A B S T R A C T

The research undertaken describes a regional health authority's approach to managing a shift away from acute hospital care towards more community-based, health-promoting service orientations in line with new legislated responsibilities.¹ It builds on earlier research of province-wide efforts to create new ways of organizing work within new regional health authority structures. The initial study explored "what matters most" to managing the restructuring of Alberta's health care system and identified ten variables as critical to the transition to regionalization in Alberta.² Four were seen to be pre-requisites to effective change: sustaining political will; pacing; resourcing; and, committing to change. Six others were described as continuous process variables: leading; communicating; informing; learning; planning; and, adjusting. This case study looks closely at the operation of these variables in a specific change process within the wider context of the Alberta health reforms.

A B R É G É

La recherche entreprise décrit l'approche suivie par les autorités sanitaires régionales pour gérer la transition vers moins de soins intensifs en milieu hospitalier et plus de services communautaires de promotion de la santé, en accord avec les nouvelles responsabilités imposées par la législation.¹ On y pousse plus loin les recherches déjà menées sur les efforts déployés dans la province pour concevoir de nouvelles façons d'organiser le travail dans le cadre des nouvelles structures des autorités sanitaires régionales. L'étude initiale examinait « ce qui compte le plus » pour gérer la restructuration du système de soins de santé de l'Alberta et identifiait dix variables essentielles pour la transition vers la régionalisation en Alberta.² Quatre d'entre elles étaient considérées comme des conditions sine qua non à un vrai changement, à savoir : le maintien de la volonté politique; le rythme du changement; l'octroi de ressources; et l'engagement à changer. Les six autres étaient décrites comme des variables continues du processus, à savoir : mener; communiquer; informer; apprendre; planifier; et ajuster. Cette étude de cas examine de près le fonctionnement de ces variables dans un processus de changement spécifique, dans le cadre plus large des réformes du système de santé en Alberta.

Transforming a Health Care System: Managing Change for Community Gain

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The research explores a health authority's strategies for altering service delivery patterns towards increased community-based, health-promoting care.³ It focusses on understanding how change is managed within health system transitions, how service delivery options are impacted, and whether links to health outcomes are possible. The primary objective of the study was to identify, describe and compare strategies adopted by the regional health authority to rebalance the delivery of health services between acute institutional treatment and health-promoting community-based care.

Secondary objectives were more outcome-focussed: to identify intended results of rebalancing efforts; to analyze progress towards expected results; and, to describe measurable alterations to service delivery.

DESIGN AND METHODS

The research is a case-study analysis.⁴ Semi-structured interviews were conducted with health managers from all sectors of care who were responsible for managing alterations in the nature and balance of acute and community-based care options. Neutral probes encouraged discussion concerning goals and definitions, strategies, impacts and challenges. Interviews were taped, transcribed, analyzed, and then triangulated with review of relevant planning strategies and activities supporting community-based care within the first two years of regionalization. Data analysis involved constant comparison of data from both documentation

and semi-structured interviews.⁵⁻⁷ While this paper focusses on data generated from the interviews, findings from documentation generally reinforced participant comments.

RESULTS

Analysis of informants' understanding of the shift to community-based care identified three overriding categories: defining the shift, influencing the shift, and measuring the shift.

Defining Shift

Informants described the nature of the shift from institutional-based care to community-based care as fundamental "cultural" shift. The descriptors (Table I) used conveyed general knowledge of the underpinnings of a community-based health care system. A thematic summary of the comments that relate to each of the descriptors is provided to reflect common perspectives.

Philosophy – This is the most fundamental descriptor. All of the informants discussed the importance of philosophical underpinnings of the shift. Most informants indicated that the Region had not yet emphasized strategies to assist people within the system and within the community to adopt a new philosophy regarding the health care system. Instead, emphasis had been on physically shifting services within the system with little opportunity to explore the underlying philosophy for such alteration. The following comments illustrate both the perceived importance of, and difficulties associated with, clarifying the philosophy of community-based care.

...fundamental thinking of managers, policy makers and health providers has to

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change in order to fundamentally move forward in the new health system. You can't reinvent the old system anymore.

But how do I actually change my thinking? ...and as a consequence my behaviour and where I want to go in reforming health care? That's the big thing.

Informants agreed that shifting to a community-based health care system requires that the public and health care professionals and managers adopt a fundamental shift of philosophy. They unanimously described a need for system thinking, not just independent initiatives; and to impact health status, not just illness.

