BUILDING A STRONGER FOUNDATION:
A FRAMEWORK FOR PLANNING AND EVALUATING COMMUNITY-BASED HEALTH SERVICES IN CANADA

Companion Document:

A SUMMARY REPORT OF SITE VISITS TO SELECTED COMMUNITY-BASED HEALTH ORGANIZATIONS IN CANADA

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1 INTRODUCTION

Site visits to selected organizations were undertaken as part of a larger initiative involving the development of a planning and evaluation framework for community-based health services (CBHSs) in Canada. The framework project, commissioned by the Federal/Provincial/Territorial Advisory Committee on Health Human Resources and approved by the Deputy Ministers of Health, is intended to support community-based health care reform activities in Canadian jurisdictions at different stages of reform and with different health priorities. The main focus of the initiative is on health human resources management.

The site visits were undertaken to supplement the findings of two systematic literature reviews on health human resource management in and organizational models for community-based health services. At the outset of the project, it was expected that the existing literature on these two issues would contain significant gaps and limitations. It was, therefore, considered important to complement the available empirical evidence by incorporating the information and recommendations provided by those individuals across Canada who possess first-hand experience in the provision of community-based health services.

The main purpose of the site visits was to solicit information about what human resource management strategies and organizational characteristics are effective in achieving the intended outcomes of community-based health services. The outcomes of interest were: quality of care, economic efficiency, equity, consumer and community empowerment and quality of worklife.

2 METHODOLOGY

Interviews were conducted with individuals from 22 community-based health services sites in six Canadian provinces and one territory (see Appendix A for a list of sites visited). The sites were selected based upon consideration of the following criteria:

- ❒ achievement in one or more of the outcomes of interest:
- ❒ service delivery across a spectrum of services (i.e., health promotion, disease prevention, curative services, rehabilitation);
- ❒ multi-disciplinary service provision;
- ❒ provision of services targeted to groups including the frail elderly, disadvantaged, maternal/child health, and mental health;
- ❒ demonstrated innovation in health human resource management and/or service organization; geographical representation across Canada;
- ❒ mix of urban and rural sites; and
- ❒ representation by “re-structured” organizations (e.g. regional/district authorities, hospital conversions).

The following types of organizations were represented in the selected sites: community health centres (including an association of health centres), home care, public health, small hospital conversions, regional/district health authorities, and provincial/territorial governments. Eleven of the sites served an urban population only, three were rural, and the remaining eight represented mixed urban and rural populations.

The site visits were conducted in May and June, 1995. A minimum of two study team members participated in each interview which ranged in length from approximately 2 to 8 hours. In order to achieve a degree of continuity, one investigator attended all visits. Approximately 80 individuals participated in the site visits. Questions posed involved the availability and content of evaluative information and the identification of human resources and organizational characteristics which were thought to contribute to the success of the site (see Appendix B). The emphasis on particular questions varied according to the characteristics of the site.

3 RESULTS

3.1 Evaluation Activity at Sites

Interviewees were asked about the availability of formal evaluations undertaken to identify the impact of alternative human resource and organizational modalities in achieving desired outcomes of CBHSs. There was a notable range of evaluation activity from none to systematically conducted formal evaluations incorporated within a strategic management framework. One organization demonstrating systematic evaluation activity noted that the process had been built over a number of years. In Ontario, there is a concerted initiative to strengthen the evaluation activity with local community health centres across the province.

The most common form of evaluation encountered was survey of client satisfaction. A number of sites indicated they relied heavily on informal evaluation, commenting that their best feedback is received from the clients though the staff.

Problems associated with undertaking formal evaluations regarding service outcomes, beyond client satisfication, were reported as follows:

- systems are not readily available for tracking evaluative data;
- evaluating outcomes is problematic due to their long-term and preventive natures; and
- there is a lack of resources for undertaking good evaluations.

Information provided in this document, therefore, primarily represents the subjective perceptions of the interviewees.

3.2 Key Factors for Overall Success of CBHSs

The factors reported to be important to the overall success of the CBHSs organization were:

- clear **vision** (evident in Board, senior management and key staff);
- **positive management culture and practices**, including:
  - proactive planning and service provision,
  - flexibility,
  - appropriate hiring (selecting the right staff), and
  - a flat organizational chart;
- strong **partnerships** which have fostered public trust; these partnerships are with
  - the community,
  - internal customers, and
  - stakeholders (e.g., related service providers);
- provision of **high profile and desired services** (e.g., home care) and which:
  - use "soft touch-low tech" approaches that value the family and community and which can be readily understood by the community, and
  - are based on a good understanding of long-term measurements and healthy public policy;
- the **range of service providers** employed; and
- **targeted energies** (i.e., "pick issues to fight for").

3.3 Key Success Factors for Specific Outcomes

The factors which were reported to contribute to the achievement of desired outcomes for community-based health services (i.e., quality, economic efficiency, equity and consumer/community empowerment) are presented below.

Quality of Care

The following factors were presented as those which were thought to contribute to high quality services:

- mechanisms which encourage **comprehensive and client-centred care** (e.g., program management model, comprehensive assessment forms, procedures for comprehensive follow-up, service provision from "before life to after death", common client records, policies discouraging double-doctoring);

- ❒ **team approach** (including the assignment of a case manager/coordinator to ensure service integration and the appropriate use of informal caregivers);
- ❒ **proactivity** (i.e., actively looking for community needs);
- ❒ **more time** devoted to individual clients;
- ❒ a **holistic perspective** which looks beyond the immediate need of the individual and considers the broader family and community context, then attempts to link the needs with appropriate providers in the community;
- ❒ willingness to provide **services off-premises**, e.g., for administering flu clinics, for following hard to reach individuals, and providing home-based services (one site reported that up to 70-75% of service time was off-site);
- ❒ **salary parity** with institutional sector personnel (i.e., enabling CBHSs organization to compete for the best people); and
- ❒ a sense of **accountability to the community** on the part of the staff.

