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ORIGINAL PAPER

The Integrated Health Hub (IHH) Model: The Evolution of a Community Based Primary Care and Mental Health Centre

Cindy Malachowski[1] · **Stephanie Skopyk**[2] · **Kate Toth**[3] · **Ellen MacEachen**[4]

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Abstract

There is increasing demand for comprehensive community healthcare that integrates community mental health and primary care services. The Canadian Mental Health Association-Durham Branch provides an example of how the Integrated Health Hub (IHH) Model evolved organically to meet this need. The Framework Method was used to analyze interviews and focus groups with 29 participants. Results reveal five key domains critical to the development of the IHH Model (1) Communication; (2) Hub 'Nuances'; (3) Leadership; (4) Staff; and (5) Challenges. These findings provide insights for other community mental health organizations wishing to provide comprehensive integrated community healthcare services.

Keywords Primary care · Mental health · Community mental health · Hub model · Integrated services

Introduction

There are approximately 7.5 million people in Canada living with a mental health problem or illness, and there are over 1.6 million Canadians that report an unmet need for mental health care (Mental Health Commission of Canada [MHCC] 2017). In 2012, the Canadian National Mental Health Strategy was unveiled, making it a national priority to "increase the availability and coordination of mental health services in the community for people of all ages" (p. 44). The report called to improve access to community care, as transitions from the institutional sector were often problematic, resulting in challenges for individuals to connect with community mental health agencies and primary health care services. Furthermore, the need for comprehensive community care services has become critical, as people with mental illness often have difficulty accessing high-quality primary care and engaging in traditional care models (Bradford et al. 2008; Ross et al. 2015; Skosireva et al. 2014).

In addition to addressing social needs in community mental health care, there are also burgeoning economic costs to consider. In 2008, it was estimated that mental illness costs the Canadian economy over $50 billion annually (Lim et al. 2008). Approximately $15.8 billion CAD is spent on mental health and community care-related services, including costs such as in-patient services; prescription drugs; physician fees; and community and social services, which include outpatient services, community mental health services, supportive housing and employment, and addictions services (MHCC 2017). Shifting integrated mental health care to the community is unequivocally the most sensible economic decision, as community mental health services are up to five times less expensive than hospital-based care (Goering 2004). This shift to the community setting has resulted in a high demand for services, and subsequently increased wait-times to access these services at the local level. Across the country, the demand for community mental health services far exceeds the availability of resources (MHCC 2017). More recently, the MHCC (2017) has again highlighted the

✉ Cindy Malachowski
cindy.malachowski@uoit.ca

Stephanie Skopyk
stephanies@cmha.ca

Kate Toth
ktoth@conestogac.on.ca

Ellen MacEachen
ellen.maceachen@uwaterloo.ca

[1] Adjunct Faculty, University of Ontario Institute of Technology, Oshawa, Canada

[2] Canadian Mental Health Association – Durham Branch, Oshawa, Canada

[3] Conestoga College Institute of Technology & Advanced Learning, Kitchener, Canada

[4] School of Public Health and Health Systems, University of Waterloo, Waterloo, Canada

priority for community mental health services to be available at the primary and community care levels, as this is where most people with mental health problems prefer to access services.

Community mental health services are commonly provided by nonprofit organizations in Canada, through government contracts with non-profit organizations (Jacobs et al. 2010). In Ontario, these community services include assessment, treatment, counseling, education, promotion, prevention, case management, crisis intervention, housing, employment supports, offender interventions, and geriatric programs as well as stakeholder training and skill development. On average, nonprofit mental health organizations across Canada receive $847.9 million from provincial sources, $18.3 million from municipal sources and $41 million from Federal sources to deliver mental health services in Canada; community mental health agencies also receive funding from nongovernmental organizations (Jacobs et al. 2010).

In reviewing the literature, there are examples of community mental health programs and services administered through several different evidence-based models that integrate primary care and mental health. These models were found to include (1) Communication Models for individuals with mild to moderate mental health needs where services are offered as separate practices, including care or case management services and psychiatric consultation; (2) Co-location and Collaborative Models for individuals with mild, moderate, or severe needs, where services are shared either through collaborative physical space or coordinated services ; and (3) Integrated Team Models for individuals with severe and complex needs, where full-service, fully integrated and/or wrap around teams provide more intensive care (Flexhaug et al. 2012). With a focus on the latter two models of community mental health care, the Canadian Mental Health Association-Durham Branch developed an Integrated Health Hub Model (IHHM) approach for programs and services to serve their clients. The IHHM has blended co-location services, specifically reverse shared care, with an integrated team model.

Co-location services at CMHA-D, or more specifically, reverse shared care supports individuals who are already engaged with the mental health system but not with primary care services. Therefore, the IHHM provides clients with direct access to healthcare and the healthcare system and offers onsite medical services to those who are traditionally not well connected with primary care. In this approach, the mental health clinician is the primary service provider, and primary care services are provided within the mental health care setting. The IHHM also incorporates an integrated team model, which provides an all-inclusive 'wrap-around' service for the individual. The integrated team model ensures that all determinants of health are provided for, either directly through the organization, or through community partnerships with other organizations. Furthermore, these services are delivered in a way that is congruent with the "Hub Model" concept, which will be explored in greater detail later in the paper.

