CGS·SCG
CANADIAN GERIATRICS SOCIETY
LA SOCIÉTÉ CANADIENNE DE GÉRIATRIE

ADVOCATING FOR IMPROVED HEALTH CARE FOR OLDER CANADIANS: WHAT WE CAN LEARN FROM APPLYING THE MARSHALL GANZ ADVOCACY FRAMEWORK

Amina Jabbar
MSc, MD, FRCPC
Division of Geriatric Medicine, McMaster University;
Health Policy Program, Faculty of Health Sciences, McMaster University

Frank Molnar
MSc, MDCM, FRCPC
Department of Medicine, University of Ottawa;
Division of Geriatric Medicine, The Ottawa Hospital; Ottawa Hospital Research Institute, Bruyère Research Institute

Samir Sinha
MD, DPhil, FRCPC, AGSF
Division of Geriatric Medicine, Department of Medicine, University of Toronto;
Institute for Health Policy, Management and Evaluation, University of Toronto;
Division of General Internal and Geriatric Medicine, Department of Medicine, Sinai Health System and University Health Network

Corresponding Author:
Amina Jabbar,
jabbaram@mcmaster.ca

Key words:
advocacy
leadership
system-level change

Abstract

Health care advocacy has evolved from patient level advocacy (e.g., obtaining resources and facilitating care) to now include system level advocacy. Current attempts at system level advocacy are often isolated initiatives led by individuals or small groups resulting in limited impact. To effect the broad changes required in health care to better care for older adults in the community, larger and better organized coalitions will be required. This article presents a framework for the creation of such large coalitions – the Marshall Ganz Advocacy Framework, which focuses on four steps: building relationships, telling stories (*story of self, story of us and story of now*), strategizing and acting. The article demonstrates, through a case presentation, how this framework was employed successfully in the English National Health System to decrease antipsychotic use. The article then makes a case for starting to further this (building relationships) by better aligning the goals and efforts of the three Canadian geriatric care-related medical specialties (e.g., Geriatric Medicine, Care of the Elderly, Geriatric Psychiatry) at both the provincial and federal levels.

This article has been peer reviewed.

Conflict of Interest: None

This article was published in July 2019.

Background

The conceptualization of health advocacy in medicine is evolving. Physicians have traditionally emphasized aspects of health advocacy that focus on facilitating individual patient needs. That may include, for example, asking community care coordinators to increase a patient's home services or ensuring a patient gets seen in a more timely way by the right provider.

This perspective is shifting. It has been increasingly recognized that the Royal College of Physicians and Surgeons of Canada (RCPSC) Health Advocate CanMEDS role (see www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e) should encompass more than individual patient advocacy but should also consider system-level advocacy.

Physicians increasingly recognize the potential for health advocacy within health care systems. Physician-based organizations, such as the Canadian Medical Association (CMA), the Canadian College of Family Physicians (CCFP) and the Royal College of Physicians and Surgeons of Canada, continue to build their capacities to advocate for health issues that facilitate systemic improvements in health care. CMA, CCFP and RCPSC position statements, for example, address a range of public health issues including the opioid crisis, improving the provision of home care, advanced care planning and improving efficiency within the health care system.

In this paper, we start with a discussion of why advocacy for improved care for older Canadians requires that we now start organizing more broadly across sectors. Next, we introduce the Marshall Ganz Framework for creating political movements and concurrently discuss the implications of using this to advance care for older Canadians. We then introduce a case example from the English National Health Service (NHS) in which the Ganz Framework was operationalized to reduce antipsychotic overuse among people with dementia.[1,2] Finally, we conclude with a brief discussion of the way forward for the geriatric care-related specialties (e.g., Geriatric Medicine, Care of the Elderly and Geriatric Psychiatry) that lead the drive to improve the quality of care for older Canadians.

Why do we need health advocacy to advance the care of older Canadians?

Our health care system was designed for a younger population with acute episodic illnesses. The aging of our population represents a success story that has, unfortunately, not been well managed – as the design of health care has not evolved to match our changing societal needs. The care of older Canadians now accounts for almost 50% of health care expenditures, and with a rapidly aging population we will see their health care needs and share of health care resources grow significantly as well.

