Alliance for Healthier Communities
Advancing Health Equity in Ontario

Supporting Health in Communities during COVID-19

How Community Primary Healthcare Delivered Continuous Care and Advanced Health Equity through the Pandemic Crisis

In response to the COVID-19 pandemic and its potential impacts on the health and wellbeing of people and communities in Ontario, Alliance members worked hard to ensure that people who experience barriers continued to receive high-quality care. The Alliance has 109 members that include AHACs, CHCs, CFHTs, and NPLCs and a FHO. When the information below describes a specific primary care model, this is indicated.

Ensuring Continued Access to Clinical Primary Care

Throughout the pandemic, the sector delivered on its commitment to providing accessible, high-quality primary care. Because salary-based clinicians did not have to wait for new billing codes to deliver virtual care, our members could shift quickly to virtual delivery of care. Most Alliance members also found ways to safely provide in-person primary health care either off-site or in the clinic with reduced capacity and enhanced safety protocols.

By the Numbers

- CHCs shifted to provide over 50% of their primary care services via virtual appointment.
- 96% continued to provide some on-site, in-person care.
- Our members saw only a 9% drop in the number of clients seen, an 11% decrease in appointments made, and a 16% decrease in services provided.
- The distribution of appointment modalities was nearly identical for all populations regardless of geography or socioeconomic status.
- There were significant increases in mental health care (85%) and palliative care (212%).

Behind the Numbers: Lessons Learned

- Delivering care virtually increased access for those who:
    - Have limited transportation options or struggle with the cost of transportation.
    - Have mobility issues.
    - Have dependents at home requiring care.
    - Work fixed hours and can't take time off work.
- Virtual care is less accessible to those with limited access to devices and/or data.
- Virtual visits work well for:
    - Health concerns that did not need a physical assessment.
    - Chronic disease management.
    - Follow-up appointments and prescription renewals.
    - Minor mental health concerns.
- Virtual visits do not work well for:
    - Health concerns that require a physical examination.
    - Clients presenting with severe mental health issues.

Keeping Communities Connected and Preventing Isolation

Alliance members made social "check-in" phone calls to clients they identified as being at risk. Sometimes a phone call isn't enough (or isn't possible), so many centres added in-person outreach. To help keep communities connected, they found ways to deliver group programming virtually.

By the Numbers

By early June 2020:

- 98% made check-in phone calls to clients.
  - 69% prioritized seniors.
  - 66% prioritized people with complex or chronic health challenges.
  - 64% prioritized people at high risk of isolation.
- 71% were doing some in-person outreach
  - 54% visited people in their homes.
  - 38% visited people in shelters.
  - 23% did street outreach.
- 82% of our members were offering virtual group programming.
  - 47% had virtual exercise groups.
  - 51% had health promotion and chronic disease management groups.

Behind the Numbers: Illustrative Examples

- Niagara Falls CHC Queer Youth Collective began meeting on Instagram, providing gender-affirming social interaction and connection to resources.
- Vibrant Healthcare Alliance combined therapeutic exercise and social interaction in virtual boccia and stretching programs offered via web and teleconference.
- Wellfort Community Health Services created the LiveWELL video series about healthy eating, diabetes self-management, oral health, and COVID-19 safety.
- ConnectWell Community Health provided fitness classes for older adults and virtual social programs such as the volunteer-led monthly coffee club.
- Seaway Valley CHC moved their exercise programs outdoors.
- At Centretown CHC and Kingston CHC community members sign up to send and/or receive personalized, hand-written "Cards Against Isolation," to or from a neighbour.
- Carlington CHC offered online COVID-19 trivia nights over Zoom to build community connections and share public health information.

Supporting Food Security and Meeting Other Material Needs

Alliance members have a long tradition of supporting the material determinants of health. During the COVID-19 pandemic, the need for these supports was intensified.

By the Numbers

- 75% of Alliance members reported starting, continuing, or increasing distribution of food hampers, hot meals, and grocery gift cards.

Behind the Numbers: Illustrative Examples

- CHCs of Northumberland delivered 60 baskets of food per week, prepared hot meals for a 40-bed shelter, and delivered hot meals to people isolating in hotels. Meals were delivered by salaried dental professionals from the CHC who were unable to provide dental services during lockdown.
- In addition to providing over 400 seniors' food boxes per month, school snacks on Fridays, and a daily outdoor supper, Kingston CHC delivered tents and sleeping bags to people sleeping in a nearby parking garage.
- Community Care, City of Kawartha Lakes delivered "happiness" packages to adult day program and respite clients, containing puzzle books, hand sanitizer, and snacks.
- Davenport Perth Neighbourhood & Community HC supplemented their hampers for Early ON clients with diapers and kids' activity kits.
- Flemingdon CHC added a temporary pop-up fresh food share program with community partners and distributed frozen meals donated by a local restaurant.
- Pinecrest Queensway CHC began delivering food to children who would otherwise have been accessing meal programs at school.
- Wellfort CHC included hygiene and dental supplies in their food hampers.
- Rexdale CHC expanded their food programs to serve over 600 clients.
- LAMP CHC delivered hampers and gift cards along with harm-reduction supplies.
- Carlington CHC delivered over 100 meals per day.

