# The little clinic that could: Bringing primary healthcare to vulnerable populations, creating space for experiential learning, and supporting transformative community-based research.

By

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## Abstract

The Fredericton Downtown Community Health Centre has not always been as big, as comprehensive, nor as connected as it is today. The idea of creating a health centre that was nurse-led and nurse-managed and would increase access to healthcare for vulnerable populations and, at the same time, create opportunities for nursing students and other allied health discipline students to engage in experiential learning, began in 2000. Members of the University of New Brunswick Faculty of Nursing came together to write a proposal for the UNB Community Health Clinic with a mandate to: 1. Increase access to primary healthcare (PHC) for vulnerable populations, 2. Create a living laboratory for various disciplines to engage in experiential learning, and 3. Engage in research to benefit the populations served by the clinic. With federal funding and support of the UNB Dean of Nursing, the Faculty of Nursing Community Health Clinic became a reality. First situated in a small heritage house in the downtown of Fredericton, New Brunswick the clinic has grown to become a multi-disciplinary and collaborative health centre which is state of the art and unique in Canada. The clinic is co-managed by a Faculty of Nursing affiliated nurse and a nurse-manager from the local health authority. In 2015, at a time when the clinic was providing PHC to approximately 1500+ recurring clients, it entered into a new partnership with the local health authority. This collaboration between the university and the health authority laid the foundation for taking the little clinic to the next level where it has been able to grow and build upon its best qualities. The clinic began with a staff of one nurse, one social worker, and one front desk manager and is now a multi-disciplinary facility that includes: nurse practitioners, nurses, licensed practical nurses, an embedded clinician researcher, medical doctors, social workers, occupational therapist, registered respiratory therapists, dietician, community development officer, community access room coordinator, and administrative assistants. We provide care to diverse populations, have students from multiple professional and academic schools completing practicums, and engage in transformative research to improve the health outcomes of our clients.

**The little clinic that could:**

**Bringing primary healthcare to vulnerable populations, creating space for experiential learning, and supporting transformative community-based research.**

**A little story.**

During the summer months we became accustomed to seeing Dave come to the clinic for a cup of coffee, to chat, to hang around, or to seek healthcare. He lived in a rooming house, had little family in the city, and was doing his best to live with alcoholism. One day, he came in, this time asking for a blood pressure check. I sat him down and proceeded to review his chart and do his BP, all the while asking him how his day was going and what he had been up to. We talked for a few minutes and I was just about to ask Dave if he needed anything else when he went very quiet. He hesitated and seemed a bit uncomfortable but eventually he said: "You know that I like to read at night and that reading keeps me from reaching for the bottle", "Yes" I responded. "Well, I don't have a lamp in my room so at night after the sun sets, I can't read anymore, and I am worried that I am going to slip." I said "Dave, you just sit here a minute, I think that I can help." I went down to the basement where we stored all manner of household goods that had been donated for the clients. There sat a lamp, that needed a new light bulb but otherwise worked. I brought it up to Dave, whose face just lit up with the biggest smile. "Thank you so much, you have no idea what this means to me."

I realized some time ago, that this episode was one that really cemented my understanding of primary healthcare as the holistic view of the client, the importance of listening and being present with the client, and the idea that sometimes healthcare is about something other than physiology. Dave had a number of slips over the following two years, but he maintained his connection with the clinic and was always welcome to come see us. Dave succumbed to a massive heart attack and was found in his room, with the light on and a book at his side. I will never forget him, and the lessons that he taught me about building relationships and providing the best primary healthcare possible. I did not need to enlist my vast laundry list of nursing skills, but rather I needed to be human and willing to listen.

The Fredericton Downtown Community Health Centre (FDCHC) was always meant to be a place **for** the clients; it truly is, **their** clinic. We serve populations that are so marginalized that they are frequently not counted on most census documents. A significant number of our clients are homeless, either sleeping 'rough' or living at the shelter, unemployed, living with mental health issues and/or substance use disorder. We offer a place to get out of the weather, to get a cup of coffee, and something to eat. We have a shower where clients can get cleaned up, cooled off, or warmed up, depending on the time of year. We have a meagre clothing bank, and when the need arises, we seek donations of specific items. Clients know that we listen, without judgment, and that we support them, in whatever way we can. We think, plan, consult, work with, and act from a position of harm reduction.