The Canadian Mental Health Association-Durham Branch

The Canadian Mental Health Association was founded in 1918, and is a national charity that helps maintain and improve mental health for all Canadians. The Canadian Mental Health Association-Durham Branch (CMHA-D) is located in Ontario, and is an integrated community mental health and primary care centre that has been providing mental health services to people in the Durham Region for over 55 years. With a range of recovery-oriented services provided through inter-professional teams, the organization is focused on providing clinically based services that, in addition to dealing with client mental health issues, also addresses social determinants of health. The programs and services offered through CMHA-D are grounded in a social justice approach, and target personal, social, economic, and environmental factors that impact the lives of individuals living with mental health problems and other complex chronic diseases that impact mental health.

CMHA-D's model of service delivery has evolved organically over the years in response to community needs and insecure government funding sources. Their approach represents a demarcation from traditional community mental health programs and funding, thus broadening their scope of services and potential funding sources. The strategic approach taken by CMHA-D is one of *differentiation*; essentially, the organization has committed to filling identified gaps in community needs to achieve the vision of "... mentally healthy people in a healthy society". By leveraging a variety of services and programs that are not typical to traditional community mental health care models, CMHA-D offers a comprehensive perspective of holistic wellness (Figs. 1, 2).

A differentiation strategy can be defined as the development of a product or service that offers unique attributes that are valued by customers and that customers perceive to be better than or different from the products of the competition (Porter 1980). Traditionally, organizations that succeed in a differentiation strategy have several internal strengths, including highly skilled and creative team members that believe in the product/service and are able to communicate its perceived strengths, and a corporate reputation for quality and innovation (Porter 1980).

By offering co-location and collaborative services, CMHA-D services are delivered in a way that is congruent with the "Hub Model" concept. Hub Models were first

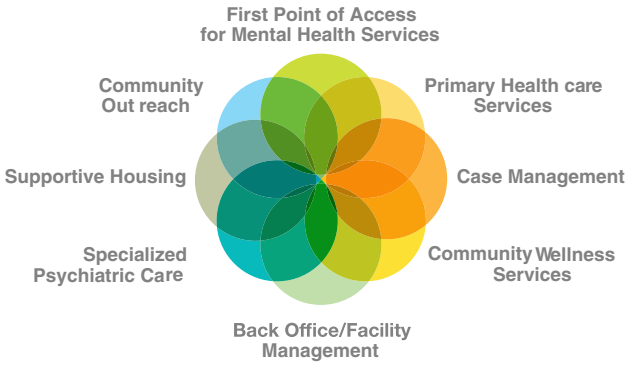

Fig. 1 The Canadian Mental Health Association-Durham Branch Integrated Health Hub Model

described in the transportation industry to speed delivery and reduce costs. The 'Hub and Spoke' business model works from a central "Hub" or core, from which several routes extend similar to the spokes of a wheel, that lead to the end result (Delve 2017). In mental health care, the Hub Model is an approach where the "Hub" is the specialized team, and the "Spokes" are the various community supports involved directly with the client (Flexhaug et al. 2012). At CMHA-D, this model of service delivery is intended to provide the infrastructure for comprehensive care coordination, and to enhance access to a variety of community supports for individuals living with mental health problems. The Hub Model concept has been promoted internationally within various social and health contexts. In Australia, a Hub model has informed social inclusion and social cohesion strategies for migrant families (Press et al. 2015); in the United States, it has been promoted to coordinate delivery of health care and social services (Agency for Healthcare Research and Quality [AHRQ] 2016); and the Hub Model has garnered empirical evidence as an approach to making rural healthcare in India affordable, available and accessible (Devarakonda 2016). In Ontario, the Hub model has typically been adopted to address rural and geographical challenges via a Rural Health Hub Framework (Multi-Sector Rural Health Hub Advisory Committee [M-SRHHAC] 2015).

The CMHA-D Hub Model has further developed into an 'integrated', 'co-location' Health Hub with the inclusion of primary care, and other services to meet multiple other needs of clients. The onsite primary care clinic is a Nurse Practitioner Lead Clinic (NPLC) comprised of three nurse practitioners, two registered nurses, three registered practical

