M3: Improving Community Health: Pathway to Pacesetter - 100MHL

Soma Stout  Rishi Manchanda  Paul Howard
Marie Schall  Kate Hilton  Ziva Mann
Laura Brennan

Sunday, March 20, 2016 | Mini-course
2016 Institute for Healthcare Improvement Summit

Agenda

12:00 PM Welcome, Introductions & Overview
   The Power of Partnerships
   Leading from Within: Guided Meditation
   Ready, Willing & Able
2:30 PM Break
2:45 PM Mapping Community Assets
   Leading Together / Leading for Equity: Engaging those with Lived Experience
4:00 PM Break
4:15 PM Leading for Outcomes: Making Change Easier - Switch
5:30 PM Close
Objectives

After this mini-course you will be able to:

- Assess where you are on your journey to improving health in your community.
- Develop skills to accelerate your improvement journey toward health, wellbeing and equity at the community level.
- Engage community members with lived experience.
- Use "switch" and asset-based thinking to identify opportunities to make your journey easier and more joyful.

No Disclosures

Reminder: We ask you to adopt the “Ways of Being”

- Share your experience
- Practice “Yes…and” vs “Yes….but”
- Stay curious
- Respect time
- Expect to experience varied emotions
- Show up, CHOOSE to be present
Our Focus

- Leading for equity
- Leading for outcomes
- Leading together
- Leading from within

Relationships, Process, Results

- Results
- Relationships
- Process
Questions That Drive Our Work

Relationships:
- How can I engage & partner with stakeholders, including “people with lived experience,” to build a community of solutions?

Process:
- Regardless of my role, what can I do to facilitate real transformation in the health and wellbeing of people, systems and communities?

Outcomes:
- Whose lives got better because we were here? How will we know it?

Equity:
- Who isn’t thriving in terms of their health and wellbeing? What will it take for that to change?
My Journey Toward an Integrated Approach to Community Health (AKA Failing Forward)

My Journey in Health and Human Services

- 4 years working in a homeless shelter, doing homeless street outreach and running a program for homeless people with a mental illness, chronic substance use issues and HIV/AIDS
- 2 years doing advocacy work to affect public policy for homeless people, people living with HIV/AIDS and people with mental illness
- 2 years leading performance improvement for human services programs
- 3 years doing resource development and fundraising
- Masters in Public Policy
- 5 years doing housing development, community economic development and communications
- 6 years doing system level consulting work
My View at the Start of My Journey

I can make the biggest difference by learning how to best help each person experiencing homelessness

My View Changes

I can make the biggest difference by learning how to improve the programs helping people experiencing homelessness
My View Changes Again

We can **end homelessness** by improving the **homeless system**

My View Changes Yet Again

We can end homelessness by improving the **homeless system**

**and tackling the failures in other systems**

**that lead to homelessness**
My Current View

We can ensure community health and end health disparities by developing and improving an integrated community health system

Why We Need to Tackle the Problem Differently?
Health and Human Services Industrial Complex

- Nonprofits are concentrated in low-income communities
- Number of such non-profits rose by 33% from 2002 to 2010
- There have never been more organizations devoted to addressing poverty and health in low-income communities
- We spend over $230 billion each year in the U.S. on programs to address poverty and health
- Effect of non-profit concentration in low-income communities on poverty and health outcomes?
Our central insight?

People’s experience of poverty and health is:
- Fluid
- Connected
- Multidimensional

The systems that respond to poverty and health are:
- Rigid
- Fragmented

What is badly needed?
- A System that reflects the way people experience the problem(s)

Ok, That Was Depressing, but What should we do about it?
Adopt the Broadest Definition of Health
(If you haven’t already!)

Definition of Health

Health is a state of complete physical, mental, and social [and spiritual] well-being. It is not merely the absence of disease or infirmity, but the addition of confidence, skills, knowledge and connection. Most importantly, it is simply a means to an end — which is a joyful, meaningful life.

Adapted from the definition of health used by the Institute for Healthcare Improvement / World Health Organization.
Work to Design a System to meet the full range of needs of your community's residents!

(notice that “system” doesn’t contain an “s”)
What’s a Complex Challenge?

Complex Challenge - a social situation that meets the following criteria:
1. The situation is **emergent**
2. There is a **constant flow of information** to negotiate
3. Actors are **constantly adapting their behavior**

Source: Hassan: The Social Labs Revolution

Ok, But Why is this distinction needed?

We have designed our planning, work and evaluation processes as if improving community health is like baking bread....
But they are more like...

