Mobilizing the Community for Better Health

What the Rest of America Can Learn from Northern Manhattan

EDITED BY

ALLAN J. FORMICOLA

AND

LOURDES HERNÁNDEZ-CORDERO

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Scaling Up

LOURDES HERNÁNDEZ-CORDERO, SUSAN STURM,
KATHLEEN KLINK, and ALLAN J. FORMICOLA

When I chose to be a public health practitioner I did so because I had the need to be of service to others. I had always focused on what I, as an individual, could do to improve the life of the collective—of my neighborhood, my workplace, and my "target community." I have never spoken about how the principles that guide my work could improve the health of the nation. I always thought that an individual voice was necessary but that it took community voices to make a change at a bigger scale.

—Lourdes Hernández-Cordero

Moments of crisis require big, bold ideas. In this chapter we will zoom out of our close examination of the Northern Manhattan Community Voices Collaborative experience to propose ways to scale up the things that worked for us in order to make them applicable at a national level. With this chapter we honor the intent of the W. K. Kellogg Foundation in its support of learning laboratories across the nation. Our goal is to contribute to the collective dialogue on how to improve the health care system. Specifically, we propose that making a healthier nation and reducing health care costs will require more than simply moving toward universal health coverage—which is essential—or implementing technologies to digitalize medical records—which is useful. As epidemiologists would say, those things are necessary but not sufficient to overhaul our ailing health care system. Instead, we propose to reduce health care costs and improve health care access by implementing a national prevention program through collaboration based on a new health compact with society—one that delivers on the promise of justice for all and (paraphrasing our forefathers/mothers) the pursuit of health.

In the previous chapter we summed up the ten-year experience of NMCVC. In this chapter we propose building on that experience and thinking broadly to solve the problems of our health care system. We will begin by defining and making the case for prevention as the cornerstone of a new health care system. Second, we will make the connection between prevention and collaboration and will draw on the Community Voices experience to propose a large-scale movement toward prevention through collaboration that activates the network of academic and community health centers and their respective community partners. Finally, we will outline a blueprint for the implementation of these ideas and provide examples of the types of policies that could make the blueprint a reality.

Here's to being bold.

Making the Case for Prevention

The nation is once more engaged in an exercise to reform our health care system. At the heart of this new round is a debate about whether and how to cover all Americans and how to improve the quality of care. We believe that this debate misses the mark if it does not address how the role of prevention can become a pillar of health reform. We also believe that the government acting alone will not be able to provide greater access to health care services and foster the systemic changes needed to improve quality of care. This task will require the involvement of many other stakeholders, including academic and community health centers, public health practitioners, and grassroots community organizers. Furthermore, since the new reality of the health status of the American people is that chronic illness constitutes the biggest burden, a system that was largely planned to contain acute illness is inadequate. Therefore, the health care system needs to be not only restructured but also reconceptualized. A reconceptualized health care system that puts prevention, promotion of healthy behaviors, and management of chronic illness at the heart of the new plan will benefit not only underserved population groups living in inner cities and rural areas that are marginalized in regard to health, but also the average American who sometimes perceives the burden of the *cost* of health care to fall on her or his shoulders.

BOX 15.1
Defining Prevention

We define prevention as activities that fall within three categories: preventive medical care, wellness promotion, and chronic disease management.

Preventive medical care: Clinical interventions including examinations, screenings, measures that guard against disease, injury avoidance driven by risk assessments, and standardized protocols. Aimed at avoiding the onset of illness and early detection.

Wellness promotion: Education and facilitation leading to healthy behaviors related to physical activity, nutritious eating, sun safety, alcohol, tobacco and other drug use, and violence prevention. Education is aimed at acquiring knowledge, shaping attitudes, and developing competency. Facilitation is aimed at improving access to healthy options and creating safe and just environments.

Chronic disease management: Treatment and close monitoring of chronic illnesses once they have been diagnosed.

