Deep Dive – Proactive Population Outreach

Proactive population outreach is the active provision of care in homes or communities rather than exclusively in facilities. These services are often preventive or promotive and initiated by the health system rather than by patients. Community health workers (CHW) or similar cadres of providers most often engage in proactive population outreach and conduct health promotion activities, education, identification of acute cases and pregnant women needing referrals to health facilities, community integrated care for common adult and child illnesses (cIMCI), family planning provision, chronic disease adherence follow-up, risk-stratified care management, and even palliative care in communities or homes.

Visual Aid - Proactive Population Outreach

Proactive Population Outreach

1. SEGMENTATION
   Ideally, all individuals receive community-based care, but health systems may need to prioritize community-based care only for specific segments of their panel.

2. COMMUNITY PROVIDERS
   Health workers with specific training deliver services within communities.

3. FOLLOW-UP
   In addition to home visits, health center, hospital, and specialist consultations are also part of the follow-up process.

Caring for people in communities and homes.
Proactive Population Outreach is a component of Population Health Management.

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Proactive Population Outreach is a component of Population Health Management.

Population Health Management
- Local priority setting
- Community engagement
- Empanelment
- Proactive population outreach

Local Priority Setting

Community Engagement

Empanelment

Proactive Population Outreach
What can you learn about Proactive Population Outreach from the Improvement Strategies?

**SECTION 1**

**What is Proactive Population Outreach?**

**What it is:** Learn more about the core principles and goals of Proactive Population Outreach and its role in PHC improvement.

**SECTION 2**

**How do I assess my performance?**

**What it is:** Learn more about some indications that improvements might be relevant in your context and what you can achieve by focusing improvements on Proactive Population Outreach.

**Vital Signs Profile:** Use the information in your Vital Signs Profile to help determine relevant areas for improvement.

**SECTION 3**

**How do I get started?**

**What others have done:** Learn from implementation approaches and challenges in other country contexts.

**How to succeed:** Consider your country context, what elements are not functioning properly, and what needs to be in place to support effective improvements.

**What to ask:** Use guiding questions to help determine how you might begin to plan and enact reforms in your country context.

*Guided by the above considerations and relevant resources, start to build out an improvement plan with your CE lead and/or focal point.*
What can my country achieve by focusing on Proactive Population Outreach?

Goals & Outcomes

- **Improve** the population’s awareness of and access to services
- **Increase efficiency** by moving certain health activities outside of the physical clinic
- **Optimize health and well-being** in ways that are person-centered by bringing services to patients and integrating delivery into the context of the community
Proactive Population Outreach – How do I assess my performance?

Learn more about whether you should focus on Proactive Population Outreach in the Vital Signs Profile.
How do I assess my performance?

Use the information in the Vital Signs Profile to help determine relevant areas of improvement.
How do I assess my performance?

Use the information in the Vital Signs Profile to help determine relevant areas of improvement.
How do I assess my performance?

Use the information in the **Vital Signs Profile** to help determine relevant areas of improvement.

Measure 24: Local Priority Setting

Measure 25: Community Engagement

Measure 26: Empanelment

Measure 27: Proactive Population Outreach
What are other indications that Proactive Population Outreach might be an appropriate area of focus?

**Other Indications**

- **Access barriers**: Patients have difficulties accessing facility-based care or are not aware of services.

- **Health inequities**: Certain segments of the population experience differences in health status or access to resources relative to other groups.

- **Overreliance on facility-based care**: Facility-based providers are overburdened with the management of conditions that can be delivered in homes and communities.

- **Discontinuous patient experience**: Services provided in the facility are not responsive to patients’ changing needs and do not promote a coherent, consistent care experience. For example, patients with chronic conditions have poor treatment adherence or are not receiving appropriate follow-up.
Proactive Population Outreach - What is it?

Learn more about the core principles of Proactive Population Outreach and what you can achieve by focusing improvements in the What it is section.
What is 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 interventions include mobile health units, transport systems, home based care, telemedicine and proactive follow-up with patients with chronic illness.
What is 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 interventions include mobile health units, transport systems, home based care, telemedicine and proactive follow-up with patients with chronic illness.

Why it’s important

- **Accessible care**
  The active provision of care in homes and communities helps to ensure the population is aware of and accesses services.

- **Effective service delivery**
  Extending services that can be managed in community settings beyond the facility can increase efficiency, support disease prevention, and ensure appropriate treatment and follow-up.

- **Person-centered services**
  Targeted outreach can help to ensure services are tailored to patients’ diverse and specific health needs.
What is 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 interventions include mobile health units, transport systems, home based care, telemedicine and proactive follow-up with patients with chronic illness.

Key steps and considerations

**Segmentation**
Ideally all individuals receive community-based care, but health systems may need to prioritize community-based care only for specific segments of their panel, such as at-risk populations or populations with specific health needs.

**Community-based services**
Health workers provide services in homes and communities, such as health prevention or promotion activities, education, and identification of acute cases.

