Module 1: Introduction to Community-Oriented Primary Care (COPC)

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Agenda

• Definitions
• History
• Why COPC?
• Steps
• Barriers
• Why now and why involve learners?
Objectives

• Define COPC
• List 3 seminal figures in the history of COPC
• State the steps involved in the COPC process
• List the potential members of a COPC team
• State the barriers to initiating COPC activities
• Provide an example of a COPC activity
Public health

Primary care
COPC defined

- A continuous process by which primary health care is provided to a defined community on the basis of its assessed health needs by the planned integration of public health with primary care

COPC Steps

• Four process steps:
• 1) Define the community of interest
• 2) Identify the health problem
• 3) Develop and implement interventions
• 4) Conduct ongoing evaluation

COMMUNITY INVOLVEMENT IS CRITICAL TO EACH STEP

Five COPC Principles

• Responsibility for the health and health care of a defined population
• Health care based on identified health needs at the population level
• Prioritization
• Intervention covering all stages of the health-illness continuum
• Community participation

COPC Team

• Must incorporate the community perspective
• Diverse
History – The Data Consumer

• William Pickles
• 1885-1969
• The only physician for 7 rural English towns
• Blended concepts of primary care and epidemiology to improve his care of patients

History – The Pioneers

• Sidney and Emily Kark
• Sidney Kark: 1911-1998
• Ran the Pholela Health Center in South Africa
• Coined the term – “Community-oriented primary health care” (now community-oriented primary care)

History – The Birth of Health Centers

• H. Jack Geiger

• “A central tenet [of COPC] is that primary care should be rooted in communities, for communities, and with communities”

• Director of the Mound Bayou Community Health Center


History – The Birth of Health Centers

• “The need is not for the distribution of services to passive recipients, but for the active involvement of local populations in ways which will change their knowledge, attitudes, and motivation.”


Why COPC?

• COPC can help make what you are already doing better
  – Community definition
  – Needs assessment
  – Quality improvement
  – Uniform Data System reporting
  – Meaningful use
  – Primary care medical home applications
Why COPC?

• Address upstream factors and get past band-aids
• More comprehensive grants
Why COPC?

• Equity: reach those that really need the resources
• Marketing
Why COPC?

- Changing funding environment

Case Study of a Primary Care–Based Accountable Care System Approach to Medical Home Transformation

Robert L. Phillips, Jr, MD, MSPH; Svetlana Bronnikov, MS; Stephen Petterson, PhD; Maribel Cifuentes, RN; Bridget Teevan, MS; Martey Dadoo, PhD; Wilson D. Pace, MD; David R. West, PhD
Why COPC?

• It’s the future of medicine
  – Affordable Care Act
    • Community Health Needs Assessment
    • Section 9007
  – CMS Health Care Innovation Awardees
  – Institute of Medicine
Responsibility for the health of a defined population – not just the people coming to your office regularly
Defining the Community

• Denominator
  – Geography
  – Pre-defined boundaries
  – Specific problems

• Numerator
  – Active users
  – The elderly
  – Diabetics
World’s Greatest Clinic - Ward 8

www.healthlandscape.org
# Demographic Data:
Data from DC Department of Health – State Center for Health Statistics Administration 1999
*Census data from Census 2000

<table>
<thead>
<tr>
<th>Demographic Category</th>
<th>US</th>
<th>DC</th>
<th>Ward 8</th>
<th>Ward 3</th>
<th>Combined Census Tracts*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>272,690,813</td>
<td>523,124</td>
<td>60,485</td>
<td>68,093</td>
<td>51,696</td>
</tr>
<tr>
<td>% of city</td>
<td></td>
<td>100%</td>
<td>11.56%</td>
<td>13.02%</td>
<td>9.88%</td>
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<tr>
<td>% Population &lt;18</td>
<td>25.80%</td>
<td>18.40%</td>
<td>33.50%</td>
<td>18.60%</td>
<td>33.7%</td>
</tr>
<tr>
<td>% Population Black</td>
<td>12.80%</td>
<td>61.90%</td>
<td>*89.60%</td>
<td>4.20%</td>
<td>95.20%</td>
</tr>
<tr>
<td>% Population White</td>
<td>82.40%</td>
<td>34.60%</td>
<td>8.30%</td>
<td>89.50%</td>
<td>2.8%</td>
</tr>
<tr>
<td>% Population Hispanic</td>
<td>11.50%</td>
<td>7.60%</td>
<td>2.30%</td>
<td>13.00%</td>
<td>0.80%</td>
</tr>
</tbody>
</table>
### Births and Deaths
Data from DC Department of Health - State Center for Health Statistics, 1999

