Promoting a New Era of Innovation in Public Health Practice: An Introduction to the Concept of a Community Population Health Practice System Approach to Promoting Success in Resource Strapped Communities

Joseph B. Hawes, MD & Ann S. Goldman, PhD. 29 August 2019

For the purpose of this article, I will assume that we are all working in pursuit of a common goal -- of achieving better health outcomes for populations living in underserved, resource strapped communities in the United States. Within any given community, the families and children that are at the greatest risk for experiencing bad health outcomes are those in the community's lowest socioeconomic tertile. With this understanding, my article seeks to introduce the concept of a community population health practice system -- to promote improved health outcomes for populations living within all communities --

regardless of geographic location.

The reality before us is that our federal, state, and local public health practice system infrastructure lacks the capacity to carry out community level needs assessment surveillance. In addition, there is little or no allowance for supporting community level capacity building to facilitate a process for communities to do it themselves. Philanthropy and other non-governmental organizations (NGO) have, for decades, assumed the role of promoting community level capacity building and supporting initiatives designed to promote good health and well-being outcomes for populations residing in poor communities.

This situation has created the belief that a myriad of collective, collaborative partnership efforts are needed in order for us to achieve better health outcomes for populations residing in these communities. Many collaborative partnerships between, and among, funding agents, between population health care systems, and other nonpublic systems operating within the community do exist but their impact is rarely sustainable .

The 2018 United Nations Human Development Index (HDI) ranked the U.S. 13th down from 8th in 2006. Internationally, the infant mortality rate (IMR) is the indicator most often used as a measure of a country's ability to take care of the health and social needs of its poor and indigent populations. The last UN report on IMR

placed the U.S. in 30th place, down from 12th in 1960, 23rd in the 1980's, and 28th in 2003. Within the U.S., IMR and MMR vary between and within states. Thus, in terms of population health index indicators the U.S. is not doing as well as other developed countries in taking care of its poor populations. The variance of rates across and within states indicates that the benefits to be derived from our public health practice systems are inequitably distributed across and within states. A common denominator within all states is that populations living in the poorer communities have the worst outcomes. Within the populations of poor communities, families and children living in poorer communities experience the worst outcomes.

The challenge we face as public health practitioners is the fact that despite decades of countless best practice initiatives and decades of extensive financial investments in community capacity building initiatives, we have not been able to achieve improved health outcomes for populations of families and children living within resource strapped communities. In terms of reversing this trend, we must re-examine our continued practice of adopting innovative approaches that often end up being a new way of doing the same old thing. Achieving the same output, of use by year expiration date best model practice -- and the same outcome, of no improvement in the fate of families and children living in poor communities, is not helping our communities to move forward.

This article is a call for us to begin to put our collective ideas and thoughts together in creating a community population health practice system (CPHPS) operating in parallel, and in harmony with our existing clinical practice and public health practice systems. Like our existing public health practice system, it will have its three core functions for protecting and promoting community population health. These core functions are: 1) to promote communities' needs assessment capacity building; 2) to facilitate communities' participation in the public health practice decision-making process; and 3) to promote workforce training capacity building based on community assessed challenges, needs, and opportunities for promoting success through maximizing the use of available local resources.

In an effort to demonstrate the potential value of a CPHPS to our existing public health practice system, I will present two examples where it would have enhanced opportunities for success. First, a state-based maternal and child (MCH) effort to improve health outcomes for mothers living in poor communities. Second, the groundbreaking, single largest philanthropic nationwide community public health practice development initiative launched in the U.S. Both represent public health practice work efforts designed to promote good health and well-being outcomes for populations residing in poor communities.

In relation to my MCH work experience, the maternal and

infant mortality rates (MMR & IMR) in the state where I served as a CDC Preventive Medicine Fellow in 1993 were among the highest in the nation. Upon review, there was a noticeable inverse relationship between under-utilization of the state's public heath prenatal prevention care (PNC) services and the occurrence of high MMR and IMR. Communities with the lowest participation rates experienced the highest MMR. In the communities with high MMR, the PNC utilization rate was typically 20 percent below the national rate. Based on these findings a state mandated MCH goal was to improve the PNC utilization rate by 20 percent in these communities.

The first challenge to this state mandated public health practice goal stemmed from the fact that a previous MCH department effort to improve PNC service participation by residents in poorer communities had met with no success. The policy adopted doubled the fleet of PNC buses available to transport mothers from these communities to PNC services. This policy originated from a study of the state pregnancy risk assessment monitoring system (PRAMS) data. The research findings indicated transportation was the main category mothers selected as their reason for not participating in state provided PNC prevention services.

