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Collective Impact: Operationalizing a Framework to Coordinate Community Services

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Abstract

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program provides comprehensive early childhood services. Federal agencies emphasize coordination of stakeholders for systems-building. Designing a well-coordinated system is complex. We reviewed MIECHV's literature and program documents to identify community-coordination infrastructure elements. We designed visual frameworks for each model to display infrastructure, components, and connections. In the independent point of entry model, families access services directly. In the coordinated point of entry model, a centralized intake and referral structure supports system coordination. In the collective impact model, relevant community stakeholders actively and collaboratively participate in service coordination. Visual frameworks allow stakeholders to align on process and infrastructure of their programs to facilitate planning activities, use these frameworks to identify whether the model under which they operate is ideal, and then evolve their infrastructure.

Introduction

In an international comparison, the U.S. falls short on many maternal and child health indicators. The U.S. has the highest infant mortality rates,1 our children are less likely to live to age 5 (1), and our rate of adolescent pregnancy is the highest among high-income peer countries (1). Improving these health outcomes requires a greater emphasis on improving modifiable factors, which account for up to 50% of premature mortality;2-5 medical care only accounts for 15% of population health (6).

Home visiting services have a long history in the U.S., with some evidence of positive impacts on prenatal, post birth, and long-term health and behavioral outcomes of mothers and children in high-risk conditions (7). Home visiting services became more common in the early 1900's, primarily funded by philanthropic organizations and local government agencies (7).

In 2010, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program was created by the Patient Protection and Affordable Care Act. The Affordable Care Act authorization and funding level for five years of MIECHV was $1.5 billion (8). Disseminated through the Health Resources and Services Administration and the Administration for Children and Families, the MIECHV program is designed to improve maternal and early childhood outcomes by providing comprehensive services to at-risk families through evidence-based home visiting programs (9). The U.S. Department of Health and Human Services' Administration for Children & Families hosts a website Home Visiting Evidence of Effectiveness (HomVEE) that catalogs and describes evidence-based early childhood home visiting service delivery models ("program models") in collaboration with the MIECHV program (10).

MIECHV legislation announced that "coordination of services with other agencies has been an essential characteristic of state and local programs… (and) will be essential to effective, comprehensive home visiting and early childhood systems" (11). The coordination of stakeholders and services can produce efficient, effective service delivery;

reduce redundancy; and enhance systemic support for target populations (12). MIECHV local implementing agencies are called to work together with the other components of the system within their communities, in order to optimize maternal and early childhood outcomes. Many state MIECHV programs believe that the most significant and feasible coordination effort concerns organizing the client's point of entry (13).

How to design and implement a well-coordinated system is complex and, as yet, unclear. To support implementing coordination of services, we identified the operational practices of various MIECHV programs and created frameworks to visualize those practices.

Methods

The theoretical basis for our approach is "collective impact," as proposed by Kania and Kramer (14), given how omnipresent the concepts have become in community-based practice. "Collective impact" is a buzzword among community-based organizations to reflect the inter-agency commitment of cross-sector organizations toward a common goal, and is comprised of five conditions for success: 1) a common agenda; 2) a backbone support organization (a highly structured process managed by an umbrella organization); 3) shared measurement systems (ways success will be measured and reported); 4) mutually reinforcing activities; and 5) continuous communication (14). A Google search of "collective impact" results in over 630,000 returns. While the collective impact concepts are not fully developed as a systems-approach (15), many organizations(16-21) and even communities (22) have developed an identity around collective impact.

We reviewed publicly available MIECHV program documents and systems-building literature to identify intake and referral practices to develop model frameworks. To qualify as a model, the program must have been attempted in more than five states and/or communities throughout the United States. We based model frameworks on identified community service delivery components and practices: the providers in the program network (community service delivery organizations), the receiver (the family), "check point" institutions with whom a family would commonly interact (schools, hospitals), and connection activities among these components (initial contact, screening, intake assessments, referrals). Check point institutions may be a part of the network; however, they tend to serve a distinct purpose in the coordination process as an optimal location for screening.

We created diagrams using Draw.io software. Each model demonstrates our illustration of the interaction of the system with one family and how the coordination among stakeholders addresses that family's needs. The red star indicates an initial contact of the family with the service delivery system. The light blue circle signifies a comprehensive, systematic assessment of needs. The green circle signifies a simpler, standardized screening activity that determines if there is a need for services. The dotted lines display the pathways of the case. For instance, a dotted line from the "school" to a central intake and referral organization signifies that the family's case has been moved to the referral organization. Red dotted lines signify that the path is not systematic (e.g. when a family reaches out to an agency). Finally, blue lines indicate services that are delivered to the families from service organizations.

Because this study does not meet the definition of "human subjects research," Institutional Review Board approval is not required.

