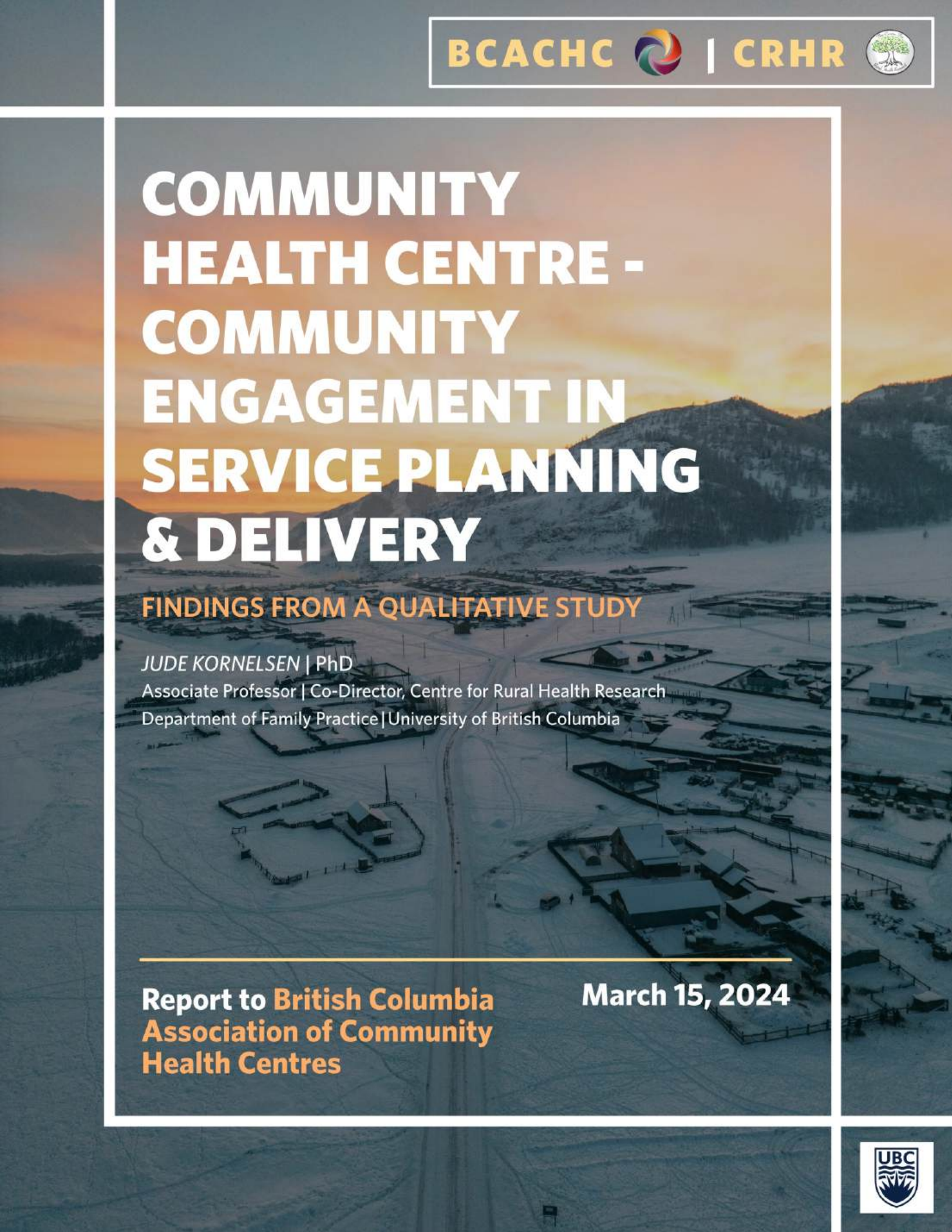

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COMMUNITY HEALTH CENTRE - COMMUNITY ENGAGEMENT IN SERVICE PLANNING & DELIVERY

FINDINGS FROM A QUALITATIVE STUDY

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Report to British Columbia Association of Community Health Centres

March 15, 2024

UBC

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INTRODUCTION

Although Community Health Centres (CHCs) have been integrated into BC's health service delivery environment for over 50 years (Reach Community Health Clinic), it has only been in the past decade that the potential of the model of care has been realized more broadly. The inclusive mandate to provide culturally resonant care for all demographic and cultural groups, through low-barrier, stigma-free programming sets the stage for recognizing and honouring not only the self-worth of all people, but gives rise to the need to include them in health care programming and delivery. We understand clearly the importance of the involvement of patients and clients in shaping models of care that best meet their needs and the success of prioritizing the interrelationship between health status and social, emotional and cultural influences. Part of the context and conditions that lead to optimizing (holistically defined) "health" are the social ties that bind us to community at a patient level, but also to community supports at a systems level. To this end, one of the necessary conditions for CHCs to thrive is community readiness; readiness for engagement, for actioning health priorities and for being involved in shaping their collective experience of care. In this way, they 'walk the talk' of being community-based.

However, the accountability inherent in community-based organizations requires the active and on-going development of pathways to ensure planning is not based on assumptions of need, but instead on the lived and living experiences of need. This directly addresses a gap current noted in community engagement in health care planning: lack of transparency and lack of accountability. As not-for-profit organizations with elected Boards of Directors, CHCs are a contrast to existing structures that lack and accountability targets beyond clinical health outcomes and costs. This is particularly relevant to those populations that have faced stigma and discrimination in the health care setting or at a social, linguistic or cultural disadvantage in accessing care and who, under existing models, may not have adequate access to care despite their elevated need. In some instances, this restricted access many also be due to challenges of navigating our health care system or basic challenges with social determinants of health, such as food and housing. Acknowledgement of the coalescence of physical and social determinants of wellness is essential to impact marginalized – and all – populations.

Team-based care, in its essence, is a collaborative practice that involves well-integrated providers from disparate disciplines to provide coordinated care to patients (Olsen et al 2011). As noted, it is characterized by interprofessional collaboration with the context of a sense of shared responsibility (Newton 2023) but also prioritize a patient-centred approach. It is increasingly recognized as a solution to our over-burdened health care system and diminished access to primary care providers (Newton 2023).

We are on the cusp of recognizing, integrating and valuing the contributions of CHCs to reduce health system costs, increase access to care for all populations but particularly for those who have been stigmatized, marginalized or who have not felt safe accessing health care, and attend to the crucial social determinants of health. Beyond this, however, is the potential for CHCs to provide a model of excellence in community engagement in planning and delivery, a model that, when robustly evaluated and understood, can increase the democratization of health care in British Columbia.

This report presents tentative first steps in explicating the mechanisms, processes and outcomes of a commitment to community engagement in health planning and delivery. We present findings from qualitative research interviews which sought to understand how CHCs are meeting their goal of being community-directed and, more importantly, the systemic, resource and cultural challenges they face. We have the opportunity in British Columbia to understand how to optimize health care delivery at a community level through a rigorous focus on the CHC model and these findings are a tentative first step.

