Request for Expressions of Interest to Collaborate on Research with Aboriginal Health Access Centres and Community Health Centres

On behalf of Ontario's Community Health Centres (CHC) and the Aboriginal Health Access Centres (AHAC), the Association of Ontario Health Centres (AOHC) is currently approaching potential partners who would be interested in conducting research with the CHCs/AHACs in response to the upcoming Canadian Institute for Health Research Community-based Primary Health Care (PHC) Strategic Initiative, as well as in future research opportunities. Research teams who are interested in partnering with the CHC/AHACs are required to contact us to discuss their project well in advance of submitting a grant proposal. CHC/AHACs are unable to guarantee participation in studies that are not discussed and developed collaboratively in advance.

Application Deadline: Wednesday, September 21st, 2011 at 5pm

Introduction to Ontario's Community Health Centres and the Aboriginal Health Access Centres

Today, one-third of Canadians live with one or more select chronic conditions and vulnerable populations are particularly susceptible to such conditions[i]. For example, the rates of diabetes and heart disease among the poorest 20% of the population are more than double the rates of the richest 20% of the population[ii]. Such excess burden of disease not only unfairly impacts vulnerable individuals and their families disproportionately but also negatively impacts society as a whole from productivity loss and higher health system costs[iii],[iv],[v].

There is a paucity of knowledge about how to tackle the burden of illness among vulnerable populations, though it is clear that a sickness-based model of primary care is ineffective[vi]. By studying alternative models of care, we can identify opportunities to expand successful programs, payment mechanisms and interdisciplinary teams to more effectively target and address the needs of vulnerable populations. Such models may also be translated to improve accessibility, appropriateness and coordination of prevention and care for all Canadians.

Ontario's 73 CHCs and 10 AHACs are located in over 150 communities and individually design specialized community-based primary health care services (CBPHC) for local vulnerable populations with an emphasis on prevention, health promotion, health education, and community development provided in partnership with organizations in other sectors, such as social support, immigration, environment, education, justice, recreation and economic development. With another 200 additional CHCs and AHACs elsewhere in Canada, there is a great diversity of settings in which to conduct research to learn from and spread innovation in CBPHC nationwide.

Ontario's CHCs and AHACs primarily serve clients who live in resource poor neighbourhoods, and who need high quality and comprehensive care as result of health and social complications. For example, in comparison to other primary care models in Ontario, CHCs serve approximately 40% more clients in the bottom two income quintiles (40% vs 56% in CHCs), four times more clients on welfare (2.6% vs. 10% in CHCs) or disability insurance (2.9% vs. 10% in CHCs) and

three times more clients with serious mental illness (1.6% vs 5.2% in CHCs)[vii].

In Ontario, CHCs are more effective in comprehensive care delivery and chronic disease management in comparison to other primary care models[viii,ix]. These studies have linked superior performance in Ontario CHCs to developing programs needed by the communities they serve; diverse interprofessional teams; longer consultations times; superior quality of chronic disease management for diabetes, coronary artery disease, congestive heart failure and hypertension; and more comprehensive and accurate charting, a key factor in successful chronic disease management. CHCs' reputation for authentic interprofessional practice is one reason why they were chosen as the comparator group for the Ontario Ministry of Health's 5-year evaluation project of the Family Health Teams and why the CHC Model of Care[x] has been implemented in many international contexts, including the U.S., Europe, Australia, New Zealand, and Africa.

Although there are dissimilarities between the Canadian and US health systems and contexts, the CHC Model of Care has been shown to generate significant cost savings to the US health systems while providing high quality care to clients with greater health and social complexities. Research suggests that CHCs save their health system $1,263 per client annually compared to other primary care providers and counties with a CHC have 25% fewer emergency department visits for ambulatory care sensitive conditions than counties without a CHC[xi].

