INSTITUTE FOR HEALTHCARE IMPROVEMENT

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SUMMARY REPORT: 90-DAY PROJECT

Working with a Geographic Region on the Triple Aim

January 31 2010

Executive Summary:
The goal of this work is to help health care organizations work in a geographic region to make sustainable change around the Triple Aim. We started this project with several questions: Why work on the Triple Aim in a region? How would you define the boundaries of the region? Who are the stakeholders and how do you proceed once you have the stakeholders together?

Many organizations were interviewed and two sites were visited. A short description of these regions is included in the paper. A framework was proposed to work in a region that consists of four main parts: understand the context, relationship management, execution of strategic initiatives and regional infrastructure. A set of platforms/projects were identified that can be used strategically to build integration in a region: Medicaid and uninsured, public health problems like childhood obesity or mammogram screening, information technology, medical issues like chronic disease, health care access issues and community benefits that not for profit hospitals are required to provide.

The paper concludes with a list of Triple Aim organizations that are working on a region and the recommendation that the platform and framework need to be tested.

I. Research and Development Team:

- Leader: John Whittington
- Colleague: Tom Nolan
- Colleague: Samantha Henderson

II. Intent:

The goal of this work is to help health care organizations work in a geographic region to make sustainable change around the Triple Aim. This will involve at least three things: define the boundaries of the region, help the health organization understand how to engage and involve other partners and insight in to how to work together on strategic problems that will build reusable structure for the region.

III. Background:

IHI has been working on the Triple Aim since 2005. The idea was researched and developed initially in 2006 and 2007. We began working with teams in 2007. We started initially with 13 and are now over 70. We are completing the third phase/ year of this work.

Here are a few observations from the first three years of working with organizations from around the world. This observation will be helpful as we think about what else is needed to work in geographic regions.

During the year /phase one of the work some important principles were discovered:

1. There is a need to distinguish between the macro integrator for a population and the micro integrator for individuals.
2. It is possible to define a population and start to move the three aims for this population.
3. Many different types of organizations can act as the macro integrator for a population. One common denominator is good leadership and another is picking a population that makes good business sense to work on all three aims.
4. The Triple Aim (TA) gave organizations a way to consolidate work they were already doing and to communicate it to others.
5. The TA gave them influence in state or county health care initiatives that they would not otherwise have had.
6. We must draw a distinction between a TA project and the TA enterprise. Improvement projects will be important, but infrastructure; capability; and system measures to support the TA will be vital to success.

During phase two of this work we added more teams and learned the following ideas:

1. The Triple Aim was an important focus throughout the world. One English primary care trust shared this, “In the past before we started working with the IHI’s Triple Aim we were working on the Triple Aim but we worked on it this way, we would go to one meeting and discuss health, we might go to another meeting and discuss experience and we would go to a third meeting and discuss cost. Now when we have a meeting on any one item: health, experience or cost we make sure that we take the other two items into consideration.”

2. In both phase one and two we also learned that the problems with health care looked similar no matter where you were in the world. Countries all struggled with high cost drivers of health care such as new drugs and technology that had low or unproven outcomes for populations, and supply driven demand-if you build you will fill it. They also struggle with low quality drivers such as over reliance on doctors, undervaluing system design and not valuing enough the role of individuals and families in the health care system.

3. We learned more about the challenge of measurement and the power of it.
We spent a considerable amount of time working on measurement with the internal team along with an IHI fellow. The measurement set listed below was the output from that work. In addition we saw how measurement could catalyze entire communities. In East Lancashire PCT they used a measure of health to develop a campaign called SMILE, save a million life years. Through a series of projects and social marketing they appeared to be impacting their communities.

IHI is now nearly complete with year /phase three of the work on the TA.

During the three phases/years IHI has seen progress from organizations working with very small populations to a larger enterprise population and finally to a population in a geographic region. It is fair to say the organizations outside of the US have always had more of a geographic focus but they too are advancing their thinking. In response to this evolution of focus we designed our first four months of workgroups around four subpopulations: 65+, employed (under 65), complex patients and children and families.

