

# Community-Oriented Primary Care

## An Approach to Healthcare for the 21st Century

BY HUGH FULMER

Healthcare systems from Kazakstan to the US are being reoriented toward primary care, and subsequently tracking their success through preventive care techniques, fewer hospital admissions, and lower operating costs. Primary care can serve as the cornerstone of effective health systems and the foundation for training new healthcare workers. One method for partnering primary care medicine with public health initiatives is through a process and practice called Community-Oriented Primary Care (COPC), which combines clinical- and community-oriented preventive medicine approaches.

Using the COPC model, community needs and resources are identified by health professionals who work in partnership with the communities they serve. Originally developed on the US Navajo Indian Reservation in the 1950s and practiced and codified in South Africa and Israel,<sup>1</sup> COPC places community participation at the center of its process by involving community members in public health initiatives from the very beginning. It never forgets the value of input and feedback from the program's community beneficiaries and ultimately aims for community ownership.

The importance of engaging the community was articulated in Chicago by more than 400 leaders from the American Medical and American Public Health Associations who, recognizing the inherent interdependency of their fields, established the Medicine/Public Health Initiative in 1996.<sup>2</sup> The initiative defines six goals for individuals in medical and public health fields across the US, the first being to engage the community and the rest focusing on developing joint efforts between the two fields.<sup>3</sup>

### COPC's Team Approach

COPC relies on a team of community representatives and health professionals who are partners in every step of a cyclical, ongoing process. While the team's composition can be fluid, with people participating as time, interest, and support allow, it must retain a strong core membership committed to taking responsibility for developing and maintaining a comprehensive

community health program. The team begins by identifying the health concern they will address, then designing an intervention and evaluation plan for it. This same process is followed for each health problem the community wishes to tackle. Through structured governance and institutionalization, the team approach may become part of a democratic civic infrastructure, thereby developing the community's capacity to address a host of health problems and issues.

### Defining Communities

Just as healthcare practitioners use specific clinical processes to diagnose individual patients, a COPC team systematically identifies and addresses community health concerns, as shown in Table 1. COPC focuses on a defined population constituting or within a community, making its scope broader than that of traditional primary care practice—which concentrates on the care of individual patients—but narrower than that of most epidemiological studies. A COPC team may define its community in several ways

- geographically according to region, such as a city, town, municipality, or county;
- geographically according to where people congregate, such as the workplace or a school; and
- specifically, such as infants and their mothers, school-age children, people afflicted by a specific disease, or the elderly.

Considering such populations as “patients,” presents an exciting challenge to health professionals who usually quantify populations as a clinical series of patients or clients, rather than a community replete with health problems in need of care. Most medical knowledge concerning population risk factors and disease originates from large epidemiological studies reported in medical or public health journals and the news media. These studies often take 5–10 years from inception to results reporting. In contrast, the time it takes a COPC team to implement an intervention and report back to the community can often be measured in weeks or months. With such immediate feedback, team members can quickly modify interventions if no beneficial change is determined.

#### COPC Model

- 1 Define and characterize the community
- 2 Involve the community; initiate the community-professional partnership
- 3 Conduct a community diagnosis; rank issues in priority order
- 4 Develop and implement an intervention
- 5 Monitor and evaluate

Table 1. Steps of the COPC approach. Once the process is institutionalized the model resembles that depicted in Figure 1 on page 12.

## Bringing COPC to the Classroom

During most of this century, the US healthcare delivery system has moved away from the community and closer to hospitals and clinics. Despite a renewed interest in primary care over the past 20 years, there has been virtually no systematic link between primary care practices and the communities they serve. Additionally, health education—particularly that of physicians—has tended toward specialization. At the same time that recent reviews of medical education programs are calling for a greater emphasis on community-relevant teaching and primary care education, medical schools are looking to develop partnerships between practitioners, academic health centers, and the individuals they serve.

To address this need, an experimental COPC residency and fellowship program was developed in the US. Initially based at Carney, a community teaching hospital in Boston, and now at the Center for Community Responsive Care (CCRC, also in Boston), the program sets the stage for both community-relevant teaching and the development of healthcare partnerships. CCRC uses “cluster committees” to teach the COPC process.

COPC begins by training multidisciplinary professionals—physicians, nurses, dentists, social workers, allied health professionals—as teams in community settings. This “learning by doing” approach allows trainees to work from the start with community members as they begin to practice community-responsive care. The cluster committee model is designed to meet the following goals

- initiate the trainee in the steps and paradigm of COPC;
- develop leadership skills;
- encourage relationships and coalitions;
- bring together the perspectives of community members, public health practitioners, academics, and local clinicians; and
- teach the principles of COPC to the community/professional partners as a group.

Each COPC program trainee subsequently convenes a cluster committee, of which they become the leader, consisting of the following subgroups

- members of the community-based primary care practice;
- public health experts from academic institutions and government agencies;
- other trainees and staff of the program;
- representatives from each major sector of the community—from business and transportation to the criminal justice system and the faith community; and
- community members not representing any vested interest or special group.