Raising Children

Use Agile Problem Solving (APS) Mindsets and Tools

To Tackle Complex Challenges
Cultivating a Growth Mindset

Embracing Failing Forward
Propelling a Bias Toward Action!

**Improvement Science**
- Harness the power of a good goal
- Use PDSA Cycles
- Use Data for Decision-making and Improvement
- Embrace Iterative processes
Human-Centered Design

Use the three phases of Human Centered Design, Inspiration, Ideation and Implementation

- Listen for and capture the needs, desires, habits of the people you serve
- Create solutions that respond to those needs, desires, habits.

Leadership in Complex Systems

- Use adaptive leadership techniques
- Build effective, cross-disciplinary and cross-sector teams
- Tackle the things you can influence (not just those you can control)
- View everyone a “ChangeMaker”
Building Movements

- Get everyone to “row in the same direction”
- Use behavioral economics and social psychology to influence behavior of movement participants
Assess your Coalition’s Experience in....

- Leading health improvement initiatives
- Meeting the goals of your health improvement initiatives
- Leading multi-sector, multi-sector collaboration around health
- Leading complex change (i.e., managing multiple initiatives to achieve one or more goals)
- Using data and metrics for improvement
- Applying quality and process improvement methods
- Spreading a pilot program from one neighborhood, city or region to another
Assess your Coalition’s Experience in....

- Spreading a pilot program from one neighborhood, city or region to another
- Including community leaders to serve as champions
- Building a stable and effective governance structure
- Sharing information reliability and getting feedback from the broader community
- Creating and sustaining joy and motivation among your coalition members

Potential Areas for Growth and Development

- Leading from within, i.e., developing personal strength, reflection and resilience
- Leading others, i.e., fostering effective relationships, facilitating meetings, growing others, leading an effective team
- Leading for improvement, i.e., creating robust plans, using data, testing and implementing change, failing forward, collective impact, etc.
- Governance strategies to achieve greater impact
Potential Areas for Growth and Development

- Implementing change more effectively, i.e., methods to make change easier and more joyful
- Governance strategies to achieve greater impact
- Implementing change more effectively, i.e., methods to make change easier and more joyful
- Creating sustainable transformation
- Applying effective strategies to close equity gaps

Improvement and Implementation Skills

- Setting an aim (a measurable "how much, by when" goal w/ metrics)
- Mapping and activating community assets
- Developing a theory of change (identify and sequence building blocks for sustained change)
- Thinking in systems (how to see the community as a set of connected, interacting structures and processes)
- Improving effectively (i.e., getting the results you want)
Improvement and Implementation Skills

- Designing an effective innovation
- Tying metrics to improvement goals
- Engaging community members meaningfully in the design process
- Scaling and spreading an improvement
- Testing fast, failing quickly
- Sustainability planning

Is your healthcare system upstream ready?

Rishi Manchanda MD MPH

@RishiManchanda
Our healthcare workforce is asking for help

“I’m a primary care pediatrician in [a rural county]. Highest teen preg rate, meth addiction, high school drop out rate... Many more issues.

Understand upstream approach for years. Try my best but falls by the wayside as I don’t have resources - No help, city/county overwhelmed.

Patients lost to follow up- I’m seeing over 30 a day. How to manage? Would like to discuss.”

Social factors account for 60% of premature death & impact the Quadruple Aim

Proportional Contribution to Premature Death

- Genetic predisposition 30%
- Environmental exposure 5%
- Health care 10%
- Behavioral patterns
- Social circumstances 15%

But only 1 in 5 MDs have confidence to address them

Robert Wood Johnson Foundation
“Health Care’s Blind Side” December 2011
Outcomes
• Less effective interventions
• Preventable illness
• Health disparities

Costs
• Wasteful spending
• Opportunity costs
• Avoidable utilization

Provider Experience
• Eroding Professionalism
• Poor recruitment & retention
• Burnout

Patient Experience
• Frustration & Helplessness
• Costs of Care
• Distrust

No social determinants integration = No Quadruple aim

I get it.
Population health is important. Everyone’s talking about social determinants.
But how do we do this?
1) Get Ready
Assess the maturity of your business processes & environment related to social determinants of health

2) Get Set
Improve engagement and planning among colleagues, key stakeholders, and community partners

3) Go Upstream
Launch a targeted Upstream Quality Improvement (UQI) initiative
Get ready:
The Upstream Readiness Assessment

As part of a healthcare system’s population health strategy, this self-assessment tool is designed:

- to help you understand your organization’s readiness to integrate efforts that address “upstream” social determinants of health.

- to engage key stakeholders in your organization, in your network of healthcare partners and payers, and among current and future community partners

Before you start

1) Find a buddy
Doing an upstream readiness assessment alone is not effective. And it’s no fun.

