Lower Columbia Community Development Team Society

Kootenay Boundary Division of Family Practice
A GPSC initiative

Health and Wellbeing Needs and Assets: Lower Columbia Regional Assessment

Final Report
September 2021

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Executive Summary

Strategic context

Access to primary care is an important social determinant of health. The BC Ministry of Health reported in 2019 that 17% of the population in the Trail Community Health Area were unattached, meaning they did not have a family doctor or nurse practitioner. According to the Kootenay Boundary Division of Family Practice, the Lower Columbia Region is experiencing a shortage of primary care practitioners, which is the main contributing factor to unattachment. Since 2017, seven physicians retired or left their family practice, and another 7-8 physicians are anticipated to retire or leave their practice within the next 2-3 years. While 7 physicians and nurse practitioners have started working in family practice in the region to date since 2017, some are working part-time and one of the seven has since left family practice for full-time hospital work. There is an emerging pattern provincially and in the Lower Columbia Region of fewer physicians working in community-based longitudinal primary care, as locum, specialized practice, or hospital work can be more attractive.

Paradigm shift in primary care

The BC Ministry of Health has implemented some changes to the structure of primary care, including the Primary Care Network (PCN) in 2019. Through PCN, there are three clinics in the Lower Columbia Region that have additional healthcare providers working alongside physicians and nurse practitioners in the same clinic, such as registered nurses, social workers, and or physiotherapists. Other recent changes to primary care funding includes new hours-based Group Contracts for physicians who work together to provide community longitudinal care, New to Practice Contracts, Health Authority run clinics call Urgent & Primary Care Centres, and some expansion of community health centres (CHCs). A CHC is any not-for-profit corporation or co-operative which provides interprofessional primary care, is community-governed and community-centred, actively addresses social determinants of health, and demonstrates commitment to health equity and social justice. The Ministry has stated that they are supporting interested communities in building a CHC.

This study

This study provided the first step in working towards establishing support for a CHC, by examining the needs of patients, healthcare, and community organization service providers, as well as existing assets that could contribute to a more holistic provision of primary care in the Lower Columbia Region. Data was collected through focus groups and individual interviews, using semi-structured questions based on five areas of inquiry: assets, needs, access, collaboration, and potential of CHCs. Perspectives were sought from community service providers, health care providers and practitioners, large employers in the region, and key community stakeholders such as the RCMP and local government. In total 26 individuals took part, for a response rate of 24% (26/109).

Five overarching themes emerged from the focus group and interview data:

1. Assets that support different aspects of health include primary care clinics, urgent hospital care, mental health services, and community service organizations
2. Health and wellbeing service gaps include adult and youth mental health, housing supports, and too few primary care practitioners
3. Transportation and being unattached are barriers to accessing health care and to wellbeing
4. Facilitating collaboration between community service organizations and primary care can address gaps such as mental health needs
5. Co-locating primary care and community services with a central navigator could help address gaps, access issues, and facilitate collaboration

Conclusions

The following conclusions were drawn from the available data on unattachment, the recruitment and retention rates of primary care practitioners, and the focus group and interview data collected for this study.

1. *The time to act is now*

Recruitment and retention of primary care practitioners is near a crisis point in the Lower Columbia Region and will remain so in the coming years. Changes in the way primary care operates, including both private fee-for-service practices and more flexible models of care, such as CHCs, may help recruit new physicians to the region and retain those practicing longitudinal primary care. The BC government appears to be supportive of communities wanting to implement CHCs and communities must capitalize on this support.

2. *Gaps in mental health care for adults and youth are found across the board*

Gaps in mental health care was the most discussed need. Participants perceived that there was a growing crisis of marginalized populations needing more mental health and substance misuse services. All youth were highly affected by the lack of mental health services for their age group and experienced the highest percentage of unattachment. Affordable and accessible mental health services for those who are without extended health benefit coverage is a major gap that has serious downstream consequences for families and communities.

3. *The Lower Columbia Region has numerous health care assets, from primary care practitioners and providers to community services*

There are many health and wellbeing providers and practitioners doing great work, although more boots on the ground are needed to serve the region's population. Communities can capitalize on the current assets and look to build efficiencies where possible. It was felt that

CHCs could make collaboration and communication between providers more efficient, but they should not take away from existing local primary care practices or community services in the region.

4. *The urgency of overcoming barriers to access should not take away from community longitudinal care*

Many in this study felt that a walk-in clinic would be a solution to unattachment and lengthy wait times. While these centres do help both attached and unattached patients access timely care, there was some discussion from the primary care group in this study that they are not solving the attachment issue as they are not fully integrated into the health care system, and they draw resources away from community longitudinal care. Recruiting more practitioners and allied health providers in team-based care settings, such as the PCN or a future CHC with urgent, same day appointment availability, would likely lead to better long-term outcomes for patients.

5. *There is a spirit of readiness in the community*

Nearly all study participants strongly felt that a CHC could help facilitate collaboration, improve communication between care providers, and make better use of the health and wellbeing resources currently available. There was agreement that mental health services, primary care practitioners, and social workers were the most important services to co-locate in a CHC. Participants who took part in this study and the study reference group who support the creation of a CHC must maintain strong ties to the community through proper communication, as community advocacy is vital to gaining the Ministry of Health's attention.

Introduction

Strategic context

Access to primary care is an important social determinant of health. Being attached to a regular primary care practice or to a practitioner (i.e., a family doctor or nurse practitioner) allows people to receive continuous, comprehensive, and timely care. The Kootenay Boundary Division of Family Practice (KBDiv) found through their 2019 Patient Experience Survey that when compared to attached patients, unattached patients:

- used the emergency department more often,
- were more likely to report experiencing discrimination in health care services,
- had lower self-reported health, and
- had higher barriers to accessing health care

Data from the BC Ministry of Health reported in 2019 that 83% of the population in the Trail Community Health Area were attached to a primary care practice, meaning that 17% were unattached, matching the provincial average [1, 2]. Children and youth under 18 years of age had the highest percentage of unattachment, at 35%. Other data sources have reported lower rates of unattachment. For example, the Interior Health Authority collected attachment data by asking "do you have a family doctor?" in their emergency departments. At the regional hospital in Trail (KBRH), 13.7% reported being unattached in 2018-2019 with a decrease to 12.8% in 2021-2021. It is important to note; however, that these are only the patients who visited the emergency department that year. It is also noteworthy that the existing data from the Ministry of Health on the attachment gap for the Lower Columbia Region is dated, collected in 2016/2017, and Health Minister Hon. A. Dix himself acknowledged that "they're estimates" [4].

About the region:
The Lower Columbia Region includes the municipalities of Trail, Warfield, Rossland, Fruitvale, Montrose and Regional District Kootenay Boundary Electoral Areas A and B. The region is home to approximately 20,000 residents, three major employers (Teck Metals Ltd., Interior Health Authority, School District No. 20) and six primary care clinics. There are a wide range of community services and supports in the Lower Columbia Region (40+) that are well documented [3].

