# Case 10 : Changing the Service Delivery Model: How to Make it Happen?

Shradha Pandey
*Western University*

Yoshith Perera
*Moyo Health & Community Services*

Mark Speechley
*Western University*, mark.speechley@schulich.uwo.ca

# CASE 10

# Changing the Service Delivery Model: How to Make it Happen?

*Shradha Pandey, MBBS, MPH (Class of 2019)*
*Yoshith Perera, MBBS, MPH(2SLGBTQ+ Programs Manager, Moyo Health & Community Services)*
*Mark Speechley, PhD (Professor, Western University)*

It was a warm summer afternoon in Yorkville, Ontario as Ruksana Kadam left the board meeting of the HIV/AIDS Caring Communities (HACC). As the 2SLGBTQ+ Programs and Community Engagement Manager, Ruksana had been chosen to carry out a momentous task. The board and the senior leadership team had a meeting one week ago where they had decided to make the service delivery model of the organization more streamlined and client-centric to better reflect the needs of the population they serve. They felt the programs and services currently provided to their clients were not optimal because they functioned in silos, which lead to duplication of services and substandard client care.

A new executive director, Tracy McLaughlin, had joined the organization six months earlier and had arrived with innovative ideas. At the meeting, she had shared her vision for the organization with the board in an effort to find ways to better serve clients and optimally utilize resources. According to the executive director, the current delivery model failed to recognize that some of the clients had complex needs, and that these clients were not being referred from one program to the other, presenting an opportunity for innovation in service delivery. Ruksana learned the board agreed with the executive director and had decided to dissolve the various teams based on priority populations within the organization. The board wanted to recognize the needs of the clients and put them at the front and centre of care. All the programs provided to their priority population would be integrated into two teams: a health promotion team and a community engagement team.

Ruksana was chosen as the lead because her public health education and her work with AIDS service organizations over the past six years gave her a unique and relevant perspective. The HACC was supposed to be relaunched as with a new name in three months, and Ruksana had to create the initial plan to restructure the organization by the next board meeting in two weeks. She was conflicted in terms of how she felt about the change. She was happy to carry out this reorganization but she was also worried about the lack of evidence behind the transformation. Where could she turn to learn more about organizational change? Have any similar agencies faced such a large change and how did they accomplish it? Are there known pitfalls that she should avoid with such an undertaking?

## DEMOGRAPHICS

The region of Yorkville has one of the most diverse populations in Ontario, and 56% of its people are immigrants. Additionally, almost 75% of Yorkville's inhabitants are racialized people. The South Asian community comprises 54%of this group, and 16% of the region's racialized

community is from the African diaspora. The region is culturally diverse and requires specific and targeted care for the members of its different communities. This involves providing culturally appropriate care to members who have diverse needs. The mean annual household income after tax in the Region of Yorkville is estimated to be $72,000, and the prevalence of low-income households in the region is 14% Therefore, it is important to provide accessible care to all members of the population, particularly to low-income individuals. The geographic, socioeconomic, and cultural diversity of the region makes it challenging to provide equitable services to all members of the community.

Five public health nurses and two community champions conducted a needs assessment in the Region in 1994 when they realized there was a gap in the regions's HIV/AIDS counselling services. The needs assessment resulted in the formation of the HACC in 1995. The HACC has been serving the communities of Yorkville for more than two decades now. The HACC is the leading AIDS service organization in the Region of Yorkville, and provides health promotion, community engagement, and client support programs to the area.

The HACC provides services to clients from priority populations; the priority populations are communities who are most affected by HIV in Ontario. These include: people living with HIV/AIDS; African, Caribbean, and Black communities; people who use drugs; gay, bisexual and other men who have sex with men, including trans men; and women at risk living in the region (Ontario Advisory Committee on HIV/AIDS, 2016). Women at risk are "cis and trans women, including African, Caribbean, and black women, women who use drugs, Indigenous women, and other women who face systemic and social inequities, more likely to be exposed to HIV through a sexual or drug using partner" (Ontario HIV Treatment Network, n.d.). The HACC also provides workshops and capacity-building training to the region's service providers about making their spaces more inclusive both to clients and staff. Ruksana was sitting at her table and looking at the binder that outlined the vision, mission, and current organizational structure of the HACC. She had read about the organization's mandate multiple times. Change was finally happening and Ruksana could not be more excited. She picked up the binder once again and started reading through the services provided by the HACC.