2) Identify a population
Is there strong agreement within your organization about the need to advance the Quadruple Aim for a specific population? Start there. Be precise.

3) Get out of the building
Jumpstart your understanding of social determinants by interviewing 5 patients in your target population. Need help? We have scripts.
### Upstream Readiness Assessment

<table>
<thead>
<tr>
<th>Question</th>
<th>Limited or unclear</th>
<th>Moderate</th>
<th>Robust</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the <a href="#">environment favorable</a> for your organization to address social determinants of health?</td>
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<tr>
<td>2. What's the <a href="#">perceived value</a> of a change to assess and address social determinants of health?</td>
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<td>3. Do you have <a href="#">executive sponsorship</a> to advance social determinants interventions?</td>
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<tr>
<td>4. How established are <a href="#">team roles and ownership</a> for your social determinants intervention(s)?</td>
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<tr>
<td>5. How well defined is (are) the <a href="#">scope</a> of your social determinants intervention(s)?</td>
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<tr>
<td>6. How <a href="#">well managed</a> is (are) your social determinants intervention(s)?</td>
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<tr>
<td>7. How <a href="#">well integrated</a> are social determinants of health with care delivery?</td>
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<tr>
<td>8. How well developed are your <a href="#">Continuous Quality Improvement</a> (CQI) processes?</td>
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<tr>
<td>9. How mature are your <a href="#">information systems and human resources</a> systems?</td>
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<tr>
<td>10. What is your <a href="#">financial readiness</a> for social determinants of health interventions?</td>
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### Step 2: What’s the perceived value of a change to assess and address social determinants of health?

<table>
<thead>
<tr>
<th>Which of the following best describes the degree to which your organization’s staff and senior leaders perceive the value of assessing and addressing SDOH?</th>
<th>Limited or unclear</th>
<th>Moderate</th>
<th>Robust</th>
</tr>
</thead>
<tbody>
<tr>
<td>A loosely organized group and/or a limited number (up to 1 in 5) of your organization’s staff or senior leadership think that improving the ability to assess and address social determinants of health is needed, important, beneficial, or worthwhile.</td>
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<tr>
<td>One or more individuals or organized groups with influence and/or a sizable number of organization staff (up to 2/3) think that improving the ability to assess and address social determinants of health is needed, important, beneficial, or worthwhile.</td>
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<tr>
<td>One or more individuals or well organized groups with influence, and/or an overwhelming number of organizational members (more than 2/3) think that improving the ability to assess and address social determinants of health is needed, important, beneficial, or worthwhile.</td>
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**Step 7:** How well integrated are social determinants of health with care delivery?

<table>
<thead>
<tr>
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<th>Robust</th>
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<tbody>
<tr>
<td><strong>Which of the following best describes the degree to which social determinant intervention(s) are integrated and defined with other care delivery services?</strong></td>
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<tr>
<td>The intervention to address social determinants of health is a stand-alone project and/or has not been defined from end-to-end.</td>
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<tr>
<td>Less than 3 of the following care delivery components have been defined:</td>
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<tr>
<td>- Screen</td>
<td></td>
<td></td>
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<tr>
<td>- Triage</td>
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<td></td>
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<tr>
<td>- Assess/Exam</td>
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<tr>
<td>- Chart/Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Refer / Linkage</td>
<td></td>
<td></td>
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<tr>
<td>- Follow-up / Care Management</td>
<td></td>
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<tr>
<td>- Between visit support</td>
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<tr>
<td>The intervention to address social determinants of health has been defined and/or end-to-end, leading to the identification of other related care delivery processes that require some redesign.</td>
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<tr>
<td>4-5 of the following care delivery components have been defined:</td>
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<tr>
<td>- Screen</td>
<td></td>
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<tr>
<td>- Triage</td>
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<tr>
<td>- Between visit support</td>
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<tr>
<td>The intervention to address social determinants of health has been designed to fit with organizational processes and IT systems and interrelated organizational processes have been redesigned to optimize performance.</td>
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<tr>
<td>At least 6 of the following care delivery components have been defined:</td>
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<tr>
<td>- Screen</td>
<td></td>
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<tr>
<td>- Triage</td>
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<tr>
<td>- Between visit support</td>
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</tbody>
</table>

