Divisions of Family Practice
A GPSC initiative

GPSC
General Practice Services Committee

Pender Harbour Health Centre (PHHC) and Sunshine Coast Division of Family Practice (SCDFP):

Case Study of Partnership and Team-based Care
Final Report

November 2018

Executive Summary:

The case study was commissioned by the General Practice Services Committee[1] (GPSC) Evaluation Team in consultation with the Sunshine Coast Division of Family Practice and with the support of the Pender Harbour Health Centre (the centre). The centre, in partnership with the Division, provides a team-based approach to health care and was recently selected as a site to develop a model of team-based care through the Division's Patient Medical Home (PMH) initiative. This provides a unique opportunity to study team functioning and its development under this partnership model.

More generally, these partners are currently working out, within the context of their community, logistics related to how Divisions of Family Practice, Patient Medical Homes, Community Health Centres (CHC) and Health Authorities fit together to create a system of care for the patients they serve. These local processes are informed and impacted by the ongoing development of provincial policy. This case study may be able to inform policy development as well as local planning. The process will also inform the centres efforts to identify new areas for service expansion in the context of increased Ministry of Health (Ministry) support for the CHC model and provide guidance to other communities as they form strategic partnerships. It should be noted that concurrent with this case study the Ministry and the B.C. Association of Community Health Centres were meeting regarding a number of the areas identified in this document.

The case study was intended to:

1. Document the status and operations of the Pender Harbour Health Centre.
2. Document the growing partnership between the Sunshine Coast Division of Family Practice and the Pender Harbour Health Centre, including the development of a model of team-based care.
3. Capture formative information that might be of use to the GPSC, the Ministry and other rural community health centres.
4. Establish a baseline of information that can be used in tracking future health centre and partnership developments.
5. Provide information regarding envisioned 'next steps' for action, and identify issues to be addressed either locally or elsewhere in the system to support the centre and/or the partnership.

The process of the case study included a brief literature review, examination of data, key informant interviews, focus groups, and patient interviews, as well as analysis of the material gathered.

To examine Pender Harbour Health Centre requires an understanding of the Health Centre's history including how the development of the centre was a citizen-driven, largely community-funded initiative arising from the closure of the local hospital, the geographic remoteness of the community, and twelve years of advocating with the then Social Credit Ministry of Health for a community health centre. Today the centre operates with community ownership under a community Board and provides a broad range of services through the centre, community, volunteers and through home-based health with a significant

[1] The General Practice Service Committee is a Partnership of Doctors of BC and the Ministry of Health.

focus on seniors' programs. The population over 55 makes up 59% of the community population and individuals over 60 make up 57% of the centre's patients.

While the centre has developed a close working relationship with a medical clinic in Sechelt over the past 15 years, and this has led to a stable physician complement of five part time physicians (totaling 1.4-1.6 FTE) serving the centre, the relationship between the centre and the Sunshine Coast Division of Family Practice only began in 2014. At that time the Division was working on the A GP for Me initiative and included the centre administrator in their discussions. Over time the project evolved into discussions regarding the Patient Medical Home and Team-based Care and the development of a common agenda regarding how to take services forward in Pender Harbour. These two partners are now working together on a seniors' pilot project that creates a Seniors' Nurse Practitioner position that is jointly supported by the Division and the centre.

The relationship between the Health Authority and the centre involves several layers of complexity because of the need for clear expectations regarding how the various parts of the health system should work together. Differences in organizational structure, complexity and size impact organizational capacity to respond, timeliness of communications and actions, and clarity of roles when the centre and the Health Authority come together. At present the long-term relationship is contractual with both parties having concerns about closer relationship with the other. The centre indicated that while they would like to work more closely with the Health Authority, they remain cautious about entering into any formal arrangements that would impinge on their autonomy. The Health Authority has expressed concern that there is no agreed upon method of quality assurance at the centre[2]. Both have recognized the potential benefits to working more closely together, and at present there is work being done by the partners. Future work should improve the timeliness of communication and explore how to manage the expectations of organizations that have different capacities to respond to changes in community needs, as well as different cultures and organizational processes.

Information from the case study led to the identification of key themes. They included:

1. **Partnerships** –The community partner relationships (with community groups and agencies) were strong and supportive of responsive services and facilitated the centre's nimbleness in responding to community needs and changing circumstances. The strategic partnerships (with the Division and Health Authority) required further development. Stakeholders and staff were unclear about the current strategic partnerships and needed to be better informed about the partnership with the Division.
2. **Trust** – A critical enabler identified for the development of strategic partnerships was the cultivation of trust between strategic partners. While the Centre provides quality services, the development of a clear quality assurance process for the centre was identified as something that would promote trust and confidence between the partner organizations. Clear, timely communication between the strategic partners was also identified as a trust building block. For

[2] Note that as of August 13, 2018, the Health Authority and the centre were developing quality assurance measures.

the team of providers within the centre, staff indicated that they are working toward team-based care, however the team could be strengthened by addressing issues relating to confidentiality, information sharing and role clarity to improve centre and worker capacity.

3. **The key role of the administrator** – Instead of a health background, the current centre administrator has brought a strategic business background to the centre that has led to broader strategic planning for expansion of health services and improved fiscal preparation for the future of the centre.
4. **Strong Board with clear separation of governance and operation**s – The Pender Harbour Health Centre Board is a mature board that focuses on governance, planning and funding. It has a strong relationship with its administrator and does an excellent job of succession planning for the Board and is preparing for the retirement of the administrator. The Board has strong community ties and is accessible to community members, supporting the responsiveness of planning for the centre. The separation of roles, the responsiveness/nimbleness and autonomy as well as community governance, ownership and funding were all seen as critical enablers of the success of the centre.
5. **Definition of team**– The importance of team work is supported by both the centre Board and administrator. Professionals at the centre work well together and physicians report that Pender Harbour Health Centre facilitates improved patient-follow-up practices (in comparison to referral-follow-up practices in other Sunshine Coast communities). Physician administrative duties at Pender Harbour Health Centre are also reportedly reduced. While the Pender Harbour Health Centre team of professionals work reasonably well at their current size, there are no processes in place to support the advancement or maintenance of teamwork should the centre continue to grow.
6. **Communications improvements**– Communication is a fundamental enabler at the team level, in working with other providers, and at the strategic partnership level. At present the strategic partners have no articulated expectations regarding effective cross-organization communications. Upon the development of provincial guidelines regarding how the parts of the health system fit together, the local organizations will need to determine how their systems and cultures (some small and nimble, others larger and slower) can improve their communications. In addition, there are challenges establishing a common Electronic Medical Records (EMR) system and confidentiality challenges with the use of volunteers. There is a need to improve data/information sharing across professions at the Health Centre and externally with other providers of health services. Barriers to technologies that support improved communication must be addressed.
7. **Funding challenges** – While the centre has had funding challenges since the centre was created, this has led to creativity and community funding. The result has been discretionary funds that allow the centre to be creative and responsive to community needs.
8. **Importance of community** – It is important to recognize the community's unique background and how that has impacted the centre in terms of ownership of the centre, the importance of retaining autonomy and the willingness to locally fund services and capital ventures that address community needs.

Focus group participants offered their suggestions for the development of closer strategic partnership and identified barriers and enablers to achieving the strategic partnerships. There was a strong interest expressed in working together to further develop this partnership.

The next steps identified by the focus group included:

- Maintaining communication between the strategic partners (including the Health Authority, the Division and the centre) and continuing the joint work of the division and the centre.
- Moving forward with the seniors' nurse practitioner pilot as a test for a common EMR system and as a pilot of a program to meet the needs of the significant seniors population in Pender Harbour.
- Establish and work with a pilot group to set up team-based care for seniors in Pender Harbour.
- Work together with the Health Authority to address quality assurance concerns/requirements within the centre and flag this issue as something the Ministry may wish to work on at a provincial level.
- As the Ministry continues to clarify how community health centres fit within the Ministry's primary care model, this thinking will be incorporated into strategic planning.

The Sunshine Coast community, through its work between the Division and the centre, provides an exemplar of a community approach to integrating Patient Medical Home (PMH) and CHCs while laying the groundwork for a Primary Care Network. The centre compliments the PMH model by supporting a broader range of services and providers to meet the unique needs of the rural community.

The observations from the case study suggest key lessons for the Pender Harbour strategic partners and other jurisdictions.

Key Lessons for Pender Harbour and Other Jurisdictions	
Observations	**What this means**
Team Building /Capacity Building – Pender Harbour Health Centre has provided an environment that brings together various health practitioners and that is supportive of team-based care. Over time this has resulted in the development of teamwork. However, as the centre increases in size, more formalized processes to foster Team-based Care may be needed. Development of the team-based care model will be facilitated by the strategic partnership of the centre, the Division and the Health Authority as well as by local site management and staff.	• Pender Harbour Health Centre may wish to consider evaluating their teamwork structure against specific criteria and providing opportunities for professionals to further bond as a team. They may also wish to align their team-based care with criteria being established in the province for evaluation purposes. This could provide useful information to the GPSC, the Ministry, other CHCs and the BC Association of Community Health Centres. • Furthering the TBC at the centre requires the strategic partners to locally tailor a definition of the Patient Medical Home model and TBC services envisioned for Pender Harbour. Implementation requires strategic partnerships/interconnection between the Patient Medical Home and the acute system to work together to meet patient needs.
Strategic Partnerships – While the centre and the Division of Family Practice have	• The GPSC may wish to consider the partnership model developed between the Sunshine Coast

developed their partnership, strategic partnership with the Health Authority involves additional layers of complexity due in part to different organizational size, structure and cultures.	Division of Family Practice and the centre as a model for exploration by other Divisions and CHCs in the province. • Policy development at the provincial level should be complimented by strategies to enable supportive, strategic relationships between CHCs, Health Authorities and Divisions of Family Practice within communities. • The three Pender Harbour strategic partners should track the development of their partnership in order to foster accountability to each other and to document what does and does not work.
Unique Community Context – After twelve years of advocating for a health centre and ultimately fund raising and assuming financial responsibility for the centre and (initially)[3]physician payment, the community has a strong sense of ownership of the centre and wants to retain its independence. At the same time, residents expect adequate quality health services for their remote and rural area. Strong community support has led to a sense of community ownership and willingness among community members to contribute to funding.	• The strong, grassroots bond between the community and the centre has led to strong volunteerism and community funding to support the Centre's services. • Patient and community engagement is at the core of the CHC model of governance and operations. As PMHs and PCNs develop strategies for patient engagement, the GPSC and the Ministry may wish to look to CHCs for insights and best practices. • Pender Harbour may have lessons for other community health centres and the Ministry when examining whether a CHC has true community support.
Nimbleness/Independence and Funding – The centre's independent funding and close ties to the community have contributed to its ability to respond quickly to changing community needs.	• CHCs operate and are embedded in communities in specific ways. The GPSC and Ministry may wish to consider the implications for how CHCs, PMHs, PCNs and other Health Authority services fit together to satisfy local patient needs in sustainable ways. • Divisions of Family Practice and Primary Care Networks may wish to engage CHCs as a means to quickly respond to community needs, recognizing their ability to bring resources to the table. • Community health centres should examine how to foster community ownership and develop fundraising capacity in partnership with their community. • The Ministry and the BC Association of Community Health Centres may wish to support CHC development of fundraising skills.

[3] Note that initially the centre paid for physician wages, however when the Fee for Service payment was introduced, the physician enrolled in that payment option.

Strong Board – Pender Harbour Health Centre has a mature Board with a strong governance focus that facilitates clear separation of governance and operations.	• The strong governance focus of the board provides an example of board structure that could be a model for other, less well-established CHCs. Such a well-functioning board that supports a strong organization will be more attractive to Health Authorities and Divisions of Family Practice in developing strategic partnerships.
Administrative Qualities – The Pender Harbour Health Centre administrator brought unique skills to the centre that has supported a more strategic approach to managing the centre's future.	• Pender Harbour and other community health centres may wish to recruit future administrators with similar strong strategic business skills along with health experience.
Quality Assurance – At present, while the centre endeavours to provide services of the same quality as the Health Authority, there is no established method to assess the quality of services provided at Pender Harbour Health Centre. This is a risk management issue for the Health Authority as it considers expanding partnerships for service delivery with the centre. Currently the centre and health Authority are working together to develop local measurement criteria.	• In order to ensure consistency across CHCs and Health Authorities, the Ministry may wish to provide guidance regarding how CHCs should address quality assurance concerns/standards, whether through accreditation or a set of made-in-BC criteria to which CHCs must adhere. • The Pender Harbour Strategic Partners may wish to develop an interim method to address this concern.
Confidentiality/Information Technology– The development of a single EMR system for Pender Harbour Health Centre continues to be the vision, but at present three different patient record systems exist, resulting in duplication of effort. The centre is piloting a joint EMR system for the new seniors' nurse practitioner. Challenges to developing a system arise from the EMR service provider. Confidentiality continues to pose challenges both within the centre and with its partners in terms of sharing patient information (e.g. release of test results requisitioned by nurse practitioners but sent to physicians, or advising that a Pender Harbour Health Centre patient has entered or been released from hospital.)	• The Pender Harbour strategic partners may wish to work together to address the confidentiality barriers/challenges. • The GPSC, Ministry, Divisions of Family Practice and CHCs may wish to follow the results of the pilot EMR program for potential spread to other communities and work together to address barriers to rural/remote services.

