Final Report

Planning and Implementation of an Innovative Francophone Community Health Centre Model for the Timmins Community

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PGF consultants

PGF CONSULTANTS INC.
202-291, RUE DALHOUSIE
OTTAWA (ONTARIO) K1N 7E5
BENOÎT HUBERT, PRÉSIDENT
TÉL. : 613 241-2251, POSTE 237
TÉLÉC. : 613 241-2252
COURRIEL : BHUBERT@PGF.CA

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SUMMARY

PGF Consultants was retained by the Réseau du mieux-être francophone du Nord de l'Ontario (RMEFNO) and the North East Local Health Integration Network (NE LHIN) to carry out planning and implementation of an innovative model for a Francophone community health centre in Timmins. This work has been fulfilled in close cooperation with the Timmins Francophone Primary Care Collaborative Committee established by the NE LHIN.

Drawing on the findings regarding the gaps and challenges in French-language health services identified in the report titled "*Examen des services de soins primaires destinés aux francophones de Timmins*" submitted to the NE LHIN in August 2016, this study focuses on the different components that would support the development of a community health centre.

The information and analyses contained in this report were informed by semi-directed interviews with executive directors and managers of Francophone and/or bilingual community health centres, a literature review, an online health service provider survey, discussion groups with key health stakeholders in Timmins, and working sessions held with consultants and the Francophone Collaborative Committee.

DELIVERABLE 1: INNOVATIVE MODEL FOR A FRANCOPHONE COMMUNITY HEALTH CENTRE

The expectation was that PGF would propose an innovative community health centre model for Francophones in Timmins and surrounding areas. The main components of this innovative model are:

- An interdisciplinary team that provides health prevention and promotion services, primary care and community support services;
- A holistic approach that targets Francophone individuals, families and communities;
- A vision that draws on the three health objectives of improving the patient experience, maximizing resources and improving the health of the entire population;
- A method of operation that focuses on developing partnerships with other service providers in order to remove gaps, meet needs and enhance the services available to Francophones;
- Governance by Francophones, for Francophones with several mechanisms to maintain strong Francophone community engagement.

DELIVERABLE 2: ALIGNMENT WITH THE ASSOCIATION OF ONTARIO HEALTH CENTRES MODEL OF HEALTH AND WELLBEING

The innovative model for a Francophone community health centre in Timmins meets the criteria of the Association of Ontario Health Centres Model of Health and Wellbeing. The model's attributes are as follows:

- Managed and governed by the Francophone community;
- Inter-professional, integrated and coordinated;
- Accessible;
- Accountable and efficient;
- Based on the social determinants of health;
- Population needs-based;
- Grounded in a community development approach;
- Anti-oppressive and culturally safe.

DELIVERABLE 3: RELEVANT PROGRAMS

The proposed programs align with the Francophone health challenges identified in the previous report. They focus especially on primary care, mental health, the health of pregnant young women and early childhood health, seniors' health and the health of people with chronic diseases. Each program and service was developed to provide integrated service throughout the continuum of care.

The programs will be supported by medical professionals including a physician and nurse practitioners, an interdisciplinary team consisting of registered nurses, practical nurses, social workers, dietitians and other health professionals, as well as early childhood educators and community stakeholders, in order to manage patients and individuals using the most appropriate resource with regard to the expected service.

Health prevention and promotion services as well as community support services will be made available to the entire community, whereas Francophones with no primary care provider will have priority access to primary care services.

For specific programs, it will be possible to receive referrals from other service providers with eligible Francophone patients. The interdisciplinary team will also be able to support other service providers in the community who do not provide this service to their clients.

DELIVERABLE 4: FOUNDING GOVERNANCE ET FINANCIAL MODEL

The key components of the founding governance are as follows:

- An annual community forum conducted with Francophone and bilingual organizations as well as individuals who would like to contribute to improving the health and wellness of the Francophone community;
- A general public meeting, in which only members are eligible to vote;
- A board of directors comprised of 7 to 11 Francophone community representatives, based on pre-established expertise and sensitivity profiles, elected for 3-year terms with the possibility of a maximum of two full terms;
- The following standing committees: Audit, Governance, Nominating, Strategy and Service Quality, French-Language Service Integration.

An interim nominating committee will be responsible for establishing the required board member profiles, conducting a call for nominations, evaluating and selecting candidates to be named to the interim board of directors. The interim board members will establish statutes and regulations, negotiate with the ministry and confirm the budget for the Timmins Francophone community health centre, analyze its location and recruit members to conduct the first general meeting in order to elect the centre's official board members.

The financial model examines various options with regard to volumes that will help to forecast the operating budget and capital required to establish the Timmins Francophone community health centre. Four key performance indicators provided by the Ministry of Health and Long-Term Care guided the analysis in order to ensure that the financial proposals meet field standards. The four indicators are as follows:

- Total centre expenses
- Number of full-time equivalent employees
- Number of visits/stays

- Number of patients seen during the year

These indicators helped establish the type and the number of professionals required to support the community health centre's programs, as well as the infrastructure cost estimates based on if the centre will be a new build or if an existing building will be renovated or leased. The goal of the financial model options is to guide the decision-making process.

DELIVERABLE 5: NETWORK PATIENT NAVIGATOR FOR FRANCOPHONES

It is recommended that the community health centre create a position for a network patient navigator, whose role would be essentially clinical in nature to coordinate care for vulnerable Francophone patients who are members of the centre or clients of a specialized program. This role is consistent with the three health objectives, specifically improving the patient experience, maximizing human resources and improving community health through service integration, patient support and referral to appropriate services.

This position will be an innovative asset to support the Timmins Francophone community health centre's operations and programs, particularly those targeting at-risk individuals and people with chronic conditions. The network patient navigator will serve as an essential resource in connecting Francophone patients with the French-language services available in the community. This in-depth knowledge of services will help identify areas where improvements are needed in order to improve and increase service delivery to Francophones through the centre. This will allow the centre's programs to evolve in tandem with unmet needs and findings supported by real-time data.

DELIVERABLE 6: NEXT STEPS

In September 2016, the report titled "*Examen des services de soins primaires destinés aux francophones de Timmins*" along with 15 recommendations were submitted to the NE LHIN. Since then, swift progress has been made to improve access to French-language primary care services for Francophones in Timmins. This study on planning and implementing a Francophone community health centre addresses many of the concerns raised and targeted in the recommendations. Also, this centre will certainly meet the primary care needs of Francophones in a very practical way. Services will be tailored to their needs, and the centre will help improve their health care experience. A number of tools are being developed by other French health service partners. These tools are expected to facilitate data collection and measure the supply and demand of French-language services with greater accuracy, and will enable evidence-based decision-making regarding French-language health services.

All in all, a number of initiatives appear to be coming together to improve health service delivery for Francophones in Timmins. However, the development of a Francophone community health centre, with its "by Francophones, for Francophones" approach, remains the focal point for improving the health of this population in a sustainable manner.

1. INTRODUCTION

PGF Consultants was retained by the Réseau du mieux-être francophone du Nord de l'Ontario and the North East Local Health Integration Network to reflect on the key elements for planning and implementation of an innovative model for a Francophone community health center and to develop an action plan based on other recommendations. This process draws on the report entitled "Examen des services de soins primaires destinés aux francophones de Timmins » submitted to the North East Local Health Integration Network in September 2016, from which emerged several recommendations with respect to improving access to linguistically and culturally appropriate services for the Francophone population.

One of the recommendations in the 2016 Report addressed the implementation of a Francophone community health centre in Timmins. This recommendation will be thoroughly examined with a focus on the planning and implementation elements for an innovative Francophone community health centre model for Timmins. The scope of our mandate includes the following six expected deliverables:

Deliverable 1: Propose an innovative community health centre model that will address the challenges and gaps identified in the report "Examen des services de soins primaires destinés aux francophones de Timmins" and fully benefit from local resources and partnerships to create a patient-based primary care model for the Francophone population of Timmins.

Deliverable 2: Ensure that the innovative community health centre model is aligned with the Association of Ontario Centres' Model of Health and Wellbeing, according to the following attributes:

- Managed and governed by the Francophone community
- Inter-professional, integrated et coordinated
- Accessible
- Accountable and efficient
- Based on the social determinants of health
- Population needs-based
- Grounded in a community development approach
- Anti-oppressive and culturally safe

Deliverable 3: Outline the primary care services and programs, including strategies for health promotion and prevention, that will be provided by the innovative community health centre model. When necessary, primary care services may be provided in cooperation with other health care providers in order to ensure that service overlap is minimized as much as possible, and that synergies among the primary care providers within the local system are maximized to benefit the Francophone population.

Deliverable 4: Prepare a cost-benefit analysis which covers the capital, clinical, and operational requirements related to the innovative community health centre model, as well as propose a strategy to develop a founding governance structure and recruit members. This work must also include a detailed project implementation plan with timelines and key stages.

Deliverable 5: Assist in defining the scope of the work, the role and responsibilities of a network patient navigator, who will contribute to move forward the implementation of the innovative community health centre model by providing assistance to the Francophones, for example: referral and orientation within the system, promotion of French language services, identifying service gaps and, if needed, identifying possibilities for potential new agreements or proposing changes to existing agreements with Francophone of bilingual facilities that could increase access – in person or through use of technology – to specialized services that are not locally accessible.

Deliverable 6: Work with the Collaborative Committee to identify other recommendations in the "Examen des services de soins primaires destinés aux francophones de Timmins" Report that have not yet been acted upon but should be addressed, and develop a multi-year action plan to address these recommendations. To the extent possible, the multi-year action plan should outline the activities to be undertaken, identify responsibility, and determine timelines for the execution of each activity.

1.1. OVERVIEW OF ADVANCES RELATED TO THE HEALTH OF FRANCOPHONES

The Francophone community of Timmins has been asking for the implementation of a community health centre for many years. However, no comprehensive study had been conducted to understand the gaps in service provision and how to fill these gaps, whether through the creation of a community health centre, through other initiatives, or a combination of both.

In 2015, the Local Health Integration Network (LHIN) issued a call for proposals to review the primary care services provided to the Francophone population of Timmins. PGF Consultants was retained to conduct a study with the following specific objectives:

- Gaining a better understanding of the socio-economic and demographic profiles of the Francophones who live in the City of Timmins;
- Reviewing existing documentation related to evidence-based practices and best practices arising from various primary care models;
- Analyzing the current status of local primary care resources to inform the assessment of unmet primary care needs and gaps within the community;
- Providing recommendations to improve the provision of primary care services to the Francophone community of Timmins.

The mandate consisted of collecting data to build a demographic and socio-economic profile of the Francophone community of Timmins, and information about the primary care services currently offered in the City of Timmins according to language. The primary care services as defined within the scope of this mandate also included health promotion and prevention services. The information collected would then be used to inform the North East LHIN and the Francophone community regarding the state of services provided, and assist in evaluating the needs and gaps, particularly with respect to the current capacity to provide French-language primary care services. We were to focus specifically on how services could be adjusted to improve the health of this Francophone population, as well as the system's performance.

The definition of "primary care services" used within the context of this study, and maintained throughout our work, is as follows:

Primary care consultations, diagnostic and treatment by physicians, nurse practitioners, and paramedical providers;

Health promotion and prevention services.

All conclusions drawn from the analysis pointed towards serious health challenges for the Francophone population of Timmins compared to the general population, related to, among other things, this community's demographic and socio-economic profile and health determinants. The analysis shows that the provision of French-language services is variable and inconsistent, there is a lack of clarity in the services offered in French, and there are no organizational policies related to active offer. Other important elements that came to light from this analysis were the shortage of bilingual health care staff and the lack of health promotion and prevention activities offered in French.

In September 2016, the North East LHIN's Board of Directors received a comprehensive report entitled "Examen des services de soins primaires destinés aux francophones de Timmins." This report provided 15 recommendations, including to begin working towards implementing a community health centre under Francophone governance.

1.2. AN APPROACH BUILDING ON CONTINUITY

The process undertaken within the scope of this mandate with respect to planning and implementation of a Francophone community health centre for the community of Timmins draws on the findings of the previous study.

This report lays the foundations for an innovative Francophone community health centre model that will meet the needs of the community by filling many gaps and improving the offer of French language health services, through an approach that provides equitable access to quality health services.

The main sections of this report focus on the six expected deliverables. The results of consultations, as well as the various analyses supporting the recommendations put forth by PGF, are integrated within each section.

2. PROPOSED MODEL FOR THE COMMUNITY HEALTH CENTRE (DELIVERABLE 1)

The proposed community health centre model is based on the results of the 2016 Report and was developed according to the following steps:

- Undertaking a review of the documentation related to community health centre models serving official language minorities;
- Conducting approximately ten semi-structured interviews with Executive Directors and Primary Care and Community Services managers in Francophone community health centres in Ontario. The purpose of these interviews was to identify best practices, innovative ideas, and technical information on other aspects, such as governance, recruitment and partnerships;
- Holding internal information- and knowledge-sharing sessions with other consultants associated with this project, in order to propose an innovative model that will be relevant for the Francophone community of Timmins.

2.1. WHAT IS A COMMUNITY HEALTH CENTRE?

Although there is no specific definition as to what constitutes a community health centre, many characteristics are found in this model. The Canadian Association of Community Health Centres proposes the following definition, which includes some key principles:

> "Community Health Centres are multi-sector health and healthcare organizations that deliver integrated, people-centred services and programs that reflect the needs and priorities of the diverse communities they serve. A Community Health Centre is any not-for-profit corporation, co-operative, or government agency which adheres to all five of the following domains:
>
> - Provides interprofessional primary care;
> - Integrates services and programs in primary care, health promotion, and community wellbeing;
> - Is community-centred
> - Actively addresses the social determinants of health
> - Demonstrates commitment to health equity and social justice." [1]

The key components of community health centres are also found in the Association of Ontario Centres' Model of Health and Wellbeing. This model is defined by its values and principles, which are common to all community health centres in Ontario, and by the following attributes:

- Managed and governed by the Francophone community
- Inter-professional, integrated et coordinated
- Accessible
- Accountable and efficient
- Based on the social determinants of health
- Population needs-based
- Grounded in a community development approach
- Anti-oppressive and culturally safe.

[1] See www.cachc.ca/2016survey/

The above attributes can be found in the community health centre model proposed for Timmins and will be examined in greater detail in Section 3 of this report.

2.2. STATE OF KNOWLEDGE AND FINDINGS REGARDING COMMUNITY HEALTH CENTRES

The 2016 Report referred to the provision of primary care services in minority language environments, and two models were presented: the centre Albert-Galliot (Manitoba) and the Saint Thomas Community Health Centre (Alberta). The latter center has interesting characteristics that are worth recalling.

SAINT THOMAS COMMUNITY HEALTH CENTRE

The Saint Thomas Community Health Centre (Alberta)[2] remains an interesting model, in that it provides primary care services, health prevention and promotion services, as well as a number of community services.

Saint Thomas is Alberta's first community-based Francophone health centre. It offers individualized service and one-stop, easy access to a broad range of health care professionals and services, community health-related education, and health promotion. This model was created in 2003, within the Government of Alberta's framework towards developing Primary Care Networks. The Networks include family physicians who work with Alberta Health Services and other professionals to better coordinate primary health services. Networks can comprise a clinic with several physicians, or many clinics on a given territory. The Networks are funded by Alberta Health Services.

Over the years, the Saint Thomas Centre was able to develop a range of integrated services geared to Francophones. The Centre has established several partnerships with other Francophone organizations, such as a nursing home, which allows for the expansion of its services.

By looking at various community health centres in Ontario that serve a Francophone or bilingual clientele, or that offer a given level of bilingualism by virtue of their designation under the French Language Services Act, we are able to draw a number of conclusions. For instance, most of these centres:

- Cover a large territory;
- Have a collaborative approach with other health or community organizations in the region they serve;
- Offer primary care services, health promotion and prevention services, as well as some community-related services;
- Provide primary care services to a clientele meeting specific criteria;
- Offer programs related to health determinants;
- Have an inter-professional approach;
- Provide a linguistic offer that can vary from one program to the next
- Have access to human resources whose language skills are in line with the language in which services are provided.

[2] Center's Web Site: www.cscst.ca

Appendix 1 outlines the list of elements that guided on reflection regarding the key components of a community health centre in a Francophone minority environment. The majority of these elements were supported through our discussions with Francophone and bilingual community health centres, which will be found in the next sub-section.

2.3. UPDATING OUR KNOWLEDGE REGARDING COMMUNITY HEALTH CENTRES

Within the context of our mandate, we conducted semi-structured interviews with the Executive Directors and managers in the following Francophone and bilingual community health centres:

- Centre de santé communautaire de l'Estrie;
- Centre de santé communautaire de Kapuskasing;
- Centre de santé communautaire de Témiskaming;
- Centre de santé communautaire du Grand Sudbury;
- Carrefour francophone de Toronto.

The information collected through these interviews guided our reflection regarding best practices and exploring the possibility for greater innovations that could assist in developing a model aimed at improving the health and wellbeing of the Francophone population of Timmins.

THE CREATION OF COMMUNITY HEALTH CENTRES

Most of these centres emerged as a result of a documented shortage of French language health services on their territory, and through concerted efforts by the Francophone community. Community mobilization is considered as being essential to the creation of a "by and for Francophones" community health centre that will meet their needs as a priority.

The majority of these centres now operate different service points across their territory to meet the needs of their Francophone communities. Some centres have focused their efforts on primary care services, particularly in rural regions with an aging Francophone population, while others have developed a strong community component that meets varying needs observed among their Francophone clientele.

These Francophone and/or bilingual community health centres have an approach based on the following main pillars:

- A patient-centred approach with an interdisciplinary team;
- A holistic approach based on the health determinants of the individuals;
- A service delivery approach that not only takes into account the needs of the Francophone community, but is also aimed at reducing inequalities in access to health services, especially for those individuals who are more vulnerable, marginalized, or who have multiple health challenges (serious cases in the traditional system.)

The strength of community health centres lies in their ability to align their programs to the needs of the Francophone population, and to establish strategic partnerships based on those needs. It is deemed essential that this model be grounded in the community and continuously fed by it, through its governance, management that focuses on a continuous dialogue with the community, and the implementation of consultation mechanisms.

THE EVOLUTION OF COMMUNITY HEALTH CENTRES

The evolution of community health centres and their satellites is usually consistent with the specific emerging needs of the population. However, this ability to adapt must be supported by an operational structure that is relatively flexible, encourages innovation, builds on ongoing training and technological development, etc.

The following key elements arose from the interviews:

- The evolution of increasingly interdisciplinary work teams;
- Careful allocation of health care professionals in relation to the service required by the patient. By providing the best cost-effective service, centers can maximize the use of human resources and capitalize on a complementary interdisciplinary approach;
- The introduction of coordination mechanisms and tools for interdisciplinary teams to support a patient-based care approach that takes his or her preferences into account;
- The development of mental health programs and services;
- The development of integrated programs and services, coupled with efficient mechanisms of coordination among them, especially for chronic illnesses that require a high level of care
- In some cases, the addition of collateral/related community services such as legal aid, housing, and employment assistance;
- The decompartmentalization of the primary care and community services components in the design of workspaces to encourage synergies, the pooling of expertise, and complementary referrals.

Best practices

Through these discussions, we were able to identify several best practices that should be considered in the development and implementation of the Francophone community health centre model for Timmins, such as:

- Implementation of mechanisms to support an emerging interdisciplinary culture, for instance, holding weekly meetings with clinical and community services staff to discuss complex cases, follow up on care plans, etc.
- Creation of a position to assist with coordination and system navigation, thus ensuring the quality and continuity of care and services, and facilitating transitions with other care providers; this position would preferably be filled by a person with a nursing profile;
- Development of a community presence strategy that not only facilitates the development of coherent partnerships, but also encourages the Francophone communities ongoing engagement, with a view to improve services and to evolve in relation to emerging needs;
- Developing standardized procedures for intake and new patient files that include a rigorous needs analysis, and that support internal and external referrals to appropriate support services in order to improve the health and wellness of the centre's patients.

HUMAN RESOURCES

We were able to receive clarification regarding team composition in community health centres, challenges related to recruitment, and interactions with other community service providers.

In most centres, we found an administrative team, a clinical team, and a community team. Resources are allocated in a way that supports their prioritization of services.

The administrative team is usually comprised of the following positions:

- an Executive Director
- a Clinical Manager
- one (or many) Administrative Assistant
- one (or many) Receptionist
- a person responsible for the infrastructure maintenance.

Based on their size, some centres have additional resources to handle finances, human resources, data and statistics, information technology, etc. Other centres prefer to entrust these tasks to managers and staff according to their skills, or to sub-contract this expertise to external sources.

The interdisciplinary primary care core team is often composed of:

- A medical expertise provided by physicians or nurse practitioners, or a combination of both. Due to difficulties with recruiting Francophone physicians, the medical staff in community health centres in Northern Ontario is often composed of nurse practitioners who receive support from consulting physicians, as needed, either in person or through telemedicine;
- A complementary interdisciplinary expertise that generally consists of registered nurses, registered nursing assistants, social works and dieticians. Some centres also receive additional support from pharmacists, psychologists, chiropractors and/or physiotherapists, or other professionals in their catchment area who are interested in collaborating with the community health centre. Some centres occasionally rely on professional services provided by dental hygienists and optometrists to meet the needs of their clientele.

The community component team usually includes a coordinator and employees working in health promotion and prevention, community development, and childhood education. Some centres also have a volunteer coordinator who facilitates the supervision and execution of community activities.

Obviously, each community health centre develops job profiles in accordance with its own specific needs within the total service continuum. Such flexibility allow centres to efficiently allocate the functions and tasks inherent to the centre's operation without necessarily having to take into account the clinical and community segmentation in the deployment of human resources. For instance, a social worker could be assigned responsibilities in the interdisciplinary clinical team, such as providing individual consultation services or therapy, as well as in the community team, such as developing public awareness workshops. A similar scenario could be seen with respect to registered nurses and registered nursing assistants, where their role could encompass providing treatment support to medical practitioners, working with patients, and providing health promotion and prevention activities.

A few ideas to facilitate recruitment of healthcare human resources

The interviews allowed us to draw upon several elements of reflection that will assist in developing a recruitment strategy geared to health care professionals.

A crucial element consists of establishing partnerships with schools, colleges, and universities offering health care programs in order to attract trainees who could potentially be interested in a career in a community health centre after graduation. The Northern Ontario School of Medicine, Laurentian University, as well as Collège Boréal, should be given priority with respect to the Francophone community health centre in Timmins.

Partnerships should also be considered with organizations such as Hôpital Montfort, the Consortium national de formation en santé (CNFS), and Société santé en français (SSF), key players in the field of French language health services that have developed several tools and partnerships geared to support training and/or recruitment of the future Francophone health care workforce in Ontario and elsewhere across the country.

It may also be possible to use telemedicine via the Ontario Telemedicine Network (OTN) to access the required expertise. The implementation of an OTN system within the new Timmins Francophone community health centre should be considered. The system could be used not only for the centre to access expertise that is not available in French locally, but also to support other providers who may need access to French language expertise as well.

In terms of recruitment, the Timmins Francophone community health centre could:

- Ensure its visibility in job fairs with a health component in Ontario, as well as Quebec and New Brunswick;
- Invest in the professional development of a local resource who has demonstrated an interest and ability to pursue further studies and acquire a certification in high demand. For example, a registered nurse could wish to become a nurse practitioner;
- Explore the possibility of offering employees the Healthcare of Ontario Pension Plan (HOOPP); although this plan is costly, it could be an incentive in attracting health care professionals who are currently employed and may be interested in bringing their expertise to a community health centre.

COMMUNITY HEALTH CENTRES' PROGRAMS AND CLIENTÈLE

Most of the community health centres we interviewed provide primary care services, health promotion and prevention services, as well as community support services, the proportion of which varies in accordance to their respective strategic priorities[3]. High-level discussions were held regarding these centres' programs, following a review of the available information on the web. The information collected served to guide our reflection on what options should be explored for the community health centre in Timmins.

Criteria for access to services and programs

It was noted that the criteria for access varied in relation to the nature of the services and programs. Furthermore, when a community health centre is recognized as being Francophone, it favours the French language in its overall operation – from governance, to administration, to service delivery. In a minority situation, this criterion is particularly important to ensure the maintenance of a Francophone environment that meets the needs of its community. That being said, several health centres are willing to accommodate Indigenous and Anglophone patients who show up at their doorsteps.

In terms to access to a physician and/or nurse practitioner, such access is reserved to registered patients (or "members") of the community health centre. Typically, persons who can become members are either "orphaned" patients, persons with no access for a physician or a nurse practitioner, or those who wish to change their health provider in order to receive primary care in their preferred language.

[3] Appendix 3 of this report provides details on the programs offered by the health centres in Kapuskasing, Estrie and Toronto.

Access to the interdisciplinary team is usually more flexible, although priority is given to the centre's patients. It is possible to widen access in order that any person in need can use the services, with or without a referral from their primary care provider.

