Institute for Healthcare Improvement

Wave 39: IHI's Role in Working with Communities to Improve Health

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Background and Aim

IHI has been working with communities to improve health and health care for nearly a decade. During that time, the work has matured and evolved, and as such, IHI now works with communities who are in different stages of maturity and who are focusing on a varied set of issues related to improving health. Some Triple Aim communities have been working with us for several years and have demonstrated strong results. In other communities, the work is new and on broad topics that reach even further into the community to address the social determinants of health, and IHI is trying to understand what can and cannot be achieved. That will take time, but prior to expanding that work, we must maintain a level of skepticism and observation about what works and what does not in pursuit of results at scale in these communities.

The aim of this inquiry was to better understand IHI's current, ideal, and future role in working with communities. Below are the themes from conversations with IHI staff and faculty who have been deeply involved with designing, executing, and evaluating IHI's community based work, particularly the IHI Community-Based Improvement Initiative: Brandon Bennett, Ninon Lewis, Kevin Nolan, Amy Reid, Marie Schall, Soma Stout, John Whittington, and David Williams. These themes also incorporate learning from the April 20-21 meeting for the IHI Community-Based Improvement Initiative (formerly Triple Aim in a Community) faculty and all-community meetings. Interviews focused specifically on understanding IHI's role in community work in the past, present and future – what IHI has learned from previous community-based work, what IHI is currently doing in communities, what IHI's ideal role is, challenges, health care's role in community work, and stages of development in community work and where IHI fits. Note that there may be some recency bias in these interviews given the current work in the three Triple Aim in a Community sites and SCALE, and the fact that some of the interviewees are newer to the community work.

While there were many areas of consensus, there were several topics for which there was disagreement about how IHI should proceed. In short, these areas of disagreement are around: 1) inclusion and exclusion criteria to determine which communities to work with; 2) the scope of IHI's role and where we enter working with a community, such as in coalition-building; 3) whether IHI should bring in faculty with content expertise or rely on community members; and 4) the role of health care organizations in participating in and funding community work. Finally, based on these interviews, we identify some potential market opportunities for IHI to work with communities going forward.

Definition of Community

IHI's community work has primarily defined "community" using geographic bounds, such as a city, county, or region, and is generally defined by the community and its governing bodies based on the desired outcome of the initiative. Individuals in a community are not all part of the same system (e.g. health care, schools), but these institutions generally serve the same population. There is generally no size constraint; the Triple Aim team has worked with as large a group as 14-15 counties and as small a group as a community district in New York City (which is somewhat larger than a neighborhood), though one interviewee cautioned that a large city such as New York City or several blocks in one neighborhood would be too large and small, respectively. The program then works with a sub-population (e.g. mothers

and their babies) within that geographic area. This is a shift from defining a community solely by a sub-population such as age, gender, or health status (e.g. diabetes patients). The consensus from interviews is that the geographic focus is working well, as long as the geographic definition does not impede the ability to do the work. Key features of an appropriate community for engagement with IHI are:

1. The participating groups are working on a common aim.
2. They have some sort of leadership structure or some means for organizing, which may or may not be formal. Note that organizing is different than governance structure for the effort.

IHI's current role in working with communities

IHI currently plays several key roles in our work with communities. The consensus among interviewees was that IHI is able to differentiate itself from other organizations working on health improvement through a combination of the Science of Improvement, improvement methods, learning system development and support, and convening multiple stakeholders from across the system.

