Community Health Centre

Requirements

November 2013

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1. Community Health Centre (CHC) Program

1.1 Model of Health and Wellbeing

The CHC is guided by the Model of Health and Wellbeing. It identifies eight attributes including: anti-oppressive and culturally safe;accessible; interprofessional, integrated and co-ordianted; community-governed; based on the social determinants of health;; grounded in a community development approach; population and needs-based; and accountable and efficient. For a full description see the attachment "The Model of Health and Wellbeing (2013) as referenced in Schedule D of the Multi-Sector Service Accountability Agreement.

1.2 Program Objectives

The CHC Program objectives are:

- to promote equity in access to health services
- to strengthen the role of the individual and the community in health and health care delivery
- to encourage linkages among health services and with social and other community services
- to develop comprehensive primary health care services which make the most efficient use of health care providers and health resources
- to promote health and prevent illness to enhance the health status of the communities served through a population health promotion framework

These objectives provide the framework for the accountability relationship between the LHINs and community health centres.

1.3 Principles for the Provision of Service

While the program focus may vary among CHCs, all centres subscribe to the following principles:

- CHCs provide accessible health care services through the optimal location and physical design of the centre; through carefully planned services that are culturally and linguistically appropriate; and through services that are available at times responsive to community needs
- CHCs provide client-centered services in a family and community context
- CHCs provide comprehensive primary care, health promotion and illness prevention services and community development initiatives.
- CHCs support individuals and communities to take responsibility for and control of their own health and health care.

1.4 Priority Populations

CHCs offer a range of comprehensive primary care, health promotion, individual and community capacity building and service integration activities in diverse communities across Ontario with an emphasis on priority populations identified by geography and/or population groupings.

A priority population has one or both of the following characteristics:

- face barriers to accessing an appropriate range of primary care services (e.g. geographic isolation, or cultural or language barriers); and/or
- a higher burden or risk of ill health due to social determinants of health, such as socio-economic status, age, environmental factors, social isolation, mental health issues, gender, sexual identity/orientation or other health determinants(e.g. chronic disease).

1.5 CHC Service Model

Key service components include:

- CHCs are non-profit corporations governed by a community-based board of directors.
- CHCs involve clients and community members in planning and developing programs.
- CHCs provide comprehensive primary care, health promotion and illness prevention services and community initiatives to a defined service area with an emphasis on priority populations.
- CHCs have interprofessional teams of salaried employees. Depending on the actual programs and services offered, CHC program staff may include physicians, nurse practitioners, nurses, dietitians, health promoters, social workers, community health workers, nutritionists, traditional healers, chiropodists, early childhood workers, therapists including physiotherapists , rehabilitation and occupational therapists; and chiropractors among others
- CHCs offer 24 hours access to primary clinical care.
- CHCs work in partnership with other health and community organizations providing services to the CHCs' client populations.
- CHCs provide co-ordinated services through interprofessional teams skilled in health care and related fields and integrated with the system of health and social services in the community.
- CHCs are mandated to provide services to people residing in Ontario who do not have OHIP coverage.

2 The CHC as a Non-profit Corporation & the Role of a CHC Board

2.1 Requirements of the CHC as a Non-Profit Corporation

- Shall be registered as a non-for profit organizations under the Corporations Act, Ontario or successor legislation; and
- governed by a community board of directors that involves members of the community.

2.1.1 A CHC shall ensure that:

- It has an established reporting relationship with their respective LHIN;
- it has access to legal counsel;
- it has access to an independent chartered accountant for auditing;
- its business is conducted in accordance with all applicable federal and provincial legislation; and
- its boards shall be supported by appropriate structures including a designated executive director or chief executive officer responsible to the board.

2.2 Governance Responsibilities of CHC Boards

2.2.1 A CHC's board of directors is accountable for ensuring that the CHC complies with its legal obligations under the Corporations Act, Ontario (or successor legislation): and to the LHIN in accordance with the terms of its service accountability agreement with the LHIN.

2.2.2 A CHC's board of directors is accountable for ensuring that the overall planning and decision making of the CHC facilitates the attainment of the goals and objectives of the organization and its programs.

A high performing CHC Board will ensure it implements its' four main roles:

1. Represent the Community:
- Act on behalf of the community and priority populations in catchment areas;
- Establish and ensure regular implementation of mechanisms to facilitate community input to, and assessments of the community to determine program priorities; and
- Be accountable to the community by proactively communicating and reporting back.

2. Lead the Organization
- Develop the strategic directions and policies in keeping with the goals and objectives of the CHC;
- Adopt and monitor the annual operating plan ; and
- Convene an annual general meeting of the CHC's members in accordance with the CHC's bylaws and governing legislation.

