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### Take-Home Advice from Community Initiatives Improving Health & Equity

Georgia Health Policy Center

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**Communities**  
JOINED IN ACTION

*Improving Health – Eliminating Disparities*

## **Take-Home Advice from Community Initiatives Improving Health & Equity**



### **A CJA UPDATE: MONITORING THE NATIONAL LANDSCAPE**

March 2016

The path towards achieving significant improvements in population health and equity can be winding and bumpy. Yet, thousands of communities are currently moving forward on their important journeys. These regular updates, produced by Communities Joined in Action (CJA), are intended to provide usable, take-home advice that can accelerate communities' efforts to towards achievement of better health and well-being for their population.

Neither catalysts nor community organizations are alone in their interest in making measurable changes towards health system transformation. A number of philanthropically funded initiatives recently launched to bring together multisector collaborators to test innovative ways to achieve improved health measures for all people. Additionally, government-funded efforts, such as the 65+ initiatives launched by the Center for Medicare and Medicaid Innovation Center, focus on testing new payment and service delivery models.

By sharing successes and challenges from others doing similar work across the country, CJA hopes to give communities useful perspectives and inspiration to accelerate achievement of their intended goals. This update highlights the wisdom of 10 leaders of catalyst initiatives, as well as insights gained from their experiences in working with community initiatives across the country.



## COMMON THEMES EMERGED FROM INTERVIEWS WITH CATALYST LEADERS.

### CJA IDENTIFIED OPPORTUNITIES FOR LEARNING AROUND THE FOLLOWING AREAS:



## IDENTIFYING SUSTAINABLE FUNDING

Sustainable funding is a key piece to ensuring innovations in health system transformation can get off the ground. Often times, initiatives need to seek diverse funding sources for long-term sustainability.

*“Finding infrastructure capital is critical. It’s not just typically one source of funding that will provide that base for your organization, so you have to understand blended funding streams and how you can weave them together to support your efforts,”* says Brenda Leath, from Pathways Community HUB Institute. Given that many HUBs are working with underserved populations, Leath says creativity is often required to craft a viable funding model.

This creativity needed to expand an organization’s funding base may require nontraditional partnerships.

*“Some of this requires tapping into organizations or industries that are not typical partners of community health collaboratives,”* explains Annette Pope, from Communities Joined in Action. *“This requires a common agenda and a common language. Community health collaboratives must understand what’s important to hospitals and other payers and in turn hospitals and other payers must understand what’s important to the community.”*



## GLAVANZING STAKEHOLDERS

Engaging the right partners requires more than just a common goal. Alignment of strategies, investments, and incentives are all necessary to develop meaningful collaborations capable of addressing multifactorial determinants of health and to achieve meaningful health improvement.

*“Local impact requires involvement from across sectors and must reach those deeply embedded in the community,”* acknowledges Debbie Chang, from Moving Health Care Upstream (MHCU). Chang recalls one of her team’s struggles with how to position adverse childhood experiences and toxic stress to key stakeholders. By working with the Building Community Resilience workgroup at MHCU, the partners are creating a shared understanding of adverse childhood experiences and toxic stress not as new areas of concern, but as social determinants that are woven through many chronic and preventable health conditions.

*“The Building Community Resilience approach brings those parties and voices from across sectors to the table as part of an overall strategic approach to address the determinants that threaten the health and well-being of children and families,”* Chang explains.

*“It has been a challenging journey as clinicians begin to recognize the uphill road ahead in building meaningful and purposeful relationships with community members and support organizations. But, we have learned that creating shared understanding is a necessary first step in helping clinicians understand their role in addressing those upstream factors that exist well outside the clinic or hospital walls.”*

Getting clinicians to think about upstream health factors is one part of health system transformation. An even broader network of engaged stakeholders is necessary and their incentive to participate in population health efforts may not always be clear.

*“We really have to fundamentally redesign the system, structures, business, and relationships that are embedded in our current system,”* says Laura Landy, from ReThink Health. *“When you move into this transformation space, you actually have winners and losers. This is going to change how we allocate resources so that people are healthier and they don’t end up in the hospital as much. Some of the amount of money that is now going to support health care has to go to building housing and education and all those social determinants of health that we don’t do as well as some of the other countries do. So the questions are: Who do you get involved? What authority do they have? What is their obligation to their organization versus stewardship and shared responsibility for the health of the community, the state or the nation?”*



## SHARING INFORMATION

Attracting collaborators and funders requires data. Data can also be used to drive informed policy and programmatic decision making based on demonstrated health needs. But, sharing information can also help communities learn from each other, such as providing each other evidence of what interventions or approaches work in given types of communities.