As the Canadian population has aged, the initial design of the health care system no longer meets our collective needs. Rather than focusing on acute episodic illness we now need to redesign health care not only for managing chronic illnesses but also for managing multiple interacting chronic illnesses. Furthermore, health outcomes have been found to be heavily influenced not only by biological determinants of health (e.g., diseases and medications) but also by social determinants of health (SDOH).[3] Consequently, older adults with complex health issues often require significant coordination between social services and home care providers, unpaid caregivers, primary care providers and multiple medical specialties. Indeed, we need high-level coordination involving multiple partners, something health care currently is not designed to deliver effectively nor efficiently. Our health care system has become an anachronism. It is time to move on and to re-engineer health care for a new reality where geriatric care plays a central role and where multiple interacting chronic diseases are not merely stabilized in hospital but where the care moves into the community including in patients' homes whenever possible.

How do we advocate for such a "sea change" in health care? To date there have been many isolated attempts to advocate for change in the form of opinion pieces in medical journals and newspapers. Clinical Practice Guidelines and Standards of Care have been published, sometimes with limited impact.

Many advocates have gone directly to political decision-makers to plead the case for improving the care of older adults. We have a robust research base of approaches to care that have been demonstrated to save money and decrease health resources utilization; however, many are either not scaled up adequately to meet the growing demands or do not even move beyond the research stage to implementation.

Rather than these isolated attempts we need broader more comprehensive approaches to advocacy. One notable leader in this regard has been the National Institute on Aging's (NIA) Alliance for A National Seniors Strategy (see http://nationalseniorsstrategy.ca/wp-content/uploads/2016/10/National-Seniors-Strategy-Second-Edition.pdf), which has provided a broad set of social policy recommendations for the future of Canada's older adults.[4] The document includes four pillars: (1) Independent, productive and engaged citizens, (2) Healthy and active lives, (3) Care closer to home, and (4) Support for caregivers.[4]

The CMA has also pursued social advocacy by engaging both health care professionals and the public via their "Demand a Plan" campaign (www.demandaplan.ca) advocating for a national seniors' strategy in Canada.

We have good building blocks in place. What more do we need to do to encourage modernization of the health care system so it can better meet our society's current and future needs? How can we move advocacy forward as effectively as possible at the individual, organizational and societal levels? What other skills or approaches do we need to consider employing to become more effective advocates?

The Marshall Ganz Framework described below offers an approach that senior care specialties (e.g., Geriatric Medicine, Care of the Elderly and Geriatric Psychiatry) can use to better collectively advance health advocacy by building a broader advocacy movement spanning a range of organizations. This represents the next step in advocacy that is required to move us towards health care system changes that will benefit older adults and thereby benefit Canadians of all ages who share the finite resources of the public health care system.

The Marshall Ganz Framework – Raising the bar on advocacy through the creation of broad coalitions

Advancing health advocacy to create a movement means cultivating conditions that enable coalitions between a broad base of people and organizations to mobilize resources for a shared purpose.[5] Marshall Ganz, a senior lecturer in public policy at the Kennedy School of Government at Harvard University and long-time organizer, explains that successful movements operationalize four stages that form the framework (https://marshallganz.com/): (1) Building relationships, (2) Telling stories, (3) Strategizing, and (4) Acting (Table 1).[2]

Building Relationships

Relationships are an exchange of resources between individuals and organizations committed to a shared vision of the future. Developing relationships with peers is as important as those we build with people in positions of power. Relationships form sources of support, collaboration and action. The process includes a commitment to cultivating leaders that engage in relational work and transfer their skills to others.[2,5]

Within Geriatrics, we need to deepen relationships between the specialties of Care of the Elderly, Geriatric Psychiatry and Geriatric Medicine to produce a shared vision of care for older adults at the systems level. We must also create alliances with people and organizations outside of Geriatrics who share interests in improving the health of older adults. These include a range of actors from governmental and non-governmental organizations (e.g., seniors' organizations, CMA, RCPSC, CCFP, other medical specialties and health care professions, etc.). A strong constellation of relationships forms the foundation from which we share resources, exchange expertise and cooperatively push a systems-level health advocacy agenda for older adults.