When the potential of Canada's CHCs/AHACs is fully maximized, the outcome will be healthier people and communities throughout Canada, fewer health inequities for Canada's Aboriginal people and vulnerable populations, and a stronger, more sustainable healthcare system. In this way, CHCs/AHACs are uniquely situated to help the CIHR deliver on its strategic priorities. For more information on CHCs and AHACs, please visit: www.aohc.org

Application Process

Interested parties are asked to respond by reviewing the CHC/AHAC Partnered Research Approach and Research Priorities, filling out the accompanying template and submitting it to the AOHC by Wednesday, September 21st, 2011 at 5pm. Electronic submissions are preferred and please send to anjali@aohc.org. On Monday, September 12th, 2011 from noon-1pm, a webinar will be held with interested researchers to review the proposal objectives, application process and answer questions from potential applicants. Subsequently, select applicants will be asked to prepare a 45 min presentation and attend a two hour meeting on Wednesday, September 28th, 2011 with CHC/AHAC representatives. The meeting and presentation will be an opportunity to get to know each other, develop relationships and discuss in further detail the contents of the proposal and application. Times will be confirmed a few days in advance.

CHC/AHAC Partnered Research Approach

It is important for CHCs/AHACs to be involved in meaningful and actionable research. To help us do this, the CHCs have articulated seven principles to inform the approach to conducting collaborative research with CHCs. They are as follows:

Research must be relevant and reflect the key priorities of the sector

CHCs are interested in research that is relevant along three dimensions. First, CHCs want to participate in research that is relevant to the communities they serve, is aligned with the key questions/issues facing their organizations as well as at a provincial policy level, and has potential to be a catalyst for positive change. Second, CHCs will support research activity that examines the quality of the services they provide with particular interest in research that focuses on client health outcomes. Thirdly, the CHC sector welcomes contributions from the academic community to identify research that represents a significant contribution to the growing body of evidence. In summary, CHCs are interested in participating in research that is relevant to the communities they serve, that relates to health outcomes and that which is relevant to the academic community,

Community-based research is the preferred methodology

One of the key challenges for research is that primary and community-based health-care settings are far less controlled environments than that of hospitals and other secondary and tertiary care centres and outcomes are sensitive to the context in which care is delivered. Contextual issues include the nature of the local health systems, client-provider relationships, culture, language and a myriad of additional ecological factors. The complexity and involvement of the community environment needs to be taken into consideration when conducting research with the CHC sector. We seek research proposals that elegantly distil this complexity into a clear research hypothesis, the design of the methods, how the study is implemented, results that are interpreted with reference to the context and relevant and integrated knowledge translation.

Research should be conducted in equal partnership with external researchers

The CHC sector would like to collaborate as an equal partner with academia. The hope is that the sector will be able to contribute its perspective in identifying the critical research questions that originate from the community and provide legitimacy to any external researcher engaging with CHC clients. To this end, an academic researcher looking to partner with the CHC sector will be asked to enter into an agreement that will clearly outlines the roles and responsibilities of the CHC sector, the researcher and the nature of the partnership. Elements of the agreement may include data ownership, privacy and consent, ethics, roles, responsibilities and acknowledgement of the expertise brought forward by all partners. By clearly outlining the terms of the partnership, the CHC sector hopes to attract researchers who share a common set of values, are interested in research questions that align with that of the sectors and view the CHCs as active participants in the research rather than simply a means to access a large number of primary care clients.

CHCs strive for high-quality research

The CHC sector understands that rigour is currency in research and is therefore looking to support a partnership that conducts research of the highest quality. The CHC sector will examine the quality of the research effort by ensuring that the work reflects the sectors values, involvement of the community and potential for positive change and favours trans-disciplinary, mixed method, realist approaches to research that ensure that the research is relevant and actionable within the community context. To demonstrate its commitment to high-quality data and high-quality care, the CHC sector is currently undergoing a significant information management transformation with the introduction of a new EMR system over the next two years. Consolidation and standardization of the clinical and other information system will allow researchers greater access to our clients' information and will assist broadly across all

knowledge portfolios within the sector. Research will benefit from these advancements and will contribute to greater evidence based decision making within the organizations.