**Follow-up**
Community providers should be linked, including through shared information systems, to higher-level facilities such as health centers, hospitals, and other specialists who can address more complicated cases with clear, bi-directional communication systems.
Proactive Population Outreach

Caring for people in communities and homes

1. SEGMENTATION
   Ideally, all individuals receive community-based care, but health systems may need to prioritize community-based care only for specific segments of their panel.

2. COMMUNITY PROVIDERS
   Health workers with specific training deliver services within communities.

3. FOLLOW-UP
   Community providers are linked to higher-level facilities such as health centers, hospitals, and other specialists who can address more complicated cases with clear, bi-directional communication systems.

- PANEL
- EXAMPLE SEGMENTS
- EXAMPLE SERVICES

- Acute illness
- Chronic condition
- Pregnancy
- At risk for disease
- Vaccination
- Education
- Medication
- Testing
Deeper dive: Targeting patients for proactive population outreach

If it is not feasible to provide proactive population outreach to all patients initially, implementers can engage strategies that prioritize care for specific segments of the population, including:

- **Targeting by specific or acute health need**, such as through the identification of acute cases and pregnant women needing referrals and community integrated care for child illnesses

- **Targeting by preventive need**, including by conducting health promotion and education activities for populations according to age, gender, and vulnerability such as poverty and malnourishment

- **Targeting by chronic disease**, such as by ensuring patient’s with HIV and/or non-communicable diseases have appropriate treatment and follow-up

- **Targeting by risk strata**, or risk stratified care management, to direct care to those in the greatest need, such as migrant and refugee populations
Proactive Population Outreach – How do I get started?

Derive information from What others have done, What to ask and How to succeed to help determine where and how you might begin to plan and enact forms in your country context.
Planning for improvement in your context

The guidance and recommendations described within the Proactive Population Outreach module are not intended to provide a one-size-fits all solution.

The considerations involved in planning and implementing strategies will depend on your local context.

Sample activities

- Consider implementation challenges and approaches in other country contexts
- Consider how the features of your health system, such as how decisions get made and the role of the private sector, will impact your improvement plans
- Identify key elements that need to be in place to support improvements
- Use the guiding questions in the Improvement Strategies to spur thinking about Proactive Population Outreach in your country context and stimulate ideas for improvement
- Start to develop an improvement plan
Planning for improvement in your context

While the specific considerations involved in planning and implementing strategies will depend on your context, you might consider...

- What are some factors that impact which patients are targeted?
  - Health system capacity and coverage
  - Sub-population health needs
  - Availability of patient registers to track the specific health needs of sub-populations

- What are some factors that impact which services are provided and who delivers them?
  - Facility infrastructure and supplies
  - Referral pathways and supportive supervision systems
  - Organization of care teams
  - Provider competencies and training
  - Provider availability and distribution
  - Community customs, values, and preferences
Learn from what others have done

**Liberia**
Ensuring access to PHC services during the Ebola Crisis

**Chiapas, Mexico**
Community-based outreach for non-communicable disease care
Liberia: At-a-glance context

- Sub-Saharan Africa | West Africa
- Low Income
- Conflict-affected and fragile state
## Liberia: At-a-glance context

<table>
<thead>
<tr>
<th>GDP per capita ($PPP)</th>
<th>Human Development Index</th>
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<th>Population</th>
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<tbody>
<tr>
<td>49%</td>
<td>39%</td>
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Learn from what others have done: Liberia

**Background**

• Prior to the 2014 Ebola Crisis, Liberia implemented several PHC-related interventions, including the National Strategy and Policy for Community Health Services

• However, there were **myriad implementation challenges**, including unreliable drug supply, inadequate supervision, and a lack of incentives

**Approach**

Building off prior reforms, Liberia used **proactive population outreach activities to maintain access** to PHC services during the 2014 Ebola Crisis

Leveraging existing community ties, **CHWs provided health promotion, case management, and integrated community case management activities** throughout the Ebola crisis, even as facility-based PHC became inaccessible

To reduce the risk of Ebola transmission for CHWs, **“no-touch” iCCM guidelines were put into place**
Learn from what others have done: Liberia

- **Emergency preparedness and provider competence:** Despite putting “no-touch” guidelines into place, it was challenging to disseminate these guidelines during the outbreak, underscoring the importance of training CHWs in infectious disease prevention guidelines prior to outbreaks.

- **Health system strengthening:** Prior to the Ebola crisis, PHC suffered challenges related to drug supply chains, supervision, and incentives. These challenges were exacerbated by the crisis and increased the difficulty of providing proactive population outreach.
Learn from what others have done: Liberia

- **Existing community-based PHC infrastructure:**
  Prior to the Ebola crisis, a number of different community-based primary health care related interventions had been implemented, including the National Strategy and Policy for Community Health Services which provided health promotion, case management, and integrated community case management (iCCM) by community health workers.
Although the primary health care system in Liberia suffered immensely during the 2014 Ebola crisis, established ties between health facilities, CHWs, and the community resulted in more effective risk communication and community action – where CHWs were a trusted source of advice, treatment for child illnesses, and Ebola prevention education -- helping to reduce risks during the outbreak and buffer the negative impact of the crisis.
Chiapas, Mexico: At-a-glace context

- Latin America & Caribbean
- Southern Mexican State
- Upper-Middle Income
- Spanish-speaking country
## Mexico: At-a-glance context

<table>
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<tr>
<td>20%</td>
<td>3%</td>
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Learn from what others have done: Chiapas, Mexico

Approach

In 2014, the NGO Companeros en Salud implemented a CHW program known as the Acomponantes Intervention.