**Current Services Provided by the HIV/AIDS Caring Communities**

1. African, Caribbean, and Black (ACB) Health Promotion Program: ACB communities comprise 16% of the racialized populations in the region and are one of the HACC's priority populations. The organization provides health promotion and community engagement activities for the ACB communities residing in the region to increase their knowledge and awareness regarding HIV/AIDS prevention and treatment. Activities are focused primarily on young ACB women, ACB youth, and ACB people living with HIV/AIDS. The program also provides HIV training and capacity building to service providers in the region pertaining to the ACB population.

2. Living with HIV: The organization provides case coordination, counselling, and referral services for people who have HIV/AIDS. The program also provides services to partners, caregivers, friends, and family members of people who HIV/AIDS. Additionally, the organization provides skills development, peer learning, and mentorship programs for people who have HIV/AIDS. This provides people with a social support network and the opportunity to engage with their community. The educational and support programs are supposed to improve access to services for people who have HIV/AIDS. The organization also provides training and capacity building workshops to the service providers in the region. The organization undertakes outreach activities at different service provider locations to reach people who find it difficult to access the services provided at the HACC site.

3. Harm Reduction: The HACC provides harm reduction supplies and health promotion activities to people who use drugs in the Yorkville region. The organization started its injection drug users outreach program in 2002. This involves community outreach activities in the form of presentations, supply distributions, seminars, and health education activities. HACC sits on a committee of service providers that support a regional response to support substance users.

4. 2SLGBTQ+ Programs: The 2SLGBTQ+ programs provided at the HACC operate within an antiracist and antioppressive framework. The main objective of the programs are to reduce the stigma and discrimination against members of 2SLGBTQ+ communities. The organization provides leadership and capacity building programs for 2SLGBTQ+ youth and young adults living in the region. Additionally, a free workshop series called “Gender Journeys” is provided to trans and nonbinary people in the region who want to share stories and start the process of healing. The agency also participates in a regional community of practice to support the health of queer and trans communities in Yorkville.

## INTERSECTIONALITY

The term intersectionality was first coined in 1989 by legal scholar Kimberlé Crenshaw. The roots of intersectionality are deeply entrenched in Black feminist theory. Intersectionality is largely used in critical theories, especially Feminist theory, when discussing systematic oppression. In her 1989 paper, Crenshaw described how black women were excluded from feminist theories and antiracist policies because the discrimination faced by them was overlapping the two and hence unique (Crenshaw 1989). She wrote: “Because the intersectional experience is greater than the sum of racism and sexism, any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated” (Crenshaw 1989).

Over the last thirty years, the use of intersectionality has expanded to talk about identities beyond race and gender such as class, sexual orientation, religion, sex, education, age, and disability. According to Bowleg, intersectionality is defined as “a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, SES, and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression” (Bowleg, 2012, p.1267). By applying the lens of intersectionality, we can better understand the social inequities and structural bias faced by marginalized communities. The concept of intersectionality helps to understand how multiple forms of oppression can interact and impact the health and wellbeing of marginalized individuals (Etherington, 2015).

Many of the clients currently receiving services at HACC belonged to one or more of the priority populations that the organization served. A client who came in to collect harm reduction supplies could also be a member of the 2SLGBTQ+ communities. Having coordination between the different teams would allow for that individual to get the maximum benefit from their single visit. Hence providing services through an intersectional lens was recognized as an important component by the board, the leadership team as well as the front line staff.