The criteria for access to specific programs are usually related to the specific health component covered by the program. Such programs can accommodate patients referred by external providers, as long as they exhibit the health complaint covered and meet the eligibility criteria.

Community services are normally accessible, without restriction, to the community as a whole. Activities are held in French, but Francophiles and Anglophones are welcome. Such activities are also considered as opportunities to promote the "Francophonie" in the community.

COLLABORATIONS AND PARTNERSHIPS

Over the years, most of the community health centres who took part in the interviews have developed several partnerships and agreements with local organizations and agencies. However, it seems that these partnerships were not developed as a means to facilitate service integration and/or contribute to the enhancement of existing services offered by other providers. Rather, the partnerships usually allow the centre access to expertise or services that are simply not available at the centre, for example, transportation or catering services. There are also partnerships with "neutral" organizations in the community (for example: schools, nursing homes, and cultural centres) that can be helpful in creating programs and public education workshops to meet specific needs.

Complementarity is always desirable but can be difficult to achieve in a context where funding of community organizations is problematic, especially when these same organizations fail to meet the expected outcomes set out by their funding agency. This results in the creation of a "competitive climate" that may perhaps be involuntary, yet reinforces an organization's position and their inability to see any benefit in increasing their offer of French language health services to any extent other than to meet compliance requirements. In some extreme, yet very real cases, this can even lead to discouraging active offer of French-language services and/or referral of Francophones to organizations that provide the service in French.

Given this context, it is evident that the implementation of the Timmins Francophone community health centre will require the support of the health system's key actors in facilitating synergies among the providers, in order that a complementary offer of health services can be developed.

Furthermore, the centre must be able to rely on the local and regional authorities that have the capacity to identify gaps and needs, for instance, through French language health service plans, and to encourage collaboration with the community health centre, in accordance with its mandate.

Technology-related elements

In light of the information collected through the interviews, it is deemed important that the Timmins Francophone community health centre consider implementing Ontario Telemedicine Network (OTN). In any minority environment, telemedicine is a tool that can ensure the sustainability of services and also allow the population to access specialized services that are otherwise difficult to receive in French outside the major centres.

Software

We have reviewed the information pertaining to the software used in Francophone community health centres. The majority of centres in Ontario use the "PURKINGUE" software. Most centres are reluctant to invest in other software, such as PS Suite or Meditech, mainly for financial reasons. In addition, many believe that hospitals, pharmacies, and other health care service providers in their territory, all use different systems. Nevertheless, it would appear that the PURKINGUE software provides a satisfactory level of collaboration and information-sharing with other providers, and some centres have recently proceeded to update their software. It will be up to the Timmins community health centre to determine which software will be best suited to manage case files and facilitate follow-ups and information-sharing with other service providers.

2.4. CHALLENGES AND GAPS TO BE ADDRESSED BY THE CENTRE

The implementation of a community health centre was part of a number of recommendations put forth in the 2016 Report which, once they were implemented, had the potential to meet the identified needs and gaps, and improve the situation of the Francophones population of Timmins. By its very definition, a community health centre offers programs aligned with the needs of the population. It is therefore important to reiterate the main results that arose from the « Examen des services de soins primaires destinés aux francophones de Timmins ».

CHALLENGES PERTAINING TO THE ORGANIZATION OF CARE AND THE OFFER OF FRENCH-LANGUAGE SERVICES, NAMELY:

- Challenges pertaining to access to health care in French;
- Challenges pertaining to hiring of health care professionals with the capacity to work in French (challenge increases in proportion to the level of specialization of the professional);
- Challenges pertaining to system navigation in French;
- Challenges pertaining to continuity of care in French;
- Challenges pertaining to the lack of consistency in the offer of French-language services, which varies from one organization to the next, or even throughout the day;
- Challenges pertaining to the lack of clear policies regarding French language services;
- access to health care in French;
- Challenges pertaining to the lack of active offer in French;
- Challenges pertaining to the fact that that providers say they do not offer French language services because there is no demand;
- The "Francophonie" element is practically non-existent in care providers' governance mechanisms;
- Challenges pertaining to the rule by which physicians cannot choose their patients (for example, choosing only Francophone patients);
- Challenges pertaining to the almost total absence of specialists who can provide services in French (for example, psychiatrists);
- Challenges pertaining to the lack of a "Francophone" space in terms of health care.

THE HEALTH OF THE TIMMINS FRANCOPHONES BASED ON THEIR DEMOGRAPHIC AND SOCIO-ECONOMIC PROFILE

- The Francophone population in Timmins is older than the population as a whole, and this difference is relatively significant. The frequency and complexity of interventions increase with age.
- Several socio-economic characteristics of the Francophone population of Timmins suggests challenges related to health determinants, such as lower levels of education, and education focusing on trades, which result in Francophones employed in jobs requiring less education and in higher-risk and precarious environments.

THE HEALTH OF THE TIMMINS FRANCOPHONES BASED ON WELLNESS INDICATORS

- According to studies on the health of Francophones in a minority situation, it is possible to assume that, as is the case with other Francophones in a minority situation, the Francophones of Timmins:
  - view themselves as having poorer general health;
  - view themselves as having poorer mental health.

THE HEALTH OF THE TIMMINS FRANCOPHONES BASED ON THE INDICATORS RELATED TO BEHAVIOURS AFFECTING HEALTH

- Having observed the indicators related to behaviours that affect the health of the Timmins Francophones, it can be concluded that they:
  - smoke more;
  - are more exposed to second-hand smoke;
  - drink more alcohol;
  - are more likely to have children at a younger age.

THE HEALTH OF THE TIMMINS FRANCOPHONES BASED ON THEIR USE OF HOSPITAL SERVICES

- Francophones use services of hospitals in a proportion greater than expected, which suggests potentially serious challenges in certain health sectors, such as:
  - endoscopy
  - oncology
  - cardiopulmonary service
  - angiography
  - electroshock therapy

THE HEALTH OF THE TIMMINS FRANCOPHONES BASED ON HEALTH ISSUES

- By extrapolation, it is possible to think that, compared to the majority, the Francophones of Timmins are more susceptible to the following symptoms:
  - arthritis
  - diabetes
  - asthma
  - high blood pressure
  - chronic obstructive pulmonary disease
  - pain, discomfort and limitations
  - high body mass index
  - mental health

2.5. PROPOSED MODEL FOR THE FRANCOPHONE COMMUNITY HEALTH CENTRE

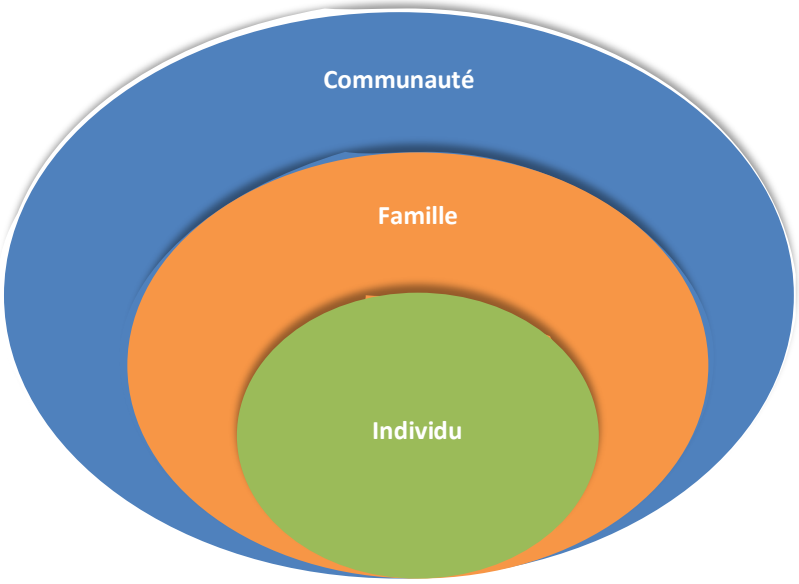
As we previously demonstrated, the Francophone community of Timmins is facing health-related challenges and gaps, with respect to the organization of health care and offer of French-language services, as well as the health status of this population. The demographic profile and socio-economic characteristics

of the Timmins Francophones result in additional challenges for this population in comparison to the majority. Although the proposed model is certainly not the only means of addressing all the challenges and health-related gaps for this population, it is our opinion that it will help in improving the situation in many respects.

The community health centre model will focus on primary care health services to address the needs and gaps identified in 2016, in order to provide a concrete and complementary response towards improving equity and access to health services for the Francophone population of Timmins.

We are proposing a holistic approach with a varied offer of services focused on the **health of individuals**, **the health of families**, and **the health of the community**.

FIGURE 1 : IMPACT DU CENTRE



GOVERNANCE

A community health centre “by and for Francophones” remains the best way to ensure that the community concretely assumes responsibility for its health and the means to achieve it. A fundamental characteristic of this community health centre will be a **Francophone governance**, composed of individuals from the community, which will operate in French. The essential elements of the Centre’s governance, namely the composition of the Board of Directors as well as the methods of operation, will be discussed in greater detail in the fourth deliverable.

In general, the policy governance model, also known as the “Carver model”, is the prevailing model in Francophone community health centres in Ontario. However, the implementation of this model, including how it is applied to current activities, varies from one centre to the next.

Most community health centres allow Francophones to become “members”, without necessarily becoming patients. This concept can take many forms. Some centres limit the number of members, while others encourage the largest possible number of persons to become members, in the hope of increasing the

Francophone community's sense of belonging towards the Centre. The membership concept includes various functions and can serve as a political and social lever to mobilize the community when it is

necessary. Being a member does not give any privilege in terms of accessing the Centre's services, however it provides individual members with a voice at the Centre's annual general meeting. In light of the importance this role can play towards the sustainability of the Centre's Francophone governance, care should be taken to ensure that members are part of the Francophone community, and it would be wise to have them sign a form by which they confirm their commitment to the Centre's purpose and values.

In their selection process for the members of the Board of Directors, which is usually composed of 7 to 11 Directors, some centres choose a regional representation within their territory, while others prefer a representation based on the type of clientele they serve and/or their service priorities, and others focus on diversity in terms of the required expertise. Ideally, there should be a balance among these approaches, while ensuring that the members of the Board of Directors, notwithstanding their profession, protect and defend the interests of all the Francophones in Timmins.

Governance "by and for Francophones" as well as the manner in which it will be developed within the Timmins Francophone community health centre are discussed in the fifth Deliverable.

A COMMUNITY HUB

Taking into account the needs identified by community representatives during the consultations leading to health-related needs study, it seems appropriate to propose a model that goes beyond a primary care offer, and provides holistic and sustainable interventions, with a view to improve the health and wellbeing of individuals, families, and the Francophone community as a whole. In this context, it is totally relevant to examine the possibility of creating a community hub for the Francophone population.

According to the Government of Ontario's definition, community hubs serve as a central, physical, or virtual access point, which:

- offer services in collaboration with different community agencies and service providers;
- reduce administrative duplication;
- improve services for residents and are responsive to the needs of their communities.

That being said, every community hub is unique and defined by the needs, services, and resources of the region it serves[4].

Consequently, it would be appropriate for the Timmins Francophone community health centre to examine the possibility of creating a community hub that would allow or facilitate access to a wide range of French-language services (social, cultural, recreational and health-related). It is important to note that such a hub could exist physically, in a building, or be virtually accessible.

The centre's ability to draw partners and create community collaborative spaces will be crucial in determining which form the community hub will take. Furthermore, the hub concept would be an excellent vehicle for the centre to reveal its community values and play a leadership role by bringing together Francophone services and expertise, in order to increase synergies and fluidity in service delivery to the Francophone community through a coordinated approach. Sharing workspaces with French-language

[4] See https://www.ontario.ca/page/community-hubs

service providers in the region would foster closer collaboration among Francophone stakeholders, and facilitate knowledge- and information-sharing regarding the needs of the Francophone community. This

would be useful in identifying gaps and improving the offer of French-language services, in a coordinated and complementary manner.

It will be important to keep in mind the need to ensure continuity between the centre's raison d'être and values, and the strategy undertaken to mobilize the community partners.

TYPES OF SERVICES OFFERED

The community health centre services must meet the health-related needs with a view to achieve sustained improvement to the health of individuals, families, and the Francophone community of Timmins.

Consequently, the centre should adopt an integrated intervention approach to the health care continuum, particularly in terms of prevention, treatment, and support to recovery. Services should be offered according to the three following intervention areas:

- health prevention and promotion services;
- primary care services;
- community support services

In each intervention area, the offer of services will be developed with a view to support individuals, families, and the community, but the impact may be variable. As shown in the following table, the primary care services will have a greater impact on the health of individuals, especially for those individuals in a vulnerable situation. Depending on the programs, health prevention and promotion services could positively influence all three targets (individuals, family, and community), while community services will have a greater impact on families and the community.

Tableau 1 : Impact variable des services sur les individus, les familles et la communauté

	SANTÉ DE L'INDIVIDU	SANTÉ DE LA FAMILLE	SANTÉ DE LA COMMUNAUTÉ
SERVICES DE PRÉVENTION ET DE PROMOTION DE LA SANTÉ	++	++	+
SERVICES DE SOINS PRIMAIRES	+++	++	+
SERVICES DE SOUTIEN COMMUNAUTAIRE	+	++	+++

This being said, such services, coupled with the fact that they are offered in French, under one roof, in a collaborative environment that capitalizes on the complementarities and expertise of an interdisciplinary team to offer patient-centred services, will surely have a significant impact on individuals, families, and the Francophone community as a whole.

UNDERLYING PRINCIPLES FOR THE THREE PROPOSED SERVICE AREAS

We propose the following underlying principles to guide the implementation of each intervention area as mentioned above for the Timmins Francophone community health centre.

Health Prevention and Promotion Services

- Services that focus equally on the health of individuals and families, which will also have a significant impact on the health of the community;
- Programs designed to meet the needs regarding French-language health prevention and promotion offered in Timmins in collaboration with local agencies and organizations, and ensure continuity for the centre's programs and services;
- Services offered in French, but open to all, to foster "living together" in harmony and promotion of the French fact (raising awareness);
- Programs based on the demographic and socio-economic profile of the Francophone population of Timmins (health determinants) and identified issues;
- Services offered primarily to the population of the City of Timmins and surrounding areas, without being too restrictive in defining its territory.

Primary Care Services

- Services that focus mostly on the health of individuals, with health-related benefits for families and the community;
- Primary care services for orphaned patients, with priority being given to chronic diseases prevailing among the Timmins Francophone community;
- Coordination of care services to improve service quality, efficiency of services, and the experience of the centre's Francophone patients being referred to specialized programs;
- Involving health care professionals early in the centre's planning process to ensure coherence in the offer of services and the design of plans, purchase of equipment, human resources planning – in terms of role- and responsibility-sharing, organization of services, development of collaboration mechanisms for the interdisciplinary team, implementation of protocols for coordination of care with other service providers in the community,
- Expansion of the team as more services are added;
- Services offered to registered patients, therefore the centre's patients – priority will be given to Francophone orphaned patients and referred patients;
- Services provided entirely in French with a capacity to offer them in English for a bilingual clientele, especially since access to a physician or health professional in Ontario cannot be restricted to the patient's language;
- Services offered primarily to the population of the City of Timmins and surrounding areas, without being too restrictive in defining its territory.

Community Support Services

- Services aimed at improving the health and wellbeing of the community as a whole, which will also have positive effects on the health of individuals and families;
- Complementary services that address health determinants in order to decrease the vulnerability of individuals, families, and the community, in the spirit of solidarity, mutual help, and community development;
- Leadership role in mobilizing stakeholders from health and related sectors, to reflect on the optimum development of the Francophone community, and to encourage joint initiatives as well as the development of multi-sectorial partnerships to enhance its vitality;

- Leadership role in mobilizing the Francophone community, creating a sense of belonging, providing opportunities to celebrate, meet, exchange, and share, in order to strengthen the social fabric of the Timmins "francophonie"

- Services offered in French, but open to all, to foster "living together" in harmony and promotion of the French fact (raising awareness);
- Services offered primarily to the population of the City of Timmins and surrounding areas, without being too restrictive in defining its territory.

INTER-PROFESSIONAL APPROACH

An inter-professional, integrated, and coordinated approach to the services offered by the community health centre must be central to the organizational culture. Mechanisms and protocols must be developed to support the interdisciplinary teams in work organization, decision-making processes, and integrated client-centred treatment and monitoring plans. It will be also be necessary to consider allocating resources for internal and external coordination. The proposed inter-professional approach will help to maximize resources by creating synergies that will facilitate the development of rigorous treatment plans that truly address the needs of the population, while improving the patient experience.

QUALITY ASSURANCE

The community health centre will adopt the Triple Aim concept introduced by the Institute for Healthcare Improvement (IHI), which proposes improving health systems by building on the following three factors:

- Improve patient experience in terms of the care and services received;
- Optimize utilization of resources;
- Improve the health of the population as a whole.

The design of the model targets the five following components to achieve Triple Aim [5]:

- Focus on individuals and families;
- Reconfiguration of primary care services and structures;
- Management of the population's health (promotion and prevention);
- Cost control platform;
- System integration.

The centre will need to develop protocols regarding the arrival of new patients and define the components of such protocols, for example, health assessment, vaccination update, needs analysis, referrals, assignment to a case manager. Furthermore, evaluation and monitoring mechanisms will have to be developed and systematically integrated within the centre's clinics, programs, and services.

OTHER ELEMENTS THAT DEFINE THE MODEL

Accountability to the Community

The community health centre will have to implement accountability mechanisms and report regularly to the Francophone population of Timmins, for example: by way of an Annual general assembly or community forum.

Reliable Data Collection

[5] See Appendix 1 for additional information regarding this model.

The community health centre shall implement appropriate methods and systems to collect reliable data. The development of data collection tools shall take in consideration how the collected data will be utilized, for example: service planning, improvement of services, supporting funding requests, providing accountability to the community.

Community Feedback Mechanisms

The community health centre shall put in place mechanisms that allow the Francophone population of Timmins to provide comments and ideas about the relevance and improvement of its services. The Francophone population of Timmins must feel that the centre reflects its needs and aspirations.

Evaluation

On a regular basis, the community health centre and, by extension, its programs shall undergo an external review that will focus on the relevance and quality of services offered, as well as their capacity to meet the needs of the population, in accordance with the principle of continuous improvement.

Collaboration

It will be crucial for the community health centre to put in place mechanisms to create and maintain links with other health agencies in the region, other Francophone organizations, and relevant provincial or national organizations. In this respect, a mechanism fostering collaboration among organizations in terms of program planning could be established to encourage and facilitate synergies among the various organizations, as well as real complementarity between programs. An example is the Health Links approach, with which the centre would be well advised to create opportunities for close collaboration.

Bilingualism

Although the community health centre is a Francophone organization that provides French-language services in priority to the Francophone population, it will be important to adopt an inclusive approach involving the other communities on its territory. Furthermore, in cases where the centre's employees are able to offer services in other languages, such information should be provided to the clientele. That being said, active offer in French must be present at all times, in person and by telephone.

Training

The community health centre must invest in an ongoing training program to ensure that employees maintain a leading edge in terms of health-related approaches and trends (i.e. collaboration, planning, diagnostics, delivery), and current issues, such as inclusive management which takes a new look at intercultural challenges related to immigration, First Nations, and the Anglophone majority. Other training can also be provided to support continuing improvement and the centre's strategic decisions.

Human Resources

With a view to facilitate the recruitment and retention of Francophone health professionals, the centre will have to offer competitive working conditions, similar to those offered in the region's other health organizations.

3. ALIGNMENT WITH THE HEALTH AND WELLBEING MODEL (DELIVERABLE 2)

This section of the report outlines how the community health centre model proposed by PGF Consultants meets the criteria of the Association of Ontario Health Centres Model of Health and Wellbeing[6].

The Association of Ontario Health Centres developed the Model of Health and Wellbeing that is being defined, firstly, by the values and principles common to all health centres in Ontario and, secondly, by the attributes of the said model.

The attributes include eight elements that influence each other, with a view to enhance and maximize the benefits for the health and wellbeing of individuals and communities.

The proposed model for the community health centre should draw on these attributes, and furthermore, integrate them in its purpose and implementation. Appendix 4 provides all the information related to the components of the model.

3.1. ALIGNMENT BETWEEN THE PROPOSED MODEL AND THE HEALTH AND WELLBEING MODEL

How does the community health centre model proposed for the Francophone population of Timmins align with the attributes of the Association of Ontario Health Centres Model of Health and Wellbeing? To answer this question, we will examine each attribute separately. Although the centre's programs, or the policies and procedures that will be put in place in the centre, may meet these attributes, the model also, whether in a general or specific manner, also meets these attributes.

ANTI-OPPRESSIVE AND CULTURALLY SAFE

Even though the Timmins Francophone community health centre targets primarily a Francophone clientele, we propose that the centre be able to serve a diversified clientele in terms of sexual orientation, language and culture, from the region's LGBT, immigrant, Aboriginal or Anglophone community.

Accordingly, we suggest that the centre's employees undertake appropriate training to support the creation of an inclusive, open, and safe work environment, in keeping with interdisciplinary collaboration among colleagues, and the patients' cultural and language preferences.

ACCESSIBLE

[6] https://www.aohc.org/model-health-and-wellbeing

The centre must be accessible to everyone. All interventions, from reception to the provision of services, will apply to every sector of the population, regardless of health condition, socio-cultural status, ethnicity, or language. Without including details regarding every single element in the proposed model, an optimal level of accessibility will be required in terms of the centre's site, physical accessibility, etc. Staff training will be an important factor in ensuring the implementation of a centre where every patient feels welcome and cared for in equal measure, regardless of their social, cultural, economic or ethnic characteristics.a«

INTER-PROFESSIONAL, INTEGRATED AND COORDINATED

The proposed model shall include an inter-professional, integrated, and coordinated approach. As previously mentioned, mechanisms will have to be put in place in order to create inter-professional teams that will work with other components of the centre and the system. This approach will initially allow the community health centre to maximize its resources, and will also ensure an integrated and complete experience for its patients. In terms of governance, we propose the establishment of mechanisms that will ensure optimum collaboration among the various services offered by the centre and, as such, seamless integration of services as well as effective and efficient coordination resulting in a high-level offer of services.

MANAGED BY THE COMMUNITY

The proposed model will encourage community engagement in various ways. Firstly, a Francophone governance will ensure a high level of engagement from the Francophone community. The fact that members of the Board of Directors come from various sectors of this community will ensure a broader representation of the Francophone community. Secondly, implementing accountability mechanisms will be helpful in keeping the community informed about the centre's activities and initiatives, as well as the results achieved in various areas, and provide an opportunity for the community to react. Thirdly, and in relation to the second point, the model proposes that to put in place feedback mechanisms in order to obtain ongoing comments and suggestions from members of the community.

In addition to governance and formal accountability and feedback mechanisms, the fact that the centre's workforce will consist of Francophones from Timmins, and that they will work with other Francophone organizations in the region, demonstrate the community's direct participation in the management of the centre.

BASED ON THE SOCIAL DETERMINANTS OF HEALTH

The 2016 report referred to determinants of health and the fact that a review of the socio-economic profile of the Timmins population suggested that this population faces certain challenges related to these determinants. The future centre's program should draw on these social determinants in order to meet the needs of Francophones in terms of health. In addition, the determinants of health will serve as the foundation for the development of health promotion and prevention services, as well as community services. Further details regarding the proposed programs are presented in the next section.

GROUNDED IN A COMMUNITY DEVELOPMENT APPROACH

The implementation of a community health centre is seen by the Francophone community of Timmins as a way to revitalize itself and take charge of its own destiny. The community hub approach that we suggest is meant to encourage community development by eventually creating a single space where the community as a whole and its various groups can meet and work together towards a same goal.

POPULATION NEEDS-BASED

Relevant data collection, accountability mechanisms, and implementation of mechanisms to obtain feedback from the population will allow for a better understanding of the Francophones' needs. That being said, formal evaluations conducted by third parties will provide a clear understanding the objectives of the programs offered by the centre and ensure they meet the needs of the population. In addition to the formal mechanisms above, the day-to-day activities and comments from the centre's employees will also serve to understand how programs are aligned with the needs of the population, and to make adjustments if necessary.

The centre's administration will have to work in collaboration with the Réseau du mieux-être francophone du Nord de l'Ontario and the North East LHIN to integrate the results of their observations, work, and research related to the health needs of Francophones.

ACCOUNTABLE AND EFFICIENT

Implementation of quality control, data collection, accountability, and evaluation mechanisms demonstrates the importance of being accountable and ensuring that a mechanism is in place to monitor ongoing improvement of current services and processes. The centre will report periodically, for instance, to the community. The centre's Web site can also serve as an accountability tool, with the publication of various documents, data, etc.

4. COMMUNITY HEALTH CENTRE'S PROGRAMS (DELIVERABLE 3)

This section outlines the proposed programs for the new Timmins Francophone community health centre; these programs are aligned with the proposed model and meet the priority needs of the Francophone population of Timmins.

