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Systems for Equitable Community Change Research

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Abstract

Systems for Equitable Community Change (SECC) proposes a model to disrupt inequitable decision-making control and economic power in medical systems. The model achieves this through cross-sector collective impact collaborations and integrating non-traditional approaches such as community-driven applications with non-traditional partnerships aimed at improving systems of care and financial policy change to address Social Determinants of Health (SDoH). The collective impact model collects ecosystem data (on outputs, outcomes, and impact) that serves as the foundation for advocacy to dismantle long-term health and racial inequities through upstream solutions. This can be carried out by a structured ecosystem composed of key stakeholders that can influence current inequitable financial policy and system changes to create new financial modeling that supports resourcing SDoH.

Introduction

Everyone's health and economic future depends on the success of reimagining life after the wake of the coronavirus, racial and social injustice, and the political climate, but more importantly, how values are shared to create transformative ecosystems that encourage a more just society. The year 2020 has caused the public health, medical, and social systems to reexamine its use of incentives and resources to deliver quality healthcare services; address SDoH through new partnerships and provision of community-based direct service programs and interventions; change organizational culture to be more race-equity centric; increase authentic engagement with the community, and change institutional, structural, and systemic policies and practices so they are fair for everyone. Additionally, all sectors must equip themselves with knowledge and compassion to address the inequities that have devastated communities across the nation, particularly among Black, Indigenous, and People of Color (BIPOC).

Systems for Equitable Community Change (SECC) proposes a model to disrupt traditional cross-sector models by integrating non-traditional approaches (including community-driven applications) with non-traditional partnerships aimed at improving systems of care and financial policy change to address SDoH. SECC addresses inequitable financial models coupled with fragmented transition of care systems that do not adequately support addressing non-medical care. The theory behind SECC is that centering community and non-traditional partnerships will result in more equitable redistribution of resources, including power, money, and access. Under a more community-centered model, these resources will flow from hospital systems and insurers to a shared ecosystem between public health, social services, alternative medical facilities (like retail clinics), and insurers to collectively deliver community-based preventive care that improves health and reduces racial inequities.

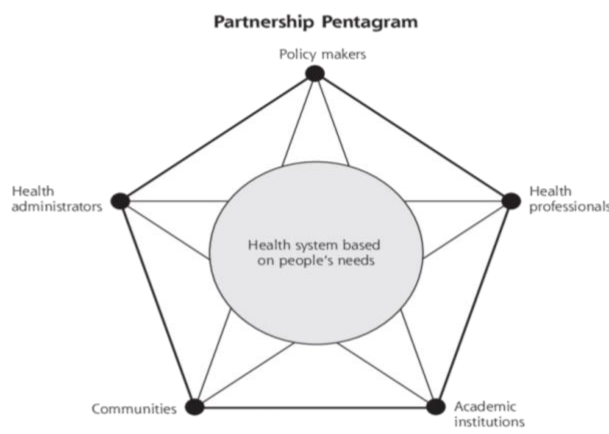
Innovation Context

Traditionally for-profit and non-profit professionals within the public health, medical, and social service systems have inherited power regarding access to resources, financial incentives, political influence, service and delivery, program design, and intervention. This often causes more harm and injustice by perpetuating health and racial inequities, particularly within marginalized low-income communities and among BIPOC. The exact population that needs public health, medical, and social services are the ones that experience the greatest health disparities and limited access to affordable quality care.

Decision-making control shifts when the community comes together with others sectors as part of the collective, armed with ecosystem and trend data. This shifts the paradigm from "being invited to the table" to one of setting the table and doing the inviting. The inclusion of diverse perspectives and lived experiences in shared decision-making—along with collaboration with medical and social service system stakeholders—ultimately dismantles discriminatory and racist practices.

Innovation Model

The SECC introduces the notion that community must be central in the cross-sector collaboration process, conversation, and policy decision-making to successfully influence the problem of financial inequities across systems of care that can ultimately address health disparities. According to Congresswoman Ocasio-Cortez, "People closest to the pain need to be close to the power."



Note: Adapted from: World Health Organization. Towards Unity for Health: Challenges and opportunities for partnership in health development. Geneva: WHO; 2000. Available at: http://www.who.int/entity/hrh/documents/en/TUFH_challenges.pdf. Accessed 7 August 2006. See also 2004 Association of Canadian Medical Colleges (ACMC) Social Accountabilities Poster. Presented at the 2004 ACMC-CAME (Canadian Association for Medical Education) annual meeting, Halifax, Nova Scotia. Available at: http://www.afmc.ca/pages/articles_social_accountability.html. Accessed 7 August 2006.

Another key component challenges local ecosystems to integrate elements of collective impact (common problem, common goal, common metrics, mutually reinforcing activities, and so on) by convening key actors across social service, public health, and medical sectors.

