Institute for Healthcare Improvement

IHI Innovation Project Charter:
Working with Health Systems and Communities
Wave 39: June 30th, 2016

I. Research and Development Team:

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II. Intent & Aim:

IHI is increasingly working with communities and regions to improve health and health care. The intent of this 90-day project is to summarize what we have learned from IHI population level work with health systems and communities in order to improve our future work. The primary discoveries for this work will be gleaned from the past and present research and fieldwork of this team.

III. Background

Hospitals and health systems are really part of a broader "health and human service" continuum in a community that is co-creating health for a community. This continuum is not population management; rather, it is community health. Co-creation of health is really community development since it includes addressing the social and equity determinants of health. Taking that a little further, hospitals and health systems are in the business of community development and community benefit is actually community investment. Hospitals and health systems need to (1) invest in the communities they serve by redeploying organizational assets beyond community benefit and (2) partner with others along the way. Hospitals and health systems, at the same time, should not drive everything or try to control it all. In this paper we would like to describe some thoughts that will help health systems and communities work together.

In the article “Pursuing the Triple Aim: The First 7 Years” the authors shared a set of observations on this topic that are helpful and we want to summarize them and use their framework to organize this paper. They “describe 3 major principles that guided the organizations and communities working on this endeavor: creating the right foundation for population management, managing services at scale for the population, and establishing a

learning system to drive and sustain the work over time." The following is a synopsis of those ideas:

-The foundation is to identify and support leadership and governance that has a clear purpose to improve the health of specific populations.

-The second principle described as managing services over time requires a series of steps. First, there is a need to segment populations for deeper understanding. This will require identifying needs and assets of specific subpopulations. Based on this knowledge a portfolio of interventions will be created to support the work.

-The third principle was to create a learning system. This is based on the fact that the work is complex and it is necessary to learn your way through it. The items they included were:

"Using population-level measures.
Developing an explicit theory or rationale for system changes.
Learning by iterative testing (eg, Plan-Do-Study-Act [PDSA] cycles, sequential testing of changes, Shewhart time series charts).
Using informative cases to "act with the individual; learn for the population.
Selecting leaders to manage and oversee the learning system.

This paper is not meant to rehash those ideas but to build upon their work.

Lastly we want to remind the reader about the Health Affairs article on the Triple Aim in 2008[1]. In that paper the authors "suggest that three inescapable design constraints underlie effective accomplishment of the Triple Aim: (1) recognition of a population as the unit of concern, (2) externally supplied policy constraints (such as a total budget limit or the requirement that all subgroups be treated equitably), and (3) existence of an "integrator" able to focus and coordinate services to help the population on all three dimensions at once." These three design constraints are still important and need to be considered in the work that follows

IV. Description of Work to Date:

Our approach was to write this paper based on the combined observations from our joint authors' experience and fieldwork with communities and health systems.

We developed a series of 11 questions. (See open questions). We had time to work on questions 2,6,7,8,9, 10 and 11 during this cycle of research.

[1] Berwick D, Nolan T, Whittington J. The Triple Aim: care, cost, and quality. Health Aff. 2008;27(3):759-769.

V. Results

I. Foundation for population management

In the Pursuing Triple Aim article we discussed the observation that building a foundation for community work included a focus on population, governance structure and purpose. [2] Leadership, local politics and economic and human resources are also important basic areas to consider when working on the co-creation of health in a community. Let us start with some additional observations on governance, leadership and resources.

Governance

In working with a variety of communities, there seems to be a series of stages to governance in community health improvement work. The first stage usually starts at a fairly similar level in most communities with a group of interested organizations coming together to solve a particular issue or to work on a disease state. The group usually forms as a result of a reaction to an issue, data point, or some external pressure needing a collective response from the community. A smaller number of communities will take on a combination of issues together to begin their efforts, but most take on a single issue and expand based on necessity of linking a singular effort to broader community efforts.

These groups usually start informally, primarily driven by the health care sector including public health, and generally form organically. The groups start out with little authority to provide a collective response to the identified issue(s) and take the first period of time working on creating a level of trust amongst partners and looking at data. The number of groups and individuals who are initial founders of a community health initiative can vary, but in smaller communities, 5 to 15 members are common. Mid-size communities tend to have 10 to 30 members, and large communities can have over 70 groups in initial efforts.