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Introduction and Purpose:

This case study was commissioned by the GPSC Evaluation Team in partnership with the Sunshine Coast Division of Family Practice as a case study of Pender Harbour Health Centre (the centre) and the Sunshine Coast Division of Family Practice. The centre, in partnership with the Division, provides a team-based approach to health care, which is a cornerstone of the Patient Medical Home model. With the recent selection of the centre as a site to develop a model of TBC through the Division's PMH initiative, there is a unique opportunity to study team functioning and its development under this partnership model.

More generally, the partners on the Sunshine Coast are currently working out, within the context of their community, issues related to how Divisions of Family Practice, Patient Medical Homes, Community Health Centres (CHC) and Health Authorities fit together to create a system of care for the patients they serve. These local processes are informed and impacted by the ongoing development of provincial policy. This case study may be able to inform policy development as well as local planning. The process will also inform the centres efforts to identify new areas for service expansion in the context of increased Ministry support for the CHC model and provide guidance to other communities as they form strategic partnerships. It should be noted that concurrent with this case study the Ministry and the B.C. Association of Community Health Centres were meeting regarding a number of the areas identified in this document.

In consultation with the GPSC Evaluation Team and the Sunshine Coast Division of Family Practice, the case study was intended to document Pender Harbour Health Centre regarding:

1. how its partnerships contribute, or could contribute, to the Patient Medical Home model and to the Coast Primary Care Network, and
2. possible models to address challenges to move the PHHC forward.

As part of this documentation, the case study would examine/identify:

- the status and operations of Pender Harbour Health Centre.
- the growing partnership between the Sunshine Coast Division of Family Practice and the Pender Harbour Health Centre, including the development of a model of team-based care.
- formative information that might be of use to the GPSC, the Ministry and other community health centres.
- a baseline of information that can be used in tracking future centre and partnership developments.
- information regarding envisioned 'next steps' for action and identify issues to be addressed either locally or elsewhere in the system to support the centre and/or the partnership.

This report sets out both the process and results of the case study. The report is arranged as follows:

Context of Pender Harbour Health Centre:	This section sets out the background and community context of the Pender Harbour Health Centre.
Background of the Division of Family Practice/ Pender Harbour Health Centre Partnership:	This section sets out the background of the development of the partnership with the Sunshine Coast Division of Family Practice.
Methodology:	Sets out the intended case study process and the actual process used with explanations for the differences.
Results:	Sets out the results of the methodology including key comments from patients, the Board, physicians/medical professionals, PHHC and Health Authority staff and the Pender Harbour community; identification of themes and results of the focus groups.
Observations/Key Lessons:	Includes the consultant's observations of the key aspects of the PHHC operations and partnerships, as well as barriers and assets that mitigate or hamper the centre or partnership, outstanding questions/issues to be answered/addressed and lessons to be learned from the centre and its partnerships.
Conclusion	Reminders of key considerations arising from the case study.

Context of Pender Harbour Health Centre:

The Pender Harbour Health Centre provides service to a unique part of the province. How and why the Centre was established and its history and connection to the community are important context in order to understand how the Centre delivers services and how and why it is supported. The following provides an overview. A more detailed account of the Pender Harbour context can be found in Appendix A.

The community of Pender Harbour began as a First Nations community with missionaries and then non-native immigrants arriving beginning in 1859. The community's isolation led to it being settled by independent loggers, fishermen, farmers and artists. The first hospital, St. Mary's, was established in 1930 and served the Sunshine Coast until 1964 when it was replaced by Sechelt Hospital. From the closure of St Mary's Hospital the Pender Harbour community advocated with the Social Credit Government for 10 years for the creation of a community health centre to serve the isolated community.

In 1974, the Pender Harbour and District Health Centre Society was incorporated with the express purpose of building a stand-alone health centre to serve the communities of Pender Harbour and Egmont.(Pender Harbour Health Centre, 2011) A new NDP government approved the funding of equipment for a centre that would be constructed using funds raised by the local ratepayer's association. After further negotiations, a referendum was held within the Sunshine Coast Regional District for approval to borrow $127,000 of a total $227,000 required to construct the centre, with the Government of B.C. contributing the balance of $100,000. An architect who lived in the area designed the new centre to give flexibility and the ability to grow. (Bonderud, 2018) The centre officially opened on December 8, 1976 with three key goals(Pender Harbour Health Centre, 2011):

1. Improve relations with the Ministry and work toward an ongoing consistent funding structure for services that the Ministry would agree to support.
2. Improve community-based health services.
3. Obtain provincial accreditation as a community clinic and purchase needed equipment.

At the same time, the Pender Harbour and District Health Centre Society knew that they were creating something outside of the established health system and that the community would be largely responsible for maintenance, equipment and future expansion. Medical and support staff would be employees of the centre—not employees of the established health system.(Pender Harbour Health Centre, 2011) The loggers and fishermen of Pender Harbour funded the hiring of a doctor[4]. (Bonderud, 2018)

Since 1976, the PHHC has gone through times of financial difficulty and times of expansion. Through all those times, the community has banded together to support their health centre. While many of the old loggers and fishermen have retired or passed away, the spirit of independence has continued in the community. Even with the influx of newcomers to the area, Pender Harbour Health Centre has remained central to the community.(Bonderud, 2018) Anecdotally, the Pender Harbour Health Centre is described as one of two assets that the community is most proud of (the Pender Harbour Music School being the

[4] This was in place until the introduction of Fee for Service funding.

second).Realtors in the areas advise that the presence of the centre is key to the attractiveness of the community to prospective buyers. (Hunsche, 2018)

Pender Harbour Health Centre at a Glance	
Years of Operation	42
Annual Budget	$700,000
Latest community contribution (from auxiliary and other community sources)	$93,000 (approximately)
Range of services	G.P., home care, physiotherapy, dentistry, mental health and addictions, Psychiatry, lab services, Chiropractors, Foot care, Public health services, home care nursing services (e.g., wound care, medication monitoring, diabetic care, post-operative follow-up), rheumatology, Women's Wellness, Youth Clinic, Senior's Services, Palliative Support, Better at Home, Community Garden, Cardiac Care, Bereavement Support, Chronic Pain self management, urgent and ambulatory nursing, diabetes care, community health programs, Massage Therapy
Days of operation	5 days/week (6 during summer)
Number of individual patients	5,699 (October 2016-October 2017)
Percent of patients over age 60	57%
Number of employees	10
Types of employees	Registered Nurses, Medical Office Assistants, Finance, Administration
Number of employee providers	5 nurses
Number of allied health care professionals and support staff providing services from the Health Centre beyond the 10 employees	30
Types of allied professionals	Physicians, nurses, dentist, dental assistants, chiropractor, nurse practitioner, mental health/ substance counsellors, dental hygienist, physiotherapist, RMT, Public Health Nurse, Psychiatrist, volunteers

Community financial support for the Centre has continued over the years. The Pender Harbour Health Centre Auxiliary has grown its financial capacity from an average $7,000/year in donations that go to the centre, to $70,000-$80,000/year.(Thomas, 2018) While various methods have been used to raise funds in the past, currently all funds raised by the Auxiliary are raised through their store, the Bargain Bin. This means that most of the funds are through small one and two dollar purchases and small donations made at the time of purchase. (Thomas, 2018) As explained by a number of informants, this is evidence that, while Pender Harbour has wealthy newcomers, the community is largely made up of moderate and low income earners who continue to fund the centre.(Bonderud, 2018)(Thomas, 2018)

In 2006, with increased funding from the Health Authority which made operations more viable, and with approval of funding from the Sunshine Coast Regional District to support some capital costs, the centre ventured into an expansion project and began fundraising in the community. They also began the *"It's Ours"* campaign to raise funds to pay off the Centre's mortgage. A target of $350,000 was established. Using garage sales, book fairs, strawberry teas, benefit concerts, luncheons, brunches, fashions shows and a grand gala, they raised $225,000 towards the goal and then an anonymous donor pushed the total to its target just before the expanded centre's grand opening in December 2006.(Pender Harbour Health Centre, 2011) This indicates that the centre is a rallying place for both Pender Harbour's 'old timers' and newcomers 'from away.'(Bonderud, 2018)

In November 2007, the Centre hired the current administrator after a period of challenges within the centre and between the centre and the community. Where previous management of the Centre had been provided by a nurse administrator, the current administrator came with a strong business background, specifically in supporting organizations that were struggling.(Bonderud, 2018) Since 2007, the centre has been described as going through a period of stability, new growth and partnership development.

Today, the Pender Harbour Health Centre's vision is of being:

A leader in community health care.

The centre's mission statement is:

To provide quality health care and respond to health-related social needs in a respectful and caring environment.

The centre serves as a hub for the delivery of a variety of services in conjunction with the community. Many of these utilize extensive volunteer hours from the community. The centre may provide staff, administrative support, or space for meetings to support these important community initiatives. For a complete list of community services, see Appendix B.

Background of the Division of Family Practice/Pender Harbour Health Centre Partnership:

The partnership between the Sunshine Coast Division of Family Practice and the Pender Harbour Health Centre is something that has evolved naturally over the past six or seven years.

Year	Event	Comment
1974-present	Centre provides space for physicians	• Initially a physician employed and paid by the centre, • Then itinerant physicians provide service in the centre a few days a week, • Currently a rotation of physicians from a Sechelt clinic provides a clinic in Pender Harbour five days a week.
2013	Formal Partnership with Sunshine Coast Division of Family Practice	• Emerging challenges to maintaining coverage at the centre due to retirements and relocations in the Sechelt clinic. • Fiscal pressures and recruitment challenges were barriers. • Pender Harbour Health Centre partnered with the clinic to address these concerns. • Successful recruitment of a physician who has now served the centre for five years.
2016	Physician services stabilize at centre	The service to Pender Harbour has continued to grow with five part time physicians(totaling 1.4-1.6 FTE) now serving the community.
2014-2016	Sunshine Coast Division of Family Practice - A GP for Me initiative	The administrator of the Pender Harbour Heath Centre invited to sit on the GP for Me steering committee. Centre involved in the recruitment of physicians to Sunshine Coast.
2015	GP for Me transitioned to Patient Medical Home (PMH) project.	Pender Harbour administrator remained involved with Division steering committees during the transition from A GP for Me to PMH and this led to the Pender Harbour Health Centre being considered a model for PMH.
2017-present	Renewal of PMH initiative	• Pender Harbour administrator participated in strategic planning with the Division. • 2018 strategic planning led to four key initiatives, one of which is the pilot of a seniors' health care initiative, including a team-based care approach, at Pender Harbour Health Centre. • The mutual goal of the Division and the Pender Harbour Health Centre is to be able to replicate the centre's seniors' health program across the coast after the pilot period. • This pilot has involved working together to define the program and the hiring of a seniors' focus nurse practitioner.

		• The centre has posted for the nurse practitioner position and is working with the Division to ensure the program roll-out is synchronized with the Division's efforts. The position is funded by the centre and space and administrative support come from the centre. The Division has been involved in the development of the Team-based Care and examining the possibility of extending the program across the Sunshine Coast.

Methodology:

The methods undertaken to complete the case study were arrived at through discussion with the Sunshine Coast Division of Family Practice and the GPSC Evaluation Team. The case study was to learn the following from the centre:

- how its partnerships contribute, or could contribute, to the Patient Medical Home model and to the Coast Primary Care Network, and
- possible models to address challenges to move the PHHC forward.