According to the Kootenay Boundary Division of Family Practice (KBDiv), the Lower Columbia Region is currently experiencing a shortage of primary care practitioners, which is likely the main contributing factor to unattachment. From 2017 to August 2021, seven physicians have retired or have left their family practice, and there are another seven to eight physicians anticipated to retire or leave their practice within the next two to three years in the Lower Columbia Region alone. While seven physicians and nurse practitioners have started working in family practice in the region to date since 2017, some are working part-time. In addition, one of the seven physicians has since left family practice for full-time hospitalist work, meaning the pre-existing net attachment gap as reported on in 2016/2017 remains. There is an emerging pattern provincially and in the Lower Columbia Region of fewer physicians working in community-based

primary care as emergency department, locum, specialized practice, or hospital work can be more attractive, which exacerbates the issue of unattachment and recruitment/retention in existing clinics [2]. Adding to the attachment challenge, the population appears to be growing in the Lower Columbia Region anecdotally, but this cannot be confirmed until new census data is released in February 2022. Increases in average home values in the region [5] support the suggestion that higher demand for home ownership is due in part to more people moving into the area.

Community leaders, including the Lower Columbia Community Development Team Society – Health and Hospital Committee (LCCDTS-HH), continue to hear stories from healthcare providers and from the community that residents cannot find a primary care practitioner. These stories, combined with the fragility of some of the region's clinics due to recent and upcoming retirement of primary care practitioners, has triggered community leaders and healthcare providers to explore options in how to best structure primary care to become an attractive workplace for new physician and nurse practitioner recruits, to make the best use of resources, and to sustain high quality patient care.

Paradigm shift: addition of the Primary Care Network and community health centres

In the past few years, the BC Ministry of Health has or is planning to support some changes to the structure of primary care. The Primary Care Network (PCN) was implemented in the Lower Columbia Region in 2019, supported by a partnership between the BC Ministry of Health, the Interior Health Authority, and KBDiv. There are three clinics in the Lower Columbia Region that form part of the PCN in Kootenay Boundary. The PCN differs from traditional physician-operated practices as they aim to provide team-based care working with local community, Divisions of Family Practice, and First Nations [4]. PCN clinics have additional healthcare providers working alongside physicians and nurse practitioners in the same clinic, such as registered nurses, social workers, and or physiotherapists, and the opportunity to connect patients to regional resources such as Aboriginal Health Coordinators, registered dieticians, and respiratory therapists. One primary goal of PCN set out by the Ministry of Health was to increase attachment through funding and hiring additional providers in primary care [4]. For instance, patients who could be seen by a registered nurse or social worker, depending on the reason for their visit, freeing up time for the physician to see other patients. By freeing up the physician's time, they can in theory attach more patients to their panel. Data collected by the Kootenay Boundary Division of Family Practice showed that the total number of attached patients has not changed since PCN implementation.

Other recent changes to primary care funding includes new hours-based Group Contracts for physicians who work together to provide community longitudinal care [6], New to Practice Contracts, Health Authority run clinics call Urgent & Primary Care Centres, and some expansion of community health centres (CHCs). The BC Ministry of Health announced plans to fund some CHCs in the province. Health Minister Hon. A. Dix spoke in the June 17, 2021, Legislative

Assembly that where communities "have expressed an interest [in building a CHC], we're supporting that" [4]. A community and primary care partnership are integral to the CHC model, which is defined as "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 or co-operative which adheres to all five of the following domains:

1. Provides interprofessional primary care
2. Integrates services/programs in primary care, health promotion, and community wellbeing
3. Is community-governed and community-centred
4. Actively addresses the social determinants of health
5. Demonstrates commitment to health equity and social justice" [7]

A recent rapid synthesis of research evidence on CHCs found that CHCs increased patient satisfaction in the delivery of care [8]. The synthesis also found CHCs increased patient engagement with disease prevention and self-management, increased adherence to recommended screenings, and helped address health equity issues. Lower Columbia community leaders hypothesize that CHCs might better address social determinants of health and connect patients to one of the many community services in the region. This connection can strengthen primary care, as having providers screen for social determinants of health and provide lists of community resources to their patients, can lead to an increase in patient connection to much needed support services available in the community [9]. Examples of CHC service designs can be found in Appendix A.

The 2020 research synthesis found that CHC had lower costs of care and provided cost savings to the healthcare system [8]. Lower Columbia community leaders believe that the CHC model may help with recruitment and retention of new practitioners in the Lower Columbia Region. Research summarized in the rapid synthesis showed one study that found CHC staff reported positive work environments and several studies reported that staff in a CHC shared similar visions around activism, advocacy and health care equity that encouraged collaboration [8]. Other research also showed that the traditional fee-for service model of primary care in BC, involving clinic ownership and management was not attractive to new physicians [2]. They were more likely to choose to practice in a salaried team-based care model in which they can focus on medicine and rather than clinic management, which is one essential component of a CHC. Anecdotal evidence from KBDiv supports this, as clinics that have been most successful in recruiting new practitioners to the Lower Columbia Region allow for job flexibility and salaried models.

The benefits of a CHC in improving patient satisfaction, linking multidisciplinary primary care to community services, and the potential to be an attractive model to new primary care practitioners prompted the LCCDTS-HH and KBDiv to commission this study into whether a CHC model would work in the Lower Columbia Region.

Purpose

This study provided the first step in working towards establishing a CHC, by examining the needs of patients, healthcare, and community organization service providers, as well as existing assets, in terms of services, expertise, or space, that could contribute to a more holistic provision of primary care in the Lower Columbia Region. The study aimed to determine:

- The community needs and assets in terms of holistic health care, including what services are available to address clients' social determinants of health, whether these services are accessible, and what services are missing in this area.
- If or how the existing health services promote respect for diversity and support clients in culturally safe ways relating to their overall health, including social, physical, and emotional well-being.
- If there is community interest in a CHC that could help with accessibility of services, what types of services might be served best by co-location, and whether health service providers are interested in potential co-location.

The outcomes of this study will inform key stakeholders on the benefits of linking community services with primary care and what types of services are needed in the area and will help create a system in which holistic or whole-person healthcare can be provided in the Lower Columbia region.

Methods

The study scope of work and methodology were conceived by a reference group and a research consultant from KBDiv. The reference group was comprised of primary care practitioners (general practitioners (GPs) and nurse practitioners (NPs)), members of the KBDiv Board (practitioners and community members), KBDiv staff (project manager, administrative support), and members of the LCCDTS-HH.

Data was collected through focus groups and individual interviews, using semi-structured questions based on five areas of inquiry: assets, needs, access, collaboration, and potential of CHCs. A semi-structured format allowed for a rich discussion and for pertinent follow-up questions to be addressed. Individual interviews were offered to accommodate all interested participants who could not attend the focus group times. The focus groups were structured by employment type, with separate groups for community organization service providers, health care providers and practitioners, and for community employers or other stakeholders such as the RCMP. While mixing group participants has advantages in terms of engagement, the separate employment groupings allowed for a tailored conversation and made efficient use of time and resources. It may have also allowed participants to feel more comfortable sharing their opinions.