Most of these groups call themselves “steering committees, ‘”task forces”, “working groups”, or other names denoting a collective effort, but a group lacking formality and often authority to make significant changes. It is not uncommon for the group to begin acting as a study group until formal authority is granted.

Few communities start with an official structure already in place where community health work is a natural fit. Communities with a natural convener tend to have a dominant player (person or

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[2] Whittington JW, Nolan K, Lewis N, Torres T. Pursuing the Triple Aim: The first seven years. Milbank Quarterly. 2015;93(2):263-300.

organization) in place who will drive the agenda of the community health improvement effort. These efforts will be more focused, driven by a specific agenda of the lead player. In these instances, the group tends not to be developed in an organic manner, but is populated with groups more prescribed to meet the needs of the dominant entity.

Both types of groups begin by planning collective action within the first year of convening. Groups that cannot reach this stage of action within the first 12 to 18 months usually collapse or fall back to being a networking group where there is minimal or no action. The ability for a group to move from problem "admiration" to creating some kind of agreed upon action steps is key to the survival of community health improvement efforts.

The time frame is similar for groups to begin to have authority to make decisions regarding community goals, resource allocation and alignment, and ability to collect and analyze data. In either the organic or dominant player types of organizations, if there is no ability to make serious strategic decisions or change how health is impacted in a community, the group will become a discussion group rather than a change agent. This is also the stage where executive leadership must be engaged if it is not already involved; executive leadership does not need to be directly involved in governance at any point in the development of a community health initiative governance structure, but executive leadership does need to give authority and responsibility to the group to make changes for both the short and long terms, including the ability to allocate resources to meet developed community goals. Lack of executive leadership support will cause community health improvement efforts either to collapse or be unable to make significant progress toward community health goals.

Within the first two years, most community health improvement groups reach a crossroads on the formality of the governance for their effort. Many groups will choose to move from a less structured effort to a more defined structure. This change is primarily done for two reasons: creation of a neutral convening entity who can serve as the backbone support organization for the effort, and to have a place where resources can be allocated to drive community health improvement efforts. The levels of formality vary, but the need to have a non-profit organization in place, while allowing for the organic nature of groups to continue to drive and lead community efforts, is a significant conversation that groups have

When a community decides to allow an existing organization to run the community health improvement effort, the hosting organization needs to make room to allow the effort to be more than just another project of the organization, and the governing group needs to ensure the hosting organization will allow a great deal of independence to the staff running the community's effort within the host organization. This is another breaking point for governance in community health efforts; when one group becomes too dominant or holds too much sway, groups will leave the

effort, diminishing the ability to spread community health work beyond a single (or a few) organizations.

In larger communities, structures can get unwieldy, even with significant structures in place with high level/executive leadership. These large community groups, while generally abundant in resources and ability to impact community health on a large scale, often find difficulty in creating a successful operational structure. Efforts in larger communities that do not continue to allow organic processes will become heavily bureaucratic and will also tend not to be as aggressive in pushing efforts at a pace needed to create momentum to significantly impact community health. Larger communities who have a superstructure to give guidance and resources and maintain the high-level community goals while giving on the ground groups the ability to move rapidly with support have had the greatest levels of success in large communities. (see appendix A for a 20-year case example of this work)

A word of caution; putting together a governance structure takes time. The governance structure moves slowly and does not tend to represent the underserved, i.e. you won't find many, if any, people with lived experience of various high needs populations on your committees. And it can get very tricky, particularly in the larger regions, to manage the governance structures. It takes a great deal of skill and energy to navigate the local politics of a community. In addition, the governance committee structure itself can directly impact the nature of the work and the value it adds to the community. All of these issues can impact any work that attempts to reduce health disparities.