- *Building quality improvement capability*. This is the most unique and core part of IHI's work in communities. Teaching community-based organizations and individuals about how to use improvement science, systems thinking, and measurement strategies to design and execute their work and to build up the community infrastructure. This includes providing ongoing coaching in improvement and serving as a QI partner in execution.
- *Convening and connecting*. Facilitate collaboration and provide opportunities for community-based organizations or individuals to come together, build relationships, and share ideas and resources. While relationship-building is often assumed to happen by simply bringing organizations to the same place and encouraging them to meet one another, more intentional facilitation of connections and relationship-building is needed. While IHI is good at bringing disparate parties together and serving as a neutral convener and facilitator, this is not unique to IHI and there are many organizations who can perform this role.
- *Creating and supporting a learning system*. This includes running collaboratives, supporting a learning network such as SCALE, and creating a platform for sharing tools and knowledge across participants. It also includes supporting data and measurement collection and analysis within the community. There are a few key components to an IHI-supported learning system in a community: 1) development and use of population-level measures; 2) development of an explicit theory or rationale for system change; 3) learning by iterative testing, e.g. PDSA cycles; 4) using informative cases; 5) learning during scale up; 6) development of a management system where data and cases are reviewed every 90-120 days. An important up-front role for IHI as part of the learning system set-up is to help teams examine their data over time, look at trends, and push them to make connections with local people to get the data that they need. Key to this is making connections with the local individuals and organizations with data so the community does not rely on IHI to collect and analyze their data.
- *Bringing focus and ambitious aim-setting to community health priorities.* Community-based organizations are often trying to do a lot at once; IHI helps coalitions select priorities and identify where to start. IHI can support the development of ambitious aims that can only be achieved through development new systems, not just working harder and faster.
- Bringing new ideas and content expertise on a specific topic (see challenges below).

- Supporting the creation of a movement to improve health within a community.

These are activities IHI currently engages in that could use additional development:

- *Support with building a community's governance structure*. Governance is always an issue in community work and IHI can help organizations improve the effectiveness of their governance.
- *Strategic planning and guidance*. One interviewee noted that IHI should playing a more strategic role in communities, similar to relationships with Strategic Partners, helping communities set aims and measures.

IHI's ideal role in working with communities and success factors

The consensus is that our current role – namely, working with community coalitions[1] on building improvement capability, convening, and building and supporting a community-wide learning system – generally seems to be the right one. There are some key success factors that can help keep IHI engaged in its ideal role (inclusion criteria):

1. *IHI needs to have a core role in the work*. This means that IHI is included in design, strategic planning and decision-making, and as a QI partner, not serving solely as teaching faculty or planning learning sessions in isolation. The further IHI is from where the work happens, the less value we can add. This means that an ideal role for IHI includes a significant amount of time interacting in-person with leadership and teams. While the level of engagement should be different for each community, a general rule noted by one interviewee is that the less QI capability a community has at the outset, the more involved IHI should be.
2. *Be explicit with communities about the use of the science of improvement*. IHI needs to be explicit with organizations that we are using the science of improvement as the backbone of the project, and the community must have an interest in using the methodology.
3. *Prioritize 1:1 work with communities* (vs. running a learning system for multiple communities). Doing the 1:1 consulting-like partnerships will be more effective if we're going to get deep results with a community, given the high degree of individual coaching that is necessary for success. The Triple Aim collaborative taught the team that a collaborative was not the right mechanism; teams needed more time and more tailored coaching for their particular environment, which was more than IHI could provide in that format. The success of 1:1 work depends on how much they understand improvement and how much their governance structure is set. One interviewee noted that if a learning system was set up with sufficient IHI staff time to provide individualized coaching to each participating team/community, then it could be successful; thus, the key aspect here is the need for individualized, tailored coaching.
4. *There should be a set of expectations and, perhaps, some inclusion and exclusion criteria, around deciding which communities we work with.*[2] There was some disagreement about what IHI

[1] IHI works with coalitions of community-based organizations, not directly with community members. While IHI encourages inclusion of individuals with lived experience as part of these coalitions, our engagement is with the CBOs/coalitions, which are not always completely representative of the communities they serve.