During year/phase three we are learning:

1. That the Triple Aim continues to attract attention. Organizations realize that the Triple Aim is strategic; it helps them develop a set of simple organizing principles.

2. Some organizations are expanding their focus from small populations to regions. Some of the newer US sites that have joined in this phase came into it with a regional focus.

3. The Triple Aim can be used to tackle huge problems. During the 3 phases of the Triple Aim there have been worldwide economic changes. Right now our English PCTs who are part of the Triple Aim are facing some harsh economic times. They need to decrease or at least limit their growth in spending. We presently have one workgroup focused on removing 15% of the total cost of healthcare from a PCT while improving or maintaining the other two aims.

4. The Triple Aim makes sense to groups outside of health care. Within the prototyping community of the Triple Aim we have a subgroup that is led by the social agency Common Ground that works on ending homelessness.

5. Working in the Triple Aim community is now more of a challenge for the new organizations that have joined recently. Because of this challenge a TA navigation document was created. It highlighted the following issues:

A. The need to assess readiness for the work along with organization capacity and capability.

B. The requirement to establish aim and measures for the population that they are working on

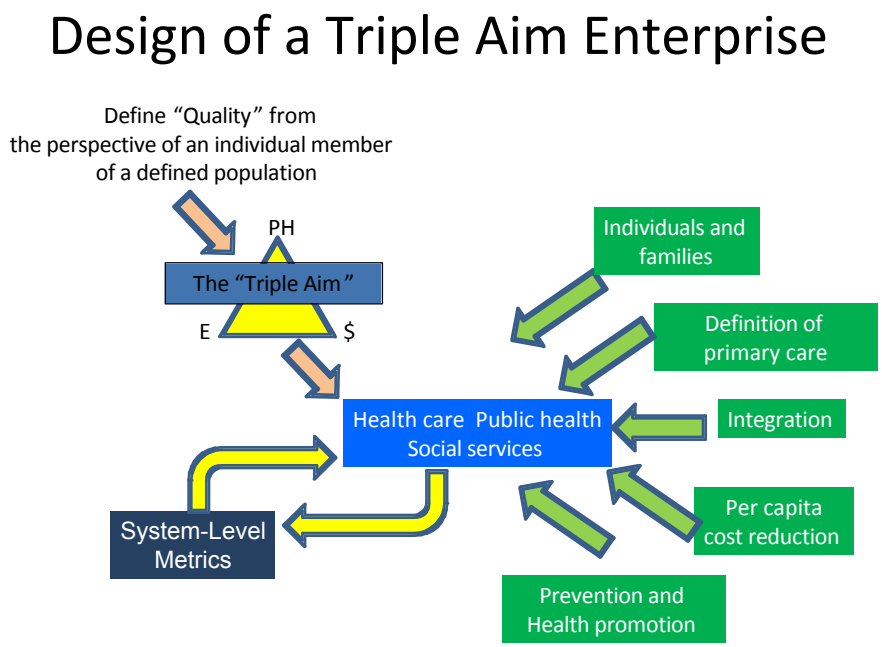
C. The need to organize a portfolio of projects in support of the Triple Aim for the population that they are working on.

D. The need to build a learning system that includes:

- System level measures
- Structure for periodic reviews
- Explicit theory or rationale for system changes
- Segmentation of the population
- Testing changes sequentially
- Learning from informative cases

- Learning from Scale-Up and Spread

The work on the Triple Aim during all three phases/years has successfully focused on a core set of concepts that can be scaled to small or large populations that the participating organizations are responsible for. The model below has been guiding our work for the last two years.