The holistic health approach, which takes the whole individual into account, provides an optimum response to the multiple needs of the Francophone population, with a view to improve not only care management and quality, but the patient experience within the health system as well. This is the recommended approach for the programs, one that focuses on the benefits of an interdisciplinary team working in a coordinated fashion across the health continuum, and on the improvement of the health and wellbeing of individuals, families, and the community.

4.1. PRIORITY HEALTH PROBLEMS TO BE ADDRESSED BY THE CENTRE

According to Public Health Ontario, chronic disease is the leading cause of death and disability in Ontario. Poor nutrition, physical inactivity, and excessive alcohol consumption and tobacco use, which constitute the main risk factors contributing to the prevalence of chronic disease, are part of the lifestyle among the Francophone community of Timmins. Furthermore, taking into account health determinants such as the level of education, the Francophone population is likely to face greater challenges and their negative effects on the health and wellbeing of individuals, families, and the community.

Consequently, the programs of the Timmins Francophone community health centre have been designed with this reality in mind, in order to provide services aligned with the Francophone population's key health challenges, given that significant gaps have been identified in terms of equity and access to French-language health services.

The model for the provision of health and community support services favoured by the community health centre is based on an integrated and complementary approach along the care continuum, ranging from prevention to treatment, and recovery support to the development and growth of individuals, families, and community. The advantage of this approach is that it facilitates professional, social, and community synergies, thereby ensuring that the Triple Aim health results, namely improving patient experience, maximizing utilization of resources, and bringing about lasting improvements in the population's health status, can be achieved.

The proposed programs represent a starting point in the development of integrated services taking into account the priority health issues directly affecting the Francophone population of Timmins. The programs will attempt to address the following realities and issues:

- An aging population;
- The prevalence of chronic disease, particularly:
    - diabetes;
    - chronic obstructive pulmonary disease (COPD);
    - inflammatory arthritis;

  - high blood pressure;
- A high rate of teenage pregnancies;
- Poor mental health.

It goes without saying that the centre's programs must constantly evolve to maintain their relevance and provide a timely response to emerging challenges related to the health and wellbeing of the population of Timmins. Furthermore, the development of primary health services and programs should focus on the need to fill the gaps in terms of primary health services in French, in collaboration with other service providers.

The centre will have to create partnerships with local institutions and organizations, as well as other primary health care, social, and community support services. This will allow the centre to capitalize on the synergies among the organizations, and maintain an integrated, coordinated, and complementary service offer, in the spirit of collaboration towards the improvement of the health and wellbeing of the Francophone community as a whole.

4.2. PROGRAMS ARE ALIGNED TO THE FRANCOPHONES' HEALTH CHALLENGES

The centre's proposed programs focus particularly on the following areas: primary health care, mental health, and the health of young pregnant women and early childhood, seniors, and persons with chronic disease.

The centre's proposed programs will be supported by a medical team comprising a physician and nurse practitioners, as well as a multidisciplinary team composed of registered nurses, registered nursing assistants, social workers, dietitians, and other health care professionals, as well as early childhood educators and community workers; this will ensure management of patients and individuals according to the best resource for the expected service.

The role of a physician in a community health centre is different than in a private clinic since the workload is distributed among the members of the interdisciplinary team. The physician does not have to monitor every patient of the community health centre, especially when care can be provided by another health care professional. Furthermore, the community health centre's physician is called upon to support, collaborate, and interact with other physicians in the community, particularly with respect to common patients, but must never attempt to replace them.

In a community health centre, the physician's skills are mostly utilized in diagnostic activities, treatment, and the development of global treatment plans, rather than in patient management and monitoring. In addition, the physician generally plays a role in the delivery of programs focusing on specific clienteles, such as patients with chronic disease. That being said, when a client from a specific program already has a family physician in the community, the physician or the community health centre's coordinator/navigator will follow up with the physician to keep him or her informed of the client's progress and challenges, and ensure coherence between the overall interventions and the global treatment plan.

Prior to the opening of the Centre, it will be necessary to update the needs and service gap analysis in order to describe the proposed programs in greater detail. In addition, it will be necessary to create partnerships with the community, systematically include evaluation and monitoring mechanisms for quality assurance and improvement, determine measurable objectives, and develop a performance measurement plan.

1. PRIMARY HEALTH CLINIC

The proposed primary health clinic will offer, by appointment, a range of services that will be delivered by an interdisciplinary team consisting of a physician, nurse practitioners, registered nurses, registered nursing assistants, social workers, specialized educators, dieticians, health promotion and prevention workers, as well as community workers.

The primary health clinic will be the central unit around which the centre's other clinics, programs, and services will revolve. This approach will foster the creation of a truly interdisciplinary and organic organizational culture, as well as encourage human resources mobility, thus allowing for more efficiency and effectiveness in the overall service and program delivery. In addition, it is expected that higher-level areas of expertise will be added to the centre's team to meet the needs of more specialized programs.

Target clientele:
Orphaned patients, with or without a medical referral, and members of their immediate family who will become patients of the centre.

2. NURSING CLINIC

The proposed nursing clinic will offer, by appointment, preventive and curative treatment services delivered by a team of nurse practitioners, registered nurses and registered nursing assistants. The nursing clinic staff will play several roles, for instance, with regard to the evaluation of patients' health, preventive advice, and education. Employees will ensure follow-up related to care plans and referrals to other health professionals, programs, and services. They will also be able to provide nursing care such as placing and removal of dressings, injections, vaccines, removal of stitches, insertion and removal of catheters, intravenous medication, etc.

The nursing clinic will help to reduce the burden on the health system and will work complementarity with other primary care providers to support them.

Target clientele:
Population groups of all ages, with or without a medical referral, who require nursing care interventions.

3. MENTAL HEALTH AND ADDICTION CLINIC

Research confirms the importance of language and culture in diagnosing and offering an appropriate treatment plan, and this is particularly important for individuals with mental health challenges. In this regard, the proposed mental health and addiction clinic will provide an integrated range of language- and culturally appropriate services to support Francophones in their attempt to reach emotional and psychological balance, and equip them in order that they may function adequately on a daily basis. Services will be delivered by an interdisciplinary team comprised of clinicians, social workers, and specialized educators, who can be consulted by appointment.

The following services will be offered:

- A mental health promotion and prevention component will offer workshops in collaboration with community partners, as well as consultation and mental health information services;
- Personalized, coordinated and proactive care including the following elements:
  - Evaluation of mental health needs and development of an action plan;
  - Coordination of care and monitoring in partnership with family physicians and specialists in the community;
  - Therapeutic services through individual couple, family, or group therapy;
  - Telephone access to support the team in the event of a crisis during working hours;
- A range of community support services, in partnership with the community, to address socio-economic difficulties (i.e.: food bank, support for school, support group).

Target clientele:
Population groups of all ages, with or without a medical referral, who require mental health or related services.

4. Program of integrated perinatal and early childhood services for families living in vulnerable conditions

The proposed program for these services would encompass the following elements:

- Health promotion and prevention, aimed at raising awareness among adolescents and young adults regarding healthy and safe lifestyle habits, in cooperation with local partners and other organizations that provide consultation services and information on issues that directly affect them (drinking and drug use, contraception, etc.)
- Family support through home visits by a worker who can meet the family's needs and act as a support in parenting practises;
- Support to the creation of environments that foster the health and wellbeing of families, by implementing projects designed to improve living conditions for families, in collaboration with organizations from the community.

The integrated program would focus on fostering children's optimum development and strengthening parenting skills. It would also seek to prevent abuse and negligence in an attempt to reduce the transmission of health and social problems from one generation to the next.

Target clientele:
These services would be available to pregnant women or mothers under the age of 20, as well as those over the age of 20 who are living below the poverty line and have no secondary school or vocational diploma, women who are newcomers to Canada, as well as fathers under the age of 20 with children from 0 to 5 years.

5. Healthy aging in the community program

The "Vieillir en santé dans la communauté" program will provide a range of services to support and empower seniors and their caregivers in the adoption and maintenance of healthy lifestyle habits that will allow the seniors to remain at home safely. This program is also intended to reduce isolation for seniors and to improve their overall wellbeing through activities that stimulate the vitality of the body and the mind, as well as community engagement.

The proposed program would consist of the following elements:

- Health promotion and prevention activities that include:
  - The PIED exercise program (Programme Intégré d'Équilibre Dynamique);
  - Nutrition workshops;
  - Activities that assist in maintaining intellectual vitality;
- Personalized, coordinated, and proactive care, such as :
  - Development of health checks, including fall prevention;
  - Assessment of physical and mental health needs;
  - Coordination of care and monitoring in cooperation with family physicians and specialists in the community;
  - Access to a case manager;
  - Support services to caregivers:
    - Support groups;
    - In-home stimulation program;
    - Psychosocial evaluation services.
- Community programs focusing on home support and community involvement, for instance:
  - A program for grocery assistance;
  - A day program for seniors;
  - A community engagement project to build a safe and senior-friendly community.

Target clientele:

These services are intended for seniors aged 60 years and over. The primary care component would be offered exclusively to patients of the community health centre and seniors without a primary care provider. Activities under the prevention and community support component would be open to all seniors from the community.

6. LIVING WITH CHRONIC DISEASE

At the centre of the approach of chronic disease programs, we find many initiatives related to health promotion and prevention, care coordination, family support, and support services to improve the health and wellbeing of persons with chronic disease.

6.1. INTEGRATED PROGRAM FOR PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

The program for patients with COPD is based on the "INSPIRED" approach that was developed by the Nova Scotia Health Authority and made available across the country by the Canadian Foundation for Healthcare Improvement (CFHI). This approach focuses on improving health care while achieving increased efficiency and cost reduction for the health system, by decreasing the number of emergency room visits, hospitalizations, and length of hospital stays among the participating COPD patients.

The main elements of the program are as follows:

- Educational activities for health promotion and prevention aimed at promoting healthy lifestyle habits, the Heart Wise exercise program, nutrition workshops and counselling, as well as consultation and information services about COPD;
- Personalized, coordinated and proactive care, such as :
  - Optimization of medication and an action plan for prescriptions;
  - Continuity and coordination of care during the transition from hospital to home care;
  - Home-based education on how to self-manage COPD;

  - Psychosocial/spiritual support at home;
  - Opportunity for advanced care planning at home;
  - Telephone access to support the team during working hours;
  - Monthly telephone follow-up for three months after home visits;
  - Monitoring and evaluation for quality assurance purposes;
- A range of services aimed at improving the health and wellbeing of patients with COPD, including:
  - Community partnerships;
  - Smoking cessation support;
  - Support groups for people suffering from chronic diseases.

Target clientele:
These services are offered to the centre's COPD patients, their families and Francophone patients who are discharged from a hospital service, in order to help them better manage their COPD at home, alleviate their isolation and distress, and reduce their dependency on emergency and hospital services.

6.2. INTEGRATED PROGRAM FOR PATIENTS WITH DIABETES

The integrated program for patients with diabetes aims to promote healthy lifestyle habits and lifestyle changes. The intention behind this program is to support people living with prediabetes or diabetes in their choices to control their blood sugar levels and live a healthy life.

The main elements of the program are as follows:

- Educational activities for health promotion and prevention aimed at promoting healthy lifestyle habits, the Heart Wise exercise program, nutrition workshops and counselling, as well as consultation and information services about diabetes;
- Personalized, coordinated and proactive care, such as :
  - Integrated care plan;
  - Medical follow-ups to do blood tests and adjust treatments;
  - Coordination of care and monitoring in partnership with family physicians and specialists;
  - Educational activities on diabetes, how to use a blood glucose monitor, and monitoring techniques for patients and their family;
  - Examinations and care of the feet;
- A range of community support services aimed at improving health and wellbeing, including:
  - Support groups for people with chronic diseases;
  - Community partnerships;
  - Smoking cessation support.

Target clientele:
These services are offered to patients diagnosed with prediabetes and/or type 2 diabetes, their families and external patients who have been referred to the centre, in order to support them in managing their illness and create social opportunities to combat isolation.

6.3. INTEGRATED PROGRAM FOR PEOPLE WITH INFLAMMATORY ARTHRITIS (IA)

This program is based on the Canada-wide approach whose care models for inflammatory arthritis aims to improve the way health care is being delivered to patients with IA.

The main elements of the program are as follows:

- Educational activities for health promotion and prevention aimed at promoting healthy lifestyle habits, the Heart Wise exercise program, workshops on pain management, nutrition counselling, as well as consultation and information services about inflammatory arthritis;
- Personalized, coordinated and proactive care, such as :
    - Integrated care plan;
    - Medical follow-ups to do blood tests and adjust treatments;
    - Accompanying the patient to get a diagnosis from a rheumatologist;
    - Coordination of the care plan with specialists (surgeon, physiotherapist, occupational therapist, pharmacist, etc.);
    - Educational activities to help patients and families self-manage their illness;
- A range of community support services aimed at improving health and wellbeing, including:
    - Support groups for people with chronic diseases;
    - Community partnerships;
    - Smoking cessation support.

Target clientele:
These services are offered to the centre's patients suffering from inflammatory arthritis, their families and external patients who have been referred to the centre, in order to support them in self-managing their illness and create social opportunities to combat isolation.

6.4. INTEGRATED PROGRAM FOR PEOPLE WITH HIGH BLOOD PRESSURE

The proposed program would be delivered by an interdisciplinary team supporting people with high blood pressure to help them establish and maintain good lifestyle habits and regularly monitor their drug treatment for their illness, resulting in lowered blood pressure which would prevent potential damage to organs like the heart, the brain, the kidneys and the eyes.

The main risk factors that contribute to high blood pressure are excess body weight, physical inactivity, excessive salt and alcohol intake, stress and tobacco use. This is why the program will focus on establishing and maintaining healthy lifestyle habits. The interprofessional team will closely monitor patients' medication and encourage them to make the necessary changes to improve their quality of life.

The main elements of the program are as follows:

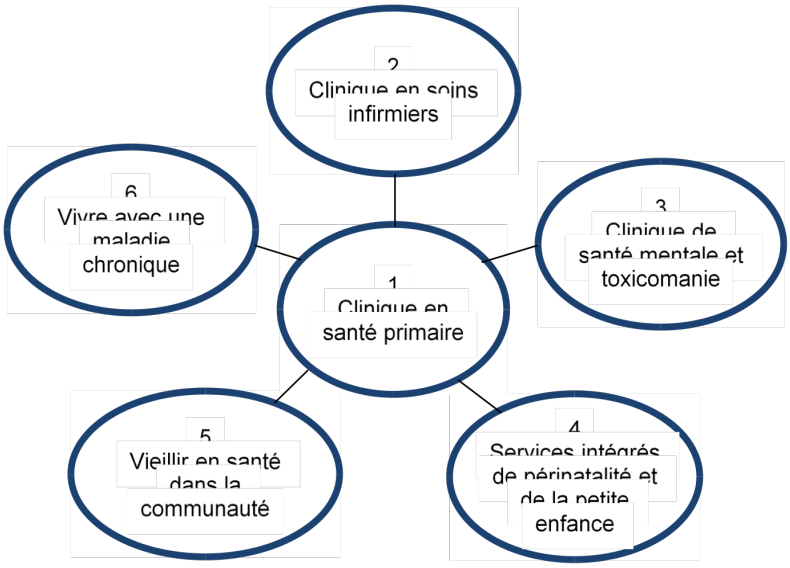
- Educational activities for health promotion and prevention aimed at promoting healthy lifestyle habits, the Heart Wise exercise program, as well as nutrition workshops and counselling;
- Personalized, coordinated and proactive care, such as :
    - Coordination of the care plan with specialists (doctor, pharmacist, etc.);
    - Medical follow-ups to do a health assessment and adjust treatments;
    - Integrated care plan;
- A range of community support services aimed at improving health and wellbeing, including:
    - Support groups for people with chronic diseases;
    - Community partnerships;
    - Smoking cessation support.

Target clientele:
These services are offered to the centre's patients suffering from high blood pressure, their families and external patients who have been referred to the centre, in order to support them in self-managing their illness and create social opportunities to combat isolation.

4.3. INTERACTIONS AMONG SERVICES

The primary health clinic will be the central unit around which the centre's other clinics, programs and services will revolve.

FIGURE 2 : ORGANISATION DES SERVICES ET PROGRAMMES DU CENTRE (IN FRENCH ONLY)



This approach will foster the creation of an interdisciplinary and organic organizational culture and encourage the mobility of health professionals and other stakeholders, thus allowing for increased efficiency and effectiveness in the overall service and program delivery. Through the analysis and allocation of its human resources, the centre will be able to identify additional areas of expertise required for the delivery of more specialized programs and services.

4.4. INTERACTIONS WITH THE COMMUNITY

Interactions with the community are essential to: 1. raise awareness about the existence of the centre, its raison d'être, vision and services; 2. encourage the Francophone community to play an active role in governing the centre and providing feedback for the continuous improvement of its programs and alignment with the needs of the population it serves; 3. establish partnerships with other community organizations and service providers that will be necessary to optimize and facilitate the delivery of health services in a spirit of complementarity and health equity for the Francophone population.

Francophone community engagement will be of utmost importance. In fact, the Executive Director is expected to establish simple and effective mechanisms and tools to collect feedback regularly from users and members of the community. Each program will be evaluated annually by its users for insurance and quality improvement purposes.

In addition, the centre will need to have a clear community vision and define its priority areas of intervention to oversee the rollout of its services in a coherent manner. It would be useful to explore the concept of a

community hub, whether in a physical location or accessed through a digital service, since it could allow for increased synergies and fluidity between French services offered by different organizations. It could also facilitate pooling community resources to take coordinated action on structural problems in order to make a lasting improvement in the health and wellbeing of the Francophone population. On that point, the centre should play a leadership role to structure the dialogue and bring together key stakeholders to support the development of the Timmins Francophone community.

4.5. COMMUNITY VALIDATION

Following the development of the Francophone community health centre model and its key program components, a bilingual online survey was conducted targeting just under forty key health stakeholders in Timmins and surrounding areas. The objective was to collect their feedback and explore possible areas where the centre and their organization complement each other. The survey was also followed by three discussion groups. Twenty-seven people completed the survey and a dozen people took part in the round table discussions. This section presents the compiled results from both of these activities.

Survey respondents represented organizations that would need to be kept informed of the Francophone community health centre's progress and with whom it would be useful to establish partnerships in order to improve the delivery of health services for Francophones in Timmins and surrounding areas.

Figure 3 shows the approval level from respondents in regards to various components of the proposed community health centre model. For most statements, the approval level is relatively high. Only one statement did not receive the same level of support as the others: only 59% of respondents are favourable (completely agree or somewhat agree) to the idea that the community health centre should offer services and programs to all Francophones. Apart from that one point, all other components of the model received an approval level of 75% or higher among the majority of respondents.

FIGURE 3 : COMPOSANTES DU MODÈLE DE COMMUNITY HEALTH CENTRE FRANCOPHONE (CSC) (IN FRENCH ONLY)

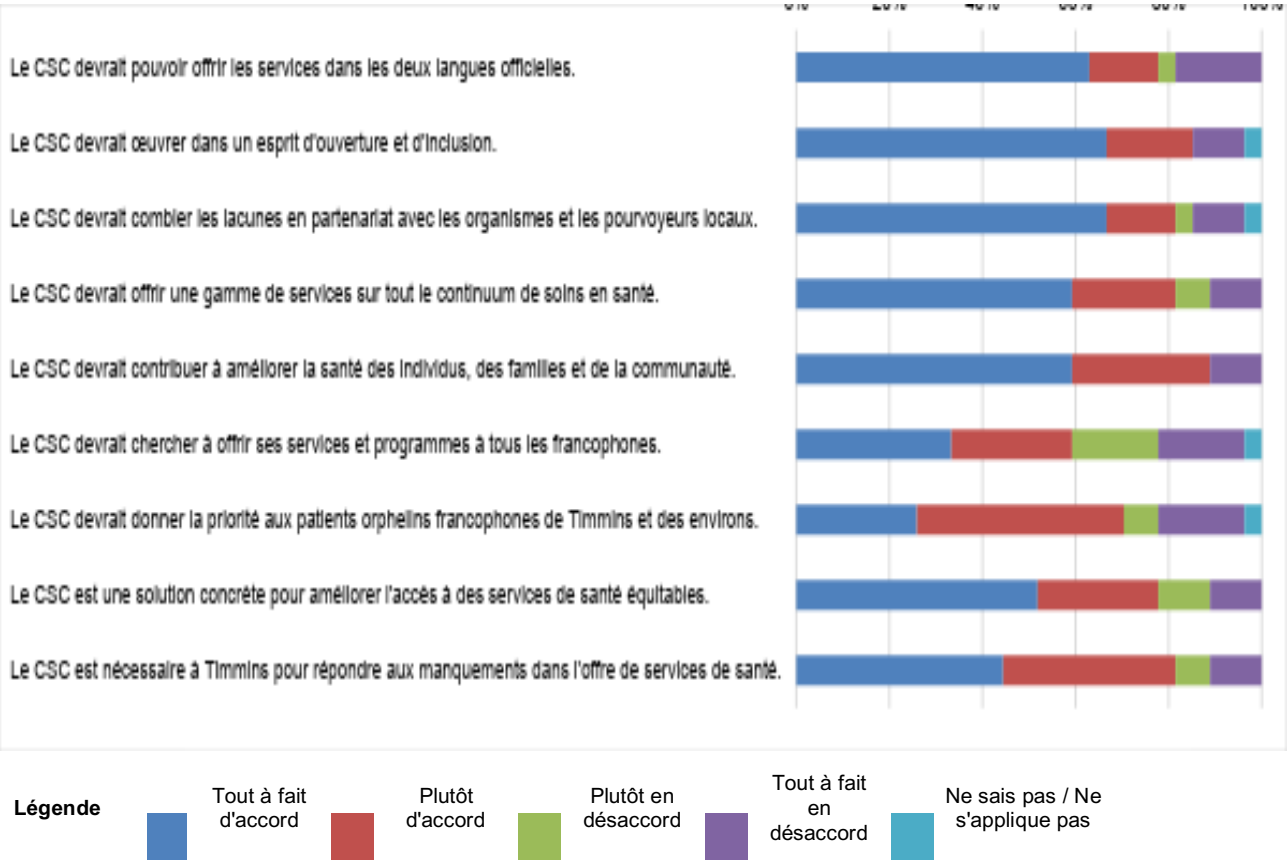


Figure 4 indicates what respondents think of the programs and services that could be offered by the centre. The results show a high level of agreement with the proposed programs, with the exception of programs offered for chronic illnesses, which received about 65% approval, a slightly lower approval level than the others. The discussion groups provided insights as to why this component received a lower result, namely that specific programs for these problems seem to be already offered in the community. An analysis of existing programs and services would therefore be necessary before developing these specific programs.