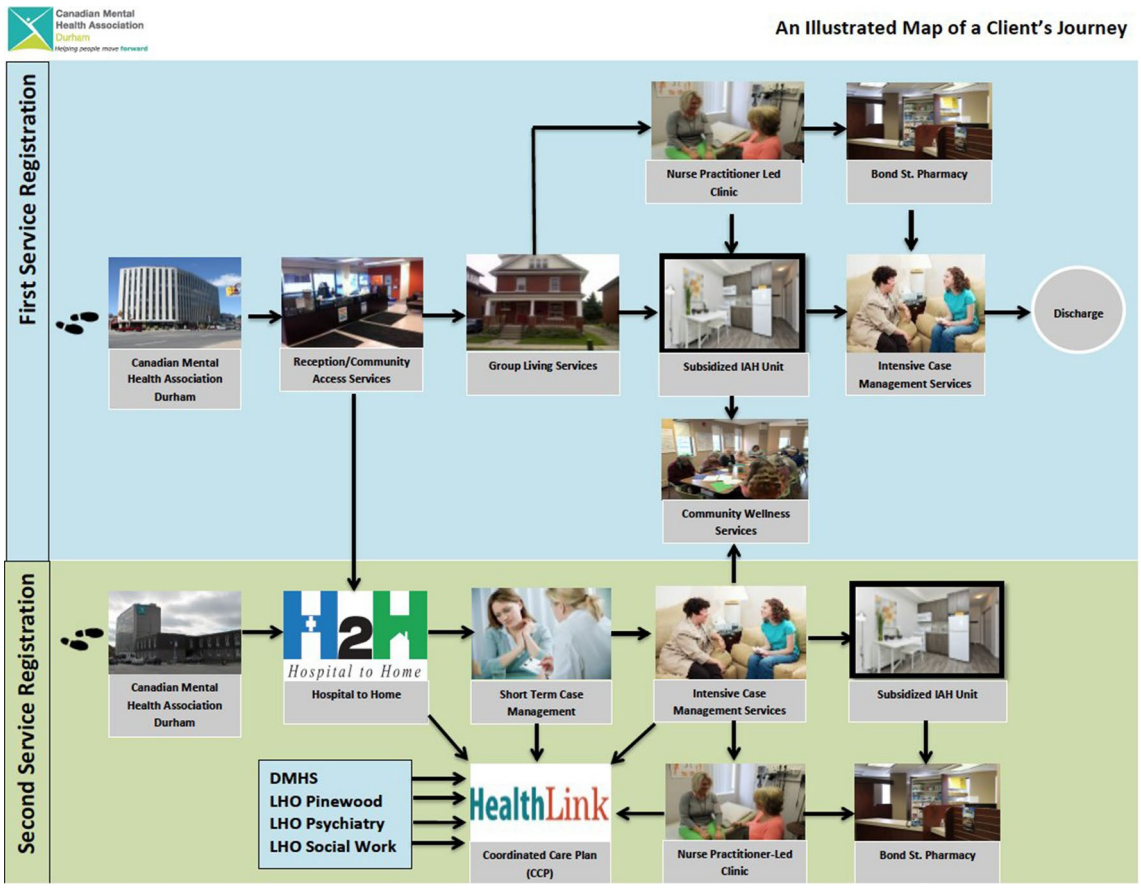

Fig. 2 An illustrated map of a client's journey

nurses and 2.4 administration staff. Psychiatrist consults occur as needed, usually via one-time using sessional funds, or via telemedicine where ongoing specialist care is needed.

The Integrated Health Hub (IHH) Model is a comprehensive, whole-health approach to wellness, and the model allows CMHA-D to addresses multiple health concerns in a coordinated and efficacious manner. Essentially, CMHA-D provides high-quality primary health care for physical and mental health care needs, while also addressing key determinants of health within the target population, working collaboratively with community partners. The integrated component of the IHH Model is intended to increases service efficiency and effectiveness through a comprehensive wrap-around, seamless approach to holistic client care. Therefore, the objective of this research was to understand how the IHHM evolved to address community mental health and primary care needs, and to explore how users and service providers view the Model, including its strengths and limitations.

Methods

We employed a Framework Method approach for data analysis (Gale et al. 2013). The Framework Method is gaining popularity as a means of analyzing qualitative data derived from healthcare and multi-disciplinary health research (Smith and Firth 2011; Srivastava and Thomson 2009). Similar to qualitative content analysis, the Framework Method analyzes data by focusing on the relationships between different parts of the data, resulting in descriptive and/or explanatory conclusions clustered around themes (Gale et al. 2013). The analysis is conducted using a matrix of rows (cases) and columns (codes) to summarize and structure the data, while keeping the views of each research participant connected to other aspects of their account within the matrix, thus allowing for data comparison *across* and *within* individual cases (Gale et al. 2013).

Ethics approval for this research was received from the University of Waterloo (ORE #21519). Seven semi-structured interviews lasting 30–60 min were conducted by the primary author. The primary author has over 10 years of experience providing occupational therapy to individuals living with mental health issues, and has completed a PhD and two years of Postdoctoral studies in workplace mental health. The subject experts were recruited through purposive non-random sampling. Subject experts were invited to participate based on their knowledge and/or experience with CMHA-Durham, and included members of CMHA-Ontario, the senior leadership team and corporate services at CMHA-Durham, and external strategic advisors for CMHA-Durham. Additionally, three separate focus groups were held with three key CMHA-Durham stakeholders: (1) representatives from the Patient Committee, (2) the Caregiver Committee, and (3) the leadership team. Front-line staff members were present on each of the focus groups as they were already members of the committee or team. There were no hierarchical relationships on any of the focus groups, and there was a well-established level of comfort among the committees and team, allowing for each participant to speak freely. Each focus group had between 4 and 10 volunteer participants for a total of 22 participants, and lasted approximately one hour.