The reference group provided the research consultant with a list of potential participants in the Lower Columbia Region. Participant criteria included first-hand knowledge about the Lower Columbia Region, its residents, and issues/problems related to accessing holistic provision of primary care that better addresses the social determinants of health. Perspectives were sought from community service providers, health care providers and practitioners, large employers in the region, and key community stakeholders such as the RCMP and local government. Care was taken to ensure that each community in the Lower Columbia Region was represented by at least one individual. Over 100 potential participants were approached via email to take part in the study.

Participant category	Examples from category (not exhaustive)	No. invited	No. who participated
Local Government	Mayors and town councilors	26	3
Community Organization Service Providers	Trail FAIR, CDS, COINS, Freedom Quest, CBAL, Family Action Network, Community Futures, etc.	20	6
Employers/public services	Teck, SD20, Ferraro Foods, Red Mountain, RCMP, Library staff, daycares, etc.	19	3
Primary care practitioners	GPs and NPs in primary care clinics	11	3
Primary care providers & medical office assistants	Registered nurses, social workers, pharmacists, dieticians, physiotherapists, etc. who work in primary care	20	5
LCCDTS Health & Hospital Committee	A group of residents working to ensure the sustainability of the regional hospital	5	5

Five focus groups and nine individual interviews were completed. In total 26 individuals took part, for a response rate of 24% (26/109).

The qualitative data were analyzed and themed based on the five areas of inquiry previously mentioned. Within each theme, the dominant issues were grouped into categories, or groups of similar responses, and are represented in bullet points. Categories included sub-categories, where a comment was noteworthy or more specific than the overall category. Frequency counts were completed (represented in parentheses) on the number of times a statement was made in a focus group or interview that fit into a category. The number next to the sub-category refers to the number of times such a comment was made and was included in the overall category count. While the frequency count can indicate which statements were made most often, it is of limited use in a focus group, as the statement might have been made only once but all members

of the focus group felt the same way. Frequency counts are more effective when looking at individual interview data alone. To mitigate this shortcoming, a second analysis using Venn diagrams was conducted on relevant questions that examined whether the different groups of participants had similar perspectives.

To determine if perspectives varied between different groups of participants, they were classified by employment type into the following categories:

- Community service organization
- Primary care (practitioners, providers such as social workers, registered nurses, or other therapists, and medical office assistants)
- Community stakeholders (employers, RCMP, local government, LCCDTS-HH)

Findings

Five overarching themes emerged from the focus group and interview data. Each theme is described with supporting quotes.

1. Assets that support different aspects of health include primary care clinics, urgent hospital care, mental health services, and community service organizations
2. Health and wellbeing service gaps include adult and youth mental health, housing supports, and too few primary care practitioners
3. Transportation and being unattached are barriers to accessing health care and to wellbeing
4. Facilitating collaboration between community service organizations and primary care can address gaps such as mental health needs
5. Co-locating primary care and community services with a central navigator could help address gaps, access issues, and facilitate collaboration

Theme 1: Assets that support different aspects of health include primary care clinics, urgent hospital care, mental health services, and community service organizations

Participants were asked to describe what was working well in terms of provision of support for all aspects of health and wellbeing. Primary care clinics, the regional hospital and emergency department, and mental health services were the most frequently identified services that supported health and wellbeing. Certain community service organizations were also often mentioned.

Reponses were grouped into the following categories:

- Primary care clinics in the region (10)
    - NP at Waneta clinic (3)
- Mental Health and Substance Use services (10)

  - Community mental health supports (3)
  - Community nurse who provides service at MHSU (1)
- Regional hospital and emergency department located in Lower Columbia Region (9)
  - Access to specialists (2)
- Foodbank (5)
- Career Development/Employment services (4)
- Kiro (4)
  - Outreach and needle exchange (2)
  - Women's health services (1)
- PCN allied health staff (4)
- Seniors' programs (3)
  - Better home program (1)
  - Beaver Valley Seniors society (1)
- Trail FAIR (3)
- Teck's yearly health checks and employee family assistant program (2)
- Transition house (2)
- Community living services (2)
- Advocacy centre (2)
- Early years programming (2)
- Recreation services like pools/outdoor space (2)
- Home health services (2)
- NP access at high school (2)
- Hospice society (2)

"I think we're very lucky as a community of about 8000 people or 20,000 in the outskirts, to have a fully functional hospital. I've lived in different places in KB, but having the local hospital brings in talented health care workers…" [Community Stakeholder]

"We have a number of support organizations in community - FAIR is fantastic and do a lot of support work with many patients…" [Primary Care]

The following assets were mentioned in one focus group or interview:

Housing supports	Public health nurses	Axis
Crisis line	Ankors	Churches
MCFD	Trail youth centre	Trail Cultural Agency
Childcare sector	Beaver Valley community centre	Pharmacy
Youth Freedom Quest	Private practice allied health clinics	

"The hospital, the clinics with a wide array of GPs, specialists, NPs, and support staff…The mental health facility. A lot of food banks, churches, groups that work with those who are impoverished, Career Development Services for vulnerable populations" [Community Stakeholder]

Figure 1 below shows that all three groups of participants mentioned primary care clinics, urgent care at the regional hospital, mental health and substance use (MHSU), and Kiro health services among the Lower Columbia Region's health care assets.

Figure 1. Most frequently mentioned assets by participant category

Respondents were also asked how existing health care services and/or community organizations promoted **respect for diversity and cultural safety**. Five comments were made that the Lower Columbia Region was not a very diverse community. Three respondents said that health care or community service staff were respectful of diversity and clients' cultural backgrounds. The following lists examples of how diversity and cultural safety is promoted in the Lower Columbia:

- Cultural safety training for staff
- The settlement worker at CBAL
- The navigator table
- Gazebo space for smudging at Trail FAIR
- Special guests at early years programs to educate children about other places and cultures
- West Kootenay Friends of Refugees volunteers

Interior health (IH) was mentioned several times in regards to promoting cultural safety, particularly that the cultural safety training and the cultural cafés were popular among staff. Other examples from IH included:

- The Aboriginal Health Coordinator, and her availability for consulting
- IH's policy changes
- IH's Inside Net resources on cultural support
- IH's collaborative care template (includes culturally relevant questions)
- The regional hospital changed their chapel to now be known as spiritual services
- The NP at Waneta who does LGBTQ2S+ and Trans care

> "Awareness is much higher than several years ago on importance of cultural safe care, I'm unsure where it's going and it needs to be worked on a bit more but awareness is there." [Primary Care]

Despite these examples, four comments were made that more awareness and education was needed to promote diversity and cultural safety. One respondent commented that they were unsure of where to access cultural safety and diversity training or resources.

Theme 2: Health and wellbeing service gaps include adult and youth mental health, housing supports, and too few primary care practitioners

Several populations were identified as not having their needs met by the current state of health care and community services providers in the region. These included vulnerable populations, specifically:

- Youth
- Indigenous people
- LGBTQ2S+ people
- Those living in poverty
- Homeless people
- Those with addictions or substance misuse
- Children with learning disabilities
- Seasonal workers

> "The gap is counselling services. For adult mental health we have group counselling but we don't do 1-on-1 counselling. Some need specific support, like those with developmental disabilities or autism...If somebody needs counselling to deal with trauma, there is a big gap, this affects their ability to become employed. There is no access to trauma informed counsellors." [Community Organization]

The most frequently mentioned gap in services was for **adult and youth mental health**.