For example, a number of state-level stakeholders were instrumental in sharing data that inspired Ohio legislators to appropriate funds to support certified HUB development.

*“The HUB model is a good one and has proof of its use as an evidence-based practice that has had major impact on moving from volume-based payments to value-based payments,” says Brenda Leath, from the Pathways Community HUB Institute. Leath says that as a nonprofit her organization could not lobby for the legislation, but her group has used the policy to create opportunities for further HUB development. “We now have a pipeline of HUBs that are currently in process for being reviewed for certification. It was a snowball effect and the legislation had a lot of influence in fostering additional interest, but everybody wants to know what works and what works well. So it is important to be able to promote the demonstration of initiatives.”*

The Wellville team in Oregon used comprehensive local data to articulate a compelling case for investing in the emotional well-being of children. Comprehensive local data was used to create a pitch to local funders and the region's school committees about the long-term value of an intervention to improve student mental health and resilience. The Wellville team highlighted the devastating impact of adverse childhood experiences on a significant number of the county's children and the specific benefits of addressing this issue based on success in neighboring states.

*“Their business case made an emotional appeal, and also provided compelling data on the benefits of reduced disciplinary incidents, increased attendance, decreased need for Individual Education Plans and other special education costs, and better outcomes for students,” says Rick Brush, CEO of Wellville, sponsor of a five-community, five-year health challenge. “The expected benefits would allow the intervention to be self-funding after three years, producing net benefits to the education system afterward.”*

According to Brush, the team has implemented a trauma-informed care approach in one school and is pursuing wider implementation, while exploring other expected benefits including increased employability and reduced health care and juvenile justice costs.



## MEASURING PROGRESS

Data is also key to measuring an initiative's progress. Ensuring that communities have the capacity to monitor and evaluate their programs results in the development of tailored trainings and tools specific to addressing community needs.

*“People are not used to using data and measurement for their own improvement. They are used to using data, as part of summative evaluation, after the fact that they have to report, but they are not necessarily using it as something that drives their own immediate goals and improvements,” acknowledges Soma Stout, from SCALE. “Our approach is a combination of education, coaching, and tools to make it easier and more attractive for people to measure and to learn and to use it to drive their own improvement goals in real time. Instead of saying ‘What are you going to measure?’ we say ‘Whose life is getting better here and how do we know that?’”*

In addition to driving improvement and goal attainment at the community level, catalysts rely upon data and measurement to assess whether their initiative is meeting the needs of the communities they assist. Laura Brennan, from the Pathway to Pacesetter Program (P2P), says their evaluation team is currently assessing: the readiness of P2P communities; how their readiness changes overtime; how P2P contributes to community readiness and capabilities.

*“Understanding these questions, will help us adapt and spread the P2P program to meet the needs of communities and promote health, well-being, and equity throughout the nation,” Brennan says.*





## MAINTAINING ADAPTABILITY

Organizations must balance the need to focus on strategic goals, while maintaining the ability to be adaptable on the ground to a changing environment, community feedback, or evaluation data.

Leslie Mikkelsen, from the Prevention Institute's Community Centered Health Homes (CCHH) program, highlights the institute's ongoing learning to improve its approach to bridging the gap between health services and community prevention.

*"Recognizing that it takes time to institutionalize this new way of thinking and doing across health care organizations, we are learning that a dedicated CCHH manager or coordinator is uniquely positioned in a clinic to interface with diverse staff and teams to help reinforce our approach," Mikkelsen says. "The institute is working on translating and refining models, strategies, and tools to advance community prevention in the health care system. We are delving deeper into learning what it takes to support and implement CCHH on the ground. We are mining the field for lessons from clinic-community initiatives to hone in on the barriers and levers to accelerate this paradigm shift."*

Soma Stout, from SCALE, illustrates how including people with lived experience at the table alongside coalition leaders is a critical part of maintaining adaptability in decision making processes.