All interviews and focus groups were conducted between August and November, 2016. Each session was lead, audio recorded, and transcribed by the primary author. The interviews and focus groups were guided by questions such as: "How does leadership affect and influence the CMHA-Durham Hub Model?"; "In your opinion, what has been the single most major achievement of the CMHA-Durham Hub Model?"; "What are the main barriers to CMHA-Durham facilitating the process of improving practice in community mental health?"; and "In your opinion, what can the organization do to help improve the serivces that you and your organization provide to the community?".

We followed the protocol for the Framework Method as outlined by Gale et al. (2013). The following processes were included: (1) transcription of audio recordings; (2) the primary author read and re-read the transcripts for familiarization, and recorded analytical notes, thoughts, and impressions; (3) an open coding process was conducted by the primary author to classify all of the data, so that it could be compared systematically; (4) then, a working analytical framework was developed and reviewed by the research team, and codes were then added and/or grouped together in an iterative process among team members. The team resolved any disagreements between codes through a discussion-based collaborative process. The final framework consisted of 11 codes, clustered in five primary categories. In step 5, data were summarized and charted using Microsoft Excel, using one row per participant and one column per code. Data were summarized using verbatim words, and were inserted into the corresponding cell, highlighting interesting or illustrative quotations (cells were left empty if no relevant content was located in the transcript for that particular informant).

Results

Application of the Framework Method revealed several insights regarding the development of IHH Model approach to community mental health services. These can be described using five categories: (1) Communication; (2) Hub 'Nuances'; (3) Leadership; (4) Staff; and (5) Challenges. These categories represent elements that were consistently raised across all stakeholder groups. Although there

were subtle nuances that were particular to each stakeholder perspective, the strengths and limitations of each category were strikingly similar across all focus groups. We will now explore each of these categories in greater depth, and demonstrate how each category contributed to the development of the IHH Model. We will also provide examples from participant data that illustrate how the IHH Model evolved to address community mental health needs.

Communication

Although a full assessment of organizational communication is beyond the scope of this paper, communication emerged as a primary theme across all participants. Several key aspects of internal communication were highlighted by clients, caregivers, and frontline staff. From a service user perspective, effective communication by the organization (promoting programs and services through brochures, pamphlets, infographics, seminars, notices, emails), and regular communication between clients and staff allowed clients to access different programs within the organization with greater ease. Open communication via client transfer meetings between staff members facilitated client transition between programs and services, and also provided opportunity for clients to transition to various components of the IHH Model without having to repeat their story each time they entered a new program/service. Caregivers also commented on the accessibility of information in the IHH Model, as one informant stated, "There is a lot of sharing of information, by emails, newsletters, 1:1 supportive counselling, the website, pamphlets… It's quite unique".

Frontline staff reaffirmed what the leadership team members reported; that clear and transparent communication is a priority for the organization:

> We share information in a very fluid fashion on all levels. We have internal committees, team meetings, quality council, leadership meetings…information flows to each group, and it's shared with the teams. We are working on improvements to communicate with each other about clients, and we have a formal "Pathways of Communication Plan" which includes clients and caregivers.

Communication strategies at the organization involved members from all 'teams', including Human Resources and information technology. It became apparent that information flowed through all levels of the organization in a fluid fashion. One frontline staff called it "a circle of information sharing" and reported, "It all filters through the CEO and the Board of Directors, it doesn't stay on one level. It goes everywhere". The communication strategy at CMHA-D was reflective of effective vertical and horizontal information sharing, thus allowing for a harmonized understanding of the organization's mission and vision.

At the operational level, the communication pathways allow front-line staff to make decisions about increasing or decreasing the intensity of services in response to the client's status and presentation. There are various ways in which communication between the different strands of services is facilitated. For example, clinical information and care coordination information is shared between program staff who are in some instances embedded elsewhere in the community (for example the hospital setting, or provincial social services such as the Ontario Works office). Other information that is communicated within the team include incident reports data, operational plans, and quality data via Leadership Council, Quality Council, Team Leads, and Coordinators meetings.

Hub 'Nuances'

Hub 'Nuances' were characterized by three distinct codes: (1) Formalizing the IHH Model: "When is a Hub a Hub?"; (2) A Holistic and Integrated Model; and (3) IHH Logistics. Each of these codes contributed to the distinct features of an IHH Model approach to community mental health, and demonstrate how an IHH Model approach differs from other traditional, stand-alone services.

Formalizing the IHH Model: When is a Hub a Hub?