**Background**

Prior to 2002, community clinical experiences for nursing students at the Faculty of Nursing included visiting the Fredericton Emergency Shelter for men, the Community Kitchen and other service organizations within the community. Faculty who were familiar with the population served became concerned because access to care was seemingly dictated by clinical practicum schedules. They also heard stories of healthcare mired in judgement, assumptions, discrimination, and stigma. The idea for the Community Health Clinic (CHC), which later became a partner in of the Fredericton Downtown Community Health Centre (FDCHC) arose from these concerns, the result of homelessness studies, community consultations with other non-profit service organizations, and a review of related literature. People who were homeless conveyed concern about their health, were interested in helping themselves, but faced a lack of coordinated, relevant, and culturally safe services. The population faced barriers to accessing appropriate and responsive primary healthcare services. The University of New Brunswick (UNB) Faculty of Nursing (FON) had faculty with years of experience working with marginalized populations.

Health clinics have been associated with academic institutions in the United States, experiencing varying degrees of success (Dykeman, MacIntosh, Seaman & Davidson, 2003). Unique in New Brunswick and in Canada, the Community Health Clinic was and remains a new and innovative model of healthcare delivery. Belief in a health clinic to address the gaps in service for vulnerable populations while providing students with experiential learning opportunities was the impetus for the development of the Community Health Clinic. Work on establishing the clinic was a collaborative effort between members of the UNB's FON: Dr. Kathleen Cruttenden, Pat Davidson, Dr. Margaret Dykeman, Dr. Grace Getty, Dr. Cheryl Gibson, Elaine Kenyon, Dr. Judy MacIntosh, and Dr. Pat Seaman. They developed a plan and applied for funding, with the support of community partners, to establish a community health clinic that would serve multiple purposes. The FON, recognizing the importance of including community stakeholders in the process, ensured that the voices of critical stakeholders were heard and that they had an opportunity to contribute to the generation of a service delivery model for the new healthcare facility that would meet the needs of both the university and the community.

There was broad support for a health clinic situated in the downtown area of Fredericton. One of the greatest barriers to care was the fact that the regional hospital is approximately three kilometers from the downtown; most of the homeless population do not have the means to pay for a taxi, nor bus fare, nor the health to walk up the hill. Our clients told us about care that was provided through a lens of stigma and discrimination. Key guiding principles of the clinic are that it is centrally located, easily accessed, and employs a client-centered approach to care that is responsive and tailored to the needs of the populations.

The FON received a grant from the National Homelessness Initiative (HRDC) in May 2002 to open a clinic for the homeless, addicted, and low-income populations living in Fredericton and the surrounding area. Additionally, the FON funded the salary for the nurse-manager and half the salary for a nurse, with the understanding that it included clinical instruction with nursing students. The HRDC funding was originally designated for the first year of operation. The clinic

was established in an older two storey eight-room building leased from the Fredericton Emergency Shelter. Prior to opening, the original building received a $60,000 facelift to bring it up to code and make it completely accessible. The community stepped up and provided many donations for the renovations including building materials at cost, man-hours, a new furnace, funding for washer and dryer, medical equipment, and furniture.

During the final stages of the HRDC funding, UNB agreed to provide some assistance with fund-raising to maintain the clinic because the services provided at CHC aligned with UNB's strategic plan; namely, it is a direct link to the community that it serves; a service-learning setting for teaching; and a research environment for conducting health-related research. The CHC engaged in multiple fundraising events in order to keep the doors of the clinic open, operating on a budget of $400,000 annually. The CHC is a living laboratory to facilitate learning opportunities for students from multiple disciplines from UNB, and other educational institutions. At the CHC, nursing students, both undergraduate and graduate, learn how to provide individualized primary healthcare for the clients while developing the knowledge of community development by working with agencies and institutions in the community.

A Community Steering Committee was established to guide the CHC's development and implementation. On December 12, 2002 the clinic opened, the Steering Committee continues to this day, to advise and support the achievement of the CHC's goals and objectives. The Advisory Committee is made up of people from the community representing our various community partners and includes members of the FON, the Regional Health Authority, City of Fredericton council members, representatives from the business community, and most importantly, clients who represent the needs of the populations served.

Following the initial opening in 2002, during the first 18 months of operation, the CHC provided services for close to 500 unique individuals, many of them receiving services on a daily basis. We identified a number of priorities that helped to focus our efforts while working within the chaos of our clients' lives. Determined to ensure that every client be provided with information

that would support prevention and health promotion; we knew that clients who have knowledge are better able to take care of themselves with a greater sense of control over their health.

