NETWORK OF ONTARIO'S COMMUNITY HEALTH CENTRES

AND ABORIGINAL HEALTH ACCESS CENTRES

MODEL OF HEALTH AND WELLBEING CHARTER

May 2013

"Let us not forget the ultimate goal of Medicare must be to keep people well"

Canadian Medicare founder Tommy Douglas

Pre-amble

WHEREAS Ontario's Community Health Centres (CHCs) and Aboriginal Health Access Centres (AHACs) constitute a dynamic movement of empowered and empowering people dedicated to building healthy individuals, families, communities, partnerships, environments and civic institutions;

WHEREAS CHCs and AHACs share a common language and a common history of more than 40 years of holistic, comprehensive, interprofessional community-based care;

WHEREAS the province's CHCs and AHACs play a unique and significant role working towards what Tommy Douglas described as the ultimate goal of Medicare, "to keep people well"; and

WHEREAS CHCs and AHACs promote political, economic and social change that advances social justice and increases health equity;

Therefore; we as the undersigned, agree to and commit to uphold the values and principles described in the CHC and AHAC Model of Health and Wellbeing, and will demonstrate the prescribed attributes through our actions and through activities carried out by our respective organizations.

Core:

Although each Community Health Centres (CHCs) and Aboriginal Health Access Centres (AHACs) across the province is different because each of us responds to the specific needs of the communities we serve, we all follow the same model to promote health and wellbeing.

This model is based on two core principles adapted from the World Health Organization (WHO):

- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.

- Health is a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity.

The vision we share

We are also united in a shared vision for the future: the best possible health and wellbeing for everyone. Our ultimate goal is for all people living in Ontario to live the healthiest, safest, and most prosperous lives as possible. CHCs' and AHACs' commitment is to work with each other, and with our partners in communities across this province, to make one of the healthiest places on earth.

To do this we must do away with social inequality and disadvantage for the purpose of reducing disparities in health outcomes. We are proactive and persistent at addressing the fact that many health problems are not just medical or biological; they are caused by social conditions that affect access to resources and power. In our society, access to resources and power is often constrained by poverty, racism, sexism, homophobia, transphobia, ageism, ableism and other forms of social exclusion, which are often interconnected. We particularly recognize the impact that racism has had – and continues to have –on creating poverty, social exclusion and health inequity for racialized individuals and communities.

We acknowledge and affirm inclusion. We affirm that Ontario's Aboriginal and Francophone communities have distinct and specific histories, needs and constitutionally protected rights. We recognize the distinct health needs of populations living in rural, remote or isolated settings, as well as in impoverished urban neighbourhoods and racialized populations. We also recognize the distinct health needs and rights of people who are uninsured or without documented status.

Because we share a common vision and core principles we have created this Charter of Health and Wellbeing which:

Sets forth further cross-cutting principles and practices that form the core of who Aboriginal Health Access Centres and Community Health Centres are and what we do;

Recalls and reminds us that community is central to everything we do and d*eclares* our work is part of a larger struggle for equity and social justice, to create a future where everyone has an equal right to access health and wellbeing services and where all aspects of human dignity are respected and nurtured.

Describes what makes us distinct as organizations and communities and *provides* an opportunity to affirm our commitment to the values, principles and practices embedded in the Model of Health and Wellbeing.

The Values and Principles that unite us:

Highest Quality People and Community Centred Health and Wellbeing

- Everyone participates, individually and collectively, in decisions about their health and wellbeing.
- Individuals and communities receive health care that meets their needs, in a timely fashion and from the most appropriate providers, and experience the best possible results.
- Health care and other service providers work in respectful, collaborative relationships with individuals, families, and communities and each other.
- The quality of care is optimized through continuous innovation and learning to improve the experience and outcomes of those accessing care, and the efficient use of resources.

Health Equity and Social Justice

- Reduction in social inequality improves Health outcomes.
- Social inequality is reduced when all people and institutions become aware of, and act on the understanding, that inequality impacts health outcomes for the already marginalized populations.
- Equity and dignity and integrity of the person is manifest in access to nutritious food, safe and secure housing, clean water, adequate and appropriate clothing, dignified and justly-remunerated employment.
- Health care appropriate to all ages and stages of life, and mechanisms of fulsome engagement and participation in civic, social and political processes.

Community Vitality and Belonging

- Safe and caring communities improve health outcomes.
- Shared values and shared vision strengthen belonging.
- All members of the community have opportunities to participate in decision making about their communities.
- Public, private sectors and community organizations work together to strengthen inclusive, caring and connected communities.