Telling Stories

Telling stories creates a public narrative that explains why an issue matters and highlights reasons for people to act. People make decisions to act (or not) based on personal moral values that rely on emotion.[2] Compelling stories tap into people's emotions in ways that move them to action on particular issues. Successful advocacy movements construct narratives that have three parts: a *story of self*, a *story of us* and a *story of now*.[2,6]

A *story of self* centres on individuals, their motivations and subsequent choices.[6] Physicians focused on providing geriatric care need to develop compelling stories of self. Our experiences with older patients exemplify the intersectionality between pain and hope. We see the pains of aging in the lives of our patients and know success stories; a patient with Alzheimer's dementia, for example, who is supported by a loving family and receives the social services they need to age safely and gracefully at home. The story includes the pains of family members who see their loved one slip away. But the same story includes hope that a person can maintain dignity near the end of life.

The *story of us* shifts the individual narrative into a collective identity with shared values and goals. Stories of people struggling to care for their aging family members, for example, are increasingly part of the cultural milieu (www.nytimes.com/2018/09/19/well/live/when-family-members-care-for-aging-parents.html). A substantial proportion of Canadians have to provide care to older loved ones. That work is most often informal, unpaid and stressful. The experiences of unpaid caregiving for older family members are likely so relatable among the mass public that they could be crafted into a story of us; a shared narrative that articulates a collective desire for aging family members to have access to a strong health care system that is tailored to their needs and helps maintain independence.

A *story of now* identifies the challenges to the collective, actions needed to protect it, and conveys a sense of urgency for change.[6,7] This narrative provides physicians focused on providing geriatric care a way to transform our individual clinical experiences into concrete plans of change that improve our health care system and benefit broader society. It should further inspire others to join in action. People may be moved, for example, to press elected officials for increased financial and social supports. Community service providers may be motivated to develop innovative community services for older adults and caregivers that keep seniors at home and out of hospital. Municipal planners may actively design age-friendly communities that enable older adults to age in place. Ultimately, the *story of now* moves people to act as a collective towards a common goal.

Strategizing

Strategizing leverages resources to influence individuals with power. At this stage, members identify resource constraints, collaborate within the movement to address their deficits and develop plans to achieve their goals.[2] For Geriatrics, this stage would build *strategic capacity* within a movement. A successful movement focused on improving health care for older adults needs motivation over the long term with the ability to focus, persist, take risks and sustain high levels of energy. This stage also focuses on building salient strategic knowledge; developing the understanding of the political and organizational contexts of health care for older adults, which is key to an effective advocacy movement. For Geriatrics, this means we need to create internal learning processes (i.e. identification of future advocates, health advocacy training and political training) that identify our knowledge gaps and plans for addressing them. Broad engagement ensures a strong leadership base. Creating this capacity, however, requires long-term organizational commitment to discuss advocacy goals, engage in professional development and develop strategic plans.

The Ganz Framework emphasizes strategizing as a *collective* act.[2] Building strategic capacity, in other words, requires geriatric-focused physicians to engage with each other and with other organizations committed to a movement focused on improving the health care system for older adults.

Acting

Action is the operationalization of a strategy through the implementation of plans and mobilization of resources.[2] Given that health care is primarily funded and organized provincially, this stage poses substantial challenges for geriatric-focused physicians in the absence of provincial organizations that provide infrastructure around which to coordinate political advocacy work and collaborate with other organizations. There is merit in having Geriatric Medicine, Care of the Elderly and Geriatric Psychiatry physicians coordinate their advocacy efforts at both the provincial as well as national levels. Work at this stage would also include developing measurable outcomes with deadlines and obtaining commitments from individuals involved within the movement. Opportunities to develop a political training advocacy program committed to coaching trainees into broad health care system leadership roles also exist but would benefit from greater expansion and refinement at the provincial and national levels to train current and future health care advocates.