A confrontational labour relations climate was identified in one province as being a major problem in responding as well as one might wish to identified client needs.

Economic Efficiency

Again, little formal evaluative documentation was presented with respect to economic efficiency. Examples of how interviewees perceived they were making most efficient use of available resources included:

- ❒ use of **nurse-practitioners and midwives**, and
- ❒ making **maximum use of other community space**.

One site suggested that having very limited or no budget for capital equipment forces staff to evaluate what is truly essential and then to find creative ways to access funding for these items. In this same site, the community appears to be actively involved in generating such funding for equipment. On certain occasions the government is approached for matching dollars.

Equity

Some of the ways in which CBHSs expressed their attempts to ensure equitable access to services included:

- ❒ a **sensitivity to cultural and language barriers** (e.g., tailoring the level of information provided, hiring staff who represent/reflect the minority populations),
- ❒ **assessment of community needs**,
- ❒ **no user fees**,

- ❒ **"walk-in" and same-day service policies** (it is noted that many hard-to-reach and lower sociio-economic group clients do not plan ahead), and

- ❒ a **case managed approach** in which access to and through services is facilitated.

One of the main problems associated with ensuring equity, as voiced by a number of respondents, was the lack of understanding regarding what services are available and how they can be accessed on the part of those who need them the most. This was thought to require investment in developing public awareness. Other barriers to access identified were poor professional attitude, system barriers such as hierarchical structures which result in immobilization, and professional resistance to working off-hours.

Community/Consumer Empowerment

When asked what makes services *community-based*, responses generally fell into the following themes:

- ❒ **partnership with and responsivity to the community** which includes having an attitude of working *with* rather than *for* clients/communities and keeping a pulse on the community's needs and wants, with the flexibility to respond in a timely and appropriate manner;

- ❒ **community involvement** in the development of the community health centre, and in the ongoing planning, implementation and evaluation of services (described as a bottom up rather than top down approach;

- ❒ **governance structures** which involve strong community representation such as through an elected Board; and

- ❒ transferring **control/power to the community or client** rather than keeping it within the health system/institution.

It was suggested by some that the types of decisions in which individuals desire to be involved are directly related to the extent to which the decision directly affects them. Thus, as a client receiving a particular service, the individual's desire for input into decision-making is front and centre. When decisions involve the delivery of health services through a neighbourhood or community with which the individual perceives a strong identity, the desire of individuals to become involved will be greater than when the decisions are removed to less tangible regional or central levels.

3.4 Health Human Resources Management

In this section, issues and recommendations regarding successful health human resources management are presented.

Health Human Resources (HHR) Continuum

HHR continuum refers to the range of health service providers that could be relied upon to improve the health outcomes of individuals and communities. These include self-care, informal (i.e., non-paid) and formal service providers.

As the selection criteria for participation in the site visits included a multi-disciplinary approach, it is not surprising that the majority of sites visited incorporated a wide range of personnel, including considerable use of informal service providers. Most programs used volunteers extensively, with one clinic reporting a volunteer-to-professional ratio of approximately 4:1. In this urban centre, the age breakdown of volunteers was reported as follows: 40-50% were of University age, 30% mid-range adulthood, and 10% senior citizens. The volunteers were also reported to be representative of the cultural mix of the community served. Some organizations indicated that they were not using volunteers as much as they would like because of union opposition.

Of those sites with a broad mandate, the home care program stood out as utilizing the greatest number of volunteers. It was noted that the greatest proportion of services are provided by spouses, children and other family members; neighbours rarely become involved directly in care, but will provide emotional/social support. It is estimated that approximately 80% of home care is provided by family members.

Several interviewees commented on the use of self-help groups. It was suggested that greater development of this concept could be potentially beneficial, if respect for client choice is retained. Several commented on the potential for abuse and on the possibility of self-care being seen as offloading the health system's responsibility. One administrator suggested a need to monitor self-help group activity, when undertaken on the CBHS organization's premises. If the group (or an individual within the group) advocates for a treatment which is of questionable value, it may be perceived that the health centre is endorsing the treatment.

Issues raised regarding the use of informal caregivers included:

- a concern with passing the burden of care to the informal caregivers (i.e., imposed volunteerism for women who have traditionally assumed the caregiver role);
- the "professionalization" of volunteers - with a strong commitment to their work comes a greater desire for formal qualifications;
- in several rural sites, confidentiality concerns regarding the use of informal caregivers was noted to be a concern (e.g., some clients express reluctance in accessing services from other community members who are well known to them).

Suggestions regarding the use of informal caregivers included:

- the need for a sound **training program** (e.g., one home care program reported that volunteers receive six weeks of training);
- the need to treat informal caregivers the same as paid staff and to provide **recognition/appreciation** in order to reinforce their value;
- a preference for **hiring and developing informal caregivers internally** (as contrasted with accessing volunteers from another community agency) as this enables greater adaptability and affiliation with the organization; and
- the need for **ongoing communication**, feedback and the incorporation of the informal providers in identifying and achieving goals common amongst all service providers.

Roles of Health Service Providers

This section deals with role substitution, expansion and diversification of formal (i.e., paid) health service providers.

The majority of interviewees reported the use of nurses in expanded roles, including greater involvement in the client assessment function, client education, and care coordination. In northern communities with limited access to physicians nurse practitioners were routinely used as the primary providers of diagnostic, treatment, education, counselling and midwifery services. Some interviewees from northern and southern sites questioned why some of the services routinely provided by nurse practitioners in remote areas could not be conducted by the same types of personnel in other parts of Canada.

