare organizations, it is recommended that:

1. The CHC commits to the values and principles captured within the Model of Health and Wellbeing (see section 2.7.1.);
2. The organization be supported by appropriate structures including a designated Executive Director/Chief Executive Officer responsible to the Board of Directors; and
3. The organization undertakes accreditation by a formalized, recognized and respected accreditation body.

CHCs recognize that health and wellness encompass much more than an individual's physical health, and services beyond primary care, such as health promotion and community initiatives, are a fundamental component of the CHC model. Clients of CHCs can access a range of health, social and community services

[2] http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06l04_e.htm

provided under the same roof. These services may be funded by sources other than the LHINs and the MOHLTC, such as other ministries, local government bodies, the United Way, and donations (if the organization is also registered as a charity). They may also be services delivered or funded by organizational partners. The most significant advantage of this comprehensive, multi-service approach is that it provides a high degree of integration of health and social services resulting in increased access for clients.

Please refer to the CHC Requirements for information regarding the CHC as a Non-Profit Corporation and the Role of a CHC Board.

2.7 Model of Health and Wellbeing

2.7.1 Model of Health and Wellbeing

In 2008, the CHC sector approved the CHC Model of Care. In 2013, the CHC ED Network refreshed its model and approved a Model of Health and Wellbeing. The Model identifies values and principles that unite CHCs: Highest Quality People and Community-Centred Health and Wellbeing; Health Equity and Social Justice; and Community Vitality and Belonging.

The eight attributes of the Model that define a collective understanding of what CHCs are: anti-oppressive and culturally safe; accessible; interprofessional, integrated and coordinated; community-governed; based on the social determinants of health; grounded in a community development approach; population and needs-based; and accountable and efficient.

The Model of Health and Wellbeing:

- sets forth as values and principles, and attributes that form the core of who CHCs are and what they do as Community Health Centres in Ontario; these principles with their underlying beliefs and values not only form CHCs internal identity, but also reflect who CHCs are to the external environment;

- describes and prescribes a way of working together, clients and providers, Centres and communities, that asserts: Every One Matters;

- recalls and reminds that CHCs' understanding of primary health care places its members squarely at the community heart of a larger struggle for equity and social justice, for the right to holistic care, regardless of status, endowment or condition, that takes into account all aspects of human dignity; and

- Acclaims the distinguishing features of CHCs collective identity as organizations and communities and provides an opportunity to affirm commitment to the values, principles and beliefs embedded in the CHC Model of Health and Wellbeing.

Please refer to the CHC Model of Health and Wellbeing manual for detailed information.

2.7.2 Priority Populations

Please refer to the CHC Requirements for information on Priority Populations.

2.7.3 Provision of Service to Non-Insured Clients

Please refer to the CHC Requirements for information on Provision of Service to Non-Insured Clients.

2.8 The CHC Results Based Logic Model

The CHC Results Based Logic Model will be updated in the near future to align with the CHC Model of Health and Wellbeing.

3. Planning, Reporting and Evaluation

3.1 The Multi-sector Accountability Agreement (MSAA)

CHCs deliver services as outlined in their Multi-sector Service Accountability Agreements (MSAA). The following is the background statement included in the MSAA:

> Prior to providing funding for the provision of services to its local health system, the Local Health System Integration Act, 2006 requires that the LHIN and the HSP enter into a service accountability agreement.
>
> The service accountability agreement is a multi-year agreement. It supports a collaborative relationship between the LHIN and the HSP to improve the health of Ontarians through better access to high quality health services, to co-ordinate health care in local health systems and to manage the health system at the local level effectively and efficiently.
>
> In this context, the HSP and the LHIN agree that the provision of services to the local health system by the HSP will be funded as set out in this Agreement.

Within the MSAA, the following CHC Schedules relate to program planning, reporting and evaluation:

Schedule A: Description of Services
Schedule B: Service Plan (CHC's Operating Plan and Budget)
Schedule C: Reports
Schedule D: Directives; Guidelines and Policies
Schedule E: Performance (including Performance Indicators)
Schedule F: Project Funding Agreement Template
Schedule G: Compliance

3.1.1 The Community Financial Policy

The Community Financial Policy sets the financial requirements CHCs are expected to meet, in addition to the terms outlined in the M-SAA. These requirements apply to both LHIN-managed and Ministry-managed programs.

