



IMPROVEMENT STRATEGIES MODEL: POPULATION HEALTH MANAGEMENT: COMMUNITY ENGAGEMENT

Led by: **BILL & MELINDA**
GATES foundation



In partnership
with:



CORE PRINCIPLES OF POPULATION HEALTH MANAGEMENT

Population health management is an approach to primary health care (PHC) provision that integrates active outreach and engagement with the community in care delivery. This approach shifts primary care service delivery from reactive to proactive management of a segment of the population. Effective population health management typically occurs both in established clinics and in the community. It requires a strong organizational structure, efficient information systems, and an appropriate mix and sufficient quantity of providers. Inherent in population health management is the provision of a broad range of health activities including curative and preventive care, health promotion activities delivered through broad public health initiatives, and engagement with social determinants of health. Within the PHCPI framework, four elements comprise population health management:

LOCAL PRIORITY SETTING

Local priority setting entails the translation of national or regional policies into local strategic action plans that respond to the burden of disease and needs and preferences of the population.

COMMUNITY ENGAGEMENT

Community engagement is a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes. Community engagement plays a critical role in planning and delivering services that are person-centered and responsive to population health needs. (1) Stakeholders should comprise multiple communities including community members, patients, health professionals, policy-makers and other sectors.

EMPANELMENT

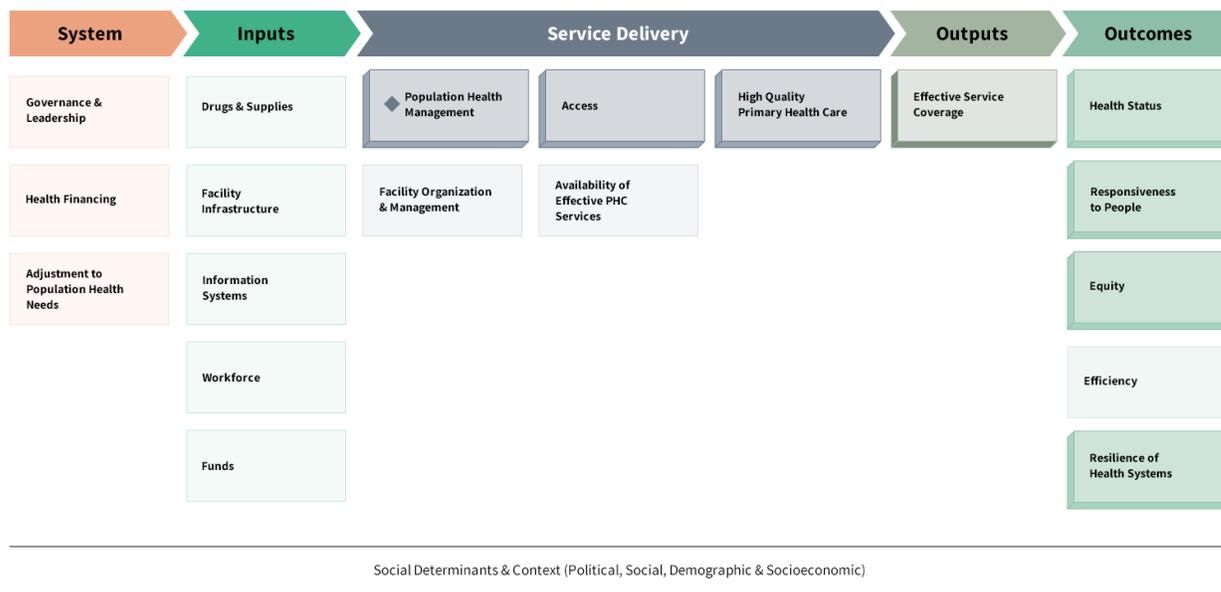
Empanelment (also referred to as population registration or rostering in some areas), a necessary aspect of primary care delivery, is an ongoing and deliberate set of actions to identify, match, and actively review and update data describing a group of people for whom a healthcare organization, care team, or provider is responsible. Additionally, both patients and providers are aware of their relationship. The listing is actively reviewed and regularly updated to ensure accuracy.

PROACTIVE POPULATION OUTREACH

Proactive population outreach involves health systems actively reaching out to communities, particularly those that are underserved or marginalized, to provide necessary services aligned with local priorities and burden of disease, and link those in need to primary health care. Examples of proactive population outreach include mobile health units, transport systems, health based care, telemedicine and proactive follow-up with patients chronic illness.