In most sites providing primary clinical services (with physician and nurse practitioner teams), the role of nurse practitioners was seen as complementary to the role of the physician (rather than substituting or embellishing the medical role). In hospital conversion sites, however, the nurses were observed to function fundamentally in their traditional role.

The successful incorporation of physician-nurse practitioner teams was reported by a number of site managers to be dependent on the development of clear role descriptions. Some indicated this is also done for the legal protection of the professionals involved.

The extent to which organizations incorporated multi-skilled workers (i.e., those providing services in more than one area of competency) varied considerably across sites. In northern underserviced areas, nurses and other service providers were observed to take on laboratory, diagnostic imaging and pharmacy support functions. In these cases, an attempt is made to tie the practice of multi-skilling to training and ongoing upgrading. In one rural area, the use of multi-skilled rehabilitation assistants (physical, occupational and speech-language therapy) providing services within a community was seen to be a more cost-effective way to deliver services than having each of a number of individuals travel to numerous communities. As well, it was perceived that this approach is more consumer-oriented as clients have to contend with fewer providers and service visits.

The use of indigenous workers was noted in rural and northern sites and in urban sites serving large multi-cultural population groups. A definite preference for identifying and developing local community members was noted. It was suggested that these community health representives could

do much of the social work in support of the professionals as they are generally more accepted in the community than are professionals "outsiders".

In one community health centre, the administrator clearly distinguished between the core professional/technical functions which each service provider possesses and those functions which are common to the centre. It is part of the corporate culture that "if something needs doing, do it". Thus, although clearly specified job descriptions exist, professionals are expected to be willing to take on non-technical functions (e.g., a program coordinator helping staff with the feeding of day-care clients, the CEO answering the telephone if the receptionist is busy). It is not deemed appropriate for a professional to state "I won't do that because it is not a nursing (or physicial therapy, etc.) function".

Several interviewees raised the issue of the importance of the "generalist" as opposed to "specialist" role in providing CBHSs. One indicated that his community health centre is not large enough to enable a high degree of specialization. Several interviewees discussed the need to be able to see individuals in their entirety or holistically in order to effectively address their health issues. As well, it was perceived that individual clients and the community as a whole were better able to relate to generalists who could see the "bigger picture" of client and community needs.

Issues raised with respect to role expansion and substitution included:

- ❒ turf issues and professional attitudes (one administrator indicated it took five years to gain support from his nursing staff to accept the concept of a generalist role);
- ❒ professional barriers are evident in expectations and attitudes about lines of authority (e.g., "I am a nurse and I do not want to report to a social worker"); and
- ❒ legal restrictions regarding scopes of professional practice; these were perceived to limit the ability to hire and/or incorporate staff in expanded roles in some provinces.

Implementation suggestions offered by those interviewed included:

- ❒ the need for **clear role definitions**, most often mentioned with respect to delineating the scope of practice between physicians and nurse practitioners;
- ❒ several indicated the need for **caution in how multi-skilled workers are utilized** (e.g., "taking this concept to the extreme may result in dangerous people") and the need to ensure **training** "keeps up" with the trend towards multi-skilling;
- ❒ when considering multi-skilling, look at **natural groupings** of professionals (e.g., rehabilitation assistants, using multi-skilled workers within rather than across programs);
- ❒ using physicians to **orient/mentor new staff** regarding how the nurse practitioners' role is coordinated with the physician role in a collaborative partnership; and
- ❒ **change the organizational structure** to facilitate a multi-disciplinary and non-specialized service delivery approach and then stick to this organizational change in spite of professional resistance (one administrator stated that "talking did not help"; organizational change was required).

Skills Acquisition

To compensate for insufficient formal training in CBHSs delivery models, a number of sites have developed intensive on-site orientation programs (including an orientation to the organization and to the philosophy, mission and unique approaches inherent in CBHSs delivery). One administrator reported that all staff receive an intensive 80 hour orientation. In northern and rural areas where recruitment of suitably trained professionals is difficult, modular format training programs have been designed for the development and upgrading of specific skills (this is most evident for the training of community health workers/representatives).

A number of interviewees indicated the need to ensure all workers possess strong qualifications. Some have developed policies regarding minimum training qualifications (e.g., Baccalaureate level nurses, physicians with specialist training in family medicine, Masters level preparation for social workers), arguing that the complexity of problems dealt with by service providers necessitate a high level of skill. On the other hand, it was suggested that higher education can work against the concept of being close to and able to relate to the public. One interviewee expressed concern with fostering higher and higher qualification requirements, indicating that community health centres are being priced out of the market with this policy. As well, having highly qualified staff was perceived to leave less workers to undertake the actual work of the centre.

Despite differing perspectives regarding qualification requirements, the majority of interviewees emphasized that formally developed technical skills were often less important than the personal characteristics of service providers. Thus, considerable attention is given to identifying the "right" individual during the hiring process. One interviewee indicated that he actively pursues and solicits the persons with these desirable traits. On occasion, such a desired person who does not possess formal qualifications will be hired, then encouraged and supported in his/her formal upgrading.

The desirable personal qualities of CBHSs workers reported by interviewees included a holistic or broad perspective, an understanding of the workings of a community, flexibility, self-reliance, common sense and intuition, proactivity, strong interpersonal skills, problem-solving capabilities, and respect for others. A philosophy which places control with the client and which views them not as sick but as healthy individuals requiring support is also advocated. One site has implemented a time-limited run to observe whether an employment candidate demonstrates a match in philosophy and approach to service delivery.