3. Evaluate the Organization:

- Recruit, evaluate, retain and terminate the employment of the CHC executive director (ED) or chief executive officer (CEO) whichever is applicable;
- Delegate the operations to the ED/CEO;
- Identify the risks and liability issues that the organization must manage and avoid;
- Regularly monitor the financial operations and capital budgets;
- Regularly evaluate policies and program effectiveness; and
- Ensure human resource policies are established and are in compliance with applicable legislation.

4. Use a Sound Governance System

- Practice governance discipline including orientation, holding regular meetings, meeting attendance, preparedness, participation, discussion, use of board policies, avoidance of conflict of interest;
- Hold regular meetings and ensure accurate recording of minutes of all official proceedings of the board and general meetings; and
- Evaluate board performance.

2.3 Recruitment of Members and Directors

2.3.1 The board of directors shall consist of a minimum number of three directors and a maximum of nineteen directors who collectively demonstrate a broad range of relevant skills and experience and reflect the community being served.

- exceptions to the maximum number of directors on the board can be made with the written consent of the LHIN.
- employees of the CHC may not be members of the CHC.

2.4 Officers of the Board

2.4.1 The board of directors shall elect the following officers at least annually:

- Chairperson – to preside over all board meetings; set the agendas for the meetings; act as the most senior spokesperson for the organisation both externally and internally;
- Vice-Chairperson – to assume the duties of the Chairperson when necessary;
- Treasurer – to ensure proper control over the financial affairs of the organisation;
- Secretary – to ensure that minutes and records of board meetings are maintained and distributed.

2.4.2 Only the functions of Treasurer and Secretary may be combined into a single position.

2.4.3 The board of directors shall ensure that a sufficient number of officers of the corporation have co-signing authority for cheques.

3. Service Delivery and Access

3.1 Access to Services

3.1.1 CHCs shall establish hours of operation that are responsive to community need including evening hours and where possible, weekend hours.

3.1.2 CHCs shall establish primary care hours of operation that include evening hours, and where possible weekend hours. During established primary care hours of operation, the reception desks of CHCs shall be staffed and clinical services shall be available to clients.

3.1.3 All CHCs will be required to provide extended primary care hours equivalent to 3-hours per FTE physician per week.

- Exceptions can be made where there are staffing limitations or shortages, or where extended hours would negatively impact the unique situation of a particular community and with written consent from the LHIN.

3.1.4 CHCs primary care service shall not be closed for more than three (3) consecutive days without prior written consent from the LHIN

3.2 Physician Services Available on a 24-Hour Basis

3.2.1 CHCs shall provide, or arrange for the provision of, and actively promote on-call physician services, on a 24-hours-a-day, seven-days-a-week basis for their ongoing primary care clients.

The CHC :

- may use physicians or a combination of physicians and nurse practitioners in meeting its on-call obligations.
- on-call services can be pooled across two or more CHCs, shared with other primary care agencies, or contracted out to another primary care agency or physician(s).
- shall keep the LHIN informed of any material changes in on-call arrangements.
- can be granted an exception to this provision (with written consent from the LHIN) where there are staffing limitations or in remote sites where access to other primary care providers is limited or non-existent.

3.2.2 These on-call services shall be made available to ongoing primary care clients for advice, information, self-care, scheduled appointments, referral to community services and to public hospitals emergency departments, where appropriate, and through mechanisms determined appropriate by the CHC (including telephone service).

3.2.3 CHCs shall advise all new clients of the availability of on-call services, as well as educating all clients through other forms of ongoing communication. When on-call arrangements are in effect, phone callers to the CHC shall be given a message advising them of the on-call arrangements that are in place.

3.3 Services for CHC Clients

3.3.1 CHCs may not charge individual CHC clients for any CHC activities funded by the LHIN.

3.4 Provision of Service to Non-Insured Clients

3.4.1 Within the resources provided by the LHIN, CHCs are mandated to provide services to people residing in Ontario who do not have OHIP coverage and are considered a priority population for the purposes of CHC services. This population faces significant barriers to accessing appropriate primary care.

3.5 Client Reporting

3.5.1 CHCs shall record and report all interactions with clients that receive services as per mechanisms designed in consultation with LHINs, CHCs and the Ministry of Health and Long Term Care.

3.6 Annual Client Survey

3.6.1 CHCs shall conduct an annual survey to ascertain client satisfaction with services and community stakeholder perspectives.

3.7 Quality of Care Audits

3.7.1 CHCs shall conduct regular audits of the quality of care provided by its professional staff.

3.7.2 Quality of care audits shall, at a minimum, be based on medical and professional standards set by the appropriate college or governing association.

3.8 Quality Improvement Plans

3.8.1 CHCs shall submit Quality Improvement Plans to Health Quality Ontario (HQO) on an annual basis. These plans will be in alignment with the direction and requirements from the HQO.