New challenges arise as organizations attempt to work outside the bounds of their own organization with other stakeholders on the Triple Aim. Principles to guide work in a geographic region are needed and possibly new models. There are many questions that need to be answered to help organizations work in a region. Certainly four that are at the top of list are: What would motivate a health system to want to work in a region? What are the boundaries for the region? Who are the stakeholders? What help do they need to work together on strategic problems that will build reusable structure for the region? (See appendix A for detailed list of questions for a region)

This paper will now focus on how to help a health organization that wants to work in geographic regions on the Triple Aim.

IV. Description of Work to Date:

The deliverables

- Support Carol Beasley as she works on HDTDT.
- Blend together the work of HDTDT and the Triple Aim in a region during this 90 day cycle.
- Work with and study three or four regions utilizing participatory action research. http://en.wikipedia.org/wiki/Participatory_action_research. We need to better

understand the three main questions: What are the boundaries of the region to work on? How will they engage others? What will they work on once engaged?
- Build change and design concepts that are needed to support a region based on the above research along with some of the principles developed by Don Berwick and Tom Nolan during the past R and D cycle.
- Work with David Kindig and begin to blend the knowledge he gained from the 23 essays on
  - Population health metrics
  - Real incentives for improvement of these metrics at the local level
  - Solid partnerships across multiple sectors necessary to make such incentives real and sustaining.

During the 90 day period Carol Beasley wrote a grant paper that blended together the work of the Triple Aim and HDTDT. This paper was submitted to the RX foundation asking for a grant to support further work on developing the Triple Aim in a region. The Triple Aim and HDTD work are communicating with each other and we have improved linkage between the two projects but further work is needed.

We were not able to work closely with three or four regions. However site visits and many phone contacts were made which will be discussed under results.

V. Results of the 90-Day Scan:

How a health care origination can work on the Triple Aim in a region.

We started this project with several questions: Why work on the Triple Aim in a region? How would you define the boundaries of the region? Who are the stakeholders and how do you proceed once you have the stakeholders together?

The following are some ideas that came from the IHI forum course by Tom Nolan and Don Berwick on why we should work on the Triple Aim in a region.

1. All the components that are needed to construct a health system are in a region.
2. Common values are more likely to emerge.
3. Solutions depend on context, and knowledge of context is more accurate locally.
4. Platforms for dialogue exist or can be created.
5. Other health determinants are attributes of a region.

One organization gave the following reason for working in a region:

"Mission-driven community health system; plus our health as a community drives our cost-- poor health status and uninsured population drive costs up for employers who then cost-shift or drop coverage resulting in more underinsured, resulting in poorer health status. We see an opportunity to intervene in this viscous cycle in our community as the major health care provider."

The following design created by Tom Nolan may help us as we think through the other questions.

Overall System for Pursuing The Triple Aim in a Region: Four Interacting Components

Understanding the context	Relationship management	Execution of Strategic Initiatives	Regional Infrastructure
1a.Process for making the political context (local and larger) explicit	2a. Process for establishing the intent to pursue the TA in the region	3a. Process for set-up	4a. Identifying existing resources or accountable organizations
1b.Plan for taking advantage of the strengths and weaknesses of the context	2b. Process for establishing and maintaining a coalition	3b. Method for understanding the system and developing a portfolio of projects	4b. Negotiating the new roles and responsibilities required by pursuit of the Triple Aim
1c.Process for recognizing and reacting to changes in the context	2c. Process for conflict resolution	3c. Process for testing and learning	4c. Capability and capacity building
	2d. Process for recognizing and reacting to changes in key individuals	3d. Process for review	4d. Information Technology infrastructure in a region for Improving population health
			4e. Governance structures

There are four parts to this model.

1 Understand the context.

Any work that is done in a region has a local context. The organization working on this needs a method to get at political issues in their community (appendix C), take into count the strengths and weaknesses and be able to monitor all of the above as they work together.

2. Relationship Management

Two things need to occur right away: Establish intent to pursue the Triple Aim in a region and build the coalition to accomplish this. The coalition needs a process to manage conflict and replace key individuals who will leave for various reasons.