BACKGROUND

Community Health Centres in British Columbia are based on five key principles including interprofessional models of care, a wrap-around approach for patients and clients, working 'up-stream' to attend to social determinants of health, attention to justice and health equity and a commitment to community governance (About CHCs, n.d.).

Community engagement is recognised as an important process to improve the responsiveness of the healthcare systems to address the needs and priorities of the communities accessing the health service (Boivin et al., 2014; Farmer et al., 2018; McClean & Trigger, 2018; Pagatpatan & Ward, 2017). It serves an essential role in policy planning and evaluation, providing community members opportunities to voice their unique needs and help shape local healthcare services that address their needs (Smith & Benavot, 2019). Mechanisms such as forums, committees, and surveys help facilitate meaningful dialogue and contribute to the design of services. The Alma Ata Declaration of 1978 acknowledges that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care" (Johnston et al., 2021). Despite the Declaration and growing recognition of the importance of community engagement (Safaei, 2015), there remains a gap between community voices and implementation of healthcare services that represent local community needs (McClean & Trigger, 2018).

The commitment to engage communities in health planning by the Ministry of Health in British Columbia has given rise to provincially specific frameworks from government (BC Ministry of Health, 2018; Island Health, 2024) as well as the social service sector (SPARC BC, 2013; BC Healthy Communities, 2024). Common to these frameworks are steps such as identifying relevant community partners (community members, organizations, agencies), taking time to understand the context (demographics, culture, history, needs) and setting clear objectives through relationship building. Stemming from objective setting, appropriate and contextually-relevant methods need to be selected, alongside an effective communications strategy about the engagement to promote participation.

However, implementing an engagement strategy requires not only a relevant, localized framework, but also resources to ensure successful application of the desired framework. Although this includes primarily human resources (for example, project managers or coordinators responsible for overseeing engagement, outreach facilitators to moderate engagement, other staff to attend to logistics), and these resources are contingent on financial resources, there are other infrastructural enablers that increase the likelihood of successful engagement. Beyond materials and supplies, they include, for example the resources needed to hold training sessions or workshops to build the capacity of those participating in the engagements (staff, volunteers, community members). To ensure inclusivity for participants, translation and interpretation services may be required, alongside transportation services (or honoraria) including efforts to ensure accommodation of peoples with disabilities (such as wheelchair ramps, sign language interpreters). Additionally, resources for a frequently overlooked component of engagement is the evaluation of the efficacy of the engagement, from a participants perspective. This requires the development of tools and resources for collecting feedback and developing competence for analyzing, synthesizing, and presenting data collected.

Beyond the provincially specific engagement frameworks, there are several key approaches to engagement noted in the international literature, which may be a starting-point to develop a context-specific strategy for Community Health Centres in BC. Five such frameworks will be reviewed in brief, below.

(1) IAP2 Spectrum of Public Participation:

https://doi.org/https://iap2canada.ca/Resources/Documents/0702-Foundations-Spectrum-MW-rev2%20(1).pdf

This framework, developed by the International Association for Public Participation (IAP2, 2018), presents five sequential levels of engagement including 'inform', 'consult', 'involve', 'collaborate' and 'empower'. It serves as both a reflective lens to ensure level of engagement matching contextual need and also a framework for engagement planning.

(2) Asset-Based Community Development (ABCD)

https://www.nurturedevelopment.org/asset-based-community-development/

ABCD is an approach to sustainable community development, focused on how to link "micro- assets to the macro environment" (Nurture Development, 2016). It is based on the contention that communities can drive the development process by identifying and

mobilizing unrecognized assets. Like other frameworks, it prioritizes networking with other community-based interest groups to optimize resources.

(3) The Community Engagement Continuum

(https://www.tamarackcommunity.ca/interactive-tools/the-engagement-continuum

The Engagement Continuum (Tamarack Institute, 2018) provides a methodology for determining current level of engagement and desired level of engagement, based on stated goals of the initiative.

(4) The Community Toolbox

(https://ctb.ku.edu/en)

The Community Toolbox, developed by the University of Kansas (2023), offers support in skills acquisition (specific support for 16 core competencies for community engagement work including assessment, planning, implementation and evaluation) along with strategic suggestions for developing partnerships.

(5) The Sherry Arnstein Ladder of Citizen Participation

(https://organizingengagement.org/models/ladder-of-citizen-participation/)

The Ladder of Citizen Participation (1969) is one of the most widely-used models in public participation and includes foundations and theories of public engagement, systemic obstacles to such engagement and a consideration of power dynamics that need to be considered.

It is useful to understand the breadth of engagement frameworks available, including ones local and specific to the BC context, to assess common principles and values propositions as a starting place for the development of a BC-specific framework that will meet the needs of BCACHC.

METHODS

This interview-based, qualitative investigation used semi-structured interviews to capture rural physician and key partners' reflections of strategies, processes, and mechanisms of engagement to ensure community-directed health service programming and delivery. Listening to the narratives of study participants provided us with a map of both formal and informal approaches, as well as challenges to community engagement.

Thirteen Community Health Centres in British Columbia representing diversity in size, location, and length of time since opening were selected to participate in the study. Each nominated a participant group who were able to speak to the mandate, values, priorities, and operations of the centre, usually including the administrator. Most engagements were conducted as one-to-one interviews, although some occurred through small focus groups (2-4 participants). One focus group had 10 members participating.

Interviews and focus groups were held both in person and virtually, with those further away. They lasted on average for one hour, although some lasted between 90-120 minutes. Interviews and focus groups were audio-recorded with participants permission and recordings were transcribed for accuracy.

Thematic analysis guided interpretation of the data (Nowell et al., 2017). This began with the coder familiarizing themselves with the phenomenon through immersion in the transcripts to achieve an overarching understanding of community engagement. They then arranged salient statements (codes) revealing understanding of the phenomenon hierarchically into a coding framework, with more expansive 'parent' codes encapsulated and refined in sub-codes. The themes were generated through direct engagement with the data as opposed to stemming from an external theoretical framework or lens (Sutton, 2022). This process was also undertaken for a select number of transcripts (3) coded independently by a second coder. Comparison of the two coding frameworks yielded a high level of congruency, with only minor variations in semantics. The combined coding framework was then applied to the rest of the dataset using the qualitative data analysis software, NVivo 12.

Methodological Rigor

Once coding was complete, the Principal Investigator (who lead all interviews) reviewed the codes to ensure verisimilitude with their interpretation of the insights conveyed through the data gathering process prior to writing up findings. Analysis of the data as done with attention to confirmability to keep interpretation rooted in the data rather than the researchers' views on the phenomenon (Korstjens, 2017) and with a commitment to reflexivity ("critically reflecting on potential biases stemming from social, cultural or knowledge backgrounds, that may influence the inductive interpretation of the data" (Cameron et al., 2022, Yeh et al., 2022). A credibility method of "persistent observation" was also used, with researchers returning consistently to the data, modifying codes and concepts as needed until the analysis yielded the "intended depth of insight" (Korstjens, 2017).