Most interestingly, the CMHA-D IHH Model did not set out at a given point in time as an intentional, deliberate, or calculated strategy. The IHH evolved in such a fashion that one informant stated "…it became a hub before it was a hub". The leadership team and senior members of CMHA-D reported that people who toured the organization referred to their programs and services as a "Hub" before their service delivery model was formalized as a Hub Model. The evolution of the CMHA-D IHHM was truly organic; when describing how the Model came to be, a frontline staff member reported that their work was "…all about being client centred within integration. We work like clockwork with a focus on the client". Another member from the leadership team stated "We've been a Hub for many years, it's just the name that has changed." The IHH Model has had a significant impact on service users. The approach allows clients to engage more fully in their recovery because they feel a greater sense of trust and safety, one client stated: "It's the wholeness. It's being part of the whole. It's comfortable. I'm not going to fall out of the community. It keeps me bound and together, and without it, I don't understand where I'd be". Clearly, the integrated nature and comprehensive

wrap-around services provided comfort and stability for service users.

However, this informal process of the development of the IHH Model was problematic for the external consultants who expressed concern over the lack of formal structure. One informant stated that the IHH Model needed to be formalized, similar to the Nurse Practitioner Led Clinic, so that politicians and decision makers would have to officially acknowledge the legitimacy of the model. The informant believed that by receiving government recognition, the Model would have some approval and backing; the lack of a formal business case for the IHHM to the Ministry of Health or other governing bodies put the model's validity and acceptability at risk. In order to mitigate the ambiguity, the external consultants felt that a formalized concrete model that people can envision, perhaps with a logo that people could see, was required.

A Holistic and Integrated Model

The act of determining the moment when a Hub Model is born can be debated. One senior leader drew attention to the notion that there is no one approach for community mental health care. This informant stated that "Best practice is too specific; it's not designed to be adopted on a whole, statistically speaking". This suggests that the CMHA-D IHH Model is synergistic, and develops in an iterative fashion in response to evolving community needs. In describing various Hub components as "pieces of the puzzle", another senior leadership team member referred to the IHHM as a "living thing that grows" in response to identified needs. Therefore, standardizing the IHH Model approach as a prescriptive rote number and collection of services may not be appropriate for other communities with different demographics, and/or it may not be appropriate across different jurisdictions.

The holistic nature of the model is that it comprehensively fills or bridges gaps specific to the local community, in the context of all diagnoses or severities of illness. One caregiver stated, "It's about your wellbeing overall; it doesn't matter what condition you are in, or how you're feeling… There is always someone there for you". This philosophy resonated with clients as well, as one participant stated "Navigating the system takes all of your energy, but here, all of your physical and medical stuff is looked after, and your social stuff too". An external consultant emphasized the importance of a holistic approach, and stated that a consumer perspective has increased demand for access to high quality, comprehensive services. One attribute of CMHA-D's IHH Model is that the concept evolved to take into account what is required for individuals living with mental health problems to become healthier, or as healthy as possible, over the longer-term, from a broader social perspective. An informant from corporate services solidified the integrated and client-centred nature of the Model by stating, "The client is always at the centre; all of the services are wrapping around—frontline or infrastructure or corporate services, rent, housing…the whole thing wrapping around to service the client".

Hub Logistics

A model that adapts to the changing sociopolitical needs of a community must do so effectively in order to remain competitive and viable within the healthcare system. The scope of services is critical, as one senior leader commented, "We do what we can, but we can't do everything for everyone. You can't stretch yourself too thin, it's a balance. You can't continue to rely on the government alone; we needed an entrepreneurial model that goes out and seeks opportunity". Frontline staff are also aware of the dynamic, changing nature of the IHH Model, both from an integration perspective, and an improvement perspective. Staff members commented on the "interdependent" nature of the Model, and how it is "…not static, but constantly moving and improving".

One spin-off benefit of this approach is that it increases the IHH Model profile and connections in the community, as it is intricately inter-woven with other community programs and services. In order for the Model to be effective, CMHA-D has to interface with the healthcare system and other community service providers to create better access to programs and services. For example, there are CMHA-D staff embedded within the hospital's psychiatric unit and Emergency department, within Social Services, Corrections, homeless shelters, and in isolated geographical areas, thus providing opportunities for their workers to be engaged with the community and external services and programs. Additionally, many strategic partnerships exist. For example, there are partnerships with rehabilitation centres, with allied health service providers, and with housing developers. These partnerships not only address client needs, but also serve to extend the continuum of care beyond the physical walls of the building. This becomes a reciprocal process, where the community gets to know CMHA-D as an organization, as well as their programs and services.

Leadership

Leadership encompassed a number of informant codes, which will be addressed comprehensively in this section: (1) Calculated Risk Taking; (2) Responsiveness; and (3) Style and Approach.

Calculated Risk Taking

A key component raised by several informants was calculated risk taking, an activity that was promoted throughout the organization and encouraged by the leadership team. One member of the leadership team stated, "Primary care being developed and added to the Hub prior to receiving funding was a huge risk. But CMHA-Durham takes calculated risks, they lay the groundwork and establish credibility. They will put people in place to provide the best possible services. They will take a risk to get it started". This type of risk taking is fostered by an organizational culture that supports innovation and creativity. A Nurse Practitioner stated "…it's the culture…explore all options, open minded, thinking outside of the box. Don't shy away from difficult conversations or services". This internal dynamic was also noted by the external consultants, as one consultant observed "CMHA-D is good at letting leaders lead. They don't micromanage. They make it clear: this is your program, keep us informed, here are the parameters".