Several interviewees commented on their experiences in transferring professionals from the acute care institutional sector to the community sector. Opinions varied regarding the success of this approach. Several indicated that this transition is huge making it very difficult to incorporate highly trained professionals to work in the community. Considerable orientation and education is needed to make this transition work. The opposing perspective suggested that some institutional sector workers possessing the right philosophical perspectives can work out better than long-term community-based health services workers who do not possess the necessary personal characteristics.

In general, interviewees perceived that academic programs were not sufficiently accommodating the shift from institutional to community-based health service delivery. Some perceive that academic institutions represent a barrier to this end, noting that they are extremely slow to change their orientation. When hiring physicians and nurses, some administrators reported favouring graduates from certain university programs with compatible philosophical approaches.

Several interviewees suggested that, given the continued "stove-pipe" organization of their training programs, universities perpetuate discipline-specific turf protection. There is a need to "better link what students learn in university and the reality of where they are going to work". For example, physicians do not go out to work in isolation, therefore their training should emphasize their role as team players. One administrator indicated physical therapy students who are still required to do their practicums "at the bedside" in hospitals are of no use in the community setting.

Some community health centres have actively worked on developing a greater CBHSs profile in the academic environment through formal linkages with the university training programs and with teaching hospitals, and by serving as a site for the practical experiences/residencies of students.

Specific suggestions offered by interviewees included:

- the need for **greater emphasis on CBHSs philosophy and approach in the formal training programs** of all health service providers (including a greater emphasis on "health" including its social, environmental and cultural context, the development of good team players -starting with joint discipline courses in the early stages of the training program, specific training in intercultural communications and community development, and more practical placements in community settings);
- **recruit individuals with desirable personal characteristics** and an inherent orientation to community; and
- provide a **strong orientation** to and **ongoing training** in the community/holistic approach, once individuals are hired.

Professional Regulation

Interviewees did not elaborate much about their perspectives on professional regulation. In some provinces it was noted that occupational legislation was a factor in restricting the use of certain types of personnel. The issue was most often associated with the limited use of nurse practitioners and midwives due to professional turf protection. Some jurisdictions appear to be active in lobbying for changes to restrictive legislation and/or have implemented strategies which get around such legislation. For example, in one province, community health centres which incorporate the services of native healers offer an honorarium rather than a salary to these traditional providers. This services the dual purpose of by-passing professional legislated restrictions and accommodating the native healers' preferences to not be health centre employees.

In northern Canada, allowances are also made to accommodate the incorporation of alternative providers. For example, although the medical profession has exclusive scope of practice, guidelines have been developed and implemented by the Health Ministry which enable nurses to prescribe medications. As indicated by one interviewee, "the reality in the north is that the professions such as the doctors have to make allowances in their professional legislation regarding issues such as native healers and the use of nurse practitioners in doing medical functions or their Act will not fly in the legislature" (which includes considerable representation by aboriginals and people from remote regions).

Provider Remuneration

Most sites visited incorporated salaried or contracted physicians. This was perceived to be important to achieving quality services and to using a holistic and multi-disciplinary approach. Professional contract arrangements were used in one centre as this is perceived to be more acceptable to physicians as they retain autonomy with respect to benefits. In one home care program, physicians were remunerated for consultation services through special fees established under the provincial medical insurance plan.

The issue of salary levels for professional staff was raised in a number of sites. One community health centre reported nurse practitioner salaries at $20,000 less than nurses with similar qualifications elsewhere. Similarly, physicians were reported to be offered salaries at $25,000 less than emergency physicians. It was noted that, in spite of the salary disparities, staff often prefer to work in the community setting due to the philosophical fit and a higher quality of worklife. One administrator indicated that her community health centre was able to achieve parity with the institutional sector through the organization's formal linkage with the institution (in this case, the health centre reports to a hospital board).

The suggestions offered regarding provider remuneration were:

- ❒ to the extent it is possible, **treat staff equally** with respect to manner of remuneration; this is perceived to contribute to the concept of a team rather than hierarchical approach amongst the various disciplines;
- ❒ the ability to **pay physicians at a level slightly higher than they would otherwise make in private practice** contributes to successful recruitment of physicians into the community setting; and
- ❒ establish **salary parity** with the institutional sector in order to ensure that centre can compete for the best health professionals.

Workforce Management

The types of HHR management approaches which were noted to be associated with increased quality of worklife for employees included:

- ❒ corporate support for and development of **multi-disciplinary teams**;
- ❒ communication of a clear **vision** to staff;
- ❒ no barriers to **internal communication** (e.g., use of e-mail, weekly multi-disciplinary team meetings);
- ❒ strong **leadership which understands the paradigm** shift to community-based health service delivery;
- ❒ a corporate **culture of trust and respect** (amongst Board, management, staff and community members);

- ❒ **staff empowerment and autonomy in decision-making** within the parameters of a collaborative team approach to care; and
- ❒ an organizational structure and management approach which enables **flexibility and creativity**.

3.5 Organizational Issues

Service Catchment

Service catchment involves the definition of the population or jurisdiction being served, including the mechanisms for ensuring service accessibility.

Interviewees suggested that *community* may be defined either in terms of geography or by issues of "common unity". All sites visited were definable by geographical catchment areas. However, they differed in the extent to which, within this geographical area, they had a broad mandate (e.g., Quebec CLSCs) versus narrow mandate for particular sub-groups of the population at large (e.g., women, disadvantaged).