## THE NEED FOR CHANGE

Ruksana put down the binder and reflected on her conversation with Tracy. They both agreed that, despite the number of services provided by the HACC, most clients were not aware of the diversity of the programs offered by the organization. The lack of coordination among different departments resulted in clients unable to receive timely care or access the services they needed. This had led to the failure in providing streamlined service delivery to the clients

accessing care at the HACC. All the programs worked in silos and hence there was an opportunity for cross pollination of programming.

Tracy stated that Ruksana would be leading the charge of changing the organization's service delivery model. The service delivery model needed to be client-centred and applied through the lens of health equity. Additionally, a decision was made to improve the communication among different programs so that better, more coordinated care could be provided to clients. The new service delivery model was supposed to achieve the following objectives:

- Provide integrated and coordinated care to clients
- Provide client-centric care
- Improve access to care for clients
- Improve capacity of service providers to provide care to priority populations
- Support clients by providing them with information about programs in the organization and service providers in the region
- Increasing transparency in the organization among the different programs

Another important discussion at the board meeting was about rebranding the organization. After listening to suggestions from clients and staff over the past few years, it was finally decided that the organization's name should change. There were three main reasons for this proposal. The stigma still associated with HIV/AIDS prevented some clients from using the services provided by the HACC. Many clients felt hesitant to visit the organization for fear of being stigmatized because the agency's title referenced HIV/AIDS. Additionally, some of the service providers working in the Region of Yorkville did not feel comfortable forming partnerships with an organization that referred to HIV/AIDS in its title. Finally, because of the advancement in treatment options for HIV/AIDS, it is now a manageable chronic condition and people can live a long and productive life after being infected. With this shift in the narrative about the disease, the organization wanted to have a name that better represented this change and was more inclusive of its diverse clientele and the services it provided. The HACC realized that they needed a name that was less stigmatized and better represented their diverse clients.

Ruksana now had two weeks until the next board meeting to design the new service delivery model and develop a plan on how it should be implemented. Her training in public health had made her the ideal candidate to take on this task. Ruksana wanted to provide a service delivery model that was not only evidence based but also considered the local context and addressed the needs of the region's very culturally diverse and marginalized population. Ruksana understood that these factors can be a huge barrier for people accessing health promotion services, and that this lack of access can lead to poorer health outcomes.

## COLLABORATION AND FUNDING

The HACC is a member of the 2SLGBTQ+ Community of Practice and is working with other agencies across Yorkville to further increase the capacity of this program. The Community of Practice was created to increase leadership and care coordination among service providers in the Region of Yorkville working in the field of health and human services.

The HACC also supports the regional Harm Reduction Strategy for Yorkville. This group is responsible for bringing together different stakeholders so that they can help each other develop solutions that will minimize the harms related to using substances/drugs. The Drug Strategy also strives to create policies, laws, and programs in the Region Yorkville that represent the values of public health. In addition, the HACC also helped establish the Yorkville Harm

Reduction Society. The aim of this group is to strengthen partnerships and collaborations among social service agencies across the region with the goal of providing better service delivery related to substance use. The Yorkville Harm Reduction Society acts as a platform for sharing information related to substance use and provides harm reduction-focused education and training on substance use in the region.

With almost twenty five years of work in the Region of Yorkville, the HACC receives funding from a number of regional, provincial and federal agencies. The organization also receives funding from different governing bodies that serve priority populations such as people who use drugs, 2SLGBTQ+ populations, people living with HIV and the African diaspora. Every funding organization has their own priority population and specific mandates. The HACC has to follow the mandate of these funding organizations to keep receiving funding for their programs.

Ruksana soon realized that the newer service delivery model would have to take into account the mandates of the various funding organizations and collaboratives they worked with. The newer model would have to meet the needs of these funding organizations, which could prove to be challenging. If the service delivery model was not implemented in an evidence-based manner, the HACC may not meet its funding requirements and this could negatively impact relationships HACC had developed with external stakeholders over the years.
Ruksana stared at her computer for a few seconds, took a deep breath, and then typed *implementation science* on the screen.