WHAT COULD YOUR COUNTRY ACHIEVE BY FOCUSING ON POPULATION HEALTH MANAGEMENT?

Population Health Management is the foundation of primary health care service delivery and, when done effectively, can contribute to an array of downstream effects:



SUGGESTED PATHWAYS FOR POPULATION HEALTH MANAGEMENT

STEP 1: EMPANEL THE TARGET POPULATION

To achieve effective population health management, providers or care teams must be able to list and locate the patients for whom they are responsible. Thus, empanelment - the assignment of a population of patients to a provider or care team - is a logical starting point and a necessary organizational structure for population health management.(1) While empanelment can serve as an organizational foundation for effective population health management, it may not be easily implemented in all settings. In these situations, empanelment should remain an aspiration, but other population health management activities can be implemented at the same time.

Populations may be empaneled in a variety of ways, including by geography, voluntary enrollment, or insurance scheme. Ideally, the entire population within a given area should be empaneled to provider teams. This may be difficult or impossible in dense urban areas, areas with large and transient migrant populations, and areas with large numbers of private PHC providers who do not coordinate with a government or larger organizational entity. However, empanelment in mixed public/private PHC systems is possible.(2) While a country works towards achieving complete empanelment, stakeholders may choose to start by empaneling certain subgroups of a population with specific health needs.

STEP 2: USE PANEL DATA TO INFORM LOCAL PRIORITY SETTING

After a population is empaneled, providers can shift their focus towards proactive care and health management. Data and registers from the empaneled population can help providers to track the health information of individual patients, plan public health services such as immunization campaigns, and

explore indicators of access, utilization, and health outcomes that in turn inform local priority setting.(3)
The identified priorities will define the mix of services and medical expertise necessary to manage the patient panel.

STEP 3: BASED ON IDENTIFIED PRIORITIES, DESIGN SYSTEMS FOR OUTREACH IN COMMUNITIES AND HOMES

After identifying priority services, decision-makers and implementers can work with communities to determine which services would be most effectively delivered in communities and homes. Often, preventive care or education-based interventions are best suited to community-based care. Ideally, all people would receive proactive care in their communities, but often it may be more feasible to start with specific groups that require special care or attention, such as pregnant women, people with chronic diseases, or children. When planning proactive population outreach, implementers must consider which cadre of provider would most effectively deliver these services based on cost effectiveness, availability, and training. Community members should be consulted throughout the planning process to ensure acceptability of services.

COMMUNITY ENGAGEMENT

Community engagement is the inclusion of local health system users and community resources in all aspects of design, planning, governance, and delivery of health care services. Community engagement is a central component of effective population health management and helps ensure that services are appropriately tailored to population needs and values. The WHO has defined community engagement as “a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes.”(1)

WHAT SHOULD I KNOW BEFORE BEGINNING IMPLEMENTATION?

Community engagement in the design, planning, governance, and delivery of health care services is essential to ensure that these services appropriately meet the needs of the people they are designed to serve.

There are two central considerations when planning community engagement:

- ▶ Where and when to integrate community engagement
- ▶ How to integrate community engagement

WHERE AND WHEN TO INTEGRATE COMMUNITY ENGAGEMENT

Ideally, community engagement should be integrated into all aspects of health design, planning, governance, and delivery. (4) The WHO’s [Community Engagement Framework for Quality, People-Centered and Resilient Health Services](#) describes how health systems can engage with communities to ensure integrated, people-centered and resilient services. Specifically, the Framework identifies key areas where community engagement practices, processes, and procedures can be embedded to support better engagement between health systems and communities, including:(1)

- ▶ Capacities for shared assessment and analysis of the situation
- ▶ Capacities to design context-specific approaches
- ▶ Capacities for shared agenda setting and planning
- ▶ Capacities for defining roles and responsibilities

Learn more about the WHO’s Community Engagement Framework [here](#).