3. Execution of Strategic initiatives

A process to set up projects that include people with adequate time to get the work done needs to be managed. Initially a coalition will likely start with one project but over time it should be managing a portfolio of projects. A learning system needs to be set up that includes testing, measures and a process for review.

4. Regional Infrastructure

If the Triple Aim is going to be pursued in earnest in a region, the infrastructure needs to be identified and used. In any given community there are actually many resources that could aid the pursuit of the Triple Aim. The problem today is they tend to be working in silos. The work here is to connect those resources and use them in a more coordinated way so identifying those resources and negotiating ways to use them is important. Building up the capacity and capability of individuals and the organization to execute this work is important. This will require development around the skills needed to do quality improvement work. A key piece for the Triple Aim in a region is developing information technology platforms and linkages throughout the region.

This model is designed to help us think through the issues that we face when working on the Triple Aim in a region. Marshall Ganz, who has done a lot of work on helping people organize, talks about five ideas that reinforce this model:

1. Enabling people to act together, Use narrative to bring out emotions and values
2. Building relationships
3. Developing organizing structures: team leadership, clear roles, clear norms
4. Turning shared values into action, focus on a few strategic priorities
5. Acting to produce results, Clear goals, specific and measurable

Here is an insightful comment from Jeffrey Brenner, MD, Executive Director/Medical Director Camden Coalition of Healthcare Providers as we think how we work in a region, “It takes a lot of time and one on one effort to build relationships with various stakeholders. It's important to deepen the relationship past the front line staff, the top leadership, or the usual community-relations folks. I think it's better to have a few relationships that are 1 mile deep than lots of superficial connections that involve one person coming to a meeting once per month. Just organizing the healthcare professionals is a full-time job and probably the best place to start. Then

it's possible to add other stakeholders as needed in project specific sub-groups. The best literature on this topic is in community-organizing. Look back to Saul Alinsky.

ER and hospital 'super utilizers' are a good place to start. No one is fighting for more homeless, substance abusing, alcoholic, mentally ill patients with heart failure, diabetes and cancer to come to their hospital or ER. They cost a lot to take care of and cause a lot of frustration for front line staff.

I think it's a mistake to pull together giant meetings with the staff/leadership from lots of different hospitals and agencies. They'll spend two years just building trust and getting started. There are too many egos in the room. Better to start small and add stakeholders over time. Success begets success, slow and steady wins the race, promise little and deliver big, win one supporter at a time, and organizing is a lot more than holding meetings. The real work gets done between meetings, behind closed doors."

He brings up a couple of good points about relationships and focus and introduces what we will call "platforms" for moving forward. He mentions "ER and hospital 'super utilizers', chronic disease patients, cancer patients, homeless, etc as a place to start working in a region because no one is competing to get more of this population. Population, initiatives and projects can be used as platforms by strategic leaders to build integration in a region.

The following is a list of regional platforms
1. Medicaid and uninsured
2. Public health problems like childhood obesity, or mammogram screening
3. Information Technology
4. Medical issues like chronic disease
5. Health care access issues
6. Community benefits that not for profit hospitals are required to provide

The following Triple Aim sites were interviewed or visited during this project. They have a regional focus at least in part. These do not represent all the sites that are working on the Triple aim in a region.

Chattanooga Tennessee

Erlanger Health System joined the Triple Aim during the last year. They joined as a coalition with the Chattanooga Tennessee Eastside task force.

The Eastside task force developed approximately five years ago from neighborhood organizations. There were concerned individuals in the neighborhoods who were motivated by the fact that they saw significant problems: high HIV rates, drug use and problems with infant mortality. They

wanted to focus on issues including: housing, health, youth, economics, and safety. They were able to get some grant funding to help the Eastside task force to carry out this work. Strong leadership existed along with a strong black church community. They focused on decreasing crime and at the same time increasing single-family ownership of residences along with other initiatives. Approximately one year ago Erlanger Health System started having discussions with this task force to explore ways they can mutually work together to improve the health of this community.