## IMPLEMENTATION SCIENCE

Implementation science is defined as “the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice and, hence, to improve the quality and effectiveness of health services” (Eccles & Mittman, 2006). It currently takes, on average, almost 17 years to incorporate best evidence-based practices into our general health care system (Bauer et al., 2015). Only 14% of research evidence enters day-to-day practice in the health care system (Westfall, Mold, & Fagnan, 2007). There are different reasons for this gap in knowledge translation (Bullock, 2018):

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|---|---|
| Awareness | Organizations are not aware of the existing research and evidence. |
| Comprehension | The research is not presented in a usable way, or the user lacks the capacity and skills to process the information. |
| Relevance | The existing research does not provide solutions to the issues faced by the organizations. |
| Recognition | The source of the evidence is not viewed with high regard. |
| Implementation | There are barriers present to achieving change in the organization. |
| Behaviour change | It is difficult to change the behaviour of the individuals, despite all other issues being addressed. |

Active implementation of evidence-based research is guided by five frameworks as identified by the National Implementation Research Network (Bullock, 2018):

| | |
|---|---|
| What | Usable Intervention—the intervention needs to be “teachable, learnable, doable, and readily assessed”. |
| When | Implementation Stages—conducting activities at all stages is important for successful system change. |

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| How | Implementation Drivers—competency drivers, organizational drivers and leadership are the three implementation drivers that support change. |
| Who | Implementation Teams—implementation teams can be external or internal to the organization. They are champions of the intervention and follow tasks and timelines to confirm that the process of implementation is focused. |
| How | Improvement Cycles—the change is supported by improvement cycles. It is based on the plan, do study, act process, and is used by the implementation teams to be informed of the changes made to the intervention.<br><br>The implementation of a study can be tested by the plan, do, study, act process. It involves planning about the change process, implementing the change, studying the change by evaluating it, followed by reflecting on the change process - did it work, did it not, what can be done to improve it and returning back to the plan phase (Agency for Healthcare Research and Quality, 2015). |

The National Implementation Research Network explains the four stages of implementation (Metz & Bartley, 2008). It is important to realize that the stages are not linear and significant overlap occurs within them. Additionally, sustainability is an important piece that needs to be practised at all stages (see Exhibit 1) (Centre for Addiction and Mental Health, 2014).

1. **Exploration stage.**
   The exploration stage is used to examine whether the program, intervention, or change is feasible and meets the needs of the population the organization serves. It is important to assess the requirement of change and the facilitators and barriers to this change. The stage involves identifying and operationalizing the core implementation components required for change. During this stage, champions of change need to be developed and important stakeholders need to be identified.

2. **Installation stage**
   This stage is often ignored during implementation. The installation stage consists of creating flowcharts and descriptions, and developing and assessing the resources the organization has, including its human resources, finances, technical equipment, and knowledge expertise.

3. **Initial implementation**
   The change or innovation is introduced to the real world setting during the initial implementation stage. It is important to recognize that mistakes and errors can happen during this stage, but it is important to find rapid cycle solutions and promote constant improvement to the system. Data collection, therefore, forms an important aspect of this change because it helps in making evidence-informed decisions.