- Adult mental health (13)
  - No one-on-one affordable, in person, and consistent counselling (4)
  - Lack of trauma informed counsellors (2)

  - Lack of culturally safe counsellors (1)
  - No OT services in mental health (1)
  - Lack of support for eating disorders/weight management (1)

> "Every year there is some mental health challenges with the youth we employ, COVID-19 amplified it. We, our HR director, searched it out to see where we could get immediate assistance, but it was hard to find anything." [Community Stakeholder]

While some of the sub-categories above also apply to youth mental health, a lack of services for youth mental health needs was specifically mentioned nine times.

Affordable and supportive housing was another gap that was mentioned six times. This category included a lack of affordable housing, especially for families (2), and a lack of supportive housing for those with addictions (2).

> "The gap is vulnerable populations, those precariously housed, MHSU issues, living on the street. There is not enough supportive housing or options at low cost, not enough wrap around service like counselling, detox, outreach on daily basis, to try to engage people into buying into a program." [Community Stakeholder]

Substance misuse services was mentioned three times as a gap.

Other gaps relating to **primary care** included difficulty accessing available primary care and community services. The most common gap was a lack of practitioners in the region.

- Not enough GPs or NPs in the region (7)
  - Vulnerable populations have the hardest time getting a primary care practitioner (1)
- Wait times for lab services (4)
- Home support for seniors (3)
- Palliative care services (1)

> "The biggest challenge is finding a doctor." [Community Stakeholder]

The gaps around existing **community services** had to do with collaboration between services and access to the services.

- Collaboration between community services needed (4)
- Collaboration needed between community services and primary care (2)
- Wrap around services and outreach needed (3)

> "Everything is disconnected, go to ANKORs to help you with this, then go here for that, so to get to all of these places becomes a barrier - access to multiple services, can't afford a vehicle so relying on public transport - which is a gap because limited in this area but needed to access service." [Community Organization]

- Information needed on how to access community services, for both providers and patients (3)

Figure 2 below shows that all three groups of participants commented on the gaps in adult and youth mental health services. Adult and youth mental health were the only two gaps agreed upon by all three groups.

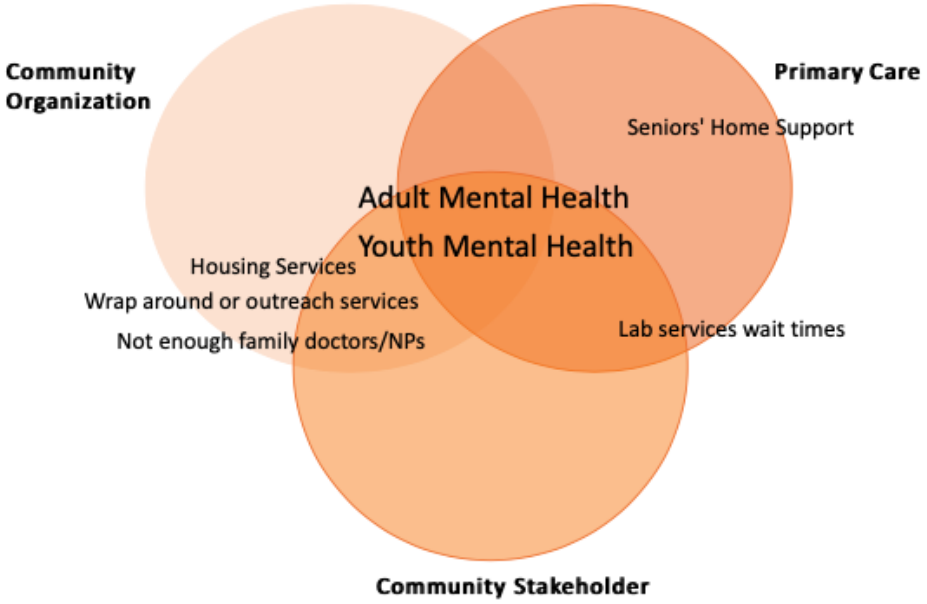


Figure 2. Most frequently mentioned gaps or needs by participant category

Theme 3: Transportation and being unattached are barriers to accessing health care and to wellbeing

Access was a major focus of all study conversations. Three categories rose from the access conversation, including transportation as a barrier, difficulties accessing primary care without a primary care practitioner (i.e., being unattached), and accessing a primary care practitioner in a timely manner.

There was consensus among most of the groups/individuals interviewed that **transportation** was a barrier to accessing health care; however, three individuals commented that there were no issues with transportation.

The main issues with transportation were:

- Inadequate public transit/infrequent trips (4)
- Not enough parking (3)
- Infrequent Handy Dart trips (1)

> "Where ever [services are] located, there will still be access issues. If downtown, people may live in Rossland or outskirts of Trail and will still need to get there through transportation." [Community Organization]

For those who cited transportation as a barrier, there was disagreement about what location was most accessible. Transportation and location came down to what population would be served best. For seniors, it was mentioned that the Waneta Mall location was the most accessible location in the region as there was plenty of parking and the building was wheelchair accessible (9). For marginalized populations, it was mentioned that Downtown Trail was the most accessible location because this population walked and "wouldn't spend their money on a bus" (5).

> "The mall is excellent for parking and access. If they're running behind at clinic you can go to the grocery store. It's central to Fruitvale. Barriers are the lab - parking is crappy, 90 yr. olds saying they had to trudge through snow..." [Primary Care]

Two people commented that marginalized populations in Rossland also have difficulties accessing services in Trail, especially in winter. It was important to participants to have some services, like primary care clinics, in local areas outside of Trail. Two people also commented that people who are referred to Nelson for mental health services have transportation barriers to attending these appointments.

Transportation barriers in the Lower Columbia region were currently being reduced in the following ways:

- Providing taxis or bus passes for local travel (1)
- Providing shuttle service from Red Mountain/Rossland to Trail (1)
- Offering phlebotomy services in Fruitvale (1)
- The seniors bus service (1)
- Offering telehealth appointments (1)

> "Having a van to pick people up and transport would be great." [Community Organization]

Suggestions of new ways to reduce transportation barriers included having a van pick people up for their appointments and talking to the city about how to improve bus services out to Waneta or making more parking available downtown Trail.

Issues around **timely access** for attached patients was the second category under theme 3. For those attached to a primary care practitioner, some felt that access was good and they could see their care provider in a timely manner (3) while many said timely access was poor as the wait was 2-3 weeks out (5).

COVID-19 was viewed as one reason timely access for in-person visits was worse (3). Physicians were not offering as many in-person appointments to limit their potential exposure to COVID-19 and to allow for increased cleaning. Two participants commented that seniors may not have wanted to do telehealth appointments, potentially limiting their access. On the other hand, one felt telehealth has improved timely access because physicians could potentially speak to more patients with shorter telehealth appointments compared to in-person. Some felt people were being pushed to access telehealth services like Babylon, as telehealth was more available and access to local primary care was worse, during COVID (2).

