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Improving a Community's Population Health: You can't do it Alone

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Perspective

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Abstract

This article discusses how community health organizations can break out of their silos and start positively impacting their community's health in an organized manner. Improving a community's health requires that the community's public health department, health care institutions, and the community partners break out of their comfort silo zones and work collaboratively. The Community Population Health Expansion Matrix discussed in the article details the steps that need to be taken to break out of the cycle of comfort silo zones.

Keywords: Population Health; Health Care; AIM

Perspective

Improving a community's health requires that the community's public health department, health care institutions, and the community partners break out of their comfort silo zones and work collaboratively. To break out of the individual/independent comfort silo zones requires building a true community collaborative that addresses specific community health issues. No one collaborative can impact an entire community's health but, we can increase the impact by the involvement of more community partners, offering new or improved existing services, and involving more community members. If these requirements are completed properly, the result will have a positive impact on the community's health status. The Community Population Health Expansion Matrix showed in Figure 1 details the steps that need to be taken to break out of the cycle of comfort silo zones.

Quadrant 1 is the current state comfort silo zone. Every community organization trying to impact a community's health in this quadrant is in their own lane or silo providing multiple services to the community which are not coordinated and in some cases are duplicative services. Each has their own voice of what is important health wise to the community. Often these voices are at odds with each other and the community receives multiple different messages from different partners telling them "this is what is important to improve the health of the community." This is often a stagnant and counter-productive way of improving one's community health.

Sometimes these different voices are shaped by grants the partners receive that focuses on one specific health aspect of a community such as heart disease, diabetes, smoking cessation, or opioid addiction. Once the grant goes away the voice ceases to exist and the community never hears why it ended – was it cured? With many voices after a while the community stops listening since they are not involved in shaping the messages the community hears. Also the messages may not be delivered in media format that the community uses on a regular basis and the message never gets heard.

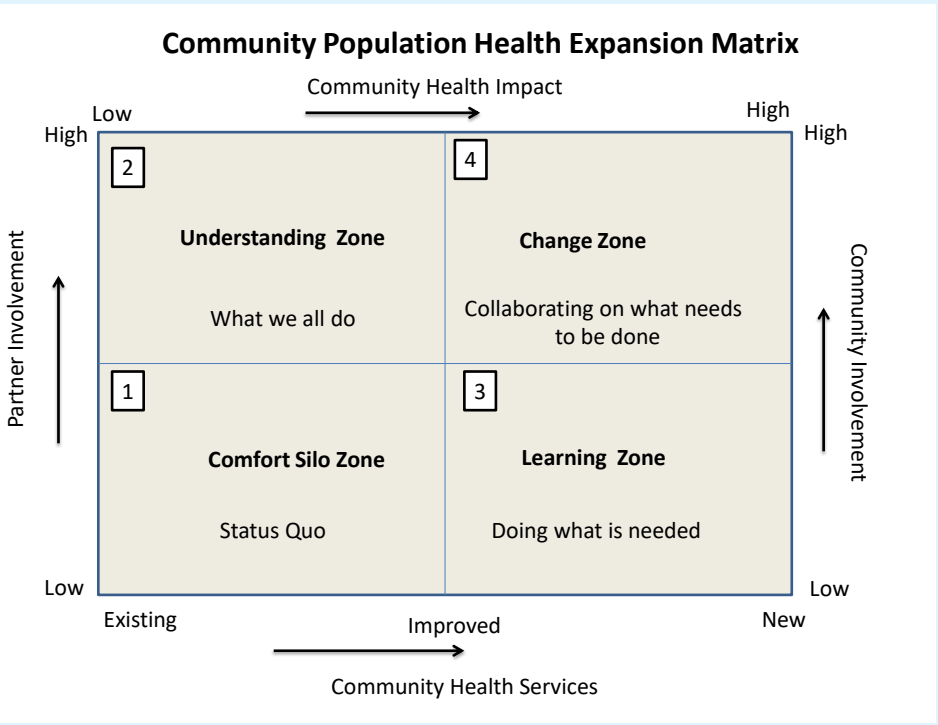

Figure 1: Community population health expansion Matrix.