3.1.2 The Community AccountabilityPlanning Submission

As outlined in Article 6.0 of the M-SAA, CHCs must submit Community Accountability Planning Submissions (CAPS) on request by the LHIN. CAPS includes financial forecasts, plans for the achievement of performance targets and risk management strategies. The CAPS submission should align to the strategic priorities of LHINS.

3.1.3 Reporting Requirements

Schedule C of the M-SAA outlines the reporting requirements and their associated submission dates. These include: Ontario Healthcare Reporting Standards / Management Information Systems (OHRS/MIS) quarterly reporting (through the Self Reporting Initiative, SRI); Annual Reconciliation Report (ARR) and Board Approved Audited Financial Statement; French Language Services Implementation and Accountability Report (annual); and Program Reporting.

As well, as part of regular program monitoring, CHCs shall conduct a survey to ascertain client satisfaction with services and community stakeholder perspectives.

3.2 Information Management

Building on the long history of applying Information Management / Information Technology solutions within the CHCs, the CHC sector has developed a strategy for eHealth that is fully aligned with Ontario's eHealth vision.

As a dynamic and forward-looking sector, Ontario's primary health care centres[3] have a long history of embracing information technology in service of client care. This commitment is in complete alignment with the province's eHealth vision, centred on the themes of connectivity, data sharing, collaboration and innovation and improving health status.

An information management strategy has been developed that will establish best practices in the sharing and management of electronic data; promote efficiencies and clinical collaborations across the sector, and improve client care outcomes.

This strategy[4], which comprises several related components, will offer the sector the runway it needs to benefit from future eHealth solutions and/or new developments in health informatics.

3.2.1 Electronic Medical Record (EMR)

A major pillar of IMS is the new EMR system provided through Nightingale Informatics Corporation and their Application Service Provider EMR offering Nightingale on Demand (NOD). This state-of-the-art, provincially certified system will be centrally hosted and bilingual when fully implemented. Its inter-operability and ability to integrate with other provincial and local/regional eHealth solutions are essential functionalities that will serve the sector well for years to come.

3.2.2 Non-Operational Reporting & Analytics/Business Intelligence & Reporting Tools (NORA/BIRT)

A second major work stream within IMS is the NORA/BIRT project, which aims to provide CHCs with a holistic view of their operations by consolidating key data and presenting it in an integrated and easy-to-analyze manner. The NORA Strategy is enabled through the BIRT solution – a system that gathers and enables robust data analysis and visualization using industry-leading business intelligence tools.

Phase I, which involved developing the BIRT Solution and establishing processes to enable the extraction of data from existing CHC information systems and being able to report MSAA indicators to the LHINs, is complete. Phase II, which entails developing a regular, automated process to extract data from the new EMR with which to load BIRT, has also been completed. The current Phase III will introduce additional datasets such as OHRS information to enable cost per unit of service insights. This phase will also enable expansion to support other membership groups of the AOHC and provide additional BI reporting capabilities. A new enterprise license agreement allows CHCs unlimited licenses for the system thereby promoting value realization from the investment in BIRT.

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[3] *This includes Community Health Centres (CHCs), Aboriginal Health Access Centres (AHACs), Community Family Health Teams (CFHTs) and Nurse Practitioner-Led Clinics (NPLCs).*

[4] *This strategy recognizes that, although CHCs are part of the LHINs, the focus on primary care and primary health care means that information management needs are different than many of the other providers within the LHINs.*

3.2.3 Drug Profile Viewer (DPV)

DPV is a key learning step toward the future Medication Management System (MMS), which will provide prescription drug histories for all Ontarians, as well as clinical and decision support tools for clinicians.