It was suggested that geographical territories are best defined as naturally as possible, such as by natural boundaries (rivers, main streets, etc.) which determine the natural flow of individuals for service, and/or by the community's own sense of belonging to and association with an area. Having the community-based health services organizational boundaries be coterminous with municipal boundaries was seen to facilitate linkages with politicians and municipal planners.

Suggested optimal population size ranged between 20,000 -150,000 and reflected the managers' particular experiences with CBHSs. Those who envisioned a comprehensive mandate for CBHSs or who represented a regional/district authority tended to suggest larger population bases than those who envisioned a more narrowly defined mandate (e.g., a single neighbourhood clinic). It is noteworthy that some sites visited demonstrated population bases (or registered CBHSs membership) of less than 10,000 community members.

Most interviewees supported the delivery of a broad range of services through small jurisdictions in order to maintain a meaningful sense of "community". A need to balance critical mass with a natural "fit" or feel of community was identified as was a strong resistance to the "institutionalization" of CBHSs through large bureaucratic structures.

The potential of using a multi-level approach was presented as being critical given the reality of "communities existing within communities" (i.e., a community may be a city or the distinct neighbourhoods contained therein). Several interviewees presented a possible model to accommodate the various layers of responsibility. In this model, the provincial/territorial governments are responsible for setting goals and standards, defining core services, and funding regional authorities. The regional authorities are responsible for identifying needs and service priorities, funding smaller service organizations or centres, and for coordinating and evaluating the delivery system. The smaller centres are responsible for the creative and flexible provision of services under the parameters established at the other two levels. These smaller centres may also have satellite sites to bring services as close as possible to distinct neighbourhoods.

A number of interviewees identified suggestions for ensuring **service accessibility** including:

- ❒ increasing the **number of physical access points** (one site reported 20+ service delivery sites within the catchment area);
- ❒ attempting to **offer all community health services from one location** (e.g., home care, public health, mental health, primary care clinic services);
- ❒ **addressing physical issues** (e.g., handicapped access, braille elevator buttons, distance and ensuring free parking close to the clinic);
- ❒ delivering **services off-site** (although it was noted that this is not always desirable as per elderly or rural individuals who are socially isolated - it is healthy for them to travel into a centre for services);
- ❒ ensuring **24 hour service access** (i.e., use of on-call systems);
- ❒ having only **one phone number** for the organization;
- ❒ providing **flexible service hours**/user-friendly scheduling (however, a tradeoff between client convenience and staff turnover was noted);
- ❒ **same-day or walk-in service policy** (this is considered especially important for the hard-to-reach and lower socio-economic groups who do not plan ahead);
- ❒ ensuring that there is **no single gatekeeper** to the various disciplines; having **multiple points of entry** into the system; and
- ❒ using a **case managed approach** whereby one person is assigned to guide the client through the system.

Service Delivery Approaches

The types of service delivery approaches reported to be associated with increased quality of care and economic efficiency included: a corporate philosophy oriented to community needs and the underlying determinants of health, a socio-ecological versus medical model of care, multi-disciplinary and integrated service delivery approaches, targeted services to address high needs, client-centred care, and a broad range of services.

Several site administrators described the underlying philosophy driving their model of care. By and large, this philosophy acknowledges the need for a medical care model for addressing routine episodes of illness. However, this is balanced with the need to identify and address the broader determinants of health. This latter model of service delivery, identified as a **socio-ecological model**, recognizes the critical links between individuals and their social and physical environments. It focuses on "health" rather than illness and, thus, involves expansion into non-direct care areas. It is undertaken in close collaboration with other community partners who possess complementary mandates. Under this model, CBHSs staff are advocates, initiators and facilitators in identifying health issues and ensuring they are addressed by the community.

Adopting a community-based philosophy was also associated with the need for clear identification of priorities and **targeting of services** to those population sub-groups with the greatest health needs. Obtaining an optimal balance between providing services to the mainstream population and to targeted groups is reported to be an ongoing dilemma. As well, the need to weigh the demands of special interest groups against the good of the whole population is reported to be a continuing challenge for CBHS organizations.

Site visit interviewees advocated strongly for alliances with **natural community partners**, where common issues and functions are evident. One site reported ongoing association with 60 external groups. Suggestions for developing and maintaining **collaborative working arrangements with external players** included:

- ❒ do not create new structures - wherever feasible, build upon existing community resources;
- ❒ integrate/coordinate whenever natural issues and functions overlap between organizations and work in complementary fashion with each other;
- ❒ build partnerships in the good times in order to sustain and support each other through difficult periods -do not wait for a crisis to occur before building linkages as such an environment is not optimal for developing relationships;
- ❒ attempt to integrate socially as well as professionally;
- ❒ working in close proximity helps;
- ❒ meet with others around common issues of concern (rather than for the sake of meeting); and
- ❒ recognize that it takes time to establish credibility and that external collaboration is a two way street - CBHS providers must be as willing to give as to ask for cooperation.

Offering a **wide range of services** and delivering these services **as close as possible to where people live** and undertake their daily affairs were seen as important components of the community-based service delivery approach. The fragmentation of community-health centre, public health, mental health, home care and social services was evident and acknowledged by interviewees in most provinces. A strong desire for greater **integration amongst these CBHSs** was expressed. In instances where greater physical proximity of staff (provision of these services out of the same location) resulted from health system restructuring, greater access to CBHS professionals from other organizations was seen to be very positive.

Interviewees from Quebec suggested that the integration of health and social services represented one of Quebec's best health policy decisions. It was suggested that approximately one third of people who come into the health centres for medical services have poorly defined or undetermined physical problems. The cost savings to the health system by having social problems addressed by social workers rather than physicians is thought to be considerable. One administrator from a northern site estimated that a 90 percent overlap in service functions existed between health and social services workers operating under different mandates in some communities.