...the first challenge is how do you start thinking as a system, because it's not in our culture. As you really look at a system, given the future issues, the community side just comes forward automatically ...thinking "system" is difficult...Therefore I underestimate at times what it's like to make that transition...it's a huge step.

The real current pressure [has been] how do you restructure allowing for a different kind of future without totally understanding what the future would look like...there is enough in the literature that would say it's too much of an illness system versus a health system.

Beyond the recognition of these challenges, there was little further consensus concerning the local philosophy of community-based care.

I would have to say though from an organization perspective we still have not adopted a philosophy around this.

Model of Care – Again, informants alluded to shifting from an illness-based system of care to a health-based model; however, no one identified a clear model upon which the shift within the Region has been based. Even though there was recognition of the need for a change in the philosophy of care, there was little clarity regarding how a new philosophy would take shape.

I suppose I could say yes, because [community-based care] is a board approved direction, but I would say we don't share an understanding of what that truly means.

Generally, the informants were speaking of a population health model that should reflect the unique characteristics of the Region and the new regional management orientation. The model also would emphasize broader determinants of health and improved access to health services.

I actually think our new structure has helped clarify the notions of population health and it liberates us to think more completely about primary health care.

Coming back to what's in the business plan, is increasing access. Some of [community-based care] will also come in terms of changing models of service delivery, identifying more efficient, effective models of service delivery.

Lack of clarity regarding specific service delivery strategies and models may well be reflective of the stage of the reform process within the Regional Health Authority.

Characteristics – Lack of clarity regarding a model for the shift to community-based care did not inhibit participant capacity to articulate characteristics of such care (Table I). The participants provided a great deal of information in this area, defining characteristics they felt the new system should embody and expressing a strong commitment to creating opportunities for those characteristics to evolve.

The benefit of looking at the community first is you have a potential to be more in tune with the community; earlier interventions really start impacting on the person's health status.

It would appear that this is the more sustainable approach to health care and it is also the most flexible, adaptable part of our system. When you build big structures, like hospitals, they are not creatures that can be readily changed in response to shifts in the community.

You can start to capitalize on the spirit of a community if you wish...you have the ability to mobilize that community for voluntarism, to use other facilities whether it be churches, community centres, whatever. You can keep it at a scale that people can relate to it and believe they can have an impact.

The issue of voluntarism provides an example of competing perspectives. While some participants indicated that the community-based system provided the "ability to mobilize the community for voluntarism," others identified a flaw in this argument: "the very agencies that used to be voluntary agencies that picked up [the needs], now are getting less funds themselves." Differing perspectives articulated with respect to this aspect of community-oriented care are illustrative of a number of issues surrounding a shift to "community" that create double-sided impacts or differences of opinion.

Pace – Discussions of pace referred to two different processes: the pace of the initial restructuring, and the pace of the shift to community-based care. While there was agreement that the initial change process occurred at an incredibly fast pace (perhaps too fast), there was also consensus around the much slower pace required for establishing a comprehensive community-based system.

And I think that the Minister and the Premier have identified that the cuts were too steep too fast and [now] they're reinvesting in the system.

The problem with population health issues is the time frame. The mapping and the time for change is over a longer time frame and that's still going to be a challenge...there are still some major problems supporting this change and the reason we never went this way is it's tougher. It's not as obvious...there's not the instant gratification.

Doubts also were expressed concerning the ability of politicians and health care managers to focus on the longer-term impacts associated with the shift towards more community-based care.

TABLE I
Descriptors of Community-based Health Care

Philosophy (way of thinking): guides how the shift is defined and how it is being advanced.	Components of community-based philosophy: <ul style="list-style-type: none"> • Requires system thinking, not just independent initiatives; and, • needs to have an impact on health status, not just illness
Model of care: reflects the philosophy and delineates structural components of community-based care.	Tenets of model of care: <ul style="list-style-type: none"> • be based upon the broad determinants of health; and, • change and improve service delivery
Characteristics: reflect the attributes of a system that is based on the stated philosophy and model of care.	Describing a system that: <ul style="list-style-type: none"> • is more accountable • is more flexible • is more personalized • has less bureaucracy • is non-hierarchical • requires a different infrastructure • requires public participation • emphasizes voluntarism • is more accessible • is dispersed throughout the community • is integrated • is in an environment that is more conducive to health.
Pace: reflects the time required to plan and implement a system that is based upon the stated philosophy and model of care and which possesses essential characteristics.	Types of pace identified: <ul style="list-style-type: none"> • The pace of the initial restructuring • The pace of the shift to community-based care
Expected outcomes: describe the broad expectations of a community-based health care.	These outcomes include: <ul style="list-style-type: none"> • early intervention • appropriate interventions based upon needs assessments/meeting needs • improved population health status • greater community input • economic benefits • reduced utilization of inpatient facilities • a shift in expenditures and personnel from acute care to community care • multidisciplinary care centres • fewer gaps in services • greater continuity of care.