The DPV project provides a history of prescriptions dispensed to clients under the Ontario Drug Benefit (ODB) and Trillium Drug Program (TDP)5. It supports increased prescription safety and a reduced need to repeat medication for ODB and TDP clients, while offering clinicians a strong foundation to recognize and prevent adverse drug reactions.

3.2.4 Community Initiative Tool (CI Tool)

This powerful web-based system was designed specifically for CHCs to document CIs and their contribution towards improving health within communities that are engaged in community development work. Conceived by CHC staff themselves, the Tool includes both an inventory as well as evaluation components. The inventory component, which was launched in 2010, shares knowledge of community initiatives by capturing information like CI objectives, planned activities and health conditions addressed. The evaluation component, on the other hand, will let CHCs assess community initiatives in terms of community response, enablers and barriers to success, lessons learned and best practices.

A second generation CI Tool will add robust BI reporting capabilities and run on a new open source platform.

3.2.5 Ontario Healthcare Reporting Standards (OHRS)/Management Information System (MIS)

This project involves the development of reporting standards by CHCs to ensure consistent and accurate financial and statistical reporting to the province. Managed by Community Care Information Management (CCIM), OHRS/MIS is also one of the work streams of the CHC information management strategy. CCIM declared the OHRS standards developed by the CHC sector as the 'gold' standard for this work.

The MIS/OHRS standard was configured into the Microsoft Dynamics GP application for CHCs. Due to the success of this initiative, other AOHC member groups are interested in using this solution.

3.2.6 Potential Areas of eHealth Alignment

This information management strategy was designed with the potential for future integration projects such as OntarioMD Hospital Report Manager (HRM), Ontario Laboratories Information System (OLIS), and various clinical document repositories across the province. Other potential areas of eHealth alignment in the near to mid-term include the development of an interface engine strategy as well as a portal strategy for accessing external data sets such as the Drug Information System (DIS).

Additionally, the IM Strategy enables health provider integration across sectors and is supporting Health Links and LHIN integration efforts.

Taken in totality, IMS will position CHCs as Information Management owners acting in concert to improve the health status of clients most in need. It will fulfill the vision of a unified sector working together to bring about better quality of care at the local level to people living in Ontario.

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[5] *This is subject to client consent.*

3.3 Program Audits and Accreditation

The MOHLTC and the LHINs use a variety of tools to ensure high-quality outcomes in Ministry/LHIN-funded programs, some of which are similar to the tools employed in accreditation processes. The Canadian Centre for Accreditation (CCA) is most commonly used by CHCs. For more details, see Section 8: Accreditation.

4. Service Delivery and Accessibility

Please refer to the CHC Requirements: *Section 3 Service Delivery and Access*

5. Financial Requirements

5.1 Financial Accountability

CHCs are required to be in compliance with the Community Financial Policy, 2013 included in Section D of the M-SAA.

5.2 Financial Reporting

5.2.1 Variances

The variances are articulated in the Schedule E series.

5.2.2 Audited Financial Statements

Please refer to Schedule C of the MSAA which requires that signed audited financial statements are submitted to the LHIN by June 30th each year.

As per the Corporations Act, each CHC must submit, by September 30, a Board-approved financial statement for the previous fiscal year and accompanying auditor's questionnaire, completed by a licensed chartered accounting firm. See Appendix C for the auditor's questionnaire.

Two duly appointed signing Officers must sign the audited financial statement certifying that it is complete and accurate.

To assist auditors with the completion of the audited financial statement, CHCs should provide their auditors with the following resource documents: the M-SAA, the Community Financial Policy, the declaration by the auditor for the previous year, the current operational budgets and a statement of program operations.

CHCs will comply with the previous year's guidelines from the LHIN regarding submission of audited documents, unless changes are specified and communicated by the LHIN by January 31 of the current fiscal year.

5.3 Recovery of Unspent Funds

Under-spending during one fiscal year will not result in a reduced budget for the following year.
Accurate financial forecasting is a requirement such that communication can be provided to the LHINs on a quarterly basis on funds that can be used in the system.

