The Canadian Journal of Program Evaluation Vol. 11 No. 2 Pages 149–157
ISSN 0834-1516

COMMUNITY HEALTH CENTERS: EVALUATION ISSUES AND APPROACHES

Corrine W. Johnston
Department of Behavioural Science
University of Toronto

Abstract: Community health centers present a challenge for evaluators because of their multiple and overlapping programs, variable client base, culturally diverse clientele, and nontraditional approach to health and wellness. This article provides an overview of the evaluation strategy adopted by a rural southwestern Ontario community health center to overcome these challenges. The purpose of the evaluation was to obtain a broad picture of the center's internal dynamics, processes, and efficacy following its first two years of operation.

Résumé: Les centres de santé communautaires représentent un défi pour les évaluateurs à cause de la multiplicité et du recouvrement de leurs programmes, la variabilité de leur clientèle de base, la diversité culturelle de leurs utilisateurs, et leur approche nontraditionnelle à la santé et au bien-être. Cet article donne une esquisse de la stratégie adoptée pour relever ce défi par un centre de santé communautaire rural du sud-ouest de l'Ontario. Le but de d'évaluation était d'obtenir une vue d'ensemble de la dynamique interne du centre, ses processus, et son efficacité, à la suite de ses deux premières années de service.

Ontario's community health center program was developed to address issues related to the efficient use of health resources, equity of access, the distribution of power between health care providers and consumers, and the shift in emphasis from acute hospital in-patient care to health promotion and illness prevention. Although established to meet specific objectives, community health centers (CHCs) are a relatively heterogeneous group that offer a wide variety of services and programs (e.g., primary care, health promotion, social services, community development, and advocacy), employ a range of health care workers, and tailor their activities to various priority groups. For example, priority groups (i.e., groups having difficulties accessing health services and groups with a greater tendency to suffer from ill health) may include ethnic

minorities, children, teens, seniors, pregnant women, and the economically disadvantaged. An additional common feature of CHCs is that they are sponsored and managed by an incorporated nonprofit community board whose members include clients of the center and individuals interested in health and social services (Ontario Ministry of Health, 1990).

Currently there are 58 CHCs in Ontario. Most are concentrated in large urban areas such as Toronto and Ottawa, but some, such as Woolwich Community Health Centre, serve rural populations.

WOOLWICH COMMUNITY HEALTH CENTRE

Woolwich CHC is a grassroots organization in that it was developed by a group of dissatisfied community members who recognized that their rural area was both underserviced in health care and in need of special services. Specifically, it was necessary for most individuals to obtain medical care in a nearby city. Travelling posed a problem because a large portion of the community is composed of Old Order Mennonites, who rely on horse and buggy as their means of transportation, and senior citizens. Furthermore, it was believed that the community would benefit from a health facility that would provide health promotion and illness prevention programs.

The health center received its funding in 1989 to deliver services to an area consisting of seven small settlements and the surrounding rural population, approximately 6,800 people. Priority groups were defined as Mennonites, the elderly, and the general rural population. The center also acquired about 400 clients who resided outside of the catchment area when they followed their family physician to her new practice at the health center. Most of these clients were Polish speaking.

In the first two years of operation, WCHC focused its efforts on recruiting clients and developing health promotion and primary care services. Staff included two physicians, a nurse practitioner, a health promoter, a chiropodist, and a social worker. The health promotion component focused heavily on cardiac health, as a needs assessment identified this area as a primary concern in the community. Public education in the form of town hall seminars was provided on cardiac risk factors and disease prevention, individual counselling and group programs were offered to assist high-risk individuals in making healthy lifestyle changes, and a health fair was held to increase the

community's awareness of available health resources. In addition, a program planning committee was formed to set service priorities, and a quarterly newsletter was produced to inform the community about the center's events and to encourage participation.

OVERVIEW OF EVALUATION OBJECTIVES

The primary objective of the evaluation, as identified by the director and staff, was to obtain a broad picture of the center's internal dynamics, processes, and efficacy following the first two years of its operation. Staff anticipated establishing a five-year evaluation cycle whereby subsequent evaluations would be compared with previous ones as a means of mapping progress and development. Further, to improve program designs and measure outcomes, feedback was required regarding program content and delivery, as well as their effects on client behavior.

EVALUATION ISSUES

The unique characteristics of Woolwich CHC and of community health centers in general presented a number of methodological and strategic challenges throughout the evaluation process. These evaluation issues and the steps taken to address them will be reviewed in the remainder of this article.

Variable Client Base

Community health centers have at least two distinct client populations: those who are registered and those who are not. To receive primary health care services, such as from a physician or nurse practitioner, clients must register with the health center. That is, they must identify the center as their principal health care provider. However, CHCs also engage in community development and offer a wide range of community-based services, such as health education, breakfast programs, and needle exchanges. These initiatives generally do not require that clients be registered.