FINDINGS

Participants in this study identified five themes when discussing community outreach: mechanisms of engagement, processes of engagement, capacity for engagement, actioning community input, and the impact and legacy of COVID-19. Each is described in more detail, below.

Mechanisms of engagement

For the purposes of this discussion, we are defining 'mechanisms of engagement' as those discrete structures which allow for engagement to occur: they are practical and tangible ways individuals can participate in feedback and planning.

In discussing community engagement, participant feedback also pertained to higher systems-level thinking. Many discussed different perceptions of what community engagement means, who they mean by community, and what kind of outreach is needed.

Several participants were clear that it was important to be very transparent about what they mean when they say, "we've consulted with the community." This included having focused awareness on the most "vulnerable members" of the community, as well as certain subcommunities that have historically been marginalized or overlooked in outreach efforts.

Participants recognized that those who can most benefit from community engagement are those who experience multiple systemically marginalized identities, not the "largely middle class patient population." The latter group was seen as the prime respondents to outreach efforts – as one participant noted, "Who represent all 8,000 of your patients? The least busy ones will be the only ones that will respond. Is that representative? Probably not."

In discussing the kind of data and engagement CHCs were striving for, participants reported that they were keen on tailoring their engagement approaches to most effectively collect data that reflects the needs of their community. They identified a desire to "make sure that we don't have significant gaps in our knowledge because we're missing communities for whom the ways we're doing outreach aren't accessible…" In this same vein, participants again voiced the importance of cultural training in order to be able to approach a "variety of the different

sub-populations, whether that's everything from Indigenous to new immigrants or the queer community…" It was also a key element of high quality engagement to be able to recognize when a CHC doesn't have the resources or staff education to meet the needs of certain groups, and to have the capacity to respond and refer clients to other organizations who are able to meet specific needs.

Participants described an array of mechanisms they used to reach out for direction and feedback on service planning and delivery, including face to face contact at community events and more traditional means including focus groups, interviews, and surveys. Overall, the more established and resourced CHCs were better able to actualize their community-driven commitment to service planning and delivery than the newer, less resourced centres, due in part to the historical legacy and organizational strategies they had developed, but primarily due to the leveraged resources they were able to gain. Each of the mechanisms of engagement noted are described in more detail, below.

Focus Groups

Focus groups, both formal and informal, were the mainstay for community engagement for many CHCs represented in this study. For some CHCs, this involved a formalized process led by consultants while for others, often those with less resources, focus groups were described more as informal conversations with service users. For most, the yield of the discussions informed their strategic planning.

Formal approaches to focus group implementation were characterized by set schedules ("And the community groups they do a focus group every year or every three years to tell how the group is functioning"), and a clear intent to learn from discrete parts of the community. This necessarily involved attention to fostering inclusivity by ensuring a safe and welcome space, as well as more practical considerations, such as language translation. As one participant said:

> *We had participation from women with developmental disabilities. And they were so pleased and honored to be participating because that was the first time they had ever been asked to participate. We had participation with Indigenous women. A lot of them. We had participation from immigrant women.*

Others emphasized focus groups arising in a specific clinical area due to the longitudinal relationships some of the providers had with their patients or clients ("[S]he was this person

that just had direct contact over 20 years with so many of our patients. So, she would collect together what we would call a focus group of people that came from different walks of life… [who] were willing to come and meet"). Some noted augmenting focus groups with enhanced ways to engage the community in service planning ("We have had a number of focus groups, and we also have a photo voice component to this research").

More informal approaches included discussions after workshops offered by the CHC (featuring questions such as "How was the workshop? Would you like to do something different? Was the time right…?") or targeted discussions with specific population groups. As one participant noted:

> *…[W]e network very closely with our seniors membership through [external organization] and run by some ideas and plans with them to get their thoughts and opinions. It's not, you know, an intensive research study at all. It's more, you know, 'What do you think about this and how would this impact you?' Little mini focus groups, I guess.*

Others described the confirmatory value of bringing people together for discussions on service planning, which were, for all intents and purposes, focus groups:

> *We were a group of four or five women who came together because we identified the need in the healthcare system to have a better, more gender-informed approach to healthcare…We convened a meeting of healthcare professionals in the region. All women, to talk about creating a vision for the future…We had 50 women come out to that meeting. They affirmed the experiences of the founding members of the CHC. They supported the direction that we were going. They broadened and deepened the conversation with us, and then they challenged us to go beyond healthcare professionals and go to the people themselves, like most vulnerable women.*

Others noted the use of focus groups internally, as part of quality improvement cycles within their CHC, to ensure optimal programming. The importance of this was underscored by one participant, who noted, "It's a really difficult environment and sometimes things go really sideways." They proceeded to give an example of the prenatal group process and the need to receive feedback from the team of providers in order to "auto correct our processes…that did not serve our client well."

Several participants noted that focus groups were not effective in populations that have been historically marginalized or stigmatized. As one participant said, "When we try to even gather small groups together, it hasn't been effective." They went on to note the importance of one-on-one conversations within the context of trust-building. This is discussed further in the next section.

Interviews

A subsequent frequently cited community engagement strategy was the use of one-to-one interviews, employed particularly to increase a sense of safety for vulnerable and/or complex populations. This included, for example, those with "mild to moderate mental health, substance use challenge who are disconnected from service provision." Understanding vulnerable populations' healthcare needs was contingent on developing trust, and interviews were both a manifestation of this trust and also a way to reinforce it. Other examples of populations more amenable to individualized outreach were older adults, specifically ones that are "…quite disconnected, very high poverty rates, typically precariously housed." One participant described in this way:

> *…[I]t's been an exciting opportunity over the last couple of years for us to build relationships with more individuals in this [MHSU] group, for them to understand that we're not reporting on them in any way. We've built a lot of trust. And in doing so, we've been able to collect a lot more information, usually in the form of stories or interviews, or that kind of information.*

Surveys

Like focus groups above, there was a range of formality to the use of surveys by participants in this study from a few questions post-event to formalized research-based surveys out to the community. Most referenced the use of community surveys to set priorities for service delivery when the CHC was starting out, while other described processes of integrating surveys into their CHC's structure. The latter was done primarily through patient satisfaction surveys ("…patient satisfaction surveys are always huge, annual or bi-annual, I think they're important…"), noting the importance of well-structured and well formulated questions.