The primary care group discussed how timely access has been helped by primary care clinics keeping same day urgent appointment spots open (3) and by having PCN staff join the clinics which has helped to free up GP/NP time (5).

To improve timely access, many agreed that extended hours would help, whether that was longer opening hours during the week (3), keeping the clinics open over lunch (2), or on weekends (5). Having clinics open on the weekends was seen by one respondent as a way to reduce wait times at the emergency department. While extended hours were viewed favourably, one person commented that the only way to make this happen would be to hire/recruit more primary care practitioners.

The third category under the access theme was that **being unattached negatively affected people's health** and health care resources. Two participants commented that the need for more primary care practitioners was strong with clinics receiving between 4-20 calls from people seeking a primary care practitioner each day (2).

Participants suggested that people in the Lower Columbia Region are unattached because they:

- Are new to the area (5)
    - Are refugees (1)
- Had their previous family physician retire (2)
- Have complex care needs (1)
- Are marginalized (1)
- Have children (1)

Being unattached, or without a family GP/NP, affected health because:

- People may not get important screening done or have access to their screening results (2)
- Marginalized populations have emergent health needs (e.g., wound care or a mental health crisis) which are not addressed because they won't wait at the emergency department (1)

- People may not receive quality diagnoses if the emergency department physician doesn't know their history (1)

> "Individuals at the shelter have immediate emerging health needs. Can't get into a doctor. If I need help looking at an open wound, I have to take people to ER. Ends with them leaving because they won't wait 8 hours - we need staff to take them up there. With the level of complex needs, when they're ready to seek health care it's not available. Most homeless have no GP or haven't been in for such a long time. A crisis happens and they can't wait for 3 weeks." [Community Organization]

Unattachment also affects health care resources as people in the Lower Columbia Region without primary care providers have to visit the emergency department to address their needs (4). The lack of family doctors:

- Creates long wait times in the emergency department (6-8hrs) (2)
- People are pushed to telehealth services like Babylon or nursing line 811 (4)
- People have to travel to Nelson or Castlegar to use their walk-in clinics (2)

The following suggestions were made to improve attachment and access to primary care:

- Create a walk-in clinic, or other form of urgent noncritical same day service where both unattached and attached people could receive same day care (6)
- Recruit more GPs and NPs (4)
    - Patients want more consistent and longitudinal care (1)
- Hire more staff like social workers to handle forms/bureaucracy (2)
- Have more clinics like Waneta (1)
- Have primary care and other health services located under the same roof (1)

> "We need a walk-in clinic in Trail. It would be an important development in terms of an access point in Trail. You could have people walk in for OAT or whatever they needed. I think the generation of doctors coming in would find it attractive, so they don't have to own a practice, and would be easy to staff with doctors." [Community Stakeholder]

While a walk-in clinic was viewed as a needed resource in the region by the community organization and community stakeholder groups, particularly for the transient population (e.g., seasonal workers and some marginalized people), this was not raised by the primary care group. One primary care practitioner commented that walk-in clinics or telehealth can dilute quality longitudinal primary care. There was some discussion around what currently helps unattached patients access care, which included the NP who will see unattached patients, clinics in Rossland who will help with minor injuries, Kiro for women's health needs and Teck's short term supports for health checks and counselling.

Theme 4: Facilitating collaboration between community service organization and primary care can address gaps such as mental health needs

The gap that could be best addressed by better collaboration was mental health services. Aspects of health that could be improved upon through **better primary care and community service collaboration** are described below:

- Mental health and counselling (3)
    - Youth mental health, via NP and community organization collaboration (2)
- All aspects of health would benefit (3)
    - Referrals would allow patient/client to be seen by the appropriate care provider (1)
    - All aspects of development for children between 18 months and 5 years, as they are not seen by a public health nurse during this period (1)
- Signs of domestic abuse and proper referral (1)
- Cancer care (1)

Participants revealed several ways collaboration was currently working:

- PCN staff shared between 3 primary care clinics (6)
    - PCN RN is familiar with community service organizations/providers (1)
    - Aboriginal Health Coordinator (1)
    - Now PCN clinics have a fee code for patient conferences (1)
    - SW in PCN clinics is part of the navigation table (1)
- NP at the high school 1 morning a week for students and staff (4)
    - Waneta online clinic at the high school (1)
    - SW at Freedom Quest refers to the NP (1)
- Mental health disorder meetings each week between RCMP and community service organizations (2)
- Motherwise program when it's happening, as funding permits (1)
- Healthy aging program in Beaver Valley, a collaboration between home health, pharmacy, advance care planning, & patient/family (1)
- Settlement worker at CBAL (1)
- Angel flights, community groups funding flights for patient health care out of the region (1)
- Sanctuary housing, funding for apartment stays for patients/families at KBRH (1)

To facilitate collaboration between primary care and community service organizations, or within community service organizations themselves, three main categories emerged: Education/sharing of knowledge, more resources/funding, and the development of a navigator role. One participant commentated that it was essential that people "let go of power struggles."

- Educate and share knowledge within and between community organizations and primary care (13)
    - Have primary care providers attend community service organization meetings, like the poverty navigation table or violence against women committee, and have community service providers attend primary care clinic monthly meetings or KBDiv board meetings (4)
    - Foster relationship between NP and students (2)
        - Educate youth about health care and the right to privacy (1)
    - Educate employers about community service organizations in the community (1)
    - Disseminate information on community services through KBDiv channels (1)
    - Share existing parent pamphlet with primary care practitioners, so they know there are other mental health resources aside from child-youth mental health (1)
    - Have lunch & learns about community services for employees at Teck (1)
    - Educate medical community on the value of community service organizations (1)
    - Create a website where target groups explain who they are and who can collaborate with each other (1)
    - Educate community services that they can fax information to a client's GP if there is a health concern (1)

> "The more you know about something, the more you refer to or ask a question." [Community Organization]

- Create specialized navigator roles to facilitate collaboration (9)
    - Create overarching structure about who does what and how to make referrals (2)
    - More roles like the Aboriginal Health Coordinator (1)
    - Create RCMP outreach role for liaison with mental health and addiction services (1)
    - Educate PCN staff about community services so they can effectively refer - to free up GP's time (2)
        - The navigator should be a SW who works in primary care clinics (1)
    - Offer navigation training to those already working with community services to avoid disruption with staff turnover (1)

> "If it's entrepreneurship or private business, they reach out to us, like fitness or physio. If it's a government organization they don't reach out - you need to look out for the services. It feels like everyone is so slammed now. Providers are so busy. The notion of them reaching out to increase their market doesn't make sense." [Community Stakeholder]

- Seek out more resources and funding to collaborate (7)

- People have no time to collaborate (1)
- Services already have enough clients, it's hard to take on more so why seek them out through referrals or sharing information (1)
- The Provincial Government needs to sort this out with physicians (1)
- Easier to do in salaried primary care clinics, not fee-for-service (1)

> "It would be nice to coordinate among community groups, people who get funding, and Interior Health, with a common goal and mission and people take on their area of responsibility." [Community Stakeholder]

Theme 5: Co-locating primary care and community services with a central navigator could help address gaps, access issues, and facilitate collaboration

Participants were introduced to the concept of a community health centre after the collaboration discussion. Focus group and interview participants were asked what they thought of the CHC model for the Lower Columbia Region and if **community service organizations should be co-located with health care providers in a community health centre** (CHC).