Whereas integration of health and social services, public health, mental health, home care and primary medical care within the community-based system was thought to be important, integration of CBHSs with the institutional sector of the health system was generally seen as detrimental. The greatest concern expressed about the latter was the potential for being absorbed by and forced into an

"institutional" paradigm, thereby losing the health promotion, holistic and flexible approaches necessary for addressing health issues at their social and environmental roots. Nevertheless, close liaison and efficient referral processes between the community and institutional sectors were advocated.

At a practical level, site interviewees indicated that integration of services within an organization is not easily achieved. Although desirable, several administrators acknowledged that their existing multi-disciplinary services are not necessarily integrated. It takes time to develop common values and to build and understand the same language. Internal integration is reported to be facilitated by **strong leadership committed to an interdisciplinary team approach, regular contact and proximity of worksite**, **program rather than functional organizational structures, common client records, joint problem-solving** and the **participation of all providers** in staff meetings.

Client-centered service delivery was defined in a number of ways: having **services driven by client needs** rather than other considerations (such as reduced length of stay), ensuring that patient choice/control is built into the service delivery process, and continuing to **follow individuals** served (in contrast to the single encounter approach generally used in hospitals). As well, **case management** which includes the development of common client objectives was perceived to enable client-centred and high quality care, especially for high-needs individuals and families. A case manager could be a nurse or any other health professional who has the greatest contact with the client.

With respect to the provision of services to immigrant clients, one urban administrator questioned the extent to which it is appropriate and feasible to provide services in the language of choice. Society has a certain obligation to make services accessible but individuals also have a responsibility to adapt to the culture of their chosen country. The policy adopted in this administrator's health centre is to attempt to achieve a balance between these two considerations. Staff will go out of their way for first generation Canadians but expect the second generation to have adapted to the Canadian culture. Approximately one third of this site's staff are reported to possess (collectively) the wide range of abilities need to respond to the needs of immigrants.

Governance

This modality refers to the structure and mechanisms through which communities or individuals participate in decisions about the organization and delivery of health services.

Differences of opinions existed with respect to whether Board members should be elected or appointed to ensure community ownership. In one province, communities were asked by the Health Minister to state their preferences for appointed versus elected membership on the regional/district health authority boards. It was found that rural areas wanted purely elected boards and that urban areas desired the exact opposite - fully appointed boards. The Health Minister in this province subsequently required a combination of elected and appointed members.

Some site interviewees closely identified an election process with the concept of being community-based or community-driven. Others were less supportive of a Board which is fully elected. They perceived that an elected Board enables the possibility of special interest groups to become influential to the detriment of the general population. As well, an elected Board process was not seen to ensure true community representation as there is likely to be a greater likelihood of participation by the more highly educated and those in the higher socio-economic status group. It is noted that in

the sites where an electoral process is in place, the actual number of individuals reported to participate in the election process often represents only a very small proportion of the community.

Several interviewees indicated that the process of Board selection was not nearly as important as the *quality* of individual, given the sophisticated nature of the types of decisions made around the boardroom table. Several administrators indicated that their community health centres had given up attempting to incorporate representation from the disadvantaged population on the Board as this population was reported to have minimal interest and/or skills in undertaking the ongoing duties of the Board. It was suggested that more appropriate methods existed for obtaining their involvement in the decisions about the services which directly affected them.

The types of **skills** which were thought to be required of Board members included leadership, business/financial abilities, health professional/practitioner perspectives and understanding of human resources management. It was suggested that there is a need to develop Board skills in order to ensure meaningful participation. The Carver model[1] was advocated by one administrator.

The suggested methods of ensuring community involvement in decision-making, beyond involvement as Board members included:

- the use of **advisory committees** to deal with specific issues (some interviewees reported that advisory committees have been much more influential in shaping the CBHSs organization and its services than has the Board);
- **informal feedback through staff** - examples included obtaining feedback directly from clients, having community health workers "keep a pulse on the community" by going to places where community members congregate (e.g., bingo halls, senior citizen lodges) in order to solicit ideas and feedback, and tracking the requests for service (e.g., a receptionist noted that a number of people were calling to ask for bereavement counselling so she alerted the staff who subsequently organized services to address this demand); and
- **networking** with other key community leaders on an informal and/or formal basis such as through regular interagency meetings (one administrator indicated she attempts to keep in touch with about 50 leaders of other community organizations).

Not much support for the use of formal surveys or public forums was expressed. Public resistance to being "surveyed to death" and the limited applicability of survey methodology for illiterate, transient individuals or those without a telephone were some of the problems mentioned. Similarly, one administrator indicated that focus groups sound much better than they actually work. Insufficient time and resources to undertake formal information gathering exercises was an additional barrier noted by several administrators.

1 Carver, J. (1990) *Boards that Make a Difference.* San Francisco: Jossey-Bass Publishers.

Problems with involving the community members in assessing their community's health needs and in providing input into service delivery decisions were raised by a number of site visit interviewees. It was emphasized that "uninformed comment on needs is not very useful". It is considered important that the community health centre be able to read the level of the community's ability to assess its own need. Every community is different in terms of issues and capacity to address these issues. It was reported by one administrator that it took about two years to develop awareness and understanding of the issue at hand before good/useful input was received from the community members sitting on a program advisory committee.

Funding

The sites visited reported that their primary source of revenue was from the provincial Ministry of Health (range reported was 70-100% of funding). Additional sources of revenue included other provincial ministries, municipality funding, local community fundraising, United Way, and private donations. The reported percentage of the provincial health budget allocated to community health centres ranged from 0.5% to 5% across three of the provinces visited. Per capita funding ranged between $44.00 and $178.00 across three sites in Alberta, Ontario and Quebec. One community health centre noted considerable community involvement in raising funds for the purchase of equipment and for facility renovations. This community involvement was perceived to reflect public ownership of and commitment to the centre.