Expected Outcomes – Given the lack of clarity regarding previous descriptors, it is interesting that there was more clarity and consensus regarding the outcomes that would be expected of a community-based health care system.

Outcomes demonstrate to me that that the value of expenditures is valid compared to how we otherwise could have spent the money or spent the resources or treated individuals.

It is a movement in the typical form of accessing care...I hope they really go to more of these multidisciplinary type settings, provide access points that don't require physician first intervention, and, you know, cut some of the red tape. And I think the entry point in the community health centres is a very important one.

The informants indicated that a community-based health system is expected to provide a number of outcomes (Table I) that would not have been derived to the same extent from the previous health care system.

Influencing Shift

Although there were similarities in the terms used to describe community-based care, there were fewer similarities in the descriptions of how such a shift should occur. While some participants identified resource shift as a key influence, others focussed on human factors as either potential enablers or inhibitors. Still other participants began to describe a "set of influences" or "ongoing processes" that would truly influence a shift to community-based care.

I think the region's done a great job. I think they've moved significant resources. They've

changed the language. They've moved resources significantly into the community. They've geared their public relations and communication initiatives to educate the public, and therefore also the provider.

I don't think it'll ever stop. I think we've initiated the process here where it's like a continuous improvement area...They'll start to notice things are better ...the last three years, we've had to tell them things will be better and try to provide leadership through a sort of darkness, but, I think we won't really know we have truly been successful until our staff tells us.

The paying public will allow you to do this, but only if their acute needs are being really looked after if they get sick. If the sense is that they've been hit so hard, there's not going to be a bed or services there for them when they need it, then you can forget community-based care.

Table II identifies both the positive and negative factors acknowledged by study participants. Despite being able to identify influencing factors, it is not clear from this analysis that the participants agree on *how* to facilitate such a shift in the Region.

Measuring Shift

Differences in opinion regarding how to support a shift to community-based care were most evident when participants discussed how to measure change.

I don't know what the percentages of increase in the home care environment expenditures are, but I would think they're probably exceeding three times the expenditure they were pre-regionalization.

I think there are a couple of measurements. The resource shift wouldn't be one that I'm very comfortable with, but it's one you would still use...You would expect to see more service and community-type options, but that can also just be chasing the philosophy... The bigger challenge then is looking at...have you impacted the health status of the population? ... Are people utilizing the hospital system less? Have the numbers of low birth weights changed? The number of unwanted pregnancies changed?

What are the critical few things that would be really good indicators of having [made a shift]? What is your rural death rate? Years lost to productive life? Then look at rates, I would say, for injuries, and numbers of things where you could see intervention... The disillusioning part [is] there are so many factors contributing you don't know what your impact was over that time frame.

Lack of clarity regarding the definition of community-based care inhibits the development of clear goals and objectives for influencing the shift and measuring impacts. While the participants used similar terms to describe community-based care, examples provided regarding where the shift has occurred referred to changes in location, not necessarily a change in the way that services are provided. For example, citing the shift of services away from facilities called “hospitals” to places called “community health centres” without changing the underlying philosophy and model of care, or, continuing to practice within separate professional boundaries. When neither goals (e.g., what is community-based care?) nor objectives (e.g., what are the expected outcomes?) are well defined, development of strategies to address goals and objectives remains problematic. Lack of clarity is reflected again in the range of recommendations regarding methods of measuring the change. Possible measurement indicators and strategies were highlighted (Table III). While many measurements are identified, their definitions remain unclear, as does ability to operationalize their development and use. The indicators and strategies represent hoped-for capacities rather than present performance appraisal capabilities.