This calculated risk taking is in part fostered by the organization's mission, vision and values statement. Not only does the organization focus on several key indicators for their external community services, many informants indicated that the same values lead the way the organization is run internally as well. These values include social justice (removing barriers that impact quality of life so that people can fully participate); self-determination (supporting individuals' involvements in decisions that affect their lives); integrity; creativity; partnership; and excellence. The frontline staff and senior leadership credited the CEO of the organization for leading this cohesiveness through transparency and openness, and for consistently promoting organizational values in communication plans, strategic reports, the CEO report, and other organizational documents. This fostered what a leadership team member called 'shared thinking', and provided a platform for all staff to uniformly strive for, and prioritize the holistic wellbeing of their clients.

Responsiveness

A key feature of the IHH Model is the responsive nature of programs and services. Members of CMHA-D reported that they continually review their service delivery, and alter the way they provide services based on trends and observed needs within the community they serve. The CEO reports, "When we see a need, we make a funding proposal. We find funding, just as we did for our youth programming; our staff take it [finding funding] as a challenge". The organization stays abreast of changes in the community by analyzing outcomes and administering various surveys to collect data regularly. These surveys include client perception of care, and community partners' evaluation of CMHA-D programs and services. CMHA-D also demonstrates responsiveness regarding the need for continual quality improvement and safety in the mental health care sector by becoming the first community mental health agency in Ontario (second in Canada) to attain national accreditation through Accreditation Canada. Accreditation Canada is an independent organization that accredits health care and social services agencies; CMHA-D received an outstanding score of 99.5% based on 762 standards in 2016.

Another concept of responsiveness was reflected in the efforts of the CEO to recognize the frontline staff and community partners for their many contributions. Frontline staff frequently have the opportunity to interact with the CEO, as the CEO regularly visits the various teams throughout the organization. A participant from the leadership team reported that the CEO "…goes to smaller teams so that it's easier to ask questions". Another member from the leadership team concurred that the CEO was an exceptional leader, by stating "…her skill set is incredible. She is visionary, and the motivation of the team. Speaks to her authority and thoughtfully modest approach. She is proud but never boastful". In addition to the CEO's responsiveness internally to the organization, CMHA-D hosts an "Afternoon with the Stars Community Partner Appreciation Event", to give thanks to community partners. The agency also hosts annual client appreciation event to recognize client commitment to wellness.

Leadership Style and Approach

The impact of the CMHA-D leadership style and approach is evident throughout all participant data. It quickly became apparent that CMHA-D prioritized an environment that fostered collaboration across all involved parties, and promoted a shared strategic vision. From a client who stated, "Leadership has valued our input. Made us feel like people. Like we have something to say. They are so receptive, if there are issues, they are right on it, following up", to a frontline staff who reported "You are truly part of the team; everyone is given opportunity to show leadership in their role in what they are good at. Working together is key…it's not a hierarchy here", the leadership style clearly promoted an environment of inspiration, respect, and approachability directed towards a common goal.

Both of the external consultants credited the organization's leadership approach for directly facilitating the development of the IHH Model. As the model developed, the senior management team moved away from a management role, and instead embraced the concept of a leadership committee. This shift resulted in an approach that removed hierarchical decision-making, and placed expectation on staff to provide input and information to direct the organization. One external consultant stated, "It's a strong leadership, willing to be

collaborative. They are so receptive to feedback, and they present as: '…yes, we are leadership, but we make decisions with people'. It is expected that people provide information for decision making".

Staff

Providing care to individuals living with mental health problems is emotionally demanding, and can often lead to staff burnout and compassion fatigue (Acker 2011; Ray et al. 2013). Data reveals that staff members played an integral role in the development and sustainability of the programs and services within the IHHM. Multiple different strategies for keeping staff engaged and invested in the organization emerged from the data, and mostly centred around two key constructs: Fostering staff commitment, and demonstrating staff appreciation.

Fostering Staff Commitment

Staff commitment at CMHA-D is fostered by various incentives, such as providing an education budget, staff recognition awards, wellness days, flex time, and shared decision making. Regular staff evaluations are conducted through 360-evaluations, providing opportunity personal and agency goalsetting, for self-assessment, and for the assessment of leaders and managers within the same process. The organization also makes every effort to promote from within. This commitment to staffing excellence was evident to caregivers, as one participant stated "People who work here are well trained and have a lot of knowledge, they will get information if they don't have it handy". The concept of staff commitment is apparent even at the beginning stages of employment with CMHA-D. Frontline staff and members of the leadership committee commented that screening people during the initial job interview is paramount. Potential candidates "…have to see part of their life as a caregiver, they have to have a passion for people, not just work for a pay cheque. We select a variety of people, unique people to bring a unique piece…to bring something different, with the underlying belief that what we do is for the client."

