Introduction

Changing policy environment

Health promotion and social determinants of health

Prof. Fran Baum
Research Team

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NHMRC Project started in 2009 with aim to assess the conditions that support Comprehensive CPHC – started with support from SA Health and Service Partners. In 2009 the road seemed a little tough but offered a clear way forward.
Project Overview

6 Services:

- Central Australian Aboriginal Congress
- SHine SA
- Aboriginal Health Team
- Playford Primary Health Care Services
- Port Adelaide Primary Health Care Services
- GP Plus Marion Primary Health Care Services

Program logic model

Evaluation methods:
- Client surveys, workshops
- Collection indicator data
- Staff interviews, surveys
- Regional, funder interviews
- Case studies of intersectoral action eg alcohol, DV
- Case tracking of patient journeys
  - diabetes
  - depression
A program logic approach

1. What’s known about an issue, why it is being tackled in a particular way and what outcomes are expected

2. An explanation of how and why an intervention or program works

3. Graphic model of the program
Southgate model of comprehensive PHC
Also developed model for each service
What changed in 5 years in SA?

- A lot!
- Reorganisation into AHS, then Local Health Networks
- New PHC infrastructure – GP+ Centres, Super Clinics
- Demise of community health centres from introduction of GP+ onwards
- Change of policy focus from a broad approach to PHC to a narrow focus on chronic disease management and some early childhood
- Medicare Locals arrived – contribution uncertain
What changed in 5 years in SA?

- McCann Review recommending against health promotion and Government endorsed most of the recommendations
- Cost cutting as policy priority but above average salary increases for clinical staff in SA Health
- Unfavourable policy shifts e.g.
  - demise of Primary Prevention Plan
  - abolition of Health Promotion Unit
- Most staff wanted comprehensiveness, only a minority supported selective approach
Policy focus on budget

“What I observe here is a primary health service that’s stuck and it’s probably in what I’d call policy confusion and funding confusion…. So it’s just sort of languishing really.

...The economic position of the jurisdiction is driving some pretty ordinary decision making, and the influence of treasury is “just cut” ... there are consequences to those cuts and there are going to be population health consequences in my view, down the track.”

Regional Health Executive, 2014
Narrowing of service focus

“The LHN have made a very clear statement that we need to be moving into a space of what we’re terming intermediate care

...  
Primary health care nurses who have previously done a very health promotion education role are now being asked to be in a much more defined clinical role – managing diabetes and respiratory illness and those sorts of things.”

Regional Health Executive, 2014
Narrowing of service focus

“We are moving towards a more clinical model of primary health ... It's not doing the health promotion, working with the well communities to do prevention work anymore.”

“Certainly culminating in the McCann review - you’ve seen a reduction of emphasis on any health promotion and illness prevention and that includes social determinants of health ... it's come down just to clinical work really.”

PHC Service Managers, 2013
Worker perspective on changes

“Sooner or later it’s going to set something off - the people that we’re not preventing now. In 10 years’ time they will be here in our chronic disease pool and everybody will be happy!”

Aboriginal Health Worker, 2013

“I had a running sheet of what was happening and ‘Be warned! ... Do not engage and don’t commit long term to anything.’ That was in bold letters. So really restricted in the work you could do.”

PHC worker, 2013
Changes in NT

• Northern Territory Emergency Response (“Intervention”) → EHSDI / Stronger Futures funding

• Close the Gap funding

• Establishment of NT Medicare Local

• Alice Springs Transformation Plan
Health promotion, SDH

- Examples of health promotion and action on SDH at state managed sites in 2009 now almost all cut

- Despite narrowing service agreement, SHine SA have kept broader brief

- Some evidence that local control may assist action on SDH – e.g. previous boards of CHC and evidence from Congress

- Congress advocacy, intersectoral action on SDH are valued in the organisation
From: Straight Road Ahead

To: Chaotic Environment
Given the changes what can the study contribute?

• Able to compare different models of PHC

• Test value of Program Logic Model

• Assess services’ ability to: act on social determinants realise equitable access foster community participation engage in intersectoral action engage in multi-d teamwork

• Track the services ability to deal with two conditions – diabetes and depression comprehensively
Given the changes what can the study contribute?

• Monitor impact of the policy changes and track staff reactions

• Monitor impact on services’ organisational structure and service mix

• Document service users’ perceptions of the service models - which enables us to determine what they value

• Pioneer evaluation methods eg. community assessment workshops patient journey case tracking
What’s different about working in CPHC?