The agreed upon methodology and amendments made to it were as follows:

1. **Literature review** of any material regarding best practices for community health centres – This was a brief look at literature on the benefits of CHCs and best practices from the BC and Canadian Associations of Community Health Centres.
2. **Key Informant Interviews** – The executive director of the Division identified critical informants from the Division's perspective and the Pender Harbour Health Centre administrator provided additional names. In total, 23 individuals were identified and 22 were contacted and interviewed either in person or by phone. (Key Informant Questions can be found in Appendix C)
3. **Focus Groups** – Initially, focus groups with staff and with clients were envisioned. The process changed during the case study so that staff were included in a focus group, but clients were interviewed individually. A final focus group was conducted with key informants as well as representation from the Division of Family Practice and Doctors of BC to discuss themes arising from the interviews, and to identify next steps for the partnership and the Centre.
4. **Contact with GPSC's PMH 'Most Significant Change' evaluation**– This was intended to include in the case study any information obtained from Pender Harbour patients by the GPSC PMH Evaluation process. This was seen as an alternative to conducting a patient journey mapping exercise as part of this case study. While GPSC PMH 'Most Significant Change' consultant and the case study consultant connected about this work, no further sharing occurred and it was suggested that interviews with centre patients was sufficient to this process. (Patient Questions can be found in Appendix D)
5. **Review of Pender Harbour Health Centre (PHHC) data**– The Administrator for Pender Harbour provided demographic and other information about Pender Harbour's community and patients, and the Centre's work. This was reviewed for significant trends. In addition, a staff focus group described patient flow through the centre and referral patterns. This information was used to create a patient flow chart.
6. **Analysis and identification of themes arising from informant interviews** – Subsequent to conducting the interviews, the consultant reviewed all interview content on three occasions to identify themes and key comments. These themes were then shared with the eight key informants, the administrator, the Division executive director and a representative of Doctors of BC at a focus group for confirmation, and identification of any errors or omissions.

7. **Preparation of a final report** – The draft report was reviewed by the Pender Harbour Health Centre administrator, the executive director of the Division of Family Practice and the contract manager for the case study from Doctors of BC.

Results:

LITERATURE REVIEW-

While evidence-based clinical best practices for CHCs are dependent upon the area of clinical services provided. E.g. obesity reduction, tobacco cessation, adolescent reproductive services, etc., specific best practices for CHC operation were only available in limited amount through Canadian and American websites. For a more information see Appendix E.

Definition of Community Health Centre and Core Criteria:

The Canadian Association of Community Health Centres provides the following 2016 definition of CHCs in Canada:

A Community Health Centre is any not-for-profit organization, co-operative, or government agency which adheres to all five of the following domains: (Canadian Association of Community Health Centres)

1. **Provides team-based, interprofessional primary care** – Teams of providers including physicians, nurses, dentists, dieticians, social workers, nurse practitioners, therapists and others provide team-based services based on patient needs.
2. **Integrates services of primary care, health promotion and community wellbeing**–CHCs integrate primary health care with health promotion, illness prevention and community health initiatives.
3. **Community Centred** –CHCs focus on services needed specifically by their community and engage the community in determination of priorities and strategies for services.
4. **Actively addresses social determinants of health** – The CHC actively supports individuals, families and the community to address social determinants of health such as poverty, isolation, housing, etc.
5. **Demonstrates commitment to health equity and social justice** – CHCs recognize that health status varies between populations because of social and institutional inequities. CHCs work to address these inequities and to ensure 'fair and compassionate access to the fruits of economic growth.'

Documented Outcomes/Benefits of CHCs:

Cost benefit analysis conducted in the United States has identified that CHCs provide a cost-effective means of serving patients. (National Association of Community Health Centers, 2011)

Average cost Per Patient Per Day			
Hospital Inpatient	Hospital Outpatient	All Physician Settings	**Health Centre**
$41.36	$7.59	$2.64	**$1.67**

CHCs in the American model were also reported to be more likely to accept new patients; provide more evening and weekend hours; offer more dental, behavioural health and pharmaceutical services; provide

care for uninsured patients; serve more chronically ill; and offer more services with translation services, than were non-CHC primary providers.(National Association of Community Health Centers, 2011)

Structure and Governance:

Areas of particular importance to CHC organizational success included: (National Association of Community Health Centers, 2011)

- Local ownership and direction under a patient-majority board
- Provision of a comprehensive array of services based on the community's needs
- Regular and rigorous community needs assessments
- Exemplification of the Patient Medical Home model where patients can receive preventative and primary care, make sense of their condition, and be coached on making behavioural changes to improve their overall health. When patients have a Patient Medical Home, they are more likely to manage their medical conditions and prevent new ones from occurring.

PHHC DATA-

This section will set out a brief summary of Pender Harbour area demographics as drawn from the 2016 Census Canada data as well as a snapshot of data of patients seen at Pender Harbour Health Centre. A patient flow and referral chart developed from a staff focus group is also provided.

Pender Harbour has the highest median age on the Sunshine Coast (59.4 years) and the lowest under 19 years demographic (9%).

Pender Harbour Population Changes 2011-2016	
Population	**Percent Change**
Ages 10-19	-4.9%
Ages 20-29	-1.2%
Ages 30-49	-3.2%
Ages 50-59	-2.4%
Overall Population change	-2%

In Area "A" those over age 55 make up 59% of the population with 37% of the population over 65. Area "A" is considered a retirement destination. Over the past decade while the overall population of the area has remained relatively unchanged, the over 60 population has increased by 46%. While Area "A" represents only 8.7% of the total Sunshine Coast population, the Area "A" seniors population represents 11.1% of the Sunshine Coast seniors. Given the Area "A" challenges with geography, isolation and transit, this points to significant need for seniors services and home-based services to be delivered in the area. (Pender Harbour Health Centre, 2018)

The Pender Harbour Health Centre served 5,699 individual patients from October 2016 to October 2017. This is an increase of 11.6% over 2016.

Origin of Pender Harbour Health Centre patients	
Pender Harbour/Area A	3,673 (86.8% of Sunshine Coast patients)
Sunshine Coast (non-Pender Harbour)	558 (13.3% of Sunshine Coast patients)
Non-Sunshine Coast	1,468 (26% of total patients)
Total patients	5,699

The number of non-Sunshine Coast patients speaks to the significant influx of summer visitors during the summer season. (Pender Harbour Health Centre, 2018) The utilization of Pender Harbour Health Centre by residents of other Sunshine Coast areas may be due to holiday visits to the Pender Harbour area, or due to the relative ease of obtaining health services at the centre.

The demographics of patients seen by the centre over the past two years[5] (approximately 21 months)reflects the Area "A" skewed demographics toward seniors: (MacDonald, Administrator, 2018)

Pender Harbour Health Center Patient Demographics (Age)		
Age Group	**Number of patients**	**% of patients**
Over 60	1220	57%
30-59	638	30%
20-29	125	6%
10-19	86	4%
0-9	74	3%

It should be noted that while this captures the demographic background of patients over the past two years, it does not track the actual number of visits for each age group. Some patients are seen daily, weekly, monthly or quarterly, depending upon their health needs.

Comparing the two snapshot periods, the actual number of patient visits has increased 12-13% from 20,900 visits (402/week) in 2015/16 to 23,580 (453/week) in 2017/18. Increases in visits vary for different health care providers.[6] (MacDonald, Administrator, 2018)

[5] This is a comparison of two snapshots, one from October 2015-October 2016, compared to May 2017-May 2018.
[6] Note that the traffic increases do not include data from the ancillary health care providers not listed in the chart. Also note that part of the increase has been made possible by the increase from one physician per day to two, resulting in seven practice days/week. The dentist has also increased hygienist time. The nursing time numbers do not include home care visits.

Increases in Visits to Various Health Care Professionals Comparing Two Snapshot Periods			
Health Care Professional	**October 2015-October 2016**	**May 2017-May 2018**	**% Change**
Nurses	5600	5800	3.5%
Nurse Practitioner	200	300	50%
Doctors	7000	8050	15%
Dentists	4250	5280	24%
Allied Health Care Professionals	2650	2950	11%
Community Programs	1200	1200	0
Total	**20900**	**23,580**	12.8%

Allied health care professionals include mental health counselors, physiotherapist, chiropractor, registered massage therapist, foot care, psychiatrist, rheumatologist, and public health nurse. Community programs include the youth clinic, FOKUS, AA, Pender Harbour seniors initiatives, Hospice Society, counselling, orthotics and health seminars, all of which are connected with the centre or use the centre space for programming to residents.

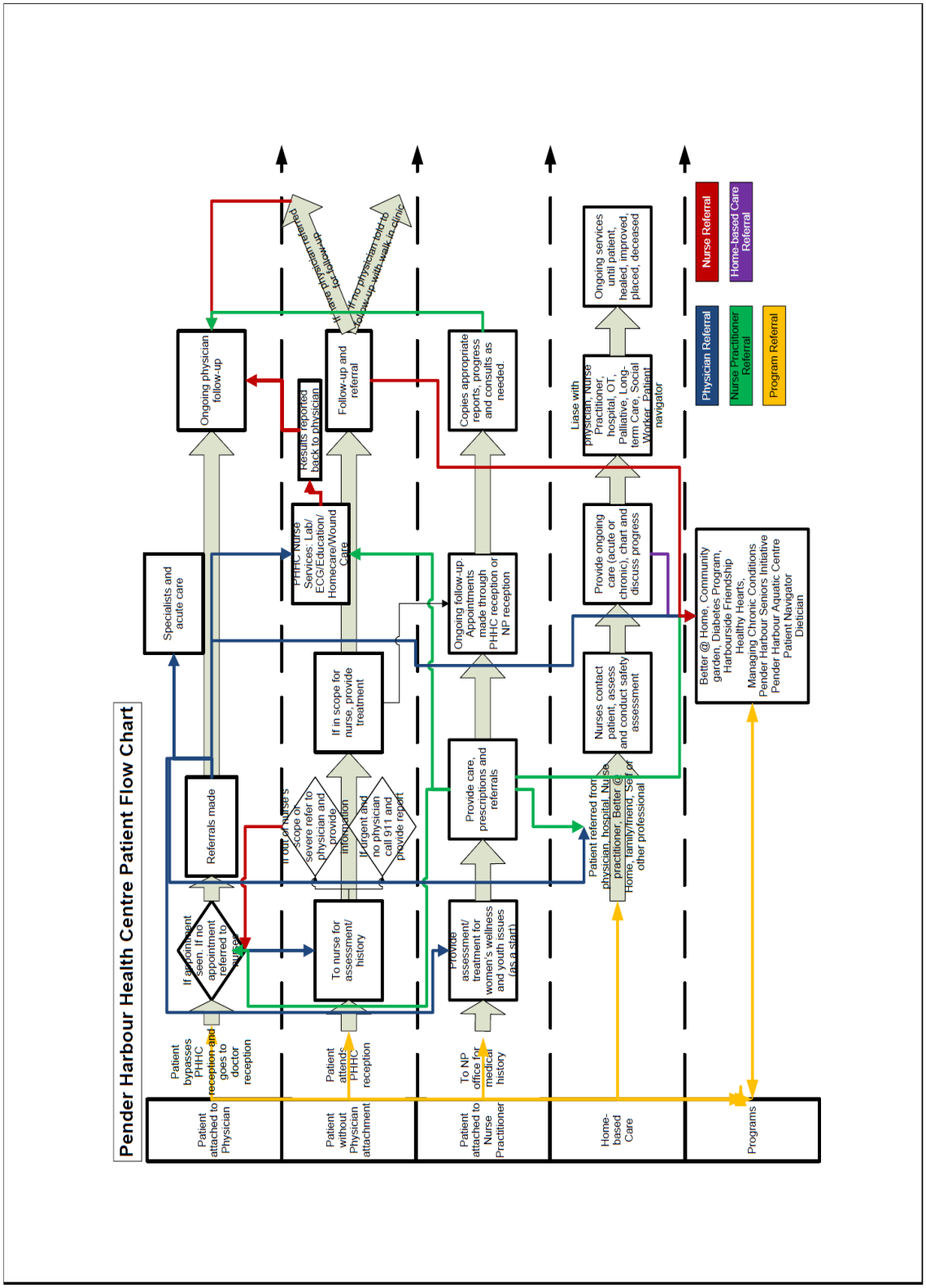
The Pender Harbour Health Centre has seen a 7% increase in on-coast[7] service demand over the past year with 6.6% coming from Area "A" and 9.9% coming from other Sunshine Coast areas (together totalling 7%). Off Coast patients showed an increase of 27.5% or 314 patients from 2016 to 2017. (Pender Harbour Health Centre, 2018)Again, this may be due to Area "A" becoming an increasingly popular vacation destination. This data represents patients seen by the centre staff due to their role as providers of ambulatory and urgent care nursing services. Other health care providers may not have seen these numbers of off-coast patients.

Patient and Referral Flow Chart

The patient and referral flow chart was developed with the advice of centre staff during a focus group. The chart sets out the independent streams of patient service that exist at the centre, for instance, Patients attached to Pender Harbour physicians, Patients unattached to Pender Harbour physicians and Patients attached to the Nurse Practitioner. The flowchart provides an overview of the patient's flow through the individual stream (the broad arrows) as well as the possible referral paths (colored arrows). Of note is the close relationship between the physicians and the nurses serving those patients unattached to a Pender Harbour physician or who present without an appointment. Where an unattached patient (or a patient without an appointment) has a severe condition, nurses can call upon the Centre doctors to provide services. Conversely, physicians who need nurse support while providing treatment, can call upon Centre nurses. In general, the chart illustrates the team-based interconnectedness of the various services at the centre through in-Centre referral and through referral to Programs supported by the Centre. For

[7] Defined as patients who reside on the Sunshine Coast.

example, a Physician can refer to the nurses, to the nurse practitioner, to the home-based care stream or to programs (the blue arrows), or the Nurse Practitioner can refer to the Physician, the nurses, home-based care, or programs (the green arrows.) While most of the team referral processes are identified as two-way, the focus group participants indicated that some referral patterns may actually be more unidirectional because some professionals are not used to capacity. They indicated that this may be due to lack of understanding of the various roles of professionals. Not noted in the chart are the various other health care professionals who are at the centre and who are also accessible either directly or through referral such as mental health counsellors, foot care specialists, massage therapists etc.