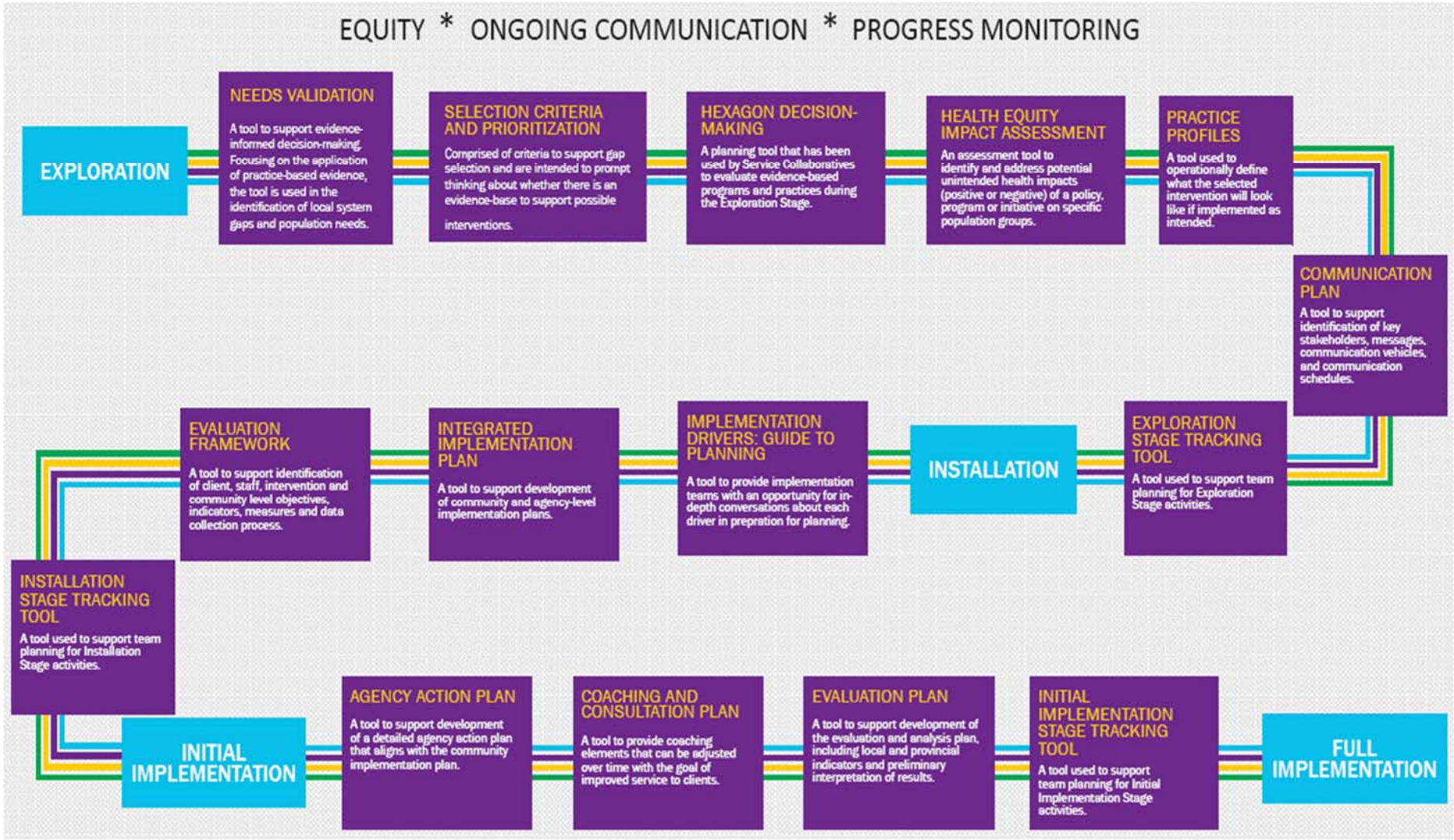
4. **Full implementation**
   Full implementation occurs when the modified system and structures are fully assimilated and the clients are served skillfully by the service providers. The change must be incorporated into all levels of the organization and there should be policies and procedures in place to support it.

Ruksana understood that any new service delivery model would have to be chosen carefully during the exploration stage before they could move further. Selecting a service delivery model that did not meet the needs of the clients, the funders, the different collaboratives, and the organization would lead to an unsuccessful change. She looked at the screen again to understand more about the components of the exploration stage.

