Engaging the Public Through Communities of Solution and Collaborative Empowerment

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Ever since the Folsom Report (NCCHS, 1967) declared that "health is a community affair," surging and ebbing waves of enthusiasm have brought people together to work toward the common goal of healthy people and populations (PHAB, 2014). Most efforts have been collaborative, but framed by a single discipline or convener in ways that do not always reflect *the robust, catalytic and sustainable* initiatives that groups such as the Institute of Medicine (IOM) Roundtable on Population Health intend.

Across the health sector, there is growing recognition of the need for community-based solutions for the wicked problems that face us. It is clear that health leaders and policy makers are working hard to develop infrastructure able to empower learning communities (Carr, 2001). Less clear is the extent to which "communities" themselves are empowered toward collective ownership and action. Such ownership requires a public imagination inspired by the value of both individual and social responsibility to promote healthy populations and communities (DeVoe and Gold, 2013). As outlined in the Folsom Report, Communities of Solution are vehicles able to foster such inspiration.

The Folsom Report was one of three national studies during the 1960s that focused on the intersection of population health, primary care and public health (DeVoe and Gold, 2013; Citizens Commission, 1966; AMA, 1966). The report introduced the idea of "problem-sheds," similar in nature to watersheds. Problem-sheds are fed by a number of overlapping but disparate environmental and institutional structures informing a single community's health concerns in a way that belies political or jurisdictional boundaries. The structural complexity of a problem-shed forms a natural barrier to effective planning across institutions. For this reason, the Folsom Report introduced the concept of Communities of Solution. Communities of Solution were defined in the report by "the boundaries within which a problem can be defined, dealt with and solved" (DeVoe and Gold, 2013). The intention was to identify a community as a motivated group, collectively affected by a problem and directly benefiting from its solution.

In the face of rapid societal growth, the 1967 Folsom Report identified fourteen critical areas able to integrate delivery of health-related services and foster the imperative that, as the title states, "health is a community affair." In 2010, the American Board of Family Medicine (ABFM) revisited and updated the wisdom of the Folsom Report for the 21st century (David et al., 2012). The ABFM's Young Leaders Advisory Group identified thirteen "Grand Challenges for Integrating Community Health Services," informed by the Folsom fourteen, and mapped those challenges directly onto opportunities represented by the American Recovery and Reinvestment Act of 2009, the Children's Health Insurance Program Reauthorization Act of 2009, the Patient Protection and Affordable Care Act of 2010, recommendations made in the IOM report *Primary Care and Public Health: Exploring Integration to Improve Population Health* and resources available through the National Institutes of Health (NIH) Clinical and Translational Sciences Awards (David et al., 2012; IOM, 2012; The Folsom Group, 2012).

As a rallying call, the Grand Challenges of the "Folsom Report revisited" offer aspirational and actionable advice for communities and health leaders. For example, Grand Challenge 1 is to "create a national network of community partnerships to self-define Communities of Solution" able to tailor community health programs at the local level. Grand Challenge 7 is to engage with community partnerships and "coordinate with municipal authorities to design and build healthy living environments." Challenge 5 is to "engage Communities of Solution to recognize and address injuries as a main preventable source of global human death and disability" (Griswold et al., 2013: 233-234). Challenge 8 is to enhance health literacy such that community members can be active participants in Communities of Solution to promote their own health and the health of those around them. Challenge 13 is to use health information technology and data-sharing networks to enable the flow of relevant knowledge to Communities of Solution able to put knowledge to action (Griswold et al., 2013).

The time is ripe to advance these challenges. Policy makers are already convinced of the urgent need for community-based solutions to population-based care (Sweeney et al., 2012). Nine case studies of Communities of Solution, published in the *Journal of the American Board of Family Medicine* (JABFM, 2013), and fourteen more published by the National Committee on Vital Health Statistics (Carr, 2011), demonstrate that the American public is also ready to embrace community-based models. However, history has often shown us that collaborations initiated by institutional directives, or projects responsive to funder calls for proposals, suffer from lack of sustainability and momentum once the central convening force steps back (Himmelman, 2001).

Successful Communities of Solution will need to invest their members with a sense of ownership and with the will for sustained action. Arthur Himmelman's Collaboration for Change framework is one example of a compelling vision able to respond to that need. Himmelman (2001) begins by defining four strategies for the ways in which people form coalitions, beginning with networking – defined as exchanging information for mutual benefit, and moving through coordinating (networking plus altering activity for a common purpose), cooperating (coordinating, plus sharing resources) to collaborating – defined as cooperating plus being willing to enhance the capacity of others. Himmelman warns that conveying community-based ownership in solutions requires a transformation of power within collaborative coalitions, from the convener to the community: "The transformation of power relations in coalitions requires that power, or the *capacity to produce intended results*, must be guided by principles and practices of democratic governance, grassroots leadership development, and community organizing" (Himmelman, 2012). Indeed, recent case studies of sustained community-based involvement in public health initiatives demonstrate the power of this model (Payne, 2001; Eilbert and Lafronza, 2005).

Communities of Solution is a powerful, motivating framework because of its ability to balance the often competing philosophies of social and individual responsibility (The Folsom Group, 2012). This is the heart of community empowerment principles. Framed by Himmelman (2001), *collaborative betterment* principles are often the basis of action for those groups with the resources to convene and initiate collective action. A typical framing of action based on collaborative betterment includes the provision of limited funds aimed at solving big problems and the requirement that found solutions be self-sustaining once the funding period has ended. The problems targeted by such actions are usually defined by the funder or convener, leaving little space for funded coalitions to self-define their purpose and approach. Ironically, Himmelman found that "…coalitions funded within this doing-more-with-less ideological framework are required to focus on more efficient and cost-effective uses of *existing* resources even as the need for substantial new resources becomes increasingly clear" (Himmelman, 2001: 280).

Although collaborative betterment is an important start, and the way in which many Communities of Solution are likely to begin, it is equally important that conveners and community members embrace the principles of *collaborative empowerment*, in which the problems addressed by a community, and the means by which they engage others in solution, become self-determined and self-defined (Himmelman, 2001).

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Together, communities of solution—focused on definable problem identification with imaginable solutions—and collaborations that move from betterment to empowerment may be the prescription for bringing primary care, public health, and communities together in joint action toward healthy people and populations.

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