Leadership

It seems that for almost any social endeavor, at some point leadership is important. All coalitions are difficult to manage because of the many self-interests, and a coalition that works on health improvement will be large with many self-interested parties. We have said in the past that the clear purpose is important, [3] and we still agree with that, but we want to highlight now the need for community leadership. So what kind of leadership do we need when no one really has oversight of the whole process, such as improving the health of a community? What characteristics may help them be effective? There is not one clear answer, but from communities that we have worked with who appear to be making progress, there are some general trends. The leaders are generally long-term residents of the community. They have vision for something better than what they are presently experiencing. They appear to be committed for the long haul. They usually are aware of a compelling health issue to support a community coalition. They have

[3] Whittington JW, Nolan K, Lewis N, Torres T. Pursuing the Triple Aim: The first seven years. Milbank Quarterly. 2015;93(2):263-300.

the ability to influence others to help them see the need for this work and to garner their participation in the work. One leader said, “You need to create a vision of inclusion and understanding of the critical nature of community engagement and learn to “let go” and allow priorities to emerge organically.” Good leaders seem to understand the local politics of a community: Who is it that needs to be part of this work for it to succeed? Who might want this work to fail? and How do we build the trust that is needed over time?

Leaders will face a challenge with patient urgency: the need to navigate the productive tension between demonstrating the patience required to engage people/get the community involved while at the same time keeping the project/initiative moving forward. Quick wins are needed to build momentum and get people to believe in what they are doing.

Resources

The final foundational issue is resources, both human and financial, to support this work.

“There are hundreds of coalitions across the US that are actively focused on improving some aspect of the health in their community. To maintain their work, they need resources, either through in-kind donation or money… There are some underlying assumptions that we hold that will influence this discussion.

1. In most communities, there are large amounts of resources that are already present in the community for improving health.
2. These resources are not being used as well as possible in a coordinated fashion.
3. There are few to no population health outcome measures attached to the present money flow, whether for health care, public health, social services, or community redevelopment, etc.

To support the work of a community health improvement system, you need money and in-kind resources to do two things. One is a relatively small amount to support core infrastructure for the committee itself, “the backbone organization,”[4] and two is a larger amount of money to fund the portfolio of projects it supports. ”[5]

Many community coalitions are supported through a variety of funding streams. Two common ways they are supported would be the sharing of personnel from the various members of the coalition and grant support. Even though various members of the coalition may have significant financial resources, the coalitions generally have limited money. Grants have a particular

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[4] Collective Impact | Stanford Social Innovation Review". Ssireview.org. Retrieved 2016-07-06.

[5] Whittington JW, Mate K,Laderman M. Sustainable Financing for the Triple Aim in a Community September 30, 2014 IHI Innovation Project Final Report

problem in that they are limited and often topically focused. It is better to have sustainable funding. One community we worked with in central Florida had converted a not-for-profit health system into a for-profit and received approximately 200 million dollars. This created a sustainable fund that they were using to support work on the Triple Aim. This type of sustainability gave them a predictable revenue stream to work with each year. We are not suggesting the conversion of not-for-profits to for-profits but we are encouraging exploration of sustainable funding. For more on this topic, we suggested the IHI R and D paper, "Sustainable Financing for the Triple Aim in a Community."

II. Managing services at scale for the population/Creating a portfolio of work to support subpopulations

In the Pursuing Triple Aim article we described assessing the population's needs and assets, using that knowledge to create a portfolio of projects, redesigning services to meet the population's needs, and delivering those services to those who needed them.

One of the biggest assets of any community is the many community-based organizations. Based on our work with communities, we have a set of thoughts regarding them that are pertinent to this work:

1. Communities have an abundant number of community-based organizations (CBOs) tackling a wide variety of social issues with little to no coordination between them.

2.True co-production with those with lived experience isn't happening well in communities. CBOs often still frame the issues and theories of change through the eyes of the practitioner or funder.

3.The CBOs generally have limited knowledge of the total needs of the community, i.e. how many people could use their service. And they may not have thought through how to reach scale, i.e the total number who could use this service. Grant funding may lead to this problem because CBOs receive grants to provide services for a specific number of individuals and not for all who could use that service.

Zero:2016 is program in 75 communities to end chronic and veteran homelessness by December 2016. It is a nice exception to the above generalization. They focus on real time, person specific data on everyone who is homeless in a community (aka By Name Lists) This allows them to track performance and know when a community will get to functional zero. At least 4 communities have reached that goal at the time of this writing.