<table>
<thead>
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<th></th>
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<th>Ward 8</th>
<th>Ward 3</th>
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<tbody>
<tr>
<td><strong>Live Births</strong></td>
<td>3,959,417</td>
<td>7513</td>
<td>1237</td>
<td>854</td>
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<tr>
<td><strong>Rate (per 1000 population)</strong></td>
<td>14.5</td>
<td>14.5</td>
<td>20.40</td>
<td>12.5</td>
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<tr>
<td><strong>Infant Mortality (per 1000)</strong></td>
<td>7.1</td>
<td>15</td>
<td>27.5</td>
<td>5.9</td>
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<tr>
<td>% of infant deaths in city</td>
<td>100%</td>
<td>30.1%</td>
<td>4.4%</td>
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<tr>
<td><strong>Deaths (all ages- per 100,000)</strong></td>
<td>877</td>
<td>1162</td>
<td>952.1</td>
<td>925.2</td>
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<tr>
<td># of deaths to children (1-19yo)</td>
<td>Not Avail</td>
<td>81</td>
<td>17</td>
<td>2</td>
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<tr>
<td>% of child deaths in city</td>
<td>100%</td>
<td>21%</td>
<td>2.50%</td>
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<tr>
<td></td>
<td>Individual</td>
<td>Community</td>
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<td>Subjective</td>
<td>Symptoms</td>
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<td>Explanatory model</td>
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<td>Perception of resources</td>
<td>Perception of resources</td>
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<tr>
<td>Objective</td>
<td>Physical findings</td>
<td>Observations of barriers, hazards, and resources</td>
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<td>Laboratory tests</td>
<td>Findings from photographs, maps, data sets</td>
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<td>Diagnostic tests</td>
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<td>Assessment</td>
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<tr>
<td>Plan</td>
<td>Patient education</td>
<td>Community education and advice</td>
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<td></td>
<td>Medications</td>
<td>Working with communities to develop appropriate interventions</td>
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<td>Interventions</td>
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Identifying Health Problems

• Key informants and focus groups

• Primary data collection

• Prioritization of health problems

Community engagement is essential

The health committee drives the agenda
Cisterns that need repair
Selecting an Intervention

• “If I have seen further, it is by standing on the shoulders of giants”

• Obtaining community specific information

• Examining the literature for existing interventions
  – AHRQ Innovations
  – Healthmattersinsf.org

• Selecting the intervention
Evaluation

• Reasons to evaluate
  – Provide feedback
  – Uncover areas of future intervention
  – Obtain funding
Evaluation

• Misconceptions about evaluation
  – Must be complex
  – Requires complicated statistical methods
  – Begins after the completion of the project
REDUCING DIARRHEA THROUGH THE USE OF HOUSEHOLD-BASED CERAMIC WATER FILTERS: A RANDOMIZED, CONTROLLED TRIAL IN RURAL BOLIVIA

THOMAS F. CLASEN, JOSEPH BROWN, SIMON COLLIN, OSCAR SUNTURA, AND SANDY CAIRNCROSS
Department of Infectious and Tropical Diseases, London School of Hygiene and Tropical Medicine, London, United Kingdom;
Department of Environmental Sciences and Engineering, University of North Carolina, Chapel Hill, North Carolina; First Water, Ltd., Bristol, United Kingdom; Fundación Sumaj Huasi, La Paz, Bolivia
Percentage of Families with Any Diarrhea

Before water filters: 85%
With water filters: 16%

Relative risk reduction: 81%
Number needed to prevent: 1.4

Chi-squared = 16.01, p < 0.0001
Community engagement can compound
Barriers

• Lack of:
  – Time
  – Expertise
  – Contacts
  – Financial incentives
Why Is the Time Right for COPC?

• Developments that address lack of time and expertise:
  – Electronic medical records
  – Online tools
Why Involve Learners?

• Idealistic
• Have to do quality improvement and scholarly projects
• Will prepare them for future funding changes
• It’s part of their CHC heritage


Take Home Messages

• COPC is the marriage of public health and primary care
• The 4 steps of COPC are: 1) define the community, 2) identify the health problem of interest, 3) develop and implement interventions, and 4) conduct ongoing evaluation
• COPC can improve the health of your community, help you write stronger grants, and improve the things you are already doing.
• To do big, meaningful things, it often takes a village
• Team engagement and community involvement are critical to successful programs
Thank you for completing the module. Please complete this evaluation survey to help us make it better!

https://www.surveymonkey.com/s/5BP3MT6

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1) Continuing Medical Education Form:
https://www.surveymonkey.com/s/53NGY5S
2) Module 1 Quiz:
https://www.surveymonkey.com/s/5G27GP2
To Obtain CME Credit

• In order to obtain CME credit, you must complete the following tasks:
  – Complete the module(s) or case study.
  – Complete the post-activity quiz (There are quizzes for each module and case study).
    • The last question of the quiz provides a prompt to indicate your email address. **If you want to receive CME credit, you must provide your email address so that we can document the score of your quiz appropriately.**
  – Score at least 75% on the quiz (For quizzes with 4 questions, you must answer at least 3 questions correctly. For quizzes with 5 questions, you must answer at least 4 correctly).
  – Complete the CME certification form.
    • **In order to match the CME certification form with your quiz, you must provide the same email address that you provided during the post-activity quiz.**