Research requires significant time and effort on the part of CHCs
Although the CHC sector seeks to be an equal partner in any research effort we must recognise that we are service delivery organizations and that care for the clients and communities that we serve often trump research efforts. Specifically, there are no CHC staff fully dedicated toward supporting provincial level research is activity. Given this limitation the terms of the partnership may include resources embedded within the CHC sector. Part of the research strategy is aimed at increasing the level of capacity within the sector to support research activity and we feel that dedicated research resources within CHCs is an effective way to ensure that any research partnership is sustainable and supports capacity development for additional research long into the future.

Research will be conducted based on clearly articulated ethics and principles
CHCs expect that any research conducted within their organizations will adhere to the highest level of ethical standards. Proposals will be reviewed by a tri-council approved research ethics board as is the requirement under Provincial legislation. However, we recognize that the conditions for research articulated in Chapter 9 of the Tri-council Policy Statement do not extend beyond Aboriginal populations to protect other vulnerable communities. Given that CHCs seek to understand community-level ethical concerns, the CHC sector may also consider an additional review by an ethics board with expertise in community based research.

The results of research must be disseminated with clear opportunities to translate findings into practice and foster positive changes in the community
CHCs hope to develop research partnerships that will catalyze positive change in our clients, their communities and the CHC sector as a whole. This could manifest, for example, in improved health outcomes of clients or changes in the ways CHCs deliver or organize services. To this end, CHCs are looking for research opportunities that involve a knowledge translation and integrated knowledge exchange process to ensure there is a lasting impact of the research. Through partnership, CHCs hope to increase the research capacity of the sector, their clients and communities. Knowledge dissemination plans that include active capacity building have the greatest potential to leave a legacy of positive change and increased capacity.

CHC/AHAC Research Priorities

The Research Priorities were identified through consultations with CHCs and other stakeholders but have significance to the broader primary health care and health and social systems. In order to ensure that the research undertaken with CHCs has relevance for CHCs, all research questions must reflect the role and impact of the CHCs with respect to the effectiveness of the CHC Model of Care. This includes the extent of impact on health equity, cost-effectiveness, client/provider experience and health/wellbeing outcomes; the contributing factors or characteristics of the CHC Model of Care that resulted in these outcomes; and recommendations and action to make improvements.

The Research Priorities are described in four themes with potential areas of focus list below in bullets:

1. *What policies, structures, approaches and service delivery models will improve the appropriateness and effectiveness of CHC services and improve the health and well-being of CHC clients and their communities?*

    - Enhancing the design and delivery of services to be more responsive to the unique needs and contexts of vulnerable populations and to leverage client strengths in care planning.
    - Effective and innovative approaches to mental health and addiction services and chronic disease management and prevention that are delivered within a social determinants of health framework.
    - Care management processes across agencies and community health and development programs.

2. *What types of policies, programs and delivery models will reduce the barriers to accessing care for at-risk populations? How can community capacity be leveraged to enhance access to health and health care?*

    - Reaching out to provide care in the location most appropriate for and preferred by individuals, families and communities at-risk by taking into consideration neighbourhood capacities and constraints and the social determinants of health.
    - Fluid and responsive primary health care system such that Ontarians receive care within or across PHC models that provide the most appropriate balance of access and quality for their needs.

3. *How can the experiences of clients be improved throughout the health and social systems? How can better coordination and integration support improved health outcomes?*

    - Building relationships and partnerships that integrate health with other community and social services to ensure the social determinants of health are recognized in the care provided to clients travelling across the health and social systems.
    - Coordinating services and programs for at-risk populations across the life course to promote health and well-being.
    - Reducing the burden on more costly forms of care by working across health and social sectors to prevent illness and promote health by proactively monitoring and managing the health and wellness of at-risk populations.