Greenville South Carolina

Bon Secours - St. Francis System is working to help improve the health of a neighborhood in Greenville South Carolina that is adjacent to their hospital.
This population has high utilization of the hospital emergency room. The neighborhood is an area of deprivation. There is a community task force that is working on improving this area. The Triple Aim team at Bon Secours - St. Francis System at last conversation was trying to understand the needs of this community.

Contra Costa County California

Contra Costa Health Services is an organization that has been with the Triple Aim since the beginning of inviting teams. Contra Costa is a county that covers 750 square miles in California. They divide their region into 4 groups: Western, Central, Eastern and Southern. The regions actually have different needs based on socioeconomic factors. Contra Costa has multiple initiatives in different parts of the county around various health issues. These initiatives are often grant funded from CDC or other sources. This funding although helpful leads to work that is done in silos because of the fact that the grant only allows work on the grant funded issue. The challenge is to take this work and build integration across the county. They would like to see IHI do more work around improving information technology in a region and also on models to help bring stakeholders to the table and keep them at the table.

Buffalo New York

Independent Health is an HMO in the Buffalo, New York region. They see an opportunity to work in a region collaboratively around the Medicaid population. The have had a coalition called P2 for a number of years that has helped with process improvement, information technology and funding of special work. As they begin to discuss working on Medicaid with other organizations there are two issues that they must deal with: anti-trust and getting adequate stakeholder involvement.

Santa Cruz California

Health Improvement Partnership Santa Cruz joined the Triple Aim during the past year. This region has been working together for some ten years. They started with a grant. They have a strong

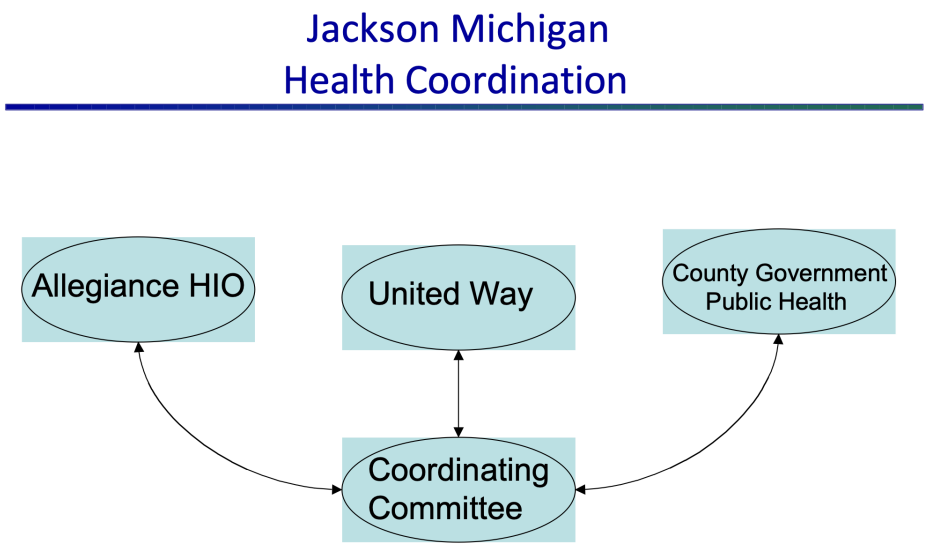
coalition made up of many stakeholders: safety-net organizations, hospitals, health foundations, emergency room partners and others. The initial work focused on providing universal health care access for children. Other projects that they have worked on are: Emergency room capacity, complex patients, childhood obesity, and regional information technology. They are a relatively low utilization area based on the Dartmouth Atlas.

Greeley Colorado

The Colorado Health Alliance has been in place for a number of years. The organization is located in Greeley Colorado. It began with a coalition of stakeholders: public health, federally qualified health center, and mental health. The coalition eventually formed a tighter union and formed the Colorado Health Alliance. The deployment of a common electronic medical record across all the partners helped the organizations learn about each other and this in turn helped build integration across the stakeholders.