Attributes of the Model of Health and Wellbeing are:

Anti-oppressive and Culturally Safe: AHACs and CHCs provide services in anti-racist, anti-oppressive environments that are safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with truth, respect, honesty, humility, wisdom, love and bravery. In practice we emphasize the presence of people from various cultural and linguistic backgrounds, resulting in their ability to control or influence the processes operating in their health services, and we believe this is one of the major ways to create a safe environment[i].

Accessible: CHCs and AHACs are designed to improve access, participation, equity, inclusiveness, and social justice by eliminating systemic barriers to full participation. CHCs and AHACs have experience in ensuring access for people who encounter a diverse range of racial, cultural, linguistic, physical, social, economic, legal, and geographic barriers which contribute to the risk of developing health problems. Removing barriers to accessibility includes the provision of culturally appropriate programs and services, programs for the non-insured, optimal location and design of facilities in compliance with the accessibility legislation, oppression-free environments, extended hours, and on-call services.

Interprofessional, integrated and coordinated: CHCs and AHACs build interprofessional teams working in collaborative practice. In these teams, salaried professionals work together to their fullest possible scope to address people's health and wellbeing needs. CHCs and AHACs develop strong partnerships and integrations with health system and community services organizations. The partnerships and integrations ensure the delivery of seamless and timely people and community-centred health, and key social determinants of health services and programs, with appropriate referrals. Referrals encompass primary care, illness prevention, and health promotion, in one to one service, personal development groups, and community level interventions.

Community-governed: CHCs and AHACs are not-for-profit organizations, governed by community boards made up of members of the local community. Community boards and committees provide a mechanism for CHCs and AHACs to represent and be responsive to the

needs of their local communities, and for communities to develop democratic ownership over "their" Centres. Community governance builds the health of the local communities through engaged participation contributing to social capital and community leadership.

Based on the Social Determinants of Health: The health of individuals and communities is impacted by the social determinants of health including income, education, employment, working conditions, early childhood development, food insecurity, housing, social exclusion, social safety network, health services, Aboriginal status, gender, race and racism, culture and disability. CHCs and AHACs strive for improvements in social supports and conditions that affect the long-term health of people and communities, through participation in multi and cross-sector partnerships and advocacy for the development of healthy public policy, within a population health framework.

Grounded in a Community Development Approach: The CHC and AHAC services and programs are driven by community initiatives and community needs. The community development approach builds on community leadership, knowledge, and the lived experiences of community members and partners to contribute to the health of their communities. CHCs and AHACs increase the capacity of local communities to address their community-wide needs and improve their community and individual health and wellbeing outcomes.

Population and Needs-Based: CHCs and AHACs are continuously adapting and refining their ability to reach and to serve people and communities. CHCs and AHACs plan services and programs based on population health needs and develop best practices for serving those needs.

Accountable and Efficient: CHCs and AHACs are high performing efficient Primary Health Care (PHC) organizations that are accountable to their funders and the local communities served. CHCs and AHACs strive to provide fair, equitable compensation and benefits for their staff. Capturing and measuring their work are essential parts of delivering Primary Health Care. Developing and implementing meaningful indicators based on our Model of Health and Wellbeing allows for reporting to all funders about services and programs delivered as well as the outcomes that follow.

By my signature below, Sandy Hill CHC ***(Centre Name) affirms and endorse the principles and practices of the Model of Health and Wellbeing contained in this charter, approved by the AHAC and CHC ED Network on May 15th, 2013 and the AOHC membership on June 4th, 2013 and I will work with my organization to affirm and endorse this Charter.***

Board Chair

Bob Walsh

Date 16. 04. 2014

Sandy Hill CHC

Community Health Centre or Aboriginal Health Access Centre

[i] Cultural Safety is a concept developed in New Zealand by nurses working with Māori that moves beyond the traditional concept of cultural sensitivity to analyzing power imbalances, institutional discrimination and relationships with colonizers. It develops the idea that to provide quality care for people from different ethnicities than the mainstream, health care providers must embraces the skill of self-reflection as a means to advancing a therapeutic encounter and provide care congruent with the knowledge that cultural values and norms of the people are different from his/her own. A central principle of "Cultural Safety" is that peoples decide what is culturally safe or unsafe, shifting the power from professionals to people The concept is spreading to other fields of human services and to other areas of the world, particularly in areas with strong minorities of indigenous people in former European colonies. Definition adapted from the work of Irihapeti Ramsden (Text provided by the Aboriginal Health Access Centre EDs Circle, April 2013).