Many other participants, however, noted their experience of the inefficiencies of surveys due to lack of broad community uptake. One participant, for example, noted that feedback to the

question of communication preference was to reduce communication ("Too many emails. Too much information") and lack of interest in participating in surveys. This was confirmed by others:

> *I'll be quite honest with you, most of the patients are like, no surveys. Yeah, they are like none. They don't want to be doing any of them. They don't recommend it. They feel that it's a turn off. So that's our dilemmas. How do we remain client centered and still gather data, right?*

Some participants from larger CHCs noted integrated processes of survey-based responses to services through mechanisms such as their Electronic Medical Records (EMR) systems. As one said:

> *There are these feedback mechanisms built into the electronic records systems now, both in dental and medical. For every dental patient, tracker sends them a little, 'How was your visit?', and they can score it with 1-10 or put comments. So, we get direct feedback from our dental patients for anybody who wants to send it back.*

Within the spirit of inter-agency collaboration, other participants noted the value of developing relationships to optimize synergies and eliminate redundancies in the community:

> *And one of the other members of our board is the Executive Director for [Organization], which is part of our area as well. They're doing a community survey on housing primarily. So, we're kind of transferring across some health questions on theirs and some housing questions on ours.*

That said, the main application of surveys by the majority of CHC participants reported were post-event ("after each workshop") and to gauge client satisfaction. Several respondents inquired about survey instruments that other CHCs were using, suggesting they would appreciate lateral learning from those who have successfully developed metrics relevant to their CHC. Other respondents saw the value of a more informal approaches, such as basic short-form "waiting room" surveys to receive feedback and suggestions.

Attendance at Events

Several participants noted the importance of attendance at community events ("[the] local

governance meetings… literary lunch and the quilters group") to create connections and collaborative bridges with the community and receive feedback about programming. Others noted a very purposeful strategy by team members to attract attention at such meetings ("[she] was at every event, every public event with her sandwich boards and her table and her banners and engaging people in surveys"). Other participants noted the challenge of community engagement during the COVID-19 pandemic and the attendant challenge of getting community members out to meetings, even on Zoom. Relatedly, several participants noted that the CHC staff and board were well-connected within their community and involved in other organizations in addition to the CHC. This led to an efficient flow of pertinent information between agencies.

Challenges with Engagement

Several participants noted lack of uptake with mechanisms of engagement for several reasons, primarily lack of human resources to create a community engagement strategy in the face of prioritizing service delivery. Others referenced set-backs due to COVID-19 when, again, other priorities took precedence, and still others referenced the aspirational intention of developing mechanisms of robust community engagement. Some referenced "quick and easy" solutions to engagement as they work towards a broader solution:

> This is something that we've been talking about for a long time and trying to figure out how to do that carefully. … if we were to have it in an email footer or something, or you know on our voicemail [like] 'Hey, we do want to know what you think and what you think we should be doing.' I think that's probably a pretty easy and safe thing to do, but this is a discussion we're having now, is like how do we engage, and ask more a little bit more directly and just solicit that ongoing feedback.

In parallel, however, several respondents noted that community-level communication was occurring organically: "The community is constantly communicating directly to us by knocking on our door and walking through, sending us emails." Another participant commented, "Most of the feedback that we do get is if anybody's unhappy… we'll get it immediately. That is something we absolutely know."

Processes of Engagement

Although related, there are fundamental differences between mechanisms and processes of engagement, with processes referring to specific steps or actions involved in engagement,

characterized by dynamic, sequential events (Saut, 2023). Processes described by participants in this study included relational processes (through advisory committees and boards), a commitment to framing engagement through the lens of Equity, Diversity and Inclusion, informal processes of engagement, and networking. For most, these processes were informed by a community needs assessment to "narrow [the] focus" of strategic priorities for their population. Each process of engagement is described in more detail, below.

Relational processes

One of the key engagement processes cited by most participants in this study were those based on authentic relationships between the CHCs and community members. These relationships were developed in several ways, one being though community advisory committees and boards that were made up of members well integrated into the community.

Many described a key element of the success of community crossover being the eclectic make-up of a CHC's board ("[The board] is made up of business consultants, accountants, retired family physicians… parent advisors, adult client advisors and youth client advisors").

For most, the advisory boards were recognized as essential in directing the development of service delivery at the CHCs. As one participant succinctly stated,

> *… they have been excellent in guiding our networks and informing what we are offering and trying to help us to sort of streamline what we're doing, and maybe focus on certain treatment modalities that are working well.*

Some advisory committees also included business consultants which, for most, were value-added:

> *…[t]hey are very much about financial responsibility, very much about monitoring outcomes, very much about being community oriented, client oriented. It's really quite brilliant. It's wonderful to have them as a part of our advisory committee and team.*

The relational foundations of engagement extended to CHC board and staff members as well, with several participants noting that their office staff were members of the community they were serving. As one commented, "…we are really embedded in the community through our workers. And so, each employee is representative of the… community." Another went on to note, "[our CHC] is a community governed organization, and our board members are representatives of the patient population that we serve. They also inform us, and they also

direct us." This reciprocal reflection of the community cohorts represented by staff was intentional for many, some noting that achieving this balance was reflected in their hiring practices, one participant noting, "If you don't have the right person in the role, it's never going to work." There was a distinct "rural advantage" in achieving this as some of the smaller CHC participants noted that community embeddedness was inevitable ("These [are] our friends, our neighbours and our families"), due to the inter-relatedness of their small community. The value of community ties, combined with professional and experiential diversity, was further amplified by other participants as a strategic approach to engaging with community members:

> *The vice chair of our group [is] a midwife. She knows every woman-serving organization in the community that addresses the needs of pregnant women and children at a minimum. And beyond that as well. And then, you know, just you recruit different people. People have different kinds of connections and experiences. One of the original members of our board was a nurse [in a local First Nation community] at one of their clinics. And so, she had all of those insights and connections, and so on…It's just organic and natural.*

Another noted that their board was made up primarily of community partners who were "ready to advocate for various populations." Others made the strategic choice to include members from municipal councils on their boards to facilitate direct connections to municipalities to ensure reciprocal updates.

Underscoring most community advisory committees was the commitment to ensuring that membership reflected the characteristics of the community. When this was prioritized, participants remarked on the innovation in programing that occurred. As one said:

> *For instance, our Aboriginal representative has a vision of constructing a council of elders, as what we call an advisory committee, [but] to her a two-way street. A way for them to reflect if their needs are being met as patients, but also to input the wisdom from their community.*

The importance of understanding cultural differences within a community was raised by several respondents, while "… honoring the need for interface between different ways of doing things." This extended to an intentional commitment to board and committee diversity for some, ("We were very white at some point, and we said we have to make sure we're hiring more BIPOC folks, because you know, there's things that we're not seeing that we need to see"). This gave

rise to the commitment, by most, to principles of equity, diversity, and inclusion.