Pender Harbour Health Centre Patient Flow Chart
Patient attached to Physician
Patient without Physician attachment
Patient attached to Nurse Practitioner
Home-based Care
Programs
Patient bypasses PHHC reception and goes to doctor reception
Patient attends PHHC reception
To NP office for medical history
If appointment seen. If no appointment referred to nurse
Referrals made
To nurse for assessment/ history
Provide assessment/ treatment for women's wellness and youth issues (as a start)
If out of nurse's scope or severe refer to physician and provide information
If urgent and no physician call 911 and provide report
If scope for nurse, provide treatment
Provide care, prescriptions and referrals
Specialists and acute care
PHHC Nurse Services: Lab/ ECG/Education/ Homecare/Wound Care
Ongoing follow-up. Appointments made through PHHC reception or NP reception
Ongoing physician follow-up
Results reported back to physician
Follow-up and referral
Copies appropriate reports, progress and consults as needed.
If need to discuss referral to physician
If no physician told to follow-up with walk-in clinic
Patient referred from physician, hospital, Nurse practitioner, Better @ Home, family/friend, Self or other professional
Nurses contact patient, assess and conduct safety assessment
Provide ongoing care (acute or chronic), chart and discuss progress
Liase with physician, Nurse Practitioner, hospital, OT, Palliative, Long-term Care, Social Worker, Patient navigator
Ongoing services until patient, healed, improved, placed, deceased
Better @ Home, Community garden, Diabetes Program, Harbourside Friendship Healthy Hearts, Managing Chronic Conditions, Pender Harbour Seniors Initiative, Pender Harbour Aquatic Centre, Patient Navigator, Dietician
Nurse Referral
Home-based Care Referral
Physician Referral
Nurse Practitioner Referral
Program Referral

PATIENT PERSPECTIVES-

Four Pender Harbour Health Centre patients were interviewed in the course of this case study. These patients were long-time residents of Pender Harbour and three of them reported having used the Centre's services since it opened in 1976. One of the patients had previously sat on the Board.[8]The four patients had used a variety of services at the centre including:

- Wound care
- Diabetes support
- Surgical follow-up nursing
- Physiotherapy
- Weight control
- Heart recovery
- Podiatrist
- Knee replacement aftercare
- Home nursing
- Better @ Home
- AA groups
- Physician services
- Dental care
- Lab work

These patients were asked to comment on how Pender Harbour Health Centre delivers health care, how the centre is connected to the Pender Harbour community and its responsiveness to the community, as well as about their experience with the centre and the most significant help they have received from their dealings with the centre.

The patients described the centre as well-connected to community needs and as continually surveying community needs and then developing programs to meet those needs. The Centre and the programs were described as accessible and one patient described the Centre as 'like a second home'. They referenced how the nurses knew them and would assist anyone who entered the facility. Another patient described the centre's services as 'individual and comfortable.'

Patients described the centre as responsive, as 'fighting for me,' and as the 'best thing we have in Pender.' Patients were aware of the limits of availability of services to five days a week, but felt that the centre developed services to meet the community needs and felt it was amazing that they could enjoy their regular doctor/patient contact. One patient described attending the centre with an infection. Apparently, the nurse "took one look and got the doctor and he was put in IV for three days." Another went in with

[8] It should be noted that Pender Harbour Health Centre Board members are residents of Pender Harbour and use the services of the health centre, consistent with the suggested criteria of the Canadian Association of Community Health Centres and with the suggestions for success outlined by the U.S.-based National Association of Community Health Centres.

sepsis and hadn't slept for a week due to undiagnosed diabetes and was immediately transported to hospital. Still a third mentioned how if he is in the dentist's chair and something 'looks funny,' the dentist can call in a doctor to take a look. The same patient said that you can walk in the door and you will be looked after by the nurses and doctors. A number had used the home nurse program and spoke highly of it. They mentioned how there are 'a lot of older people here and also more children and youth' who are served. They felt that the centre ran smoothly and the management of the centre was very good.

Patients reported that while they might have issues with other aspects of the health system, they have not had any issues with Pender Harbour Health Centre and complimented the receptionist and the nurses. They felt that information was shared appropriately between the various professionals and advised that they provided permission to share information.

All of the patients indicated that Pender Harbour Health Centre was well-positioned in the community to provide health care and was well publicized to community members. Its location next to the highway was thought to help community members know about this important community resource. So was word of mouth, and community members are described as being very proud of the centre. Beyond word of mouth and the centre's presence, the centre is also highlighted in Welcome Wagon material and is also a regular presence in the local *Harbour Spiel* Magazine which goes to all Pender Harbour residents.[9]

With regards to most significant help, patients offered the following stories:

"The connection to the centre and the home nurses was crucial because I was trying to sort out my life as a juvenile diabetic. Everyone at the health centre helped. It took a long time to join the diabetic program as I didn't want to accept help. It took XXXXXX[10] to teach me to help myself. I'm an amputee and receive home care. The more I pay attention, the better I do… All these years they've been fighting for me, so now I want to give back and help."

"They saved my life and provided the follow-up after I got out of the hospital. I was going in daily for wound care and had some home care for six to eight weeks. I never had an issue with the centre, but after care at XXXXXX[11] I ended up in St. Paul's Hospital a second time for seven weeks. The centre took care of me when I was released the second time, too."

"I really appreciated the house calls because I had a lot of trouble getting my warfarin dosage settled after heart surgery. They were there daily. They also provided service to my husband."

With regards to any potential changes the centre needed to make, none were suggested other than that the clinic needs to be prepared to grow with the community.

[9] The centre provides regular information on health issues for the community and regularly advertises the services at the centre.
[10] A particular nursing staff member
[11] Another part of the health care system

THEMES-

The results of the numerous key informant interviews were reviewed multiple times to identify the common themes that arose during the interviews. These themes were:

1. Partnerships
2. Trust
3. Key role of the administrator
4. Strong Board with clear separation of governance and operations
5. Definition of team
6. Communications improvements
7. Funding challenges, and
8. Importance of community

1. **Partnerships –**

Given the mandate to examine the partnership between the Sunshine Coast Division of Family Practice and the Pender Harbour Health Centre, key informants were asked to identify the Pender Harbour Health Centre partnerships. Those identified included (in no particular order):

- Community volunteers
- Health Authority
- Sunshine Coast Regional District (SCRD)
- Community groups
- Organizations such as the Aquatic Centre
- Staff
- Physicians
- Division of Family Practice
- Centre tenants
- The Health Centre Auxiliary
- Health Centre Board

How partnership was defined and how the partnership manifested differed for each of the partnerships mentioned, except that all partners were concerned with ensuring services to Pender Harbour residents. Partnerships described included:

1. Strategic partnerships that involve planning together regarding services to Pender Harbour (e.g., planning with the Division of Family Practice)[12]
2. The centre providing space/support for community programs delivered by other organizations (e.g., space for Alcoholics Anonymous groups or providing administrative support for Better @ Home, or volunteer scheduling for the Pender Harbour Health Centre Auxiliary)

[12] Note that this strategic level of partnership was less frequently mentioned than the other forms of partnership.

3. Where the centre provided rented space for delivery of a professional program (e.g., dental, physician, chiropractic, public health or mental health services)
4. Where the centre and other organization partner together to deliver programs (e.g., joint programming with the Pender Harbour Aquatic Centre to deliver seniors' health programming.
5. Contracted relationships for service (e.g., Health Authority funding for home health care)
6. Funding relationships such as that of the Pender Harbour Health Centre Auxiliary, a volunteer non-profit that raises funds to support centre programs and operations or other costs (there are no restrictions on these funds other than supporting the centre.)

While all of these partnerships contribute to the overall connectedness of Pender Harbour Health Centre to its community, not all of them contribute to the strategic development of services in the same way. From a strategic perspective, the relationship with the Division of Family Practice and with the Health Authority is key, and yet not all key informants, including some board members, identified these partnerships during the interviews. Key informants mentioned that for two-way partnerships to work, there must be a common understanding, communication, respect and trust within the relationship and common clarity regarding the logic behind any initiative. This is especially the case for strategic partnerships.

With regards to how local partnerships impact the day-to-day delivery of services at Pender Harbour Health Centre, key informants were also asked about the formal or informal nature of the partnerships. Most recognized that the partnerships were not formalized except where contractual relationships existed. Other opinions indicated that the current landlord/tenant relationship was sufficient to support the current partnerships and that moving beyond that limited relationship could impact (restrict) the autonomy of the community-driven centre. A number of informants recognized that while current relationships are built on the historical trust that has developed from working together at the centre, as services at the centre expand and the centre becomes larger and systems within the centre become more complex, the qualities that have supported the partnership (e.g., trust) may be challenged as more staff from more programs become involved.

Comments/concerns regarding creating more formalized partnerships within the centre included:

1. Maintaining autonomy so that the centre can continue to mix public and private providers within the centre
2. How to ensure a common vision of the centre
3. How to set expectations regarding shared space

2. **Trust –**

As reflected in the partnerships discussion above, the issue of trust came up frequently in discussions and reflected two levels of concern:

1. Trust between staff/volunteers/professionals operating out of Pender Harbour Health Centre
2. Trust between strategic partners

Trust between staff/volunteers/ professionals at the centre was reportedly good with most staff feeling that they worked well together. However, two areas of challenge were noted in relations to information sharing and role clarity components of team-based care:

1. Information Sharing: There were challenges relating to exchange of information, which was sometimes perceived as 'one way.'
    a. For example, confidentiality concerns posed a barrier to confirming physician appointments, meaning that volunteer drivers could not confirm whether their services were needed to transport patients to the centre.
    b. For other professionals requesting lab work, etc., often the results would flow to the physician and the results weren't shared with the professional who originated the lab request.
2. Role Clarity: There were also concerns about professional roles. Staff indicated that some professional roles were not fully understood and thus the professional capacity of the worker was underutilized. Conversely, on occasion, services were replicated because one professional did not understand that another worker was already providing the service.

The informal partnership between the Division and the centre has resulted in a level of trust between the partners. This trust has had time to develop through the mutual planning efforts of the Division to address the A GP for ME and Patient Medical Home model and planning for services on the Sunshine Coast. The inclusion of the centre administrator in these discussions and the recognition/validation of the Pender Harbour Health Centre as a site for a pilot seniors' program that could potentially be replicated elsewhere on the Sunshine Coast have contributed to the trust relationship. On a more personal level, the interest of the Division executive director in the Pender model and the executive director's willingness to meet and discuss opportunities with the centre administration and Board have contributed to the development of trust relationships.

The relationship between the centre and the Health Authority involved additional layers of complexity, including:

1. ***Timeliness of communications and follow-through impacting the trust between partners.*** A number of key informants mentioned the nimbleness of the centre and how learning needs to take place to develop effective ways for the larger health system and the centre to interact. The centre has the advantage of working in a non-unionized environment and, in some cases, has discretionary funds. It can redeploy its assets quickly to respond to community needs. For the Health Authority, resources within the community are often tied to specific requirements. The difference between the two systems has been described as contributing to distrust.
2. ***Quality assurance concerns***. While the Pender Harbour Health Centre works to ensure that its services are of a quality consistent with the services provided by the greater health system, at present Pender Harbour Health Centre has not participated in a quality assurance process such as accreditation through the Ministry or from an independent accrediting organization. For the Health Authority manager responsible for Sunshine Coast services, this is a concern from a quality

assurance and risk management perspective. This can pose a trust barrier to strategic partnerships geared toward expanded services.

3. ***Union versus non-union environnent.*** At present services provided by Vancouver Coastal Health are unionized. Services provided by Pender Harbour Health Centre are non-union. While Health Authority staff currently rent office space at the Pender Harbour Health Centre in order to deliver local services, it would be very difficult for the Health Authority to decide to contract existing Health Authority services to the Pender Harbour Health Centre due to the nonunionized environment. This poses a barrier to discussion of expansion of the centre and contributes to some of the challenges between the two organizations.
4. ***Planning for Pender Harbour.*** At present there are separate planning processes for health services in Pender Harbour. The centre recently conducted an extensive community consultation process as well as a review of demographic information to develop a plan for services. Within a similar timeframe, the Health Authority also conducted a planning process for Pender Harbour as part of the larger planning for the Sunshine Coast. While Pender Harbour (the community) demographic information was included in both planning processes, the consultation information was not accessed in the Health Authority process. There would be significant benefit in sharing and exploring the alignment of these plans to leverage the strengths and perspectives of both organizations. Movement toward more integrated planning processes would be a positive sign of the development of trust within the partnership.