Results

Three common models emerged concerning service delivery coordination. Figure 1 displays the coordination models. We define the Independent point of entry (POE) model

as one in which the POE of a family is isolated to one organization, which does not systematically coordinate with other community service providers' intake processes. The Independent POE model represents a framework without a comprehensive, systematic service coordination among providers. Service providers have organization-specific intake and referral practices that may lack coordination due to inconsistent knowledge concerning the specifics of the other organizations' services.

Coordinated POE displays a system where services are coordinated by a central intake and referral structure, typically operated by a separate organization or a central data system. Coordinated POE is designed to coordinate services by comprehensively identifying family needs; the missions, services, and activities of community organizations; eligibility requirements; capacity of each organization; and other considerations for suitability, including the evidence for the various models targeting a particular need. This model presents the systematic connection of services to families. If successful, agencies in the community would theoretically spend less time and resources recruiting and managing intake. This would result in reducing time providers spend answering calls, screening for services, and managing waitlists; reducing the number of times families are screened; and providing more logical service delivery, leading to better outcomes for families and optimizing total community resources by reducing duplication throughout the system (23).

The Collective Impact model has emerged as a recognized approach for bringing stakeholders together to coordinate the assignment of complementary tasks for the purpose of achieving a common aim (12,14). Ideally, the organizations participating in collective impact should offer complementary services (i.e. one might offer transportation services and another might connect clients with health care). To coordinate and align services, the organizations would regularly collaborate on placement of families and to satisfy five conditions that define this model: a common agenda, mutually reinforcing activities, continuous communication, shared measurements, and backbone support (14).

Discussion

MIECHV clients commonly have complex needs. We identified three operational models concerning service delivery coordination. The highest-level systems model is the collective impact model. Families would benefit from collective impact interventions, which introduce coordination at the backbone support-level and attempt to provide a more comprehensive alignment of client needs with service foci. The burden of keeping track of services in the system does not fall on the family or one agency, but rather, that support is collaboratively built into the system.

In order to achieve true coordination, the Centers for Disease Control and Prevention (24) suggest formal partnerships. Structured partnerships can be used as a tool to build in ownership and contribute to the composition of meaningful networks. Organizations in the collaborative effort should offer varying, complementary services (i.e. one might offer transportation services and another might connect clients with health care). Collective impact in communities requires systems-level effort (15,25).

Collective impact also involves the systematic targeting of eligible clients. Families seeking services may not be the ones that need services the most. Thus, service delivery systems might reach target populations more comprehensively if processes were embedded into key community check point institutions (schools and health care organizations). Health care organizations are especially well-suited to capture the MIECHV target groups given their focus on families with children prenatal to kindergarten entry.

Therefore, health care providers have the opportunity to serve a distinct purpose in the centralization and coordination of the intake process with the use of simple, standardized screening activities.

Planning for systems change requires that stakeholders first identify the root causes of problems. Analysis of 'the problem' should be complemented by an assessment of the existing organizations, collaborations, and structural elements (e.g., other sectors, the public policy landscape) that have the potential to play roles in the effort (25). Collective impact is fundamentally not about creating a whole new initiative, but rather connecting and strengthening existing efforts and filling gaps. The output of this landscape assessment could range from a simple list and description of the above elements, or it could be a more sophisticated "systems map" that visually depicts the relationships between the various elements"(25). Regardless of the format, the goal is to identify current work that can be expanded.

The initial planning for building collective impact in communities might include the following steps:

1. Define a common agenda (14).

Because the MIECHV program required that states conduct a needs assessment to identify areas for MIECHV services, the common agenda is improving maternal and early childhood outcomes.

2. Define the system.

Identifying community stakeholders and how they connect within communities allows MIECHV to understand which players address which needs, and how.

3. Engage organizations toward collective impact perspectives.

Shift from a competitive stakeholder perspective to "We are critical participants and givers in this collective effort and we all need to contribute to making it happen" (26).

4. Build conceptual models of the system.

Figure 1 contains models that describe service delivery systems.

5. Compare the models with the real world.

Currently, many MIECHV communities operate as the first model, Independent POE.

6. Develop desirable and feasible interventions (Mutually Reinforcing Activities (14)).

These interventions might start with stakeholders:

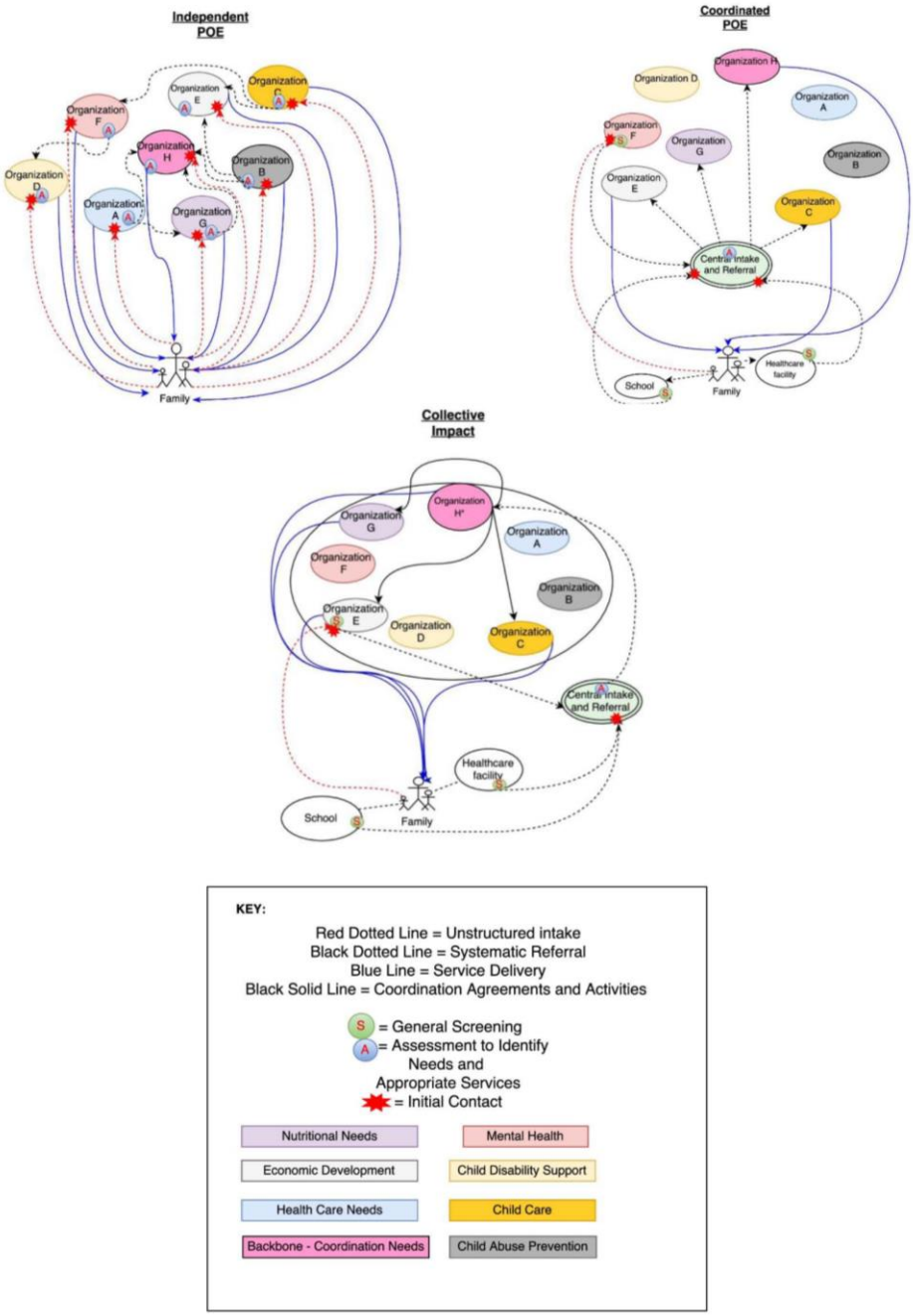
- Determining how much time each organization is capable of contributing to select responsibilities for eligible families and developing the infrastructure for that initiative (Continuous Communication (14));
- Identifying client information they are willing and permitted to share, and discussing data linkages to inform how client progress will be tracked across agencies (Shared Measurements (14));
- Aligning each agency's intake criteria and capacity (to identify gaps and strengthen coordination);
- Designating which stakeholder will support the coordination of services delivered to families (Backbone Support Organizations (14)).

Visually displaying and comparing 'current state' to 'future state' coordination models may support MIECHV efforts to strengthen inter-agency coordination by providing a high-level awareness to stimulate thought around planning activities.

We recognize there are a few limitations to this work. First, we applied our model frameworks to the MIECHV literature. We would welcome testing the replication of

these ideas in both the MIECHV literature, as well as in broader community-based practice. To that end, future research would entail testing the efficacy and effectiveness of operationalized collective impact initiatives against the POE model to confirm improved outcomes.

Figure 1: Models for Coordination of Services and Stakeholders in Early Childhood, 2015-2016



Implications for Policy and Practice

What is already known about this topic? The MIECHV program points to coordination as a key strategy in early childhood systems-building. Systems-building approaches vary, but most agree that coordinating the public and private pieces in the system is a useful strategy. Collective impact has emerged as a desired framework to achieve targeted outcomes, although in many cases remains a buzzword or theoretical ideal rather than an operationalized reality.

What is added by this report? Many MIECHV programs operate as independent POE models without a universal intake and referral process. MIECHV programs would be strengthened by taking concrete steps to implement collective impact partnerships to serve clients with diverse needs.

What are the implications for public health practice, policy, and research? Visualizing models of coordination frameworks allows programs to reflect on their current service delivery system. Using the guidelines listed might be a practical strategy for communities who choose to move toward implementing collective impact.

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