Equity, Diversity, and Inclusion

Striving for diverse voices reflective of the community to guide the development, growth, and maturation of CHCs was common to most of the participants in this study, with the question of "How best to do this?" salient for many. As one participant said, "I think it's form following function. So, where is the value proposition in getting this voice? Well, there are lots of value propositions. Then it's, how do you best get it?" The participant went on to observe that when serving a "largely middle class patient population" ensuring voices are well heard is not as urgent as when trying to meet the needs of those who are socially stigmatized or disadvantaged, within the context of avoiding tokenism.

CHCs that served a diverse patient population were expressly attuned to creating conditions for broad community input by prioritizing appropriate locations and formats for AGMs. As one participant noted:

> *When we do our AGMs…we look for a space where we will have four corners away from each other, because we have to do the interpretation in all these languages… There's a bit of juggling and…it takes longer, but that's the way AGMs are [here]. And we also try to value the multiculturalism… Each year we have guest entertainment and music of one of the communities playing to just have an introduction. Some AGMs we do dedicate to respect of multiculturalism and inclusivity and diversity.*

For some, there was a keen awareness of the lack of equity for the populations they served, whether this was due to language and cultural barriers (for immigrant, refugee, and newcomer populations) or social stigma (directed towards those with mental health and substance use issues), leading one participant to note: "[T]he healthcare system unfortunately is not built in a way that will consider…diversity in the population. It is one of the main missions and visions of [our CHC], to provide equitable access." Others emphasized the aspirational goal of more fulsome integration with disparate sub-communities within their catchment, including the underhoused. Recognition of the discrete needs of sub-populations directly informed programming for some, either through board or committee awareness or direct advocacy on behalf of the population:

> *The community is especially strong on advocating for mental health needs and addiction,*

and that's pretty much across [our catchment]. If we want to say things that get community approval, we talk about the need for better mental health services. And so that's very much been identified.

Several participants recounted growing success in building relationships with marginalized populations, relationships that had the dual role of improving service planning but also better meeting the healthcare needs of the population. As noted above, the key enabler of these relationships is trust, which allowed for the sharing of experiences so service gaps could be identified, and modalities of preferred care could be enacted. For some, this meant moving from not accessing any primary care to full access to the care they required. Most participants noted that successes were contingent on the combined effort of the CHC team including outreach workers and support staff along with healthcare providers.

Some CHCs were explicitly created in response to lack of culturally appropriate care for the communities they serve, with the visionaries being leaders from the marginalized communities themselves. In the case of Indigenous patients, Elders in one geography observed the lack of attention to the impacts of colonialization and the consequent intergenerational trauma, and that person and family centred care was needed. The origins were rooted in the valuation of social care, in addition to clinical care and attention to culturally embedded ways of providing this care. The participant described this evolution as "the second part" of the organization, the maturation into a truly community-responsive model of care.

The need for a nuanced approach ("low barrier and non-judgemental approach… to make them feel culturally safe") to particular patient cohorts was not exclusive to Indigenous populations. Other participants noted the challenges of meeting the needs of street-entrenched populations, and again, the attendant need for mental health resources beyond the clinical care provided. This extended to the need for gender-based violence programming and the consequent need for support in facilitating improved social determinants of health. For yet others, it was the focus on care for the 2SLGBQ+ population or those who were previously incarcerated. Key to all these efforts, as noted above, was facilitating safe access to care for these populations. As one participant discussing care for people with HIV/AIDS noted:

[Regarding] HIV services and supports … our strategy was ensuring that we're constantly destigmatizing. So, low barrier approach. There's a back door entrance for folks who don't want to come through the front of the centre.

Larger, established CHCs were able to work this imperative into their structures by creating specific departments or teams to focus on health equity and community engagement, although even these CHCs lacked funding and resources. As one participant noted:

> *We are dramatically needing more resources. One of the biggest parts of our models is that interpersonal connection with our community. We could be doing so much more and helping so many more people if we had a clinic manager or another individual that could go out into the community and attend those meetings… Having that person who could really inform and find out what the needs are more personally, rather than, you know, on the fly, would be brilliant. If we could have that clinic, that individual who could gather more of this information and help grow this model within our region, I think we would be way more effective that way.*

Funding challenges for the CHCs who were able to secure additional grants to attend outreach to communities that take more intentionality to engage were complicated by the cyclical (usually annual) nature of the grants, meaning funding was not guaranteed for more long-term program development.

Informal Processes

Several participants spoke of the "informal" nature of community outreach which often happened in an ad-hoc way, due to the more immediate task of "just keeping afloat." Others recognized the disparate work being done across their programing (for example, "reaching out over the phone") but that "it really needs to be more unified." And again, as noted above, some participants pointed out the direct community engagement in response to CHC programming through natural conversations with clients on a daily basis. Some pointed out the organic development of ties with other agencies that helped them meet their outreach mandate ("And part of that comes through the community networking because it's the most effective way of doing it") and avoid the paralysis of "not getting anything else done."

Network Building

As noted previously, taking positive advantage of established and emerging networks between CHCs and other health and social service agencies allowed many of the CHCs represented in this study to optimize their resources. Several respondents spoke of the value of "multi-agency partnerships," for example, tables where "we have the healthcare and settlement sector coming together [to] discuss the needs of the community." As one participant said:

And that's what came from the research, that you really needed to have a large collaborative network in order to really serve your population, be client-centered. In working with the foodbank, we're in the process of hopefully hiring another in office dietician to work directly, because there's high needs with our local food bank.

Others took a grounded, pragmatic approach to facilitating the interface between their CHC and other community organizations by, for example, choosing a clinic location that was in walking distance to other services:

It is one of the reasons why I positioned the clinic [here], because everything's within walking distance. The community gardens is in walking distance, the foodbank is in walking distance, the Save on Foods where we do grocery tours is in walking distance, and many of the schools are within walking distance to the clinic. So, it's quite a community centered clinic. And when we are working with the local food bank, we really want to be able to give them permission to refer clients to our men's groups, to our parent's groups for anxiety, to our psychiatrists if they need help...

For some, their networks extended beyond health and social services to include resources for the CHC itself, such as social work practicum students through local universities and colleges, medical residents, and counselling students. Aside from their contributions to the CHC, several respondents also reflected on the larger objective of socializing the integrative model of healthcare to those who will be contributing to health and social care in the future. To this end, several participants described the importance of building ties to their local Divisions of Family Practice, some with more success than others. Other outreach was more politically directed, noting work to create bridges with their local town councils and MLAs.

Participants from lower-volume rural communities expressed a strong imperative for networking within their geographies, in order to reduce unnecessary redundancies and minimize the draw on the larger community. Shared context and common values tended to make these networks productive ("Our small [communities] know each other's language.") The participant went on to note the value and efficiency of not trying to duplicate service delivery models in several communities, but instead to fill in gaps. The ultimate outcome – better client care – was directly noted by some. As one responded succinctly said,

And collectively, if we can all be on the same page, our clients have better continuity of care. And so, we don't think that we're the end all be all. We know we're not. And so,

helping to influence other places, or at least tag teaming, is really important. Sitting on different committees has been really integral.