Dr. Sara Javanparast
Policy changes
Multidisciplinary care
Outcome measurement

Different funding streams
Culturally respectful health system
Restructure
McCann Review
Reporting

Enthusiasm
Efficiency
Chronic disease management

Service location
Service affordability
Selective approach
Flexibility in responding to clients needs

Referrals
Cost shifting
Skills

Organisational support
Actions on social determinants of health

Health Promotion cuts
Individual care
Workforce

Out of hospital care
Health reforms
Advocacy

Quality of care
Opportunities for intersectoral collaboration

Equity of access
Medicare Locals roles

Workload

Public awareness
Data collection system
…What’s different working in CPHC

• The impact of different PHC service models and organisational environment

  • Stronger community voice and response to community needs in Congress/ more sustainable programs and funding
  • Higher impact of policy changes, health re-organisation and structural changes on state funded services
  • SHine SA as an NGO had more ability to seek other funding to maintain their broad mandate
SHine SA broad mandate
e.g. workforce capacity building

• Training, networks, building capacity of workforce in community and primary health services (general practice, nursing, disability, teaching, and other workforce)

• Service qualities fostered in workforce, social justice and values based “from the word go”
Different for different programs/disciplines

More comprehensive approach for the early childhood teams / less affected by policy change than programs targeting adults

Different over time

- Changing service priorities
- Shift to 1-to-1 clinical services
- Less group & community work

SA state-funded decline in comprehensiveness
Staff survey results – percentage of time spending on individual, group and community works

- **State-managed services (N = 49)**
  - 66%: Percentage of time spent working with individuals
  - 19%: Percentage of time spent working with groups
  - 15%: Percentage of time spent working with communities

- **SHine SA (N = 35)**
  - 52%: Percentage of time spent working with individuals
  - 30%: Percentage of time spent working with groups
  - 18%: Percentage of time spent working with communities

- **Aboriginal health service (N = 69)**
  - 44%: Percentage of time spent working with individuals
  - 25%: Percentage of time spent working with groups
  - 31%: Percentage of time spent working with communities
Multidisciplinary care

• A strength in all participating services
• 90% of practitioners reported working with other disciplines within the service (N = 154)

Staff survey results: mechanisms used for multidisciplinary work
Intersectoral collaboration: successes and challenges

- The impact of restructuring and changing government policies as major barrier to intersectoral collaboration in the state funded services

“This broader kind of concept of PHC around the whole life of the person and working with other sectors to actually impacting factors outside health - those broader social things are not health’s concern now. That’s definitely off the agenda around health.”

PHC worker, state-managed service, 2012
People’s Alcohol Action Coalition

• Congress as a lead player and strong advocate for effective public health policy and addressing SDH

“...what we have seen is what is now around, I think, a 15% reduction in overall consumption of pure alcohol in Alice Springs, which has resulted in a decrease of around 120 [hospital] admissions of Aboriginal women for assault. So, if you look at admissions into hospital that means that the assault is quite serious, and so that sort of advocacy work in getting the tap turned down a bit through a price mechanism has resulted in a decrease in some pretty awful statistics around harm of Aboriginal women.”

Congress staff, 2013
SHine SA’s Focus Schools Program

- Strong collaboration with government departments, schools, parents, students and health professionals

“Just good relationships and communication and by having a MOU [now memorandum of collaboration] in place...And we’ve got funding from DECD sitting on the reference group and they’re our conduit. And with the Aboriginal Focus Schools Program we have community representation on there as well as Aboriginal Health Council...If you’ve got a problem you’ve got somewhere to turn to.”

SHine SA staff, 2013
Climents’ perspectives

Community Workshops
- 1-3 workshops in each service (total=10)
- Clients’ ratings of service qualities

Client survey
- Waiting room survey
- Mailed survey

Client Interviews
- Case tracking of clients with diabetes and depression
Comprehensive PHC service qualities

- Holistic
- Effective
- Efficient
- Supports and empowers community
- Mix of treatment, prevention and promotion
- Responsive to community needs
- Uses by those most in need
- Increases Individual control
- Culturally respectful

Flinders University
inspiring achievement
Clients’ perspectives

1. Holistic

2. Increasing Individual Control

- defining features of Primary Health Care services that differentiate them from other health service experiences participants have had, such as GPs and hospitals
Culturally respectful
A highlight in the Aboriginal health services

1
“I think it’s a welcoming kind of place. And the thing is, I think one of the good things is, some of us, we at least know one or two people that work there hey, because they’re people in our community, and they’re not all strangers to us.”
CAW, Congress, 2012