A review of the answers per selection category of the answers to the PRAMS data set regarding reasons for not participating in early PNC utilization revealed that the category choice of "other" received the highest

percentage of responses -- getting almost twice as many responses as the category for transportation. This is an indication that there is a reason beyond what the answer choices offered. Further review of actual handwritten notes attached to the “other” category, revealed the following recorded comments:

- The bus came at a time when mothers were occupied with getting their children off to school. Thus, they couldn’t use the bus and had no other means of transport;
- Agency policy did not allow mothers to be accompanied by a child; given their inability to afford day care, these mothers had to pass up on the bus offer;
- All buses had big red signs on the side that read “MEDICAID BUS,” community members referred to the bus as “the free bus” for poor people.

In reality, the outcome of this effort is not a matter of poor compliance on the part of the community mothers but rather the failure of the policymakers and the MCH department to generate appropriate intervention policy programs and services to address the challenges residents living in poor communities face in participating in available state health promotion services. While the challenges were many, the required solution was an adjustment in the existing bus service utilization policy and not further financing for an expanded version of the same approach.

A CPHPS practice with its three proposed core functions and its community participatory focus will possess the ability to promote capacity building for the state public health practice system and promote community awareness capacity building. For public health practice, it will provide state and local public health officials with the ability to understand community challenges to success to better generate policy, programs, and services to address the needs for residents living in the community. For community residents it will provide them with the ability to better participate in existing health promotion and sickness prevention efforts operating within the community. For public health research, it will remove the need for the category "other" in community needs assessment research.

The 1996, *"Turning Point (TP): Collaborating for a New Century in Public Health Initiative,"* implemented in 14 states and 41 communities across the U.S. was a national community, public health capacity building initiative jointly funded by the W.K. Kellogg Foundation (WKKF) and The Robert Wood Johnson Foundation (RWJF). Its approach to achieving success was through promoting public health capacity building within communities. This capacity building would provide existing public health practice systems with the ability to develop and implement intervention policies, programs, and services that address the needs of the community's populations.

The projects' two funded agents, an RWJF funded tertiary

institution of learning and an organization representing local city and county health officials, funded by WWKF, were tasked with the responsibility of developing innovative strategies for collaborating and seeking opportunities to transform and strengthen public and community health practice through partnership development. An expected output was that through this array of collaborative partnership building the public health practice systems would be brought in contact with the communities they serve.

The focus of promoting community public heath capacity building gave community residents some understanding concerning the technical aspects of how public health practice works in protecting the community from health threats and in promoting good health outcomes for the families and children living with the community. The 41 participating communities were tasked with the responsibility of carrying out comprehensive assessments of existing public health systems and to produce their own community public health systems improvement plans for implementation. My public health practice work was carried out with these 41 community units.

Although it achieved many successes, the “Turning Point: Collaborating for a New Century in Public Health” was unable to meet its goal of providing our existing public health practice systems with the ability to promote better health outcomes for populations residing in poor resource trapped communities. The first major barrier to success

was that the 41 communities were ill prepared for participating in a project of this technical magnitude. The lack of community organization capacity hindered the communities and their residents' ability to participate in and benefit from any additional resources the presence of the project provided.

Second, the two funded agents independently and collectively lacked or failed to show sufficient technical expertise and lacked the administrative infrastructure capacity necessary to generate innovative strategies for collaborating between themselves or with the state and local public health practice system. The organizational infrastructure of the association of local city and county health officials did not have the necessary capacity to facilitate public health practice learning or skills building training opportunities within the communities.

The net impact of this deficiency was that once the RWJF and WWKF funding ended the partnerships between association and the 41 participating communities immediately collapsed -- and many of the auxiliary partnerships that were generated through the project faded away. In the face of the collapse of this partnership infrastructure support, and in the face of the existing lack of asset building, the communities were unable to sustain achievements gained.

Over the last two decades, I have successfully applied adaptations of this "Turning Point" community public

health capacity building concept model in my work as Chief Medical Officer (CMO) and director of health care services working within the British health care provision system and as a public health consultant working within the Tribal health care system. Dr. Goldman has, for the better part of the last two decades, worked on researching the costs and cost-effectiveness of public health prevention programs at the community level to prevent neglected tropical diseases and to achieve good dental outcomes for children living in poor underserved regions.

In our collective opinion applying the “Turning Point” community public health capacity building model within an institutionalized community population health practice system, with its three core functions -- is the solution to ensuring lasting improved health outcomes for populations residing in poor resource strapped communities’ -- now and for generations to come.