FIGURE 4 : COMPOSANTES DE LA PROGRAMMATION DU COMMUNITY HEALTH CENTRE (CSC) (IN FRENCH ONLY)

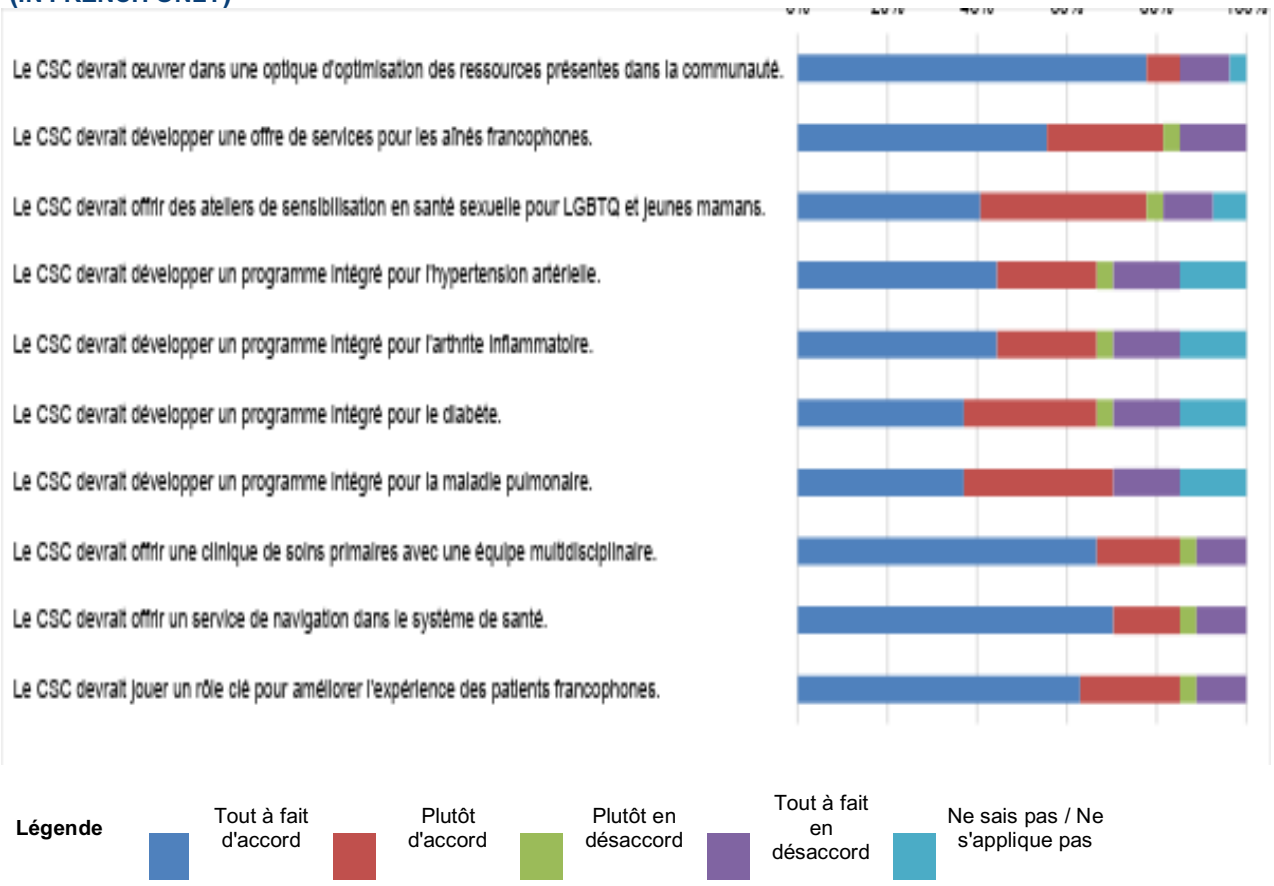
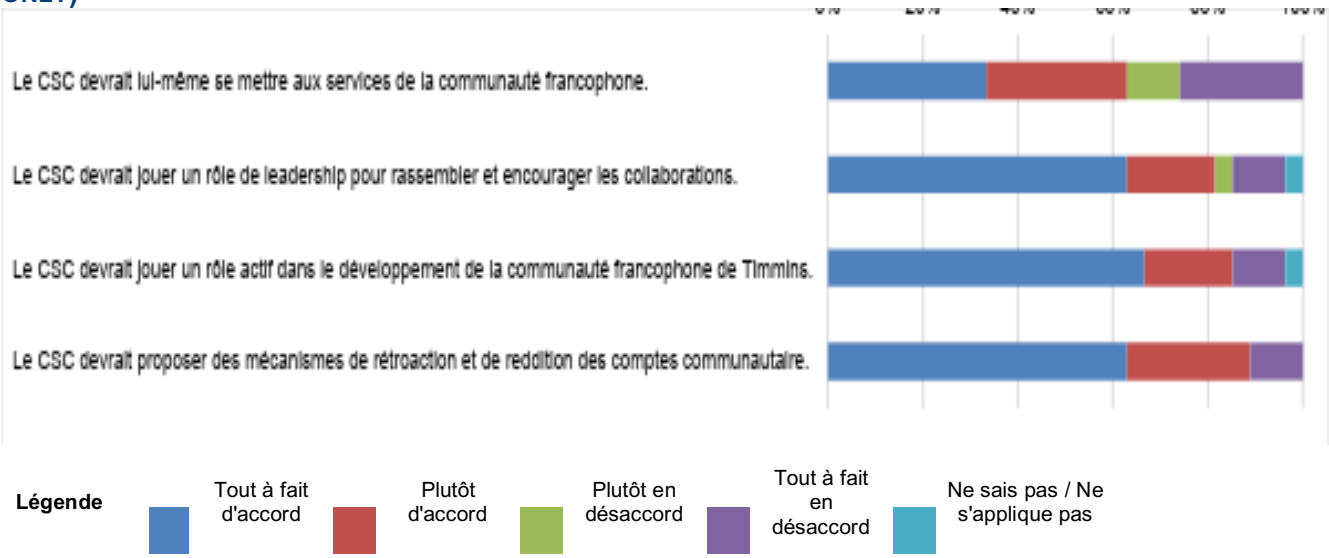


Figure 5 shows respondents' approval level on the topic of proposed roles for the Francophone community health centre. The results indicate that the centre should play a leadership role in bringing different organizations together and encouraging collaboration, ensure the development of the Timmins Francophone community and establish feedback and transparency mechanisms.

FIGURE 5 : RÔLE QUE DEVRAIT POURSUIVRE LE COMMUNITY HEALTH CENTRE FRANCOPHONE (CSC) (IN FRENCH ONLY)



IN YOUR OPINION, HOW COULD THE FRANCOPHONE COMMUNITY HEALTH CENTRE MEET THE UNMET NEEDS OF THE FRANCOPHONE POPULATION OF TIMMINS AND SURROUNDING AREAS?

The key word that recurs in almost all answers to this question is collaboration. Respondents believe that the gaps in French language health services should be filled by a collaborative, complementary approach focused on partnerships. Such an approach would not only avoid duplication of services but also i the offer of French language health services. It is clear from these answers that the efficient use of human and financial resources is a real concern.

Some respondents believe that since there are already several bilingual health professionals in the Timmins area, it is important to identify existing French language programs and services in order to develop other programs that fill the gaps between supply and demand that have been observed and documented. These unmet needs will need to be analyzed and prioritized by the Timmins community health centre to ensure that the resulting initiatives will reach an optimal number of individuals.

Accessing mental health and pediatric services in French seems to be a major challenge for the Francophone community and should be part of the mandate of the Francophone community health centre.

In addition, it is expected that the community health centre will play a key role in offering primary care services to orphaned patients. The idea of a community hub or central point of service capable of attracting a range of services in French was brought up a few times. Several respondents also expect the Francophone community health centre to facilitate referrals to health services available in French and provide space for other Francophone stakeholders to enable the delivery of services to Francophones.

Others fear that the arrival of a new community health centre would cause tension and division among the Francophone, Anglophone and Aboriginal communities. This being said, the fact that the Francophone community health centre is open to possibly accommodating patients of Anglophone and Aboriginal descent could allay these fears. In addition, many respondents have expressed relief about the arrival of the Francophone community health centre. They believe it will be a safe place, where Timmins and area Francophones can go to receive primary health services in French.

In relation to your organization's mandate, which synergies or collaborative links can be established with the Timmins Francophone community health centre to improve services to the Francophone population of Timmins?

In response to this question, some respondents saw limited partnership opportunities with the community health centre since many health organizations and agencies already work hard at offering services in both official languages. However, some recognize that it would be advantageous to increase the offer of French language health services. Others would like to receive the support of health professionals working at the community health centre in the delivery of their own services to Francophones.

Here are the suggestions for tangible support that came out in the survey and discussion groups: translating documents, pooling human resources and sharing physical spaces, facilitating workshops, providing services in Francophone seniors' residences, accepting Francophone interns, sharing information, referring patients.

In what way do you think your organization will collaborate with the Timmins Francophone community health centre?

The responses received to this question generally expressed the following:

- Increasing French language health services in the region;
- An interest in supporting the Francophone community health centre by sitting on the Board of Directors, by pooling expertise for creating a non-profit community organization and/or strategic advice;
- Ongoing professional training for the Francophone community health centre stakeholders;
- Sharing spaces with the community health centre employees;
- Developing partnerships focused on patients' interests and needs.

What type of support would you need from the Timmins Francophone community health centre?

Most responses involve creating collaborations and synergies to better serve the Francophone population of Timmins. Others think the community health centre should serve the entire population regardless of language or culture.

More specifically, some expect to call upon the centre's professional staff to:

- Facilitate workshops for linguistic and cultural awareness in French, as well as workshops on health promotion and self-management of chronic diseases;
- Offer primary care services to their students, residents and other vulnerable Francophone clients;
- Develop bidirectional referral protocols;
- Pool resources and share health professionals.

5. GOVERNANCE AND FINANCIAL MODEL (DELIVERABLE 4)

This section describes the proposed governance structure and financial analysis required to support the creation of the Timmins Francophone community health centre.

5.1. GOVERNANCE

For several years now, the Francophone community in Timmins has campaigned for the creation of a Francophone community health centre governed by the Francophone community. The centre hopes to achieve a culturally and linguistically appropriate governance by and for the Francophone community, a governance that would be accountable to and comprised of administrators from the Timmins Francophone community, to meet the health needs of the Francophone population in Timmins and surrounding areas.

Francophone governance is a fundamental element for developing the centre's full potential and ensuring the sustainability of French language health services. Furthermore, the Canadian Association of Community Health Centres (CACHC) and the Société Santé en français (SSF), create a strong correlation between governance and the level of interest in French language health services. In their joint report, they indicate that "in English-language or bilingual establishments, French-language services have a tendency to disappear when Francophone engagement declines."[7]

The advantage of establishing a Francophone governance model is that it would be free of the tension between the Anglophone majority and the Francophone minority that exists in unilingual Anglophone and/or bilingual governance models, where health services for Francophones are diluted within a multitude of needs and types of clients. Moreover, during the decision-making process, the purely rational calculation of return on investment, which is difficult to reconcile with living in a minority community, often takes precedence over the development of a real, active offer of French-language services.

Several studies and observations in the field of French language health care show that the more the governance model is Francophone, the more the development of health services in French occupies an important place within the organization's vision. Francophone governance is therefore necessary for supporting a decision-making process – both in developing strategic directions and in allocating human and financial resources – that is fully focused on the needs of the Francophone community.

Community governance, which is local governance **by and for** Francophones in Timmins and surrounding areas, remains the best way to ensure real community empowerment and the measures to achieve it. In fact, community governance tends to help organizations adapt to "the community's changing demographics and the emergence of new needs so that the range of services and programs offered can be updated smoothly."[8]

Francophone community governance is the recommended approach for supporting the development and sustainability of the future Timmins Francophone community health centre in relation to the proposed

[7] ACCSC and SSF (2017), A Scan and Study of Primary Health Care Models for Francophone Communities in Minority Settings across Canada, p. 27.

[8] ACCSC and SSF (2017), Guide pratique pour l'implantation d'un community health centre destiné aux communautés francophones et acadiennes en situation minoritaire, p. 23.

health model, especially since the centre's vision is to improve the health of individuals, families and the Francophone community as a whole.

That being said, if a community hub is created, depending on the way in which it will be designed and rolled out, collaboration mechanisms will need to be developed to reach the common objectives, especially if it expects to integrate the services of a number of organizations with separate accountability and funding agreements. These collaboration mechanisms can be more or less formalized based on the goals and obligations of participating organizations. This way, it will be possible to opt for a more flexible collaboration structure on a voluntary – even contractual – basis, and even explore the option of creating a new governance structure for the community hub as a separate entity[9]. Nonetheless, brainstorming models of collaboration among Francophone organizations will be part of the second phase, after the creation of the community health centre which, at the moment, requires its own governance.

In developing collaboration mechanisms, it is also preferable that the centre adopt an inclusive approach which leaves room for dialogue with the region's organizations, agencies and institutions that work in the health industry but are not necessarily bilingual, without this being perceived as an obstacle to a Francophone governance committee, which itself aims to be close to the individuals that make up the Francophone community. When developing their regulations and policies, the administrative committee will have to find the proper balance in strategies aimed at consulting with the community, partners and key actors of the system in order to plan for services that are both relevant and aligned to specific needs.

COMMENTS ON POLICY GOVERNANCE

The policy governance model, also known as the Carver model[10], is the prevailing governance model in Francophone community health centres in Ontario, which we have consulted as part of the study. This model emphasizes the importance of the global responsibility of the Board of Directors on the organization's mandate, which is mainly assumed by implementing clear policies and delegating responsibilities to their only employee, the Executive Director.

Understanding the Carver model components has sometimes caused some boards to refrain from creating constituent committees, since they seem to conflict with the concept of global responsibility. However, these committees are essentially working committees that help advance different projects or files simultaneously. They are also responsible for making recommendations with justifications to help the Board of Directors as a whole make an informed decision.

Because it focuses on policies, the Carver model can also be perceived as being too detached from operations management, which can consequently reduce the role of the Board of Directors to that of a regulatory body rather than one of governance. The board of directors is the decision-making body that provides guidelines for all the organization's strategic components, whether it is for programs and services, or for human, material, information or financial resources, as well as relations with partners and funders. It is responsible for implementing the necessary mechanisms without being limited to policy development, which allows the board to meet all its obligations and carry out an ongoing and efficient follow-up for this purpose.

[9] If the community hub wants to establish a formal governance structure, the bicameral governance model should be considered.

[10] John Carver and Miriam Carver (2001), Carver's Policy Governance® Model in Nonprofit Organizations.

Richard P. Chait et al.[11] defines three main modes of governance of a board of directors which allow it to govern an organization successfully through the different cycles it encounters: the fiduciary mode, the strategic mode and the generative mode.

The **fiduciary mode** is applied through policies that ensure the control and monitoring of the organization's efficiency and effectiveness. These policies generally deal with managing the organization's human, material, information and financial resources. More and more, and especially due to increasing requirements from funders, organizations are adopting policies to support the quality and safety of their services. Beyond developing policies, it is crucial that the Board of Directors remains informed about the enforcement of these policies through reports from the Executive Director and the management team.

The **strategic mode** implies that the Board of Directors dictates the organization's direction with respect to its mandate and the goals expressed by its members. By doing so, it defines the organization's vision, mission, guiding principles and/or values. With guidance from the Executive Director, it establishes the strategic results it wants to pursue through its programs and services. In the Executive Director's annual accountability cycle to the Board of Directors, it is important that a follow-up (done at least quarterly) be in place to monitor the organization's progress towards achieving its expected results. These exchanges are important for generating a rigorous decision-making culture based on solid evidence, managing risks and determining relevant mitigation measures, building a common understanding of the challenges met and identifying the lessons learned which would help support the organization's continuous improvement.

The **generative mode** evokes the notion of monitoring or looking out for the organization's capabilities regarding the environment in which it evolves in order to ensure its long-term relevance. It is important for the Board of Directors to be aware of changes occurring within the organization's environment so that it may support the necessary changes in a proactive way and continue to respond to the current needs and expectations of the organization's clients and funders. To do so, the Board must take time to reflect on trends, needs and challenges, and gauge the pulse of the community and key stakeholders, with the goal of planning these interventions to increase the positive impact on the health and wellbeing of the Francophone community in Timmins.

Although policies are important to the governance process, the importance of follow-up mechanisms and strategic reflections for ensuring the sustainability and proper performance of an organization should not be minimized. That is why the fiduciary mode is as important as the strategic and generative modes. These three components influence and enrich one another mutually in the exercise of good governance. This governance must meet high decision-making standards, while maintaining the necessary flexibility to allow the organization to adapt quickly to the changing environment in which it evolves.
Therefore, it is not the intention of the Board of Directors to interfere with the organization's daily operations management – a function entrusted to the Executive Director – but rather that it remain involved in the major components of the organization by focusing on its strategic elements, notably through policies, follow-ups and reflections.

[11] R.P. Chait, W.P. Ryan and B.E. Taylor (2006), Governance as Leadership: Reframing the Work of Nonprofit Boards.

5.2. PROPOSED FRANCOPHONE COMMUNITY GOVERNANCE MODEL

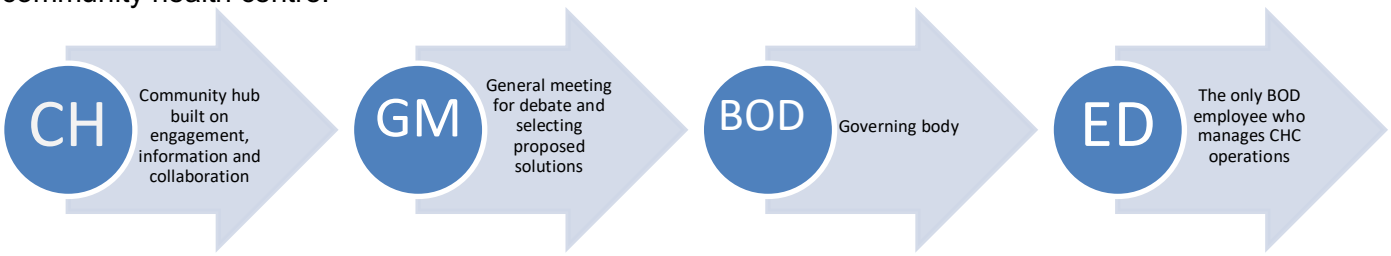
The Francophone community governance model developed for the Timmins community health centre is comprised of various authorities that share different decision-making processes. First, there is the general meeting during which directors are elected and the Board receives information on the organization's financial and organizational performance. The Board of Directors, the organization's legislative authority, provides the vision and objectives and ensures the organization's sustainability. Lastly, the Executive Director manages the organization's daily operations within the established mandate and budget. We suggest that a community forum be added to these three components. The forum would not be a decision-making body, but rather a space for consultation, dialogue and collaboration to bring key players together at least once a year to brainstorm on the development and health of the Francophone community in Timmins and surrounding areas, in a collaborative setting.

COMMUNITY HEALTH CENTRE LEGAL STATUS

Legally, the Timmins Francophone community health centre will be considered a non-profit community organization just like similar organizations.

MAIN BODIES OF FRANCOPHONE COMMUNITY GOVERNANCE

Four components make up the Francophone community governance of the Timmins Francophone community health centre.



COMMUNITY FORUM

It is recommended that the community health centre includes an annual community forum in its governance operations open to all those who support the organization's mission. The forum is not a decision-making body, but rather a space for dialogue, consultation, information exchange and collaboration on emerging issues and concerns of the Francophone community. It is a space used by the organization to gauge the pulse of the community and its partners and to encourage a collective commitment favouring the development and health of the Francophone community, with the goal of implementing the most promising collaborative solutions for improving the wellbeing of Francophones.

A community forum would be an effective way to give life to the community leadership that the Francophone community health centre aims to achieve, as it would bring key players together and support the development of synergies to create structuring projects for the "Francophonie" on a local level.

Although the forum is not a place for decision-making, the members, directors and managers of the Timmins Francophone community health centre can benefit from the dialogues and considerations that can be drawn from this public discussion for their own brainstorming and decision-making. Ideally, the community forum would close off each year with a collective action plan, or at least some concrete measures to support community engagement and build solidarity for the wellbeing of Francophones.

GENERAL MEETING

Each year, at least one general meeting should be held where all members of the organization, including its Board of Directors, would be invited to discuss and decide on solutions. The general meeting can also be an extraordinary annual meeting. Although it would be preferable to invite the entire Francophone public to participate in the presentation of annual results and the relevant community-related discussions, only members of the community health centre hold the right to vote.

The general meeting supports transparency in the management of the Timmins Francophone community health centre and maintains an open and wide-ranging dialogue with other members of the Francophone community to make informed decisions.

During the annual general meeting, members must at least:

- receive the report on the previous year's activities;
- receive the audited financial report;
- select the external auditing company;
- review any changes to the Regulations;
- elect board members.

Most Francophone community health centres have a pool of between 30 and 400 members. This pool is made up of individuals from the Francophone community who support the organization's missions and values. A nominal membership fee, generally $5 or $10, may be required on an annual basis. Membership requests must be approved by the Board of Directors.

Members of the Francophone community centre do not necessarily need to be patients. For members who are also patients, membership in no way provides privileges for access to the centre's services. Membership essentially gives people the right to take part in dialogues, make proposals and vote during the general meeting.

Apart from this purely formal dimension, membership also offers the opportunity to form a group of citizens involved in the success of the Francophone community health centre, who can be mobilized in support of the centre's communication, community mobilization, service promotion and representation efforts. This member pool not only provides access to a greater diversity of individuals to enrich brainstorming, but also makes it a place to raise awareness and mentor new talent for the Board of Directors.

BOARD OF DIRECTORS

The Board of Directors is the main governing body whose mandate is to ensure the sustainability of the Timmins Francophone community health centre. Board members must act with integrity and good faith in the organization's best interests at all times.

The tasks of a community health centre Board member are:

- to define the organization's strategic direction;
- to properly monitor the organization and its environment;
- to determine governance rules and processes, specifically the role and responsibilities of Board members;
- to ensure effective risk management;
- to ensure that the expected strategic results are met;
- to promote the organization's mission;

- to protect the organization's assets and financial viability;
- to propose any changes to the Regulations during the general meeting;
- to adopt the organization's policies;
- to recruit, train and evaluate the Executive Director, as well as dismiss this person as required.

Size of the Board of Directors

Boards of directors of Francophone community health centres are generally composed of 9 to 14 board members based on the size of the territory and the services offered. Ideally, the community health centre should aim to have a maximum of 7 to 11 members to ensure effective governance.

Director profiles

Some community health centres select their directors based on the regional representation of their catchment area, while other opt for a representation by type of clients and/or priorities in the services they offer, and others yet focus on the diversity of the expertise required. The ideal approach for the Timmins Francophone community health centre would be to find a balance among these approaches while ensuring that, regardless of their profession and origin, its directors acknowledge that when they serve on the centre's Board, they must above all advocate for the primary and community health interests of the Francophones of Timmins.

Implementing a new organization such as the Timmins Francophone community health centre involves selecting at least some directors with experience in governance, primary health and community development, in order to establish a solid foundation and successfully launch the organization. It is also important to seek to recruit directors from a variety of professions and sectors that reflect the community in order to solicit a wide range of ideas and perspectives and increase the ability to reach and enter different sectors of the Francophone community.

The concept of representativeness is very objective in terms of governance, and even more so when it comes to serving on a board of directors to represent the needs of a particular clientele who has not necessarily had input into the election of that director as their spokesperson. For this reason, within the context of a health care centre, rather than opting for a Board of Directors that is considered purely representative, it is preferable to consider a Board of Directors that leverages a variety of backgrounds, skills and sensitivities and that works in synergy with each member's expertise for the success of the entire organization.

Application and nomination process

The application and nomination process varies from one Francophone community health centre to another.

Generally, a nominating committee oversees this process, which involves:

- determining the profiles and skills of sought-after directors;
- promoting the call for applications in local Francophone newspapers, on the organization's website and social networks, as well as among the organization's members;
- receiving and evaluating applications;
- making recommendations during the annual general meeting.

Interested candidates should introduce themselves to the nominating committee in accordance with the terms outlined and justify their interest by meeting the selection criteria. Candidate selection is normally done during the annual general meeting.

Term duration and number of terms

Generally, directors are elected during the annual general meeting for a term of two to three years. It would be preferable to provide a mechanism to ensure a structured turnover on the Board to maintain a balance between new and experienced directors, thereby ensuring a certain continuity to strengthen the organization's governance. One way to do this is to renew one third of the directors on an annual basis. To do so, during the first election only, one third of the directors would be elected for a period of one year, another third for two years, and yet another for three years.

Director turnover is an important catalyst for an organization's momentum, vitality and innovation. A large number of organizations that do not have policies in place limiting the number of terms for their directors become bogged down by a stagnating Board which lacks vision, innovation and discussion after a number of years.

According to principles of good governance, each Board of Directors should provide, in addition to constituent policy documents, an annual budget for training and professional development to support its members in the performance of their duties. These mechanisms are necessary for the skills development of all directors, which would avoid dependency on a limited number of directors in order to function.

Unless the organization is grappling with a real challenge in recruiting directors, it is important to specify a maximum number of consecutive terms that directors may carry out. The number of consecutive terms should be limited to two, for a maximum of six years. After a break equal to the length of an entire term (three years), directors interested in renewing their involvement with the Timmins Francophone community health centre can submit their application and may be reelected during the annual general meeting.

Procedure for attributing various duties on the Board of Directors

Once elected to serve on the Board of Directors, all directors have a duty of loyalty and diligence toward the organization. Members may take on additional duties on the Board of Directors. Generally, three to four positions must be filled by directors to ensure the Board runs efficiently: chair, vice-chair, treasurer or secretary. These positions are usually subject to a vote during the first annual Board of Directors meeting.

Board of Directors decisions

In the majority of Francophone community health centres, the decision-making process is based on the majority, although a consensus is preferable. Nonetheless, each director has a vote. Once a decision is made, all members must support the decision.

Director financial compensation

Directors do not receive compensation. However, they are eligible for reimbursement for reasonable expenses incurred during the exercise of their functions.

Meeting frequency

Most boards meet on a monthly basis from September to June, with a break during the holidays and the summer, for a total of eight to ten meetings per year. These meetings are generally attended in person and take place on a weeknight.

In addition to monthly meetings, most centres hold a two-day annual strategic retreat to review the past year and discuss in detail the organization's challenges and goals.

Board of Directors committees

Although all directors are equal under the law, some of them may be delegated to sit on one or more subcommittees, based on their expertise and/or interests. These committees often do some preliminary work and share their recommendations with the Board of Directors for decision-making purposes. These committees may or may not be permanent.

Most boards of directors include:

- an auditing committee, which is responsible for efficient resource allocation and risk management;
- a governance committee[12], which is responsible for developing regulations, policies and processes, and for reviewing them regularly;
- a nomination committee, which is responsible for developing and overseeing the application process for Board members and the Executive Director;
- a strategy and service quality committee, which is responsible for playing a quality assurance role and improving services;
- an advisory committee for integrating French language health services, which would be responsible for advising the administrative committee on existing clinical initiatives in the Timmins community. It would be important for the centre's patient navigator to be part of this committee in order to share his or her experience and that of patients for the purpose of pursuing collaborations which would help improve services and reduce the gaps in health equity and care quality for Francophones;
- special committees, created to support a process or an initiative in line with objectives set by the organization (i.e. strategic planning and communication strategy).