1. Needs validation – To understand that an evidence based change is required based on the needs of the population (Fixsen et al., 2013).
2. Selection criteria and prioritization – It is a toolkit that helps the organization to think whether there is an evidence base to support the change (Fixsen et al., 2013).
3. Hexagon decision making (Exhibit 2) (Metz & Louison, 2019) – This tool helps the organization during the exploration stage to evaluate the evidence based options.
4. Health Equity Impact Assessment – The health equity impact assessment tool helps to identify unintended health impacts of the change, both positive and negative, and how to address them (Ontario Ministry of Health and Long-Term Care, n.d.).
5. Practice profiles – Innovations that are “teachable, learnable, doable and assessable” are important to reach desired outcomes and create effective supports for implementation (Metz, 2016).
6. Communication plan – It is important to have frequent and accurate communication between the implementation team and the other members of the organization, as well as the external stakeholders to facilitate the process of change (Fixsen et al., 2013).
7. Exploration stage tracking tool – The exploration stage tracking tool is used to support the planning for the Exploration stage (Fixsen et al., 2013).

It had been two weeks since Ruksana had started working on the change process and she was excited to share her plans at the board meeting tomorrow. She had shared her proposal with Tracy yesterday and was waiting for her feedback. The entire plan would take about two years to implement, but Ruksana was confident that the change would provide care to the clients through a health equity and intersectional lens, and she was excited to play an important role in the organization’s structural reform. Just then, Ruksana received an email notification and she panicked – Tracy was informing her that the board is giving them only three months to implement the new delivery model which would coincide with their relaunch with a new name. Several questions were running through Ruksana’s mind at this moment – would she able to complete this in time? What would the coordination between the leadership team look like? Has any other organization done it before and where should she look for help? Ruksana thought she would need all the help she can get from her colleagues and partners to make this happen.

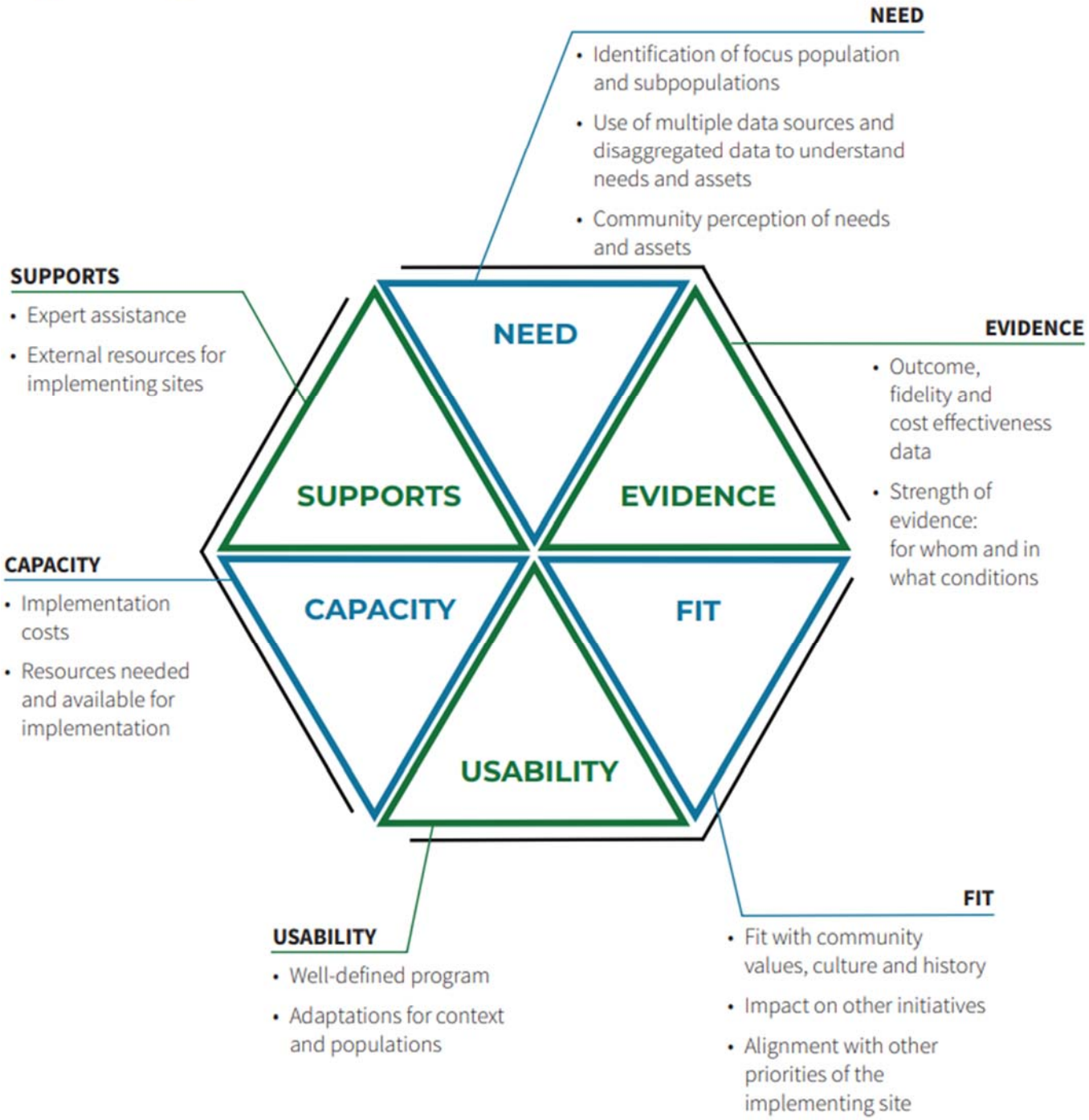
## EXHIBIT 1
**Tools to Support Moving Through Implementation Stages**