*"We had been working with a community based organization that focuses on youth unemployment and food insecurity. As they went through the process of creating driver diagrams and figuring out how to localize on a rapid cycle, there were some significant episodes of violence in the city. They realized they could focus all of their efforts on these real needs, but if they didn't address the more prominent concern around safety, they couldn't achieve their ultimate goals," Stout explains. "So they broadened their mission to take on livable neighborhoods. So, a big part of what we are trying to say is don't spend all your time, don't spend a year in planning. By all means take a step back and look at what needs to happen but then set those aims and then begin to try them out in the world and see what makes sense and what doesn't make sense to move forward."*



## FOCUSING ON UPSTREAM HEALTH DRIVERS

The term health system transformation still conjures images of the care delivery, despite the increasing recognition that socioeconomic factors are real drivers of health and wellness. Leaders of community health improvement efforts are aware that a broader view must be employed that includes an expansion of "health" stakeholders to include representatives in the fields of housing, education, transportation, economic development, and city planning—all of which will need to play a role in supporting a system that supports keeping people healthy and safe.

*"The moments that signify the most progress towards this goal of addressing all of the factors that influence length and quality of life have been when I've seen communities move beyond saying that social and economic factors are important to truly doing something about it," says Julie Willems Van Dijk, from County Health Rankings & Roadmaps. "Community leaders are open to learning and taking new, and often uncharted, paths to connect with each other."*

Willems Van Dijk recalls when a public health department listened to the community and declared low high school graduation rates as the top public health priority. The public health department then worked with leaders from business,

education, and other community organizations to deploy strategies that raised that the rate of high school graduation from 60 to 80 percent in just six years.

Often players in the health care delivery system are aware of these inequities in health and social well-being, but the drivers are deeply entrenched in under-resourced communities. Debbie Chang, from Moving Health Care Upstream, discusses her organization's Building Community Resilience (BCR) workgroup's efforts to address deeply entrenched inequities in health and social well-being. One of five BCR teams is working to build resilience in an underserved Texas neighborhood that has been in steep decline.

*"Over the course of 30 years these three-zip-codes lost more than half its middle class, leaving behind under-resourced neighbors who lack access to public transportation, well-staffed schools, banking, and the simple luxury of well-stocked grocery stores. Left unaddressed, it is factors like these and other social determinants (such as community and domestic violence, substandard housing conditions, racism, and unemployment) that add up to toxic stress," Chang says. "Using BCR as an organizing platform for health practice, policy, and social change this community initiative, in partnership with the local children's hospital, is developing a place-based network of child health practitioners, community-based organizations, childcare providers, and social service agencies to build resilience in the neighborhood and among residents. There is a growing recognition that these upstream drivers need to be addressed in order to help children, families, and communities grow up healthy."*





## ENSURING STAKEHOLDER READINESS

Transforming the health system is no easy job and while stakeholders may be willing, they may not be fully ready to align strategies and investments under a collaborative's common agenda.

*"One of the biggest challenges that communities face in advancing their health journey is when they believe that financial resources are the solution to their problems," warns Julie Willems Van Dijk, from County Health Rankings & Roadmaps. "Of course, money is important, but it will never take the place of teams who have clear direction, alignment and commitment around the goals they are striving to achieve. And often, the process of creating trust and shared purpose identifies resources within the community that can be used to support their efforts."*

All organizations have faced funding challenges, but the concepts of multisector collaboration and health equity are new and often daunting. Stakeholders working together must work to balance their own organizational agendas with the priorities of the collaborative. And while, both might state they share the end goal of wanting to improve the health of the community, aligning individual and population needs is a challenge.

Karen Minyard, from Bridging for Health, shares her experience of working with early-stage collaboratives around the concept of stewardship.

*"We shared this definition of stewardship and what stewardship means with groups that were already action," Minyard recalls. "It was a not just an individual insight or a group insight, but many of the people in the room started using stewardship language. They were already thinking about if they have the right people at the table and how they should build this way of thinking among their partners. It began to change the way they think of their organization and their role in that organization."*



## UPHOLDING VISION AND FOCUS ON INITIATIVE GOALS

Transforming the health system requires a shift in mindset among stakeholders. While it is important to remain adaptive in a rapidly changing environment, organizations must balance the need to uphold the focus on the long-term vision and initiative's goals.

*"One of the challenges in institutionalizing our Community-Centered Health Homes (CCHH) model is expanding the mindset and culture of health care from individual treatment to include community-wide health. While there is increasing recognition of the importance of addressing the community factors that impact health, it takes multiple touchpoints for health care providers to become fully grounded in the CCHH model and its upstream approach," says Leslie Mikkelsen, from the Prevention Institute. "We have found that starting with where they are in improving clinical quality and reframing this to include community prevention at every step has allowed them to broaden their view from a focus on a single diagnosis or disease*

*to understanding what factors in the community environment are driving poor health outcomes in the first place, and then identifying partners in the community to address those conditions."*

But, sometimes it is easier to focus on short-term milestones than to maintain a long-term focus on system-wide transformation.