[2] The IHI team should consider developing a set of decision criteria to evaluate new opportunities to work with communities on improving health.

should not be doing, particularly around working when we do not have content expertise, such as poverty. Some interviewees believe that we must bring content expertise in addition to QI expertise, while others believe that relying on the community to bring content expertise is sufficient and thus that we should not rule out opportunities in content areas where we do not currently have expertise. Several interviewees noted that IHI should try and stay away from coalition-building in the absence of any existing organization and, in particular, trying to bring together a group of organizations that has not historically collaborated. However, this was not a consensus view. Communities that are poorly organized continue to get left out in grant-making opportunities and in community health improvement plans. If we come with the approach that you have to meet certain criteria for it to make sense for IHI to engage, we leave out people who are in the greatest need of support.

These factors should influence our decision about what work to pursue with communities. They could include:

1) Consider where we want to be working: on building will and ideas or on execution. If execution: work with communities who have a strong governance structure and partnerships already in place to build on, so they can move quickly to execution rather than ideas. This was part of the criteria for SCALE communities.

2) Connections with leaders on several different levels, including a point person / day to day leader who is not the most senior leader.

3) Community-based organizations (CBOs) need to have QI expertise or be willing to learn QI as part of our work with them.

4) Need a really compelling topic that touches on multiple social determinants, like poverty.

Some red flags for when IHI should consider not pursuing work (exclusion criteria):

- Getting marginalized in a niche role that isn't strategic, such as just being a teaching faculty or an ad-hoc advisor.
- IHI should never be contracted as just the "capability builder".
- If part of the role for IHI is to try and force collaboration in a dysfunctional community and serve as a mediator or referee.
- Coalition building and organizing community partnerships and trying to convene people who traditionally haven't been convenable, particularly since IHI does not have knowledge of local issues, history, and politics. However, while we may not want to do coalition building ourselves, it is frequently a key part of this work. Thus, we need to partner with people who do bridge-building and negotiation, conflict management, to help bring coalitions together when needed.

Out of the box ideas for an ideal role for IHI given gaps in the community (from Brandon Bennett):

- *IHI could act as an escrow account.* There are times when diverse actors in a community need to come together and pool resources. They're not always sure of how to do that, be it financial resources or others. Facilitating that for small organizations who don't always have the infrastructure necessary to have a joint pot of money. IHI could front the money if there needs to

be a large capital expenditure and organizations could pay into it. IHI could act as a collector and distributor without having to assume any financial risk.

- *IHI could serve as a resource repository of people*. Organizations could purchase people's time from IHI while they go about recruiting someone for a position, which can take some time. IHI helps with coaching, etc. and have a stable of people – faculty or internal staff – who could be lent to an organization for short periods of time. Right now, faculty works much less intensively (low dose) comparatively and in this scenario, they'd be an on loan full time staff person.
- *IHI could serve as a measurement resource*. Community-based work really struggles with measurement, and while we coach and teach them about measurement, we can also be the infrastructure for that at times. IHI could provide the platform and expertise on measurement selection and the human resources to do some of the early data collection.

Challenges in Working with Communities

Not surprisingly, there are numerous, diverse challenges to working with communities. Several interviewees expressed concern that some of these challenges will limit our ability to see results in the allotted time frame. Themes from conversations about challenges include:

- *Very low QI capability in community-based organizations*. Individuals working with community-based organizations are often starting from a much more basic level with QI skills than in our work with health care organizations. Getting them up to speed so they can actually make improvements with the amount of time we can spend with them is a huge challenge. One interviewee is concerned that we're under-dosing on the science of improvement, teaching people about it too loosely through short engagements. Individuals' ability to practice that in their community-based work at the front line is very low, and there is little bench strength within the community to support improvement. The dose isn't high enough for them to understand how the science of improvement can help them or to practice it in a way that lets them be successful.
- *Data collection and measure identification.* This includes logistical challenges of obtaining data that make up measures and the perception among many individuals in CBOs that data is collected for a funder report or for evaluation or judgment rather than for improvement. Big measures such as secure attachment and school readiness are difficult to define, and there may be different perceptions of what success looks like, particularly when it takes such a long time to see movement in the overall measures and aim.
- *Lack of ability to give individual support to each team*. Given the number of teams participating in these large initiatives such as POINT, it is just not possible to give each team individualized support, but teams often greatly benefit from individualized coaching.
- *Setting aims.* In the current Triple Aim in a Community work, some communities don't have a clear operational definition of the outcome of interest and they do not yet have "how much, by when" aims. They know where they are heading and have set a direction, but don't have a specific aim yet. Projects need a broader aims to work towards, with associated sub-aims, which currently are not in place in all communities. Selecting a topic that isn't too specific, but also is manageable. Additionally, if the impact is questionable – too narrow a topic, or they're not being

bold in their aim, even if they choose a very high impact topic, our ability to get results may be diminished.