4. No mechanism in the CBOs to identify those at highest risk for significant social/ economic problems.

5.CBOs often measure activity and not outcomes.

6. CBOs generally have limited quality improvement skills. Their focus is on implementing programs and not learning their way to an implementation.

7. The community coalition will need to add value to the work of the CBOs. That may come in the form of quality improvement training and support, coordination among CBOs, new financial resources and supporting the data needs of the various portfolio activities.

One other observation that deals with subpopulations is the fact that often as a portfolio of work is put together for a community, those with lived experience do not inform it. For example, when working on ending veteran homelessness, consider involving some homeless veterans in the design of the work.

III. Establishing a learning system to drive and sustain the work over time.

In this final section, we want to make a few comments based on observations from the use of a learning system: outcome measures, system changes, quality improvement support and oversight.

Money flow in a community is not determined by improvement in outcomes. There is no direct link between the health of a community as measured by big outcomes and the flow of money in that community to CBOs or public health or health systems.

Communities have lots of data. It tends to be scattered. No one person or organization is generally taking responsibility for it. We helped one communith to think through a Triple Aim dashboard of measures. This mainly relied on publicly available data. In another community, we helped them create a community-based scorecard on poverty. This required a lot more support since organizations were required to submit data.

Again, using the example of Zero: 2016, their advice on measures is “Be clear, public and relentless about what it means to end veteran homelessness early on. Politics will creep up and attempt to roll back your attempts at data rigor-- you have to believe that the way you measure

matters. As you think about measurement, here's your North Star: based on your definition of zero, will people who are experiencing homelessness believe we have ended homelessness?"

The following are all observations related to quality improvement:

> Quality improvement jargon doesn't mean much, therefore we need to strip down the terminology to the most simple terms, e.g., 'System of Profound Knowledge' to 'Four Lenses of Curiosity."
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> Teaching of quality improvement has to be able to adapt to the situation and resources of CBOs.
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> Because many CBOs are very small organizations, the desire is to provide them with the minimal content on quality improvement that will require the least amount of time, but still help them make progress. That necessary minimal content is unknown at this time. We have been teaching about: charters, PDSA cycles, run charts, driver diagrams and using open-ended client interviews.

VII. Conclusions and Recommendations:

In this paper we shared observations from our work with communities and health systems that are working to improve the health of their communities. This content will be used to support our work with the State of Michigan.

There is a complementary paper written by Mara Laderman that specifically focused on questions 8 and 9 below that deal with IHI roles and opportunities to work with communities and health systems.

VI. Open Questions:

1. How can we help communities and health systems develop an appropriate measurement strategy? Communities tend to have a lot of data but are information poor.
2. How do we engage community-based organizations in this work? How do we train them on quality improvement and actually do the improvement work?
3. Communities tend to be resource rich with service organizations and coordination poor. How do we help with coordination?
4. True co-production with those with lived experience isn't happening in communities. Communities often still frame the issues and theories of change through the eyes of the practitioner or funder. How do we change this dynamic?

5. Health systems are developing tools to identify complex patients who are at high risk for future high health care costs. The communities lack tools to identify other high risk situations such as high risk for unemployment, homelessness or dropping out of school, etc. What tools could help identify these individuals?
6. Readiness assessment has been a big part of the SCALE initiative. How should readiness assessment be part of any future community work?
7. Putting together a governance structure takes time, and the value of this remains unclear. The governance structure often moves slowly and does not tend to represent the underserved. And, the larger the region becomes, the more complex things can get. It takes a great deal of skill and energy to navigate the local politics of a community. All of these issues can impact any work that attempts to reduce health disparities. Given this, how should we think about governance?
8. What is IHI's role in working with communities? What should we do and what should we not be doing based on our strengths and weaknesses? What defines a community and where does IHI engage?
9. What stages does IHI see in the development of community health improvement work? What stages are most ripe for IHI to be inserted (and leave) in order to best move a community forward in health improvement?
10. What partnerships can IHI make with other entities working with communities and health systems?
11. What are some key issues to consider in working with communities, including mitigating the perception that a community is being "learned about" or experimented on?