5.4 Other Financial Requirements

5.4.1 Provision of Service to Non-Insured Clients

Through quarterly reporting this protected envelope of funding is closely monitored by both the CHC and the

LHIN to ensure that the CHC will have sufficient resources to meet the demand in any given year. Provision of in-year one-time funding to meet increased demand for these services remains a Ministry and LHIN priority.

CHCs are responsible for advising the LHIN of a potential shortage of non-insured funds immediately at any point during the fiscal year. Services shall not be refused to these clients unless:

1. The LHIN has been advised that all non-insured funds have been expended and that demand for service remains; and

2. The LHIN has communicated in writing that it is unable to provide additional non-insured funding in the given period.

The Community Financial Policy provides additional details regarding the funding of non-insured services.

5.4.2 OHIP Claims

CHCs must use their best efforts to ensure that no claims for payment are made to OHIP for primary care services provided by CHC staff. If the CHC enters into a contractual agreement for which a fee is paid with specialists to provide medical services to clients at the CHC, the CHC must use its best efforts to ensure that no claims for payment are made to OHIP for the provision of such services.

If the CHC arranges for a specialist to provide medical services to clients at the CHC on a fee-for-service payment basis, the specialist may submit claims for payment to OHIP provided that the specialist did not receive any funding from the CHC or any payment from the patient for services.

5.4.3 Claims for Interactions with Clients from other Canadian provinces

CHCs are not entitled to receive or use ministry funds for out-of-province clients. CHCs must make claims for interactions with out-of province clients by using the OHIP out-of-province claim forms, or by billing Régie de l'Assurance Maladie du Québec (RAMQ) directly, in the case of residents of Quebec.

6.0 Facility Planning and Use of Space

6.1 Capital Planning

The MOHLTC will consider approval of projects involving a range of physical solutions to meet LHIN-endorsed program and service needs including leasehold improvements, renovations, expansion additions, land purchase, or construction of a new purpose-built structure.

If interested in seeking a MOHLTC capital grant, first obtain a copy from the Health Capital Investment Branch (HCIB) or through your LHIN's website of the latest version of the MOHLTC-LHIN Joint Review Framework for Early Capital Planning Stages Toolkit (or its replacement). In addition, request a copy of the Pre-Capital Submission Form (or its replacement).

Additional documents (or their replacements) that are important to consult during the planning phase, include:

- Capital Planning Manual (1996)
- Community Health Service Provider Cost Share Guide
- Space Planning Guide for Community Health Care Facilities
- Broader Public Sector Procurement Directive found at http://www.fin.gov.on.ca/en/bpssupplychain/documents/bps_procurement_directive.html
- Capital Planning Bulletin, Planning Design Guidance: Infection Prevention and Control
- Capital Community Projects Directive Memo
- Any other available Capital Bulletins and relevant documents.

Be sure to get the latest version of these documents from HCIB.

6.2 Source of Funding of Capital Projects

6.2.1 MOHLTC Funded Projects

Capital projects that are funded all, or in part, by the MOHLTC are known as MOHLTC Funded Projects.

The government provides MOHLTC with an annual capital funding allocation to meet the capital needs of the following community sectors:

- Community Health Centres
- Aboriginal Health Access Centres
- Community-Based Mental Health Programs
- Community-Based Substance Abuse (Addiction) Programs
- Long-term Care Supportive Housing Providers (typically supporting programs for the frail elderly, acquired brain injury, physically disabled and HIV/AIDS)

6.2.2 Own Funds Projects

When an organization engages in a Capital project with funding from sources other than the MOHLTC, that project is known as an "own funds" capital project.

Historically, it has been the MOHLTC expectation, as described in the *Capital Planning Manual (1996)* that capital projects valued at $100,000 and under are funded as "own funds" projects through the organization's operational funding allocation.

If your organization is pursuing an own funds capital project (i.e. one with funding other than from the MOHLTC capital community funding allocation), first obtain a copy from the Health Capital Investment Branch (HCIB) or through your LHIN's website of the latest version of the MOHLTC-LHIN Joint Review Framework for Early Capital Planning Stages Toolkit (or its replacement). In addition, request a copy of the Pre-Capital Submission Form (or its replacement).