The "Partnership Pentagram" is a recognized strategy outlining the key actors that need to be convened to affect local change and adapt current health systems to a health system based upon people's needs.[1]

The Community-Centering Process

By placing community at the center in SECC, they can serve as convener of medical and non-medical providers, policymakers, and other community stakeholders. Once convened, the partners collectively identify and address the wrong-pocket problem, defined below, within their community ecosystem that address health and racial inequities, thus driving policy and practice decisions.

The wrong pocket problem is defined as the misalignment between funding streams and community health priority needs. It is clear from growing epidemics of preventable chronic health conditions and increasing health disparities among at-risk populations that the intersectionality of social determinants of health (SDoH) and wellbeing requires a dynamic and dramatically new paradigm in community health funding.

Innovative, community-driven projects around the country, many led by Black, Indigenous, and People of Color (BIPOC), are convening diverse stakeholders, including partners from sectors with deep pockets that have not traditionally been at the table for public health discussions, such as government, health sector, and financial institutions, to create SDoH equity collectives for ecologically driven community action.

In this innovative model, the inclusion of retail clinics as part of the medical system along with public health, community-based non-medical service providers, and health workforce trainers (i.e., academia) means there is a shared agenda to work collaboratively to reconceptualize funding landscapes and deploy novel approaches that reimagine the rules, relationships, and structures of the existing financial paradigms that nurture and reproduce poverty, racism, and inequality. By reconfiguring the social and political cannons that define access to resources, and redirecting funds from well-heeled government, medical, and financial institutions toward community-centered, cross-sector, collective equity ecosystem models of funding, the status quo is being disrupted. The Community Centering Process, founded upon a framework of social justice and racial equity, has the power to enact collective decision-making processes, create community power, and change policy.

Community is defined as consumers or benefactors who are, in the best-case scenario, often engaged or invited to participate in various forms, including feedback, design, or generation of ideas. However, the community is rarely present when financial or policy decisions are made, resulting in persistent structural forms of inequity. Community as convener can break the continual cycle of inequitable power distribution, financial resources, and access.

Centering Community is a process that draws from a Collective Impact Model with which is the first step in driving change. Below is outlined an example of the different partners within a health ecosystem to be convened. Once convened, the first step is for the community to agree upon a mutual common goal.

MODEL: Collective Impact Model with Community as Convener

Community as the Convener of Community Groups with a Collective Impact Framework. Community is defined as Community Foundations, Non Profit Service Providers, Advocates, and Consumers of Services. Community works to improve social and economic conditions that is at the core of healthy individuals and healthy behaviors (healthy food, work, recreational opportunities, housing, clean water). Leads to public accountability and transparency with government policy makers who influence health insurance providers who influence health systems and provides more opportunities for revenues to underlying issues of social and economic conditions.

Policy Makers/Government: Partner of Collective Impact and Convener of Multi-Sector Partners. Receives public dollars to care for the most vulnerable. Sets policy for medicaid/medicare reimbursement. Sets policy and determines accreditations (i.e. academic) and approved health systems.

Health Insurance: Incentivized by Collective to Invest in Prevention. Receives the majority of health care premiums: Incentivized by high premiums and low payments. Will drive more reimbursement dollars to preventive care.

Health Systems: Incentivized by Collective to Include Community Workers as part of outpatient. Receives the majority of Health Care Private and Public Dollars: Incentivized by procedures and not preventive care.

Academic Institutions: Incentivized to become Socially Accountable organizations by training health workforce to consider both clinical and preventive efforts. Trains the healthcare workforce. Medical and Nursing curricula focused on clinical interventions. Is not focused on preventive care or patient context.

Intersectionality of Social Determinants of Health and Healthcare Delivery

Uniting cross-sector ecosystems as a collective can address institutional and social factors. These factors drive health and economic outcomes and quality of care related to the intersectionality of SDoH and healthcare delivery. It forces the medical care sector, which has much deeper pockets and decision-making control, to address SDoH (non-medical factors) along with racism, poverty, and access issues through financial policy change.

A community-based ecosystem is comprised of multiple non-profit service organizations, intermediaries, funders, and government officials that have collectively agreed upon a common problem, common goal, common measurements, and mutually reinforcing activities directly related to programs and services that address SDoH. In the provision of SDoH programs and services, each partner within the collective is individually gathering and collectively combining service provision collective data (outputs, outcomes, and impact). The collective data serves as the foundation for advocacy to dismantle long-term health and racial inequities. A structured ecosystem collective, composed of key stakeholders, can influence current inequitable financial policy and system changes and create new financial modeling supporting addressing SDoH.

For decades, public health professionals have known that only 20% of improved health outcomes are derived from access to healthcare services. Therefore, emphasis should be on SDoH. SDoHs such as neighborhood, environment, health behavior, and social conditions are responsible for up to 80% of health outcomes. Despite knowing this, cross-sector collaboratives still struggle to improve health outcomes and address health equity.