> "We should definitely co-locate services. It allows for relationship building for true team-based care, helps with efficiency and trust in services and that everybody does good work, for flow and access and to create a web - more effective than silos for high quality care." [Primary Care]

Nearly all participants agreed that a CHC was a good idea, and the main reason was because it would allow for improved communication, operation, and better health outcomes for patients (6). Providers could work together to better serve clients. Another benefit was that a CHC could increase provider work satisfaction due to hallway conversations about clients/patients and more provider-to-provider interactions (2). Another benefit could be that primary care providers wouldn't have to work out of the CHC full time – they could do virtual appointments with an RN or SW present with the client and still provide wrap around care (2), or simply do 1-2 in-person shifts per week (3). It was felt by some that this model would attract new GP and NP recruits to the Lower Columbia region (2).

Some participants did express concerns about a CHC. Concerns included:

- The services included within the CHC and how these were laid out. Some people might not want to be seen accessing certain services, like mental health counselling (2)
- In the context of the COVID-19 pandemic, a CHC might mean too many people in one building (1)

> "Hallway conversations can happen [if co-located], puts a face to a name and a different way of being able to connect and communicate with others, more informal connection." [Primary Care]

- The financial costs with creating a CHC are too high (1)
- Outer areas of the region would not want to lose their primary care clinics for one large CHC (1)
- A large enough space may be too hard to find (2)
- Not all family physicians would be ready for this model (1)
- A CHC would need a good board to oversee operations (1)
- It would need to be welcoming for vulnerable and affluent people alike (1)

> "...having everyone in the same building would improve communication and operation. A new building that offered a number of services would be excellent. A one stop shop would increase effectiveness." [Community Stakeholder]

Navigation became a central category in theme 5. Some felt that a CHC housed in one building wasn't necessary if there was a navigator role for central communication and referrals from PCP to community services (5). Others felt that a navigator was a key component of a CHC, and this could be someone in the central reception or administration hub (3).

> "Capacity is a real issue - we will never have a place big enough to house all of these services but having someone to connect to others is key." [Community Organization]

When asked what services were the most important to be housed in a CHC, a navigator or central administrator/reception was one of the most commonly mentioned role (8). The other most requested grouping of services was **primary care combined with social workers and mental health services**. The list below shows specifically the most commonly mentioned services:

- Mental health services (9)
  - Mental Health Substance Use (1)
- Social workers (6)
- Primary care practitioners (GP/NP) (5)
- Registered nurses (4)
  - Home health nurse (1)
- Laboratory services (4)
- Social health supports like FAIR (4)
  - Family Action Network (1)
- PCN services (3)
- Housing supports (3)
- Addiction supports (3)
- Physiotherapy (3)
- Diabetes care and education (3)

> "It needs an administrative hub, secretary talent, booking, know all systems, do everything...technology and electronic communication are absolute key. It starts with hiring someone who is going to run this facility, need strong leader at the top, lots of programs and timing running at the same place to organize." [Community Stakeholder]

- Respiratory therapists (2)
- Youth services/Freedom Quest (2)
- Indigenous supports/COINS (2)

> "Prioritize, doctors first then cascade. PT, RT, dealing with diabetes care, chronically ill heart failure patients, mobility issues...what is convenient to collocate. Accommodate complex care needs first." [Community Stakeholder]

Some felt the CHC should focus on families (1), on the community services organizations that have the most clients/visits (1), on complex care needs (1), or on whatever aspects of physical or mental health that need immediate attention (1).

Other services that received one mention included:

CBAL	Neighbourhood house	Midwives	Acupuncture
CDS	Food cupboard	Pharmacy	Dietician
X-ray	Occupational therapy	Orthopedics	Kiro services
Dental services			

Figure 3 below shows the most frequently mentioned services that should be housed in a CHC. All three groups of participants identified mental health services, primary care practitioners, and social workers should be co-located.

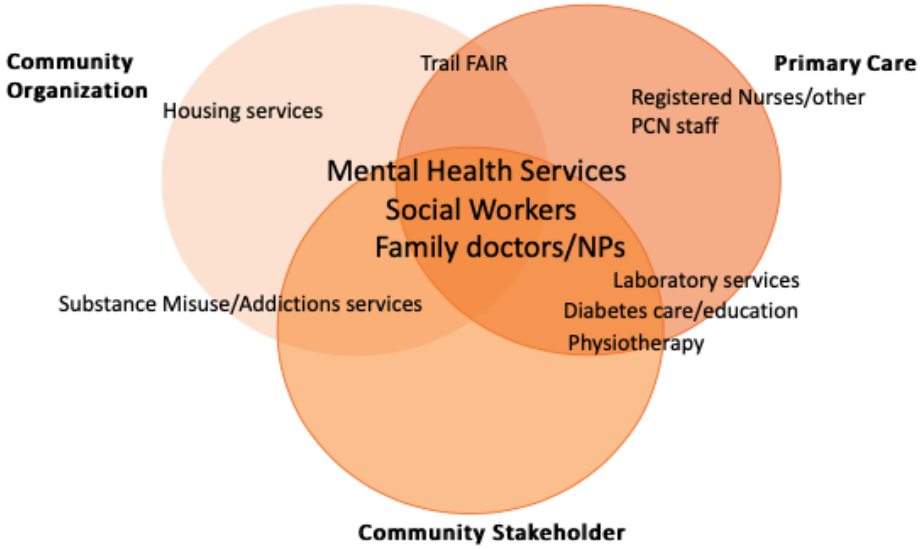
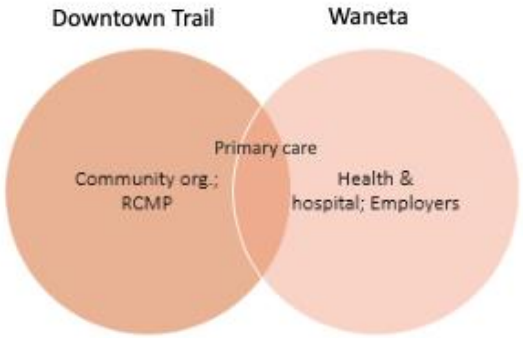


Figure 3. Most frequently mentioned CHC services needed by participant category

The **location of a CHC** in the Lower Columbia region did not reach consensus among study participants. As with earlier findings around accessing primary care, there was a split between the Waneta Mall (6) or Downtown Trail (4) as preferred locations. Regarding the Waneta Mall, this was viewed as the best location for seniors due to the ample parking and building

accessibility. Some felt that there might be more insight into how this location could work after the COVID-19 vaccine clinic was operating in the mall. Others felt that to reach vulnerable populations with mental health needs, then Downtown Trail was the best location as it would best service walk-ins. One participant suggested that a CHC need not be one building, but could be rather a courtyard of buildings within a couple of city blocks. Other suggestions for locations included

- Next to KBRH
- A 3-level building owned by the United Church
- Memorial Centre space
- Old Middle School in Fruitvale
- Old city hall building or LeRoi building in Rossland



In terms of which participant groups favoured a downtown Trail or Waneta location, results were mixed. Community organizations and the RCMP strongly favoured Downtown Trail. Other members of the community stakeholders group favoured Waneta. Some members of the primary care group favoured downtown while some favored Waneta.