Prevention as the Cornerstone of a New Health Care System

A lot has been said about what prevention can or cannot do. The jury is still out in many ways with regard to how much (or if) prevention can help reduce health care costs. Some preventive measures that are highly valuable (e.g., flu shots, cervical and prostate cancer screenings, cholesterol and high blood pressure screenings) are not necessarily cost-savers. Other preventive measures (e.g., vaccinations for toddlers, vision and hearing screenings), wellness promotion, and chronic illness management strategies have mountains of evidence supporting their cost-saving benefits.

TABLE 15.1
The Economics of Prevention

Net savings in health care costs of an investment of $10 per person per year in proven community-based disease prevention programs:
In 1–2 years: $2.8 billion annually
Within 5 years: $16 billion annually
Within 10–20 years: $18 billion annually

Source: Trust for America's Health (2008).

A New Health Compact

However, there are more important reasons for putting prevention at the center of a health care system than cost savings. Putting prevention as the cornerstone of the health care system is the right thing to do. The great health compacts that gave us Medicare and Medicaid raised our expectations that—just as education is seen as a right—access to basic health care would also be a right. Now, almost forty-five years later, our nation has veered from this direction in benefit of economic interests and has bought into the idea that health care benefits are a privilege. Bold, swift action is required to call to task a variety of stakeholders—from academia to service providers, from professionals to lay health workers. Bold, swift action is needed to make activities serve more than one purpose—to rethink service as a way to learn, and as a way to serve. Bold, swift action is indispensable to regain a leading role globally as a just and fair country that cares for its citizens—all of them, not just the ones who can afford it. Bold, swift action is needed to change the status quo.

There are two main reasons why fostering prevention is the right thing to do: equality and opportunity. Prevention is about equality because the bulk of the burden of disease and illness falls on the poor and people of color. Reducing their share of the burden would be a step toward reducing health disparities. Prevention is also about opportunity because there is a close link between health status and economic attainment. The direction of the relationship between health and education or health and economic status is not clear yet. That is, we do not know with certainty if people who are sick do less well in school because of their illness *or* if being more educated can inform and enable people to choose healthy behaviors. The research

evidence, however, indicates that there is a direct correlation between health and level of education as well as health and socioeconomic status. That is, the higher a person's level of education, the better their general health. The higher their socioeconomic status (i.e., earning a living wage, having stable housing), the better their general health.

Coverage for everyone is one way of improving the health care system. But it is not the only way. We propose that an important step toward improving the health care system is to enact a new health compact that flips the current system toward prevention as the priority.

Prevention Through Collaboration

The connection between prevention and collaboration is not obvious at first. If, after reading this chapter, it becomes apparent and logical, we would have fulfilled our goal to contribute to the collective dialogue on how to improve the health care system and sowed the seeds of making prevention a national priority.

The tasks we call for to make prevention a cornerstone of the national health care system—preventive medical care, wellness promotion, and chronic disease management—are not difficult to understand. They are, however, complex to achieve. The reason why they are complex is that they require not only the kind of knowledge generated through research (e.g., the discoveries of new and effective treatment options, the identification of risk and protective factors that can be altered through healthy behaviors, standardized protocols), but also knowledge about translating research into practice, about adapting strategies to make them culturally relevant, and about the "goodness of fit" of an initiative to local needs and resources. Some of this knowledge is contained outside of the institutions that are part of the health care system, and within the community itself.

We propose that prevention works best when many stakeholders are involved in the planning, dissemination, and implementation of activities because each stakeholder brings a unique and crucial perspective. Going from a one-dimensional view of a problem to a multidimensional view compensates for any organizational blind spots that may exist. Collaboration is the mechanism through which stakeholders can be convened and work can be carried out.