- *Lack of content expertise*. This is one area where there were significant differences in opinion among interviewees. IHI is not an expert in some of the other social determinants of health and we haven't always been asked to provide the content expertise, such as in the NYC Early Years work. Additionally, teams have relied on community members for content expertise, such as in the POINT work, which has its pros and cons. A challenge here that is different than health care improvement work, particularly in the poverty reduction work, is finding a content expert who has improved the system and not just researched it. Recruiting relatively open-minded content experts who recognizes the complexity of the space they're in and is willing to try and find a problem. But, a content expert is an essential team member.

- *Perception of IHI's role*. Some communities have a long history of people coming from the outside and telling them what works. The work has to be wholly owned by the community, and IHI has to be viewed as a partner rather than as a consultant or experimenter. IHI needs to consider the vocabulary we use ("test bed") in health care and how that might be perceived in the community who may feel that they are being experimented on.

- *Bringing in community members with lived experience*. It can be difficult to find people with lived experience who feel confident enough to become an advocate and be on an improvement team, or to be able to take time off work to attend a learning session. The notion that lived experience = expertise or evidence is new. There should be at least two community members.

- *Sustainable funding.* Sustainable funding is always an issue at the community level; CBOs can do short-term fundraising and find grants for different projects. For such large societal issues with as poverty reduction or childhood readiness, the work will last for many years; CBOs will need a sustainable funding structure in place to support this ongoing work. Health systems could come in here – they have a lot of money, including community benefit dollars.

Health Care's Role in Community Health Improvement Work

IHI often comes to community work through our relationships with health systems who realize the need to engage with their communities in a cross-sector, Triple Aim effort. Health care has to be a partner within a cross-sector approach; if the aim is to improve health, then health care has to be a part of that effort. While the level of engagement depends on the aim (for example, a community might take on an aim with high relevance to a hospital like infant mortality; since they count pre-term births, it will be very hard to get the data and get results without the children's hospital on board), and on the health system's priorities, health care has to be at the table in some way. In most cases, health care organizations are generally a partner at some level in community work and are "just another team".

Some interviewees would like to significantly enhance health care's engagement given their power in communities, because they are large employers, potential funders, have responsibility for a proportion of health-related outcomes, have QI capability, and can set an example for other community-based organizations. There are many well-meaning health systems who don't really understand how to work with the community, for a variety of reasons. Because of health system competition in an area, they often don't collaborate, so that can be a barrier. Some CBOs have a poor impression of health care based on previous experience. The role health care plays depends on the existing relationships they have within the community, and historically with community partners. It also depends on the level of

commitment of the health system being involved in population health at the board level of the hospital, and if they're ready to move from care delivery to addressing social determinants to serving as a core partner in community health improvement efforts. Now that not for profit health systems are required by the IRS to complete a Community Health Needs Assessment (CHNA) every three years to identify and prioritize the health needs of the communities they serve, health systems are learning more about their communities and beginning to expand their scope to partner with CBOs to take on some of these larger issues.

Engaging health care organizations outside of large hospitals and health systems is key in community work to improve health. Health care happens in the community outside of the places where IHI has traditionally had good relationships and strong knowledge, or where we have traditionally partnered or worked, such as public health clinics, women's health clinics, schools, AIDS services, and naturopathic providers, to name a few.