3. **The Key Role of the Administrator –**

The importance of the current centre administrator was identified by almost all key informants. The current administrator is unusual in health service administration because he comes from a business background, rather than from within the health system. The incumbent's background is in assisting struggling organizations and helping them to stabilize. This background reportedly has helped the incumbent to maintain a 'big picture' solution-focus perspective to administering the centre. Apparently this is new for the centre and has led to things like looking beyond the Ministry/Health Authority funding to support the centre.

While all of the parties indicated their strong support for the incumbent and the excellence of his work in preparing the centre for future expansion/development, there were concerns expressed regarding succession planning and what happens after the incumbent retires. The Pender Harbour Health Centre Board is currently identifying recruitment qualities that will support continuation of the centre's excellent management in preparation for that eventuality.

4. **Strong Board with Clear Separation of Governance and Operations –**

The Pender Harbour Health Centre Board is a strong board with clear governance, planning and funding focus. This is important as it focuses the Board members' energies and clearly separates Board governance and centre operations. While this is not the only model for successful Society operation, it clarifies the

roles of the administrator and the Board and stops the potential for board members to become involved in matters better left to administration (e.g. personnel matters).

The current centre administrator is the sole employee who reports to the Board and regularly keeps them updated on the centre operations, partnerships and issues. Operational issues are left to the administrator unless the administrator requests Board involvement/support. The Board's ability to take this 'hands off' approach to governance is due to their trust in their administration.

Beyond their clearly delineated role, the Board also has a very strong connection to community. Board members are community residents who were recruited for specific expertise that they bring to the Board. For example, health service expertise, human resources expertise, legal background, etc. Before a board member with a specific expertise retires, the Board recruits someone new with the needed expertise and supports an overlap period for the newcomer to orient themselves before the retiring board member leaves. This provides continuity.

In addition to the board conducting community consultation to support their decisions, the board members are community residents and are accessible to other community members. This means that community members will share feedback and ideas for new services with the Board as well as local staff members. This type of ongoing feedback flow allows the centre to adjust direction and services to best meet community needs.

5. Definition of Team –

In recent years, Team-Based Care (TBC) has received increased attention within the B.C. health system. On the Sunshine Coast, there are professionals who suggest that Pender Harbour Health Centre has been practicing TBC for the past 25 years. With the selection of the centre as a site to develop a model of TBC through the Division's PMH initiative, there is a unique opportunity to study team functioning and its development under this partnership model.

Feedback from centre patients indicated that they experience the centre as a team of professionals. Information from staff also indicated that the various professionals have found equilibrium in working together, however there were suggestions for improvement through formalization of what it means to be a team member, ensuring good communication and ensuring all team members are used to capacity so that the right professional provides the right service to the right patient. The benefits of the team approach to providing patient care were noted by health practitioners:

"There is a noticeable difference in practice between Pender Harbour Health Centre and [traditional practice in[13]] *Sechelt. Patients are less demanding in Pender Harbour. If I am worried about a patient, I can talk to the nurses down the hall regarding checks/supports for the patient and be confident that the checks will occur. Having staff living and working in the community is a benefit. In Sechelt, I can call home support for a patient I'm worried about and will find out on Monday morning that the visit/check never happened. As a result, there is less stress in Pender Harbour. In Sechelt there is more work and more*

[13] Added by the report writer for clarity.

administration (for doctors). The face-to-face work with other professionals in Pender Harbour is immediate."

"As a dentist I see all sorts of medically compromised patients who see the doctors on the other side of the building. I can go over with a release of information and obtain the medical information immediately. It is a very special situation. The centre is for the community, by the community."

At present the culture of a team approach has largely been driven by the Board and management. This has been adequate to serve the centre to this point. Informants suggested that furthering the TBC at the centre will require a clear articulation of a vision for a locally tailored Patient Medical Home model, including the team-based care services envisioned for Pender Harbour. Buy-in from strategic partners will then be critical to realize the implementation of this vision. They believe that implementation requires strategic partnerships/interconnection between the Patient Medical Home and the acute system to work together to meet patient needs.

Various key informants suggested that the future of Pender Harbour Health Centre should include more specialists delivering services at the site, and more hours of service at the centre from professionals like the chiropractor, the mental health practitioner, physiotherapist, etc. They also mentioned that the centre has some capacity to hire private service providers who could become part of the team. While an informal process of team development has worked in the past, comments suggested that in future this may not be sufficient as services expand and become more varied and complex. It was suggested that a process for ongoing team development needs to be established.

6. Communications Improvements –

Communication was identified as a critical enabler of the work of the centre, both to enable the team structure within the centre and to strengthen the strategic partnerships within the community. The case study process identified several areas for communications improvement. Within the centre these relate to communication between physicians and other team members like the nurse practitioner. For strategic partners, these include:

- Learning how to interact across organizations of significantly different size, structure and culture. For example, the centre's single layer of management and non-unionized environment mean potential quick response times, while the larger Health Authority requires longer response times to address requests for services/equipment.
- Working on mechanisms to facilitate information sharing regarding Pender Harbour Health Centre patients being released from hospital to home. By improving information sharing between the acute and community systems, there is an opportunity for the centre staff to connect with patients to provide support, and ultimately impact the patient's successful return home and reduce returns to acute care.
- Lack of common EMR system for the Pender Harbour Health Centre staff. While the centre physicians originally tried to establish an EMR that would also work for centre nurses so that a single patient medical record system could be established, barriers arose due to the EMR

provider. A unified system is still the goal of the centre in partnership with the Division. In the interim, the centre continues to operate with two record systems, one electronic and the other on paper. As was suggested by one professional, it would be good to establish a common EMR that would automatically highlight a patient as the number of issues begin to accumulate. In that way, actions could be planned together to support the patient.

- Finally, the potential for something like a Telehealth unit was also mentioned for the centre, given the challenges the area's geography places on residents when trying to access services.

7. Funding Challenges –

Historically, Pender Harbour Health Centre has had challenges obtaining core funding from sources outside of the community. This might be perceived as a deficit, but it has also forced the centre and its Board to seek other funding sources and to build/foster community support.

Both unionization issues and quality assurance issues will need to be explored and considered if the centre and Health Authority are to consider expanded service agreements. From an operations perspective, the centre has been creative in seeking funding from the Sunshine Coast Regional District and has had the support of the community to do so. This provides some maintenance and capital funding.

Just as important, the funding provided by the Pender Harbour Health Centre Auxiliary provides the centre with discretionary funding for new programs, staff training and other initiatives that help to meet the community's needs. The community's financial support for the centre allowed the centre to pay out the mortgage for its current facility as a result of the 'It's Ours' fundraising campaign. This ability to go to the community for financial support of important initiatives has allowed the Board to decide what should be implemented and then seek funding opportunities to implement new initiatives in stages as target fundraising goals are met. Not being wholly dependent upon external funding has allowed the centre to develop and implement creative projects and programs even when health system programs are being scaled back elsewhere.

8. Importance of Community –

Key informants almost unanimously mentioned the uniqueness of Pender Harbour in both its history and the character of its residents as impacting how services are developed and delivered. The community, while small, has a clear expectation that they will receive quality service in their community. This expectation is common across 'old time' residents and 'newcomers.' Informants felt that this requires providers to ask who is best to deliver THIS service to THIS community and not to base services and delivery on how they are currently provided.

At this point, informants indicated that the centre continually takes the pulse of the community through its staff and Board, and formally provides consultation opportunities. The community sets the direction for the centre and has a strong sense of ownership of the centre that has grown from

the original community advocacy for a centre, through the community's own implementation and ownership of the centre, to the recent fundraising that paid off the centre mortgage.

FOCUS GROUP RESULTS: ANALYSIS OF KEY INFORMANT INTERVIEW RESULTS–

The focus group of key informants took place on May 9,2018 at the Pender Harbour Music School. The themes (above) were presented and discussed. Further discussion considered what the partnership between Pender Harbour Health Centre and its strategic partners might look like, identified key lessons arising from the themes, identified barriers and enablers to that partnership, next steps needed to move forward, and lessons/messages for the province regarding Patient Medical Homes/Primary Care Networks or Team-Based Care. In addition, because the centre administrator was unable to attend the focus group, he provided his responses in writing. The results of both are included below.

Comments regarding the themes–

Overall, the participants were supportive of the themes identified by the consultant. Focus group participants were concerned about the potential loss of the centre's nimbleness and community ownership if it grows too quickly and if the centre becomes too involved in the health bureaucracy.

Beyond this concern, the focus group participants felt that the identified themes adequately captured their thoughts regarding the centre, its partnerships and operations.

Key Lessons arising from the themes–

The focus group participants identified the following key areas arising from the themes:

1. A lack of understanding regarding the Division of Family Practice and of the relationship between the Division and Pender Harbour Health Centre. At present, people have difficulty understanding the difference between the doctors as individuals and the Division and how they each work with the centre.
2. In order to address issues around clarity of roles and worker capacity there is a need for a process to get people out of their respective offices and talking with other professionals.
3. To explore models for accreditation, the centre could provide a pilot site.
4. To enhance team-based care, improved data/information sharing is critical to patient service.
5. Addressing barriers to virtual care/telehealth is critical. A model for Area "A" could provide a prototype for B.C.'s rural practice.
6. Retain the centre's capacity to be nimble in developing responses/changing directions as community's needs change.
7. The centre must retain its independent funding and community governance and ownership.
8. Strategic partnerships are critical and must continue to be developed.

Perspectives regarding a common understanding of a future partnership between Pender Harbour Health Centre, the Division of Family Practice and the Health Authority–

The focus group participants identified the following points of guidance for the development of a closer strategic partnership:

1. The partners will recognize the limitations attached to the funding of the various partners. Usually funding streams come with limitations/caveats attached that direct areas for funding. This is the case for all Pender Harbour Health Centre funding sources except for the funding through the Pender Harbour Health Centre Auxiliary, which allows the funds to be used as needed to support center operations/programs. This suggests that the partners need to work together to determine how available funding fits within envisioned services for the centre.
2. Communication must be improved. Communication between partners needs to be more timely and clear. There needs to be critical work done regarding sharing of information. This includes development of a common EMR system as well as addressing confidentiality barriers that detract from patient care.
3. The partners will share the completed Pender Harbour Health Centre needs assessment and the identified specific needs, so that the information becomes part of the Health Authority planning for the Sunshine Coast. This was viewed as having potential to impact how the Health Authority delivers services in Pender Harbour. The needs assessment must be specific and focused on Pender Harbour issues that impact service, such as the limited transportation and the challenges involved when staff serving the community must commute to the community.
4. The strategic partners will work together to identify common quality assurance expectations across the centre, VCH and the Division to address the current barriers to partnership.
5. The partners will consider Pender Harbour Health Centre as a 'strategic incubator' for developing innovation in service delivery and communications (both strategic and operational). Part of this may be exploring how Pender Harbour Health Centre can be positioned to improve efficiencies for both the Health Authority and the Division of Family Practice. For example, in reducing acute emergency room visits or reducing physician administration to allow more patient time.
6. The partners will explore areas/options that may be non-traditional and/or 'uncomfortable' in order to work together to address barriers.
7. The partners will recognize the importance of the organic development of services to address community needs and seek options for models to meet those needs[14].
8. The partners will work together with the lens of service delivery in a rural/isolated community.

[14] Note that this would include recognizing the broader health and wellness mandate of community health centres and will require development of services based on patient-focused, Team-Based Care built upon understanding of the services needed and who is best to deliver the service.

9. The partners recognize that as Pender Harbour Health Centre develops, and given the primary care and health promotion efforts of the centre, over time other representatives may need to be added to the partnership table.

In addition to the perspectives of the focus group participants, the vision for the future of the centre is for it to continue to increase its capacity and expand services to include as many community primary care services/urgent care services up to those requiring an emergency room visit. This will provide an opportunity to address issues identified in the needs assessment around seniors' aging and care needs as well as increased community wellness programs based on the social determinants of health. The centre does not need to deliver the services but should be an enabler to the delivery in the community.

During the meeting the focus group also identified barriers and enablers toward achieving strategic partnerships as well as next steps to take forward their local strategic partnerships. In addition, two points were identified that required Provincial and/or Ministry action. (For the complete list of barriers and enablers as well as next steps, see Appendix F.) These two provincial/Ministry areas were:

- Establish the quality assurance requirements for community health centres – Given that Pender Harbour Health Centre faces the question of quality assurance, it is likely that other CHCs face similar concerns from their Health Authorities. It therefore makes sense that a common approach to quality assurance be established by the province, and
- Clarify how CHCs fit within the Ministry's primary care model including what services are required to effectively deliver community-based primary care. CHCs could then assess their services within the context of their community to ensure basic needs are met.