Some respondents noted that like community engagement in general, networking was another activity that took resources away from their service delivery objectives and that to do it effectively, additional funding was needed ("At a partnership level, we are not anywhere big enough to try to do those things right now…"). Some reported achieving this funding through leveraged grants while others noted that networking was a "requirement" of grant funding. Regardless of the catalyst, however, the spark to pursue networks led, for many, to assembling productive tables (referred to by some as 'situation tables') where key community partners (such as fire department, emergency services, police, healthcare, MCFD, local food banks, and schools) could come together for collaborative dialogue and action. One participant expressed the value in this:

[I]t was at the time quite valuable in not just addressing issues that we were having with clients in common but enabling us to take time together to look at what are the issues, what are the strengths, etc., you know.

For some, these alliances created relationships for the first time between, for example, RCMP and the healthcare providers, which was seen as an advantage: "[We] are all doing very similar work with probably a lot of the same clients." One participant provided an example of how the inter-agency networking improved patient care:

An example that I can think of is, you know, ambulance is called to the house for an elder in whatever type of distress and they recognize getting into the house is nearly impossible.... And so, they're able to bring forward to us this elder's entrance way and getting up and down the stairs is dangerous, and we need to find a way to get them attached to resources to help. You know, sort out safe strategies for moving in and around the house… We wouldn't have any idea. It's what paramedics or police or fire would be able to alert us about. And you know, same goes with people that are living in some level of squalor or any sort of safety issues that emergency providers are seeing in those moments, there should be an avenue for them to discuss this with us, so we can connect people to the right resources. I'm big on prevention.

Others with primarily a virtual presence for the services they offer were even more emphatic about the need for active networking, emphasizing how important it was to create the

connections that may happen more organically if there was a bricks and mortar structure to walk by. Some mentioned the historical importance of social media platforms like Facebook in creating these connections, but that they had a renewed strategy to more actively seek out organizations with intersecting populations. One participant noted that this was done through "making lists of all these other organizations that provide services that we might want to refer out to and folks we might want to get in touch with."

The most salient take-home message on network-building by participants in this study was recognition of their essential role in actualizing the mandate of their CHC. As one said,

> *If we don't have the partnerships, then we don't do anything. It's the partnerships that make us that strong. We wouldn't be that strong otherwise. The Heat Workshop that we did, it really was in a partnership with [other organizations]. Because it's not just us.*

Iterative Direction-Setting

Given resource and time constraints, several participants described a process of iterative, community-led direction setting by engaging through established mechanisms of service delivery, such as soliciting direction from attendants at health promotion groups as to what participants want to see for future discussions ("They give us direction, they request some topics. And also in each community group meeting, they discuss something that the group asked for…"). Others spoke of the pipeline to the community through board members and staff that are community engaged, or through peer support groups.

Capacity for Engagement

Funding

In describing CHC's capacity to engage with communities, most participants cited a lack of funding as the limiting factor. Fewer funds meant less leadership and administrative staff, and a required focus on the "bare bones" elements necessary to running the CHC, rather than contributing financial resources to the higher order principle of engagement. Each participant affirmed the importance of engagement work, but voiced frustration at the limitations they identified.

"Good strong core funding" was an enabler for CHCs to work better and to engage with the community. For the CHCs who had more financial resources, they explained their engagement

work had grown in parallel along with their funding:

> *It's progressed in leaps and bounds, and we feel so strongly that it is the way to make things work in our community from all the angles. From a health equity perspective, from an economic, an efficiency model for making the most utilization of our human resources…It is the only way to go...it's the dream that makes so much fore-sense from every perspective.*

On the other hand, participants shared that while staff, community, and their boards were supportive of engagement work, and that the conceptual commitment to engagement "is there", many were unable to move forward with concrete steps because of the financial burden.

Some participants reported reliance on grants to augment capacity for engagement, as well as to pursue more formal evaluation processes. In these cases, episodic funding through grants enabled progress for limited periods of time, but most CHCs were unable to sustain the progress past the grant funding periods. For example, one participant explained:

> *Because of the pressures of other things…once the grant was over, we couldn't sustain it. But it was at the time quite valuable in not just addressing issues that we were having with clients in common, but enabling us to take time together to look at what are the issues, what are the strengths, etc.…we long have agreed with the need to have grassroots community input into the services that are being delivered to us.*

Some participants suggested they would put augmented funding towards marketing, to inform more people of their existence and services offered. This was couched by the fact that raising awareness of their CHC means potentially more service utilization, and a mandate to meet that increase.

> *There's always that fine line in health… If we let people know, they're going to come. Do we have the resources to serve them? That's the dilemma that we've been in. But I believe in the opposite. Inform people and then we'll find the resources. Let's operate differently rather than glass half empty and being fearful. Let's operate from a place of open-mindedness, that we are going to get the resources.*

Many participants also cited a specific desire for funding that supported growth in cultural

safety, as well as in exploring the impacts of colonization, and mental, emotional, physical, and spiritual well-being. Some shared that funding streams don't often acknowledge the "role that culture played or honoring knowledge holders or cultural practitioners and their skills in addressing health." Some participants identified progress made in these priorities during COVID, and after the identification and affirmation of unmarked graves in British Columbia.

> *[Regarding] Indigenous approaches to health and wellness, we didn't have the funding to be able to do that, and yet, that was our mandate for a long time. In order to meet clients where we're at, we need to be able to understand. And so, peers, survivors, they're a huge piece of the work and they're just starting to find a place where they can be honored to do the work. We're really excited to continuously engage that and just keep continuously pushing back to make sure that the right voices are being put at the table to be heard.*

Participants also suggested that with overall limited funding and human resources, there was not enough time or funds to pay staff to focus on the administrative work associated with community engagement. A common desire was for a "clinic manager" or organizer, who would be able to facilitate interpersonal connections in alignment with the "values of our clinics."

Others shared that the administrative work being done right now was often volunteered by staff and done "off the sides of their desks." CHC leaders shared that many of their coordinators are also doing client-facing work: "All of our monies goes to client-centeredness or practitioner education. [Administrative work] is done all on my own time. If we were able to build that into the model, it would be brilliant. It would be absolutely brilliant." Others noted that administrative costs were an unexciting expense, yet absolutely fundamental to the success of CHCs and their ability to perform meaningful community engagement work. Frequently, these expenses were covered by the donated time and resources of CHC's boards or community connections. One shared, "So much community support we've received for this vision. But it would all be a little bit easier if there was money."

Human Resources

Participants also emphasized the availability of human resources as a factor limiting their capacity for engagement. Participants across the board were interested in having a point-person paid to lead community engagement activities as a part of their quality improvement portfolios.

