

8 Critical Activities and Phases of Community Development

Over the last ten years, grant makers have devoted substantial resources to community-based solutions for the health care access, quality and disparities crisis. These include:

Kellogg: Community Care Networks

RWJF: Communities in Charge

RWJF: Covering Children and Families

HRSA: Rural Network Development

HRSA: Community Access Program/Healthy Communities Access Program (HCAP)

Results of Investments

It is estimated by the Bureau of Primary Health Care that there are over 600 communities who have signed on to the 100% Access with Zero Disparities campaign, 260 of whom have been Healthy Communities Access Program (HCAP) grantees. HCAP collected seven years of rigorous evaluation data from grantees every six months. This data shows that:

- Grantees impacted 45 states and 45% of the people who live in the U.S.
- Provided access to 6.2 million more people while saving \$2 billion
- Leveraged \$6 for every grant dollar invested

Phases of Community Development

By looking at the experiences of communities over the last ten years, patterns begin to emerge. For instance, communities tend to implement the blueprint for a 100% Access with Zero Disparities delivery system in phases.

Phase 1: Create the “Community Engine”

During this phase, the community guides the creation of a formal community health collaborative. These collaboratives introduce a set of evidence-based service delivery components, identify capacity gaps and define the delivery system integration path. This creates the platform for attracting, leveraging and coordinating resources across funding silos to financially support phase two. The “engine work” includes:

- Managing a portfolio of services such as:
 1. Convening partners to identify solutions
 2. Finding benchmark communities to replicate
 3. Generating un-surfaced assets by coordinating funding silos
 4. Planning to build the capacity for a sustainable safety-net building off what assets exist in the community to avoid competition for resources and duplications of functions
- Conducting Return on Community Investment (ROCI) evaluations that broker the opportunities
- Creating the community-readiness to restructure the delivery-system to provide better value to purchasers
- Mobilizing grassroots support for refinancing the health care system

Phase 2: Build Sustainable Safety-net Capacity

During this phase, the community health collaborative manages the adaptation, testing and coordinated implementation among multiple organizations of the “8 Critical Activities” that need to be in place for a sustainable safety-net. These 8 Critical Activities have been developed by putting together a portfolio of best practice communities who have already achieved results. The activity management responsibilities assigned to the Collaborative during this phase include:

- Assessment of health status, disparities, and effectiveness of services
- Integrated program Information Systems (IS)
- Common client referral and tracking system
- Community development scorecard
- Community mobilization that creates the readiness to operate a community-based health system

Evaluations of the best practice communities show that the portfolio of the following activities create the foundation for capturing the savings to sustain an adequate supply of safety-net providers, which in turn improves access and care quality while reducing disparities. The 8 Critical Activities are:

1. Outreach & enroll into eligible programs
2. Provide culturally & linguistically competent medical homes
3. Assure access to prevention & wellness services
4. Provide affordable prescription drugs
5. Assure access to specialty & hospital care
6. Manage chronic diseases
7. Coordinate comprehensive care
8. Develop strategies to cover low-wage workers

Phase 3: A Community-Based Health System

Once the provider safety-net is stable, the Collaborative is in a position to promote a Community-based Health Care System. The Collaborative convenes providers and funders to make the delivery and finance restructuring deals that achieve better health for everyone at less cost. This includes calling for and celebrating success in:

- **Combining funding**
 - Reduce the silos resulting from multiple funding sources
 - Count and factor in uncompensated care and what patients pay
 - Get new contributions from employers and community fundraising
- **Capturing savings**
 - Subsidize shared IS technology to improve productivity and patient satisfaction
 - Practice evidence-based treatment and reduce unnecessary procedures and errors
 - Invest in disease prevention and health management
 - Reward health and consumer stewardship
- **Achieving 100% Access with Zero Disparities**
 - Create a county-level community-based health care system with community prioritized service decisions
 - Invest fully in primary care and prevention and purchase risk protection for other services
 - Pay providers using one common method

Challenges

Despite the experience with many innovative community access projects, it is still a challenge to sustain these projects and take them to scale through public/private financing. For instance, there are many communities in phase 1, yet only a few who have evolved to phase 3. Two structural factors get in the way: 1) health care funding sources are not set up to support these programs, and 2) the providers don't have platforms or traditions where they come together to build the level of integration needed. In addition, programs that create savings in the system don't benefit from those savings, and the organizations that benefit are not set up to seek or recognize the payoff.

Opportunities to “Put the Framework Together”

- State affiliates of CJA could define a model for community health collaboratives that describes the “engine work” and promote the value proposition
- Grantors could call for community health collaboratives to customize and implement the blueprint, including funding tracks that fit with the three phases of community development
- State purchasing agencies could define the “job” of the health care safety-net Chief Financial Officer (or “virtual manager”) and mechanisms for the state to partner with local communities to implement common agendas
- Local United Ways could provide leadership development and coordinate evaluation of outcomes