In order to involve staff proactively, and to balance accountability and patient safety CMHA-D has implemented a 'just culture'. A just culture is a framework that is oriented toward patient safety and promotes constant improvement (Boysen 2013). Members of the leadership report that when there is an incident, it is dissected from a systems or process perspective. Frontline staff are consulted and involved in the process because the leadership team states, "We go to the ones using it best to make changes; they live and work with it, so we involve staff in everything, every decision because they have the knowledge and expertise". Fostering a just culture provides opportunity for staff to be fully engaged and committed, without fear of reprimand or retribution.

Staff Appreciation

It quickly became apparent through multiple participant reports that staff members of CMHA-D were frequently recognized for and appreciated for their work. Staff retreats are provided that incorporate relaxing events; one frontline staff stated these retreats were important to her, because they were seen "…as a reward for the work that we do day in and day out, it's a refreshing day." There are also celebrations at Christmas, and after each accreditation cycle. One caregiver reported:

> They [CMHA-D] prioritize self-care, not just for their clients, but for their staff. I hear there is stuff available for staff, like yoga, massage therapy, they get the day off for their birthday, there are wellness days for appointments. It's a change in mindset. A change in phrasing from sick to wellness.

This sense of gratitude for staff is further fostered by the CEO, who frequently visits with teams and staff members, and personally delivers 'thank you' cakes in appreciation for all of their hard work.

Challenges

Competition for Resources

In addition to barriers such as linking patient information across IT systems and various ministries, two of the most significant challenges for CMHA-D involve human and financial resources. There are substantial concerns regarding skilled staff retention due to the comparative low-paying nature of community mental health work. In efforts to mitigate challenges with remuneration, CMHA-D utilizes an independent Human Resources consultant to regularly review the status quo, and to devise creative compensation strategies. The discrepancy in pay for staff in the community mental health sector, including primary care providers, in comparison to their hospital counterparts was noted across numerous participants both external to the organization, and at the senior level of the organization. However, a frontline staff member reported, "I'm proud to work here, proud of the accomplishments given the resources and funding. It's incredible what we've done, we are very resourceful and good at finding resources." The leadership team acknowledged that healthcare in general is competitive. There are financial resources only to serve specific priorities and even those resources are becoming scarce.

Sociopolitical Challenges

The complexity and uniqueness of the IHHM has resulted in some lack of clarity with regard to exactly what services and programs CMHA-D provides, and what model(s) of care provision they enact. This has had a significant impact on the organization, as many participants felt that funding agencies did not understand CMHA-D on a conceptual level. Participants felt that deviating from the traditional silo mentality healthcare model is incongruent with current hierarchical funding structures. Furthermore, including complex sociodemographic factors into a traditional healthcare model was seen as impossible within the current system. With limited opportunity for control over healthcare reform, community agencies feel powerless against decisions that dictate healthcare restructuring such as multi-organization integration.

In this age of what seems to be continual healthcare reform, there are many unknowns of what 'reform' means for the community sector. An external consultant described this as "…defensiveness; everyone wants to protect their turf, and enhance their own capacity. There are consistent cuts to funding, and changes to structure…basically a constant changing political landscape that results in a struggle for resources, and competition for clients." Staff echoed this observation, by reporting that community partners were often competitive, that there were inconsistent opportunities to compete for resources, and that there was a purposeful lack of collaboration that was difficult to explore or address. Staff across all levels of the agency observed the lack of transparency of healthcare reform at the local level, and noted that many decisions appeared to have been made that did not always seem to prioritize patient outcomes or best care. This has implications for the IHH Model, as programs and services integrate with a variety of community partners' programs and services; thus, often leading to stressors with outside organizational cultures, and discord with different funding structures and protocols.

Discussion

Amidst the rapidly changing healthcare landscape, community mental health organizations need to continually advance their programs and services in response to precarious funding and client needs. Participants in this study have identified five key categories relevant for the evolution of an IHHM approach to community mental health. These categories shed light on how one organization deviated from traditional, mainstream community mental healthcare delivery, and strategically operationalized their objective of providing comprehensive, holistic and integrated healthcare for people living with mental illness.

Our findings indicate that the IHH Model differentiated itself from traditional community mental health care by providing integrated, wrap-around services that focused on whole-wellness of individual clients. By including several key determinants of health within their model, CMHA-D has organically developed their model of service delivery, as opposed to selecting and implementing a particular model. This organic approach is not designed to be a best-practice 'cookie-cutter template', and may not be appropriate in other communities; however, the five key strategies used by CMHA-D to evolve their programs and services can be replicated by other organizations to enhance services and programs within their own unique community settings. Similar findings in integrating behavioral health and primary care services have been reported by Ramanuj et al. (2018). This research supports the importance of teams, communication, organizational culture, care coordination in facilitating coordination of care. However, it also highlights that the process often occurs along several parallel pathways with numerous factors that both hinder or facilitate one another. Fundamentally, even when particular models of service delivery are selected, their implementation is not easy.