HOW TO INTEGRATE COMMUNITY ENGAGEMENT

An implementation model that draws on experience from a diverse array of settings describes eight stages of community engagement: (3)

- ▶ Step 1: Aim - Stakeholders define the focus of the community engagement intervention. In order to do so, leaders must be selected to champion community engagement.
- ▶ Step 2: Type of engagement activity - Stakeholders determine in what aspect of the health system community engagement will take place. This should include consideration and discussion of what systems and processes are already in place.

- ▶ Step 3: Participants - Stakeholders identify community participants for engagement activities. The selection process for participants will differ significantly depending on the type of engagement activity that is planned.
- ▶ Step 4: Preparedness to be involved in community engagement - The stakeholders who will be interacting with community members should receive necessary training and education.
- ▶ Step 5: Engagement models - Considering the types of engagement activities, stakeholders should determine how community input will be collected (shared decision making, focus groups, public inquiries, etc.)
- ▶ Step 6: Measurement of community engagement - evaluate and measure the community engagement activities with a focus on both process and outcome
- ▶ Step 7: Barriers - Identify and address barriers to community engagement (i.e. cost, culture, population-specific limitations).
- ▶ Step 8: Facilitators - Identify and harness facilitators (i.e. government support, key groups).

Simply acknowledging that community input is welcomed in the planning, provision, and governance of health services is not enough to catalyze effective engagement. Formal systems must be implemented to encourage, solicit, and respond to community members' concerns, suggestions, and needs. While there is no single best way to engage communities, a range of methods are available for health systems to facilitate community engagement. This continuum includes simple, passive mechanisms to solicit feedback such as suggestion boxes or complaint lines as well as more active methods such as community ownership, sign-off, and decision-making. While deeper community engagement is preferable and will yield the most person-centered services, it may be helpful for health systems to begin by implementing more basic forms of engagement and planning strategies for scaling to more active engagement.

One common method for formally integrating community engagement in the health system is the use of a village (or regional/district level) health committee. Village health committees have been shown to play a variety of roles in LMIC. These committees stand at the intersection between community engagement, social accountability, and [facility management organization and leadership](#). A systematic review of leadership committees in LMIC found a number of common functions of such committees. Although these functional are all ideal, they may not be functional or feasible in all community committees: (5)

- ▶ Governance - to strengthen the accountability of the health facility to the community and public
- ▶ Co-management - of health facility resources and services
- ▶ Resource generator - in the form of material resources, labor, and funds for health facility
- ▶ Community outreach - to help the health facility reach into the community for the purpose of health promotion and improving health-seeking behavior
- ▶ Advocacy - to act as a community voice to advocate (e.g. to local politicians and health managers higher up the health system) on behalf of the health facility
- ▶ Social leveler - to help mitigate social stratification by empowering marginalized sections of the community/public

Community advisory boards often fulfill similar functions but may focus more on facility management and oversight as opposed to community engagement. These boards may also engage in community-based participatory research or approval of research.(6) Other systems for community engagement include community meetings, feedback forms at facilities and/or community centers, and the integration of community members in health system planning and management activities. By valuing the voices, opinions, and expertise of end users, health services will be more acceptable, accessible, and appropriate to the communities they serve.

One example of robust community engagement is Patient and Family Advisory Councils (PFACs), a strategy that can improve patient-provider respect and trust by establishing and recognizing community members as key contributors to the health systems. In PFACs, community members meet with providers to discuss quality improvement and facility interventions to improve patient care. The following step can be taken to establish and sustain PFACs:

- ▶ Establish a PFAC team within the facility - The providers in the PFAC should be champions for community engagement in the health system. Roles and responsibilities for the providers within the PFAC include a leader to manage the PFAC, a logistics coordinator, a community recruitment coordinator, and a scribe.
- ▶ Define the mission, vision, and goals of the PFAC - These components will eventually be discussed and formed by the community members as well, but it may be helpful to establish the baseline mission, vision, and goals between provider members to ensure alignment.
- ▶ Meeting logistics - the providers should consider how and when PFAC meetings are held. Some important considerations to ensure inclusion include transportation, reimbursement, and child or elder care.
- ▶ Identify patient and family advisors & recruitment - The PFAC team should next consider how they want to select community members. It is important to include patients who have some familiarity with the practice and are willing to contribute their feedback. Providers can be asked for suggestions. The best methods for contacting potential members will depend on context but may include: email, patient portals, regular mail, notices in newspapers, or through community-based organizations.
- ▶ Invitations and first meeting - Identify and consolidate materials to orient patients to the goals of the group. During the first meeting, important topics include: introductions, discussion and feedback on the mission, vision, and goals, establishing topics or agendas for the next few meetings.
- ▶ Ensure sustainability - some suggestions for ensuring that PFACs are sustainable include: allocating staff time and resources to PFACs, sharing information on feedback from the PFAC and how it was incorporated with communities, recognize and actively appreciate the contributions of community members to these groups, ensure that patient members are diverse and represent all segments of the population.(7)

More detailed information on PFACs, as well as sample resources for roles and responsibilities and discussion questions can be found [here](#).