We are dramatically needing more resources. One of the biggest parts of our model is that interpersonal connection with our community. We could be doing so much more and helping so many more people if we had a clinic manager or another individual that could go out into the community…

Participants reported that with the work of keeping their CHC operational, they had reduced time and energy to dedicate to community engagement work. In response, many cited that extra clerical support staff with a focus on pulling together data from the community would be a significant asset.

Participants also discussed the critical role that volunteers play in augmenting their human resource capacity. Nevertheless, many explained that with so few resources, engagement "will always be a struggle. Even when you have brilliant volunteers involved and everything else, there are limits." While volunteer capacity was a critical element of the success of CHCs, many especially rural communities were described as "board heavy", where many community members sit on committees with "empty seats." In these instances, the volunteer resources were also limited. The demographic of volunteers was also described by several as mainly seniors, so participants discussed the importance of engaging young people to support the ongoing success of their CHCs.

Despite shortages of health human resources, participants reiterated the values propositions of staff and volunteers regarding engagement. Engagement was described as a "huge aspect for this kind of work…In all of our roles there is an aspect of community engagement. It's essential, really, to provide an effective service. I think that expectation is deeply entrenched." In terms of healthcare workers, some participants noted that burnout and exhaustion also limited providers' capacity to do thorough community engagement. Despite interest, participants reported difficulties with mobilizing providers around things like QI.

Increased capacity through government support

Participants discussed support from the government as one area that may expand their capacity to engage in community outreach work. Some participants discussed ways the Ministry could better support CHCs, for example, having emergent CHCs apply to the Ministry for start-up funding and support linked to regional health authorities. In the current state, participants were worried that the CHC model was at time not in sync with local health authorities, leading

to “pitting two models of healthcare against each other…” Participants hoped that further support from provincial level health administrators could help to develop processes that make expanding the CHC model more feasible.

In some cases, participants discussed ways that health authorities and governmental organizations had meaningfully engaged with CHCs, leading to better care. For example, one participant, involved in Indigenous cultural safety, shared that they had been invited to support the health authority in improving the cultural safety of their vaccine clinics. This enabled and was demonstrative of a positive and trusting relationship between the Health Authority and their CHC. This participant described the interaction like this:

> *They facilitate the stream of funding, and they work with us. They partner with us in services they are not set up well to support, and I think that’s the beauty, is we provide a gap because of our process they can’t fill, and so they support us in that.*

On a more local government level, other participants shared that their municipal government had been instrumental in finding funding and support for the CHC. One participant reported that when the community had been at risk of losing healthcare services, they had successfully turned to their local municipality who offered support. This was an enabler to the CHC model and their ongoing capacity.

Others, however, had fewer positive experiences of support, or lack thereof, from the Ministry of Health and their regional health authority. In a few cases, participants were frustrated by the lack of system-level support from existing health organizations. Participants reported that “coming at it from a community perspective, the whole healthcare system is so opaque. You can't even find out who the people are that you should be talking to, because it's so complex. And there's so many levels of management.” In some cases, participants reported that even recognition from the government, of the “burden that community health centers are carrying to ensure that clients and their families and communities are being served accordingly” would be a helpful start.

Actioning Community Input

Participants discussed examples of times where community input was actioned, as well as expanded on further barriers to action.

Inaction

Several respondents discussed their frustration with feeling like they know what resources and strategies they need to improve their CHCs, yet not being able to secure them to action change. Another shared that again and again, they were limited by the "shortage of money and funding and programs…" Even if strategies to improve care through community engagement were identified, participants were unsure of how to access resources to make the changes. One participant shared,

> *We, on a lot of levels, know what we need here…It's not difficult. It's not rocket science. We don't need more studies. We don't need surveys. Our surveys, we've done I think three housing surveys to date. But we haven't got the housing because nobody takes any notice of the survey. And all your energy goes into the survey…things happen when we can hire somebody.*

Participants explained that frequently, staff and leadership at CHCs know what the community needs, based on previous surveys and studies, as well as working day after day with community members on the ground. The missing link, instead, is the funding to hire a team member to create actual change in response to these findings. This paralysis led to expressions of frustrations with limited funding.

Disconnect between community and HA/clinic-identified needs

Additionally, participants discussed a "disconnect" between "…what the community wants and what the health authority and the clinics and the physicians think is best." These disconnects were considered especially delicate given the scarcity of physicians as a resource, especially in rural communities. In some cases, the actioning of community engagement was limited by community reluctance to formalize complaints or even suggestions, for fear of upsetting or alienating primary care providers.

> *It's really challenging. So many individuals don't want to upset the physicians and the physician balance…The messaging we keep hearing over and over again, is if you lose your physician, you'll never get another one. So, they're very reluctant to complain.*

Given the sense, real and perceived, of physicians as a scarce resource, the thought of putting into action changes or responding to community concerns was at times complicated.

While participants discussed the challenges of disconnects between physician and community identified priorities, others shared examples of very positive alignment between physicians and the CHC model. Where there was a sense of support from physicians, opportunities to develop the CHC model further were apparent.

Established feedback pathways

Multiple participants expressed a desire for better solidified feedback pathways, from their CHCs to higher, systems level decision-makers. There was a significant desire to see changes to the ways that community feedback could be actioned at regional, health authority levels. Many participants expressed frustration with feeling unheard by systems level decision makers:

> *I can send a million emails and just complain…to people, but I don't know…while we are being the boots on the ground and the first people in this in the system to develop something, where do we go with that information?*

Participants shared that based on their direct involvement with community members, and their role in regularly performing "needs assessments" for their communities, a pathway to report feedback at a systemic level would be immensely valuable. For a few participants, with the current systems in place, reporting community feedback and information at a systems level felt futile: "I'm banging on a door, and I don't know that anyone is listening." Nevertheless, participants reported ongoing desire to see community feedback reflected at a policy level.

Examples of Action

Despite challenges, participants also shared positive examples of when they had been able to action change based on community engagement. For example, participants discussed adding new team members, such as doulas, to maternity programming, based on identified needs, as well as expanding programs such as those targeting folks living with HIV, HCV, or TB. Others discussed their outreach with at-risk community members through focus groups: "We're constantly trying to look at how we do this better."

Some participants suggested further partnerships between existing CHCs, or new partnerships with regional health authorities, to examine the landscape of community needs and to come up with approaches to actioning change.

Finally, participants also spoke to the strengths of small communities specifically in filling unmet gaps in community-based settings. One shared, “When there isn't the health authority government stepping in, the community often does fill those gaps quite well…” Small communities were seen to have particular strengths in actioning change at a local level, even when experiencing under-resourcing at a systemic level.

Legacy of COVID-19

Some participants discussed the initial and ongoing effects of the COVID-19 pandemic on their CHCs, sharing both challenges faced, as well as silver-linings.

