Global Advantage Framework

Cover & Define

Coverage and access gaps should be mapped at the community level, and gaps in the ability of individuals and families to access and afford primary health services should be well-defined.

In order to act strategically and efficiently within a defined community at existing resourcing levels, a backbone or a local integrator organization could be designated and developed to:

1. Define the geographic boundaries, demographics, and payer coverage and gaps including the uninsured.
2. Determine the primary health practices or clinics that serve them, as well as gaps in care or structural barriers to living a healthy life.
3. Utilize data analysis tools to determine who lacks access to health services or faces challenges in meeting their basic needs, including the need for social support.
4. Achieve community agreement on the role and the limits of the health system in meeting basic needs, and where coordinated community development activities should begin.
5. Continuously educate community members and frontline workers about policy changes that could impact their health and lead to more effective advocacy goals.

Anchor & Embed

Primary care health practices are anchor institutions in their neighborhoods. Practices should know where their patients live, and they should proactively link them to a community-based team and local services.

In order to make primary care and community-based partnerships the foundation for breakthroughs in community health, a local integrator organization should be enabled to:

1. Identify all traditional primary care and population health-related assets,and map how they interact with community development activities.
2. Assign patients to health teams based on neighborhood, forming the basis for long-term relationships with health systems.
3. Engage the community in mapping community assets, rating the quality of existing services and identifying important cultural partnerships (e.g. congregations, advocacy groups for vulnerable populations).
4. Define and plan the ideal size and scope of activity for a community health team that includes health coaches, community health workers, community-based social workers and health care coordinators.
5. Develop a coordinated action plan that involves local social service agencies and relevant businesses to ensure that patients are able to meet their basic needs beyond clinical care.

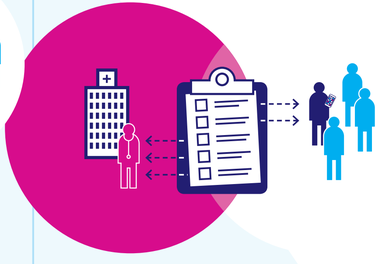
Shared & Actionable Goals

Integrate mobile technologies that follow journeys of community members' care and track collaborations between the health system and community.

Progress should be displayed in a way that motivates communities and health systems to action.

In order to ensure a common set of goals that are shared between health systems and communities, and to build a shared and participatory implementation strategy, a local integrator organization should:

1. Design a participatory strategic planning and goal prioritization process.
2. Develop performance management systems that value improved health outcomes (vs outputs).
3. Create compelling public-facing dashboards in community spaces to amplify progress and challenges to better health.
4. Integrate mobile technologies that follow journeys of community members' care and track collaborations between the health system and community.
5. Incorporate local knowledge and context to improve the design and effectiveness of health system workflows and follow-up.

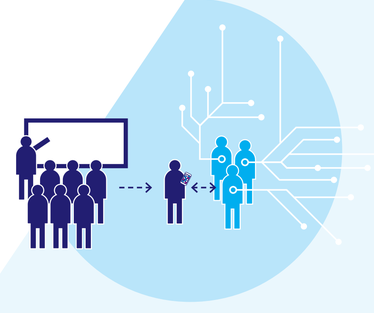


Simple Protocols & Accountable Care

In order to develop an integrated community-based health workforce, a local integrator or backbone organization should foster ownership for health management in community settings.

Accountable care has transitioned from a United States concept to one that is increasingly being adapted globally Simplicity and community participation are increasingly emphasized abroad.

1. Help to define the complementary roles and responsibilities of different actors across community organizations that participate in the clinical or social care of a geographically-defined population.
2. Simplify care for people with chronic conditions by defining opportunities within care protocols where non-clinical providers can advance clinical goals.
3. Clarify and improve hand-offs with community-based clinical workers, social service workflows, and caregivers.
4. Ensure that the community is incentivized to support the health system in assembling the right care in the right place at the right time, particularly if it relates to their basic needs.
5. Incorporate community-generated protocols and workflows into clinical systems with appropriate confidentiality and permissions in place.



Train & Organize

Develop a network of community-based workers to organize community members, with the goal of identifying the most pressing health needs.

In order to build an effective community health team that enables everyone to sees themselves as change agents, a local backbone organization should equip people to:

1. Train facility and community-based workers in joint teams to build situational awareness of roles and responsibilities required to accomplish shared goals.
2. Organize community members and caregivers to raise concerns and goals in dialogue with local health systems, which can act as partners in health.
3. Define one to three shared, high-priority goals that leverage health system investments as well as community-based assets and social capital.
4. Ensure clinical or public health communications are available to community stakeholders in clear, compelling language.
5. Co-design processes to include the voices of the community's most vulnerable people.

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