Jackson Michigan

Allegiance Health joined the Triple Aim this past year. They are located in Jackson Michigan. Two years ago the health system explicitly stated that their goal was to help Jackson County be the healthiest county in Michigan. About 10 years ago Allegiance Health formed a health improvement organization (HIO). The HIO is a subcommittee of the board. However in any community there are other organizations that also are working on improving the health of that community. The diagram below illustrates groups working on health in Jackson Michigan



Several years ago members of the various committees: HIO, United Way, Public Health and County Government recognized the need to form a coordinating committee. The coordinating committee does not oversee the work in the other three groups, but does try to coordinate activities where it makes sense and at least inform each other of work that is going on.

VII. Conclusions and Recommendations:

We need to identify organizations to work with, provide faculty expertise and help teams test the model and platforms to accelerate their work in a region.

A. Identify Organizations to work with

We have the opportunity to partner with a large number of Triple Aim sites to test out the models and ideas in this paper. The following list of organizations in the Triple Aim are now planning or working on the Triple Aim in a region. In addition to our work with them, they are also pursuing regional activities that make sense such as the recent Beacon Community information technology grants and also position themselves to act as accountable care organizations (ACO).

1. Health Plans
Blue Cross Blue Shield of Michigan (MI)
CareOregon (OR)
Independent Health (NY)

2. Integrated Delivery Systems (w/ Health Plans)
HealthPartners (MN)
Martin's Point Health Care (ME)

3. Public Health Department
Washington DC Department of Health (DC)

4. State Initiative
Vermont Blueprint for Health (VT)

5. Integrated Delivery Systems (w/o Health Plans)
Allegiance Health (MI)
Bellin Health (WI)
Bon Secours - St. Francis Health System (SC)
Cascade Healthcare Community, Inc. (OR)
Cincinnati Children's Hospital Medical Center (OH)
Erlanger Health System (TN)
Genesys Health (MI) (Ascension)

6. Safety Net
Contra Costa Health Services (CA)
Health Improvement Partnership of Santa Cruz County (CA)
North Colorado Health Alliance (CO)
Primary Care Coalition Montgomery County (MD)

B. Select Faculty with Regional Expertise- three key individuals have been identified

C. Test the model and platforms – Encourage organizations to select a platform, work on bringing stakeholders to the table and begin the work in the region

VI. Open Questions:
1. Is there any region that has worked in a coordinated/intentional way to keep health care low in the US?
2. What are the big Antitrust Issues in a region?
3. What is the best way to proceed on IT for a region?
4. What model of payment reform will work best to support improved primary care?

VIII: Appendices:

Appendix A: Questions for a region

If an organization can figure out why they should try to work on the Triple Aim in a region, they will need to understand how they can do this and who should help them. The following is a detailed list of questions that may need to be answered:

1. How do you define the boundaries of the region that you will work with?

2. How do you build a collaborative community approach for the Triple Aim? What compelling reason will bring stakeholders together? How then do you bring key players to the table despite payment systems or other drivers which move people in the opposite direction?

3. If you can get them together, what should the organizational structure look like for that community? Assuming that each community has a unique structure, what principles should guide the design of this structure? Should you start working on payment issues right away?

4. What framework should you be using for this work? Is the present Triple Aim model sufficient or should other pieces be added to it?

5. What are the main challenges to keeping this structure united and moving forward?

6. How will you choose where to put your energy? Is thinking about population segments important?

7. What kind of assessments do you need for a community? When should you do the assessment? What should be included? What data is crucial for the work?

8. How does the community connect work that many of the stakeholders are doing individually with this overarching framework at a community level?

9. How do you make sure that the clinical community is participating in and helping to drive change?

10. What do you need to do to improve quality improvement capacity and capability at a regional level?

11. How do you avoid the Primary Care, Secondary Care, and Social Care battle and talk more about integrated approaches to health and health services? How do you pull wasted cost from one segment and move it to another?

