The Growth and Evolution of a CHC: Responding to Changing Needs using a Dynamic, Decentralized Model of Care

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1. Introduction

Access Alliance Multicultural Health and Community Services (Access Alliance) works to improve health outcomes of socially vulnerable and medically complex residents of Toronto (including immigrants, refugees, and racialized groups) through ensuring equitable access to quality care and services by an inter-professional team. Since its inception in 1989, Access Alliance evolved from a small, ethno-specific community health centre (CHC) to a large multi-service organization with decentralized[1] operations and dynamic service delivery approaches. This case study will showcase how four driving forces, facilitated by three critical enablers, promoted the evolution and strategic growth of a community health organization (Figure 1).

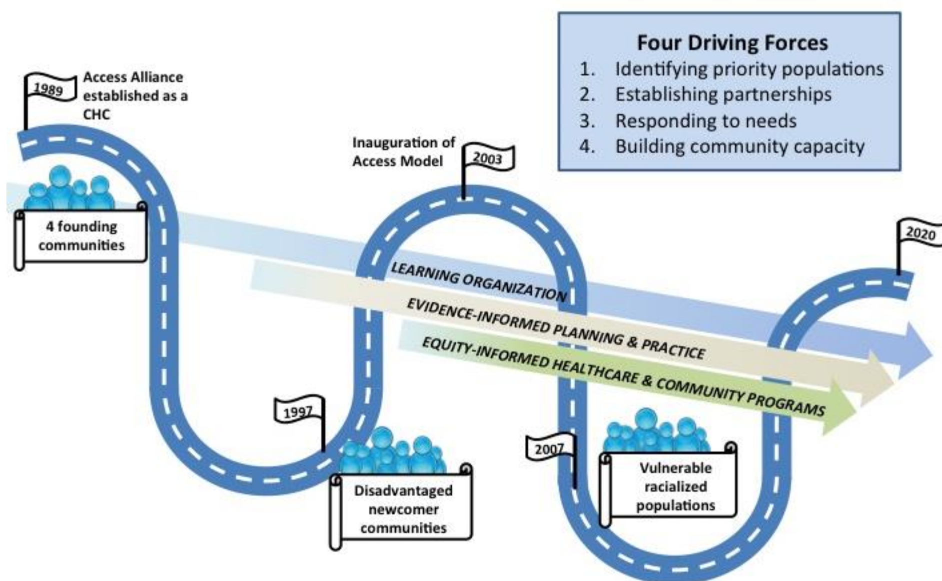

Figure 1. Strategic growth of Access Alliance as a CHC over three decades

1. Here, decentralization refers to the intentional expansion of facilities, programs and services to under-resourced and high-need neighbourhoods, through permanent and itinerant service locations.

2. The Vision of Access Alliance: Origin and Transformation

Immigration has been a driving force for the City of Toronto for more than five decades. However, the health sector in particular has been seen to pose many barriers to service access for immigrants, refugees, and other vulnerable populations. Considering limitations in the capacity of 'mainstream[2]' organizations to serve these populations, a coalition initially comprised of more than fifteen ethno-specific groups, formed to advocate for accessible, language-specific and culturally competent services that were community-led and community-owned. Because of funding constraints, four ethno-specific communities (Vietnamese, Portuguese, Spanish-speaking, and Korean) sustained their engagement with the coalition, and established Access Alliance Multicultural Community Health Centre (Access Alliance) in 1989. Three strategic directions defined the period of 1999 – 2002, whereby Access Alliance would (i) build a healthy organization, (ii) become recognized as a lead organization in the immigrant/newcomer health sector, and (iii) meet the needs of its community. The organization thus began its work to promote health and well-being and improve access to services for immigrants and refugees in Toronto. Its mission focused on addressing client's medical, social, economic and environmental issues through the provision of primary care services, promoting health, and the training of bi-lingual community members as community workers.

3. Four Driving Forces - Realizing our Vision

3. 1. Identifying Priority Populations

In the beginning, Access Alliance focused on serving clients from the four founding communities, where 'country of origin' and 'immigration status' were the main indicators for defining the organization's service eligibility. By the mid-1990s, newcomers beyond the founding groups were seeking access to health care. Access Alliance began to rigorously study sociodemographic and health

2. In this context, mainstream refers to organizations without an explicit mandate to serve immigrant, refugee or newcomer communities.

status information, and found that those populations experiencing multiple and intersecting barriers to the determinants of health experienced the poorest health outcomes. This included groups that had not historically been identified as priority populations, such as newcomers from lesbian, gay, bisexual, transgender and queer (LGBTQ2+) communities. With this knowledge in hand, the organization made a strategic decision to evolve from its founding communities to focus on the *most disadvantaged newcomer populations.* By 2007, Access Alliance uncovered strong evidence revealing that second and third generation newcomer populations, particularly those from racialized communities, were also experiencing significant barriers to the social determinants of health. The organizational mandate evolved once again to include the *most vulnerable racialized population*s. The agency continues to conduct research on the intersections of race, poverty, and health-implemented evidence-informed programming, and advocates for system-wide health inequities to be addressed.

3.2 Establishing Partnerships

Access Alliance has long embraced partnerships as a strategy to address the systemic barriers that influence the wellbeing of its priority populations. The organization recognized "that it is part of a larger system of service providers and needs to work continuously to break down silos and build linkages in order to increase access to services" (Nerad and Janczur 2000, 227).