**Step 8:** How well developed are your Continuous Quality Improvement (CQI) processes?

<table>
<thead>
<tr>
<th>Limited or unclear</th>
<th>Moderate</th>
<th>Robust</th>
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</thead>
<tbody>
<tr>
<td><strong>Which of the following best describes how well developed your organization’s continuous quality improvement (CQI) processes are?</strong></td>
<td></td>
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<tr>
<td>The organization lacks a CQI officer and/or does not have an updated CQI plan that includes established processes a) for identifying QI priorities within programs and services and b) for continuous evaluation to see if programs are working as intended and are effective.</td>
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<tr>
<td>30% or fewer leaders &amp; staff:</td>
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<tr>
<td>- Are trained in basic methods for evaluating and improving quality, such as Plan-Do-Study-Act.</td>
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<tr>
<td>- Are engaged in established, consistent efforts to integrate lessons from QI activities into daily practice and operations.</td>
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<tr>
<td>- Have the authority to change or influence practices to improve services within their areas of responsibility.</td>
<td></td>
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<tr>
<td>The organization has a CQI officer, has an updated CQI plan that includes established processes a) for identifying QI priorities and b) for continuous evaluation to see if programs are working as intended and are effective.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 50% of leaders &amp; staff:</td>
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<tr>
<td>- Are trained in methods for evaluating and improving quality, such as Plan-Do-Study-Act, and redesign approaches, such as Human-Centered Design.</td>
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</tr>
<tr>
<td>- Are engaged in established, consistent efforts to integrate lessons from QI activities into daily practice and operations.</td>
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<tr>
<td>- Have the authority to change or influence practices to improve services within their areas of responsibility.</td>
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<td></td>
</tr>
<tr>
<td>The organization has a CQI officer, has an updated CQI plan that includes:</td>
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</tr>
<tr>
<td>More than 50% of leaders &amp; staff:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Are trained in methods for evaluating and improving quality, such as Plan-Do-Study-Act, and redesign approaches, such as Human-Centered Design.</td>
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<tr>
<td>- Are engaged in consistent efforts to integrate lessons from QI activities into daily practice and operations.</td>
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<tr>
<td>- Influence organizational strategy based on QI priorities.</td>
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**Step 10:** What is your financial readiness for social determinants of health interventions?

<table>
<thead>
<tr>
<th>Limited or unclear</th>
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<th>Robust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Which of the following best describes the degree to which your organization's financial structure is conducive to social determinants of health interventions?</strong></td>
<td><strong>Your organization:</strong></td>
<td><strong>Your organization:</strong></td>
</tr>
<tr>
<td>Has limited processes to support management of patients with high-volume, high-cost chronic diseases</td>
<td>Has systems in place to support management of patients with high-volume, high-cost chronic diseases and the ability to aggregate clinical information across networks and between clinics, hospitals, and physician practices.</td>
<td>Has demonstrated positive outcomes and ROI for patients with high-volume, high-cost chronic diseases.</td>
</tr>
<tr>
<td>Has limited ability to aggregate clinical information across networks and between clinics, hospitals, and physician practices</td>
<td>Has a very small percentage of payments tied to value/outcomes-based mechanisms. The majority of value-based payment models are in performance-based contracts, e.g., primary care incentives or performance-based contracts, rather than capitated or shared savings-risk models.</td>
<td>Has established ability to aggregate information across networks and between clinical and non-clinical partners.</td>
</tr>
<tr>
<td>Has a very small percentage of payments tied to value/outcomes-based mechanisms. The majority of value-based payment models are in performance-based contracts, e.g., primary care incentives or performance-based contracts, rather than capitated or shared savings-risk models.</td>
<td>Has established basic budgeting and accounting practices, providing ability to track capacity and costs across various units, and track expenses related to indirect costs associated with managing programs.</td>
<td>Has robust budgeting, accounting, and financial management practices, showing both financial and nonfinancial indicators for different management areas.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The chart of accounts' structure has multiple levels, providing detailed analysis (for instance by organizational units, regions, or projects/programs).</td>
</tr>
</tbody>
</table>

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**Get Set:**

Use the results of your readiness assessment to reflect and focus

Engage your staff, key stakeholders and community partners in a transparent review of your readiness assessment

With clinic and community partners, discuss and focus on potential upstream solutions to just one population and one set of problems.

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Get Set:

Whose job will it be to implement your upstream solution?

Who are your healthcare-based upstreamists?