*"We cannot in this country point to what we would call a transformed community. They don't yet exist," acknowledges Laura Landy, from ReThink Health. "There is this sense of burnout when things get difficult. You also have some of these earlier improvement stages. If you do a great diabetes campaign and you reduce diabetes by 10 percent, everybody says hooray and then they're done and they go home. But, it dispels the energy and the momentum that could have gone from that point to a higher, bigger purpose around how you realign the behavior, business models, and to actually change the system."*



## THE CATALYSTS

### Bridging For Health: Improving Community Health Through Innovations in Financing

Bridging for Health is fostering connections among diverse stakeholders to align investments in health to achieve improved population health outcomes. This is done through focusing on innovations in financing; collaboration and collective impact; and health equity. The Georgia Health Policy Center is the national coordinating center of the initiative, supported by the Robert Wood Johnson Foundation.

### Community-Centered Health Homes

With Community-Centered Health Homes, the Prevention Institute outlines an approach for community health centers to promote community health, as they deliver high-quality medical services to individual patients. The research-informed recommendations provide steps to achieving improved outcomes through the population health intervention model including: inquiry (collecting data and forming partnerships), analysis, and action.

### CJA—Communities Joined in Action

CJA is a national, private, non-profit membership organization with nearly 200 members representing a variety of public and private organizations, all committed to improving health, access to care, and eliminating disparities in their communities. CJA mobilizes and assists these community health collaboratives through its ability to broker important dialogues and to convene stakeholders. The Georgia Health Policy Center is the administrative home for CJA.

### County Health Rankings & Roadmaps

County Health Rankings & Roadmaps provides a reliable source of local data to help communities identify opportunities to improve health. The annual Rankings measure vital health factors to provide a snapshot of how geography influences health. The Roadmaps provide guidance to understand the data and strategies to move towards action. The program is a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

### MHCU—Moving Health Care Upstream

Moving Health Care Upstream tests, shares, and accelerates population health innovations. The focus is on helping clinic systems go upstream. While the lens is children and families, the work applies generally to communities and learnings will be available on an open source platform. MCHU is funded by The Kresge Foundation with additional support from the Dorris Duke Charitable Foundation.

### Pathway to Pacesetter

The Pathway to Pacesetter program is the result of the 100 Million Healthier Lives and the Spreading Community Accelerators through Learning and Evaluation (SCALE) teams' efforts to identify simple, scalable, affordable ways to make meaningful technical assistance available to all communities. The Pathway to Pacesetter program will support over 100 communities in accelerating their improvement journey.

### PCHI—Pathways Community HUB Institute

PCHI is the certifying agent of the Pathways Community HUB model of care coordination, which connects payment to the value of services provided and actual improvements in health outcomes. HUB Certification ensures an accountable and sustainable community care coordination system that leads to better health and lower costs. PCHI is supported by The Kresge Foundation, in partnership with the Community Health Access Project, Inc. and the Rockville Institute.

### ReThink Health

ReThink Health works with communities to help them foster catalytic leadership and test innovative ideas for bridging and redesigning their health and health care systems to achieve system-wide change. ReThink Health envisions a "healthy health system"—one that bridges stakeholders from across the community by focusing on the critical domains of active stewardship, effective strategy, and sustainable financing. At the core of its approach is the interactive ReThink Health Dynamics Model. The Ripple Foundation and the Robert Wood Johnson Foundation fund ReThink Health.

### SCALE—Spreading Community Accelerators through Learning and Evaluation

SCALE is the first community-based phase of the 100 Million Healthier Lives initiative. The goal of SCALE is to equip communities with skills and resources to achieve significant community health improvement, to ultimately close equity gaps. The 20-month SCALE intensive involves partnering of "pacesetter" and "mentor" communities. SCALE, an Institute for Healthcare Improvement initiative, is funded by the Robert Wood Johnson Foundation.

### Wellville

Wellville is a national, nonprofit organization helping communities accelerate better health and financial outcomes through entrepreneurial zeal and data-driven accountability. Currently, five communities around the U.S. have committed to a five-year challenge to make significant, visible, and lasting improvement in measures of health and economic vitality. Collectively, these initiatives could lead to big improvements in the lives of the people who call these communities home.



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