In terms of evaluation, difficulties arise because the nonregistered clients are often an unknown population. Clients may receive services or educational programs, but it may be impossible, if not unethical, to collect information such as sociodemographic data, utilization rates, and changes in health attitudes or behavior. For

newer centers such as Woolwich, data from nonregistered clients are valuable not only for the purpose of assessing program outcomes, but also for determining community health care preferences or needs and attracting new clients.

Woolwich CHC engaged in several initiatives that reached both registered and nonregistered clients, including a community-wide education program addressing contamination of the area's drinking water. However, to make the most efficient use of limited resources, the programs selected for outcome evaluations were those that were delivered in a confined space over a short period of time (e.g., a health fair and a workshop). Participants could then be easily identified and asked to participate in the evaluations. Other community-wide programs underwent a formative evaluation whereby the quality of the process or implementation was documented and assessed.

Multiple and Overlapping Programs and Services

A significant challenge for CHCs is the development of an evaluation framework that reflects the range of programs and services offered by the center. As previously outlined, CHCs engage in a variety of activities both independently and in collaboration with other organizations. In many cases, these programs and services may have overlapping goals, content, and clientele.

The presence of multiple and overlapping programs and services raises a number of evaluation issues. For example, how do we determine which programs or goals should be evaluated? What weight should be afforded to each program when drawing global conclusions about the health center? Is it in fact possible to draw global conclusions about the CHC based on an examination of its parts?

It is undoubtedly useful to assess program outcomes; however, evaluation of programs alone cannot adequately reflect processes occurring within the CHC at large. As a consequence, a trilevel evaluation strategy was adopted. This approach entailed a series of program evaluations, a project evaluation based on global objectives, and an intermediate level assessment that examined a cluster of activities associated mainly with primary health care.

Criteria for determining which programs would be evaluated included the ease with which clients/participants could be identified and surveyed; the extent to which programs reflected variations in

target groups (e.g., community-wide or high-risk groups) and overall objectives (e.g., education or behavioral change); and the availability of measurement tools. The intermediate-level evaluation took the form of a client satisfaction survey that was distributed to a random sample of registered clients. Questionnaire items addressed five main service areas: general satisfaction, accessibility and resources (e.g., convenience and range of services), technical quality (e.g., professional competency), dissemination of information (e.g., regarding treatment plans and the activities of the CHC), and provider conduct (e.g., confidentiality and respect). Finally, to obtain a broad picture of the health center's performance, its activities were examined in terms of the Ministry of Health's key concepts and coinciding objectives for CHCs. These objectives focus on accessibility, health promotion and illness prevention initiatives, community participation, efficiency, and integration. Systematic documentation and observation of the center's activities, judgements, and perceptions of staff and of the experiences of clients provided a rich "institutional diary" that formed the basis of this project evaluation.

The trilevel approach was extremely effective in providing a broad overview of the functioning of the health center. It facilitated the development of themes and objectives to guide a coordinated program plan and identified areas requiring further research and planning. The weakness of this evaluation lies in its piecemeal approach, in its failure to conceptualize the health center as an integrated whole.

An evaluability assessment of CHCs has indicated that health centers have a common rationale, clearly specified objectives, and a coherent philosophy (ARA Consulting Group Inc., 1992). Although this philosophy is extremely complex—it links together concepts of accessibility, empowerment, health promotion, and coordinated services with improved health status of individuals and communities (Ontario Ministry of Health, 1989, 1993a, 1993b)—it offers an opportunity for a future long-term impact evaluation of CHCs as integrated multiservice centers.

Cultural Diversity

Multiculturalism poses dilemmas in evaluation when there are conflicting and diverging values or interests within the population to be examined, and when these values are not understood by the evaluator (House, 1992; Merryfield, 1985; Seefeldt, 1985). Weiss (1983) argues that the stakeholder approach holds the most promise for

legitimizing competing interests. Yet even when these interests have been identified, synthesizing and prioritizing them may be difficult. As CHCs were developed to meet the needs of diverse groups such as ethnocultural minorities, this is a pervasive problem.

At Woolwich CHC, two groups presented challenges because of cultural differences. The Old Order Mennonites are a unique religious and cultural group because of their evangelical Christian faith and their desire to remain apart from the industrialized and modernized world. The significance of the Polish-speaking group was only realized after a random sample of registered clients was drawn for the client satisfaction survey. Closer examination revealed that this group constituted 17% of the total patient population and approximately 80% would have difficulties completing an English-language questionnaire.

Community consultation served to explore evaluation issues among the Mennonites, as well as to determine culturally appropriate ways in which this group could participate in the evaluation. An Old Order Mennonite Advisory Group had been established by the executive director during the developmental stages of the health center to provide insight into their health needs. This advisory group also linked the evaluators with other members of the Mennonite community and later participated in focus groups to discuss the design and implementation of the evaluation.