Essentially, organizational strategy is achieved when all parts of the system work together, and every employee understands their role in achieving the organization's goals. Clear, effective communication throughout the organization is key to making this happen. CMHA-D has a strong communication network, both horizontally and vertically. Internal and external communication are critical components in facilitating the seamless flow of referrals and information from one part of the IHH Model to another. It was apparent that staff were engaged, involved, and invested, and that there was significant transparency throughout the organization with regard to common goals and unified work plans. In fact, staff that aligned with the culture of the organisation were so critical to the organization's success, that potential employees were vetted at the hiring stage to determine if their beliefs and convictions aligned with the mission of the organisation. This facilitated a unified front, and enabled effective communication that was essential in supporting the success within and between programs, as well as communicating and marketing the program to the community.

The structure and logistics of the IHHM developed in a way that provided direction, yet allowed the model to grow and adapt in response to identified needs of the community. The organic nature of the IHH Model resulted in a model that is dynamic, and constantly changing in response to identified needs over the longer-term. This is a continuous balancing act, where resources are allocated to imminent needs, while also planning for emerging needs in the community. The entrepreneurial aspect of the organization further allowed boundaries to be pushed into new territories for funding, services, and programs, thus allowing for

non-traditional services such as acupuncture, foot care, and corporate services.

Leadership style had a significant impact on staff, and has played an integral role in the development of the IHH Model. Organizational culture is fostered through leadership. Data from this study support the conclusion that servant leadership was, and continues to be, a key factor in driving the evolution of the IHH Model. Described by Greenleaf in 1977, servant leadership focuses on the growth and well-being of people, and the communities to which they belong. Servant-leaders will share their power, and they put the needs of others first in order to help people develop and maximize performance. By engaging in a servant-leader approach, the CEO of CMHA-D has successfully fostered an organizational culture that functions to maximize the potential of their staff, the clients they serve, and ultimately the community at large. This leadership style prioritizes staff empowerment, commitment, and appreciation; as a result, the organization has successfully created a culture where bold risk-taking and creative problem solving is encouraged.

Pursuing a differentiation strategy has not come easily for CMHA-D, and several challenges to the organization were identified throughout the participant data. The challenge in explaining the comprehensiveness and inclusivity of services was disconcerting for the staff and organization as a whole. As with any differentiation strategy, CMHA-D has set themselves apart from mainstream and traditional community mental health care service delivery. However, although this differentiates CMHA-D as leaders and innovators, it also makes integration with existing support systems and funding structures very challenging.

Limitations of this research include the specific sociopolitical context within which the CMHA-D Model evolved. Although the same funding structures and agencies are not likely to be replicated elsewhere, other organizations and agencies can glean insights into how this particular model evolved. This research also sheds light on the strengths, limitations, and challenges of this particular approach in one setting. These insights may provide opportunity for alternate differentiation strategies within other local contexts.

Conclusion

In conclusion, the CMHA-D IHHM developed in response to client and community needs within the context of a healthcare reform and insecure funding. The evolution of the model represents a differentiation approach to traditional community mental health programs and funding; this research explicates five key categories that should be considered by community mental health service providers wishing to develop an integrated health hub. CMHA-D organically developed their model through assessment, strategic communication, and consistently striving for a holistic and integrated approach to client wellness. A servant leadership approach was foundational to creating staff commitment to the organization's mission and vision.

Although there are tensions between the organic manner in which CMHA-D has developed and the need for explicit structures to be delineated for policy makers, there are many benefits to an organically-derived model of community care. One primary advantage is that it creates an environment conducive to providing a full spectrum of services, delivered in a way that allows for seamless movement internally and in response to the need/demand. Future policy should take into consideration the importance of funding structures that would support such responsive service provision. Despite challenges that include competition for resources and an unstable sociopolitical climate, CMHA-D's approach allows them to continually develop their service model in response to client and community needs. Future research needs to address the evolution of community mental healthcare delivery models with a focus on integrating technological infrastructure, and ensuring consistent data collection and reporting.

Appendix

Interview guide

1. How many years have you belonged to this organization (i.e. working, receiving services, consulting, etc.)?
2. From your perspective, can you please describe how the programs and services at CMHA- Durham operate?
    a. What are the strengths of this approach?
    b. What are the limitations?
3. Who is responsible for sharing information, and how does information get shared?
    a. Within the organization?
    b. Outside of the organization?
4. In your opinion, what are the main types of resources that CMHA-Durham offers?
    a. Can you give an example of this internally?
    a. Can you give an example of tis with community partners?
5. What are the primary factors that affect and influence CMHA-Durham?
6. In your opinion, what has been the single most major achievement of CMHA-Durham?

7. What are the main barriers to CMHA-Durham facilitating the process of improving practice in community mental health?
8. In your opinion, what can the organization do to help improve the work that you and your organization provide in delivering services?

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