The Community Voices Experience

Reviewing the work of the NMCVC, three lessons for effective collaboration can be distilled: (1) community–institutional collaboration can lead to successful community-wide prevention initiatives; (2) prevention initiatives can be put into place when set within the mission of an institution and partnering organizations (a corollary of this lesson is that sometimes outside "carrots and sticks" must be used to restate the mission of an institution to be in line with the goals of the prevention tasks); and (3) cooperation between institutions and community-based organizations in underserved urban areas can lead to increased capacity for prevention, a richer learning environment grounded in service, and opportunities for cutting-edge research that benefits all stakeholders.

A Large-Scale Movement Toward Prevention

The proposal we make is ambitious and only possible if an equally ambitious challenge is posed to the stakeholders we aim to mobilize. The challenge we propose is that all academic and health centers expand their missions to put service as an important component of what they do rather than a byproduct of afterthought of their intellectual and clinical pursuits. Service provides the way to connect teaching and research. When treated as a core activity, it offers a way to develop a research agenda with the promise of improving the health status of underserved communities. When treated as a way to equip students to advance a public health mission, service ennobles teaching and enables learning. When you think of service as an opportunity for learning, it naturally becomes part of a curriculum that prepares professionals for real life. When you think of service as an important application of intellectual work, it can lead to cutting-edge research that benefits both the researchers and research participants. Service is a valid way to build a professional record of excellence while also building the trust of the communities in which one works.

Public health and health science professionals from all over the nation affiliated with institutions that share a backyard with impoverished communities can provide service that advances the prevention agenda while also meeting the goals of their funders and receiving accolades for their

scientifically rigorous work. For this to happen, a shift in institutional mission and what is valued must occur to include addressing health care needs of underserved communities. And this shift can be accomplished by strategically linking funding and reporting priorities to a service component, successfully activating a vast network of academic and health centers.

Activating Academic and Health Centers and Their Community Partners

The idea of community–university partnerships is not new. The U.S. Department of Housing and Urban Development has an Office of University Partnerships that funds and supports campus–community partnerships aimed at economic development through job creation and neighborhood building. Similarly the Community–Campus Partnerships for Health, a nonprofit organization, facilitates partnerships between communities and institutions of higher education aimed at promoting health.

The NMCVC brought together several schools from the Columbia University Medical Center. The Medical Center is home to a dental school, a medical school, a public health school, a nursing school, and a nutrition institute. While only three of those institutions were actively involved in the first nine years of the project, the renamed Center for Family and Community Medicine has sought to engage also the nursing and nutrition faculty. The kind of mobilization for prevention that we propose would activate the vast network of academic and health centers across the nation to collaborate with community-based organizations in their own backyard by linking incentives (funding, recognition, accreditation credit) and creating policies to ensure that prevention activities are a priority in the work, service, and research agenda of academic and health centers.

Think about the potential for national reach.

There are 158 accredited medical schools, 40 accredited schools of public health, 58 accredited dental schools, and 468 nursing schools and programs. This list includes private and public institutions, big and small, based in urban and rural areas. Furthermore, there are 1,067 Federally Qualified Health Centers and over 7,000 community health centers throughout all fifty states and the U.S. territories.

Now imagine the possibilities.

Blueprint for Collaboration

We propose a plan to meet the health needs of all Americans that is based on the principles of (1) a national health care system that prioritizes prevention and (2) policies that reward and foster collaboration. Prioritizing prevention means flipping the health care system's priorities from a crisis-reaction-driven system that reveres specialization to a proactive system grounded in primary care and collective solutions. We believe that by expanding what we consider to be the purview of the health care system beyond the medical encounter, we can reach so many more people—especially the underserved who carry a disproportionate burden of disease—and so begin to "mind" the health gap. Fostering collaboration for prevention is the framework for success. The policies and incentives we call for would help identify a broader set of stakeholders, a more comprehensive set of priorities, and a series of mechanisms that build on research and learning/teaching to increase and improve service. Mechanisms for research and learning/teaching that encourage real-life, community-based collaborations need not sacrifice scientific integrity or academic freedom. On the contrary, we propose that these new mechanisms encourage creative problem solving, research in in vivo settings that can be translatable, and a rich learning environment that at the same time provides much needed service. Research for the sake of research is not good enough. Service without a research or evaluation component is not good enough either. These two tasks must complement each other. When they do, teaching and learning are enhanced. Next, we present the who, how, and what of the blueprint for collaboration.