Advancing Digital Equity

Over the past decade, the growth of virtual tools, smartphone usage, and advances in information technology have made access to and comfort with digitally delivered content and programs another key determinant of health. This was accelerated by the pandemic, as clinical and social care were increasingly delivered online.

By the Numbers

- 635 phones with data plans for one year provided so far (partnership with TELUS Health and the United Way).
- 2000+ clients to benefit from devices and data to come (pursuing funding from Ontario Health).

Behind the Numbers: Digital Equity in Action

- Sandy Hill CHC provided English and French Zoom tutorials in Spring 2020
- ConnectWell Community Health partnered with CyberSeniors to deliver customized training for their seniors' fitness class participants
- Vibrant Healthcare Alliance provided set-up calls to help clients get set ready to use Webex for their online programs.
- Program leads at WellFort CHC call clients in advance of their online classes to assess internet access and support needs.
- The Yet Keen seniors program at Somerset West CHC provided Introduction to Zoom classes in Cantonese and Mandarin.

- West Elgin CHC runs a Digital Device and Training program for seniors and people with disabilities. Through this program, they have lent 25 iPads and provided training on how to use them to access CHC programs & services and connect with loved ones.
- At South Riverdale CHC, people can drop off old cell phones to be refurbished and distributed to people in need. They have donated 150 SIM cards/smart phones with 3 months of connectivity
- Unison Health & Community Services has delivered 30 tablets, and Toronto Public Library has provided hotspots for at-risk seniors in the Englemount-Lawrence area.

Advancing Health System Leadership & Collaboration

While some OHTs had to pause their integration work so their members could focus on responding to the pandemic, some OHTs found strength in the crisis and collaborated in new ways to meet new needs. CHCs also found new ways to expand and enhance community partnerships beyond health care.

Illustrative Examples

- The Ottawa Health Team started Counselling Connect, a partnership project of 6 CHCs and 15 community mental health organizations that provides same/next-day access to virtual counselling services. It was co-designed with clients and implemented in a span of 7 weeks. (Video).
- In the Mid-West Toronto Health Team, Access Alliance Multicultural Health and Community Services provided multilingual communication support for vaccine clinics, and the Centre Francophone du Grand Toronto provided French-speaking nursing students.
- The East Toronto Health Partners distributed vaccine confidence resources and implemented a COVID-19 Immunization Plan to help people in their communities access vaccines as quickly as possible.
- The CSC de Timmins partnered with the Franco-Ontarian Psychiatry Program of the Royal Hospital and the University of Ottawa to access a French-speaking psychiatrist through OTN.
- The London Intercommunity Health Centre began working more closely with the city homelessness prevention team, local shelter providers, and their public health unit to increase access to care for people experiencing homelessness.
- The CSC du Témiskaming partnered with local organizations to open a volunteer-run telephone hotline to connect people to providers as needed.

Advancing Access to Team-Based Care

Even before there were OHTs, there were TeamCare, PINOT, SPIN, PACT, and similar programs. These initiatives enable unattached primary care providers to refer clients to Alliance member organizations for interprofessional primary healthcare and social/material supports.

By the Numbers

- 30 communities across Ontario.
- Over 20,000 new clients (21,709 in June 2019)
- Over 1100 participating primary care providers (MDs and NPs) (1,153 in June 2019)
- Over 62,000 visits as of June 2019.

Illustrative Examples

- Through Patients Accessing Care Teams (PACT), a health navigator from Black Creek CHC works part-time in the ED of Humber River Hospital, connecting patients with health-supporting resources.
- TeamCare at London Intercommunity Health Centre provides support East London, an area that has the most vulnerable population and which previously had the lowest access to team-based care in London.
- In Thunder Bay, NorWest CHC embedded their interprofessional services onsite at three partnering primary care clinics.
- The South East Grey CHC's People In Need of Teams (PINOT) program enables local physicians to refer patients to an interprofessional team, ensures access to primary-care followup within 24 hours for patients discharged from the local hospital, and provides community memory clinics in partnership with the Alzheimer's society. (Video).
- The Windsor Team Care Centre partners with CMHA to provide mental health and addictions care, embeds care coordination into primary care for complex clients, and provides solo practitioners with access to interprofessional teams (infographic).