Key Lessons for Pender Harbour and Other Jurisdictions:

The following section provides the consultant's synthesis of the information received during this case study and the key lessons that may be of interest to the GPSC, the Ministry, Community Health Centres (CHCs), Divisions of Family Practice and Health Authorities working with CHCs in their jurisdiction. These observations and lessons are drawn from a unique CHC serving a unique rural community with issues such as isolation and a significantly skewed demographic population. Other communities may not have such a confluence of factors impacting their operations. In addition, this section references how the centre contributes to the Patient Medical Home and Primary Care Network on the Sunshine Coast. This section is set out under Overarching Observations and eight headings identified as areas of particular importance.

Overarching Observation:

The Sunshine Coast community is an exemplar of a community approach to integrating Patient Medical Home (PMH) and CHCs while laying the groundwork for a Primary Care Network. The centre compliments the PMH model by supporting a broader range of services and providers to meet the unique needs of the rural community.

The PMH model is intended to enable patients to access quality primary health care within a broader, integrated system of primary and community care. The goals of PMH include: (Prepared for General Practice Services Committee, 2017)

- Increase patient access to appropriate, comprehensive, quality primary health care for each community.
- Improve support for patients, particularly vulnerable patients, through enhanced and simplified linkages between providers.
- Contribute to a more effective, efficient and sustainable health care system that will increase capacity and meet future patient needs.
- Retain and attract family doctors and teams working with them in healthy and vibrant work environments.

The Primary Care Network (PCN) is defined as a network of PMHs linked with primary care services, community-based social and other health services delivered or contracted by a health authority and community-based social and other health service organizations. In most instances a person's primary care needs will be met by their PMH, though some aspects may be provided within the network. (Ministry of Health, 2017)

The centre's development of extensive home-based care and support of volunteer-based services contributes to this system of care, particularly in the context of transportation challenges and the resistance to care of many isolated seniors. The centre supports programs such as the Better at Home program, the Cardiac Care/Happy Heart Program, and Harbourside Friendships, and has developed strong linkages between providers, volunteer organizations, and prevention/wellness organizations (e.g. the local aquatic centre) all of which support vulnerable patients.

The centre's developing strategic partnership with the Division and its working relationship with a major clinic have led to the centre making financial, space and working commitments in order to attract and retain physicians. As one physician who serves Pender Harbour noted, physician practice is different in the Pender Harbour Health Clinic, freeing doctors from some administrative tasks, facilitating and speeding up things like lab work, and allowing the development of linkages with other professions. As a result, physicians report less stress working in Pender Harbour Health Centre than in a general medical clinic.

The centre not only directly provides primary health care services, it provides a local site for physicians and other health professionals to operate in a single location towards offering comprehensive primary health care, prevention, and wellness services. Given the large seniors population in Pender Harbour, coupled with the remoteness of Pender Harbour bringing professionals into the community under this co-located team-based care model makes sense to ensure service accessibility. The current Seniors Nurse Practitioner pilot with the Division demonstrates the capacity of the partnership to provide services to vulnerable populations consistent with the PMH and PCN goals.

With regards to the centre's contribution to the broader Primary Care Network, the centre is connected to the Health Authority through its contracted services, and by providing space for practitioners from outside Pender Harbour to provide service in that community. Examples include the Public Health Nurse as well as visiting mental health specialists. The centre has the capacity to provide more linkages like this. As well, its plans for the new space to be constructed on a neighbouring plot of land increase this capacity and the capacity to support initiatives that address broader social determinants of health such as housing, poverty and isolation.

Key Lessons for Pender Harbour and Other Jurisdictions:

1. ***Strategic Partnerships***

The development of strategic partnerships has been spotty over the existence of the Pender Harbour Health Centre. Relationships with the Health Authority were contractual in nature and the working relationship with the Division of Family Practice has only developed since the A GP for ME initiative when the centre administrator became part of the working group. The working relationship that has developed between the Division executive director and the centre administrator has led to a level of trust where the Division and the centre have jointly developed plans for a senior's nurse practitioner. The expectation was that the doctors' medical office assistant would support this new position and this was a resource issue. Through strategic partnership with the centre, the position will be on the physicians' EMR system, but Pender Harbour Health Centre has privately funded medical office assistant support as well as provided space for the nurse practitioner. This is an example of the type of innovation/experimentation that can occur through strategic partnership.

The partnership of the centre and Division with the Health Authority involves additional layers of complexity, with less frequent contact and trust developed among the three key parties. At present, while

the Health Authority plans for Pender Harbour, it has not included Pender Harbour Health Centre in its planning.

The Health Authority, the centre and the Division all recognize these challenges and the need to address them. However, the development of a true strategic partnership requires trust which will require ongoing development. To enable this process the expectations of the partners and how their various systems/cultures and organizations should work together all require clarification in areas like:

- improvements in, and timeliness of, communication,
- addressing quality assurance/risk management concerns,
- roles of the partners, and
- how CHCs and Health Authorities are to relate to each other.

The commitment of the strategic partners to meet around issues like quality assurance, and the Health Authority's interest in accessing the centre's recent community needs assessment to support Health Authority planning bode well for the ongoing development of partnerships.

What does this mean?

The developing working relationship between the Division and the Pender Harbour Health Centre provides a good example of the creativity and synergy that can occur when Divisions and CHCs understand and align their planning. This is a model that other CHCs and Divisions may wish to explore together.

To facilitate partnership development and synergy between Divisions, Health Authorities and CHCs, the Ministry and GPSC may wish to provide a policy framework regarding the system roles and how systems can work together.

Specific to Pender Harbour, the three strategic partners should track the development of their partnership, both to foster joint accountability for their partnership, and to document what works and what does not work.

2. *Team Building/Capacity Building*

Consistent with the PMH, PCN, and Team-based Care initiatives, the Pender Harbour Health Centre has provided an environment that brings together a variety of health care practitioners. More recently, the centre was selected as a site to develop a model of TBC through the Division's PMH initiative. Over time, as the professionals have worked together, and as the Board and administrator supported it, a sense of team work has developed between the various practitioners. Physicians experienced the benefit of the centre model as the ability to directly refer to home support and know that the support would be provided. Nurses mentioned the ability to immediately call in a physician when a patient required more emergent assessment or treatment. The dentist identified the benefit of being able to obtain lab tests or medical records quickly on site. That said, the arrangements within the centre are primarily those of

landlord and tenant and nothing specifically sets expectations regarding how professionals are to work as a team.

According to centre staff, there may be room to improve the utilization of the skills brought by some of the centre's professionals. They suggested that physicians may not fully understand the capacity of some of the other professionals operating from the centre, leading to under-utilization of some professionals and, in some cases, service overlap by physicians. At present the centre does not offer regular cross-professional team meetings. Communications within the team has also been identified as having challenges and while the Board and management support team work, this does not form part of the centre's mission or vision statement.

With the envisioned growth of the Pender Harbour Health Centre, retaining and enhancing a team atmosphere could become more challenging. How to retain and build the teams at the centre will depend upon the support of the Board, management and the various professionals working from the site. Literature regarding multi-service teams[15] suggests the following characteristics of a good interdisciplinary team: (Nancarrow, 2013)

Characteristic	Description
1. Leadership and management	Having a clear leader of the team, with a clear direction and management; democratic; shared power; support/supervision; personal development aligned with management; leader who acts and listens.
2. Communication	Individuals with communication skills; ensuring that there are appropriate systems in place to promote communications within the team.
3. Personal rewards, training and development	Learning, training and development; training and career development opportunities; incorporates individual rewards and opportunities, moral and motivation.
4. Appropriate resources and procedures	Structures like team meetings, organizational factors, team members working from same location; ensuring appropriate procedures are in place to uphold the vision of the service (for example communications systems, referral criteria defined, etc.).
5. Appropriate skill mix	Appropriate skills, competencies, practitioner mix, balance of personalities, ability to make the most of each member's background; having a full complement of staff; timely replacement/cover for empty positions.
6. Climate	Team culture of trust, valuing contributions, nurturing consensus; need to create an interprofessional atmosphere.
7. Individual characteristics	Knowledge, experience, initiative, knowing strengths and weaknesses, listening skills, reflexive practice; desire to work on same goals.
8. Clarity of vision	Having a clear set of values that drive the direction of the service and the care provided. Portraying a uniform and consistent external image.
9. Quality and outcomes of care	Patient-centred focus, outcomes and satisfaction, encouraging feedback, capturing and recording evidence of the effectiveness of care and using that as part of a feedback cycle to improve care.
10. Respecting and understanding roles	Sharing power; joint working; autonomy.

[15] Based on systematic review of the literature on interdisciplinary team work, and the perceptions of over 253 staff from 11 community rehabilitation and intermediate care teams in the UK.

While the Pender Harbour Health Centre appears to embody many of these characteristics, there appears to be room to improve clarity of roles and resources and procedures that support team work. In addition, the Board/administrator may wish to further articulate the vision of the team beyond the current co-location of separate services and identify a process for evaluation of the Team-based Care model.

What does this mean?

Pender Harbour Health Centre may wish to consider evaluating their teamwork structure against specific criteria and providing opportunities for professionals to further bond as a team. They may also wish to align their team-based care with criteria being established in the province for evaluation purposes. This could provide useful information to the GPSC, the Ministry, other CHCs and the BC Association of Community Health Centres.

Furthering the TBC at the centre requires better definition of the Patient Medical Home model and TBC services envisioned for Pender Harbour, and then buy-in from strategic partners to implement services. Implementation requires strategic partnerships/interconnection between the Patient Medical Home and the acute system to work together to meet patient needs.

3. *Community Context/Uniqueness*

Perhaps the most fundamental observation of the case study is how the centre was established over forty years ago by a community that experienced a sustained need for health care services. They created a society to fill that need. In British Columbia communities have rallied behind their hospitals when threatened with closure. For Pender Harbour, the 1964 closure of the hospital and the resulting dearth of health services due to geographic isolation led to community action.

The form that action took is reportedly a direct reflection of the types of people who lived in Area “A” of the Sunshine Coast, namely, people who were independent and self-sufficient. They not only took action to advocate to the government, but also assumed responsibility to support their health care centre, creating a strong sense of community ownership.

This community governance/ownership is a key quality of CHCs but Pender Harbour goes beyond having a community board and would appear to exemplify this fundamentally. Community ownership impacts the community interest and involvement in planning for services in directly providing feedback and suggestions regarding services, and significantly fosters the community’s willingness to support the centre financially—including rallying around the centre during tough times and paying off the mortgage on the centre. All of this contributes to the relevance of the centre to the community so that today, even while the community experiences a shift in demographics as more newcomers move to the Pender Harbour area, the Pender Harbour Health Center remains one of the top points of pride in the community.

What does this mean?

The strong, grassroots bond between the community and the centre has led to strong volunteerism and community funding to support the Centre's services.

Patient and community engagement is at the core of the CHC model of governance and operations. As PMHs and PCNs develop strategies for patient engagement, the GPSC and the Ministry may wish to look to CHCs for insights and best practices.

Community engagement in Pender Harbour suggests that the centre might have key lessons for other CHCs and for the Ministry when they are examining whether a CHC has true community support and involvement. This information may also be of use to Divisions of Family Practice and Health Regions in developing Patient Medical Home/Primary Care Network and Team-Based Care models that are closely connected to the community.

4. *Nimbleness/Independence and Funding*

Pender Harbour Health Centre has been described as nimble in its ability to respond to community needs and the needs of its strategic partners. That nimbleness is the result of not only a mindset of responsiveness, but also of the willingness of the Pender Harbour Health Centre to seek diverse funding sources. This, along with the unique history of the centre and the community, have contributed to the Board's and management's mindset of independence.

Direct community funding (through fundraising campaigns) and fundraising/donations through the Pender Harbour Health Centre Auxiliary have raised significant funds (up to $80,000 from the auxiliary alone) that provide the centre with resources to support staff training and program development, and address capital costs like paying off the centre mortgage. The ability to support staff training allows the centre staff to be kept current or to learn new skills. The ability to support new programs means that the centre does not have to wait for external sources to find and approve funding in order to address emerging community needs. Community residents are able to see the direct results of their giving in what is available in the community, presumably contributing to the community sense of ownership and pride.

Lastly, community funding is also a resource that has helped to ensure that the centre has continued to operate, even during times of extreme financial duress when program funding has otherwise been reduced.

It is interesting to note that while Pender Harbour has seen an influx of more wealthy individuals over the past few years, the area still has a large population of low and middle-income earners and fixed income retirees. While large donors have assisted with the fundraising campaigns, low and middle-income earners consistently support the centre auxiliary fundraising.