The CHC began with an NP as nurse-manager and nurses as the providers of healthcare. As a part of our vision for a truly inter-disciplinary approach to healthcare we evolved from having a medical doctor provide prescriptions for Methadone to having NPs working to full scope of practice, with the collaborating physician being off-site for the majority of the week. Recognizing that the nurses could provide many services, we also understood that there were times when the client's needs were beyond our scope of practice. We made connections for clients with other services such as social development, housing, literacy, counseling, and diabetic education to name a few. When necessary, our primary care team would refer the client to other healthcare providers. What was most important was to assess the need and make the connection to the services that best fit the need. What we quickly learned was that while working at the CHC we began to notice trends and patterns that alerted us to gaps in services experienced by clients. As with the establishment of the methadone program, we see an important part of our job as being able to identify the gaps and how to address them.

As a way to respond to the needs of the community, we kept our ears open and enhanced our outreach program. An example of a service/program that we identified as being needed began when we noticed newcomer women with young children telling us about being or feeling lonely and isolated. They were in Canada, with young children and no extended family for support. We set up an International Moms and Babes drop-in once a month. At the drop-ins we met women from around the world, frequently the language barrier meant we played a lot of charades! Women got to know each other, were interested in each other's stories, and found companionship for themselves and their children. Eventually, the need for the program dwindled because connections were made and we were no longer needed by the mothers. While sad to say goodbye to what was often a lively and fun morning, we were glad that newcomer mothers were finding and making 'family'.

Although the initial populations to be served by the CHC were the homeless, the near homeless, and the addicted population, since that time other populations have been included in the continually and responsive changing program dynamic. The province of New Brunswick, understanding the partnership between the FDCHC and the Multi-Cultural Association of Fredericton (MCAF), asked for help as Canada prepared to receive the first wave of Syrian refugees. Because of the collaboration between MCAF and FDCHC a number of processes were developed to address the healthcare needs of the refugee population.

**Access to care – through building partnerships and becoming the first door, as the right door, and the only door.**

Over the next 10 years the local heath authority, Horizon Health Network, increasingly recognized the value of the UNB CHC and its approach to serving vulnerable populations in Fredericton's downtown core. A Health and Wellbeing Needs Assessment, conducted by Horizon Health Network in 2012, confirmed a growing need for access to primary healthcare and primary care in the core of Fredericton.

The final report stated that the UNB CHC's "on-going contribution to the health and well-being of the city's most vulnerable citizens is deeply appreciated by the community and the healthcare system. *"The nursing school's CHC is the lynchpin for students, our vulnerable populations and the newcomers."* The CHC's success now has it bursting at the seams. " The report went on to state, "This is an opportunity for Horizon Health Network, the Department of Health and the province of NB to commit to a partnership with community organizations, the universities and business community through the establishment of a downtown CHC. "

In February 2014, the provincial government committed funding for a new Community Health Center in downtown Fredericton and Horizon Health Network's Community Health Program and the University of New Brunswick formed a partnership to become integrated in a unique CHC model.

The FDCHC is a dynamic organization that engages innovative methods to achieve its vision of a community in which each person has access to primary healthcare. Although the needs of the community are fluid, changing with time, the vision continues to drive all work being done. The mission of the FDCHC is to provide evidence and community-based and academically integrated primary healthcare to poor and at-risk populations in Fredericton through a harm reduction lens, while also providing a rich environment for research that is based in the community. The mission is driven by continuing to develop partnerships between UNB and community agencies. Operating within a Primary HealthCare (PHC) framework and from a community development perspective, the focus is on social justice, the social determinants of health, and caring. The mandate of the FDCHC is:

1. To provide a supportive service-learning environment in which students in healthcare disciplines can acquire clinical skills
2. To provide a supportive research environment in which interdisciplinary health and community-based research can be undertaken, and
3. To provide a comprehensive, accessible and responsive primary healthcare service to individuals and families who are homeless, who have addictions, and /or who live in poverty, as well as others in the downtown Fredericton core who are unable to access a family physician.