Discussion

This qualitative study into the needs and assets of the Lower Columbia Region revealed that participants felt the region had high quality care from primary care practices and the regional hospital, and they perceived that the many community services supported social determinants of health. There was overwhelming agreement that a large gap was found in mental health services for adults, particularly for marginalized and vulnerable adults, and for youth across the board in the region. Participants also agreed on the populations in the region who are most likely to not have had their needs met by current primary care and community organizations. Youth and marginalized groups were frequently mentioned, such as those who were homeless, living in poverty, and/or people who misuse substances. Indigenous populations were also mentioned, although some felt that this has improved with the addition of the Aboriginal Health Coordinator role in the PCN. It is important to note that the Kootenay Boundary Patient Experience Survey (n=1598) found that a greater percentage Aboriginal respondents reported experiencing discrimination (15%) compared with non-Aboriginal respondents (5%), and greater difficulties accessing primary care when they needed it. This comparison supports the view from some study participants that continued cultural safety training was needed in the region.

Spotlight – Collaboration in the Lower Columbia Region: Motherwise is a mental health support group for new moms. A local church donated the meeting space, a MHSU counsellor facilitated the sessions, Trail FAIR helped with administrative tasks, child care, and linking clients to the program, and KBDiv worked with community actors on fundraising and advocacy work to secure sustainable funding the groups. Community members may volunteer to facilitate programs, help with fundraising for primary care clinic equipment, write grants, or rent space within the building to help with overhead and improve access to services.

The gap in mental health services could be addressed if better collaboration could occur between community organizations and primary care, such as through links with Child and Youth Mental Health services, which employs psychologists to counsel youth. Mental health and other health services could also be improved through primary care re-design, such as having more social workers in primary care clinics by expanding the PCN or through a CHC. As outlined in the report Thriving for All: Lower Columbia Poverty Reduction Plan there are many community organizations in the Lower Columbia Region, but it can be difficult to know where to go for what service [10]. As a result of the 2017 report, a poverty navigation table was established, but a crucial connection to primary care remains missing. A CHC could help by integrating primary care with some community services. This type of integrated primary care would benefit patients in many ways, through better health outcomes and increased satisfaction in the care they receive. Some CHCs have taken on social prescribing as a structured way to integrate healthcare and social supports so primary care practitioners prescribe medications along with "dance lessons, cooking classes, volunteer roles, caregiver supports, single-parent groups, and connections to bereavement networks" [11]. Other supports include partnerships that enable practitioners to provide patients with bus fare or child care services so they can attend appointments, extending clinic hours or providing outreach to where people live and work, and offering a culturally safe practice environment.

Health care navigation was a central theme identified in this study. The navigation function in a CHC would be more than one person's role, as team-based care between physicians, medical office assistants, PCN staff, and community service providers can improve navigation. It would also include components such as a central receptionist for the CHC and someone working to connect patients with the appropriate service, whether in the service is in primary care setting or community setting. Participants in this study agreed that having services co-located in a CHC was important for efficiency and communication, such as allowing for informal hallway chats to occur. But questions were raised about space and how many different services could fit in a CHC. One way to overcome this was through the navigator role, as services could be housed off site if still connected via a central navigator. Having space in a CHC for providers to use part-time could also alleviate some pressures on staff as they could work in more than one location, like the CHC at certain times and private practice, hospital, or other CHCs at other times. Allowing for variety of practice opportunities could also help with recruitment and retention of practitioners. The central booking system would be essential to making this work. One concern voiced in this study was that care needed to be taken when designing a CHC to ensure there

was no stigma around accessing certain types of care, like mental health. An advantage of a CHC is that by having a central reception, other people in the waiting room would not know what service the person was accessing, thereby potentially reducing stigma around seeking treatment. Research supports the importance of a navigator role in a CHC model, as incorporating a navigator has been shown to improve patient experience in a CHC in addition to improving relationships between patients and providers [8].

Another theme central in this study was issues around accessing primary care. The issue was framed in many ways, but essentially came down to a lack of timely access to primary care. This may be because many people are unattached and are left with little choice but to seek primary care at the emergency department, or that if they are attached, they may face a long wait time for an in-person appointment. Data collected by KBDiv showed that the average wait time for attached patients across the Lower Columbia Region's PCN clinics increased by 17% over the past twelve months. The delay is likely due at least in part to COVID-19 protocols, but this supports what this study found. There was a perceived shortage of primary care practitioners, heavily stressed by community stakeholder and community organization. This was not mentioned by the primary care group, with the exception of some saying that they were receiving many calls a day from people looking for a family doctor – up to 20 calls a day according to one study participant. Stories from KBDiv around a net attachment gap in the Lower Columbia Region, where in-coming practitioners are often working part-time with a smaller panel size of patients compared to full-time practitioners retiring, supports the shortage even if attachment figures from the Ministry of Health or Interior Health show only between 12-17% of the population are unattached. It was thought by one member of the study's reference group that the shortage of primary care practitioners was not stressed by the primary care group, rather they focused on the benefit of adding more PCN staff, as trying to attach more patients is the new normal for this group. They have been feeling the pressure for years with little solution until PCN resources were added to some clinics. Over the next year or two, data may reveal higher levels of unattachment, as new census data may show population growth in the region with no change in GP or NP numbers, making these early conversations and studies into primary care re-design even more crucial. A CHC can improve timely access because team-based care, like the collaboration between primary care practitioners, social workers, and community organizations, can free up time for the practitioner to see more, and potentially attach, more patients. If the population's health needs are being cared for, this may also lead to the person requiring fewer visits to the CHC, freeing up more time and resources. Research has shown that CHCs provide more comprehensive and coordinated care, while using less healthcare resources in the process [7]. A CHC model, with a greater focus on medicine and less on clinic management, may also be more attractive to newly graduated physicians [2] and thus could help KBDiv recruit to the Lower Columbia Region.

Many participants in this study in the community organization and community stakeholder groups perceived that the issue around timely care could be solved by creating a walk-in urgent

primary care centre in Trail. Some in the primary care group disagreed, including one participant who expressed concern that a walk-in clinic would lead to fractured care. Note that the primary care group was not specifically asked for their opinion on walk-in clinics, but these were the points that arose naturally from the semi-structured focus group questions. The walk-in clinic discussion came before the concept of the CHC was introduced to the group, and they may have thought that a walk-in clinic was the only option to improve timely access. A CHC was viewed by most as the preferred option for primary care re-design, but there were some who felt certain populations did need same day walk-in urgent primary care, like the marginalized or seasonal workers. A CHC could offer same day urgent appointments and other services for unattached as well as attached patients. This option would allow for integrated and continuing care should the patient need or want it, something that is difficult in a walk-in clinic setting.