What does this mean?

Partial independence from government funding appears to facilitate the CHC's ability to respond to community needs in a timely fashion. This supports the importance of community ownership and suggests that CHCs should develop fundraising capacity in partnership with their community.

CHCs operate and are embedded in communities in specific ways. The GPSC and Ministry may wish to consider the implications for how CHCs, PMHs, PCNs and other Health Authority services fit together to satisfy local patient needs in sustainable ways.

Divisions of Family Practice and Primary Care Networks may wish to engage CHCs as a means to quickly respond to community needs, recognizing their ability to bring resources to the table.

Community health centres should examine how to foster community ownership and develop fundraising capacity in partnership with their community.

The Ministry and the BC Association of Community Health Centres may wish to support CHC development of fundraising skills.

5. *Board Strength and Focus*

The Pender Harbour Health Centre Board has had 42 years to mature into the strong community Board of Directors that it is today. Critical to that strength is the governance focus on planning/policy setting, funding/finance and supporting their administrator employee. Also critical is the fact that Board members are also community members and users of the centre services. The Board leaves management of the centre to the administrator, but ensures that they have an administrator with the necessary qualities to develop the centre as envisioned by the community Board. The Board collects community input on an ongoing basis, but also supports more formal consultation processes.

The Board itself is strategic in its thinking, both in terms of its planning for the centre and for its own future. The Board recruits for specific skills on the Board and ensures overlap to orient new members to the organization, the Board and the issues. This ensures that the centre Board is always well-positioned to address issues and to support the centre as required.

What does this mean?

The strong governance focus of the board provides an example of board structure that could be a model for other, less well-established CHCs. Such a well-functioning board that supports a strong organization will be more attractive to Health Authorities and Divisions of Family Practice in developing strategic partnerships.

6. *Administrator Qualities*

The current Pender Harbour Health Centre administrator comes with a business background focused on revitalizing struggling organizations. As the current incumbent said, he comes with a focus on finding a way to get to 'yes.' His strategic focus has allowed the centre to build new partnerships, stabilize physician retention, and address barriers to service such as using non-traditional providers to obtain medical equipment. This ability to look beyond traditional ways of doing business has apparently brought results that have energized the centre and facilitated its partnership with the Division. The strategic focus has

also contributed to the creation of the BC Association of Community Health Centres, which has opened dialogue with the Ministry.

What does this mean?

While the Pender Harbour Health Centre Board may not recruit for the same qualities as the incumbent administrator upon his retirement, the success of the current administrator suggests that CHCs could benefit from recruiting individuals with strong strategic business skills in addition to health care experience.

7. *Quality Assurance*

Quality assurance was identified by the Health Authority as a barrier to strategic partnership with the Pender Harbour Health Centre. While the centre endeavours to have its staff trained to the same standards as those provided by the Health Authority and to provide the same/similar levels of care, how to demonstrate this within the Health Authority system remains unclear. As a result, risk management and quality of care questions remain unanswered, impacting the centre's ability to expand their services.

While this case study's focus group discussion indicated that the local partners are prepared to work toward addressing the challenge, the issue would seem to be applicable to all CHCs.

What does this mean?

In order to ensure consistency across CHCs and Health Authorities, the Ministry may wish to provide guidance as to how CHCs are to address quality assurance concerns/standards. The matter has been raised with the Ministry. This could include accreditation, or a made-in-BC set of criteria to which CHCs must adhere.

In the interim, the strategic partners on the Sunshine Coast may wish to determine a means to address this barrier until such time as Ministry directions are forthcoming.

8. *Confidentiality/Technology/Electronic Medical Records (EMR)*

At present, while key informants indicated that a single EMR system would improve patient planning and care, the Pender Harbour Health Centre currently has two patient record systems in place. Physicians currently use the EMR provided by Sechelt Medical Clinic. Nurses at the centre operate with a paper system. Visiting practitioners like the women's health nurse practitioner operate on a separate EMR operated for the Health Authority. This redundancy of systems results in replication of effort as well as increased chances of critical information not being shared between the professions.

In the past, the Division and the centre attempted to introduce a single EMR for the centre, but changes introduced by the EMR provider and limitations in their internet service to rural areas made the project unviable as well as making technological initiatives such as Telehealth unavailable. The planned seniors' nurse practitioner will be introduced on the same EMR as the physicians as part of the pilot, with the centre assuming responsibility for providing space and medical office assistant support.

Confidentiality continues to be an issue for the centre, both internally (e.g., sharing confirmed appointment information with volunteer drivers) and externally (e.g., the centre does not receive information about its patients who have entered the hospital, and does not receive information on their release).

What does this mean?

The Pender Harbour strategic partners may wish to work together to address the confidentiality barriers/challenges.

The GPSC, Ministry, Divisions of Family Practice and CHCs may wish to follow the results of the pilot EMR program for potential spread to other communities and work together to address barriers to rural/remote services.

Conclusions:

The Pender Harbour Health Centre is a unique, community-owned provider of health services that grew out of the need for health services after the closure of a hospital in the remote community of Pender Harbour. The community worked for ten years to gain government support for the venture and fundraised locally to employ physicians and develop the services it perceived were needed in the community. This has led to a community health centre that is nimble and able to quickly respond to community needs beyond services funded by government and Health Authorities.

While the centre has worked alone to develop services in the past, it is interested and well positioned to develop partnerships that will improve local services. This has led to partnerships with a variety of local volunteer organizations. Over the past ten years, the centre has developed closer ties with the Division of Family Practice as a result of provincial initiatives that encouraged the Division to include the centre in its planning processes. Over the past ten years, a level of trust and respect have developed so that at present the centre has been selected by the Division and centre as a pilot site for seniors' initiatives.

The relationship with the Health Authority is not as well developed, but they are working together to address logistical matters. The Health Authority expresses quality assurance concerns in expanding centre services, while the centre does not want to lose its autonomy and nimbleness through increased involvement in government/Health Authority bureaucracy. Both parties have expressed interest in overcoming these barriers and in developing a strategic partnership with the Division. The recent focus group for this case study was described as a starting place for furthering this relationship.

The centre offers a unique space that draws health providers into the community to deliver service. Space availability allows the various health professionals to practice, and the opportunity for a team approach to wellness and health care to evolve. This suggests that the centre compliments PMH by facilitating PMH services and providing access to services beyond traditional health care. While staff noted areas where teamwork could be improved, patients of the centre viewed the current arrangements as working. While the current arrangements appear to work, there is concern that with growth, the team approach may suffer. For that reason, the centre may wish to examine the list of characteristics of multiservice teams and/or Team-based Care criteria developed in B.C. to determine actions that might strengthen the team environment as growth occurs.

Beyond this, there are a number of key lessons outlined in the report that may be helpful to other community health centres, to GPSC, to Divisions of Family Practice who are considering partnering with a community health centre, to Health Authorities examining partnerships with a community health centre and for the Ministry.

In finalizing this report the case study consultant became aware that the Ministry and BC Association of Community Health Centres are already working together to address a number of the previously mentioned challenges, and to develop a Ministry CHC policy specific to community-governed CHCs.

Appendix A

Detailed History of Pender Harbour

This section sets out key historical information about the community and the Centre.

Pender Harbour and environs (Electoral Area "A"—1091sq.km.) of the Sunshine Coast Regional District is a rural area of small and remote communities strung (on the west) between the Malaspina Strait coastline (including Nelson and Hardy Islands)and the Sunshine Coast Highway, northward to the communities of Earl's Cove and Egmont and continuing up the Jervis Inlet, eastward to follow the Caren Mountain Range southward to just north of Halfmoon Bay. Pender Harbour itself is made up of the Francis Peninsula, Garden Bay, Irvine's Landing and Madeira Park communities and the numerous housing developments that are appearing in the area.

Historically, Pender Harbour area was the winter capital of the Shishalh First Nation with Catholic missionaries arriving in 1859. (Bigpacific.com)Gradually groups of non-natives moved into the area, including those of Chinese, Japanese, German, Portuguese and British origins. Fisheries, oyster farming and farming became prevalent and the area became popular with the yachting set. Various writers, artists and 'characters' settled in the area. Logging began as early as the 1870s. (Bigpacific.com) This history of self-sufficient individualism continues today as the core of Pender Harbour.

"What you see isn't what you get with Pender Harbour. It looks like a little village, but it used to be a community with a vibrant fishing and lumber industry. People ran their own businesses and had a 'get out of my way and I will do it' attitude. People are deeply independent. They have the ability to look into the future and see what is needed." (Bonderud, 2018)

In the early part of the 20th century, health care was only available from a physician who had lost his license due to malpractice. Dependence on this type of care continued until after the First World War. Anglican minister Reverend Alan Greene of the Columbia Coast Hospital organized the building of the Garden Bay Hospital (St. Mary's), that officially opened in August, 1930.(Bigpacific.com)

During the time of St. Mary's Hospital, people from the surrounding area were brought down by boat for medical care because land transportation did not exist. The hospital was busy and when space could not be found in the hospital, people stayed in, and were treated in, boats moored along the shoreline. (Bonderud, 2018) The hospital served the Pender Harbour area well, because of the challenge of accessing any other source of health care.

In 1964, St. Mary's Hospital was closed due to the opening of the then-new Sechelt Hospital in Sechelt.(Archives of the Anglican Diocese of New Westminster and the Provincial Synod of BC and Yukon, 2009) At the time, the population of Pender Harbour asked for assurances from the Social Credit Government that they would have a health centre in the community. Over 1,800 letters, reports and briefs supported the need for such a centre, documenting issues such as the limited physician time in the community (afternoons two days a week in a makeshift clinic) and a two-and-a-half-hour ambulance

response time for ambulances to arrive in Pender Harbour and take the patient back to Sechelt over 19 miles and 45 blind corners (in one 11-mile stretch.)(Tyner, 1977)

From 1968, the Pender Harbour and District Ratepayers Association, amongst others, urged the Social Credit Minister of Health to establish a properly equipped medical clinic in Pender Harbour. In 1971, at a Special General Meeting of the Ratepayers Association with over 300 members in attendance, the Minister indicated that "he would do everything in his power to see that Pender Harbour got a medical clinic."However, in 1972, newspaper articles indicated that the Minister said that there was no intention of establishing a government doctor and clinic, and indicated that such a clinic would be entirely at the discretion of the doctor. ((Tyner, 1977)

The community reacted to what was seen as a broken promise and in 1973 a new NDP government Health Minister approved the funding of equipment for a centre that would be constructed using funds raised by the local Ratepayer's Association. After further negotiations, a referendum was held within the Sunshine Coast Regional District for approval to borrow $127,000of a total $227,000 required to construct the centre, with the Government of B.C. contributing the balance of $100,000. The referendum passed with a majority in excess of 91%. (Tyner, 1977)

Appendix B

Current Pender Harbour Health Centre community partners include:

- Harbourside Friendships –The longest running program (started 1990), it provides a safe, secure environment for seniors to connect to other seniors and develop support friendships.
- Women's Wellness Program – In partnership with the Health Authority, the program provides a nurse practitioner as an alternative to women having to access a physician. The program began when only male doctors were available in Pender Harbour. The centre provides space and equipment.
- A Youth Clinic –Offered in conjunction with the Health Authority, the clinic provides health services to young people both at the health clinic and at the local high school.
- Pender Harbour Seniors' Initiative – Offers services to isolated seniors from Middle Point to Egmont through provision of outings, exercise programs and information sessions.
- Better at Home Program – Focused on supporting seniors and funded by the United Way, this program is supported through space access at the centre and through close coordination of the program coordinator and nurses at the centre.
- Pender Harbour Community Garden – Planted on the centre site, the garden provides space for neighbours to come together, socialize and grow healthy food.
- Palliative support – Uses trained volunteers to support patients and families, while home care nurses provide daily and call-out support.
- Bereavement Support – Started by a centre nurse, the eight-week program provides information, as well as support and opportunities to meet together.
- Cardiac Care/Happy Hearts program – Started as a partnership between Elder College, the centre and the Aquatic and Fitness Centre, the program focuses on managing stress and having a healthy heart through diet and exercise. Nursing support is provided as needed.
- Chronic Pain Self-Management Program – Four facilitators are trained in the University of Victoria aging program on pain self-management.

Appendix C

Pender Harbor Health Centre Case Study

Key Informant Questions

1. **Introduction:**
   a. Tell me about the PHHC, how it delivers primary health care and how it is connected to the general health system on the Coast.

2. **Partnerships:**
   a. Who are the PHHC's key partners and how were the PHHC partnerships established?
   b. Are these formalized partnerships?
   c. Tell me about the function of the partnerships? How do they work together?
   d. What supports the partnership continuation?
   e. For the sunshine coast to work towards TBC, what partnerships will be needed?
   f. Are there partnerships that need further development? How and why? Why not in place now? Are there challenges/barriers?