To break out of this community health comfort zone requires answers to the following questions:

- Is the current way we are operating counter-productive or duplicative with regards to other health care providers in our community?
- Do we realize we cannot do it alone but can we effectively collaborate and do it together?
- If we can collaborate, can we develop one voice for community health?

Quadrant 2 is where we take our first steps outside our silo and begin to expand our knowledge of what is going on in the community and start understanding what each community partner offers. To accomplish this we do an inventory of current services being offered by community partners to address a particular health issue. This inventory is called "What Is In My Backyard?" The inventory gives us a comprehensive overview of what the current service network consists of to help a community deal with improving their health. The inventory helps us to see where overlaps are, where gaps that need to be closed, and where improvements can be made.

The Community Stakeholder Services Map[1] takes this a step further by providing a visual of the physical location of where the services are located in relationship to each other. This visual makes the service network come to life since we can see the process a person needing service must navigate to obtain those needed community services. This map helps broaden our view of improvements to be made that could include transportation, accessibility, and safety issues for those needing the services being offered. It is a good idea to review the map yearly to see if any shifts in the community demographics may have an impact on where the services are or should be located.

Once this is completed we need to ask the following questions:

- Are needed community services readily available and accessible?
- What community services are duplicative?
- What community services are missing?

[1]www.phf.org/resourcestools/Pages/Community_Stakeholder_Services_Map.aspx

- What are the major obstacles to community residents to access needed services?

Quadrant 3 is where we gain insight into how effective our individual services and approaches have been in improving the community's health and what are the gaps we need to close. This is where we must be willing to share our metrics and objectively analyze the data. This is where we move from data insight to understanding the actions that are needed to improve the community health.

To do this we must answer the following questions:

- What are the community health trends and are they linear or cyclical?
- What are the contributing factors causing the data to go in its current direction?
- What are the limiting factors preventing it from going in the right direction?
- Based on the data what must we continue doing, improve, start doing, or stop doing?

Quadrant 4 is where we start to make some changes in what services we offer and how we deliver them. This is a place where a Population Health Driver Diagram[2] is useful to develop with the community partners to determine what should be done in the community to improve health. A Population Health Driver Diagram identifies primary and secondary drivers of an identified community health improvement objective and serves as a framework for determining and aligning actions that can be taken within a community for achieving improved health. This framework offers not only a starting point for discussion but also flexibility for identifying and addressing unique community characteristics, assets, and needs. It helps create an atmosphere of cooperation by enabling each participant, working to address the specific community health objective, the opportunity to identify and articulate roles already being played by that individual's organization and to develop an understanding of how what he or she is doing fits in with other community organizations. In addition, this framework can be used to determine other actions that can be taken individually and collectively to positively impact the particular community health objective.

To make this work we must answer "Yes" to the following questions:

- Are we willing to be partners and collaborate, cooperate, and coordinate resources for the collective good of the community?
- Can we agree on a common health improvement AIM for the community?
- Can we work collaboratively to achieve the community health improvement AIM?
- Are we willing to pool and leverage our partner assets?
- Are we willing to consolidate programs and services to make them more efficient, effective, and available to achieve the community health improvement AIM?
- Are we willing to allow community residents on our collaborative task forces?
- Are we willing to allow community residents to shape the voice of health for their community?

Summary

Improving a Community's Population Health: You Can't Do It Alone shows the need for all involved in improving a community's health to collaborate, coordinate, cooperate, and co-exist in the community. We must be able to work together to optimize all of the resources for the good of the community. We need to be willing to remove the walls of our individual silos and encompass a healthy collaboration among all groups working to better the health of the community.

[2]www.phf.org/resourcestools/Pages/Using_a_Population_Health_Driver_Diagram_to_Support_Health_Care_And_Public_Health_Collaboration.aspx