Appendix B: Community Activation subproject
Samantha Henderson (shenderson@ihi.org)

Background

When a health organization integrator, such as a Triple Aim site, decides to work on improving the health of their community or region, the integrator rarely can do this on their own. Community-wide change by one organization alone must be extremely difficult, if not impossible, especially since community-wide antipathy or apathy can prevent effective and sustainable change. Also, one of the most helpful factors for community change is widespread buy-in, either across the community or among key stakeholders. Thus, integrators wanting to change health throughout their community would benefit from a partnership with at least one or more organizations. To form

these partnerships around regional health improvement and to gather the resources helpful for community-wide initiatives, the integrator must "activate" their community to become involved in the initiative.

For the purposes of this project, a community or region is loosely defined as a geographic area, often unified by government, a common identity, and/or shared infrastructure. Different organizations may have varying definitions for the community(ies) found in one geographic area. However, this does not matter for the purposes of this project; the integrator may define a community as they wish. In this project, community activation is defined as the engagement and use of community organizations, members, and resources toward an initiative or coalition.

Aims and Deliverables:

The original aims of this project were to:

- Investigate health organizations that are working on community activation
- Develop an approach to engaging community partners to support or implement change

This project is organized around Marshall Ganz's framework for change. This framework has five components:

1. Narrative
2. Relationships
3. Organizational structure
4. Strategy
5. Action

Community activation focuses mainly on the second component: building relationships and creating commitments to common purposes. Community activation draws on narrative as the motivation and the story behind these relationships, and organizational structure as the discipline and structure that holds the partnership together. This project focuses on community activation as building relationships, while the greater Triple Aim in a Region superproject offers a narrative and the Working in a Country subproject provides a start to organizational structure.

Deliverables:

- Description of existing community activation programs that health organizations have initiated – *Completed*
- Review of IHI programs working at a regional level – *Completed*
- List of the top ten resources to identify and gather key stakeholders – *Completed*
- Recommendations for the integrator to start, outlining key points of a community activation program – *Completed*

IHI programs that use community activation include Triple Aim Phase IV, How Do They Do That, STAAR, and IHS. IHI contacts from each of these programs were consulted for their input on deliverables, and their wishes were incorporated.

Organizations working on community activation include:

- Bolton PCT
- Common Ground
- Genesee County
- Eau Claire Coalition for Youth
- Independent Health
- King County
- Massachusetts Health Quality Partners (MHQP)
- Bon Secours – St. Francis

Recommendations for an Integrator to Start Activating Their Community:

It is debatable whether the first component necessary to activate a community is a) a specific need the partnership can work to meet, or b) partners with whom to work on regional health improvement. Needs can be identified by reviewing community data, particularly in comparison to similar communities. Needs are helpful to start with because it is relatively straightforward and easy to connect potential partners that have a demonstrated interest in the chosen need. For example, organizing the initiative around fighting childhood obesity suggests several partners with an obvious interest in children – parents, the education system, etc. However, selecting the idea too early can alienate potential powerful partners that are apathetic about the need. More importantly, the community often rallies around a need whose importance is broadly recognized. These needs are frequently identified by listening to community leaders ("grasstops"), organizations, and individuals ("grassroots"), which requires at least some exploration of potential partners.

An integrator can find potential partners for regional health improvement by contacting any previous or usual partners; these can be partners in business transactions, in previous initiatives, etc. Finding partners can be easy to start with because once they are part of the initiative, they can help direct the scope and direction of the work. The integrator can also find potential partners by understanding community demographics and dynamics; knowing key groups in the community can point to organizations linked to these groups that may be valuable partners for community-wide change. As mentioned above, partners may have strong beliefs or needs that can strengthen their commitment to the work, so long as their beliefs align with the initiative's purpose. Thus, needs are also integral to activating a community. Consulting partners and needs should be parallel processes, and it is most beneficial, for both the integrator's ease and the initiative's hopes of success, when each process can inform the other.

