Alliance for Healthier Communities
Advancing Health Equity in Ontario

Evidence shows that CHCs Work

Community Health Centres (CHCs) are often said to be expensive and ineffective when compared to other primary care models in Ontario. This is based on outdated data. As a sector, we have worked hard to make continual improvements. The following facts (based on research and evidence) demonstrate that CHCs are a contributing primary care partner. The Alliance for Healthier Communities and our members believe that all primary care models are important and contribute to the health system. The information below is written in that spirit and meant to address the misinformation that we hear from stakeholders in the health system.

Myth #1: CHCs are expensive

- CHCs are funded for primary care as well as a broad range of services that address the social determinants of health of the community they serve. Most CHCs are multi-funded, which makes comparison to other primary care models challenging.
- The average cost per patient for clinical primary care is similar between CHCs and FHTs ($483 and $430 respectively in 2022/23) when costs are adjusted for age, sex and clinical diagnoses. Based on the adjustment, CHC clients are expected to require – on average – 68% more clinical primary care compared to FHT patients. However, the adjustment does not account fully for 57% of clinical clients living in poverty and additional determinants of ill-health that CHC clients may face
- The FHT costs include physicians working in FHTs (FHO) and the interprofessional team (FHT). (Often both are not included in comparisons). Additionally, while CHC costs are actual 2022/23 costs, the costs for FHTs are conservative because they are based on older data inflated to account for physician and interprofessional practitioner pay increases over the past 10 years.
    - *Note: To ensure equivalency in the comparison, the reported CHC costs are only for clinical primary care. The costs do not include costs for health promotion, community outreach, and other services required for serving such an at-risk population.*
- CHCs are saving $27M per year by reducing the need for ED visits.
    - CHCs provide care for a populations that are 68% more complex, on average, compared to the average Ontarian (on average FHOs/FHTs, serve the average Ontarians).
    - Despite this complexity, clients served at CHCs go to the ED less than expected - resulting in over $27M saved every year.
- CHCs partner with at least 10+ community organizations to provide additional programming and services which ensures people have access to connected, convenient and accessible care.

Myth #2: CHCs Physicians see fewer patients than other models

- Overall, CHCs are reaching 92% of expected panel (active clientss seen by a physician or nurse practitioner).
    - 16 CHCs are below target panel size due to challenging, complex populations, e.g. Northern, Indigenous & Francophone sites; racialized populations; and populations with very high mental health care needs or substance use.
- Clients counted in the CHC panel only include those seen within two years by a nurse practitioner (NP) or physician.
    - In other models, an estimated 22% of rostered patients have not seen their physician. When this 22% is excluded from calculations, CHC clinicians see as many or more clients actively.

    - An additional 500,000 clients who are rostered outside of the CHC (including those rostered to a FHT) receive non-primary care services at CHCs.
- CHCs proactively manage their panel size to make primary health care as accessible as possible.
- CHC nurse practitioners work to full scope and have their own case load of clients, unlike other models.

Myth #3: We don't know if CHCs are effective

Compared to other primary care models, CHCs have demonstrated, published results indicating:

- Superior chronic disease management.
- Patient- and family-centredness.
- Patient satisfaction.
- Positive team climate.
- Prevention activities.
- Health promotion.
- Internal and external coordination.
- Access to care.

Myth #4: The 2017 AG report was critical of CHCs

The 2017 AG report acknowledged CHCs' leadership in serving medically and socially complex clients, reducing social isolation, and meeting the needs of vulnerable populations. It also questioned the Ontario government's capacity to standardize CHCs and hold them accountable. Alliance members responded by building their individual and collective capacity for measurement and reporting

- Finding #1: No overall evaluation of primary care models in Ontario.
    - Since 2017, numerous published studies have demonstrated the high quality and accessibility of care at CHCs and their positive impacts on population health.
- Finding #2: Ministry of Health (MoH)/LHINs do not request utilization data on CHCs.
    - Since 2008, CHCs have reported performance & financial data quarterly as part of their accountability agreements. This data is available to the MoH & Ontario Health (OH) regions.
    - CHCs participate in OH's annual Quality Improvement Plan process with additional sector-specific indicators.
    - Active panel size is reported quarterly. On average, CHCs are at 92% of target.
- Finding #3: MoH does not have patient & provider data.
    - CHCs are the only primary health care model that collects standardized electronic medical record (EMR) data on clients, providers, and visits.
    - CHCs' EMR data is shared with MoH for accountability (and a data-sharing agreement with OH is in development) and with CIHI and ICES to inform system planning & population health research.
- Key Finding #4: MoH/LHINS have not defined what providers/services CHCs should deliver.
    - CHC data allows MoH and OH regions to examine the range of services offered.
    - Each CHC's provider mix is tailored to local needs and assets and to ensure health equity.
- Key Finding #5: No requirement for accreditation.
    - Despite not being mandated, Alliance CHCs undergo accreditation every 4 years.
    - No other primary care model in Ontario consistently undergoes accreditation.