For the Timmins Francophone community health centre, these committees will be especially important during the start-up phase to establish proper structure and distribute tasks among directors.

Accountability process

The accountability process generally requires that the Board of Directors justify to the community and the centre's funders the proper management of public funds received.

Accountability to the community is done through the annual general meeting and in particular with the presentation of the centre's annual report which outlines its strategic direction, the results achieved and the financial management of its resources. Once the annual report has been adopted at the annual meeting, it must be accessible by the entire community on the organization's website.

Accountability to funders is done in part through the annual report, but also by filling out other reports and forms provided in the funding agreements.

Depending on its mandate, the community forum could also be an avenue for communicating and sharing results obtained for the entire community, not just those of the Timmins Francophone community health centre. Especially when an action plan is created to solve a particular community issue on which a group of

[12] The governance committee and the nomination committee can be grouped together as a single committee. However, given the scale of the tasks allotted to the interim administrative committee, it is better to keep this committee on its own during the centre's start-up.

organizations commits to collaborate or take action within their field of competence to effect change, communication with the community will be necessary to share the fruit of these collective efforts.

Relationship with management

The Executive Director is the only employee of the Board of Directors who is entrusted with managing the daily operations of the Timmins Francophone community health centre within the parameters of the agreement reached. The Executive Director does not have voting rights. This person participates in general meetings and Board of Director meetings and informs members as needed.

The Executive Director is a position that requires extensive knowledge of the health care community, both clinically and in operations management. Furthermore, the Executive Director has a key role to play in establishing partnerships and developing synergies with other service providers. This person must also be actively involved in forums for clinical dialogue and health care service planning in place in the Timmins community. This ensures proper representation of the Timmins Francophone community health centre and the needs of Francophones with regard to their experience within the current system, and helps identify different possible and desirable areas of collaboration.

Increased community involvement

The Francophone community can leverage the community forum to make its needs known and propose initiatives to improve the wellbeing of the Francophone population. Whether brought about by initiatives of the Board of Directors or the Executive Director, other consultation mechanisms and mechanisms for evaluating service quality will be made available to the community to encourage feedback when developing and improving the centre's services, initiatives and activities.

5.3. RECRUITMENT STRATEGY FOR THE GOVERNANCE MODEL

Prior to establishing the Timmins community health centre, it is recommended that an interim nomination committee be created to identify the members of an interim Board of Directors. This committee should be comprised of approximately five individuals recognized for their involvement in the Francophone community and would be set up for a period of three months to:

- determine the various profiles of suitable candidates;
- draw up the mandate of the interim administrative committee;
- outline the call for applications process, including term duration, communication strategy, follow-up and evaluation mechanisms;
- launch and promote the call for applications process;
- receive and review applications;
- select the directors.

The current Francophone collaborative committee, which oversaw the work of the present mandate, can play the role of interim nomination committee described above. This committee can nominate candidates and evaluate applications to ensure that all required and essential skills are covered to successfully proceed with the following steps. The Board of Directors has an important strategic role in the negotiation and establishment of the Timmins Francophone community health centre, which is why the proper selection of profiles for interim directors is so important.

Ideally, the interim Board of Directors should be made up of individuals with various expertise, background, and identity and community sensitivities that reflect the "Francophonie" in Timmins.

These interim directors would be appointed for approximately nine months to carry out the mandate provided by the interim nomination committee. They would also have the opportunity to submit their application to be formally elected to the Board of Directors during the centre's first general meeting.

The mandate for the interim Board of Directors should include the following tasks:

- start negotiating with competent authorities for implementation;
- drawing up the organization's constitution and regulations;
- incorporating the organization;
- drawing up general conditions for members and recruiting for the first member pool in order to conduct the first annual general meeting;
- assessing different possibilities for the centre's physical location;
- determining the official concept of community hub (if applicable), and the implementation strategy;
- contributing to the creation of a strategic plan for the centre and/or the hub;
- recruiting the Executive Director;
- developing partnerships to support the recruitment of human resources;
- developing a community involvement and mobilization strategy that reaches orphaned Francophone patients and any Francophone patients who wish to join the centre.

It is recommended that the committee carefully consider the profiles of interim directors, as these individuals will create the pillars of the Francophone community health centre, which will have a structural impact on the centre's identity and outreach. The implementation of the centre requires significant involvement by interim Board of Directors members and requires complementary expertise to ensure a successful rollout.

It will be important to ensure that chosen candidates support the community health centre's model and vision, and are committed to completing the project and making it a space devoted to improving the health and wellbeing of the entire Francophone population. If chosen candidates are also employed by another health care service provider, it will be important to determine whether a conflict of interest exists and confirm their ability to act in support of the Francophone community health centre's interests.

In regards to technical skills, it will be important to recruit Francophone individuals with experience in:

- negotiation;
- governance;
- community development;
- finance and budgeting;
- primary health;
- community health.

It will be equally important to create a pool of candidates who are varied in age, gender and ethnic backgrounds in order to regroup a variety of sensitivities reflecting the Francophone population in Timmins.

The proposed recruitment strategy for putting the governance model in place takes approximately twelve months, depending on how quickly the steps are completed. It focuses on local players who are well

established in the community, in order to select the centre's first directors who have not only the required skills, but also the interest and time required to work on the launch of the long-awaited Francophone community health centre.

5.4. FINANCIAL MODEL

In order to deliver the expected outcomes of the Ontario Ministry of Health and Long-Term Care's Strategy, recently published in the *Excellent care for all Act*, health care service providers continuously seek to improve their delivery of quality care, increase accessibility and efficiency in a fiscal environment where funding (net of inflation) is continuously decreasing. One of the most efficient ways to reach this goal is through a benchmarking exercise with comparable peers. Benchmarking exercises provide basic key performance indicators that drive health care service provider agendas towards best practices and change management.

Key elements of a successful benchmarking exercise consist of:

- the gathering of quality data;
- the inexistence of bias on the outcomes;
- the use of results that are statistically un-refutable.

In fulfilling PGF's mandate towards the development of a financial model for the future Community Health Centre in Timmins, it became clear that the availability of data for service utilization per clinical program by the francophone population was non-existent. Consequently, the main driver used for the proposed financial model was overall service utilization per program by Community Health Centers with overall expenses under $4.3 million (notwithstanding of language[13]). This helped determine the required number and category of full-time equivalents per program, square footage needed to operate within the benchmark, efficient operating expenses from peers per program, cost centres and finally, a detailed capital cost including wear and tear index for capital replacement.

In the absence of volume per program for Timmins, the proposed financial model provides a realistic level of service utilization, efficient number of full time equivalent to accompany the proposed model, a total operating budget that maximizes resource utilization and a high-level capital budget built with the Ministry of Health and Long-Term Care's capital branch template.

METHODOLOGY

In order to develop an operation and capital budget for the Timmins francophone CHC, we employed a methodology based on key performance indicators arising from the Ministry of Health and Long-Term Care Healthcare Indicator Tool. The goal was to determine a range of patient activities that could then be applied to the 10,920 Francophones of Timmins as well as Francophones from surrounding areas[14]. This is the stepping stone of our model which dictates the number of required full-time equivalents (excluding physicians), operating budgets, square foot and capital cost of the future Francophone CHC in Timmins.

[13] One francophone CHC with expenses over $4.3 million was added to this group to ensure all francophone CHCs were included in the group.

[14] 2016 Census, Total population with French as their mother tongue.

From the Ministry of Health and Long-Term Care Healthcare Indicator Tool, the following key indicators were chosen to build comparable peer CHC groups:

- **Total operating expenses**: Relevant for calculating the 50th percentile that will represent the efficient available funds to provide the targeted level of patient activity. PGF decided to use the 50th percentile in all calculations based on the fact that it's the benchmark measure for most health care service provider in Ontario. Reaching this goal in all key performance indicators will assure profitability and an efficient utilization of resources;

- **Total Service provider interactions**: This indicator measures the number of services provided to the population. This is the key measure of patient activities in that it measures the number of times each patient receives services from CHCs. For example, on the same day, if a patient undergoes a consultation with his physician, a nurse and a social worker, the total of interactions would be of 3 for that day. If the same patient came back to the clinic within the same fiscal year we would add those new interactions to the previous 3;
- **Number of full time equivalent**: Relevant to calculate the efficient level of interaction per full time equivalent (excluding physicians) and the number of needed square foot as a benchmark;

- **Total of individuals served by organization**: Relevant to calculate the percentage of the population that will be patient of the Timmins Francophone CHC. We will use this result to estimate the total service provider interactions applying the average number of occurrences per individual.

From these key indicators, seven compatible groups were formed to calculate the number of required full time equivalent per cost centre and the cost per service provider interactions. The following criteria were used to build the 6 subgroups[15]:

- All CHCs with operating budgets less than $4.3 million + one remaining Francophone CHC with a budget above;
- Sub-group of CHCs with a high number of Francophone clients;
- Sub-group of CHCs with operating budgets of less than $3 million;
- Sub-group of CHCs with operating budgets between $3 and 3.6 million;
- Sub-group of CHCs with operating budgets of 3.7 to 4.3 million;
- Hybrid sub-group composed of 10 CHCs with the highest level of compatibility with the four key indicators mentioned above;
- Sub-group off all rural CHCs.

For all these groups, from information obtained through the Ministry of Health and Long-Term Care Healthcare Indicator Tool, we were able to[16]:

- Allocate costs between the following cost centre, administration and support, diagnostics & therapeutics services, therapy and chronic disease clinics, health prevention and promotion clinics and clients support based on level 1 of the Ontario MIS guideline on reporting activities and cost for each CHC;
- Calculate a number of full time equivalent (excluding physicians) per cost centre mentioned above;
- Identify the number of interactions per CHC;

[15] See Appendix 7 for a detailed list of CHCs used for the benchmarking exercise per sub-groups.

[16] See Appendix 8 – 9 for detailed data for our 31 CHCs and sub-groups.

- Calculate a total and clinical cost per full time equivalent (excluding physicians) and per interactions.

PGF's original goal was to create a financial model with financial and statistical indicators from the sub-group of CHCs with a high number of Francophone clients. After analysis of results from this sub-group, the presence of a bigger CHC (Community health centre de l'Estrie) seemed to have too much of an influence on our key indicators. Hence the reason why we decided to create other sub-groups as listed above, to ensure the appropriate amalgamation of CHCs was used for our scenarios.
One of the key findings of this benchmarking exercise is that all groups are highly statistically comparable with a small variance between average and median on the following indicators:

- Percentage of cost centre to total operating expenses per CHC;
- Total and clinical cost per full time equivalent (excluding physicians);
- Total and clinical cost per interaction.

Assured that our groups are comparable, all operating financial calculations and utilization of resources are at the 50th percentile to ensure that the operating budget is efficient and optimizes the utilization of resources. These benchmark indicators will drive efficiency and will be the starting point of the functional program which will be presented to the Ministry of Health and Long-Term Care.

For capital expenses, rates and categories of expenses are based on Ministry of Health and Long-Term Care Capital Branch for a new construction. The costs for renovations of an existing building and 10 years rent requiring leasehold improvement were also included.

PROPOSED SCENARIOS

The next step of our process was to come up with a rationale to create scenarios that would be in line with the proposed model of service. While comparing CHC utilization in urban and rural environments, a clear trend arose: per capita utilization is higher in a rural environment. We then established the utilization ratio in adding up all the rural population surrounding CHC's and we divided it by the number of patients attending these facilities. Our finding was that one individual out of six (16,67%) is a CHC patient in rural area. From the Ministry of Health and Long-term Care Healthcare Indicator Tool, these patients are recognized as frequent users in the sense that they use CHC's professional services 5 to 9 times per fiscal year (total interactions in rural environment divided by the number of patients attending these CHCs). With this clinical activity we built three scenarios that will allow for growth and efficiency. Our calculations are also based on the assumption that the Francophone population of Timmins is no different from the rest of Ontario regardless of the language determinant and they will also be patients in the future Timmins CHC for Francophones from 5 to 9 visits per fiscal year. For example, at the low end of the activity projection, 2,481 Francophones of Timmins would become patients (Francophone population of 14,885 X 0.1667) with 5 interactions per year, which translates into 12,405 interactions.

The proposed scenarios are the following:

- *SCENARIO #1* is for a volume of 14,000 service provider interactions. It's based on data of the sub-group of CHCs with operating budgets of less than $3 million. With the assumption that 12,405 interactions would be from Timmins Francophones, it's fair to think that the remaining volume will come from Francophone population outside of Timmins and from the Anglophone population. For cost per service provider interactions, PGF used the average cost of $195.39 which results from the 31 CHCs used in the analysis;

- *SCENARIO #2* is for a volume of 18,000 service provider interactions representing the average volume of rural CHCs. Again, for cost per service provider interactions, PGF used the average cost of $195.39 which results from the 31 CHCs used in the analysis;
- *SCENARIO #3* is for a volume of 20,000 service provider interactions. PGF evaluates this is a reasonable growth based on the actual number of Francophones. On the other hand, PGF used the average cost of scenario 1 and above with an additional effort at the median cost minus 5% for efficiency.

5.5. PROPOSED HUMAN RESOURCES PLAN

As outlined and explained in the programming section of this report, the proposed interdisciplinary primary care clinic will facilitate access to a wide range of services for patients with chronic obstructive pulmonary disease (COPD), diabetes, inflammatory arthritis, arterial hypertension, and will ensure health promotion and prevention for the elderly, and deliver integrated perinatal and early childhood services and out-patient mental health services. By combining resources and expertise of human resources within the primary care clinic, the model will improve the quality of programs and services and even develop interdisciplinary models of collaboration to enable optimal management of health conditions. Physicians, health care workers and support staff will be bundled within the Primary Care Clinic and they will be the central point of contact for all programs and community services.

The benchmarking results from the group of 31 CHCs and sub-group discussed above and the Standardized ACG Morbidity Index (SAMI) were used to measure the level of acuity and guided us in the development of the proposed staffing pattern.

Considering the proposed model and program for the new Timmins CHC, three staffing options are presented below based on the estimation of service provider interaction expected.

Table 2: Human resources by estimation of service provider interactions

Service provider interactions	14000		18000		20000	
Medical team						
Physician $ 325 000 funded rate 2018	1.00	$ 325,000.00	1.00	$ 325,000.00	1.00	$ 325,000.00
Nurse practitioner $ 103,822 funded rate 2018	2.00	$ 207,644.00	3.00	$ 311,466.00	3.00	$ 311,466.00
Medical team sub-total	**3.00**	**$ 532,644.00**	**4.00**	**$ 636,466.00**	**4.00**	**$ 636,466.00**
Clinical team						
Primary Care Coordinator $ 70 989 funded rate 2018	1.00	$ 70,989.00	1.00	$ 70,989.00	1.00	$ 70,989.00
Registered Nurses	1.50	$	2.00	$	3.00	$

$ 69 335 funded rate 2018		104,002.50		138,670.00		208,005.00
Registered Nurse OTN $ 69 335 funded rate 2018	0.50	$ 34,667.50	0.50	$ 34,667.50	0.50	$ 34,667.50
Registered Practical Nurse $ 49 115 funded rate 2018	1.00	$ 49,115.00	1.00	$ 49,115.00	1.00	$ 49,115.00
Pharmacist $ 92 260 funded rate 2018	0.50	$ 46,130.00	0.50	$ 46,130.00	0.50	$ 46,130.00
Psychologist $ 140 809 funded rate 2018	0.50	$ 70,404.50	1.00	$ 140,809.00	1.00	$ 140,809.00
Social workers $ 71 756 funded rate 2018	1.00	$ 71,756.00	1.50	$ 107,634.00	1.50	$ 107,634.00
Registered Dietetian $ 69 335 funded rate 2018	0.50	$ 34,667.50	0.50	$ 34,667.50	0.50	$ 34,667.50
Physiotherapist $ 78 777$ funded rate 2018	0.50	$ 39,388.50	0.50	$ 39,388.50	0.50	$ 39,388.50
Early Childhood Worker $ 55 857 funded rate 2018	0.50	$ 27,928.50	0.50	$ 27,928.50	0.50	$ 27,928.50
Health promoter/Educator $ 69 335 funded rate 2018	0.50	$ 34,667.50	1.00	$ 69,335.00	1.00	$ 69,335.00
Pivot patient navigator $ 61 944 funded rate 2018	1.00	$ 61,944.00	1.00	$ 61,944.00	1.00	$ 61,944.00
Community coordinator $ 55 857 funded rate 2018	1.00	$ 55,857.00	1.00	$ 55,857.00	1.00	$ 55,857.00
Clinical team sub-total	**10.00**	**$ 701,517.50**	**12.00**	**$ 877,135.00**	**13.00**	**$ 946,470.00**
Support and administration team						
Executive director–Level 2 $ 95 398 funded rate 2018	1.00	$ 95,398.00	1.00	$ 95,398.00	1.00	$ 95,398.00
Assistant to E.D. $ 52 426 funded rate 2018	1.00	$ 52,426.00	1.00	$ 52,426.00	1.00	$ 52,426.00
Administrative assistant $ 45 926 funded rate 2018	1.00	$ 45,246.00	1.00	$ 45,246.00	1.00	$ 45,246.00
Financial / Data / outcome measures analyst $ 70 613 funded rate 2018	1.00	$ 70,613.00	1.00	$ 70,613.00	1.00	$ 70,613.00

Maintenance Worker $ 35 804 funded rate 2018	1.00	$ 35,804.00	1.00	$ 35,804.00	1.00	$ 35,804.00
Admin & support sub-total	**5.00**	**$ 299,487.00**	**5.00**	**$ 299,487.00**	**5.00**	**$ 299,487.00**
Total Full Time Equivalent & Salary Estimated Budget	**18.00**	**$ 1,533,648.50**	**21.00**	**$ 1,813,088.00**	**22.00**	**$ 1,882,423.00**

The next step with regards to the human resources strategy would be to finalize volume of patient activities per program in a functional program, and then to validate the number and category of staff required. From that, a clear definition of roles and responsibilities per type of personnel would feed the recruitment and remuneration plans.

5.6. OPERATING AND CAPITAL BUDGET

From the scenarios mentioned above, here's the step by step procedure utilized (using scenario #1 as an example) to produce the opening operating budget:

1. First step was to calculate the weight of each cost centre;
2. For each cost centre, we multiplied the service provider interactions by the total cost per Service Provider Interactions, and then multiplied it by the average CHC cost centres weight of the total operating budget. Weights for cost centres are the following:
    a. Administration and support average of 25%;
    b. Clinics & Programs average of 68%;
    c. Health prevention & promotion clinics average of 7%.
3. The requested full-time equivalent is calculated with the ratio of Service Provider Interactions divided by the lowest Service Provider Interaction;
4. The total cost per interaction is the average cost;
5. The total clinical cost is the total operating budget minus administration support services divided by the Service Provider Interaction.

Table 3: Operating and Capital Budget

Operating budget	**Scenario # 1** # 1 -Lower volume - average cost per intervention of the 31 CHC's	**Scenario # 2** # 2 -Median volume - average cost per intervention of the 31 CHC's	**Scenario # 3** # 3 -High volume - average cost per intervention of the 31 CHC's minus 5% for efficiency
Service provider interactions	14,000	18,000	20,000
Expenses per cost centre			
Administration and support	$668,825	$859,918	$907,692
Clinics & Programs	$1,858,759	$2,389,835	$2,522,603
Health Prevention & Promotion	$207,897	$267,296	$282,145

TOTAL OPERATING BUDGET	$2,735,482	$3,517,048	$3,712,440
Number of Full Time Equivalent (FTE)*	**14.8**	**17.6**	**19.2**
Total Cost per Service Provider Interactions	**$195.39**	**$195.39**	**$185.62**
Clinical cost per Service Provider Interactions	**$147.62**	**$147.62**	**$140.24**
Service Provider Interventions per FTE's	**943**	**1,024**	**1,043**
Capital budget			
Number of Full Time Equivalent (FTE)	14.8	17.6	19.2
Gross Square Foot	25,997	30,800	33,570
Infrastructure Scenarios			
New construction	$22,679,013	$26,869,055	$29,285,703
Renovation	$11,605,985	$13,750,239	$14,986,958
Renting cost (Ten years lease contract)			
Leasehold improvement	$1,384,978	$1,640,858	$1,788,440
Renting cost	$1,438,047	$1,703,732	$1,856,969
Total renting cost (yearly)	$2,823,025	$3,344,590	$3,645,409

* Number of Full Time Equivalent (FTE) excludes physicians and their salary.

KEY FINDINGS OF THE FINANCIAL PROPOSAL

The following elements constitute the key findings and the main takeaways for financial consideration:

- Projected volumes vary from 14,000 to 20,000 permitting future growth;
- The Timmins CHC for Francophones should be allocated an operating budget (excluding physician) of 2,7 million $ at the lowest level of activities and 3,7 million $ at full capacity using 2016-17 dollars (no inflation);
- All scenarios are at the 50th percentile meaning that they are efficient and would ensure positive returns on the annual funding;
- Scenario #3 is more aggressive with a plan to get to the 25th percentile;
- Total full-time equivalent staff is aligned with the proposed staffing pattern and service model as per other deliverables of the mandate;
- Each full-time equivalent would provide around a thousand interactions per fiscal year;
- The new centre would require between 25 to 34 thousand gross square feet to be functional;
- The cost of a new construction (class D) would be between $24 to 30 million, a reduction of 50% if done through the renovation of existing space;
- The possibility of a 10-year rent with leasehold improvement was included. This option adds between $1.4 and 1.9 million dollars to the operating budget.

5.7. FORECAST OPERATING BUDGET

This section presents a high-level forecast for the operating budget of the Timmins CHC in five and ten years. The assumption used are the following:

1. Operating cost: Annual increase of 1,5 % per year, aligned with recent wage increases as per collective bargaining agreements;
2. Service Provider interactions: Annual increase of 0.5%, aligned with the arrival of new services. Depending on the level of integration and collaboration of existing health care providers, this increase could be more than 0.5%;
3. With an annual increase of 0.5% in services, we don't believe that additional full-time equivalents would be required;
4. We're assuming that the new centre will either be a new construction or a renovation of existing space fully financed by a Capital Grant from the Ministry of Health and Long-Term Care.

Table 4 : Forecast Operating Budget

Five year after opening	Scenario # 1 # 1. Lower volume - average cost per intervention of the 31 CHC's	Scenario # 2 # 2. Median volume - average cost per intervention of the 31 CHC's	Scenario # 3 # 3. High volume - average cost per intervention of the 31 CHC's minus 5% for efficiency
Service provider interactions	14,354	18,455	20,505
Expenses per cost centre			
Administration and support	$720,512	$926,373	$977,838
Clinics & Programs	$2,002,405	$2,574,521	$2,717,550
Health Prevention & Promotion	$223,963	$287,952	$303,950
TOTAL OPERATING BUDGET	**$2,946,880**	**$3,788,846**	**$3,999,337**
Number of Full Time Equivalent (FTE) *	**14.8**	**17.6**	**19.2**
Total Cost per Service Provider Interactions	**$205.31**	**$205.31**	**$195.04**
Clinical cost per Service Provider Interactions	**$155.11**	**$155.11**	**$147.35**
Service Provider Interventions per FTE's	**967**	**1,049**	**1,070**

* Number of Full Time Equivalent (FTE) excludes physicians and their salary.

Ten year after opening	Scenario # 1 # 1. Lower volume - average cost per intervention of the 31 CHC's	Scenario # 2 # 2. Median volume - average cost per intervention of the 31 CHC's	Scenario # 3 # 3. High volume - average cost per intervention of the 31 CHC's minus 5% for efficiency
Service provider interactions	14,716	18,920	21,023
Expenses per cost centre			
Administration and support	$776,196	$997,967	$1,053,409
Clinics & Programs	$2,157,158	$2,773,490	$2,927,572
Health Prevention & Promotion	$241,272	$310,206	$327,440
TOTAL OPERATING BUDGET	**$3,174,627**	**$4,081,663**	**$4,308,422**
Number of Full Time Equivalent (FTE) *	**14.8**	**17.6**	**19.2**
Total Cost per Service Provider Interactions	**$215.73**	**$215.73**	**$204.94**
Clinical cost per Service Provider Interactions	**$162.98**	**$162.98**	**$154.83**
Service Provider Interventions per FTE's	**991**	**1,076**	**1,097**

* Number of Full Time Equivalent (FTE) excludes physicians and their salary.

6. ROLE OF THE PATIENT NAVIGATOR (DELIVERABLE 5)

The ongoing transformation of the health system in Ontario is part of a drive to reduce the burden on the health system, improve patients' experience by putting their experience at the heart of the system, and increase the efficiency and effectiveness of primary health service providers. This transformation results in the decentralisation of services to members of the community, thereby making it more complicated to identify appropriate health services and resources for the population and establish networks for them – especially for members of Francophone communities.