In the next section, we introduce a case study from the English NHS in which the Ganz Framework was successfully operationalized to decrease inappropriate use of antipsychotic medications among individuals diagnosed with dementia.

Case Study

Overuse of antipsychotics within the English NHS existed despite widely disseminated clinical practice guidelines. In 2011, the English NHS Institute for Innovation and Improvement engaged in a large-scale process to organize and mobilize a range of individuals to reduce the inappropriate use of antipsychotic medication among individuals with dementia over an 18-month period.[1] The Institute developed a "call to action" to facilitate that change. In this section, we review how they operationalized the Ganz Framework in a context relevant to geriatric-focused physicians.

Building Relationships

First, the initiative identified key stakeholders that were critical to building relationships. The Institute developed a successful working relationship with a central organization made up of more than 100 smaller organizations called the Dementia Action Alliance (DAA). The Institute and the DAA had access to each other's social networks, stakeholders, expertise, and a means through which to share financial resources. The partnership further encouraged another 700 health professionals to join the initiative after its media launch. The "call to action" involved a wide range of individuals including people with dementia, family members, primary care physicians, psychiatrists, hospital physicians, leaders of care homes, and others.

Telling Stories

Second, the initiative built its narrative. At this stage, the initiative identified characteristics necessary to a successful narrative within their context. They identified that a narrative needed to convey the current state as intolerable; a commitment with a clear and specific action; appeal to emotion while drawing upon clinical evidence; and be adaptable to different audiences. Many health professionals disclosed discomfort sharing a *story of self,* given that clinical contexts generally discourage frank expressions of emotion. The initiative, however, helped legitimize the use of storytelling. Many health professionals that received training to develop their narratives later understood the power of a well-crafted story that conveys a sense of urgency to action. Patients and their caregivers also felt narratives helped amplify their experiences.

Strategizing

The initiative also invested heavily into building strategic capacity among its participants, the third step of the framework. Participants, for example, received coaching to improve their personal understanding of antipsychotic overuse among people with dementia. The support was vital for health professionals who

otherwise did not feel comfortable relating their stories. Subsequently, many felt an increased sense of motivation and confidence translating their messages to different audiences.

Groups also engaged in training focused on developing skills related to mobilizing and organizing. Additional training sessions built leadership capacity through a *"coaching the trainers"* program.

Acting

As part of the last stage, acting, the initiative produced a range of resources. Pharmacy management leads helped co-design an education and support program to help pharmacists review medication use. Care home leaders developed and implemented an audit of their care homes to decrease inappropriate anti-psychotic use. Education campaigns targeted residents, hospital teams and primary care physicians. Medical directors and directors of nursing regularly contributed to a column within a newsletter for health professionals that circulates among 25,000 people. People with dementia and caregivers facilitated workshops with health professionals. All resources were coordinated and addressed antipsychotic overuse among people with dementia.

This English NHS case recognized the potential of mobilizing and organizing on a large scale to facilitate change. The initiative bound together seemingly disparate groups of individuals to create a cohesive movement working towards a shared and common goal. Specifically, they saw this as a means to engage health professionals, create working networks across sectors, develop a deeper well of individuals with leadership skills and build an infrastructure from which they could organize in the future.

Conclusion: The way forward for Geriatrics

The Marshall Ganz Framework offers an approach through which the three Canadian specialties providing geriatric care (e.g., Geriatric Medicine, Care of the Elderly and Geriatric Psychiatry) could partner to generate such a movement. We provided in this paper a brief introduction to the approach. The framework is increasingly being adapted into health care contexts. The Institute for Healthcare Improvement (IHI), for example, has firmly embraced the approach and offers a course called, "Leadership and Organizing for Change" (www.ihi.org/education/WebTraining/Webinars/Leadership-Organizing/PublishingImages/Pages/materials/Leadership%20and%20Organizing%20for%20Change%20-%20Syllabus%20-%20Fall%202018%20-%20Updated.pdf) modelled after Ganz's work.