The goal of the FDCHC is to be a healthcare facility that is multi-disciplinary, multi-functional, and accessible to members of the community who need it the most. While we are no longer a walk-in clinic (except for STBBI screening and to provide nursing services to members of the homeless and street involved population), we have increased the capacity of the clinic to respond to the needs of the community. Some of the services offered by the FDCHC are:

- Primary Care, delivered in large part by NPs
- Nursing assessment and Ambulatory Care
    - STBBI testing and treatment
    - Well-women services

        - IV therapy
        - Wound care
        - Access to free footcare
        - Immunizations and other injections (B12, psychiatric medications, contraceptives, publicly funded vaccines)
        - Screening (Mantoux, urine drug screen, STIBBI etc)
        - Medication counseling/coaching
- Addiction treatment
- Practicum experiences for
    - UNB NP, nursing, and law students
    - St. Thomas University social work students
    - New Brunswick Community College licensed practical nursing and administrative assistant students
    - Atlantic College of Massage Therapy students
    - Dalhousie University medical students
    - Eastern College occupational and physio therapy assistant students
- Mental health services
- Volunteer opportunities
    - Community access room
    - Multiple volunteer rolls at the Out-of-the-Cold shelter
- Occupational health, Registered dietician services, and Respiratory Health services
- Physical assessments (newcomer/refugee and employment)
- Social workers and Occupational Therapists to help with accessing services needed
- A barrier free Community Access Room that provides
    - A safe place to come for a cup of coffee and some conversation

        - Access to laundry services, a shower, and limited clothing, household goods, and food
    - Massage therapy (students provide the service once a week)
    - AND helping make connections to address whatever else is needed by the clients

The FDCHC nurse manager proudly suggests that we 'RANT' (Rapid Access to Nursing Treatment). Referrals to both nursing and social work also come from the Community Access Room Coordinator and our community partners. There are social work walk-in appointments in the early morning and you can also make appointments with social work and occupational therapist without being a patient of the clinic. People seeking STBBI screening can walk-in anytime to see the nurses. The partnership with the health authority allows for the UNB CHC (the little clinic) to continue to exist as a non-profit entity within the larger FDCHC.

**Partnerships**

A key component to the success of the FDCHC has, and continues to be, the many partnerships that have been forged. Partnerships often begin due to an identified gap in care and services that we could not address alone.

From the early days of the clinic's existence important partnerships with various community and service organizations were developed. One such partnership was with the Public Health Office. With changes to their mandate and delivery of services, they connected with the CHC on a number of initiatives. The first was for people coming into Canada, through various methods (as landed immigrants, temporary foreign workers, refugees, international students, and provincial nominee program) who had had a history and physical done prior to leaving their country and were flagged as having latent tuberculosis. These clients came to the CHC, to provide their history, to administer and read the Mantoux skin test, order a chest x-ray, obtain bloodwork for further diagnostic information, and start them on medications as needed and monitor progress. Frequent consultations with one of the Medical Officers of Health helped us to navigate some of the more complicated cases. Dealing with tuberculosis at increasing rates

required that we develop a care/treatment algorithm that is still being used by the Department of Public Health. The work that we did to address latent tuberculosis required that we reach out to doctors with expertise in treating infectious diseases. As a result, we have attracted and supported various infectious disease specialists to come to our clinic as visiting physicians to treat clients living with tuberculosis, hepatis C virus, and human immunodeficiency virus.

Through our relationship with Public Health we have established ourselves as a site for STBBI testing and treatment. Clients seeking STTBI screening do not have to be registered nor a client of the primary care team to access services. We offer non-judgmental, client-centred care, testing, counselling, contact tracing, treatment, and follow-up. All of the work is completed by the RN seeing the client, using best practice guidelines developed in partnership with Public Health.

The partnership with the Multicultural Association of Fredericton (MCAF), developed during the first few years of the clinic. Formed in 1974, MCAF plays a vital role in establishing communication and fostering understanding between the community, settled immigrants and newcomers. MCAF accomplishes this by offering programs and services that encourage and promote the concept of diversity and inclusion; to provide newcomers to Canada with settlement services, language instruction, employment services, and community networking; and create an inclusive and welcoming community. The partnership between the MCAF, Public Health, and ourselves has always been important and mutually beneficial.

The partnership between the CHC and MCAF grew out of an urgent need for healthcare for newly arrived refugees. Newcomers deemed the sickest by MCAF for health assessment were referred to the CHC. It became clear that the majority of newcomer refugees were going to need complete health assessments; as many refugees experience common chronic diseases frequently un-diagnosed and un-checked, such as diabetes, high blood pressure, and mental health issues. The Federal Interim Health Fund covered the cost of an initial assessment, which allowed for compensation to the CHC for the assessments completed. Treatment for identified health needs was provided by the clinic's NPs. There have been a number of important

outcomes from this partnership. We will discuss two that specifically highlight the initiative and unique learning opportunities for students.