VIII: Appendices:

Appendix A: Case Study from Central Oregon involving St. Charles Health System (SCHS) and communities of Bend and Redmond Oregon

In the 1990s, both the independent hospitals in Bend and Redmond were actively engaged in community health activities, sponsoring health events, serving on local and regional committees and task forces looking to contribute to improve health. Both organizations were collaborative with other community, taking careful pains not to be viewed as over bearing, paternalistic, or prescriptive. That approach is indigenous to the Central Oregon cultural. There were two main attempts fostering cooperation and collaboration: (1) Central Oregon Network of Hospitals (CONet), comprised of the seven independent hospitals in Central and Eastern Oregon and (2) Central Oregon Health Council (COHC), a multi-sector volunteer partnership convened to identify health gaps in Central. CONet nurtured trust between hospitals and ultimately served as the impetus for the merger between the Redmond and Bend hospitals in 2001. The work of the COHC ultimately led to the identification of the need for the residential behavioral health

treatment and subsequent construction of Sage View Residential Behavioral Health Center at SCHS in 2002. Incidentally, Sage View was originally a partnership between SCHS and Deschutes County Mental Health. COHC continued to convene and meet regularly through 2007. In 2006, Health Matters of Central Oregon, the regional health collaborative, was formed to address the high uninsured rate in the region.

In 2008, the successor to COHC was created—the Central Oregon Regional Health Authority, a loose collaboration of former COHC members and several additional partners. Examples of partners were SCHS, the FQHC, county commissioners from the three counties, public health, mental health, the local health plan, the large multi-specialty private clinic, the IPA, and some community citizens. The Authority carried on the purpose of the original COHC, fostering trust and relationships between the many partners. SCHS serves as a convener and funder of the Authority's activities. Eventually when John Kitzhaber, MD was elected governor again in 2010 and Oregon's version of health reform was announced (post-ACA) involving coordinated care organizations (CCO), the Authority was converted to a 501c3 Central Oregon Health Council. The second edition of COHC was constructed to serve as the multi-stakeholder body, the purposes of which was to be the governing body of the Central Oregon CCO. Representation on the COHC was unique in the state. It was the only CCO governing body which had equal representation from multiple stakeholders involved in health care and including representation from the general public—specifically, end users of the state's Medicaid services. For example, SCHS held only one seat on the 13-member board of COHC despite the fact that SCHS was the recipient of 50% of all expenditures of the Medicaid population in Central Oregon. The primary goal of the one member, one vote rule on COHC was to engender trust and collaboration between all parties. It was critical for SCHS to create a forum and structure that welcome and supported community engagement and multi-sector participation in the co-creation of community health in Central Oregon. This was important because it allowed full participation and generated "buy-in" to decisions affecting the health and welfare of the communities. It was never the purpose to "force decisions on what's in the best interest of the communities from the perspective of SCHS—or from health care providers for that matter." This approach was consistent with SCHS' philosophical orientation.

Observations from this case study

1.There needs to be a catalyzing agent or facilitator willing to bring together disparate and competitive partners to the greater good. And, the catalyzing agent must be willing to invest forward to underwrite the work of the collaborative venture. This was SCHS.
2.There needs to be a leader who creates a vision of inclusion and understands the critical nature of community engagement.
3.The participants (representing the communities, must own the process, work, and outcomes—success or failure. Failing forward is an acceptable outcome.

4.One person, one vote, one voice. There can be no prima donnas in the process.
5.All participants, including HHS, must check their egos and interests at the door and think about the best interest of the community.
6.Trust is key. Conversations must be open and transparent, respectful and collegial. No secrets and no surprises. Surprises erode trust and can kill a partnership.
7.Find common ground with as many partners as possible and use that to build experience and cooperation.
8.Relationships matter. Only very mature partnerships can survive the change of key players.
9.Always have a meaningful agenda for all meetings; don't waste people's time.
10.HHS are not the center of the universe; the community is—make that clear.
11.Listen well and listen deeply; HHS should practice WAIT: Why am I talking?
12.HHS must be generous with their assets, being willing to redeploy assets for the betterment of the community versus retaining them on the balance sheet.
13.HHS should spend 3X the required community benefit amount.
14.Create an innovation fund to foster and support new and innovative ideas coming out of a community partnership.
15.HHS should learn to "let go" and allow priorities to emerge organically.