Challenges

In a few cases, participants described that the opening of their Community Health Centre was unfortunately aligned with the onset of the pandemic. In these instances, participants faced challenges with hiring and gaining momentum as new CHCs, which stunted their initial growth. As one participant shared:

> *We’d just got a number of individuals hired and settled, and then we decided as a team to stay opened […when COVID hit]. And to stay open we had to stay at about 40% capacity. So that hindered our ability to hire…*

Along with difficulty in adding positions due to limited capacity, participants also shared that there was hesitancy in the job market, especially in early days of the pandemic, as people were tentative about moving into new positions during a period of such uncertainty.

Others noted that COVID meant redirecting energy and resources towards “getting through” the pandemic. Consequently, higher order principles such as active community engagement were put on hold. One participant reported that they have not had a full, in-person community meeting since COVID began. While they had held consistent AGMs, these meetings were held virtually, “in the context of pandemic restrictions.” Participants noted that this limited the number of people that attended.

Similarly to comments made around health human resource shortages, participants also shared that the legacy of COVID-19 solidified a need for a leadership team. In the context of a pandemic, where big decisions were required, participants noted that a solid and sound

leadership team, directly focused on decision-making, was crucial. This was contrasted with the reality of many CHC coordinators being involved in direct patient care: “In a perfect world, if I can have them strictly administrative that would be incredible, but of course, we just don’t have the funding for that.” The onset of COVID meant this need was made even more explicit.

Silver-Linings

Along with these challenges, participant did discuss a few ‘silver linings’ of COVID, including that it “forced” the development and expansion of virtual care systems – something that participants identified as a want and need in their communities. Virtual care options meant increased access to providers and especially specialist who may not be available in a smaller community, for example, psychiatrists. One patient summarized this silver lining:

> *I do feel like the concept of being able to use technology to ease travel, it’s something that many patients want, and I think it’s something that we increasingly provide. That’s one thing, an upside from COVID, that it’s allowed the system to do that, and I don’t think it’s going anywhere.*

Additionally, for at least one interview participant, COVID revealed opportunities for their CHC to adapt and respond to the needs of the community. Their CHC tailored services to offer testing and COVID assessments. Additionally, recognizing that the main need of the community early in the pandemic was information, they began developing an informational bulletin to answer questions and spread awareness. They shared, “… everyone was supportive of pivoting our services to support the community where the community needs were.” In this way, though COVID presented certain challenges, this CHC found ways to adapt services to meet community needs.

POINTS TO CONSIDER

Although all participants in this study expressed an aspirational goal to actualize their CHC's commitment to be community-directed in their programming and service delivery, there was variation between CHC participants in their capacity to actualize this vision. The CHCs that were more established and were able to secure leveraged funding were more likely to have set pathways of community engagement for the purposes of service planning and delivery. This makes sense, as the most-cited reason given by participants for not actualizing community engagement goals was lack of resources in the context of necessary prioritization of service delivery. Below are some key points that the data revealed:

1

The need to clarify individual definitions of community. Although this was most straightforward in smaller, rural locations where the service delivery catchment was well-known, it became more difficult in larger urban centres or for virtual services with an extended mandate. One participant articulated this succinctly:

> *… we have very loosely defined community in the past [as] kind of amorphous… It's quite a vast area. And I mean, there's some outliers as well. Part of the question was, who do we belong to? Who's our community? Because it was really based on co-op membership, which is quite diverse.*

Moving forward, a clear methodology for defining and mapping "community" – either geographically or by group of interest – will be an important cornerstone from which to build an engagement strategy.

2

Likewise, creating a clear, resonant definition for community engagement would allow common benchmarks for determining success and a clear aspirational target. To action the values underscoring CHCs, a definitional standard and metric development should be done in close collaboration with community members. As one participant noted:

> *I think it would take what we're doing to that next level that we would want. So, we would have some really clear outcomes that we were wanting to address. Because community engagement is a very broad concept, so we would be more clearly defined and probably have a broader scope in terms of what we were wanting to understand with our community engagement process.*

3

There is a clear need for local adaptation of any strategic approach to meet community needs, further enhanced when needs were understood through a diversity lens (one size does not fit all). CHC participants in this study were all aware of the need totailor engagement approaches, although not all had the resources to do so. Those who were *able to tailor outreach to the specific demographics of their communities achieved the most self-reported success.*

4

A thematic finding included the importance of networking with other settlement and social service agencies to create linkages to services that were out of scope for the CHCs or that they were unable to meet. The concept of networks extended to systems-level agencies or organizations, such as Divisions of Family Practice, to ensure strategic ties to other aspects of health system planning and delivery. Network development, like other areas of non-service delivery work, was deemed to be a key enabler of success for many of the CHCs in this study; consideration of how network development can be supported and grown will be a key determinant of CHC success moving forward.

5

The imperative to start engagement early in the development of CHCs was expressed by almost all participants. This referred to the actual birth of new CHCs, but also to new programming, designed to meet the needs of the population. The idea that "it starts with community" was succinctly articulated by one participant:

> *[S]tart early. Honestly. Anything we do in terms of new initiatives, it always starts with the community. It's so critical… For us being geographical, being small, physically isolated communities, I can't quite imagine how we would do somethings without community input…But developing an effecting community engagement committee early on saves you so much grief, because you've got a way to do the necessary check-ins that you want and need to do, and that input is incredibly valuable. It steers you in the right direction.*

6

It is necessary to ensure a systems approach to engagement and planning to align with larger provincial strategies and priorities, such as the focus on team-based care, equity, diversity, and inclusion and meeting the needs of Indigenous communities in a culturally appropriate, community-directed way. Aligning with existing provincial mandates will better position CHCs to offer reciprocal value to health planners and decision-makers, beyond the value of reducing population-level morbidities and health costs. The niche of understanding community needs were stated clearly by one participant:

And of course, we so much want to make sure that what we're gathering is going to be valuable for that [provincial] level of decision making, but we also really want to have that deep understanding about what works at a community level.

Finally, there is a clear need to distinguish between feedback and community engagement. Although all three are critical to the success of CHCs, understanding the nuances of the terminology – which underscore the activities – is essential, as they are distinct concepts. In brief, feedback refers to information or opinions provided by patients/clients about their experiences of healthcare, reflecting the strengths and weaknesses of the services or system. It is generally collected through mechanisms such as surveys, suggestion boxes, or through direct conversation with the objective of providing areas for improvement.

Engagement, however, refers to more active participation of the community in shaping healthcare programming and delivery in a longitudinal way (as opposed to discrete, one-off events). It is characterized primarily by its capacity to reflect the values and priorities of the engaged community.

The primary assets of CHCs in BC are the underlying values propositions suggesting how services should be delivered. Although all participants in this study were aligned with these priorities, some were unable to achieve them currently due to constrained resources and the need to prioritize access to care. With additional, centralized support for common activities, such as outreach, engagement, and evaluation, CHCs will not only be able to meet their mandates but provide a model of best practices for other parts of health service delivery in BC.

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