Who are your strategic community partners?
A workforce model for US healthcare

By 2020,

- 25,000 Upstreamists
- 260,000 Comprehensivists
- 450,000 Partialists

Health Systems Improvement
- PI/QI
- Practice Transformation
- Payment Reform

Population Health
- Public Health
- Community Development
- Social Services

Population Medicine
- Community
- Preventive
- Social

Value-based ‘Upstream Quality Improvement’

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An ‘QI Project Canvas’ to develop upstream innovations

Pick a starting point: Upstream QI matrix
Example: Diabetes & Food insecurity

<table>
<thead>
<tr>
<th>Primary Prevention</th>
<th>Secondary Prevention</th>
<th>Tertiary Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient-Level</strong></td>
<td><strong>Organization Population-Level</strong></td>
<td><strong>General Population-Level</strong></td>
</tr>
<tr>
<td>Financial literacy, support, &amp; nutrition programs for low-income families with strong family history of DM</td>
<td>Provide on-site Farmers’ Market, gym, walking trails, or financial counseling for families at risk for DM</td>
<td>Advocate for local increase in minimum wage and supports for low-income families, particularly those at risk of DM</td>
</tr>
<tr>
<td>Poverty screening &amp; financial assistance for DM patients at-risk of end-of-month hypoglycemia</td>
<td>Subsidize vouchers to local Farmer’s Market or hire a financial counselor for low-income DM patients</td>
<td>Change timing and content WIC &amp; school food programs to avoid food insecurity among DM</td>
</tr>
<tr>
<td>Reduce ED use among high-utilizer severe diabetics using food and income support referrals</td>
<td>Coordinate with local banks, collectors, lenders, to reduce debt burden forutilizer diabetics</td>
<td>Support legislation/regulations to provide financial and “hotspotter” services to severe diabetics</td>
</tr>
</tbody>
</table>
With ‘upstream’ quality improvement, we can create community-integrated healthcare systems that make sense

Baseline

Community health center provider confidence to address housing & other social needs

After 11 months

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To improve social determinants, it is necessary, but not sufficient, to engage and transform health care

We can't get health care as a right without addressing social determinants

We can’t get health care right without addressing social determinants of health

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Objectives

- Discuss why we map actors and assets
- Explore an example
- Practice!
Why map actors & assets?

Why Map Actors & Assets?

- Recognize people as our greatest asset
- View stakeholders as partners in health
- Build power ‘with’ – instead of doing ‘to’ or ‘for’
- Develop our strategy ‘from within’
- Promote reciprocity & mutual respect
- Generate collective power to co-produce health

ORGANIZE!
The Shift From Needs Assessments

- Needs-focused assessments risk defining an organization, neighborhood, or community by its problems – that generally require outside expertise and resources to "fix." (Roehlkepartain, 2005)
- Negative effects: they force community leaders to highlight their communities’ worst side in order to attract resources.

McKnight & Kretzmann, 1996
The Shift From Needs to Assets

<table>
<thead>
<tr>
<th>Needs</th>
<th>Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Deficiencies require outside resources</td>
<td>• Strengths build power from within</td>
</tr>
<tr>
<td>• Results in fragmentation of responses to local deficiencies</td>
<td>• Builds relationships among people, groups, and organizations</td>
</tr>
<tr>
<td>• Makes people consumers of services, builds dependence on services</td>
<td>• Identifies ways that people and organizations give of their talents and resources</td>
</tr>
<tr>
<td>• Gives people little voice in deciding how to address local concerns</td>
<td>• Empowers people to be an integral part of the solution to community problems and issues</td>
</tr>
</tbody>
</table>

Asset Mapping

- Built on the notion that communities are built on the capacities and assets of the people and the place (not their deficiencies)
- A rallying point for collective action
- It does not imply ignoring problems and needs or throwing out rational, strategic planning
Our strategy is based on turning the **ASSETS** we have into the **POWER** we need to get the **CHANGE** we want.

Who are our **people**?
“Can you tell us what people who live here have done together to make things better?”

Building Communities From the Inside Out, 1993

Map of Actors

- **constituency**
  - leadership

- **support**
  - individuals & organisations

- **competition**
  - individuals & organisations

- **opposition**
  - individuals & organisations
What are our people’s assets?
Mutual Exchange

Relationship as Interest

Commitment

Relationship as Asset

Interests

Assets

Interests

Assets

1. What change do we want? (What is our interest?)
2. Who has the resources to create that change?
3. What do they want?
4. What resources do we have that they want?