Stages of development of communities working to improve health

One aim of this project is to understand the stages of development in community health improvement and to understand where IHI fits in. Interviewees agreed that IHI's most significant role is at the beginning, getting the system set up properly, building improvement capability, and bringing all the partners together. The earlier that IHI can be involved in any community-based work, particularly in the design, the higher potential for success. IHI can be most effective when improvement has been designed into the work at the get go. Interviewees agree that IHI can't just run a series of collaboratives and then leave; there needs to be more of a partnership relationship in the community.

After the initial front-loaded work, there should be a plan to transfer it to the coalition and their governance body. The Triple Aim 10-point scale, a milestone-based approach to identifying where a community is on key competencies such as governance, aims, learning system, QI capability, and demonstrating effectiveness in different areas, is a good framing for thinking through the stages of work. Some interviewees see IHI's role as tapering off considerably after 1-2 years of work, while others wondered whether we should commit to multiple years until certain aims are achieved given the scope and complexity of the aims, understanding that IHI's role may move to a more advisory role as people's ability to use improvement methods in their daily work becomes stronger.

Another key question is when IHI should leave a community. There should always be a plan to leave at the outset. There may always be a place for IHI to have a connection, but understanding when our role starts and ends will be important for future work. Based on interviews, this could be when the community and IHI deem (criteria TBD) that there is enough capability built so they can continue on their own; when they have a stable governance structure; when they have been able to execute against a couple of portfolio items; they have a robust, ongoing measurement system; and they are thinking at scale.

Proposed stages of community work:

- Understanding of current state of the system and identifying problem they are trying to solve
- Coalition-building and organizing
- Engagement of leadership in the recognition that they can accelerate their work by using QI skills and by learning methods like learning sessions, etc.

- Building improvement capability and a learning system
- Prototyping → Piloting → Implementing
- Seeing results from that work with the initial communities
- Scaling up positive results. How many in their population have they reached with initial effort and how capable are they to scale that up so they can reach even more people in their target population? (e.g. children in South Bronx, families in Summit County).

Areas for Improvement and Open Questions

- Adapting and tailoring our work. How do we make QI pragmatic, accessible, and help people without academic backgrounds and computer skills to use it? How can we simplify our work? What is the core QI curriculum for a community? There is an opportunity for IHI (which the team is already working on) to identify the minimum set of starter tools that can help people, such as simplifying the number of chance concepts from 72 to 7, or focusing on 7-10 improvement skills that are really helpful and accessible, like process mapping, simple line run charts, and PDSA cycles. There are also lessons to be learned from work in Africa where they have simplified QI training.
- What is the right dose of improvement methods in a community setting? What do we have the bandwidth to do? What is the right pace and when should the points of contact be to build improvement capability among all participants?
- How does IHI put together a team for community work? To ensure our credibility in community work, the team composition has to be different than our usual team for health care-based work and should include individuals with improvement experience outside of health care to ensure that multiple perspectives are represented. This includes improving the diversity of the team members who work on community-based projects.
- Give better guidance around establishing aims for communities working on complex issues and being able to identify what measures would be appropriate for those aims. Big aims are important for people to be motivated, but it's important to figure out what the number is. A lot of communities never stop to say what achieving the big aim means.
- Develop faculty with expertise in different content areas re: the social determinants of health.
- What is our approach in a community where there is no governance structure set up? What are the implications for what we can hope to achieve in a certain time frame?

Market opportunities – where can IHI move in the future?

- Develop and execute a learning system with a select few communities to demonstrate results – to provide more proof of concept that quality improvement methods and systems thinking can be deployed to address a complex community health need and get communities farther than they can go without it. The learning system design would require a high level of IHI staff and faculty time to provide the requisite level of individualized, tailored coaching to teams, content tailored for community work, and a diverse team to deliver the content.
- Develop a strategic partnership with a community.

- Develop a program to deliver tailored QI capability-building content to communities. In isolation, this is unlikely to bring about results (KP 4, changes in outcomes), but it could be a program to increase knowledge and perhaps some changes in behavior.