3. **Governance:**
   a. What is the governance structure for the PHHC and how does it function in light of the partnerships?
   b. How are governance and partnerships connected, or what is the relationship between the partners and the governance structure?

4. **Administration:**
   a. Tell me about the funding process for PHHC and how that supports or challenges PHHC operations? How do funding processes affect PHHC partnerships and the development/implementation of team-based care?
   b. Tell me about the planning processes for the PHHC and how that supports or challenges PHHC operations? How do current partnerships affect planning processes and the development/implementation of team-based care?
   c. How is the PHHC administered internally? E.g., who employs staff? Who manages budget?
   d. How is the PHHC administered externally? E.g., relationships with funders? Determining directions? How that supports or challenges PHHC operations?
   e. How important to the PHHC is the common EMS system on the Coast? Why? How did it come to be?
   f. How does staffing/recruitment for the centre and coordination between professions work? What are the challenges and how have you overcome them?
   g. How are service needs identified and addressed/developed at the PHHC?

5. **Service Delivery:**
    a. What are the patient intake and management processes that support a team approach? How do people learn about, enter and move through services (including newcomers to the community). How does that work for seniors or for children and youth?
    b. How does the PHHC coordinate with other care providers on the coast?
    c. How are the PHHC and the Division of Family Practice working together? E.g., how many patients seen? Issues? How do patients view services?
    d. The Patient Medical Home speaks of 'contributing to more effective, efficient and sustainable health care that increases capacity and meet future patient needs.' How does the PHHC contribute to this and how might it enhance this in future?
    e. How did, or did, the PHHC develop a team approach within the PHHC and how does it maintain that culture (or how can it enhance the culture to advance team-based culture)?
    f. What services are delivered at the PHHC and what is the vision for the future? Are there particular areas of concern? Are there partnerships/relationships that would support addressing those concern areas?

Follow-up:

a. Is there process data that provides a sense of PHHC function (e.g., client or staff satisfaction surveys?)
b. Are there any literature reviews/articles re: the PHHC or CHCs that they suggest I review?
c. Are there particular community members that I should speak to re the PHHC's place and function in the community?
d. Are there particular physicians/staff/volunteers who I should speak in the PHHC?
e. Are there particular patients/clients who I should speak to about their experience?
f. Are there particular areas that you think I should explore with clients/staff/ partners during interviews/focus groups?
g. Is there anything further that you would like to tell me that I haven't already covered?

Appendix D

Pender Harbor Health Centre Case Study

Patient Questions

6. **Introduction:**

a. Tell me about the PHHC, how it delivers primary health care.
How is it connected to:
   - Pender Harbour
   - the general health system on the Coast.

b. How are services planned for PHHC?

7. Service Delivery:

a. How do people learn about, enter and move through services (including newcomers to the community). How does that work for seniors or for children and youth?

b. What services have you received at PHHC? Have you been referred to other programs? Have there been challenges/issues? When you have had challenges/issues, how have you addressed them?

c. The PHHC tries to deliver services as a team. Can you tell me about experiences that demonstrate this?

d. How has the PHHC served the community? Have there been challenges/issues? How were they addressed?

e. Tell me about community feelings toward PHHC? To recent planning consultation?

f. What is your vision for the future? Are there particular areas of concern? Are there partnerships/relationships that would support addressing those concern areas?

g. Do you have doctor at PHHC? How is moving back and forth between the doctor and other professions? Do the different professions seem to share enough information? How often do you need to tell your story again?

h. What is the most significant help you have received from your dealing with PHHC?

Appendix E

Literature Review

Identification of evidence-based clinical best practices for community health centres is dependent upon the area of clinical services provided, e.g., obesity reduction, tobacco cessation, addictions/mental health services, adolescent reproductive health, physician primary care, etc. Guidance for community health centres overarching operations are apparently suggested by provincial and national organizations; however, this consultant was unable to find this type of documented guidance through B.C. Canadian or American websites.

Definition of Community Health Centre and Core Criteria:

Community Health Centres (CHC) in various forms exist in many parts of the world, from the United Kingdom to Portugal to China to the United States and Canada. (Wikipedia, 2018) In Canada, the first CHC was established in Winnipeg in 1926. (Canadian Association of Community Health Centres) This has been followed by the development of CHCs in all Canadian provinces and territories. (Canadian Association of Community Health Centres) The Canadian Association of Community Health Centres provides the following 2016 definition of CHCs in Canada:

A Community Health Centre is any not-for-profit organization, co-operative, or government agency which adheres to all five of the following domains: (Canadian Association of Community Health Centres)

1. **Provides team-based, interprofessional primary care** – Teams of providers including physicians, nurses, dentists, dieticians, social workers, nurse practitioners, therapists and others provide team-based services based on patient needs.
2. **Integrates services of primary care, health promotion and community wellbeing**–CHCs integrate primary health care with health promotion, illness prevention and community health initiatives.
3. **Community Centred** –CHCs focus on services needed specifically by their community and engage the community in determination of priorities and strategies for services.
4. **Actively addresses social determinants of health** – The CHC actively supports individuals, families and the community to address social determinants of health such as poverty, isolation, housing, etc.
5. **Demonstrates commitment to health equity and social justice** – CHCs recognize that health status varies between populations because of social and institutional inequities. CHCs work to address these inequities and to ensure 'fair and compassionate access to the fruits of economic growth.'

This suggests that these are core criteria to be assessed in examining a Community Health Centre.

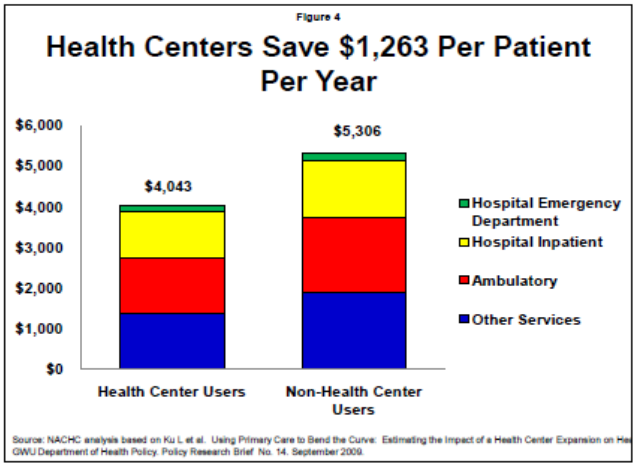
Documented Outcomes/Benefits of CHCs:

Cost benefit analysis conducted in the United States has identified that CHCs provide a cost-effective means of serving patients. The following provides their assessment of savings per patient for locations of medical care and comparison of CHC vs. non-CHC costs. (National Association of Community Health Centers, 2011)

Average Cost Per Patient Per Day

1. Hospital Inpatient	$41.36
2. Hospital Outpatient	$7.59
3. Emergency Room	$3.64
4. All Physician Settings	$2.64
5. Health Center	***$1.67***

Source: 1-4: Agency for Healthcare Research and Quality. Medical Expenditure Survey Summary Tables, 2008. Available at http://meps.ahrq.gov. 5: Bureau of Primary Health Care, Health Resources and Services Administration, DHHS. 2009 Uniform Data. System



This supports the value of CHCs in the American model. American CHCs were also reported to be more likely to accept new patients; provide more evening and weekend hours; offer more dental, behavioural health and pharmaceutical services; provide care for uninsured patients; serve more chronically ill; and offer more services with translation services, than were non-CHC primary providers.(National Association of Community Health Centers, 2011) This additional list also is suggestive of aspects to consider when examining a model for CHCs.

Structure and Governance:

Finally, areas identified as particularly important to CHC organizational success included: (National Association of Community Health Centers, 2011)

- Local ownership and direction under a patient-majority board
- Location in high need areas that otherwise have limited access to physicians
- Provision of a comprehensive array of services based on the community's needs
- Regular and rigorous community needs assessments
- Exemplification of the Patient Medical Home model where patients can receive preventative and primary care, make sense of their condition, and be coached on making behavioural changes to improve their overall health. When patients have a Patient Medical Home, they are more likely to manage their medical conditions and prevent new ones from occurring.

The themes, patient perspectives and focus group information provided below will illuminate how Pender Harbour Health Centre has addressed or is seen to address these various suggested practices.

Appendix F

Details of Focus Group Analysis:

Barriers and Enablers of Strategic Partnership and Next Steps

Barriers and enablers to achieving the strategic partnership–

Barriers –

1. Funding – At this point there is limited sustainable operational funding to support partners planning expanded services. The limitations/caveats attached to funding also hamper coherent service development and force a focus on opportunism, e.g., focusing on developing certain services because funds are available rather than because the service it the greatest priority.
2. Demographics – The demographics of the area indicate the largest growth in population is in the over 60 age categories. This increase in population puts significant pressure on existing services, while the population becomes less mobile and thus less able to transport themselves to larger centres for services. At the same time, while the pressure for more seniors services takes the majority of focus, the community has young single mothers with young children who also require services.
3. The EMR requirements – The speed of internet services in Area "A" is a barrier to the implementation of EMR, to day-to-day communication between nurses and doctors, and to the implementation of virtual care. The current provider (TELUS) must be worked with to improve these services.
4. Transportation continues to be an issue both between Pender Harbour and its larger neighbour to the south, and within the various smaller communities within Area "A" (i.e., Egmont.)
5. Willingness to engage about the partnership – The strategic partners must improve their engagement and be willing to come to the table to seek partnership and support for ideas and directions. Key to that is clarifying the partnerships with the Health Authority (an issue across all CHCs).
6. Obtaining clarity from the Ministry regarding the role of community-based primary care, and to ensuring that stakeholders understand and accept their respective roles.

Enablers –

1. The focus group was viewed as a starting place for further developing the Health Authority. There were a number of challenges identified such as communications, quality assurance and union vs. nonunion staffing, but these could be overcome if the partners worked together. At the same time, the centre's positive working relationship with the Division and Sechelt doctors was identified as a strength.

2. Government appetite for initiatives like Pender Harbour Health Centre – Government interest in initiatives like Patient Medical Home and Primary Care Networks were seen as opportunities for funding, given Pender Harbour Health Centre already operates from that model. BC Housing is also supportive.
3. Board strength – the Board is well prepared to govern Pender Harbour Health Centre and has the strength and diversity of skills needed to lead in a period of growth and change. They also have in place a strong administrator to lead through this period and plans to address his succession.
4. Community support – The Pender Harbour community led the creation of the centre and has continued to be a strong supporter of 'their' centre. They provide input into planning both through formal consultation and regular feedback to staff and board members. They also continue to be committed to funding donations to the centre.
5. The current centre space is at capacity with its physician space, dental space, nurse/lab space, itinerant offices, and specialist offices and community meeting space/administration space. With the centre having purchased the lot adjacent to the current centre there is significant potential for staged growth.
6. Nimbleness – The centre's capacity to respond quickly to community needs was seen as one of its greatest assets. This is a critical quality that they want to retain by not becoming to enmeshed in government bureaucracy.
7. Volunteer support – A number of key programs that facilitate centre services are only possible because of volunteer support. These range from the volunteer drivers who ensure patients attend doctors' appointments, to those who volunteer at the Bargain Barn to facilitate donations to the centre, to volunteers who support those in need in the community in various ways through groups like "people who consent to be asked.'
8. The strong clinical staff at the centre.

Next Steps to inform future work–

The key informants who participated in the focus group, as well as the centre administrator, were asked to identify critical next steps and whether those next steps must be addressed locally or at a provincial level. The following were identified:

Next steps	Responsibility
1. Maintain the communication between the strategic partners – The discussion at the focus group provided a platform for building a working strategic partnership. The centre and the Division need to maintain their working relationship and improve their working relationship with the Health Authority.	Local
2. Place the proposed Pender Harbour Seniors' Nurse Practitioner position on EMR as soon as possible – The position is an initiative identified by both the centre and the Division as a means to address seniors' needs in the Pender Harbour Area "A" and supports the concept of Pender Harbour as a pilot site for a model of seniors' services on the Sunshine Coast. The inclusion of the nurse	Local

	practitioner on the physician EMR will provide a test of the expanded EMR use envisioned for the centre.	
3.	Establish, and work with, a pilot working group for Pender Harbour Health Centre looking at Team-based Care for Seniors – As noted above, the Division of Family Practice has already identified the centre as a pilot site for seniors.	Local
4.	Establish the quality assurance requirements for community health centres – Given that Pender Harbour Health Centre faces the question of quality assurance, it is likely that other CHCs face similar concerns from their Health Authorities. It therefore makes sense that a common approach to quality assurance be established by the province.	Province/Ministry
5.	Clarify how CHCs fit within the Ministry's primary care model including what services are required to effectively deliver community-based primary care – This recognizes that Primary Care Network and team members change depending on the patient's needs, but could provide a template against which CHCs could assess their services to ensure basic needs are met.	Province/Ministry

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