## COPC Competency Skills

1. **Generic**
  - a. Order priorities according to a demonstrable systematic rationale
  - b. Identify the decision-making process within an organization/agency and its points of influence
  - c. Identify and obtain needed multidisciplinary skills to address a health issue
2. **Communication and teaching skills**
  - a. Contribute to organizing and developing a multidisciplinary team
  - b. Function effectively as a team member
  - c. Able to facilitate a meeting
  - d. Able to teach according to principles of adult learning
  - e. Skilled in written communication
  - f. Communicate in a clear and effective manner findings and rationale for selected interventions
3. **Community-related skills**
  - a. Able to orient and work appropriately in a historical and organizational context
  - b. Skilled in identifying and understanding multiple dimensions of the community
  - c. Able to work with communities to identify and set priorities on community health problems
  - d. Able to work with communities to plan and implement health interventions
  - e. Able to contribute to organizing community groups and helping the community participate in activities that support community health programs
  - f. Participate in community coalitions
4. **Epidemiology/biostatistics**
  - a. Apply community-based epidemiology
  - b. Presentation of epidemiologic data
5. **Data evaluation skills**
  - a. Able to obtain and analyze primary and secondary data
  - b. Able to monitor/evaluate/modify a healthcare intervention
6. **Administrative**
  - a. Set goals and objectives for a given health issue
  - b. Design an implementation plan to address goals and objectives
  - c. Design an evaluation/quality assessment plan based on measurable criteria
7. **Leadership skills**
  - a. Able to function as a change agent in promoting a site's advancement relative to COPC principles
  - b. Demonstrate ability to identify conflict and negotiate effectively
  - c. Able to take a lead role in improving a community's health and quality of life
  - d. Able to take a lead role in using and applying new federal/national/state health planning tools
8. **Cultural skills**
  - a. Interact sensitively, effectively, and professionally with persons from diverse cultural, socioeconomic, educational, and professional backgrounds
  - b. Identify the role of cultural, social, and behavioral factors in determining disease, disease prevention, health-promoting behavior, and medical service organization and delivery
  - c. Develop and adapt approaches to problems that take into account cultural differences

**Table 2. COPC competencies are skills learned through doing. The cluster committee process takes knowledge learned in the classroom and applies it to the real world.**



Each cluster committee convenes for a series of five meetings held at monthly intervals to define the issue to be tackled and review the COPC process as it applies to their specific community. The COPC trainee spearheads an intervention program that focuses on the defined priority. Community support for the initiative is usually fostered from the outset due to this bottom-up approach. Since 1988, over 50 cluster committee series have been convened in Boston neighborhoods and Massachusetts communities (one series was also held in El Salvador).

Many have evolved into ongoing health promotion/disease prevention steering committees or coalitions based at the trainee's clinical site.

Cluster committees have been proven by evaluation of the Kellogg Foundation to be a powerful vehicle for applying COPC principles and combining medical and public health initiatives.<sup>4</sup> While a cluster committee may resemble any advisory group convened from various fields to discuss ways to work toward a common goal, it has features that distinguish its unique potential for addressing public health issues (see below). Cluster committees also offer the opportunity for various members of a community—including health professionals often isolated from

- work collaboratively and in partnership with community members to identify, characterize, and prioritize a community's health concerns;
- solicit voluntary, low-cost, or employed community and professional assistance in designing, creating, and implementing intervention measures; and
- quantify and communicate future health improvements in terms of better health outcomes, taking into account economic considerations.

COPC principles and practices are applicable anywhere in the world. With the current renaissance in primary care, there is an opportunity to involve community members at every level in the healthcare systems that address their specific needs and concerns. Because it involves many individuals within the community—including those who often have no voice—COPC's greatest potential may be its capacity to help health professionals influence a democratization of the healthcare system. These communities can lay the groundwork for a healthcare system global in scope and local in action.

## References

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3. S. Cashman *et al.*, "Carrying out the medicine/public health initiative: The roles of preventive medicine and community-responsive care," *Academic Medicine* **74**, 473–483 (1999).
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## Suggested Reading

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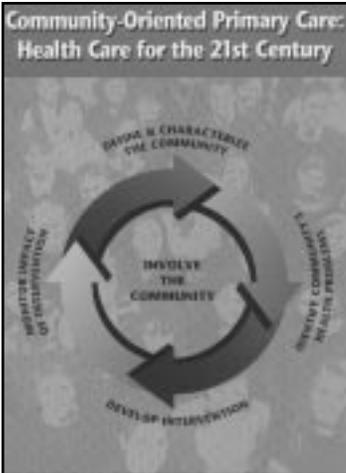


Figure 1. Published by The American Public Health Association, *COPC: Healthcare for the 21st Century*, documents the successes of national rural and urban programs that have incorporated COPC strategies into their public health efforts. The illustration depicts the fully operative model, as defined in Table 1, with the community in the center and steps 2–5 articulating the continuous process.

one another within their own institutions—to come together to effect coordinated change.

Using this educational module, CCRC helps trainees—through their Cluster Committee leadership—develop competencies necessary for community-oriented, twenty-first century practitioners. It combines COPC and multidisciplinary training, leading to the development of a set of abilities (see Table 2) on the part of the health professionals, shared in part by the community. It is aimed toward institutionalizing a process that will result in the community taking ownership of the system that serves it (see Fig. 1, above).

The ideology and practice of COPC may help responsive healthcare practitioners be better designers of more effective intervention and prevention strategies. Practitioners who design tomorrow's community health systems will be those who learn to

- measure health problems relative to a specific population;