Implications

Findings are drawn directly from the management team responsible for leading the process of change to a regionalized system of care that emphasizes “community-based care encompassing illness-preventing, health-oriented interventions.” Exploring relationships among the definitions of community-based care, influences of change and measurements of impacts may help the Region move towards a workable strategy for community-based care. Table IV frames

TABLE II
Factors Influencing the Shift

Positive Factors	Negative Factors
Organizational Factors <ul style="list-style-type: none"> • new infrastructure • communication strategies/plans • supportive structures • shared vision • creating a new mindset • competition • collaboration • sufficient time for change to occur 	Organizational Factors <ul style="list-style-type: none"> • lack of infrastructure • lack of a communication plan • lack of control over funding • lack of control over priorities • lack of control over deadlines • competition • multisectoral nature of health • instant gratification mentality
People Factors <ul style="list-style-type: none"> • skills (people who have the skills to support the change process) • supporting professionals and public through educational opportunities • disciples (people who have had positive experiences within the new system) • sufficient time for change to occur • leadership style • commitment • collaboration • competition • trust 	People Factors <ul style="list-style-type: none"> • lack of support from professionals • lack of support from public • lack of support for public • lack of support for professionals • people (professionals and public) who have had negative experiences within the new system • expecting too much, too fast • leadership style • lack of ownership • power plays • competition • mistrust

TABLE III
Measuring the Shift

Identified Indicators Include:	Highlighted Strategies Focus On:
<ul style="list-style-type: none"> • resource shift • health status • integration/connections • cost effectiveness • client and professional satisfaction • commitment • understanding • social shift • relationships • quality of life • mortality • institutional stress. 	Developing capacities for – <ul style="list-style-type: none"> • Defining • Capturing • Tracking • Trending • Disseminating... indicators measuring “community shift” – In credible and consistent ways.
The “indicators” listed are those identified by the participants; they each require operational definitions and measures.	

TABLE IV
Linking the Categories for Descriptor: Philosophy (Way of Thinking)

Defining the Nature of the Shift	Factors Influencing Change toward Descriptor	Measuring the Change toward Descriptor
Requires systems thinking, not just independent initiatives; requires a change in existing mindset.	Communication; leadership style; disciples; supporting staff; building collaboration, commitment and trust.	Assessing client and staff satisfaction and commitment; monitoring stress; tracking attitudes and actions.

this linkage for the first identified descriptor – *philosophy*. The experiences and decisions of these “change agents” will significantly influence the nature and direction of strategic activity supporting health reform inside the Region. They may provide lessons for other regions and communities grappling with the challenges of shifting the

nature of care within traditional health care systems:

- It takes committed time and resources to conceptualize and model new health policy goals;
- It takes even more time and resources to actualize these same health policy goals; and

- Shared strategies promoting understanding, learning, action and evaluation are required.

DISCUSSION

This study provides insight into how managers perceive changes they try to make to a health system and, in so doing identifies impediments that make the changes difficult to implement. Results suggest that the new structures and processes required for sustained change in health care delivery are often elusive and run counter to existing professional turfs and traditional funding priorities. Issues of management style, clarity of language, commonly understood goals, and collaboration all stand out as areas of challenge. New strategies are required for collaborating within the health care system and for embracing external linkages to other social service systems and communities of interest.

The timing of this case study presumed that two years following the transition to regionalization, RHAs would be able to quantify shift in the location and balance of care. The analysis to date demonstrates both a general difficulty in tracking quantifiable shifts and a need for considerably longer lag times prior to assuming that health goals are sufficiently shared, and change strategies are mature enough, to produce measurable alterations to health care and/or health status. At the time of the study, it was clear that the Region was some distance from a well-defined understanding of what community-based care was to be in the Region.

Elsewhere, the whole concept of "community" is being revisited.^{8,9} Many health

care jurisdictions have knowledge of change processes that support shifts in health policy goals, including shifts to community-based care.¹⁰⁻¹² There remains a substantially untapped opportunity to learn from other experiences of health policy shift.¹¹⁻¹⁶ Health systems attempting to create more community-oriented approaches need to take account of this literature but also need to develop goals and objectives that are locally appropriate and attainable. One definition increasingly referenced in the literature may provide a platform for adopting a local philosophy for community-based service delivery.

'Community-based programming' does not mean simply that programs are offered within a community setting rather than an institution. The term as we use it refers not to the location of the program, but to the *locus of control* (ownership). A truly community-based program will revolve around needs and solutions as identified by the community itself.¹⁷

By investing in joint research and practice initiatives, health authorities can create capacity to share learning and progress with other health care jurisdictions concerned with moving towards community-based models of care. Their challenges alongside their successes can help bridge knowledge gaps and enhance strategies for strengthening community-based health care supporting community-focussed health improvements.

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