WHAT HAS BEEN DONE ELSEWHERE TO IMPROVE COMMUNITY ENGAGEMENT?

GHANA

Ghana's Community Health Planning and Services (CHPS) program provides an example of how community engagement activities can be integrated into all aspects of health reform plans. The program deploys trained nurses, called Community Health Officers (CHOs), as well as volunteers into communities to provide preventive, curative, and promotional health activities. In an effort to scale-up the CHPS program, the Ghana Health Services is constructing an implementation guide informed by implementation successes and failures since initiation of the pilot program in 1994. Part of this guide includes a document on "[15 Steps and Milestones for CHPS Implementation](#)". The 15 steps are grouped into six milestone achievements including:

- ▶ Detailed plan
- ▶ Community entry complete
- ▶ Community health compound
- ▶ Essential equipment
- ▶ Nurse posted
- ▶ Volunteers deployed

The majority of the community engagement activities occur during "community entry". Specifically, after planning and consultation with health workers, District Health Management Teams (DHMT) meet with community leaders to collaborate on implementation and sensitize the chief and elders to the program. Subsequently, community leaders and the DHMT hold community information meetings to delineate roles and address questions or concerns. A Community Health Management Committee is selected and approved by the community, and data are collected on the specific needs, demographics, and customs of the community. As CHOs and Community Health Volunteers are selected, they are introduced to and approved by the community in meetings.(8)

However, evaluations during implementation between 2000 and 2003 found that the community-entry activities appeared to be a bottleneck to implementation of CHPS. While 85% of districts had completed CHPS planning, only 30% had engaged in community-entry.(9) The authors suggested that this gap may be due to a lack of understanding about this core component of CHPS. In these areas where community engagement and participation had not been fully implemented, health outcomes were worse than anticipated under CHPS.(10) Despite these implementation challenges, in places where CHPS has been successfully established, both the community and health workers encouraged its spread, qualitatively suggesting that these activities are widely appreciated by the community once implemented. Read more about CHPS in Ghana [here](#).

KERALA, INDIA

Health outcomes in Kerala - a southwestern state in India - have surpassed those in the rest of the country for decades. Among several other factors, this positive deviance can be attributed to community participation in the health system. Health care reform in the 1980s focused on decentralization, and as a result, villages assumed decision making power over the functioning of PHC centers.(11) The rationale behind this change was that villages would be more aware of health needs, and village-level stakeholders could help identify smaller-level changes in service delivery that would contribute to better access and positive health outcomes.(12) This system resulted in increased collaboration between providers and

communities with community members actively solicited for determining important health priorities. This case highlights the intersection between community engagement and local priority setting, and in Kerala this process was facilitated through decentralization. More information on Kerala's PHC system is available [here](#).

ALASKA, UNITED STATES

Another example of extensive community engagement is the Southcentral Foundation's Nuka System of Care. The Southcentral Foundation has ensured that community members are at the center of all health system decisions and changes. Since 1999, the Alaska Native Tribal Health Consortium has owned and managed the Alaska Native Medical Center meaning that patients have full purview over the operations of their health care system.(13) All decisions are made with strong consideration of the customer-owners and the ethos of the organization. For instance, stakeholders considered instituting a gatekeeper model for access to specialty care to help improve cost-containment, but this was ultimately rejected because it did not align with the health system's focus on the autonomy of customer-owners.(14) This model of care requires significant reorganization of management and financing but highlights the range of engagement that heath systems can foster with community members.

WHAT QUESTIONS SHOULD BE CONSIDERED TO BEGIN IMPROVEMENTS?