2
“I feel more comfortable going to the Clovelly Park doctors than going to the white fella doctors …. I feel completely comfortable when I’m in these services”
CAW, Aboriginal Health Team, 2011
Helping with issues outside health

Examples: Transport, housing, legal issues, access to benefits such as Centrelink, job training, Childcare (client survey, N = 315)
Community Awareness

• Lack of community awareness of services particularly for the state funded services:
  • More advertising of the services
  • In contrast 97% of respondents felt that Congress is known in the community

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<thead>
<tr>
<th>Site</th>
<th>N</th>
<th>Percentage</th>
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<td>Congress</td>
<td>83</td>
<td>97%</td>
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<td>State-managed services</td>
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Community participation and empowerment

Dr. Gwyn Jolley
Community Participation Typology

**Consultation**
- Limited, usually one-off activity controlled by organisation. Asks for people’s opinions and reactions to policy plans.

**Participation as a means**
- Instrumental, lasts for the life of the initiative. Organisation drives and determines agenda. No shift in power.

**Substantive Participation**
- Active involvement, some shift in power but ultimate control remains with organisation. Scope initially determined by those introducing initiative but may change over time.

**Structural Participation**
- Driven by community. Potentially empowering to individuals, organisation and community. Scope of activities as broad as the community wishes.

*Flinders University*
## Study sites and community participation

<table>
<thead>
<tr>
<th>Study site</th>
<th>Level of CP</th>
<th>Example</th>
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<tbody>
<tr>
<td>Congress</td>
<td>Mainly structural</td>
<td>Community BoM</td>
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<tr>
<td>SHine SA</td>
<td>Mainly substantive</td>
<td>Youth advisory teams</td>
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<tr>
<td>State-managed PHC 2009</td>
<td>Consultation and participation as means</td>
<td>Input to program content</td>
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<tr>
<td>State-managed PHC 2013</td>
<td>Mainly consultation</td>
<td>Feedback sheets</td>
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Opportunities for participation

• 58% staff agreed community members/groups been involved in planning and implementation of services

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<tr>
<td>SHine SA</td>
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Opportunities for participation

- 30% clients reported being invited to provide feedback

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<td>35%</td>
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<td>Congress</td>
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- 4% clients reported opportunities to get involved in planning

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Implementing CP
(state-managed PHC)

- All services reported a policy for CP but implementation perceived to be inadequately resourced and supported
- Responsibility for CP has been shifted up to regional level with less local responsiveness
- Few examples of actual change as a result of CP
- Barriers reported as budgets and lack of service flexibility
Community Participation examples

- **Aboriginal Health Team**: Clients chose what personal development and health topics they wanted for groups eg Mums and Bubs.

- **SHine SA**: Development of youth participation framework: young people consulted throughout, involved in design and writing.

- **Congress**: Alukura advisory group who provide cultural and governing advice to management and staff.

- **State-managed**: Community Foodies (cut in July, 2013)—“working with community members as peers” to prevent future health problems.
Climate for community participation

“...we have a bums on seats imperative; outcome quality be damned it would seem. So it means that we don't have the time or resources to dare put that level of effort and collaboration [into CP]”
SA service, 2012

“We’re a community controlled organisation. And the reason we’re driving this agenda is because this agenda has actually been endorsed by a representative board of the community.”
Congress, 2013
Community perceptions of opportunities for participation: State-managed services

- Services responsive to individual clients but less so to community needs

- Most feedback opportunity was through feedback forms at end of sessions

- Participants suggested that services should make more effort to be known in community and gain community input by attending local events
Community-controlled Congress provides a model for increasing structural participation

NGOs have more mechanisms for accountability to community e.g. board of management

In state-managed PHC:
  - opportunity for CP has declined
  - CP is mandated but is less noticeable in practice
  - CP generally limited to individual feedback on specific program i.e. ‘consultation’ or ‘participation as means’
In absence of community control, CP quality would be improved by:

- stronger focus on CP policy implementation and evaluation of outcomes
- CP policy more actively implemented by management and SA Health
- resources to support staff and community in participatory activities
- mix of formal and informal opportunities for CP
- more flexibility to respond to community input

Community-controlled model has much to offer and could be extended to mainstream services
Equity

Dr. Toby Freeman
Elements of equity of access

Availability
(Locally delivered, availability of appointments, childcare, priority access)

Affordability
(Free or affordable services)

Acceptability
(Culturally respectful, welcoming, informal)

Engagement
(Awareness raising, familiarisation and entry points through community activities, community participation)

Freeman et al (2011) http://dx.doi.org/10.1071/PY11033
Changes in location, new GP Plus / Super Clinic buildings

- New infrastructure
- Colocation
- More visible

- Loss of connection to Aboriginal teams
- Less welcoming
- Privacy concerns
SA Services

• Emphasis growing on 1:1

• less groups, community development, “other”, home visits, transport support, outreach

• State-managed: no advertising permitted

Since community health became GP Plus, health staff are much less able to participate in community and assist us to access other services. They are stuck in the office.