Issues raised about organizational funding included:

- the low funding level for community-based health services;
- how to ensure that people seek services within the jurisdiction in which funding is received without restricting client choice;
- limitations imposed by the provincial governments (e.g., excessive regulations or the provision of funding for programs which are not local priorities, required emphasis on curative over health promotion services).

One administrator reported that, with hospital cutbacks, the government tendency to require increased involvement in curative rather than in health promotion and disease/injury prevention programs is exacerbated. Along with this tendency has come the requirement to evaluate services according to medical yardsticks.

Opinions varied about the desired funding model for community-based organizations. Several administrators advocated for funding based upon the **population's health needs** with some adjustment for factors unique to specific jurisdictions (e.g., for teaching facilities). It was noted that global funding allowed for greatest flexibility in addressing the community's needs. This was seen to be most workable for good financial managers. However, there was a recognition on the part of several administrators of the need to link funding with the provision of particular programs to ensure accountability for the use of public funds. User fees were not supported due to their detrimental effect on achieving equity.

It was suggested by one administrator that the type of funding used should be dependent upon the ability of the organization to demonstrate sound fiscal management; thus it may be appropriate to require line-by-line budget accountability from those not meeting their budget targets.

Additional suggestions for the funding of community-based health service organizations included:

- the need for the provincial government to specify and fund **core services** (i.e., having a stable source of funding is very important);
- the need to **protect funding for prevention and health promotion programs** (this was noted to be met with resistance by at least one regional/district authority which had assumed responsibility for funding allocations);
- implementation of an **incentive system** to encourage people to seek services in one area (e.g., surtax charged if an individual seeks greater than 20 percent of his/her care outside of the home jurisdiction); and
- attempt to **reward organizations on the basis of demonstrated outcomes**.

Organizational Structure

The most common organizational structure used within the sites visited was a **program structure**. In some instances, a modified matrix structure was employed in which direct accountability and line authority followed a program structure but discipline-specific coordinators were employed to look after issues specific to the disciplines. A **flat organizational structure** with little hierarchy and which is not dominated by any one discipline was considered important for achieving service integration, ensuring no impediments to staff decision-making, and for using a socio-ecological rather than medical model of service delivery. One administrator indicated he is comfortable with having a large span of control (e.g., up to 50 staff for one manager).

Regional/District Health Authorities

Of the seven provinces/territories visited, four had introduced some level of devolution in recent years. The extent to which this policy has impacted the delivery of community-based health services positively or negatively varied across these provinces and across interviewees.

The positive aspects of regionalized or district models as reported by interviewees who came from the acute care sector included:

- Board members and staff learned much about the uniqueness of communities and how these communities made decisions;
- Board members became more accessible and responsive to their communities;
- when hospital closures occurred, communities were forced to look at health as more than the provision of hospital services and started to talk about broader issues such as mental health, crisis intervention, health promotion, home-based services and wellness clinics;
- through the use of community advisory committees, useful input from communities to the regional/district board was ongoing;

- ❒ Board composition which included representation by the various health sectors ensured that issues specific to particular sectors (e.g., home care) were not lost;

- ❒ the hiring of CEOs with backgrounds in community-based health service delivery (as opposed to hospital administrators) assisted in achieving the necessary paradigm shift underlying health reform;

- ❒ increased integration was beginning to result in a reduction of service fragmentation and duplication;

- ❒ as there was a wider range of professionals involved in decision-making, the region/district was perceived to be building upon the unique strengths of different people within the health system; and

- ❒ a perception that a single governance structure will, in the end, lead to an integrated system and a "health care system" (previously an oxymoron).

The negative aspects of regionalization as perceived and reported by those who came from the community sector were:

- ❒ the medicalization of health promotion and disease/injury prevention services; a perception of being forced into a medical or acute care model and not seeing a shift to prevention and health promotion as advocated in health system restructuring;

- ❒ a noted lack of vision and poor understanding of appropriate lines of communication and protocols on the part of the Board;

- ❒ a general sense of discomfort and distrust amongst the various players within the health system -community members and health professionals who had developed comfortable working relationships with each other and with the Ministry of Health had to develop new means of working together;

- ❒ a return to centralized decision-making at the top of the organization rather than shared power with staff and the community - senior administrators did not consider communities and staff to be competent;

- ❒ increased organizational hierarchy has resulted in slowed decision-making processes;

- ❒ lack of understanding of *health* and CBHSs delivery approaches on the part of the Board and senior management has resulted in increased control and reduced flexibility/responsiveness in addressing the community's needs; staff must wait for strategic direction from above;

- ❒ poor understanding of CBHSs has resulted in the application of inappropriate measurements for evaluating CBHSs (one administrator reported that approximately 10% of staff time has shifted from service delivery to justifying their existence); there is very little commitment to long-term measurement and a heavy emphasis on "means" rather than "ends";

- ❒ diminished linkages with community partners; with changes happening very quickly there is no time to meet and work together with other community players;

- ❒ reduced access to homes and schools as the previous "community health" identity has disappeared and trust between the acute care sector and key community players has not yet been developed;

- ❒ community health councils have not worked when top-down approaches were used and when a solid understanding of community health and community development was lacking;

- ❒ differing philosophies and values of the multiple cultures do not mesh, therefore staff feel they are being pulled in many directions;

- ❒ a perception that integration is not always desirable (e.g., with a large employee base there will be regional/district staff who have an addiction requiring counselling who will not want to access this service from their employer - therefore it may be advantageous to contract out some services);

- ❒ hospital facilities provide a poor "feel" for individuals seeking CBHSs (e.g., inappropriate locations such as on the edge of town or on a hill, long and sterile hallways, uniformed staff, and requiring payment to leave the place!)