Physicians have substantially broadened their conceptualization of health advocacy over the last decade. The focus has shifted from principally doing so at the individual patient level to broader political advocacy at the government level. Activities have focused, for example, on understanding legislative processes or lobbying elected representatives more effectively on specific health issues.

Individual patient and isolated government advocacy alone will not be able to create the large-scale health care system changes required to provide for the current and future growing needs of older adults. Systemic changes to our health care system need to address a variety of issues, including but not limited to, recognizing and addressing the social determinants of health, providing more care closer to and in people's homes, as well as providing more multi-specialty integrated care for people living with multiple chronic health conditions. Creating change at this level will require a broad political advocacy movement. Geriatric Medicine, Care of the Elderly and Geriatric Psychiatry, as Canada's three principal specialities leading the care of older adults, have an opportunity to advance health advocacy by creating a broad coalition of individuals and organizations that share interests in improving the health system for older adults both at provincial and federal levels. The first step for these three specialties and the potential to actualize the advancement of health advocacy begins with developing a clear commitment to build relationships – the first step in this critical journey to improve the care of older Canadians.

Table 1. The Marshall Ganz Framework

Steps	Definition	Implications for Geriatrics
1. Building relationships	• Links between individuals and organizations committed to a shared vision of the future • Exchange of ideas and resources towards common goals • Development of leaders that engage in relational work and with the capacity to train others	• Deepen relationships between Care of the Elderly, Geriatric Psychiatrists and Geriatric Medicine subspecialists • Develop relationships with government and non-government organizations
2. Telling stories	Successful stories have three parts: • *story of self* • *story of us* • *story of now*	• Create compelling personal narratives about the importance of geriatric care • Shift the personal narrative to a collective identity with a shared vision for the health care system • Transform the vision into concrete plans

3. Strategizing	• Building strategic capacity through creating:
	  ○ Motivation
	  ○ Salient knowledge
	  ○ Learning processes
	• As a collective act
		• Build strong understanding of the political and organization context of health care
		• Develop internal learning processes to identify knowledge gaps and address them
		• Build strategic capacity with other organizations involved in the movement

4. Acting	• Obtaining commitments • Developing measurable outcomes with deadlines • Volunteer tasks are motivational • Provide coaching • Include contingency plans	• Develop the organizational infrastructure for the operationalization of strategic planning

REFERENCES:

1. Boyd A, Burnes B, Clark E, Nelson A. Mobilising and organising for large scale change in healthcare: 'The Right Prescription: A Call to Action on the use of antipsychotic drugs for people with dementia' [Internet]. 2013. Available from: https://dspace.stir.ac.uk/handle/1893/21381#.XNHfWY5Kg2w

2. Ganz M. Leading change. [Internet]. Handbook of Leadership Theory and Practice: A Harvard Business School Centennial Colloquium. 2010. 527–566 p. Available from: http://www.ncbi.nlm.nih.gov/pubmed/23431922

3. The Marmot Review. Fair Society, Healthy Lives The Marmot Review [Internet]. 2010 [cited 2019 May 8]. Available from: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

4. Sinha S, Griffin B, Reppas-Rindlisbacher C, Stewart E, Wong I, Callan S, et al. An Evidence-informed National Seniors Strategy for Canada Alliance for a National Seniors Strategy [Internet]. Toronto; 2016 [cited 2019 May 8]. Available from: http://nationalseniorsstrategy.ca/wp-content/uploads/2016/10/National-Seniors-Strategy-Second-Edition.pdf

5. Ganz M, Lin ES. Learning to Lead: A Pedagogy of Practice. In: Handbook for teaching leadership: knowing, doing, and being [Internet]. 2011. p. 353–66. Available from: http://leadingchangenetwork.com/files/2012/05/Chapter-8-Ganz-Lin.doc

6. Ganz M. Public Narrative, Collective Action, and Power. In: Accountability Through Public Opinion: From Inertia to Public Action. 2011. p. 273–89.

7. Ganz M. The Power of Story in Social Movements The Power of Story in Social Movements. In: Annual Meeting of the American Sociological Association. Anaheim, California; 2001.