CHWs were women who were nominated from their local community and then selected for the program on the basis of a formal interview process.

CHWs’ roles are intended to improve access to existing care rather than fill gaps or task-shift responsibilities.

Findings

• CHWs providing outreach in communities improved disease control and medication adherence for patients with diabetes and/or hypertension.

• Strategies following the “community-based accompaniment” approach such as this one are most effective if they are added to an already functional PHC system.
Learn from what others have done: Chiapas, Mexico

Strengths

- **Comprehensive, community-based services:** CHWs provide basic diagnosis and treatment for diabetes and hypertension during home visits.

- **Person-centered, coordinated care:** CHWs worked with 4-8 patients each, visiting their homes regularly, accompanying them to clinic visits, and discussing their care management with providers.
Learn from what others have done: Chiapas, Mexico

What supporting elements were in place?

- **Provider retention mechanisms:** CHWs received compensation in the form of food and consumable items, worth a dollar amount approximately equivalent to the monthly stipend given to participants in Prospera (formerly Oportunidades), a Mexican national conditional cash-transfer programme.

- **Existing PHC infrastructure:** CHWs role to improve access to existing care was supported by an already functional PHC system. In health systems with substantial gaps in the delivery of comprehensive primary health care at facilities, proactive outreach may not be the most effective initial intervention.

What elements should be in place to support effective improvements in Proactive Population Outreach?

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<td>Availability of Effective PHC Services</td>
<td>Comprehensiveness</td>
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<td>Innovation &amp; Learning</td>
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Social Determinants & Context (Political, Social, Demographic & Socioeconomic)
Successful proactive population outreach depends on **information systems with broad, fundamental capacities** to track and stratify a given patient population and clear referral pathways.
What elements should be in place to support effective improvements in Proactive Population Outreach?

There must be an adequate supply of appropriately trained, reliable, and available community-based providers integrated into broader care teams to effectively provide community-based proactive outreach and care.
What elements should be in place to support effective improvements in Proactive Population Outreach?

It is important to ensure **Community Engagement** during implementation of proactive population outreach, particularly when services are delivered outside of facilities.
Questions to ask to help you get started

The specific considerations involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful starting place to determine how you might begin to plan and enact reforms in your context.

Sample questions

☐ If proactive population outreach activities were implemented, how would providers know whom to visit and which services to provide?
The specific considerations involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful starting place to determine how you might begin to plan and enact reforms in your context.

Sample questions

☐ If proactive population outreach activities were implemented, how would providers know whom to visit and which services to provide?

☐ What are the health needs of the population? How are their living conditions?
Questions to ask to help you get started

The specific considerations involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful starting place to determine how you might begin to plan and enact reforms in your context.

Sample questions

☐ If proactive population outreach activities were implemented, how would providers know whom to visit and which services to provide?

☐ What are the health needs of the population? How are their living conditions?

☐ Which providers are capable of delivering the services identified? Are there sufficient numbers of these providers, and do they need training?
The specific considerations involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful starting place to determine how you might begin to plan and enact reforms in your context.

**Sample questions**

- If proactive population outreach activities were implemented, how would providers know whom to visit and which services to provide?
- What are the health needs of the population? How are their living conditions?
- Which providers are capable of delivering the services identified? Are there sufficient numbers of these providers, and do they need training?
- How will providers be integrated into the health system to ensure continuity of care?
Questions to ask to help you get started

The specific considerations involved in planning and implementing strategies will depend on your local context.

The questions listed may be a useful starting place to determine how you might begin to plan and enact reforms in your context.

Sample questions

☐ If proactive population outreach activities were implemented, how would providers know whom to visit and which services to provide?

☐ What are the health needs of the population? How are their living conditions?

☐ Which providers are capable of delivering the services identified? Are there sufficient numbers of these providers, and do they need training?

☐ How will providers be integrated into the health system to ensure continuity of care?

☐ What drugs, supplies, equipment and other infrastructure would these providers need to deliver services effectively? Is there a system in place to procure these?
Recap: Proactive Population Outreach

Proactive Population Outreach  Caring for people in communities and homes

1. SEGMENTATION
   Ideally, all individuals receive community-based care, but health systems may need to prioritize community-based care only for specific segments of their panel.

2. COMMUNITY PROVIDERS
   Health workers with specific training deliver services within communities.

   - Vaccination
   - Education
   - Medication
   - Testing

3. FOLLOW-UP
   Community providers are linked to higher-level facilities such as health centers, hospitals, and other specialists who can address more complicated cases with clear, bi-directional communication systems.

   - Homes
   - Public spaces
   - Community clinics
   - Health centers, hospitals, and specialists