The issue around access also included transportation barriers. The idea of best location for a CHC was really divided between study participants. Emphasis was placed on Downtown Trail or Waneta, as most study participants were from Trail. To focus on the biggest gap in services, mental health needs for marginalized populations, an ideal location would be downtown Trail to overcome transportation barriers for this population. The ideal scenario could be to have several CHCs in the Lower Columbia Region, or perhaps a larger CHC in Trail and satellite CHCs in Rossland and the Beaver Valley to serve these local populations. It is also important to note that CHCs would not be the only type of primary care in the region. Some practitioners would still prefer the traditional model of fee-for-service care. A combination of traditional clinics and the CHC model in a few locations throughout the region would hopefully meet the needs of patients and providers alike.

Limitations

This study describes the perceptions on health and wellbeing needs and assets in the Lower Columbia Region and is limited to the perceptions of those who took part in the study. The different groups of people who took part, such as those who work in primary care, community organizations, and members of the community at large, allowed for greater generalizability of responses.

Opportunities for further research

1. Look to other examples in region or rural BC for ideas on collaboration:
- Valley Community Service Centre in Creston
- The Rural Coordination Centre of BC has conducted a needs and assets study. Contact for regional info
- Neighbourhood House in Trail is also conducting a feasibility study looking at colocation of services to support families with young children
2. Include healthcare and community organization professionals in the design of the CHC space.

Conclusions and recommendations

Through the available data on unattachment and recruitment and retention of primary care practitioners, existing literature, qualitative data gathered in this study, and through discussions with the study reference group, five conclusions have emerged:

1. The time to act is now

Recruitment and retention of primary care practitioners is near a crisis point in the Lower Columbia Region and will remain so in the coming years. This is evident to KBDiv members as well as to patients, as unattachment was identified as a major barrier to accessing care in this study. Changes in the way primary care operates, including both private fee-for-service practices and more flexible models of care, such as CHCs, may help recruit new physicians to the region and may help retain those already practicing longitudinal primary care. The BC government appears to be supportive of communities wanting to implement CHCs and communities must capitalize on this support.

2. Gaps in mental health care for adults and youth are found across the board

Gaps in mental health care was the most frequently mentioned need, by all three participant groups in different areas of the Lower Columbia Region. It was apparent that a wide spectrum of people needed better access to mental health care. Participants perceived that there was a growing crisis of marginalized populations needing more mental health and substance misuse services. All youth were affected by the lack of mental health services for their age group, and they also experience the highest percentage of unattachment, indicating a potential area of focus for a future CHC. Affordable and accessible mental health services for those who are without extended health benefit coverage is a major gap that has serious downstream consequences for families and communities.

3. The Lower Columbia Region has numerous health care assets, from primary care practitioners and providers to community services

Participants revealed that primary care clinics, the regional hospital, mental health services, and the number of community service organizations were community assets. There are many providers and practitioners doing great work, although more boots on the ground are needed to serve the region's population. Communities can capitalize on the current assets and look to build efficiencies where possible. It was felt that CHCs could make collaboration and communication between providers more efficient, but it is not to take away from existing local primary care practices or community services in the region. Building better team-based care in the region through multiple CHCs could improve the ability of patients and providers alike when navigating the health care system.

4. The urgency of overcoming barriers to access should not take away from community longitudinal care

Being unattached was perceived to be one of the most impactful barriers to accessing primary care. Some participants in this study who were attached reported facing lengthy wait times to see their family practitioner as another barrier. Many in this study felt that a walk-in clinic would be a solution to this problem. Urgent primary care centres are fairly new to BC and aim to improve attachment. While these centres do help both attached and unattached patients access timely care, there was some discussion from the primary care group in this study that they are not solving the attachment issue as they are not fully integrated into the health care system, and they draw resources away from community longitudinal care. Recruiting more practitioners and allied health providers in team-based care settings, such as the PCN or a future CHC with urgent, same day appointment availability, would likely lead to better long-term outcomes for patients. Advocacy should be focused on recruiting and retaining practitioners in community longitudinal care.

5. There is a spirit of readiness in the community

When the concept of a CHC was introduced to study participants, nearly all strongly felt that a CHC could help facilitate collaboration, improve communication between care providers, and make better use of the health and wellbeing resources currently available. There was agreement that mental health services, primary care practitioners, and social workers were the most important services to co-locate in a CHC. Participants who took part in this study and the study reference group who support the creation of a CHC must maintain strong ties to the community through proper communication, as community advocacy is vital to gaining the Ministry of Health's attention. If the community is ready to act, the support for a CHC was voiced in this study. The study participants were from a wide range of backgrounds and areas of expertise, and there is support from KBDiv to move in this direction. A next step should be contacting the region's Member of the Legislative Assembly to advocate for CHCs in the region and then contacting them about this again and again.

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Appendix A: Community Health Centre Service Design Examples

- The Cool-Aid Society in Victoria is actually a housing society, and offers tenants full community health and dental care services, employment and volunteer opportunities, Pharmacy, and food/nutrition programs
- STEPS in Kamloops offers a general family practice with support from a Registered Nurse, Social Worker, Occupational Therapist, Respiratory Therapist, Dietitian and Diabetes Educator, and has a specific team offering gender-affirming care for LGBTQ2S+ members
- Yakima CHC has a Primary Care Team, Dental Care, Pharmacy, Home Visiting (Care Coordinators, RNs, MSWs), Behavioral Health, Nutrition Services, Patient Navigators -- Outreach / Enrollment, Street Outreach, Supportive Housing / Supportive Employment
- Community organizations may be able to provide space for fitness classes, organize a speaker for a community Senior group, support groups or organize a health program following hospital discharge for Chronic Disease Management
- Mental health challenges can be supported through promoting crisis hotlines and inventory available community services, develop mental health screenings and collaborate with schools on education seminars and at risk youth after-school programming.
- The role of Business has included investing time and money into health equity, such as the Campbell Soup Initiative which worked with corner store owners to introduce healthy foods, built vegetable/garden centres for children, offered 60-min of structured physical activity a day, and worked with educators to bring nutrition classes to families in the area.
- The Southwestern Vermont Medical Center partnered with local governments on projects like building biking and walking paths between two affordable housing complexes to promote safe, active transportation and developed a small green space into a community park with community gardening plots.
- Examples of linking dental care services with primary care include Community Health Center of Snohomish County (CHC) who offers a sliding fee discount for dental care at their clinic, the scale is based on household income and family size for those without insurance
- For meeting the needs of indigenous populations, some communities have used "client navigators" to coordinate care in a culturally sensitive manner. They also work with primary care providers by offering workshop and training opportunities in traditional healing models to better ensure indigenous traditional healing knowledge exchange and contribute to indigenous human resource development. Diabetes has been addressed through examples like the Northern Store program, an initiative to increase low-fat and sugar free options in grocery stores, the Home Visit program to aid in health promotion and diabetes education to interested families, as well as a school-based diabetes

curriculum developed by a PhD student, local Oji-Cree teacher and elders from the community.