Nevertheless, progress is being been made in regards to a service delivery approach that focuses on health determinants to provide sustainable improvements to the health and wellbeing of individuals, families and communities. This approach fosters the emergence of holistic treatment approaches delivered by interdisciplinary teams that work together to support patients in their treatment and recovery plan. Since recovery of health usually happens in the community, it must be supported by mechanisms that allow a smooth flow of communication and information between the primary health sector and second-line services. This networking of primary care and community-based information and services is all the more important to adequately support the monitoring and recovery of patients.

The language skills of health professionals who deliver health care services and community services add an extra level of difficulty in identifying the scope of available services and properly referring patients to health care and community services that are culturally and linguistically appropriate for them.

The need for better coordination and integration and a more thorough follow-up on clinical interventions involving multiple stakeholders led to the creation of similar positions within the health system, but with job titles and responsibilities that vary from one organization to another. Examples of this diversity of job titles include personal service coordinator, case manager, nurse navigator, clinical coordinator, patient navigator and network navigator, to name only a few. These stakeholders generally work to reinforce the coordination of services and ensure a coherent care plan for patients with complex health issues. The tasks that these stakeholders perform include the following functions:

- ensure that a treatment plan is developed with the input of all relevant health providers and professionals;
- coordinate services between all relevant health providers and professionals;
- follow up with patients and ensure they understand the available treatment options and their consequences;
- update the information in the patient's file and share it with relevant health providers and professionals;
- refer the patient to other relevant resources to aid in his recovery within the community, as required;
- advocate for patients' rights.

In this report, we will use the term "patient navigator" to describe a position that was created to improve service integration and patient experience and to support efficiencies within the health system.

In the following sections, we will touch on a few inspiring patient navigator models that exist in Ontario, clarify the scope of stakeholders who work at integrating health services in Ontario, and explore the key components of the role of patient navigator suggested for Francophone community health centres, and specifically for the future community health centre in Timmins.

6.1. EXPERIENCE OF OTHER FRANCOPHONE COMMUNITY HEALTH CENTRES

Most of the Francophone community health centres surveyed by PGF Consultants for this mandate do not currently use patient navigators. However, many of them feel that this could be an interesting approach to improve the experience of Francophone patients and the coordination of services with other providers.

The Kapuskasing community health centre recently revised its job description for a social worker, adding the follow-up and coordination of care for patients with complex health issues. It should also be noted that the Executive Director of this facility indicated that nursing experience was an asset for patient navigators who initiate dialogue with all health providers on the topic of patient care, coordinate the prescribed care and help patients and their family understand their illness, their treatment options and the consequences of their treatment options.

6.2. SOME PATIENT NAVIGATOR MODELS

The patient navigator is perceived as a key player to improve the quality of services offered to patients receiving care from multiple sources. Patient navigators generally integrate a range of services for a given client across the entire continuum of care – from health promotion and prevention to treatment and recovery in the community.

Recent studies have confirmed the positive contribution of patient navigators in the process of individual recovery. For example, thanks to funding provided to the Northern Ontario Independent Living Association (NILA), the position of community navigator was created to help people who have had a stroke and their family adjust to life back in the community. A navigator helps clients access community resources, develops personalized recovery plans and evaluates a client's progress. According to the study, "stroke patients who opted for navigation recorded a significant improvement in their Return to Normal Living Index (RNLI) scores six to twelve weeks after their discharge from hospital. The patients who used a navigator also reported the service benefitted their overall sense of well-being."[17]

North York General Hospital also created the position of patient navigator for patients receiving a hip replacement. This role is performed by a clinical nurse specialist who begins communicating with patients up to nine months before their scheduled date for surgery to discuss preparations, anticipate the recovery process, assess the need for additional specialists to support recovery, as well as develop and coordinate a care plan that ties in all steps and aspects of care required by patients.[18]

Since 2012, the Ottawa Hospital has a patient navigator for First Nations, Inuit and Métis (FNIM) cancer patients. This hospital recognizes the need to "help FNIM overcome their higher cancer incidence and mortality rates and better navigate the complexities of the cancer system by building more cultural competency within the system and bridging the divide between health-care professionals and their

[17] Timmins and District Hospital (2016), Stroke Navigator Program for Stroke Patients.
[18] MHLTC, "Navigating the Way to Improved Patient Care – North York General Hospital".

Aboriginal patients."[19] The patient navigator helps FNIM cancer patients better understand their illness, enhances their awareness and educates them on treatment options and procedures, referring them as needed to additional resources to help them cope with their cancer and potentially improve treatment results.

Other FNIM patient navigator positions exist throughout the province to facilitate the coordination of culturally adapted care, reduce the disparity of access to services and improve health outcomes for FNIM, which are disproportionately lower than those of non-Aboriginal Ontarians. It is possible to draw a parallel with minority Francophone populations who struggle with similar issues to FNIM people, albeit to a lesser extent. It nonetheless remains that the creation of a patient navigator for FNIM patients recognizes the importance of helping marginalized or minority populations navigate the health system and receive linguistically and culturally appropriate care. The results show the positive impact of this approach on patient awareness and engagement in the management of the disease and in the recovery process.

Bruyère Continuing Care also created the position of community health navigator to improve equitable access to community resources (ACR) for Francophone patients receiving primary care. The ACR patient navigator works with primary health care practices and provides Francophone patients with services and information in French, including practical assistance, social support, referrals and advocacy to help people overcome barriers and access community resources.

Although the Bruyère Continuing Care ACR patient navigator model focuses on helping Francophones access community resources, it proposes interesting suggestions that can serve as inspiration for the Timmins Francophone community health centre model, specifically in regards to its role in:

- developing an active offer of community and social health services in French with a view to facilitating the coordination and assessment of services offered by external providers;
- fostering understanding between care providers and patients regarding linguistic sensitivities, interpreting cultural norms, roles and beliefs that could interfere with understanding the required care, and the process of individual recovery;
- collecting data on the needs of Francophone patients as well as the availability and use of French language resources, from the point of view of the patient navigator who collaborates directly and coordinates services with external providers and follows up with patients about their experience and the quality of services received.

The role of third-party data collection by the patient navigator is worthy of interest for Timmins as a way to build a quantitative and qualitative database focused on the experience of the patient navigator and the Francophone patient (wait times for appointments, language of service offered, etc.). This database would meticulously document the Francophone experience in the health system for the purpose of maximizing transparency and supporting the changes needed to achieve health equity. Such a database could foster dialogue with health care providers, from whom many Francophones would not be able to receive health services in French, on how these services could be improved.

[19] The Ottawa Hospital, Newsroom: "Champlain Region to Appoint Patient Navigator and Regional Cancer Lead to Improve Aboriginal Care", December 5, 2012.

6.3. SCOPE OF VARIOUS SERVICE COORDINATOR POSITIONS

Many terms are used to describe the function of service coordinator for patients and their family. We will take a closer look at what distinguishes three types of coordinator positions to shed some light on the potential role of the Timmins Francophone community health centre patient navigator.

CASE MANAGER

The case manager is a common position in mental health and addiction services as well as in services for frail elderly people. People in this position often have a background in social work.

In mental health and addictions, case managers are responsible for evaluating their clients' needs, expectations and priorities, developing a relevant action plan, following up with their patients, offering counselling and support, and referring them to other community resources to achieve full integration into the community, whether it be for housing, assistance or employment assistance or social and legal services.

In the field of services for frail seniors, case managers generally have nursing experience, which allows them to evaluate their clients' needs and environment in order to identify and retain appropriate external services that can help them continue to live safely at home or in the community for as long as possible. This function also involves regular follow-ups, making patients aware of the choices available to them, coordinating services and referring patients to other relevant resources in the community.

Currently, LHIN case managers fall into this category, since they identify patients' needs and retain services from community or private suppliers to meet these needs, while offering a more limited range of clinical services. Nonetheless, it is possible that the future Timmins Francophone community health centre will seek a closer collaboration with Francophone case managers from the NE LHIN to facilitate the alignment of services and referrals for Timmins' Francophone population.

INTERNAL PATIENT NAVIGATOR

The internal patient navigator is generally the main link between the patient and the health care facility. This person ensures that patients and their loved ones receive the assistance and support they need and that the interventions and services provided by various health care stakeholders are integrated. The internal patient navigator also facilitates dialogue with interdisciplinary teams and the development of a shared care plan with stakeholders from the health care facility while respecting the patient's preferences. The focus is on improving the patient's experience and increasing efficiency and effectiveness by coordinating the care offered by a given health care facility. This role does not involve coordinating and integrating interventions and services offered by other providers.

NETWORK PATIENT NAVIGATOR

The mission of the network patient navigator is essentially to improve the integration of services for a specific clientele from more than one facility and to ensure that a personalized care plan is developed in concert with all internal and external stakeholders, while respecting the patient's preferences. In addition, the network patient navigator conducts a needs evaluation, follows up with patients and relevant service providers, updates patients' files and shares their progress with relevant stakeholders, measures patient satisfaction, refers patients to other community resources and advocates for patients' rights and interests.

The network patient navigator works to integrate and improve health services for a specific vulnerable clientele through a client-centred approach that often goes beyond the employer's mandate.

6.4. Recommended role of patient navigator for the Timmins Francophone community health centre

It is recommended that the patient navigator for the Timmins Francophone community health centre take on the role of "network navigator" so that the incumbent may develop specific knowledge about the experience of Francophone patients, identify available French language resources and collect solid evidence that can help guide decision-making with a view to improving the health of the Timmins Francophone community.

The network patient navigator would take on the role of clinical supervisor for Francophone patients at risk with complex health issues for clients of the Timmins Francophone community health centre and others, namely hospitals and primary care providers who have Francophone patients matching the profile and who want to benefit from this service. The network patient navigator would also support and accompany Francophone patients at risk with complex health issues in order to facilitate the integration of all services that require coordination and promote communication among internal and external health care professionals involved in their personalized care plan.

In this context, the network patient navigator would be the contact person for the patient, his family, members of the community health centre's interdisciplinary team, as well as stakeholders from other primary and community service providers.

The function of the network patient navigator is well aligned with the three health care objectives proposed in our model, namely improving service integration and patient experience and supporting efficiencies within the health system. In addition, it gives weight to the Timmins Francophone community health centre's objective of playing a leadership role in the health of the Francophone community.

It is possible to categorize the network patient navigator's duties into five main responsibilities: clinical supervision, needs assessment, coordination and integration of clinical activities, community liaison, and support and assistance during the patient's clinical treatment path.

Role of clinical supervision

- act as a contact person for patients, families, health care stakeholders and other professionals;
- develop a personalized care plan in concert with all key stakeholders while respecting the client's preferences;
- contribute to developing different interdisciplinary collaboration tools with key stakeholders;
- perform relevant clinical follow-ups as required;
- update the client's file to include evaluations of other professionals;
- initiate and facilitate interdisciplinary meetings with key stakeholders.

Role of needs assessment

- evaluate the patient's global state of health, as well as his needs and those of his family;
- develop an action plan with the patient according to his expectations and priorities;

- provide information about the disease and various treatment options;
- perform a follow-up and an evaluation of the interventions received by the patient;
- collect data in real time.

ROLE OF COORDINATION AND INTEGRATION OF CLINICAL ACTIVITIES

- ensure coordination of clinical activities with all relevant stakeholders and providers (hospitals, home care, community services, etc.);
- coordinate the services and care to be provided to the patient within the same facility or by external providers;
- update the patient's file and ensure proper communication and understanding among all key stakeholders.

ROLE OF COMMUNITY LIAISON

- update the active offer of French language services available in the community and other facilities;
- provide referrals and references for additional complementary resources (interpretation, social services, legal services, community services, etc.)
- create structural collaborations with other providers in the community to provide adequate services to Francophone patients;
- make stakeholders aware of linguistically and culturally appropriate services;
- make recommendations about any gaps observed and possible collaborations to improve services to Francophones.

ROLE OF SUPPORT AND ASSISTANCE

- meet with patients and their family and explain patient navigator role, along with services they can access;
- follow up on the patient's objectives;
- support and assist the patient and his family on the journey towards stabilizing their health and reaching their optimal.

The network patient navigator will be an innovative asset to support the rollout of the Timmins Francophone community health centre and its programs, particularly those targeting individuals at risk and suffering from chronic disease. This person will be a valuable resource to link Francophone patients with French language health care services available in the community and identify areas of improvement to enhance services to Francophones at risk, as well as services that could be offered at the Francophone community health centre. This would allow the centre's programs to evolve to fill unmet needs, a finding that could be supported by real time data.

Knowledge of community services will also be an asset for establishing and reinforcing structural collaborations for the Francophone community health centre. Information collected from the network patient navigator and Francophone patients will help guide the allocation of roles and responsibilities among service providers.

7. MULTI-YEAR ACTION PLAN TO ADDRESS OTHER RECOMMENDATIONS (DELIVERABLE 6)

The last deliverable in the report that PGF Consultants was mandated to prepare was the development of a multi-year action plan to address the 15 recommendations contained in the 2016 report. During the meeting held in Timmins on November 28, 2017 between PGF Consultants and the Collaborative Committee on primary care offered to Francophones in Timmins, the discussion on this last deliverable was brief. It was noted that progress had been made over the last year and a half and for this reason, rather than outlining a multi-year action plan, this section presents an update on recent progress and some ideas for next steps.

Recommendation #1

That the LHIN, in collaboration with the Réseau du mieux-être francophone du Nord de l'Ontario (RMEFNO), establish a standing committee (with the LHIN) for the coordination and the integration of health care services in French in Timmins that will oversee the implementation of the recommendations contained in this report. Committee membership must be representative of the community and service and care providers, as well as the partners involved in the delivery of health care services for the Francophone population.

This recommendation resulted in the creation of the Collaborative Committee on primary care offered to Francophones in Timmins, but as a non-permanent committee with a mandate to *conduct a detailed study of the recommendations contained in the report and develop an action plan to improve the delivery of primary health care services to Francophones in Timmins.*[20] This issue constitutes the focus of this study, and efforts involved in the planning and implementation of a community health centre for Francophones in Timmins were supervised by this committee.

Nonetheless, given the existence of other standing committees within the NE LHIN, it was decided that the Collaborative Committee would not be a permanent committee. It would therefore be advisable to continue discussions on implementing recommendations and to ensure follow-ups are done during meetings of the *Carrefour santé* of Timmins under the leadership of the RMEFNO.

Recommendation #2

That the MOHLTC and the LHIN work together to develop a Community Health Centre managed by Francophones, in order to serve the Francophone population in the City of Timmins.

This recommendation is already in progress with the current study on the planning and implementation of an innovative model for a Francophone community health centre in Timmins.

Recommendation #3

That the LHIN, through its standing committee, initiate bilateral discussions as soon as possible with key designated and identified service and care providers in order to outline the problems related to insufficient health services in French and examine realistic solutions or initiatives for improvement that could have short-term impacts.

[20] Exerpt from "Collaborative Committee Terms of Reference", January 2017.

This work is already underway thanks to the efforts of the LHIN staff. Every three years, designated health service providers under the French Language Services Act are evaluated against criteria linked to their legal obligations to deliver services in French. A guide to help health service providers who wish to become designated has been developed by the *Réseau des services de santé en français de l'Est de l'Ontario*.[21]

In addition, the LHIN performs an annual progress review of health care providers identified under the French Language Services Act in order to assess how they are meeting the needs of their clients' who want to receive services in French.

It is also worthy of note that the MOHLTC recently mandated the *Réseau des services de santé en français de l'Est de l'Ontario*, together with the French Language Health Planning Entities and LHINs, to deploy an online tool which all LHIN-funded service providers in the province will use to provide an annual update on their compliance status in regards to their designation under the French Language Services Act. They will also need to provide an overview of their ability to offer services in French.

Recommendation #4

That the LHIN, through its standing committee, develop a strategy for the promotion of health services available in French, together with service and care providers and the RMEFNO. In addition, the LHIN should collaborate with public health partners to ensure that information shared with the public regarding services in French is up to date. Once the Community Health Centre's programs have been developed, the LHIN and the standing committee should include this information in community promotion efforts.

Primary health care providers regularly collaborate with the Porcupine Health Unit to ensure the ongoing implementation of various health promotion strategies for the entire population of Timmins, including Francophones. That being said, more efforts could be made to increase the promotion of French services offered by health care providers in the region. The creation of a Francophone community health centre for Timmins will certainly play a key role to this end.

Recommendation #5

That the LHIN actively support the Francophone Community Health Centre in developing the Centre's initial programs, in collaboration with service and care providers in Timmins as well as the standing committee. LHIN leadership will be essential in order to optimize the offer of French-language services and complement the current service offer, with the goal of increasing synergies to benefit the Francophone population. In addition, the measures must take into account the literature review completed in this study, as well as the new directions emanating from current transformations within the health system.

This recommendation is already underway. Deliverable 3 of this report recommends that the initial programs developed for the Francophone community health centre take into account the needs of the Francophone population, services that already exist in the community and partnerships that need to be created to complement the services offered by existing providers and organizations.

[21] French Language Health Service Network of Eastern Ontario (2013). Designation Guide. On line: http://rssfe.on.ca/upload-ck/designation_guide-2013.pdf

Recommendation #6

That the LHIN oversee the establishment and maintenance of Francophone representation for the governance of designated and identified service and care providers and that the RMEFNO, in collaboration with the Francophone community in Timmins, identify ways to increase Francophone participation in the governance of identified and designated service and care providers.

This recommendation is a responsibility that is shared by the whole community. Given the time commitment involved to sit on a board of directors, it is not easy to recruit Francophone volunteers. Governance will also be considered in the tool developed by the *Réseau des services de santé en français de l'Est de l'Ontario*. Thanks to this tool, within a few months the LHIN and the RMEFNO will have access to data that will help inform their decisions on this topic, enable them to make annual comparisons and identify solutions to guarantee that Francophone voices are heard and considered.

Recommendation #7

That the LHIN, taking into account the current health system transformation process, and in collaboration with the Porcupine Health Unit, the RMEFNO, service and care providers and the other relevant players in the health care sector, revise the health promotion and disease prevention strategies geared to the Francophone population in Timmins, in order to better integrate and coordinate the different components of the system and thereby better serve the population.

One of the benefits of the new provincial Patients First strategy has been continuous improvement in the collaboration between the Porcupine Health Unit and the NE LHIN, which is working to implement sub-regions to increase the flow of information and address the region's health promotion and disease prevention needs. It is important to mobilize all partners, including schools and community organizations, since these are often the first to notice emerging issues. Nonetheless, some progress has been made in this regard over the past year. It is expected that the Francophone community health centre will play an important role in implementing this recommendation.

Recommendation #8

That the LHIN, in collaboration with primary care physicians and the organizations for which they provide services, establish coordination mechanisms in order to make it easier to refer Francophone patients to physicians able to serve them in French. These mechanisms could be integrated into efforts for finding physicians for orphaned patients in Timmins. The LHIN could potentially suggest to the MOHLTC that this issue and others related to improving the offer of French-language services in Timmins be raised with the Ministry of Health Advisory Committee for discussion.

It appears that the LHIN cannot take on a major role in this matter; rather, collaboration has to be initiated by the organizations themselves. Nonetheless, the creation of a Francophone community health centre will improve the situation and potentially support reflection on possible solutions that can help pair up Francophone patients with Francophone health care professionals.

Recommendation #9

That the LHIN create or designate a position dedicated to referrals and navigating the health system in French for the Francophone population in Timmins. The person who holds this position could thereby raise awareness among service and care providers regarding the importance of an active offer of services in French.

This recommendation has been addressed in this study, which proposes that the Timmins Francophone community health centre hire a network patient navigator to facilitate referrals of Francophone patients and help them navigate the health system.

Recommendation #10

That the LHIN standing committee work together with Health Force Ontario to develop a strategy to attract and retain Francophone human resources in the health care field for the clinical and medical positions deemed most critical. These efforts should be made jointly with key service and care providers in the city, including Timmins and District Hospital and educational establishments in Northern Ontario. This strategy should build on the Action Plan for French-language health care human resources in Ontario, under review by the MOHLTC.

Health Force Ontario recently hired a professional recruitment coordinator to cover the NE LHIN region. The mandate aims to accomplish this objective and will need to integrate recruitment support once programming for the future health centre is approved. Although the office for this position is located with the LHIN, the incumbent collaborates with and works two days a week at the Northern Ontario School of Medicine.

Recommendation #11

That the LHIN, in order to provide safe, quality primary health services, support the development of specific agreements with Francophone or bilingual facilities, or facilities with the necessary resources (with regard to specialists), to increase the availability of Francophone specialists. Modern technology must be leveraged to address the gaps in services currently unavailable in Timmins and better structure visits from external specialists to the city. This programming of external services could then become an integral part of the LHIN's promotion efforts among the Francophone population.

The study on the Timmins Francophone community health centre suggests that an OTN (Ontario Telemedecine Network) system be installed at the centre. Having the required infrastructure in place would allow the centre to access external specialists to meet the needs of the entire community. The rollout of telemedicine services would also help reduce the vulnerability of Francophones face when trying to access Francophone health care human resources.

Recommendation #12

That the LHIN develop a strategy to improve data collection on Francophones by service and care providers, and revise its service planning strategy for Francophones in the City of Timmins so that it better reflects this data, mainly by:

- *creating an inventory of the data available (including linguistic data from sites in a position to collect this data);*
- *providing systematic follow-ups with providers who are required to collect linguistic data regarding both the patient's first language and language of choice;*
- *applying the results of the data analysis to plan the rollout of the French-language service offer in Timmins;*
- *sharing the data with the RMEFNO in order to better inform the advice that it will provide to the LHIN concerning the planning of services for Francophones.*

The tool developed by the *Réseau des services de santé en français de l'Est de l'Ontario* provides a means to collect relevant data on how Francophones use health care services. In addition, the province's current initiative to add linguistic data to the health card will also address this recommendation. The RMEFNO and the NE LHIN will need to integrate these new data sources in their planning for the rollout of health services in the Timmins area.

Recommendation #13

That the LHIN revise its reporting requirements for designated service and care providers to include a clause related to the fulfilment and respect of the designation criteria in its accountability agreements, in accordance with the French Language Services Act.

This recommendation is in progress. The tools developed by the *Réseau des services de santé en français de l'Est de l'Ontario* will enhance the accountability that health service providers have towards maintaining their compliance with designation.

Recommendation #14

That the LHIN, through its accountability agreements, require that identified service and care providers, including family health teams, adopt language policies, strategies related to the active offer and promotional documents in both official languages. In addition, the LHIN should require that these policies be made public or that a mechanism be established in this respect so that the population knows what to expect in terms of French-language services.

Given the private nature of family health teams, the LHIN has neither the responsibility nor the jurisdiction to require them to improve their offer of service to the Francophone population. That being said, it is possible to influence other partners within the health system. The LHIN works closely with other health service providers to this end.

Recommendation #15

That the Francophone community, in partnership with the RMEFNO, establish formal and informal mechanisms to promote the offer of proactive health services in French in Timmins, thereby creating accessible and inspiring models for the entire community.

The *Réseau du mieux-être francophone du Nord de l'Ontario* has posted several active offer resources to its website that can be accessed by members of the community and health care providers. The Réseau continues to promote its tools with health service providers and other key community players.

Appendices
(in French only)

PGF consultants

ANNEXE 1 : ÉLÉMENTS DE CONSIDÉRATION POUR LA MISE SUR PIED D'UN CSC

Le rapport de 2016 intitulé « État de la situation et étude de modèles de soins de santé primaires offerts aux francophones vivant en situation minoritaire au Canada »[22] relate les résultats d'un inventaire des community health centres offrant des services en français au pays, de même que d'entrevues avec des personnes œuvrant dans le milieu. À partir de cette analyse, il a été possible de dégager des tendances qui, nous en sommes persuadés, sont d'un intérêt certain pour la mise en place d'un community health centre à Timmins.