Commitment

OUR WORK

LEADERSHIP
CONSTITUENCY
SUPPORT
COMPETITION
OPPOSITION

INTERESTS

INTERESTS

RESOURCES

RESOURCES
Example:
Delmarva Foundation For Medical Care

The Challenge

Baltimore City, Maryland

- Economically depressed inner-city neighborhoods
- High rates of chronic disease (heart failure, pulmonary disease, diabetes and kidney disease)
- ED visits: 45% higher than the state overall
- Life expectancy: 20 years less than neighborhoods only 2 miles away
- Lack of engagement from target community
- Little trust in outside projects and agencies

The Goal: to improve health outcomes of seniors who frequent urban senior centers by increasing access to health education and wellness resources
Relational Strategy

“Listening campaign”
(1) 60 seniors from Baltimore City
(2) 75 health and community service providers

Attention
Interest
Exploration
(ask-answer)
Exchange
Commitment

Upstreamist Analysis

Geography-Based Data Analysis
Black = Senior homes & centers
Red = Areas identified as food deserts (no grocery store)
Mapping Actors & Assets

Supporters:
- Public Health
- Hospitals
- FQHCs
- Community Organizations

Constituents:
- Community members, local businesses, public & clinical health groups

For food project:
- Owners, distributors, farmers, wholesalers and consumers

Opposition:
- Groups objecting to organizing approach to address public health issues, those not included geographically as part of first project, current corner store owners

Leadership Team:
- Westside & Eastside Hospitals
- FQHC
- Public Health
- Public Health
- City Government
- Community Members
- Local Food Retailers
- Non-Profits

Competition:
- East/West HEZs
- Food PAC
- CAHT
Delmarva convened a coalition of 40 stakeholders to coordinate an expansion of services and resources to improve chronic disease outcomes for seniors. The coalition identified food deserts as an actionable focus and formed Healthy Eating Leading Partnerships with Seniors (HELPS).

**HELPS: Healthy Eating Leading Partnerships with Seniors**

- New services coordinated (at no additional cost) at ONE STOP Service Centers for senior citizens:
  - Delivery of nutritious food to former food deserts: Real Food Farms Mobile Market & Baltimore City Health Department’s Virtual Supermarket Program
  - Cooking demonstrations and nutrition education
  - Reimbursable Adult Wellness Visits for seniors at FQHCs
  - “Ask the professionals” meetings to discuss diabetes care
  - Information sessions on Medicare & Affordable Care Act
  - Electronic card-scanning technology for enrolled seniors to track use of community support services
- Sustainability: HELPS Coalition continues to grow under its Advisory Board (including Baltimore City Health Department)
  - Expanded to 11 sites, led by community leaders
Your Turn!

Use the handout to begin mapping actors & assets

- Try to be as specific as possible
- Consider whether actors belong in more than one category
- Identify each actor’s values, interests and assets
What did we learn?

Some Lessons

- You have one mouth and two ears, use them proportionally to get to know your people.
- Understand values and interests in relation to actors and assets to create a basis for mutual exchanges.
- Actors can have multiple identities (i.e. support, constituency, opposition, etc.).
- It is a ‘living’ map – update as you go.
- The map itself is an asset!
Some Lessons

- Seek “war stories” (i.e. successfully overcoming challenges) to identify assets
- Ask what the organization or individual does or has now, and what they would like to do or be prepared to offer with additional support
- Remember to use health care as a second language only
- Assume that you will need to lose a bit of control for much, much more power

Other Asset-Based Tools

Asset Based Community Development Institute:
- Asset Exploration Assessments
- Asset Inventory Tools
- Sample Map Templates
Other Asset-Based Tools

The Community Tool Box:
- Asset Mapping
- Questions to Ask While Asset Mapping

Leading together, Leading for equity
Engaging those with lived experience
Taking a deeper dive into the map:

A community member with lived experience

“Is an individual who has expertise not through formal learning or training, but through living it. They are familiar with many of the issues and hold valuable perspectives about how to tackle them. They can offer local solutions and are aware of what would work in their communities, and can provide strength to a cause. A community member with lived experience is the insider.”
Community members with lived experience offer:

- “expertise through living it”
  - experiential expertise: with issue, systems, the work of health in their community
- “local solutions”
- “what would work in their community”
  - design
  - how to engage
- “can lend strength”
  - link to community social networks

Learning from each other: Healthy Waterville
Using the community’s rhythms: ECOR

ECOR: sustainable through co-design, co-implementation
ECOR: Lessons learned

- We are able to create more effective solutions by drawing on local knowledge from a diverse group.
- Meet people where (and when) they are at!
  - link to community traditions
  - engage in what matters to the community
- Learning happens best in comfortable environments
  - comfortable = language, environment, peers
- Engagement improves:
  - communities’ skills in problem solving
  - willingness to work towards a shared goal
  - acceptance of projects or solutions
- Working with the community increases communication, understanding, and trust in our organization
Consider:

- What are your interests?
- Who has resources that can help you?
- What matters to them?
- What resources do you/your partners have that fits with their interests?