As the organization grew, the leadership decided to deliver services outside the downtown core, in priority neighbourhoods which were characterized by a high number of newcomers and a serious lack of service infrastructure. Building trust with community members and service providers was critical, and was facilitated by bringing evidence, organizational capacity, and a willingness to mobilize collective resources in response to community needs. Access Alliance continues to embrace its commitment towards meaningful partnerships – those which are increasingly geographically and functionally diverse - to advance shared goals for community development.

3.3 Responding to Needs

In 2003, Access Alliance launched the Access Model, which officially defined a formal strategy for responding to the needs of the community, by extending services and deploying resources to

neighbourhoods throughout the city. Over time, the model evolved to be the 'Access-through-Equity-Model', reflecting a commitment to address systemic barriers caused by geography, language, poverty, racism and discrimination. Today, Access Alliance conducts community-based research, planning, and evaluation. Such practices ensure that the gathered evidence is timely, reliable, and useful to the communities served. Client needs are identified through the annual Client Experience Survey, and broader community needs through Community Health Needs Assessments (Access Alliance 2013; Access Alliance 2017). Programs and services are redesigned according to their feedback, insights, and expressed needs. For example, Access Alliance Language Services (AALS) was created to remove language barriers for clients.

3.4 Building Community Capacity

Strengthening community knowledge, behaviours, and skills has been an organizational health promotion goal since the beginning (Nerad and Janczur 2000). Access Alliance prioritizes volunteers and students by offering training programs on community-based research, planning, evaluation, anti-oppression, and the CHC model of care. Access Alliance's Peer Outreach Program is a flagship initiative where peers are trained to conduct outreach, link residents to services, and participate in local service provider networks that aim to reduce service gaps and enhance service pathways. Since 2003, the agency has trained and supported many newcomer women to improve access to services for community residents in priority neighbourhoods. The Peer Researcher program is an adaption of this model for building the research capacity of the community.

4. Three Critical Enablers

4.1. An Organization that Values Learning

Access Alliance has continuously articulated its aspiration to be a 'learning organization' with a culture "that is based on openness and trust, where employees are supported and rewarded for learning and innovating, and one that promotes experimentation, risk taking, and values the well-being of all employees" (Gephart et al. 1996, 39). To this end, Access Alliance supports creative and critical thinking

among staff, and accepts mistakes as learning opportunities. The organization appreciates the value of learning within a team environment, where teams are encouraged to critically appraise decisions as well as to make new suggestions. Students, volunteers, staff, senior management, and board alike share a common vision, to support vulnerable Torontonians to achieve health with dignity.

4.2. Planning and Practice that is Evidence-Informed

Evidence is gathered systematically through different channels, such as the Client Experience Survey and Community Reference Group meetings, to inform programs and services. The agency also routinely audits client clinical records to inform its clinical practices. Such planning advises practitioners to be deeply aware of their clients' unique values, preferences, and circumstances, and integrate this knowledge with the relevant scientific evidence to inform their practice (Ciliska 2012; WHO 2019).

4.3. Equity-Informed Healthcare and Community Programs

Access Alliance is in engaged in building the capacity of the community health organizations in Ontario around planning, implementing and evaluating health and community programs using an equity lens. Such a practice ensures vulnerable communities have barrier-free access to services and patient-centered care in order to achieve quality of health with dignity. For example, Access Alliance collects equity data on sexual orientation to build solid evidence for developing appropriate programs for members of the LGBTQ+ community in a safe space.

5. The Future: A Vision for the Next 30 Years

Within the current landscape, the pace of change seems to be accelerating. Organizations like Access Alliance have to work hard to make sure that the needs and challenges of the communities we work with do not get swept away or overlooked. Some of the questions we need to be asking are:

- How do we stay grounded in community and meaningfully engage community members in our discussions and thinking?

- What are the emerging critical issues and what changes does our organization need to make in order to adapt and respond effectively?
- What does the future hold and how does Access Alliance get ahead of the curve – for example, in terms of technology, organizational structure, multi-stakeholder collaborations, and the blurring of lines between private and public organizations?

Research has shown that visible support from senior leadership, consistent measurement and monitoring, and connectivity, can drive and sustain change within complex systems – our practice, our partnerships, and our staff and client engagement surveys reflect this. How does Access Alliance build on the past 30 years of learning and success to ensure continuous innovation and creative responses? Only time will tell; however, organizational practice and foundational commitments will provide guidance and inform future visions.

For more information about any of the areas of discussion in this paper,

please contact: research@accessalliance.ca.

To learn more about Access Alliance MHCS, visit: https://accessalliance.ca/

References

Access Alliance Multicultural Health and Community Services (Access Alliance). (2013). Jane community health assessment report. Internal Access Alliance report: unpublished.

Access Alliance Multicultural Health and Community Services (Access Alliance). (2017). *Community health needs assessment: Taylor Massey Neighbourhood*. Internal Access Alliance report: unpublished.

Ciliska, D. (2012, May 25). *Evidence-informed decision making*. Canadian Institutes of Health Research. **https://cihr-irsc.gc.ca/e/45245.html**

Gephart, M. A., Marsick, V. J., Van Buren, M. E., Spiro, M. S., & Senge, P. (1996, December). Learning organizations come alive. *Training & Development, 50*(12), 35-45.

Nerad, S. & Janczur, A. (2000). Primary health care with immigrant and refugee populations: Issues and challenges. *Australian Journal of Primary Health, 6*(4), 222-229. https://doi.org/10.1071/PY00056

World Health Organization (WHO). (2019). *What is EVIPNET?* Evidence-Informed Policy Network. **https://www.who.int/evidence/about/en/.**