4. *What evidence would support policy development, resource allocation and the delivery of primary health care services that address health inequities and the social determinants of health?*

    - Enhancing the structures, norms and values that support leadership, management and health service delivery in efforts that promote equity in the community support and primary health care sectors.
    - Identifying ways in which federal, provincial and regional institutions, health care organizations and decision-making processes influence the allocation of resources related to health and its social determinants.

- Systematically incorporating health equity into the development, monitoring and evaluation of policies and programs.
- Designing organizational structures that promote the ability of individuals and their communities to influence health policy making and inter-sectoral action on the social determinants of health.

We thank all interested parties in advance for their interest. If you have any questions please contact:

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Key dates and deadlines

Monday, September 12th, 2011 from noon-1pm:
CHC/AHAC-Researcher Information Session via webinar
Register by clicking: https://student.gototraining.com/2h95l/register/4964337117441781504

Wednesday, September 21st, 2011 at 5pm:
Application deadline – see below for template to fill out and submit

Wednesday, September 28th, 2011:
Two hour meeting with 45min presentation by researchers

[i] Health Council of Canada. (2007). Population Patterns of Chronic Health Conditions in Canada: A Data Supplement to *Why Health Care Renewal Matters: Learning from Canadians with Chronic Health Conditions.* Toronto: Health Council of Canada. www.healthcouncilcanada.ca.

[ii] Health Council of Canada. (2010). *Stepping It Up: Moving the Focus from Health Care in Canada to a Healthier Canada.* Toronto: Health Council of Canada. www.healthcouncilcanada.ca.

[iii] The Ontario Physicians Poverty Work Group (2008) 'Why poverty makes us sick', 'Identifying poverty in your practice and community', 'Strategies for physicians to mitigate the health effects of poverty', 'The Many faces of poverty', 'Poverty reduction: policy options and perspectives'. *Ontario Medical Review*. Toronto: Ontario Medical Association. https://www.oma.org/Pages/OntarioMedicalReview.aspx

[iv] Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security. (2004) *Reducing Health Disparities — Roles of the Health Sector: Discussion Paper* Ottawa, Ont.: Public Health Agency of Canada. http://www.phac-aspc.gc.ca/ph-sp/disparities/pdf06/disparities_discussion_paper_e.pdf

[v] Health Council of Canada. (2010). *Stepping It Up: Moving the Focus from Health Care in Canada to a Healthier Canada.* Toronto: Health Council of Canada. www.healthcouncilcanada.ca.

[vi] Jaakkimainen L, Upshur REG, Klein-Geltink JE, Leong A, Maaten S, Schultz SE, Wang L, editors. (2006) Primary Care in Ontario: ICES Atlas. Toronto: Institute for Clinical Evaluative Sciences.

[vii] Rayner, J. (2011) Complexity of Care and Panel-size Studies. In: Acting Today, Shaping Tomorrow: An International Community Health Centre Conference. June 9-10, 2011. Toronto: Association of Ontario Health Centres.

[viii] Russell, G, Dahrouge, S, Tuna, M, Hogg, W, Geneau, R, Gebremichael, G. (2010) Getting it all done. Organizational factors linked with comprehensive primary care. Family Practice. 27(5): 535-541.

[ix] Russell, G, Dahrouge, S, Hogg, W, Geneau, R, Muldoon, L, Tuna, M. (2010) Managing Chronic Disease in Ontario Primary Care: The Impact of Organizational Factors. *Annals of Family Medicine.* 7(4):309-318.

[x] Association of Ontario Health Centres. (2009) The CHC Model of Care Manual. www.aohc.org/index.php?ci_id=4125&la_id=1. *Accessed: August 31, 2011.*

[xi] National Association of Community Health Centres (2011) Community Health Centres: The Local Prescription for Better Quality and Lower Costs. NACHC: Washington, DC.