Improving Community Health Work in the Next Decade

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Agenda

- How do we ‘improve’ community health work?

- Framework for improving community health work: Collective Impact and Results Based Accountability

Improving Health requires a large scale social change

"Large scale social change requires broad cross-sector coordination. Yet the social (or health) sector remains focused on the isolated intervention of individual organizations".

John Kania & Mark Kramer . Collective Impact. Stanford Social Innovation Review, 2011

How do we plan for community health improvement?

- Improving community health **starts with ends** and **works backward**, step by step, towards means.
- Improving community health requires **data-driven, transparent decision making**

What is the end?

- a) increase in the ‘percent of people receiving primary health care’, or
- b) increase in the percent of people who are healthy

The **Action Plan** for improving community health will be very different depending on the goal.

If our goal is improving the health of a community….

- Access to health centers/clinical settings (hospitals) would be a component of the strategy;
- But the health sector cannot do it alone. Contributions of patients, families, municipalities, the business community, the media, etc. are also essential.
- So the Action Plan will show actions to strengthen the role and leadership of health professionals while recognizing that healthy lived environments, individuals and families, businesses and other municipal departments must contribute significantly to the health of the population.

- Mark Friedman, **Trying Hard is not good enough,** 2005.

The Health Care Sector Cannot Do it Alone

Definition of co-production of health: "Care that is delivered in an equal and reciprocal relationship between professionals, people using care services, their families and the communities to which they belong. It implies a long-term relationship between people, providers and health systems where information, decision-making and service delivery become shared."

WHO: Framework on integrated, people-centred health services. A69/39

If co-production of health is the goal; what is the approach?

The approach shifts from…

- “isolated impact” e.g., what the health professional, the health center, the Ministry of Health, etc. can accomplish to improve health;
- To… “collective impact” e.g., to the commitment of a group of important actors from different sectors to a common agenda for solving a specific problem.

TWO EXAMPLES

1. Reducing Falls
2. Improving health outcomes via patient activation

Example 1: Reduce falls in older adults

- Goal: reduce falls by one-third over three years.
- Convener: The Health Department
- Collective Impact Team: Stakeholders with common agenda: hospital, health centers, pharmacists, social services providers, housing, city planning, fire department, university public health faculty, older persons, etc.

Conditions of Collective Impact Goal: Reducing Falls in Older Adults

- Common agenda: All stakeholders have a shared vision of change, one that includes a common understanding of the problem of falls in older persons in the community and a joint approach to solving it.
- Shared measured system: All stakeholders share data, and stories about falls as well as develop a share measurement system. From the where, when, and how of falls specific approaches to prevent falls are developed and indicators to measure collective impact are agreed.

- Mutually reinforcing activities: All stakeholders develop activities in their areas of competence:
  - Retiree association delivers evidence-based falls prevention programs in senior centers, churches, parks;
  - Municipality fixes side walks around elderly housing buildings, health centers and senior centers and works with business to ensure that rails and ramps meet the ADA regulations;
  - Health Department works with pharmacists and health centers to detect meds interactions that may lead to falls in the home and gets commitment to teach patients to avoid drug related fall hazards;
  - Social Services provides family caregiver training for preventing falls at home.
  - Fire Department and Emergency Medical Services offer training to first responders on detecting falls hazards in the homes they visit. (ETC)
  - University commits to work with occupational therapy and architect students to provide home modification for older persons who live alone.

- Continuous communication:
  - Developing trust among different government agencies, non-for-profit, businesses and community activists is a monumental challenge. The collective impact team needs time to see that their own interests are represented and that decisions will be made on the basis of objective evidence, for the good of commonly shared goal. E.g., Weekly conference calls, webinars or in-person meetings with a common ‘dashboard’ with chosen quantity and quality indicators.
  - Develop common vocabulary. All in the team have to be able to understand multiple ‘languages’ spoken by stakeholders.

- Backbone Support Organization:
  - Managing ‘collective impact’ work requires a convener and staff with specific set of skills to serve as a backbone for the entire initiative. The expectation that collaboration can occur without a supporting infrastructure is frequently the reason why community health projects often fail.
  - PAHO, for instance, often plays, and should continue to play the role of a neutral backbone organization working with several stakeholders for the goal of improving community health. That requires a dedicated staff both at the regional and national level with the necessary skills to serve as ‘back office’ for improving community health.

Example 2: Improve health outcomes in older adults

- Goal: Improve health outcomes in older adults.
- Convener: The Health Department
- Collective Impact Team: Stakeholders with common agenda: Social Security Health Programs, Public health centers, community partners such as clubs of older persons, patient's organizations, faith-based organizations, university public health faculty, older persons, etc.

Conditions of Collective Impact
Goal: Improving health outcomes in older adults

- Common agenda: Older adults living with chronic conditions will have tools, skills and support to become activated patients able to manage their conditions and improve health as partners in the production of better outcomes.

- Shared measured system: All stakeholders share data, and stories about patients that seem to be unable to actively self-manage and develop indicators to measure success. Collectively they agree to implement the Chronic Disease Self-Management Program (Tomando Control de su Salud)

- Mutually reinforcing activities: All stakeholders develop activities in their areas of competence:
  - PAHO becomes responsible for program license and the training of all partners in the CDSMP/Tomando Control program
  - Ministry of Health prepares policies for prescribing self management programs to patients with chronic conditions
  - Two Senior Centers agree to train two staff and three volunteers in the program and deliver FIVE (5) workshops yearly serving older adults in their neighborhoods
  - Three Clinics agree to train three community health workers (promotoras) and offer in their geographical area FOUR (4) workshops a year.
  - Social Security commits to train two staff and three volunteers in each of their local centers and deliver a minimum of THREE (3) workshops in each of their seven (7) centers. Total 21 workshops.

Collective Impact

- The local Arthritis organization, the Diabetes organization, the Heart organization, each commit to train a minimum of five patient educators and deliver five (5) workshops in a year. Total 15 workshops.
- Local health journalist commits to collect stories from participants and write about them in the newspaper/radio
- University public health contributes students to assist with data management and fidelity monitoring of community programs.

RESULT: 45 workshops each serving approximately 12 persons = 540 adults with chronic conditions receiving an evidence-based program that ensures improved health outcomes.

	Quantity	Quality
Effort:	**How Much We Do**	**How Well We Do It**
	How much service did we deliver? • 540 older persons served • 45 workshops delivered	76 % of all who registered finished the program 95 % of audited programs were delivered with fidelity to program manual
Effect:	**Is Anyone Better Off?** What quantity/quality of change for the better did we produce?	
	# 410 had improved outcomes	15 % of older persons with chronic conditions had improved outcomes

In Summary: Conditions of Collective Impact

- A common agenda
- Shared measurement systems
- Mutually reinforcing activities
- Continuous communication
- A backbone support organization

Performance Measures: Results Based Accountability

There are three kinds of performance measures:

- How much are we doing?
- How well are we doing it?
- Is anyone better off?

The most important advantage of adopting evidence-based programs is that you have the confidence that if the program has followed the doses and method of delivery proven to work; the patients that completed the required doses will be better off than before they took the program.