Who: Broad Array of Stakeholders

We propose that the "who"—the stakeholders—carrying out collaboration for prevention should include academic health centers, community health centers, advocacy groups, public bodies, intermediaries, and foundations. All of the stakeholders may not be present in every community, nor may they be the right partners for all initiatives undertaken. Nonetheless, they all need to be engaged for a nationwide mobilization to occur.

Academic health centers have the responsibility to train health care professionals and the opportunity to provide services through the training

experience. For example, practica, internships, and faculty who provide care or technical assistance while teaching are all resources that academic health centers can bring to collaborations. All of these activities can become part of the research portfolio (i.e., as evaluations, Community-Based Participatory Action Research, or translational research). Through the NMCVC years, we learned about leveraging the role of academic health centers as anchor institutions for collaboration. They are in a position to develop the new generation of transformative leaders committed to ongoing collaboration and knowledge development. As recipients of tax exemptions and indirect costs from government grants, academic health centers have accepted public support for their work. Therefore, policy could and should be deployed to encourage these institutions to promote responsibility for community health as part of their core mission by requiring active collaboration with community-based organizations with which they would interact in assessing priorities, designing programs, and managing the ongoing process of helping develop the national health system.

Community health centers—many located in medical shortage areas—are also anchor institutions and an important venue for the deployment of information, program implementation, and convening of stakeholders. Collaboration would boost a community health center's ability to carry out prevention activities, to serve as a site for wellness promotion, and to effectively manage chronic illness. As the flagship institutions for primary care delivery, community health centers are a keystone in flipping the health care system toward prevention.

Advocacy groups, which are mainly community-based organizations, are essential not only because they serve as the "voices" of the community, but also as drivers of policy that is informed by reality. Because of their intimate knowledge of communities and the populations that they serve (and represent), they are a vital sounding board in policy development and enactment as well as the logical leaders in many prevention activities.

Public bodies (in the case of northern Manhattan, the City Council and the Community Boards) in many instances have a bird's-eye view of what is going on programmatically in the community. When public bodies are incorporated as collaborators, duplication of efforts is minimized and synergy can be garnered.

Intermediaries are boundary-spanning institutions that operate across multiple systems, organizations, and fields. Community Voices became this kind of cross-cutting catalyst that brought together different groups to

address shared problems and mobilize change. These intermediaries play a crucial role in creating space for ongoing collaboration and maintaining linkages across the silos that typically separate universities, communities, and policy makers. They also translate the needs and insights of these groups to policy makers and funders.

Foundations can be key intermediaries providing an architecture to support ongoing change. The W. K. Kellogg Foundation's role as the catalyst for Community Voices offers one example of how an intermediary can use resources to stimulate a process of leadership, collaboration, reflection, problem solving, and institutional change that makes good business sense. In our story, foundations featured prominently as agents that allowed us to solidify, legitimize, and elevate the impact of our work.

How: A Multilevel Ecological Approach

One of the most striking things about the Community Voices story is the number of people from different positions and backgrounds who worked together to bring about change over a long period of time. This kind of multilevel, long-term collaboration was crucial to the successful adoption of prevention as a strategy. The Community Voices story illustrates how a multilevel, ecological approach can take hold by creating an architecture supporting ongoing learning, transformative leadership, long-term university–community partnerships, and systems change. A convergence of commitment among leaders within the community, the university, health care institutions, and foundations gave rise to an infrastructure to support ongoing change. We propose that by taking an ecological approach, the role of all stakeholders in the overall design of the health care system could be sustained and could provide the driving force for prevention through collaboration.