The questions below may be a useful starting place for determining whether Community Engagement is an appropriate area of focus for a given context and how one might begin to plan and enact reforms:

WHAT ARE THE CURRENT SYSTEMS FOR AND FORMS OF COMMUNITY ENGAGEMENT, IF ANY?

Community engagement can take on a variety of forms throughout all stages of health service planning, design, implementation, and evaluation. Understanding how communities/stakeholders are viewed or defined in a particular context can improve the design and implementation of engagement mechanisms.

WHAT SYSTEMS ARE IN PLACE TO SHARE DATA AND CHANGES TO THE HEALTH SYSTEMS WITH THE COMMUNITY IN A TRANSPARENT MANNER? WHAT VENUES EXIST FOR FUTURE INFORMATION SHARING?

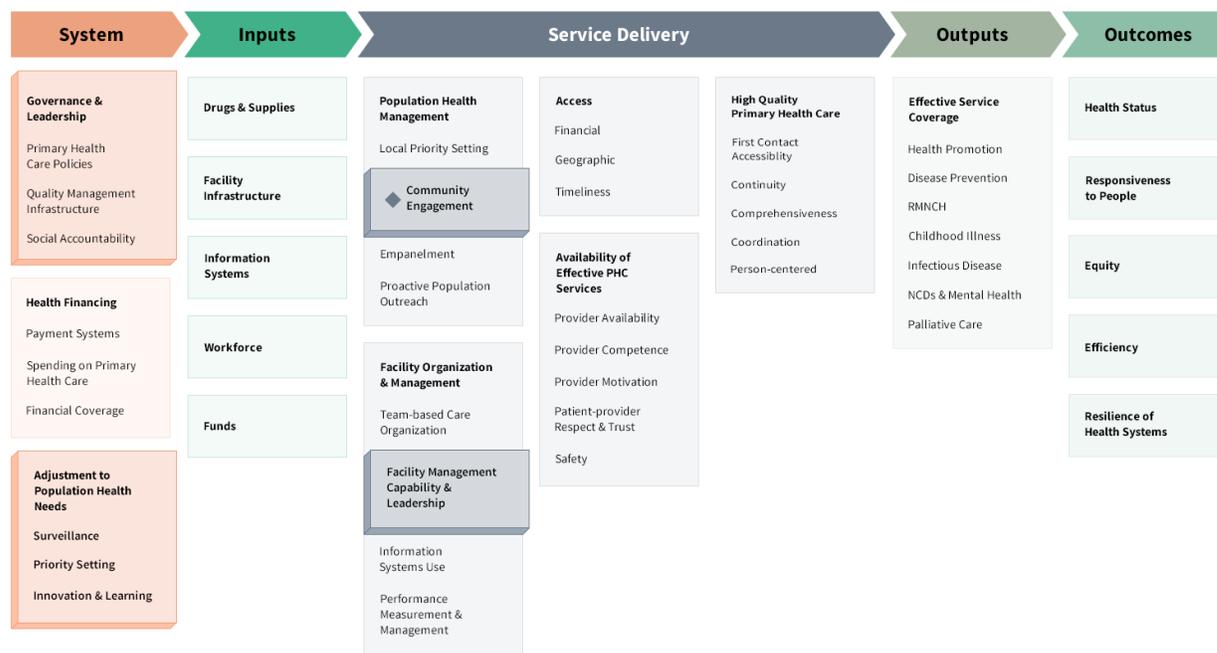
An important component of community engagement is the dissemination of important data or changes relevant to the health system and the delivery of care. Methods of dissemination will depend on existing venues such as community meetings, special interest groups such as mother groups or religious organizations, or through other community-wide communication methods.

WHAT ARE THE EXISTING COMMUNITY GROUPS (HEALTH COMMITTEES, WOMEN'S GROUPS, RELIGIOUS GROUPS)?

These existing groups may be suitable starting points for soliciting feedback and sharing information because they are pre-established, meet regularly, and are likely comfortable discussing their concerns or suggestions with one another.

WHAT ELEMENTS SHOULD BE IN PLACE TO SUPPORT EFFECTIVE IMPROVEMENTS?