- Les communautés francophones doivent continuellement s'adapter aux réalités politiques et économiques en ce qui a trait à la promotion des soins de santé primaires. Pour cette raison, elles se retrouvent avec différents modèles de santé primaire et de soins de santé primaires.
- Plusieurs communautés francophones rencontrent des défis politiques dans la mise sur pied de community health centres, d'où la nécessité de travailler étroitement en partenariat avec des organismes nationaux comme la Société Santé en français et l'Association canadienne des community health centres. Ces organismes peuvent aider à établir des liens avec d'autres organismes francophones ou bilingues situés ailleurs au Canada.
- La mise sur pied d'un community health centre en milieu minoritaire peut être longue et ardue. Les communautés qui ont réussi réitèrent l'importance :
  - d'obtenir l'appui d'un champion du secteur de la santé (médecin ou autre professionnel de la santé) afin de donner de la crédibilité au projet;
  - de mobiliser des partenaires clés comme les conseils scolaires francophones, les associations provinciales et territoriales de défense des droits des francophones, les organismes communautaires, la communauté francophone et les municipalités;
  - d'embaucher un infirmier praticien tôt dans le processus afin d'inclure des services de prévention et de promotion de la santé dans l'offre de services;
  - de mettre en place un modèle de gouvernance francophone qui soit à l'écoute des besoins des francophones en matière de santé.
- Il est important de commencer avec un projet de petite envergure et d'attirer des médecins et/ou des infirmiers praticiens francophones afin de recruter des patients et de démontrer aux bailleurs de fonds la nécessité d'une telle infrastructure pour mieux servir la Francophone population.
- Dans le contexte actuel de restriction budgétaire, il est important de travailler en partenariat avec des centres ou des institutions de santé déjà en place afin de réduire les dépenses en capital pour démarrer le projet.
- Il faut adapter le projet aux réalités régionales (centre qui fonctionne en français, mais qui offre des services aux francophones, aux autochtones et aux anglophones; community health centre en milieu rural qui inclut des lits de soins ambulatoires ou palliatifs, etc.)
- La gouvernance par et pour les francophones permet d'être à l'écoute des besoins réels de la communauté et de tirer parti de la diversité des compétences et des relations de confiance que les bénévoles apportent à une organisation. Le modèle de carrefour communautaire qui existe au Nouveau-Brunswick et qui est à l'étude présentement en Ontario regroupe un ensemble de services aux francophones (santé, culture, emploi, établissement). Il présente de nombreux avantages pour les bailleurs de fonds et pour la clientèle. Selon l'ACCSC, ces modèles de

[22] *État de la situation et étude de modèles de soins de santé primaires offerts aux francophones vivant en situation minoritaire au Canada*, rapport réalisé pour le compte de l'Association des centres de santé communautaire du Canada et la Société santé en français, 2016.

carrefour communautaire prennent racine dans les centres locaux de services communautaires (CLSC) qui ont vu le jour au Québec dans les années 1970. Les CLSC au Québec étaient parmi les premiers community health centres au Canada.

- ➢ Le gouvernement fédéral a accepté de financer un projet pilote de community health centre en milieu minoritaire en Alberta pour une période de trois ans sur une base expérimentale, la clinique francophone de Calgary. Cela crée un précédent important sur lequel les communautés peuvent s'appuyer pour poursuivre le travail avec le gouvernement fédéral.

ANNEXE 2 : LA PROGRAMMATION DES CENTRES DE SANTÉ COMMUNAUTAIRE

CSC KAPUSKASING

Soins primaires			
Diabète	• Suivis réguliers aux trois mois • Suivis téléphoniques • Séances d'éducation • Ateliers et présentations communautaires	Immunisation	• Vaccins pour réduire les risques de contracter des maladies tels l'influenza, le zona, les maladies infantiles
Tension artérielle	• Suivis réguliers selon le besoin • Accès à un moniteur de pression pendant 24 h • Séances d'éducation sur la prévention, les causes et les symptômes • Ateliers et présentations communautaires	Consultations pharmaceutiques	• Révisions et analyses complètes des profils médicamenteux • Séances d'information individualisées pour répondre aux questions de la clientèle du Centre concernant leurs médicaments • Démonstrations de l'utilisation de certains appareils comme les inhalateurs • Consultations auprès de l'équipe des soins primaires afin de trouver le médicament qui sera le plus efficace, le plus sécuritaire et parfois le moins coûteux
Prévention des chutes	• Évaluations des facteurs de risques • Ateliers d'éducation et d'information • Séances sur la gestion des médicaments	Services diététiques	• Consultations individuelles pour diverses raisons (p. ex., maladies chroniques, allergies ou intolérances alimentaires, saine alimentation durant les stades de la vie, troubles gastro-intestinaux) • Rendez-vous téléphoniques • Visites à domicile pour la clientèle à mobilité réduite • Ateliers nutritionnels
Soins des pieds	• Examens, nettoyages et coupes des ongles • Bains de pieds • Traitements de callosités • Éducation et prévention • Ateliers		

<table>
<tr><td>Santé mentale</td><td colspan="3">• Service professionnel et confidentiel de thérapie pour la clientèle du Centre
• Thérapie individuelle, familiale, conjugale pour des raisons variées telles que l'anxiété, le deuil, la séparation, la relation de couple, les problèmes relationnels, la dépression, les troubles de comportement, les troubles de colère, le stress
• Soutien émotionnel, écoute active
• Accompagnement du patient pour trouver des solutions appropriées à sa situation
• Présentations communautaires touchant divers sujets reliés à la santé mentale
• Ateliers et groupes de soutien
• Références à d'autres programmes et agences</td></tr>
<tr><td colspan="4">Promotion et prévention</td></tr>
<tr><td>Promotion</td><td>• CHAQUE PAS COMPTE (programme de marche) (en savoir plus...)
• Programme d'exercices libres (en savoir plus...)
• Vivre en santé avec une maladie chronique (en savoir plus...)
• Groupe de soutien mensuel « Vivre en santé avec une maladie chronique »
• Cuisines collectives
• Capsules santé à la radio CKGN</td><td>Prévention des chutes</td><td>• P.I.E.D. (Programme intégré d'équilibre dynamique)
• P.I.E.D. santé (une séance d'exercices hebdomadaire pour les gens diplômés du programme P.I.E.D.)
• P.E.D. (Programme d'exercices à domicile)</td></tr>
<tr><td colspan="4">Services communautaires</td></tr>
<tr><td>Services diététiques</td><td colspan="3">• Activités du mois de la nutrition
• Présentations et ateliers communautaires auprès des groupes cibles
• Consultations avec les organismes communautaires</td></tr>
<tr><td rowspan="2">Programme communautaire</td><td colspan="3">Activité de tricot et bingo</td></tr>
<tr><td colspan="3">Comité jeune en santé</td></tr>
<tr><td>Programme vieillir à domicile</td><td colspan="3">• Matin santé rempli d'activités de sensibilisation, sociales, récréatives, sportives
• Matin construction pour hommes aînés qui se rassemblent afin de travailler ensemble à créer des projets de bois et de soudure
• Journée santé remplie d'activités de sensibilisation, sociales, récréatives, sportives
• Transport et aide-épicerie pour faciliter les déplacements à l'épicerie. Des bénévoles circulent pour aider les personnes âgées à trouver des articles.
• Gestion de cas : répertorier et évaluer les besoins de la personne âgée en matière de santé et d'intégration sociale afin de la référer aux différents services communautaires, ou encore coordonner l'offre de services auprès des différents organismes
• Programme de prévention des chutes comprenant le programme P.I.E.D. (Programme intégré d'équilibre dynamique), des classes d'exercices d'une heure proposées deux fois par semaine, le yoga sur chaise pour les personnes âgées francophones.</td></tr>
</table>

CSC ESTRIE

<table>
<tr><td colspan="4">Santé physique</td></tr>
<tr><td>Consultation médicale</td><td>• Sur rendez-vous
• Avec un médecin ou un infirmier praticien
• Visite à domicile lorsque cela est requis</td><td>Clinique ados</td><td>• Consultation dans les écoles avec un infirmier praticien</td></tr>
<tr><td>Soins infirmiers</td><td>• Prise de sang
• Injections
• Vaccin
• Pansement
• Retrait de points de suture</td><td>Diabète</td><td>• L’équipe du programme d’éducation sur le diabète est composée d’un diététiste et d’un infirmier ayant comme mandat d’enseigner aux diabétiques la façon de prendre en charge leur santé et la gestion de leur maladie.</td></tr>
<tr><td>Clinique vaccination</td><td>• Campagne annuelle – vaccin contre la grippe</td><td>Projet pilote Lombalgie</td><td>• Équipe de chiropraticiens avec le matériel spécialisé pour offrir des services de traitements, d’évaluation, de références et d’éducation</td></tr>
<tr><td colspan="2">Santé mentale</td><td colspan="2">Clinique de nutrition</td></tr>
<tr><td colspan="2">• Thérapie individuelle
• Thérapie familiale
• Thérapie de couple
• Groupe de soutien (suicide, proche aidant, etc.)
• Groupe thérapeutique (pleine conscience, anxiété, etc.)
• Atelier sur des thématiques variées</td><td colspan="2">• Consultation : diabète, conseils et éducation pour manger sainement, régime, problèmes de poids, hypercholestérolémie, prévention des maladies cardiovasculaires et autres
• Le programme baptisé Équilibre pour un poids sensé :
○ destiné aux adultes de tout âge qui ont un surplus de poids et ceux à risque élevé ou vivant avec le diabète et qui désirent perdre du poids;
○ inclut un volet sur l’alimentation, l’activité physique, les techniques pour surmonter les</td></tr>
</table>

			obstacles à la perte de poids ainsi que des démonstrations culinaires.
Santé communautaire			
Boîte verte	• Achat de fruits et légumes à petit prix	Enfants en santé	• Programmation ciblée avec des partenaires locaux
Prévention des chutes	• Pour les 55 ans et plus • Programme d'exercices avec chaise 2 fois par semaine • Inclut trois volets, soit les exercices en groupe, les exercices à domicile et la prévention à domicile	Gestion des maladies chroniques	• Atelier « Vivre en santé avec une maladie chronique » : aide les gens ayant des problèmes de santé chronique à mieux gérer leurs symptômes et leur vie quotidienne
Dépistage visuel	• Pour les enfants – niveau jardiner 1re année • Les promoteurs santé et infirmiers du CSCE peuvent dépister les troubles de la vue chez les élèves qu'ils rencontrent.	Programme d'exercices Corps à cœur	Les programmes d'exercices Corps à cœur sont conçus pour les personnes soucieuses de leur santé cardiaque et des maladies chroniques (Institut de cardiologie du l'Université d'Ottawa).

CENTRE FRANCOPHONE DE TORONTO

<table>
<tr><td colspan="3">Service de santé</td></tr>
<tr><td>Consultation médicale</td><td>• Une équipe de médecins, d'infirmiers praticiens et d'infirmiers autorisés fournissent un suivi médical ainsi que des services de consultation et de soins aux familles.
• Sur rendez-vous
• Info santé après les heures de travail</td><td rowspan="2">Diabète
• Consultations individuelles auprès de la diététiste et de l'infirmier du programme diabète du Centre francophone de Toronto pour accompagner les personnes vivant avec le diabète de type 2 en leur offrant des conseils pour : l'alimentation saine, l'activité physique, la planification de menus, la gestion de médicaments, les soins de pieds, la gestion des glycémies, la gestion de l'insuline
• Ateliers d'information – Diabète Action, un groupe d'information, de soutien, d'échange et d'entraide pour personnes vivant avec le diabète. Les rencontres ont lieu trois fois par mois et permettent aux participants de faire le suivi de leur diabète.</td></tr>
<tr><td>Bilan santé et vaccination</td><td>• Avec un infirmier : Bilan de santé générale, physique, sociale, comportementale et alimentaire destiné aux enfants âgés de 0 à 6 ans</td></tr>
<tr><td colspan="2">Santé mentale</td><td>Nutrition et diététique</td></tr>
<tr><td colspan="2" rowspan="2">• Santé mentale – adulte : Évaluation psychosociale, counseling et psychothérapie (sur un plan individuel ou familial), intervention sociale pour répondre aux besoins de base, accompagnement communautaire

• Santé mentale – jeunesse 0 à 18 ans : évaluations spécialisées (psychologique et psychiatrique), counseling et psychothérapie (sur un plan individuel ou familial), ateliers de développement d'habiletés parentales, soutien pour les élèves et ateliers en milieu scolaire

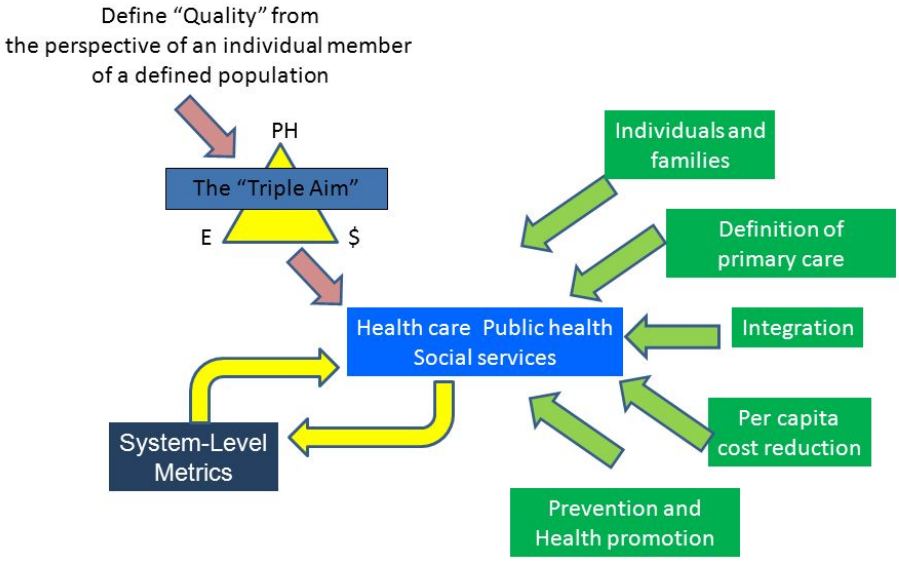
• La passerelle : un programme d'intervention en santé mentale en milieu scolaire pour les élèves présentant des troubles de comportement graves, affectifs ou sociaux qui entravent leur fonctionnement en classe</td><td>• Consultation individuelle
• Services personnalisés sur l'alimentation et la nutrition des bébés et des jeunes enfants
• Activités sociales pour un style de vie sain</td></tr>
<tr><td>Promotion et prévention</td></tr>
<tr><td colspan="2">Services de soutien communautaire</td><td>• Mieux vivre avec une maladie chronique : comme une maladie du cœur, l'hypertension, le cancer, le diabète, le syndrome post polio, l'anémie chronique (falciforme, thalassémie), le VIH, l'asthme, l'arthrite, les maladies mentales, etc. Programme comprenant : des rencontres d'informations éclairantes, des ateliers communautaires variés, et des coachings santé spécialisés
• Marchons pour la forme : trois types d'activités de mise en forme</td></tr>
<tr><td colspan="2">• Comptoir de vêtements</td><td></td></tr>
</table>

APPENDIX 3 : TRIPLE AIM – CONCEPT DESIGN

Triple Aim – Concept Design

INSTITUTE FOR HEALTHCARE IMPROVEMENT

Optimize the health system taking into account three dimensions:
the experience of the individual; the health of a defined population; per capita cost for the population



7

Dimension	*Measure*
Population Health	1. Health/Functional Status: single-question (e.g., from CDC HRQOL-4) or multi-domain (e.g. SF-12, EuroQol). 2. Risk Status: Composite health risk appraisal (HRA) score. 3. Disease Burden: summary of the prevalence of major chronic conditions; summary of predictive model scores. 4. Mortality: life expectancy; years of potential life lost;standardized mortality rates. *Note: Healthy Life Expectancy (HLE) combines life expectancy and health status into a single measure, reflecting remaining years of life in good health. See http://reves.site.ined.fr/en/DFLE/definition/.*
Patient Experience	1. Standard questions from patient surveys, for example: - Global questions from US CAHPS or How's Your Health surveys - Experience Questions from NHS World Class Commissioning or CareQuality Commission - Likelihood to recommend 2. Set of measures based on key dimensions (e.g., US IOM Quality Chasm aims: Safe, Effective, Timely, Efficient, Equitable and Patient-centered).
Per Capita Cost	1. Total cost per member of the population, per month. 2. Hospital and ED Utilization Rate.

1. Individuals and Families

The Chasm Report of the Institute of Medicine in the United States contains the following two passages.

> *"Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over the decisions that affect them. The health care system should be able to accommodate differences in patients' preferences and encourage shared decision making."*
>
> *"The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice or when choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction."*

A. For medically and socially complex patients, establish partnerships among individuals, families and caregivers, including identifying a family member or friend who will be supported and developed to coordinate services among multiple providers of care.
B. Jointly plan and customize care at the level of the individual.
C. Actively learn from the patient and family to inform work for the population.
D. Enable individuals and families to better manage their own health.

2. Redesign of "Primary Care" Services and Structures

Basic health care services are provided by a variety of professions: doctors, nurses, mental health clinicians, nutritionists, pharmacists, and others.

A. Have a team for basic services that can deliver at least 70% of the necessary medical and health-related social services to the population.
B. Deliberately build an access platform for maximum flexibility to provide customized health care for the needs of patients, families, and providers.
C. Cooperate and coordinate with other specialties, hospitals, and community services related to health.

3. Prevention and Health Promotion

A. Work with the community to advocate and provide incentives for smoking prevention, healthy eating, exercise, and reduction of substance abuse.
B. Develop multi-sector partnerships, utilize key stakeholder resources (worksites, schools, etc.) and align policies to provide community-based support for all who wish to make health-related behavior change.
C. Integrate healthcare and publicly available community-level data utilizing GIS mapping to understand local context to determine where and for whom health-related strategic community-level prevention, health promotion and disease-management support interventions would be most useful.

4. Cost Control Platform

Many countries are concerned with the rate of increase in health care spending. In the United States the task of mitigating this increase is termed "impacting the trend." In United Kingdom and other countries with government sponsored health care systems it is framed as "receiving value for money."

A. Achieve < 3% inflation yearly for per capita cost by developing cooperative relationships with physician groups and other health care organizations committed to reducing the waste of health care resources.
B. Achieve lowest decile performance in the Dartmouth Atlas measures by breaking or countering incentives for supply-driven care.
C. Reward health care providers, hospitals, and health care systems for their contribution to producing better health for the population and not just producing more health care.
D. Orient care over time - the "patient journey" - targeted to the best feasible outcomes.

5. System Integration

If the experience of the individual is the primary driver of the Triple Aim system, the health of the population and the per capita cost become constraints. Individuals cannot get all the services that they might want or perhaps even need.

A. Match capacity and demand for health care and social services across suppliers.
B. Insure that strategic planning and execution with all suppliers including hospitals and physician practices are informed by the needs of the population.
C. Develop a system for ongoing learning and improvement.
D. Institute a sustainable governance and financial structure for the Triple Aim system
E. Efficiently customize services based on appropriate segmentation of the population.
F. Use predictive models and health risk assessments that take into account situational factors, medical history, and prior resource utilization to deploy resources to high-risk individuals.
G. Set and execute strategic initiatives related to reducing inequitable variation in outcomes or undesirable variation in clinical practice.

ANNEXE 4 : MODÈLE DE SANTÉ ET DE BIEN-ÊTRE DE L'ASCO

Valeurs et principes du modèle de santé et de bien-être[23]

<u>Qualité du plus haut niveau, centré sur la personne et la communauté, santé et bien-être</u>

- Toutes les personnes participent, individuellement et collectivement, aux décisions concernant leur santé et leur bien-être.
- Les personnes et les communautés reçoivent des soins de santé qui répondent à leurs besoins et qui sont fournis en temps opportun par les fournisseurs les plus appropriés, et elles obtiennent les meilleurs résultats possibles.
- Les fournisseurs de soins de santé et les fournisseurs d'autres services ont des relations de travail respectueuses et axées sur la collaboration avec les personnes, les familles et les communautés, et entre eux-mêmes.
- La qualité des soins est optimisée par l'innovation et l'apprentissage continus, qui améliorent l'expérience et les résultats des personnes qui accèdent aux soins, et par l'utilisation efficiente des ressources.

<u>Équité en santé et justice sociale</u>

- La réduction des inégalités sociales a pour effet d'améliorer les résultats de santé.
- Les inégalités sociales sont réduites lorsque tous les gens et toutes les institutions acquièrent la compréhension que les inégalités influent sur les résultats de santé des populations déjà marginalisées, et qu'ils agissent à cet égard.
- L'équité, ainsi que la dignité et l'intégrité de la personne sont respectées quand elle a accès à une alimentation nutritive, un logement sûr et sécuritaire, de l'eau propre, des vêtements convenables et appropriés, un emploi décent et rémunéré de façon juste.
- Les soins de santé sont appropriés à tous les âges et à toutes les étapes de la vie, et des mécanismes assurent l'engagement et la participation à part entière aux processus civils, sociaux et politiques.

<u>Sens d'appartenance et vitalité communautaires</u>

- Dans des communautés sures et qui se soucient de leur bien-être, les résultats de santé sont améliorés.
- Le partage de valeurs et d'une vision renforce le sens d'appartenance.
- Tous les membres de la communauté ont des occasions de participer à la prise de décisions concernant leur communauté.
- Les secteurs privés et publics, et les organismes communautaires travaillent ensemble au renforcement de communautés inclusives, soucieuses de leur bien-être et reliées.

[23] https://www.aohc.org/fr/mod%C3%A8le-de-sant%C3%A9-et-de-bien-%C3%AAtre

Attributs du Model of Health and Wellbeing

- Anti-oppressif et culturellement sécuritaire : Les Centres d'accès aux services de santé pour les autochtones (CASSA) et les CSC fournissent des services dans des environnements non racistes et non oppressifs où les gens sont en sécurité : les personnes ne sont pas agressées, on ne questionne pas et ne refuse pas leur identité, ni qui elles sont ni ce dont elles ont besoin. Le respect est mutuel, l'intention, les connaissances et l'expérience sont partagées afin d'apprendre, de vivre et de travailler ensemble dans le respect, la vérité, l'honnêteté, l'humilité, la sagesse, l'amour et le courage. En pratique, nous insistons sur la présence de personnes de diverses origines culturelles et linguistiques, ce qui donne à ces personnes la capacité d'influencer ou de maîtriser les processus en œuvre dans leurs services de santé, et nous croyons que c'est là l'un des principaux moyens de créer un environnement sécuritaire.
- Accessible : Les CSC et les CASSA sont conçus pour améliorer l'accès, la participation, l'équité, l'inclusion et la justice sociale en éliminant les obstacles systémiques à une participation à part entière. Les CSC et les CASSA détiennent l'expérience nécessaire pour assurer un accès aux personnes faisant face à divers types d'obstacles, d'ordre racial, culturel, linguistique, physique, social, économique, juridique et géographique, qui pourraient engendrer des problèmes de santé. L'élimination des obstacles à l'accès suppose la prestation de programmes et de services culturellement appropriés et de programmes pour les personnes non assurées, un emplacement optimal et des installations conçues conformément à ce que prévoient les dispositions législatives sur l'accessibilité, un environnement non oppressif, des heures de service prolongées et des services de garde.
- Interprofessionnel, intégré et coordonné : Les CSC et les CASSA sont dotés d'équipes interprofessionnelles qui travaillent en collaboration. Les professionnels salariés qui forment ces équipes travaillent dans le champ le plus vaste possible pour répondre aux besoins en matière de santé et de bien-être des gens. Les CSC et les CASSA établissent de solides partenariats et intégrations avec le système de santé et les organismes de services communautaires. Les partenariats et intégrations garantissent la prestation de soins de santé ininterrompus et opportuns, centrés sur la personne et la communauté, et de services et de programmes axés sur des déterminants sociaux clés de la santé, avec des aiguillages appropriés. Les aiguillages couvrent les soins primaires, la prévention des maladies et la promotion de la santé, et les interventions se font sous forme de services individuels ou de groupes de développement personnel, et à l'échelon communautaire.
- Géré par la communauté : Les CSC et les CASSA sont des organismes sans but lucratif, gérés par des conseils d'administration composés de membres de la communauté locale. Les conseils d'administration et comités communautaires constituent un mécanisme permettant aux CSC et aux CASSA de représenter leur communauté locale et de répondre aux besoins de celle-ci, et aux communautés de réaliser l'appropriation démocratique de « leurs » centres. La gouvernance communautaire renforce la santé des communautés locales au moyen de l'engagement participatif qui contribue au capital social et au leadership communautaire.
- Axé sur les déterminants sociaux de la santé : La santé des personnes et des communautés subit les effets des déterminants sociaux de la santé, comme le revenu, l'éducation, l'emploi, les conditions de travail, le développement de la petite enfance, la sécurité alimentaire, le logement, l'inclusion sociale, le filet de protection sociale, les services de santé, le statut d'autochtone, le sexe, la race et le racisme, la culture et la capacité. Les CSC et les CASSA s'efforcent d'améliorer les soutiens d'ordre social et les conditions sociales qui influent sur la santé à long terme des personnes et des communautés, et ce, en participant à des partenariats intersectoriels

et multisectoriels, et en préconisant l'élaboration d'une politique publique saine dans un cadre fondé sur la santé de la population.