Submission of Part A and B pre-capital forms to the LHIN are required to ensure that the LHIN supports the proposed project and identifies to MOHLTC all capital projects over $100,000 and any capital projects under $100,000 that include changes and/or additions to clinical space.

For "own funds" projects, also be sure to request a copy from HCIB of the latest versions of the Community Capital Projects Directive of April 2012, the HCIB recommendations regarding CHCs design of own funds projects, and any other relevant documents indicated by HCIB.

The Infrastructure Ontario Loan Program expansion to include Community Health Hubs provides another potential source of funding for CHCs that meet the health hub criteria. Details can be found here: http://www.infrastructureontario.ca/What-We-Do/Loans/Community-Health-and-Social-Service-Hubs/

7.0 Human Resources

As independent organizations, each CHC determines its own human resource policies and protocols.

7.1 *Provincial Salary Structure*

Community Health Centres are committed to maintaining a provincial salary grid and to conducting a province-wide compensation review every 3 years, taking into account funding considerations as appropriate. The CHC Executive Director's Network has commissioned this in the past (2004 and 2009) and is committed to regularly updating a market analysis.

In May 2013 , the Association of Ontario Health Centres (AOHC), the Association of Family Health Teams of Ontario (AFHTO) and Nurse Practitioners Association of Ontario (NPAO) adopted a provincial interprofessional primary care compensation structure and revised wage grid for Aboriginal Health Access Centres (AHACs, Community Health Centres (CHCs), Family Health Teams (FHTs) and Nurse Practitioner-Led Clinics (NPLCs) that built on the 2009 CHC Compensation Structure.

It must be noted that The Broader Public Sector Accountability Act, 2010, implements compensation restraint measures for designated executives at hospitals, universities, colleges, school boards and designated organizations. The restraint measures were effective March 31, 2012, and are in place until the province ceases to have a deficit

7.2 Compensation of Overtime Hours

Consistent with the *Employment Standards Act*[6] and other applicable provincial and federal legislation, CHCs shall compensate overtime hours worked as time-off in lieu.

8.0 Accreditation

[6] http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_00e41_e.htm

It is expected that all CHCs commit to participation in an accreditation process.

The Canadian Centre for Accreditation (CCA), that was developed based on the Building Healthier Organizations program, is used by many CHCs.

The following are Components of the CCA accreditation program for Community-Based Primary Health Care and are provided here as a guideline for those areas of activity in which CHCs should strive to meet minimum standards of excellence:

CCA Organizational Standards Module	**CCA Community-Based Primary Health Care Module**
Governance	Using a Community-Based Approach
Stewardship	Planning Programs and Services
Organizational Planning and Performance	Delivering Quality Programs and Services
Learning Culture	Ensuring Safety
Human Resources	Evaluating Program and Services
Human Resources – Volunteers	
Systems and Structure	
Community	

Appendices

Appendix A: Model of Health and Wellbeing

Appendix B: CHC Results Based Logic Model (under revision)

Appendix C: Auditor's Questionnaire

MODEL OF HEALTH AND WELLBEING

May 2013

"Let us not forget the ultimate goal of Medicare must be to keep people well"

Canadian Medicare founder Tommy Douglas

The Ontario's Community Health Centres (CHCs) constitute a dynamic movement of empowered and empowering people dedicated to building healthy individuals, families, communities, partnerships, environments and civic institutions.

CHCs share a common language and a common history of more than 40 years of holistic, comprehensive, interprofessional community-based care.

The province's CHCs play a unique and significant role working towards what Tommy Douglas described as the ultimate goal of Medicare, "to keep people well".

CHCs promote social justice and health equity.

Core:

Although each Community Health Centre (CHC) across the province is different because each CHC responds to the specific needs of the communities they serve, CHCs all follow the same model to promote health and wellbeing.

This model is based on two core principles adapted from the World Health Organization (WHO):

- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.

- Health is a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity.