What: Building Collaborations for Prevention

We are proposing a large-scale initiative aimed at making a healthier nation. The initiative will reduce health care costs through collaboration for prevention. Flipping the current health care system to prioritize prevention is, admittedly, a huge undertaking. Fortunately, there is no need to

start from scratch. Drawing on the local experience of the NMCVC, we believe the following blueprint can form the basis for a mobilization effort on a national scale.

Enlist organizational leaders. Within organizations, visionary leaders with fresh thinking and an understanding of the benefits of a health care system grounded on prevention should be identified. These leaders will bring core institutional support to the collaboration and ensure long-term support for joint activities. Educational and health policy should foster the development of new leaders with vision, commitment, and organizational ability.

Pay attention to structure. While the NMCVC counted over thirty-five partner organizations, not all participated in every initiative. A structure was set in place (working groups, executive and steering committees) that enabled participants to get things done, to gather data needed to inform action, and to learn from those who had the knowledge of what was needed and what would work. The partners involved in each specific initiative varied according to their expertise, interests, and capacity.

Keep relationships first. Requests for proposals may come and go, but relationships will remain. Relationships are built on small gestures (e.g., attending an event or meeting for the sake of support, even if no immediate benefit is secured) and support big efforts (e.g., large-scale projects, sharing of resources).

Articulate a joint, affirmative vision. State what stakeholders stand for (instead of what they are against) and how they want to go about achieving a community-wide goal of health for all. This vision then becomes the rule of thumb measured against all new projects. If a new initiative does not pass muster, then it is a diversion and the collaborative is better off passing on it than losing its focus.

Seek mutuality, practice reciprocity. Look for those things in common that stakeholders may have. They may not all agree on all issues, but a working agenda can be drafted based on common goals. Once commonalities are found, strive to exchange resources, services, favors, or obligations. A collaboration can be built this way in the absence of (or while waiting for) external funding.

Map and match like things. List and map all existing policies or activities in the ecological framework articulated for the community at hand. This will aid stakeholders to match those initiatives or opportunities for easy wins—existing resources that can be shared, programming that can be enhanced, or information that can be disseminated.

Build capacity and infrastructure for ongoing organizational transformation. By focusing on building capacity and infrastructure change, prevention can become second nature, the default position rather than a special activity or a deviation from the norm.

Develop organizational catalysts. Also referred to as "champions of a cause," leaders who are also catalysts understand that leading is more than managing. Good leadership enables the growth of all staff, the enhancement of programming, and the optimization of resources. In this regard, training community individuals, such as community health workers, as integral to prevention programs serves as a bridge between large institutions and community residents.

Sustain community participation and accountability. Design policies and programming with the goal of sustaining work beyond the funding period. Make all stakeholders accountable for their share and for providing checks and balances to others in an empowering way (rather than in a policing way).

Policies to Implement the Blueprint

For this blueprint to be implemented at the national level, we suggest the following list of policies (this not an exhaustive list):

- Prioritize public and private funding for prevention.
- Prioritize funding for research and training activities with an explicit service component.
- Implement incentives to promote collaboration.
- Favor long-standing collaborations, and foster new ones.
- Require systems for reflection and assessment in all funded projects. Reflectivity seeks a reality check, and evaluations seek to measure impact or change. Both are important and should be required as part of regular reporting and as a way to provide feedback to improve policies and initiatives.
- Connect individual innovation and systemic change. Create processes whereby experiences at the local level can be leveraged and inform the crafting of the new national health care system.

In summary, just as the participants in the Northern Manhattan Community Voices Collaborative sought to learn from and share their own

experiences and struggles, this book is an effort to enhance the work of researchers, educators, and practitioners who also seek to engage in these efforts. Rather than a final word, it is the continuation of a dialogue.

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