Potential Partners: List of Top Stakeholders in a Community

When attempting to activate the community, it is absolutely necessary to learn the circumstances of the actual community with which the integrator works. The dynamics specific to an individual community can be key levers in community activation. Below is a list of top resources to identify and gather key stakeholders for a regional initiative. This list is written from as broad of an angle

as possible, since creating too specific of a list here would hinder the complete evaluation of a community. The list was compiled with the input of several people experienced at community activation, as well as with the analysis of several existing community-wide initiatives.

This list is intended to act as a checklist of general stakeholder groups to trigger the thought process of an integrator using this list. Stakeholders #2-5 are meant to act as resources of other resources; these individuals and groups often know the community well and can offer valuable community-specific information. For example, an elected official (#2) or a journalist (#3) knows the key constituencies, visible community leaders, and the different stories of a community. This information can direct the integrator to previously unknown sources of influence and resources. Stakeholders #1 and 6-12 represent categories under which an integrator can find and activate organizations, individuals, and resources. Many of these are grouped under a common interest

1. Area health care organizations – A list of potential willing and able health care organization partners may include providers, hospitals, primary and specialty practices, long-term care facilities, behavioral health organizations, therapy services, payers, professional societies, hospital and other associations, non-profit organizations, local and regional departments of health, unions, etc. These organizations can be one of the richest resource groups, as they are likely to work with the integrator already and they have a vested interest in health care.
2. Local elected officials – They can connect you with or offer government support, and give guidance on the area's key constituencies. They will also have personal stories that you can tap into.
3. Journalists – They are familiar with the area's key constituencies and community leaders, as well as any non-profit, volunteer, or other organizations that may be able to contribute. They can also contribute to publicity efforts, especially if you build a relationship and feed them stories.
4. Chamber of Commerce – They can identify key employers or local/regional industry organizations that might sponsor a regional initiative. Chambers representing a population are a subgroup under this category.
5. Local government – Connection with the local government will provide access to infrastructure, services, and funding already available. Useful government departments include Health, Social Services, Council on Aging, Emergency Services, Transportation, Housing, Education, Justice, etc.
6. Education system – The education system – such as local public schools, community colleges, universities, workforce training programs – offer a focus on evidence as well as rigorous academic and other resources.
    a. Parents' associations – PTAs, PTOs, and other school-based parents' associations often represent a substantial portion of the community organized around a common interest – their children.
7. Interfaith and religious organizations – Religious organizations often are strong communities that are accustomed to mobilizing around service projects.

8. Local professional associations – Professional associations are already organized around a common interest; they can include different health professions but also lawyers, real estate agents, unions, and others.
9. Service organizations – American Red Cross, United Way, Boys' and Girls' Clubs, Corporation for National and Community Service, YMCA, Habitat for Humanity. etc.
10. Foundations –This site lists some national and local foundations: http://www.foundations.org/grantmakers.html.
11. National, regional, state/provincial associations or advocacy groups - This can be health or otherwise - Lung Association, HIV/AIDS, pedestrian safety, legal services, AARP, child advocates, ethnic organizations.
12. Local heroes – They can help draw attention to the initiative.

An integrator can choose which partners to activate in several ways. The easiest partners to recruit may be past and existing partners, as well as players with a clear self-interest related to the need or the coalition. These potential partners are likely to have low barriers to joining an initiative because they are familiar with working with the integrator or have a clear desire to do so. New partners can be identified by someone who knows the community "lay of the land." This facilitates inclusion of the community voice, which both uncovers the true needs of the community and brings widespread community buy-in. Even if widespread buy-in is mostly symbolic, the integrator should include as many stakeholders as possible. This deters opposing factions from forming and encourages others to join by creating an "everyone's doing it" sense. However, most of the work may be done with only a few partners behind closed doors, which is why it is important to cultivate deep relationships with a few partners. Finally, the integrator should ensure the initiative has any necessary or desired funding and resources by recruiting partners who can bring these resources to the table.