Methodology

Evaluation methodologies to test the SEEC model consist of empowerment and systems thinking that explicitly evaluates power-sharing and its impact on equitable policy and system change that addresses the overall effect of the wrong-pocket problem solution on the

understanding of how to identify and evaluate changes related to the underlying systemic drivers of inequity. Research Methodology should be based on Community Based Participatory Research (CBPR) and its validated tools.[2] These tools have been widely used in public health research over the last decade to develop culturally centered interventions and collaborative research processes where communities are directly involved in the construction and implementation of these interventions and all aspects of the research of their effectiveness.

Discussion

Everyone's health and economic future depends on the success of reimagining life after the wake of the coronavirus, racial and social injustice, and the political climate, but more importantly, how values are shared to create transformative ecosystems that lead to a more just society. The SECC proposes a new model as the solution to the wrong pocket-problem of inequitable financial models coupled with fragmented transition of care systems that do not adequately address non-medical care.

SECC needs to study to what extent in which using community centering processes and non-traditional partnerships will redistribute current inequitable power, redistribute financial resources and improve access, from hospital systems and insurers to a more equitable community-centered model shared between public health, social service, alternative medical facilities, and insurers to collectively deliver community-based preventive care that improves health and racial inequities. To that end, SECC proposes the study of existing SDoH ecosystems that use a community-centered engagement model (i.e., collective impact). This model is defined as a process to bring people together, in a structured way, to achieve social change as an intervention to address and resource SDoHs among BIPOC. [3]

To achieve greater equity, the SECC needs to employ a racial lens that includes: (1) targeting BIPOC within their community; (2) addressing systemic barriers that create inequities for BIPOC within the social, public, and medical systems, and (3) centering community voice in SDoH ecosystems to share power and lived experiences that will collectively influence financial policy and systems-change decisions.

Conclusion

Systems for Equitable Community Change proposes a model to disrupt decision-making control and economic power within the hands of actors within the medical sector through cross-sector collective impact collaborations by integrating non-traditional approaches such as community-driven applications with non-traditional partnerships aimed at improving systems of care and financial policy change to address SDoH. The collective impact model provides the collection of ecosystem data that serves as the foundation for advocacy to dismantle long-term health and racial inequities. A structured ecosystem collective composed of key stakeholders can influence current inequitable financial policy and system changes to create new financial modeling that supports addressing SDoH and redistributes resources for community-based preventive care through retail clinics.

End Notes

[1] James Rourke, “Partnership Pentagram,” accessed on June 21, 2021, https://www.researchgate.net/figure/A-partnership-pentagram-showing-the-5-broad-groups-of-stakeholders-infl-uencing-the_fig2_6791729.

[2] Jennifer A. Sandoval et al., “Process and Outcome Constructs for Evaluating Community-Based Participatory Research Projects: A Matrix of Existing Measures,” September 21, 2011, https://pubmed.ncbi.nlm.nih.gov/21940460/.

[3] Collective Impact Forum, “Too Many Organizations Are Working in Isolation from One Another,” *Collective Impact Forum*, 2014, https://www.collectiveimpactforum.org/what-collective-impact.

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About the Authors

Vanessa Briggs, CEO of Brandywine Health Foundation, is a native to Philadelphia and a renowned leader in public health. Ms. Briggs applies her expertise to working with communities to solve complex problems through multi-sectoral strategic partnerships, community engagement, health promotion and education, and disease management interventions. Prior to joining Brandywine Health Foundation, Ms. Briggs served as Vice President of Community Health in Maryland and Executive Director for Health Promotion Council—an affiliate of Public Health Management Corporation—for 15 years. During her time at the Health Promotion Council, Briggs led a team and enhanced the organization's budget three-fold, while developing and leading several large-scale regional and national childhood health equity initiatives. Briggs's prowess optimizes the capacity of non-profit organizations by building multi-sector partnerships between health providers, policymakers, and community members.

Nicholas (Nick) Torres, M.Ed., CEO/Co-Founder, has over 20 years of experience in executive management. Nicholas serves as the executive director of The Network: Towards Unity for Health (TUFH), an official non-state actor of WHO. He is also Co-Founder and CEO of Social Innovations Partners, which publishes the Social Innovations Journal, manages the Social Innovations Institute and Lab, and incubates and launches high-impact social sector models and enterprises. He teaches Nonprofit Leadership, Social Policy, and Social Entrepreneurship at the University of Pennsylvania. He serves on many regional boards, including the Free Library of Philadelphia and Springboard Health National Advisory Board. Nicholas has led and founded multiple for-profit and not-for-profit social ventures that are driven both by social impact and financial sustainability measures. Some of his launched social ventures include charter schools, an early literacy technology platform; school-based health centers; and community-based satellite college sites.