Overall, the interests and values of the Mennonites did not differ widely from those of other groups. Concerns that did arise were related to professionals' respect for their choice of religion and lifestyle and the payment of health care services. Old Order Mennonites decline government funding and therefore do not receive benefits such as health insurance and pensions. Consequently, one client satisfaction criterion identified by the Mennonites was the extent to which the health center accommodated their differences in service payment. As this was a concern exclusive to the Mennonites, it was not incorporated in the satisfaction survey, but rather was assessed independently using a qualitative approach. On the other hand, because respect from health professionals was an issue commonly identified by clients participating in the design of the evaluation, it was incorporated into the client satisfaction scale under the "provider conduct" dimension.

Whereas communication and consultation with the Old Order Mennonites was planned and ongoing, the Polish Advisory Group

was established hastily when it became apparent that the number of Polish speakers was substantial. The main function of this group was to translate the client satisfaction survey and to make follow-up telephone calls to Polish clients who had been selected to receive the questionnaire.

Information regarding community consultations and focus groups pertaining to the evaluation had been posted around the rural areas and announced in the health center's newsletter, which was distributed to all residents of the catchment area. However, the Polish clients resided mainly in Kitchener-Waterloo—outside the center's "official" catchment area. As a result, their health care values and interests were largely excluded from the evaluation process. It was not surprising to later learn that the return rate on the client satisfaction surveys was significantly lower among the Polish clients than the non-Polish ones. This outcome underscored the value of the stakeholder approach in gaining client input and involvement.

Broad Perspective on Health and Wellness

Like many health organizations, CHCs have adopted the new community health promotion philosophy. Some of the prominent features of this approach include: a broadening of the definition of health to include socioeconomic determinants; an effort to remedy causes of illness within the social and political context; the employment of community development as a health promotion strategy; and the acceptance of empowerment as a key concept in health promotion (Robertson & Minkler, 1994).

The shift away from the traditional perspective on health—which views it simply as a physical state of being—has necessitated the development of new strategies and indicators that are more consistent with the notion of health as "political." Conventional criteria, such as changes in health behavior, utilization patterns, and incidence of illness, need to be supplemented with indicators that tap into issues related to, for example, the distribution of power, dissemination of information, and advocacy efforts.

The cluster survey at Woolwich CHC included a preliminary examination of three empowerment dimensions: knowledge, participation, and control. For example, survey items assessed the extent to which clients (a) were informed about the operation of the CHC; (b) were provided with opportunities to serve as a board or committee

member; (c) participated in decision making in the therapeutic relationship; and (d) experienced a sense of control over their health. A more comprehensive assessment of empowerment may include an examination of the composition of the board of directors, with particular attention paid to the presence of community representation.

CONCLUSION

As CHCs establish a foothold within Ontario's health care system, interest in determining their ability to improve the health of individuals and communities grows. This article provided an overview of the some of the evaluation issues that arise as a consequence of CHCs' unique characteristics. Specifically, CHCs are multiservice centers that focus on priority groups, recognize the significance of social determinants of health, emphasize community-wide health promotion, and are community governed. Future evaluation efforts would benefit from the development of a comprehensive model that reflects the underlying philosophy and integrated approach to health care.

REFERENCES

ARA Consulting Group Inc. (1992). *Final report: Evaluability assessment of Ontario's community health centre program*. Toronto: Author.

House, E.R. (1992). Multicultural evaluation in Canada and the United States. *Canadian Journal of Program Evaluation, 7*(1), 133–156.

Merryfield, M.M. (1985). The challenge of cross-cultural evaluation: Some views from the field. In M.Q. Patton (Ed.), *New directions for program evaluation*, No. 25 (pp. 3–18). San Francisco: Jossey-Bass.

Ontario Ministry of Health. (1993a). *Community health centres in Ontario: A picture of health*. Toronto: Community Health Branch, Ontario Ministry of Health.

Ontario Ministry of Health. (1993b). *Community health centre program, Ontario Ministry of Health: Strategic directions, 1993/94–1996/97*. Toronto: Strategic Planning and Evaluation Project, Ontario Ministry of Health.

Ontario Ministry of Health. (1990). *How to apply for funding for a new community health centre*. Toronto: Queen's Printer.

Ontario Ministry of Health. (1989). *Community health centres: Program resource manual*. Toronto: Community Health Branch, Ontario Ministry of Health.

Robertson, A., & Minkler, M. (1994). The new health promotion movement: A critical examination. *Health Education Quarterly, 21*(3), 295–312.

Seefeldt, F.M. (1985). Cultural considerations for evaluation consulting in the Egyptian context. In M.Q. Patton (Ed.), *New directions for program evaluation*, No. 25 (pp. 69–78). San Francisco: Jossey-Bass.

Weiss, C.H. (1983). Toward the future of stakeholder approaches in evaluation. In A. Bryk (Ed.), *New directions in program evaluation*, No. 17 (pp. 77–90). San Francisco: Jossey-Bass.