The vision CHCs share

CHCs are also united in a shared vision for the future: the best possible health and wellbeing for everyone. Our ultimate goal is for all people living in Ontario to live the healthiest, safest, and most prosperous lives as possible. CHCs' commitment is to work with each other, and with our partners in communities across this province, to make to make Ontario one of the healthiest places on earth. .

To do this, CHCs must address social inequality and disadvantage for the purpose of reducing disparities in health outcomes. CHCs are proactive and persistent at addressing the fact that many health problems are not just medical or biological; they are caused by social conditions that affect access to resources and power. In our society, access to resources and power is often constrained by poverty, racism, sexism, homophobia, transphobia, ageism, ableism and other forms of social exclusion, which are often interconnected. We particularly recognize the impact that racism has had – and continues to have –on creating poverty, social exclusion and health inequity for racialized individuals and communities.

CHCs acknowledge and affirm inclusion. They affirm that Ontario's Aboriginal and Francophone communities have distinct and specific histories, needs and constitutionally protected rights. We recognize the distinct health needs of populations living in rural, remote or isolated settings, as well as in impoverished urban neighbourhoods and racialized populations. We also recognize the distinct health needs and rights of people who are uninsured or without documented status.

Because CHCs share a common vision and core principles, a Model of Health and Wellbeing was adopted that:

Sets forth further cross-cutting principles and practices that form the core of who Community Health Centres are and what they do;

Recalls and reminds CHCs that community is central to everything they do and d*eclares* that their work is part of a larger struggle for equity and social justice, to create a future where everyone has an equal right to access health and wellbeing services and where all aspects of human dignity are respected and nurtured.

Describes what makes CHCs distinct as organizations and communities and *provides* an opportunity to affirm their commitment to the values, principles and practices embedded in the Model of Health and Wellbeing.

The Values and Principles that unite CHCs:

People and Community Centred Health and Wellbeing

- Everyone participates, individually and collectively, in decisions about their health and wellbeing.
- Individuals and communities receive health care that meets their needs, in a timely fashion and from the most appropriate providers, and experience the best possible results.
- Health care and other service providers work in respectful, collaborative relationships with individuals, families, and communities and each other.

- The quality of care is optimized through continuous innovation and learning to improve the experience and outcomes of those accessing care, and the efficient use of resources.

Highest Quality

- Communities and people served access evidence-based, best practices grounded in the attributes of the Model of Health and Wellbeing.
- People served receive continuous, integrated, coordinated care and assistance in navigating health and social services systems to keep them healthy.
- Interprofessional teams work to full scope of practice and provide efficient, coordinated care..
- Interprofessional teams practice with a social determinants of health approach that is built on anti-oppression and cultural safety and reducing barriers to health and wellbeing.

Health Equity and Social Justice

- Reduction in social inequality improves Health outcomes.
- Social inequality is reduced when all people and institutions become aware of, and act on the understanding, that inequality impacts health outcomes for the already marginalized populations.
- Equity and dignity and integrity of the person is manifest in access to nutritious food, safe and secure housing, clean water, adequate and appropriate clothing, dignified and justly-remunerated employment.
- Health care appropriate to all ages and stages of life, and mechanisms of fulsome engagement and participation in civic, social and political processes.

Community Vitality and Sense of Belonging

- Safe and caring communities improve health outcomes.
- Shared values and shared vision strengthen belonging.
- All members of the community have opportunities to participate in decision making about their communities.
- Public, private sectors and community organizations work together to strengthen inclusive, caring and connected communities.

Attributes of the Model of Health and Wellbeing are:

Anti-oppressive and Culturally Safe: CHCs provide services in anti-racist, anti-oppressive environments that are safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with truth, respect, honesty, humility, wisdom, love and bravery. In practice we emphasize the presence of people from various cultural and linguistic backgrounds, resulting in their ability to control or influence the processes operating in their health services, and we believe this is one of the major ways to create a safe environment[i].