Source: Centre for Addiction and Mental Health, 2014.

## EXHIBIT 2
**The Hexagon: An Exploration Tool**

The Hexagon can be used as a planning tool to guide selection and assess the fit and feasibility of potential programs and practices for use. It includes three **program indicators** and three **implementing site** indicators.




Source: Metz, A. & Louison, L. (2018).

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# INSTRUCTOR GUIDANCE

# Changing the Service Delivery Model: How to Make it Happen?

*Shradha Pandey, MBBS, MPH (Class of 2019)*
*Yoshith Perera, MBBS, MPH*
*(2SLGBTQ+ Programs Manager, Moyo Health & Community Services)*
*Mark Speechley, PhD (Professor, Western University)*

## BACKGROUND

The case follows Ruksana Kadam, the 2SLGBTQ+ Programs and Community Engagement Manager at the HIV/AIDS Caring Communities (HACC). She has been tasked with developing and implementing a new service delivery model to be adopted at the HACC. The board and executive director are seeking change in order to improve services and care for its diverse clients. The new service delivery model would involve dissolving the current teams, which focused on priority populations such as people who have HIV/AIDS, 2SLGBTQ+ individuals, those who need harm reduction services, and African, Caribbean, and Black communities. The plan would involve creating two new teams – a health promotion team and a community engagement team. Where can Ruksana turn to learn more about organizational change? Have any similar agencies faced such a large change and how did they accomplish it? Are there known pitfalls that she should avoid?

The goal of the case note is to allow students to understand the perspectives of stakeholders such as community members, funding organizations, and partnering organizations in a region with a very diverse population. The students will also be given an opportunity during class to formulate the exploratory stage of implementation.

## OBJECTIVES

1. Adopt a systems-thinking approach to understand the contextual factors influencing HACC's decision to change their service delivery model.
2. Understand the perspectives and motivations of different internal and external stakeholders who may promote or oppose this change.
3. Apply implementation science principles to formulate a plan that will help the organization in transitioning from working in silos to providing collaborative care.

## DISCUSSION QUESTIONS

1. Was there a need to change the service delivery model of the organization? How will the new model address intersectionality?
2. How would the demographics of the Region of Yorkville play a part in the creation of a new service delivery model?
3. How would the different external stakeholders and funding organizations influence the change in the service delivery model?
4. What are the potential facilitators and barriers to the change during the exploration stage?

**KEYWORDS**
Active implementation; implementation science; intersectionality; service delivery; systems-thinking approach; change; service delivery models.