- ❒ acute care professionals speaking the rhetoric of community development and health promotion, however they "know not of what they speak" and are only re-discovering what is already decades old news to CBHSs professionals; at the same time, in their zeal to reform the system, they are destroying effective community health systems and services already in place.

It was suggested by one interviewee that regionalization is undertaken in order to pass the buck rather than out of a true interest in empowering local communities. However, the public is not fooled and they will readily by-pass the regional health authority by going directly to the Health Minister for action.

4 DISCUSSION

The site visit interviews were undertaken in an attempt to identify specific indicators to be incorporated in a planning and evaluation framework for community-based health services. The bolded items throughout this document were those considered in the development of the final framework. It must be noted that certain limitations exist with respect to the use of the results of this site visit process. First, because the participants were specifically selected according to established criteria, their responses are not necessarily representative of all CBHS organizations. Second, because very little hard evaluative data exist, the information represents the subjective perceptions of those interviewed. The approaches suggested by site visit interviewees are referenced as being "experientially-based" or "proposed" rather than "empirically-based" indicators in the framework.

It is also important to note that this exercise was not an attempt to evaluate and compare particular models of CBHSs delivery. Rather, it was an attempt to develop a greater understanding of what aspects of human resource management and organizational approaches are associated with the desired outcomes of CBHSs.

Of particular interest to the investigators was the broad range in perspectives evident across provinces and across individuals interviewed. This is reflective of the diversity in service delivery models and historical evolution of CBHSs across Canadian jurisdictions. It is apparent that a "one-size-fits-all" model of CBHS delivery is not feasible nor appropriate, given this diversity. A planning and evaluation framework should incorporate considerable flexibility for individual jurisdictions to plan and evaluate services according to their unique characteristics.

APPENDIX A

LIST OF SITES VISITED

1. Boyle McAuley Health Centre, Edmonton, Alberta
2. CLSC Hochelaga-Maisonneuve, Montreal, Quebec
3. CLSC NDG/MTL-O, Montreal, Quebec
4. CLSC Saint Hubert, St. Hubert, Quebec
5. CLSC St. Louis de Parc, Montreal, Quebec
6. Health Action Centre, Winnipeg, Manitoba
7. KLINIC Health Centre, Winnipeg, Manitoba
8. Lakeshore Area Multi-Service Project, Toronto, Ontario
9. Leduc-Strathcona Home Care Program, Sherwood Park, Alberta
10. MacKenzie Region Health Service (including Rae Community Health Centre), Yellowknife, N.W.T.
11. McAdam Community Health Centre, McAdam, New Brunswick
12. Metro Toronto Department of Public Health, Toronto, Ontario
13. New Brunswick Department of Health and Community Services, Fredericton, N.B.
14. New Brunswick Extra-Mural Hospital, Fredericton, N.B.
15. Northwest Territories Health and Social Services Department, Yellowknife, N.W.T.
16. Ontario Association of Health Centres, Toronto, Ontario
17. Prince Albert Health District, Prince Albert, Saskatchewan
18. Sandy Hill Community Health Centre, Ottawa, Ontario
19. Saskatoon Health District (including Borden Health Centre), Saskatoon, Saskatchewan
20. South East Ottawa Service Centre, Ottawa, Ontario
21. Wetoka Health Unit, Wetaskiwin, Alberta
22. Woolwich Community Health Centre, St. Jacobs, Ontario

APPENDIX B

INTERVIEW QUESTIONS

1. What information is available about your site with respect to:

a. achieving community ownership/involvement and satisfaction with service provision?

b. improving health outcomes and quality of care?

c. improving efficiencies?

d. improving access to services, especially for groups with greatest health needs?

e. improving the integration of services within the health sector and with other sectors in the community?

f. increasing interdisciplinary collaboration?

g. the changing role of hospitals from acute care facilities to community health/ community care?

h. the impact of devolution and regionalization on service delivery and funding models?

i. the effect of innovative management approaches on service delivery?

j. the effects of alternative funding models on the efficiency and effectiveness of services?

2. How do you define "community-based" health services?

3. What are the key factors that have contributed to the success or lack of success of your community-based organization/program?

4. What aspects of health human resource (HHR) management have contributed to the success or lack of success of your organization/program? Consider specifically:

a. ***HHR Continuum*** - the range of service providers or caregivers, including the use of self-care strategies, informal network of caregivers such as family and community supports, volunteers, etc.;

b. ***Role of Health Services Providers*** (formal caregivers), including the use of nurse practitioners, health assistants, and multi-skilled workers;

c. ***Skills Acquisition*** - key "new" skills required for community-based care as well as the best methods of training for self-care, informal caregivers and formal caregivers;

d. ***Multi-Disciplinary Teams*** - effectiveness of and best methods of achieving interdisciplinary collaboration and integration of services;

e. ***Models of Remuneration*** - fee-for-service versus salaried or other models of remuneration;

f. ***Professional Regulation*** - the effects of changing patterns in terms of scope of practice, credentialling, licensure, accreditation, and professional legislation/regulation; and

g. ***Quality of Worklife*** - provider perceptions of what contributes to job satisfaction.

5. What organizational characteristics have contributed to the success or lack of success of your organization/program? Consider specifically:

a. Service catchment and accessibility;

b. Funding sources and models;

c. Management structures and systems;

d. Governance structures and systems of accountability;

e. Integration of services.