Accessible: CHCs are designed to improve access, participation, equity, inclusiveness, and social justice by eliminating systemic barriers to full participation. CHCs have experience in ensuring access for people who encounter a diverse range of racial, cultural, linguistic, physical, social, economic, legal, and geographic barriers which contribute to the risk of developing health problems. Removing barriers to accessibility includes the provision of culturally appropriate programs and services, programs for the non-insured, optimal location and design of facilities in compliance with the accessibility legislation, oppression-free environments, extended hours, and on-call services.

Interprofessional, integrated and coordinated: CHCs build interprofessional teams working in collaborative practice. In these teams, salaried professionals work together to their fullest possible scope to address people's health and wellbeing needs. CHCs develop strong partnerships and integrations with health system and community services organizations. The partnerships and integrations ensure the delivery of seamless and timely people and community-centred health, and key social determinants of health services and programs, with appropriate referrals. Referrals encompass primary care, illness prevention, and health promotion, in one to one service, personal development groups, and community level interventions.

Community-governed: CHCs are not-for-profit organizations, governed by community boards made up of members of the local community. Community boards and committees provide a mechanism for CHCs to represent and be responsive to the needs of their local communities, and for communities to develop democratic ownership over "their" Centres. Community governance builds the health of the local communities through engaged participation contributing to social capital and community leadership.

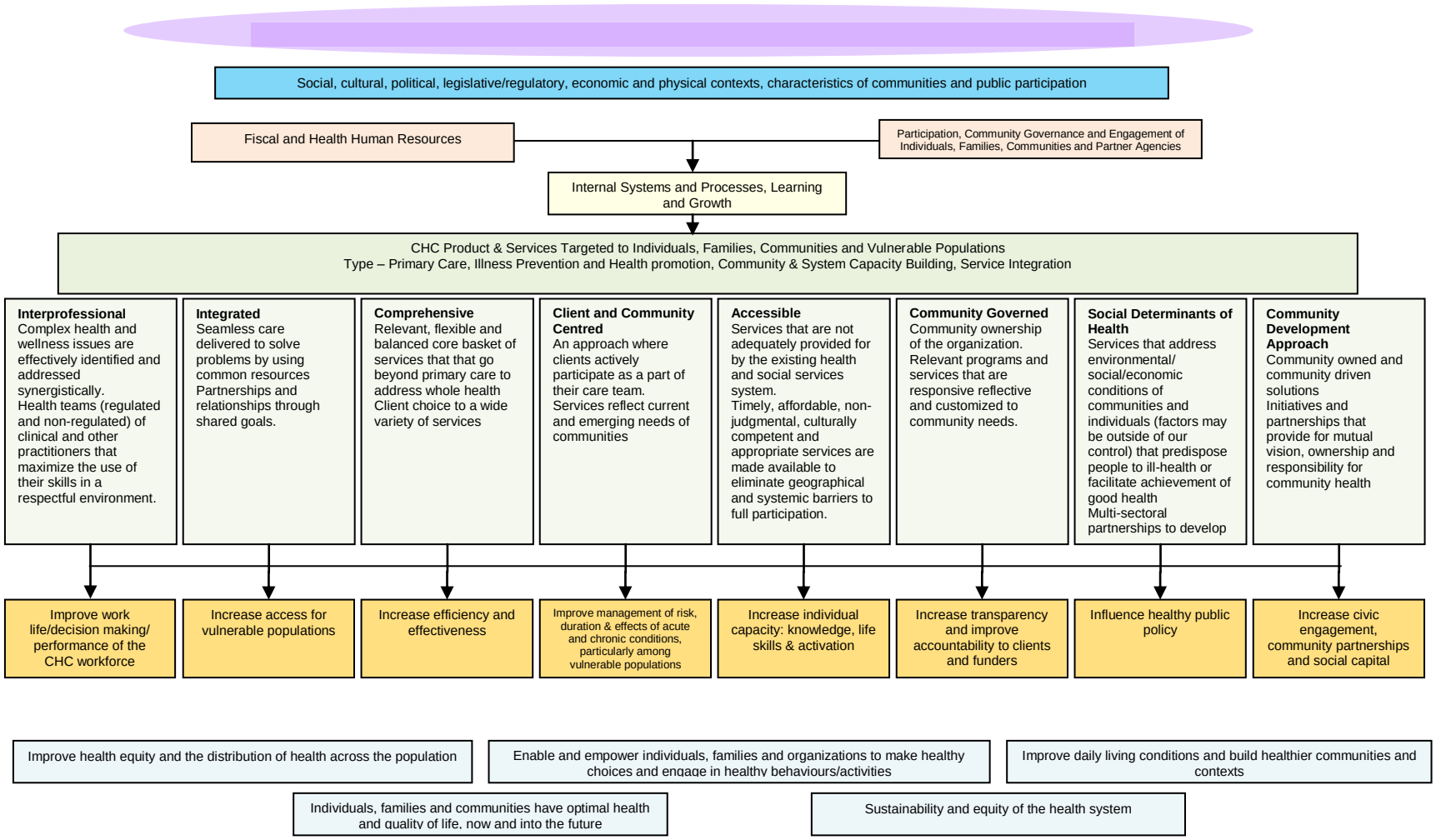
Based on the Social Determinants of Health: The health of individuals and communities is impacted by the social determinants of health including income, education, employment, working conditions, early childhood development, food insecurity, housing, social exclusion, social safety network, health services, Aboriginal status, gender, race and racism, culture and disability. CHCs strive for improvements in social supports and conditions that affect the long-term health of people and communities, through participation in multi and cross-sector partnerships and advocacy for the development of healthy public policy, within a population health framework.