Community engagement should be pursued regardless of the systems, inputs, and service delivery elements already in place. Even a poorly functioning health system should be able to solicit community feedback. Thus, there are no dependencies relevant to community engagement. However, there are number of elements that may help enable community engagement:



Social Determinants & Context (Political, Social, Demographic & Socioeconomic)

GOVERNANCE & LEADERSHIP AND ADJUSTMENT TO POPULATION HEALTH NEEDS

While community engagement most often occurs at the local or clinic level, national policies that are supportive of a population health management approach will aid decision making and service delivery. Primary health care policies that promote community engagement and national systems for social accountability can help enable community engagement at all sub-national levels of the health system. Such policies may include the establishment of community advisory boards or the inclusion of community members - and historically marginalized groups in particular - in facility management decision-making. Additionally, national priority setting exercises that allow flexibility and encourage adaptation with community input at a local level will better serve the needs of heterogeneous populations within a given country.

Learn more in the [Governance & Leadership](#) and [Adjustment to Population Health Needs](#) Improvement Strategies modules.

FACILITY MANAGEMENT CAPABILITY AND LEADERSHIP

While national policies will help enable local stakeholders to implement systems for community engagement, facility leaders must work to highlight the importance of community engagement, develop systems for community input, and champion adaptation to community needs. Thus, in order to ensure that community engagement translates to actionable and tangible changes at the facility level, strong facility leadership is necessary.

Learn more in the [Facility Management Capability and Leadership](#) Improvement Strategies module.

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REFERENCES – COMMUNITY ENGAGEMENT

1. WHO. WHO Community engagement framework for quality, people-centred and resilient health services. World Health Organization; 2017.
2. Black RE, Taylor CE, Arole S, Bang A, Bhutta ZA, Chowdhury AMR, et al. Comprehensive review of the evidence regarding the effectiveness of community-based primary health care in improving maternal, neonatal and child health: 8. summary and recommendations of the Expert Panel. *J Glob Health*. 2017 Jun;7(1):010908.
3. Sarrami-Foroushani P, Travaglia J, Debono D, Braithwaite J. Implementing strategies in consumer and community engagement in health care: results of a large-scale, scoping meta-review. *BMC Health Serv Res*. 2014 Sep 18;14:402.
4. WHO. WHO | Community engagement for quality, integrated, people-centred and resilient health services [Internet]. [cited 2019 Dec 4]. Available from: <https://www.who.int/servicedeliverysafety/areas/qhc/community-engagement/en/>
5. McCoy DC, Hall JA, Ridge M. A systematic review of the literature for evidence on health facility committees in low- and middle-income countries. *Health Policy Plan*. 2012 Sep;27(6):449-66.
6. Nyirenda D, Sariola S, Gooding K, Phiri M, Sambakunsi R, Moyo E, et al. “We are the eyes and ears of researchers and community”: Understanding the role of community advisory groups in representing researchers and communities in Malawi. *Dev World Bioeth*. 2018 Dec;18(4):420-8.
7. National Partnership for Women & families. Key Steps for Creating Patient and Family Advisory Councils in CPC Practices. 2013. Report No.: April.
8. Summary of 15 steps and milestones for CHPS implementation.
9. Awoonor-Williams JK, Sory EK, Nyonator FK, Phillips JF, Wang C, Schmitt ML. Lessons learned from scaling up a community-based health program in the Upper East Region of northern Ghana. *Glob Health Sci Pract*. 2013 Mar 21;1(1):117-33.
10. Koku Awoonor-Williams J, Tadiri E, Ratcliffe H. Translating research into practice to ensure community engagement for successful primary health care service delivery: The case of CHPS in Ghana [Internet]. Primary Health Care Performance Initiative. [cited 2017 Aug 9]. Available from: <http://phcperformanceinitiative.org/translating-research-practice-ensure-community-engagement-successful-primary-health-care-service-delivery-case-chps-ghana>
11. Kerala, India: Decentralized governance and community engagement strengthen primary care.
12. Varatharajan D, Thankappan R, Jayapalan S. Assessing the performance of primary health centres under decentralized government in Kerala, India. *Health Policy Plan*. 2004 Jan;19(1):41-51.
13. Southcentral Foundation History [Internet]. Southcentral Foundation. 2017 [cited 2017 Aug 9]. Available from: <https://www.southcentralfoundation.com/about-us/history/>
14. Primary Care Systems Case Collection Behavioral Health and Financing for Southcentral Foundation’s Nuka System of Care (B). 2015;(March).