- Ancré dans une approche de développement communautaire : Les services et les programmes des CSC et des CASSA se fondent sur les initiatives et les besoins de la communauté. L'approche de développement communautaire vise à tirer parti du leadership, du savoir et des expériences vécues des membres de la communauté et des partenaires pour que ceux-ci contribuent au mieux-être de leur communauté. Les CSC et les CASSA renforcent la capacité de la communauté locale à répondre aux besoins de la communauté tout entière et à améliorer les résultats de santé et de bien-être des personnes et de la communauté.
- Fondé sur les besoins de la population : Les CSC et les CASSA ne cessent d'adapter et de raffiner leur capacité à rejoindre et à servir les personnes et les communautés. Ils planifient des services et des programmes en fonction des besoins en santé de la population et élaborent des pratiques exemplaires pour répondre à ces besoins.
- Tenu de rendre des comptes et efficace : Les CSC et les CASSA sont des organismes de soins de santé primaires (SSP) très performants et efficaces qui rendent des comptes à leurs bailleurs de fonds et aux communautés locales qu'ils servent. Les CSC et les CASSA s'efforcent de fournir à leur personnel une rémunération et des avantages justes et équitables. La nécessité de cerner et de mesurer leur travail est essentielle à la prestation de soins de santé primaires. L'élaboration et la mise en application d'indicateurs pertinents axés sur notre modèle de santé et de bien-être permettent de faire rapport aux bailleurs de fonds sur les services et les programmes fournis ainsi que sur les résultats auxquels ils donnent lieu.

ANNEXE 5 : SOMMAIRE DE LA PROGRAMMATION PROPOSÉE

Continuum de soins			
	Prévenir « Promotion de la santé et prévention des maladies »	**Guérir** « Soins curatifs »	**Soutenir** « Services de soutien communautaire »
Clinique de santé primaire			
Services	• Ateliers de promotion de la santé et de prévention des maladies • Services de consultations et d'informations	• Bilan de santé et suivis • Coordination avec les autres pourvoyeurs de services de santé intervenant dans le traitement du patient • Consultation médicale	• Programmation communautaire pour soutenir l'entraide et la solidarité nécessaire pour penser le développement communautaire (activités sportives, déjeuner communautaire, souper spaghetti, distribution alimentaire, etc.)
Clientèle	• Tous les membres de la communauté	• Patient orphelin • Clients du Centre • Patient francophone	• Tous les membres de la communauté
Clinique de soins infirmiers			
Services	• Ateliers de promotion de la santé et de prévention des maladies • Services de consultations et d'informations	• Évaluation de la santé du patient et des besoins • Suivis du plan de soins et référencement • Soins des pieds • Soins infirmiers complets (injection, vaccin, pansement, etc.)	• Idem précédent
Clientèle	• Tous les membres de la communauté	• Patient orphelin • Clients du Centre • Patient francophone • Référencement/partenariat avec d'autres pourvoyeurs	Tous les membres de la communauté
Clinique de santé mentale			

Services	• Ateliers de promotion de la santé et de prévention des maladies • Services de consultations et d'informations	• Évaluation des besoins de santé mentale • Développement d'un plan d'action / de traitement • Coordination des soins et des suivis de concert avec les médecins de famille et les spécialistes dans la communauté • Services thérapeutiques par l'entremise de thérapies individuelles, de couple, familiales ou de groupe • Accès téléphonique au soutien de l'équipe en cas de crise pendant les heures de travail	• Gamme de services de soutien communautaire en partenariat avec la collectivité, qui vise à surmonter les difficultés socio-économiques (banque alimentaire, appuis scolaires, groupe de soutien, etc.)
Clientèle	• Tous les membres de la communauté	• Population francophone de tout âge avec ou sans référence médicale	• Tous les membres de la communauté
Services intégrés de périnatalité et petite enfance			
Services	• Ateliers de promotion de la santé et de prévention des maladies • Services de consultations et d'informations	• L'accompagnement des familles par l'entremise de visites à domicile par une intervenante qui répond aux besoins des familles et qui est en soutien aux pratiques parentales	• Un soutien à la création d'environnements favorables à la santé et au bien-être des familles par l'élaboration de projets en partenariat avec des organismes du milieu, visant l'amélioration des conditions de vie des familles
Clientèle	• Adolescents et jeunes adultes	• Femmes enceintes de moins de 20 ans, ou à faible revenu, ou nouvellement arrivées au Canada, et les pères avec de jeunes enfants	• Adolescents, jeunes adultes et famille à faible revenu
Vieillir en santé dans la communauté			

Services	• Le Programme d'exercice PIED (Programme Intégré d'Équilibre Dynamique) • Des ateliers de nutrition • Des activités qui contribuent au maintien de la vitalité intellectuelle	• Bilan de santé et évaluation des besoins en santé physique (risque de chute) et mentale • Coordination des soins et des suivis de concert avec les médecins de famille et les spécialistes dans la communauté • Thérapie individuelle, de couple et familiale • Soutien aux proches aidants (groupe de soutien, programme de stimulation à domicile et évaluation psychosociale)	• Programme d'aide-épicerie • Programme de jour pour aînés • Programme d'engagement communautaire pour bâtir une collectivité sécuritaire et amie des aînés
Clientèle	Tous les membres de la communauté	• Patient orphelin de 60 ans et plus • Clients du Centre de 60 ans et plus • Patient francophone de 60 ans et plus	Tous les membres de la communauté
Vivre avec une maladie chronique			
Maladie pulmonaire obstructive chronique (MPOC)			
Services	• Ateliers de promotion de la santé et de prévention des maladies • Services de consultations et d'informations • Conseils nutritionnels • Programme d'exercices « corps à cœur »	• L'optimisation des médicaments et un plan d'action pour les ordonnances • La continuité et la coordination des soins de transition de l'hôpital à domicile • Une éducation à domicile concernant l'autogestion de la MPOC • Un soutien psychosocial ou spirituel à domicile • La possibilité de faire une planification préalable des soins à domicile • Un accès téléphonique en cas de crise au soutien de l'équipe pendant les heures de travail • Un suivi mensuel au téléphone pendant trois mois après les visites à domicile	• Partenariats dans la collectivité • Soutien à la cessation du tabac • Groupes de soutien pour personnes atteintes de maladies chroniques
Clientèle	Les patients du Centre atteints de MPOC avancée et leur famille, ainsi que les patients externes francophones à la suite du congé d'un service hospitalier. Possibilité d'accueillir des patients francophones sur référencement d'un autre pourvoyeur de services de santé primaire		

Diabète			
Services	• Ateliers de promotion de la santé et de prévention des maladies • Services de consultations et d'informations • Conseils nutritionnels • Programme d'exercices « corps à cœur »	• Suivis médicaux pour faire le bilan sanguin, ajuster le traitement, et un plan de soins intégrés • Coordination des soins et des suivis de concert avec les médecins de famille et les spécialistes • Enseignement pour l'utilisation du glucomètre, sur le diabète et les techniques de supervision pour les patients et leurs familles • Examen et soins des pieds	• Partenariats dans la collectivité • Soutien à la cessation du tabac • Groupes de soutien pour personnes atteintes de maladies chroniques
Clientèle	Les patients du Centre atteints de prédiabète et de diabète de type 2 et leur famille, ainsi que les patients externes sur référence afin de les accompagner dans l'autogestion de la maladie et créer des occasions de socialiser pour lutter contre l'isolement		
Arthrite inflammatoire			
Services	• Ateliers de promotion de la santé et de prévention des maladies; • Services de consultations et d'informations. • Conseils nutritionnels • Programme d'exercices « corps à cœur ».	• Suivis médicaux pour faire le bilan de santé, ajuster le traitement et le plan de soins intégrés; • Accompagnement pour l'obtention d'un diagnostic auprès d'un rhumatologue; • Coordination du plan de soins avec les spécialistes (chirurgien, physiothérapeute, ergothérapeute, pharmacien, etc.); • Enseignement pour favoriser l'autogestion par le patient et leurs familles;	• Partenariats dans la collectivité; • Soutien à la cessation du tabac; • Groupes de soutien pour personnes atteintes de maladies chroniques;
Clientèle	Les patients du Centre atteints d'arthrite inflammatoire et leur famille, ainsi que les patients externes sur référence afin de les accompagner dans l'autogestion de la maladie et créer des occasions de socialiser pour lutter contre l'isolement		
Hypertension artérielle			
Services	• Ateliers de promotion de la santé et de prévention des maladies • Services de consultations et d'informations • Conseils nutritionnels • Programme d'exercices « corps à cœur »	• Coordination du plan de soins avec les spécialistes (médecin, pharmacien, etc.) • Suivis médicaux pour faire le bilan de santé (pression artérielle), ajuster le traitement et le plan de soins intégrés	• Partenariats dans la collectivité • Soutien à la cessation du tabac • Groupes de soutien pour personnes atteintes de maladies chroniques

Clientèle	Les patients du Centre atteints d'hypertension artérielle et leur famille, ainsi que les patients externes sur référence afin de les accompagner dans l'autogestion de la maladie et créer des occasions de socialiser pour lutter contre l'isolement

Partenariats à explorer pour soutenir la prestation des services

Prévenir « Promotion de la santé et prévention des maladies »	**Guérir** « Soins curatifs »	**Soutenir** « Services de soutien communautaire »
• Conseils scolaires de langue française • Organismes communautaires • Agence de santé publique • Résidences pour aînés • Municipalité	• Hôpital Montfort pour la télémédecine, notamment en santé mentale • Les bureaux de médecins • Les pourvoyeurs locaux de services primaires, de santé publique et de services sociaux	• Conseils scolaires de langue française • Organismes communautaires • Agence de santé publique • Résidences pour aînés • Municipalité • Croix rouge

ANNEXE 6 : PRATIQUES EXEMPLAIRES EN MATIÈRE DE GOUVERNANCE

En 2006, dans une étude nationale sur les pratiques de gouvernance des conseils d'administration du secteur bénévole et sans but lucratif au Canada[24], les organismes canadiens ont répertorié un certain nombre de thèmes et de pratiques relatifs à la bonne gouvernance de leur Board of Directors, susceptibles d'inspirer le community health centre dans l'élaboration de ses pratiques de gouvernance.

Parmi les thèmes énoncés, on retrouve :

- l'importance du **leadership** assuré par le président du Board of Directors, ainsi que de la sélection et du maintien en poste d'un président-directeur général compétent;
- le défi que représentent le **recrutement et le maintien en poste d'administrateurs** compétents, et les problèmes associés à la nomination des administrateurs;
- le besoin d'assurer le **perfectionnement** des dirigeants de conseils et de **planifier la relève** pour le poste de président-directeur général;
- la nécessité de **bien définir les rôles** et de veiller à ce que les administrateurs comprennent bien leurs obligations et leurs responsabilités fiduciaires;
- l'importance de la **formation et du perfectionnement continus** des membres du Board of Directors;
- la façon dont les **attentes et les exigences accrues des donateurs et des bailleurs de fonds** influent sur le rôle du Board of Directors;
- l'importance de veiller à ce qu'une bonne **culture** se développe au sein du Board of Directors et d'assurer l'équilibre entre celle-ci et la rigueur des politiques et des méthodes;
- l'importance d'avoir des **réunions du conseil efficaces** qui permettent d'accomplir le travail du conseil et de favoriser la participation des membres;
- la nécessité de bien comprendre le rôle du Board of Directors en matière de **planification stratégique** et d'accroître la compétence de ses membres dans ce domaine;
- l'importance de se doter d'outils d'évaluation du rendement pour mesurer l'efficacité du Board of Directors;
- la nécessité de disposer de meilleurs processus, politiques et outils pour assurer la **gestion des risques**.

Le rapport recense également un nombre de pratiques exemplaires dans les conseils d'administration qui encouragent et qui facilitent la pleine participation de tous leurs membres :

- Leurs politiques les guident suffisamment pour qu'ils puissent diriger l'organisme adéquatement. Elles sont révisées régulièrement et divulguées publiquement.
- Leurs administrateurs consacrent plus de temps à leur formation et perfectionnement.
- Les administrateurs sont informés de manière efficace.

[24] Grace Bugg, Sue Dallhoff, Strategic Partners Inc. (2006), « Étude nationale sur les pratiques de gouvernance des conseils d'administration du secteur bénévole et à but non lucratif du Canada ».

- Leur conseil procède à des auto-évaluations officielles et évalue la direction générale selon des critères et échéanciers établis.
- Ils ont en place des politiques officielles de gestion des risques et de gestion de crise et ils ont confié à une personne ou à un groupe la responsabilité de cette gestion.
- Ils se sont dotés d'une vision stratégique, laquelle a été traduite en objectifs et en repères mesurables afin que le conseil puisse en assurer le suivi.
- Ils ont établi des objectifs annuels pour le conseil et ses comités, lesquels suivent un plan de travail clairement défini qui indique la façon dont ces objectifs doivent être atteints et qui forme l'ordre du jour du conseil pendant l'année.
- Aux réunions du conseil, ils consacrent plus de temps à des débats animés sur des stratégies.
- Les réunions du conseil ne sont pas dominées par une ou deux personnes.
- Ils ont un budget équilibré.

APPENDIX 7 : OPERATING BUDGET OF COMMUNITY HEALTH CENTRES

CHCs with an operating budget under $4.3 million + one remaining francophone CHC with expenditures over $4.3 million

KENORA MARY BERGLUND CHC
COCHRANE MISIWAY MILOPEMAHTESEWIN
WINDSOR CMHA WINDSOR-ESSEX COUNTY
KAPUSKASING CSC
TIMISKAMING WEST NIPISSING CHC
TORONTO PLANNED PARENTHOOD OF TO
HAMILTON HAMILTON URBAN CORE CHC
SIMCOE THE SOUTH GEORGIAN BAY CHCS
DURHAM BROCK CHC
TORONTO STONEGATE CHC
ELGIN CENTRAL CHC, ST THOMAS
OXFORD WOODSTOCK AND AREA CHC
STORMONT SEAWAY VALLEY CHC
NIAGARA NIAGARA FALLS CHC
TIMISKAMING CENTRE DE SANTÉ SUDBURY E
TORONTO ANNE JOHNSTON
OTTAWA SOUTH EAST GREY CHC
KAWARTHA LAKES COMMUNITY CARE
NIAGARA QUEST CHC
TORONTO DAVENPORT PERTH
TORONTO CENTRE FRANCOPHONE
SIMCOE CENTRE DE SANTÉ CHIGAMIK
TORONTO ANISHNAWBE HEALTH COMM HLTH
CHC DE L'ESTRIE
TORONTO EAST END CHC
TWEED GATEWAY CHC
TORONTO TAIBU CHC
SUDBURY CENTRE DE SANTÉ
LEEDS_GRENVILLE COUNTRY ROADS CHC
BRANT GRAND RIVER CHC
WEST ELGIN COMMUNITY HEALTH CENTRE

Sub-group of CHCs with a high number of francophone clients

CHC DE L'ESTRIE
KAPUSKASING CSC
TIMISKAMING WEST NIPISSING CHC
TIMISKAMING CENTRE DESANTÉ SUDBURY E
TORONTO CENTRE FRANCOPHONE
SUDBURY CENTRE DE SANTÉ

Sub-group of CHCs with operating budgets of less than $3

KENORA MARY BERGLUND CHC

COCHRANE MISIWAY MILOPEMAHTESEWIN
WINDSOR CMHA WINDSOR-ESSEX COUNTY
KAPUSKASING CSC
TIMISKAMING WEST NIPISSING CHC
TORONTO PLANNED PARENTHOOD OF TO
HAMILTON HAMILTON URBAN CORE CHC
SIMCOE THE SOUTH GEORGIAN BAY CHCS
DURHAM BROCK CHC
TORONTO STONEGATE CHC

Sub-group of CHCs with operating budgets between $3 and 3.6 million

ELGIN CENTRAL CHC, ST THOMAS
OXFORD WOODSTOCK AND AREA CHC
STORMONT SEAWAY VALLEY CHC
NIAGARA NIAGARA FALLS CHC
TIMISKAMING CENTRE DESANTÉ SUDBURY E
TORONTO ANNE JOHNSTON
OTTAWA SOUTH EAST GREY CHC
KAWARTHA LAKES COMMUNITY CARE
NIAGARA QUEST CHC
TORONTO DAVENPORT PERTH

Sub-group of CHCs with operating budgets between $3.7 and 4.3 million

TORONTO CENTRE FRANCOPHONE
SIMCOE CENTRE DE SANTÉ CHIGAMIK
TORONTO ANISHNAWBE HEALTH COMM HLTH
TORONTO EAST END CHC
TWEED GATEWAY CHC
TORONTO TAIBU CHC
SUDBURY CENTRE DE SANTÉ
LEEDS_GRENVILLE COUNTRY ROADS CHC
BRANT GRAND RIVER CHC
WEST ELGIN COMMUNITY HEALTH CENTRE

Hybrid sub-group composed of 10 CHCs with the highest level of compatibility

KENORA MARY BERGLUND CHC
COCHRANE MISIWAY MILOPEMAHTESEWIN
WINDSOR CMHA WINDSOR-ESSEX COUNTY
KAPUSKASING CSC
ELGIN CENTRAL CHC, ST THOMAS
OXFORD WOODSTOCK AND AREA CHC
NIAGARA NIAGARA FALLS CHC
TIMISKAMING CENTRE DE SANTÉ SUDBURY E
SIMCOE CENTRE DE SANTÉ CHIGAMIK
BRANT GRAND RIVER CHC

Sub-group off all rural CHCs

KENORA MARY BERGLUND CHC

COCHRANE MISIWAY MILOPEMAHTESEWIN

KAPUSKASING CSC

TIMISKAMING WEST NIPISSING CHC

SIMCOE THE SOUTH GEORGIAN BAY CHCS

OXFORD WOODSTOCK AND AREA CHC

STORMONT SEAWAY VALLEY CHC

TIMISKAMING CENTRE DESANTÉ SUDBURY E

SIMCOE CENTRE DE SANTÉ CHIGAMIK

TWEED GATEWAY CHC

BRANT GRAND RIVER CHC

WEST ELGIN COMMUNITY HEALTH CENTRE

ANNEXE 8: DONNÉES DES CSC ET DES SOUS-GROUPE

Operating and Capital Budget (Class D type)

All: All CHCs with operating budgets less than $4.3 million + one remaing francophone CHC wi
Sub-group 1: Sub-group of CHCs with a high number of francophone clients
Sub-group 2: Sub-group of CHCs with operating budgets of less than $3 million
Sub-group 3: Sub-group of CHCs with operating budgets between $3 and 3.6 million
Sub-group 4: Sub-group of CHCs with operating budgets of 3.7 to 4.3 million
Sub-group 5: Hybrid sub-group composed of 10 CHCs with the highest level of compatibility wit
Sub-group 6: Sub-group off all rural CHCs

	All	Sub-group 1	Sub-group 2	Sub-group 3	Sub-group 4	Sub-group 5	Sub-group 6
Operating budget							
Service provider interactions (SPI)	19 609	22 998	13 677	18 782	22 463	15 329	18 319
Expenses per cost center							
Administration and support	$1 006 014	$1 318 803	$587 534	$990 229	$1 328 625	$800 959	$852 658
Diagnostics & Therapeutics services	$48 618	$4 426	$31 475	$51 219	$38 773	$39 554	$41 666
Therapy & Chronic disease clinics	$2 314 955	$2 715 053	$1 411 713	$2 193 869	$3 218 167	$1 843 477	$1 806 509
Health Prevention & Promotion clinics	$284 227	$323 063	$212 165	$153 656	$602 354	$149 738	$208 329
Clients support	$177 642	$168 170	$46 630	$194 631	$279 166	$138 437	$190 472
TOTAL OPERATING BUDGET	**$3 831 456**	**$4 529 514**	**$2 289 517**	**$3 583 604**	**$5 467 085**	**$2 972 165**	**$3 099 634**
Number of Full Time Equivalent (FTE)	**18,0**	**19,0**	**14,5**	**18,0**	**23,5**	**17,5**	**17,5**
Total Cost per SPI	**$195,39**	**$196,95**	**$167,41**	**$190,80**	**$243,39**	**$193,90**	**$169,20**
Clinical cost per SPI	**$144,09**	**$139,61**	**$124,45**	**$138,08**	**$184,24**	**$141,64**	**$122,66**
SPI per FTE's	**1 089**	**1 210**	**943**	**1 043**	**956**	**876**	**1 047**
Capital budget							
Number of Full Time Equivalent (FTE)	18,0	19,0	14,5	18,0	23,5	17,5	17,5
Gross Square Foot	31 526	33 277	25 396	31 526	41 159	30 650	30 650
Cost							
Program space	$12 307 117	$12 990 846	$9 914 067	$12 307 117	$16 067 625	$11 965 253	$11 965 253
Mechanical & Electric Space	$1 120 392	$1 182 636	$902 538	$1 120 392	$1 462 734	$1 089 270	$1 089 270
Building Gross	$2 055 116	$2 169 290	$1 655 511	$2 055 116	$2 683 069	$1 998 030	$1 998 030
SUB TOTAL PROGRAMS	$15 482 625	$16 342 771	$12 472 115	$15 482 625	$20 213 428	$15 052 552	$15 052 552
Site work (13%)	$2 012 741	$2 124 560	$1 621 375	$2 012 741	$2 627 746	$1 956 832	$1 956 832
Design scope allowance (20%)	$3 499 073	$3 693 466	$2 818 698	$3 499 073	$4 568 235	$3 401 877	$3 401 877
SUB TOTAL CONSTRUCTION	**$20 994 440**	**$22 160 798**	**$16 912 188**	**$20 994 440**	**$27 409 408**	**$20 411 261**	**$20 411 261**
Construction contingency (3%)	$629 833	$664 824	$507 366	$629 833	$822 282	$612 338	$612 338
Project Ancillaries (20%)	$4 198 888	$4 432 160	$3 382 438	$4 198 888	$5 481 882	$4 082 252	$4 082 252
FF&E / IT (6%)	$1 259 666	$1 329 648	$1 014 731	$1 259 666	$1 644 564	$1 224 676	$1 224 676
Minor non-depreciables (2%)	$419 889	$443 216	$338 244	$419 889	$548 188	$408 225	$408 225
TOTAL CAPITAL COST	**$27 502 716**	**$29 030 645**	**$22 154 966**	**$27 502 716**	**$35 906 324**	**$26 738 752**	**$26 738 752**

ANNEXE 9 : SOMMAIRE PAR ÉTABLISSEMENT

	Centre de l'est	KAPUSKASING CSC	SUDBURY CENTRE DE SANTÉ	TIMISKAMING WEST NIPISSING CHC	TORONTO CENTRE FRANCOPHONE	TIMISKAMING CENTRE DE SANTÉ SUDBURY EST
Dépenses d'opération						
Administration et support	2,925,323 $	925,411 $	1,109,605 $	773,561 $	1,022,853 $	949,260 $
% des dépenses totales	30.30%	42.40%	26.80%	31.60%	28.00%	29.30%
Services diagnostiques et thérapeutiques	0 $	0 $	0 $	0 $	3,653 $	0 $
% des dépenses totales					0.10%	
Cliniques thérapeutiques et maladies chroniques	6,178,900 $	1,104,382 $	2,562,857 $	1,488,371 $	1,800,951 $	2,199,820 $
% des dépenses totales	64.00%	50.60%	61.90%	60.80%	49.30%	67.90%
Cliniques promotion et prévention	550,308 $	152,780 $	467,856 $	186,046 $	686,772 $	90,714 $
% des dépenses totales	5.70%	7.00%	11.30%	7.60%	18.80%	2.80%
Cliniques support à la clientèle	0 $	0 $	0 $	0 $	138,816 $	0 $
% des dépenses totales					3.80%	
Total des dépenses	**9,654,532 $**	**2,182,574 $**	**4,140,318 $**	**2,447,979 $**	**3,653,045 $**	**3,239,794 $**
Utilisation des ressources						
Équivalent temps complet						
Administration et support	10.1	-2.5	14.2	-3.8	-12.0	3.1
Cliniques thérapeutiques et maladies chroniques	44.2	14.5	5.7	16.8	14.8	14.9
Cliniques promotion et prévention	0.7	0.0	0.1	0.0	19.9	0.0
Cliniques support à la clientèle	0.0	0.0	0.0	0.0	2.3	0.0
Total	**55.0**	**12.0**	**20.0**	**13.0**	**25.0**	**18.0**
Coût total par équivalent temps complet	**175,537 $**	**181,881 $**	**207,016 $**	**188,306 $**	**146,122 $**	**179,989 $**
Coût clinique par équivalent temps complet	**149,871 $**	**86,701 $**	**522,537 $**	**99,668 $**	**70,988 $**	**153,727 $**
Visite /fréquentation						
Total	**48,201**	**11,242**	**21,709**	**16,150**	**15,094**	**25,591**
Coût total par visite/fréquentation	**200.30 $**	**194.14 $**	**190.72 $**	**151.58 $**	**242.02 $**	**126.60 $**
Coût clinique par visite/fréquentation	**139.61 $**	**111.83 $**	**139.61 $**	**103.68 $**	**174.25 $**	**89.51 $**

PGF CONSULTANTS INC.
202-291, RUE DALHOUSIE
OTTAWA (ONTARIO) K1N 7E5
BENOÎT HUBERT, PRÉSIDENT
TÉL. : 613 241-2251, POSTE 237
TÉLÉC. : 613 241-2252
COURRIEL : BHUBERT@PGF.CA