Community member, client survey, 2014
Efficiency Reaching those Throughput vs most in need

“You just go to work and do what walks through the door but don’t branch out any further in that fear of ‘will you get into trouble?’”
- Practitioner (State managed), 2013

“It’s ... the ones who don’t come that need more intensive case work and outreach work because they’re not visible, or organised enough or motivated enough or resourced enough to get into the services.”
- Congress manager, 2013
Staff survey results

Percentage reporting adequate access for specific groups
(N = 154)

- People with low income: 12.4%
- People with physical disabilities: 20.3%
- People over 65 years old: 23.5%
- Children: 17%
- Youth: 19.6%
- Refugees and new arrivals: 29.4%
- Aboriginal People: 22.9%
- Working people: 34%

Yes | No | Not applicable to this service
Staff survey results

Percentage reporting barriers to access (N = 154)
State-managed services argued that …

• Those most in need, in most disadvantaged circumstances “our bread and butter” (Regional Executive, 2014)

• Services designed, provided in a way that takes into account SDH
  ➢ eg approach to non-attendance

• Community development helps ensure patient safety
SA Services

Availability
Down: transport, crèche cuts, SHine criteria

Affordability
Same

Acceptability
Down: Changes aren’t what clients want?

Engagement
Down: less awareness raising, community activities

Hard to reach services?
MEANWHILE... over the same period at Congress...

• Safe and Sober program – “engagement happens out in the creek bed” (2011)
• Targeted and Intensive Family Support – inc. with open child protection cases
• Early childhood intervention prioritising Family & Community cases – “possibly the most severely disadvantaged kids in the community” (2013)
• Ingkintja Men’s shed teaching job skills
Availability
Increased?: More programs

Affordability
Same

Acceptability
No evidence of change

Engagement
Increased with new programs?
Program logic
Testing the model

1. Are results congruent with program theory?
2. What happens without CPHC?
3. Are there alternative explanations, exceptions?

- Logical chain of events and outcomes
- Timing
- Experience and observation
- Matching content to outcomes
- Comparison across cases
- Modus operandi
- Compare trajectory before and after
Capturing context

- Local context: organisational culture, staffing, history, beliefs…

- Wider political and policy context
Evidence of change

...looking for empirical evidence of change at each of the points along the pathway.
Chronic conditions

1. Undertook rapid review of literature, summary of evidence based interventions

2. Drew on expert opinion of Associate Investigators

3. Southgate model populated with evidence based interventions specific to **diabetes and depression**
Depression model

Southgate Model for Comprehensive Primary Health Care: Depression

Mechanisms
- Social Justice and Social View of Health
- Accessible, locally delivered
- Community driven
- Mix of direct care, prevention, and promotion
- Multi-disciplinary teamwork
- Intersectoral and interagency collaboration
- Cultural respect

Context
- Inputs / Resources
  - Staff, FTE, Funding
  - Drugs, Equipment, Supplies
- Priority Populations
  - Children and Adolescents
  - Older People
  - Aboriginal and Torres Strait Islanders
  - Rural and remote
  - CALD
  - Institutionalised

Community Context
- Socio-demographics of area and changes
- Resources available for health in community
- Infrastructure to support participation and social connectedness

Organisational Operating Environment
- Funding (amount, cycles, silos)
- Externally prescribed programs
- State/regional strategic plans
- Higher level governance

Socio-political context
- Social equity/inequity
- Public policies: economic growth, education, housing, food, health

Depression Management
- CognitiveBehaviouralTherapy, Behavioural Activation
- Interpersonal psychotherapy
- Couples therapy, Family therapy
- Guided or therapist assisted self-help
- Self care Exercise diet, relaxation
- Drug therapy (where medical practice)
- Collaborative care
- Links to other services e.g. housing, employment, financial management, education
- Improving access and utilization for groups known to be at higher risk
- Mindfulness

Depression Care / Treatment
- Assessment/watchful waiting
- Self care Exercise, diet and relaxation
- Direct to Self-help
- Social connectedness activities e.g. community gardens, men’s sheds, playgroups
- Collaborative care/Referrals
- Chronic condition self-management support
- Resilience programs
- Links to other services e.g. housing, employment, financial management, education
- Addressing known pre-cursors to depression (e.g. alcohol abuse, violence, poverty)
- Grief counseling, grief and loss groups
- Outreach/Participatory mechanisms
- Community awareness and capacity building