Action plan: engaging community members with lived experience

In the next 90 days, I will:
- engage with: ____________________________
- by doing: ____________________________
- I will benefit because ______________________
- they will want to engage with me because ________________________
### Community Engagement

**ASK, LISTEN & LEARN**
- Ask open, honest questions:
  - What’s the issue?
  - What can I offer?
  - What can I learn?
- Communication cycles
  - what learned, what’s being done
- Interview
- Community meetings
- Survey
- Focus groups

**BUILD RELATIONSHIPS**
- Identify local leaders
- Create partnerships
- Find and grow other leaders
- Form teams, working groups, councils
- Sustain ongoing communication with partners

**QUALITY & EFFECTIVENESS**
- Hire local community champions
- Support local champions
- Continually hear feedback and adapt:
  - Strengthen the work
  - Improve outputs and outcomes
  - Enhance value
  - Evaluate programs / systems
- Shared accountability
- Build co-ownership

**MEANINGFUL PROGRAMS/SYSTEMS**
- Evaluate community needs & strengths
- Guide what will work
- Set priorities
- Find / design solutions
- Enhance relevance
- Define success
- Solicit feedback

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### Engagement Framework

**ASK, LISTEN & LEARN**
- The Village
- focus groups
- ongoing check-ins

**BUILD RELATIONSHIPS**
- community members engaged at every level
- ongoing connection to informal community leaders, ongoing programs

**QUALITY & EFFECTIVENESS**
- community members implementing work
- assessing effectiveness

**MEANINGFUL PROGRAMS/SYSTEMS**
- community members designing and testing strategies
Making it work: essential elements

- know your map!
- shared interests
- accessible environment
- language
- shared information and strategy
- mutual respect and trust
- relational strategies that connect and grow

Leading for Outcomes: Switch Thinking

Paul Howard
Using Switch Thinking to Build a Movement

Goals of This Session

• Understand how a “Movement” can be a great vehicle for kickstarting change

• Learn about how “Switch Thinking” can help you use rational thinking and emotional motivation to spur people to change

• Hear some real world case examples from the 100,000 Homes Campaign, organized by Community Solutions

• Begin thinking how Switch Thinking can be applied to your work
What do we mean by a “Movement”?

Movement
Community Solutions uses a broad definition

• a series of organized activities working toward an objective; also : an organized effort to promote or attain an end (e.g. the civil rights movement) – Merriam-Webster

• “A form of association between persons who have at least a minimal sense of themselves as connected to others in common purpose and who come together across an extended period of time to effect social change in the name of that purpose” – Paul James and Paul van Seeters

• Other definitions?
Why Movements?

- Movements have a proven track record of changing systems and solving complex social issues
- Successful movements can achieve much more than individuals or organizations acting alone or in loose coordination with each other
- Complex challenges like community health require that multiple stakeholders agree to work together

Building and Growing Your Network
Understand Roger’s Diffusion of Innovations

Understand Roger’s 5 Stages of Adoption

1. **Knowledge** – person becomes aware of an innovation and has some idea of how it functions
2. **Persuasion** – person forms a favorable or unfavorable attitude toward the innovation
3. **Decision** – person engages in activities that lead to a choice to adopt or reject the innovation
4. **Implementation** – person puts an innovation into use
5. **Confirmation** – person evaluates the results of an innovation decision already made
Start Your Movement with the Innovators

• No movement begins with every stakeholder on board

• Raise awareness (1. Knowledge) to identify your likely innovators and early adopters

• Know how to recognize your Innovators and spur them to act with you (2. Persuade)
  Innovators are risk takers who are willing to fail
  Like to be the first to try new things and be seen as innovative even without proof that the innovation will work (3. Decision)

• They will be quick to try your innovation(s) (4. Implementation)

• If the innovation shows any promise, they are likely to stay with you (5. Confirmation)

Secure Early Adopters to Cause a Tipping Point

• Early Adopters are Opinion Leaders (positive or negative buzz)

• Often well regarded and respected among your potential network

• Are more cautious in their adoption choices than innovators

• Others often look at them and follow their cues (strong social networks)

• So important that it is worth having a specific strategy for this group
  Let them “kick the tires”, give them a “backstage pass” or “special trial-offer without commitment”

  Answer questions, find out their concerns and address them

  Incorporate their suggestions into the next iteration of your innovation

  Encourage them to promote the movements within their networks
Adoption of Innovations Don’ts

- Don’t concentrate on naysayers at the beginning no matter how big and important they seem
- Don’t forget the 5 stages (each group goes through this)
- Don’t forget to customize your message based on the group you are after
- Don’t forget your movement will have multiple innovations and iterations (so the diffusion curve and adoption stages will come into play throughout)
- Don’t forget that some people/organizations will be Innovators for certain things and fall elsewhere on the diffusion curve for other things