The first involved petitioning the government to change the policy of newcomer refugees to have to wait three months before being issued a Medicare card. The refugees often need healthcare from the first day of arriving in Canada. MCAF and CHC wrote letters to the Federal government to impress upon them the need for changes to Medicare card issuance policies. As a result of the pressure applied, changes to the policy were realized and Medicare cards were issued to refugees upon arrival in Canada and New Brunswick, thereby guaranteeing equal access to healthcare services.

The second important initiative developed as a result of completing the health assessments. We noted that a large cohort of the refugee population were not up to date with immunizations, a situation that required extensive collaboration with the Public Health Office and coordination with the MCAF. Public Health's guidance helped to determine which immunizations and the timing for administration were needed to bring them up to New Brunswick Immunization Schedule. In the beginning, working with both partners and engaging nursing students, the CHC organized an immunization blitz and in one afternoon immunized over 90 refugee newcomers to Canada. Since that time, initial immunization and follow-up has been provided by the FDCHC for refugees to ensure that their immunization status is sufficient to provide them with the same protection as any other Canadian, who chooses to be immunized.

**Methadone Maintenance Treatment**

One of the first 'programs' established at the CHC was the first clinic-based Methadone Maintenance Treatment (MMT) Program. In 2002, the only option provincially was a doctor in Moncton whose practice included prescribing methadone, but was limited to his patients. We consulted with agencies in Ontario and British Columbia familiar with working with methadone as a treatment option for opiate addiction. They gave us a lot of support and materials needed to safely run our own MMT program. In order to run an MMT program, we recruited a doctor

willing to get a special prescribing license for methadone. The doctor would accommodate our needs, spending one day a week seeing clients living with addiction to opiates. We identified a pharmacy and built a partnership with them. They were willing to fill the methadone prescriptions, which we would pick up in the morning. Clients initially saw the doctor weekly and prescriptions were faxed to the pharmacy. Observed dispensing of methadone allowed us to see each client daily to assess their progress and collect random urine samples for drug screening. The social worker on staff provided counselling as an integral part of the treatment.

As methadone is usually a once a day dosing schedule, we had to ensure that clients received doses over the weekends. Volunteer nurses were recruited to work four hours on Saturdays and Sundays to dispense methadone to the clients. The methadone program continued in this manner until the pharmacy was able to take over dispensing. Clients seeking help with their addictions came from all over the province, sometimes making a four hour drive each way just to see the doctor, get counselling, and renew their prescription. After five years of successfully treating people, we sought additional funding from the government of New Brunswick Department of Health. We felt that it was a vital service deserving of governmental support to continue. Instead, the province decided that they could/should provide the service, establishing Addiction Services. Because of the relationships built with our clients and the comfort they felt in the care provided they often told us about new drugs coming into Fredericton and people being arrested or hospitalized. Clients trusted us enough to share potentially incriminating information and to advocate on their behalf, which we did frequently.

**Outreach**

One of the important programs that began when the CHC first opened in 2002 is the outreach program. It began with two staff members walking the streets of downtown Fredericton to identify where people gathered, who were the familiar faces, and to inform them about the CHC and the services offered. Red backpacks that were filled with condoms, clean needles, business cards for the clinic, bottles of water in the summer and hot chocolate in the winter, clean socks, a BP cuff and stethoscope identified the outreach staff. Outreach grew to include

rooming houses in the downtown core. We identified more people who were further isolated and difficult to reach, for various reasons. Outreach included visiting low-income seniors' apartment complexes where we found seniors whose healthcare and social needs were not being met on a number of levels. Making connections and building trusting relationships with this population was very important to gaining access. We offered our business card, told them about our services, and encouraged them to come to the CHC as needed.

Outreach was, and remains, a significant component of the student experience. Students are taught about why we do outreach and how to do it safely. They are taken out in small groups and "shown the ropes" by a mentor. One of the reasons for the success with outreach is that on the first day of the students' clinical practicum we give them an experience that was developed by nurse educators employed at the CHC. The experience is called "Eight Homeless Hours". Students are asked to come to the clinic where they leave bags, wallets, lunches, etc. They are paired off and given a scenario such as: You are a young man recently released from jail, you have no family, no money, and no job or You are a teenager who finds herself pregnant and kicked out of the house, or You are someone living with a mental health diagnosis that prevents you from working and you have lost your housing because of behavioral issues, You are a young man who made some bad choices, using street drugs, and now find yourself homeless, without means of taking care of yourself. The scenarios are based on clients of the CHC. The students are then ushered out the front door and told to come back in eight hours with a list of things that they learned to try to address their specific situations, what services are available, and where to find them.