Depression Governance
- Social connectedness activities e.g. community gardens, men’s sheds, playgroups
- Advocacy and action on known risks to mental health e.g. violence, alcohol
- Advocacy and action on determinants of good mental health
- Activities that support positive early childhood environments e.g. parenting groups
- Activities that support Reconciliation
- Resilience programs

Depression Outputs: Service Qualities
- Comprehensive PHC mechanisms are embedded in processes, systems and structures
- Services that are:
  - Encouraging of individual and community empowerment to undertake and sustain healthy behaviours
  - Responsive to community needs and priority populations
  - Holistic
  - Efficient and Effective
  - Universal and used by those most in need
  - Culturally respectful

Activity Outcomes
- Comprehensive PHC service delivery
- Sustainable PHC oriented health system
- Reduced risk factors for depression in community
- Reduced incidence of depression in community
- Improved knowledge, skills, and self-management of depression
- Slowed progression of depression
- Reduced complications arising from depression
- Complications arising from depression treated
- Improved quality of life for people with depression
- Reduced deaths caused by depression
- Improved health and wellbeing of individuals and the community
- Increased health equity
**Elizabeth GP Plus**

**Client 7**
50 years old
Female

- Internal referral from Dietician

- 4/6/2012: Social Work – counselling appointment
  - Financial issues
  - Unemployed

- 2/7/2012: Social work – counselling appointment
  - Positive response to counselling

- 28/8/12: Social work – counselling appointment
  - Self-reported improvement in mood, increased motivation
  - Completing daily living activities and taking on more challenges such as seeking employment

- 14/2/2013: Social work – counselling appointment
  - Client contacted health service again – not using strategies to manage stress

- 6.6.2013: Social work – counselling appointment
  - Some improvement in mood, emotionally stable
  - Client utilizing Mindfulness strategies
  - Client happy not to reschedule any further appointments

- 2/4/2013: Social work – counselling appointment
  - Client attending Mindfulness Group at the health service

- 29.4.2013 Social work – counselling
  - Client continues to experience depression and anxiety

- Gave information about local GPs

**Suggestion to attend Mindfulness Group**
Aboriginal Family Clinic

Client 3  DOB: 7/6/1988  25 years  Postcode: 5043  Female

Client self-referral

20/8/2012 Appointment with PHC nurse and GP at Aboriginal Family Clinic. Client starts accessing the service for depression
- Single parent pension
- Homeless
- Transition housing – Baptist Care
- Limited social support – no extended family

Referral to counselling at SAFKI Medicare Local (2 week waiting list)
Referral to Anglicare – parenting course

5/9/2012 Appointment with Mental Health Nurse/Aboriginal Clinical Health Worker
- “Stay Strong” mental health plan
- Risk assessment and K10
- Needs help accessing childcare
- Front door needs a lock as she lives on a main road and child got out onto road

Phone call to childcare centre to access extra days

29/10/2012 Appointment with Aboriginal PHC Nurse and then GP
Nurse check blood levels and then

Housing support letter sent to Housing SA

30.10.2012 Aboriginal Clinical Health Worker and Mental Health Nurse home visit (morning)
Client had put on Facebook that she was suicidal. Client was not home.

30.10.2012 Aboriginal Clinical Health Worker and Mental Health Worker home visit (afternoon)
Client home.

Mental health assessment - high risk of self-harm

External referral to Mental Health Triage Service (MHTS) – Assessment and Crisis Intervention Services

Home visit to client and assessment

External referral to Marion Mental Health Team to manage client’s risk of self-harm
Emerging Findings

1. Narrowing of service focus in South Australia – move from relatively comprehensive model to largely selective.

2. Strong staff commitment in all services to comprehensive model. Considerable distress amongst staff in SA Services about changes and process of change management.

Emerging Findings

4. Staff perceive that while cuts to PHC were on the grounds of cost, policy changes will be expensive in long-term to population health & health sector cost.

5. Multi-disciplinary teamwork is preserved within health sector in all services. In terms of working with individual clients holistic and the aim of increasing individual control is preserved.

6. Equity is compromised by the changes in South Australia.
Benefits of community controlled model:
• Greater control over resources and how they are used
• Comprehensiveness of approach to equity
• Stronger implementation of community participation, intersectoral collaboration, social determinants of health elements of CPHC mandate