Switch by Chip and Dan Heath

- Movements are about change and this book teaches you the science of changing things
- Was used as the playbook for the 100,000 Homes Campaign
- Used Switch to ask the right questions in designing campaign components
- Went back to Switch to help problem-solve when things didn’t go as planned
Rational Brain Vs. Emotional Brain

- Difficult changes require motivation
- We like to think that we are motivated by information. But we are also motivated because we were made to feel something.
- Our emotional brains are so often in control, and that’s not bad
- Here are some strategies for harnessing both of these important pieces of people’s brains, to create some building blocks for your movement

Find The Bright Spots

- Ask the exception question
- Ask the miracle question
- Ask what is working and how you can do more of it?
Recipe for Finding Bright Spots

1. Gather Data on the issue
2. Study the data to find the bright spot(s)
3. Make sure you understand the “normal way” things are done
4. Then study the bright spot(s) to see what they do differently
5. Make sure these practices are “exceptional” in some way
6. Find a way to reproduce/adapt the practices of the bright spots

Find The Bright Spots

- All 100,000 Homes Campaign staff and communities charged with identifying (and disseminating) Bright Spots.
- Formal Quantitative and Qualitative Study of High and Low Performing communities to determine which practices correlated to higher housing placement rates.
- Campaign helped communities believe that they all did something extraordinary well that could be implemented by other communities (everyone gets to be a hero)
- Communities that showed dramatic improvements in housing placement rates were invited to present their innovations on monthly “All Hands on Deck Calls”.
Find the Bright Spots - Examples

• Phoenix decreased the housing placement time for chronically homeless people. **Bright Spot:** They Used “Navigators” to help people through the housing placement process

• Riverside County was achieving housing placement rates much higher than what appeared possible based on their “known resources”. **Bright Spot:** They had received a set-aside from the local Public Housing Authority for homeless Veterans

• Bellflower, California was placing a lot of people into housing even though it looked like they had virtually no homeless housing resources. **Bright Spot:** They introduced a “house-share” program where 2 or more clients, if they were willing, would be matched to housing that they could afford together

Script the Critical Moves

• Be clear about how people (or program, communities, etc.) should act
• Pick one place to start
• If you can’t nail it exactly, consider the best approximation
• Kill the abstractions
• Evaluate your Critical Move candidates
Script the Critical Moves

Simple 100,000 Homes Campaign Manifesto:

- **Know Every Homeless Person by Name** (± needs/preferences) by conducting a Registry Week
- **Implement Housing First Principles**
- **Track Your Progress** by reporting all housing placements each month
- **Improve your Local Systems** by redesigning your housing placement process to make it as efficient as possible
Checklist for Scripting the Critical Moves

1. Does it evoke emotion?
2. Does it feel doable?
3. Was it a part of success stories in the past? (Bright Spots)
4. Does it connect with the big picture? (Point to the Destination)
5. Will it provide a quick win?
6. Will it create positive peer pressure?
7. Is it consistent with the way people/stakeholders think about themselves?

Point to the Destination

- Paint a rich, detailed picture of what the destination looks like
- Avoid metrics as destinations when possible
- Make sure it passes the “Champagne Test”
- Move from process to outcome
- Consider a black & white goal
Point to the Destination - Examples

- **Campaign Goal** – Place 100,000 of our most chronic and vulnerable homeless people into permanent housing in 4 years

- **Monthly Housing Placement Target** for each community (chronic/vulnerable homeless population)

- **Take-Down Target** (pace for ending chronic homelessness) for each community

Why might these examples not be ideal?

Point to the Destination - Examples

- Know every homeless person in your community by name

- Build a housing placement system that can move any person from the streets into permanent housing in 30 days

- End homelessness among our most chronic and vulnerable citizens
Shrink the Change

- Try to put 2 stamps on your team’s passbook
- Think in terms of one’s
- Kick the ball forward
- Plan for small wins
- Don’t let the success feel too distant

SHRINK THE CHANGE - Examples

- Begin by reporting the housing placements you know about
- Improve housing placements by 1 person next month
- Decrease the number of steps to housing placement by 1 step
- Registry Week Boot Camps and Acceleration Boot Camps
- Self Assessment Tool (SAT) Report provided feedback on next steps (but not all steps) a community could take to improve their housing placement
And Now It’s Your Turn...

• Write down on a sticky note one thing you can do differently starting when you get back to your job next week

• Write down on a second sticky note, one thing that you will try to do in the next month to move forward a movement you are working on

  Put this sticky in a place at your desk that you can easily see
  Take 30 seconds each work day at the beginning of your day to look at it

Wrap Up