The experience was developed because we noted students had previously very little, if any, interaction with people who are homeless, drug-addicted, or street involved. Students needed a crash course in reality, which this experience provides. When they return, we ask that they go home, enjoy a hot meal, jump into a shower, and reflect upon the experience. They are encouraged to express their reflection in various academic or creative formats. We have received some amazingly creative representations of the experience over the years; poetry, art,

music are a few examples. The most common initial reaction from students is “I didn’t know, I never knew we had a homeless population in our city!” Myths and assumptions about the lives of the clients are explored, which allows students to meet people where they are, rather than allow preconceived misconceptions and biases to interfere with therapeutic relationships and learning opportunities. Outreach has a profound effect on the service and experiential learning opportunities of students.

Nursing and other allied health students are actively involved in the provision of primary healthcare. The experiential nature of service-learning provides experiences that would be challenging to recreate in a laboratory setting. The FDCHC is the most sought-after community clinical setting for students. They develop a richer understanding of community development, social justice and engaging with vulnerable populations. The following story written by a nursing student highlights the benefits of experiential learning for both the students and our clients.

**My Encounter with “F”: A Student’s Experience**

Our first encounter with F occurred during street outreach in one of the many rooming houses in downtown Fredericton. We were a team of four; myself and one other Nursing student, a social work student, and the Community Access Room Coordinator. We were standing at the top of the stairway entrance into the building when we heard the door open. I don’t think any of us immediately noticed someone coming up the stairs until we saw F. He appeared to be somewhat disheveled; he was sporting a long beard and his skin was reddened with sunburn. As with anyone else, we said hello, introduced ourselves and mentioned that we were from the CHC. We gave a quick run-down of the services offered – social work and counseling, nursing, etc – and then waited for F to speak. He said hello, and without warning, began to cry uncontrollably in front of us.

F is a man in his late fifties who has been a resident of the Fredericton area for many years. As he began to share his story with us, he spoke of feeling hopeless. He described having been a working man who had always been able to provide for himself through honest hard work. F shared that he had suffered a seriously debilitating stroke seven months prior. He shared that he remained hospitalized for many weeks, during which he worked with physiotherapy and occupational therapy to regain as much functionality as possible. However, F described frustration with the hospital system; having been given the Heart and Stroke Foundation's stroke rehabilitation handbook, but because of illiteracy he could not read it. He was feeling hopeless because he now had no way of obtaining an income –unable to work efficiently with his hands and not knowing how to navigate the EI system. He talked to us about not having a family doctor in the area and little or no access to the most basic of healthcare services.

Our hearts immediately went out to F. Happily, we told him that the CHC had many of the services he needed and that we could help him begin the journey of becoming connected with these services to begin to meet his needs. I have never seen such a display of sheer relief than I saw in F that day – it was as though we were telling him that he had a second chance at life. In essence, that is exactly what the CHC gave him.

We were able to explain directions to F to help him get to the CHC; he arrived that afternoon as a walk-in. He spoke with the social worker at the Clinic, and then met with the Nurse Practitioner who was able to take him onto her roster. Within two weeks, we were able to complete a full health assessment for F and mobilize many of the resources he needed. Social workers were able to advocate for new housing for F through the John Howard Society, and that an entire team of social workers and various community workers were able to partner together to advocate on F's behalf.

For the remainder of the summer, F continued to stop into the clinic and often stated that he considered us to be his unofficial family. On two occasions, we sat with F for hours and

helped him try to navigate the EI system. He applied to start receiving his old-age pension early, and was waiting to hear the result. However, for some reason, his attempts to apply for disability employment insurance were consistently denied. Because of his illiteracy, F did not know what information needed to be included on his applications and was unable to gain any information for himself because he could not read. He felt disempowered on his journey, although he was determined to help himself as much as possible.

Currently, F continues to live in Fredericton and visits the FDCHC regularly. He uses a bicycle to commute (despite the deficits left from his stroke) and acquires income from collecting recyclables. He is one of the kindest-hearted people I have ever had the pleasure of meeting. I am so glad that our paths crossed that day in the rooming house, and I truly have no idea what he would have done otherwise. I am sure that F's life will never be the same; I certainly know that mine will not be after working with him. I am so grateful for the FDCHC's existence and the life-changing services that are available to the most vulnerable population of Fredericton. Stories like F's are evidence that healthcare services like those offered at the FDCHC need to be more widely accessible in small cities like Fredericton.