Grounded in a Community Development Approach: The CHC services and programs are driven by community initiatives and community needs. The community development approach builds on community leadership, knowledge, and the lived experiences of community members and partners to contribute to the health of their communities. CHCs increase the capacity of local communities to address their community-wide needs and improve their community and individual health and wellbeing outcomes.

Population and Needs-Based: CHCs are continuously adapting and refining their ability to reach and to serve people and communities. CHCs plan services and programs based on population health needs and develop best practices for serving those needs.

Accountable and Efficient: CHCs strive to be high performing efficient primary health care organizations that are accountable to their funders and the people and local communities they serve. CHCs try to provide fair, equitable compensation and benefits for their staff. Capturing and measuring their work are essential parts of delivering Primary Health Care. Developing and implementing meaningful indicators based on our Model of Health and Wellbeing allows for reporting to all funders about services and programs delivered as well as the outcomes that follow**.**

Appendix B : CHC Results Based Logic Model (Under révision)



Appendix C Auditor's Questionnaire

This Auditor's Questionnaire is provided to give direction to auditors completing financial audits for CHCs. The 2006 version is the most recent questionnaire furnished by the MOHLTC.

1. We have verified that the attached financial statements agree with the books of the Community Health Centre.

2. We are familiar with the Ministry of Health Act and related Regulations, insofar as they pertain to financial and accounting matters, and insofar as they relate to the agency on whose financial statements we have reported.

3. We have reviewed all minutes of the following bodies up to (insert date)
   a) Board of Directors
   b) Finance Committee
   c) Audit Committee
   d) Other
   and in our opinion have satisfied ourselves that proper recognition has been given to all items recorded therein, which affect the financial position of the Centre.

4. We have reviewed the correspondence during the year between the "Name of LHIN" and the Centre as provided by the client (including the annual operating and financial guidelines) which has a direct bearing on its financial position or accounting system.

5. We have verified that funds flowed by the "Name of LHIN" in excess of current requirements were invested to earn additional revenue. We have also verified that the revenue earned on the above funds has been reported as revenue. (Please comment below if this is not the case.)

6. We have reported in writing to the Board of Directors in the form of a management letter any weaknesses in internal controls which came to our attention during the course of the audit which, in our opinion, might expose the Centre to a material loss of funds or other assets.

7. The terms of our engagement are covered in an engagement letter with the Board.

8. The Centre has complied with the previous audit recommendations in all material respects.

AUDITORS' COMMENTS:

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_____

Date: Signature of Auditor(s)

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