Nursing and social work students continue to provide outreach services while completing their practicums. Nursing students are also hired through a work/study programs through UNB. These positions allow a student to complete a maximum of 10 hours per week during the fall and winter academic terms. With the help of provincial and federal government student employment grants and other sources of funding like the United Way Central NB two or three nursing students are hired each year over the summer months. As a result of our exemplary work in providing experiential learning opportunities, the UNB CHC was awarded the J. W. McConnell Family Foundation Community Service-Learning Award in June 2013.

**Hepatitis C Prevention, Support and Research Program**

The Hepatitis C project was initially a Public Health Agency of Canada (PHAC) funded research grant for two years (April 2011-April 2013). The project, titled "Hepatitis C Prevention, Support

and Research Program" was meant to allow for provision of education and support services to those living or affected by Hepatitis C Virus (HCV). The initial goal of UNB's CHC was to use money from the project to develop a community-based primary healthcare program for individuals living with HCV.

With help from community partners, individuals with lived experiences and nursing students, seven educational modules were developed to present to our population. Topics ranged from prevention and transmission, liver health, treatment options to mental health, and nutrition.

The modules were used initially to start an HCV group that would meet weekly, rotating through the modules and providing education and support to people who came. The group has evolved over the years to become a support group of peers who are living with HCV or who are supporting others in the community and is jointly facilitated by the FDCHC and AIDS NB.

The project-lead developed and continues to provide education sessions and knowledge translation. Since 2011, the treatment of HCV has been rapidly changing. After almost 11-years of the same long, physically and mentally demanding treatment (pegylated interferon + ribavirin (PEG/RBV), newer and better treatment options emerged. A new era of HCV knowledge was becoming accessible to both healthcare professionals and people living with HCV, who were sick and frequently ended up on the liver transplant list.

A hepatologist began seeing patients at FDCHC on a regular basis and working with the visiting Infectious Disease Specialists. Treatment options were much easier on patients and restrictions on coverage for treatment were decreasing. The new treatment options make it possible for patients to be taken off the liver transplant list and cured of the virus.. The doctor continues to come to FDCHC to treat and cure most patients of HCV with nurses providing treatment monitoring. The HCV group has become a monthly drop-in and still educates people on prevention and the importance of testing. We continue Outreach to AIDSNB for POC testing for Sexually Transmitted Blood Borne Infections (STBBI) on a monthly basis. FDCHC has become a

centre for HCV treatment in the city and has developed a reputation for sexual health in general.

The connection to a pharmaceutical representative working with Bio Script (a distributor pharmacy who works with specialized medications like HCV drugs), and with our new facility, the FDCHC, we were able to arrange to have the Fibroscan machine come to the clinic on a regular basis. Fredericton does not have a Fibroscan machine, and several specialists in our community, mainly the GI docs and the hepatologist, utilized this service. The Fibroscan machine is a tool used to assess the density of the liver and has replaced the more invasive biopsy procedure. It is a key player in treatment as treatment guidelines require a fibrosis score prior to beginning treatment.

As a result of positive evaluations by an external evaluator, the original project funding was ultimately extended until 2017. We successfully applied with AIDSNB to receive another three years. The new project focused on HCV prevention/education and HIV co-infection. The funding has allowed the FDCHC to offer point-of-care (POC) testing as an outreach endeavour at AIDSNB's office every two weeks. The HCV group was changed to a one-hour drop-in every two weeks. We offered a gift card to people who came to learn about HCV as an incentive. Although the project funding has now come to an end, we have ensured that the HCV initiative would be self-sustaining

**Research**

In the spring of 2013, Dr. Rickards, who has been a part of the CHC/FDCHC since 2005, applied for and was granted a four-year CIHR Embedded Clinician Researcher (ECR) Salary Award. The award provides Dr. Rickards with time to engage in transformative research focused on the health needs and outcomes of vulnerable populations. The ECR is encouraged to develop a culture of research in which employees see the benefit of, and participate in, research that ultimately informs practice. Research generated from the FDCHC generally has a goal of addressing specific client needs and is frequently community-based with patient engagement. A sampling of some of the projects are:

1. **Evaluation of the role of the NP in New Brunswick.** Investigating the role of the NP and the experience of patients' receiving healthcare from NPs, provided confirmation of just how important and well received the NP role is.
2. **Diabetic Soles.** Using footcare as a tool for engagement with vulnerable seniors with diabetes we discovered that many low-income seniors were living with multiple health problems, were isolated and lonely.
3. **An analysis of the relationship between housing status, service usage, and health outcomes in a small city community health centre?** This study was initiated by a medical student completing a Research in Medicine project. The purpose of the study is to collect information about the clients' housing and health status and the pattern of service usage at the FDCHC. The project is ongoing and will be completed by the medical student before graduation.
4. **PROGRESS – patient centered, upstream interventions to improve COPD care.** An upstream and multi-disciplinary team approach to screening people 35 years and older, with at least two COPD risk factors. To identify COPD early, allow for early treatment, provide patients with peer-support to encourage self-management and ultimately improve the long-term life expectancy, quality of life, and decrease hospital usage.
5. **Collective Case Study Review of the Bernese Method: What Can We Learn from Our Clients?** The idea for this research resulted from discussions with our methadone prescribing physician who had recently begun using the Bernese Method to transition clients from methadone or opiates to buprenorphine for treatment of addiction. The outcome of the research will allow us to gain a richer understanding and to identify potential opportunities for improving the service and the client experience.

What is really impressive and important about having an ECR on site at the FDCHC is that staff who would not normally be involved in research, are becoming more comfortable with the idea of inquiry and seeking answers to questions that ultimately inform practice and improve patient outcomes.

**Community Impact**

The FDCHC has decreased the use of existing urgent and acute healthcare services by many of the current clients by taking care of health problems that are not emergent in nature or preventing them from occurring (e.g., abscesses from needle use, etc.). Addicted clients receiving care within the clinic are no longer being admitted to the regional detoxification center for services, reducing the number of in-patient beds used by these individuals. For a very long time the clinic was one of the best kept secrets in town however, referrals are now being made to us by street involved people, physicians, and community services.

**Employee Success Story**

Julie's story – In 2003, Julie came to the clinic through Jobs Unlimited, a non-profit organization for men and women with an employment barrier. She was hired to work 20 hours a week as a custodian. It soon became clear that she would become so much more than that. Because of her knowledge of Fredericton's low-income and vulnerable population she became a natural conduit between the clients and the staff. When Julie started, she was shy and unsure of herself. With guidance she grew to become an out-going, capable, invaluable, and the longest reigning employee.

Julie cleaned the CHC from top to bottom, did laundry for clients who used the service, oversaw use of the shower, which meant providing people with a towel and some personal hygiene products then cleaning it between uses. She organized and oversaw the clothing/food bank housed at the CHC. She gathered and counted the returnable bottles and organized the household items that people donated to the CHC. With guidance, Julie learned to gather statistics about the work accomplished, taking on more responsibility she now works 30 hours a week.

Most importantly, she provides each staff person with a massive bear hug on a daily basis. Always concerned about others, she is an important part of our caring team. Her kindness and nurturing abilities make her the first person to cuddle any baby who comes to the FDCHC. Over the years Julie has worked to evolve the role of Community Access Coordinator and has become a valuable peer support worker. She has grown in her ability to interact with

people and manage difficult situations. She has been the stable and constant person where clients come to have a cup of coffee and chat. For the staff of the FDCHC, Julie is frequently the best person to consult when concerns arise about what is going on in the vulnerable community. Julie will know and be happy to share whatever she knows.

The FDCHC is able to continue to innovate in the way it provides primary healthcare to the vulnerable populations of Fredericton. The spirit and the patient-centered-harm-reduction approach to the care delivered needs to be maintained and to continue to evolve. During the fall months discussion began that centered on the health of people who were living 'rough'. Knowing that the winter months were coming and that there were several people who did not use the emergency shelters, a decision was made that is a perfect example of how we continue to respond to the needs of the clients. The FON agreed to support an Out-of-the-Cold (OOTC) shelter to the most vulnerable people in the community. Through collaboration with the Anglican Church and an army of volunteers we have kept up to 20 people per night out of the cold. Additionally, because the OOTC shelter is staffed by two social workers and a registered nurse we have been able to make connections for people with social services, mental health services, assessment for and access to supportive housing, and other services.

**Conclusion**

For the last 17 years the 'little clinic that could', did and continues to, deliver innovative primary healthcare to vulnerable populations, meeting them where they are and addressing the most pressing needs in the moment while also looking towards the future. We have created a space that is unique in its ability to offer exceptional healthcare, learning and teaching opportunities, and a place where transformative community-based research is growing and informing the care that we provide.