INVEST IN YOUR COMMUNITY

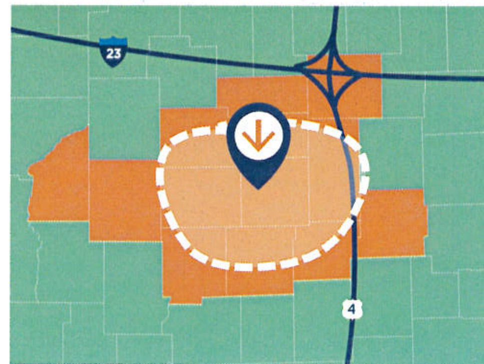
4 Considerations to Improve Health & Well-Being *for All*

WHAT **Know What Affects Health**

www.countyhealthrankings.org

WHERE **Focus on Areas of Greatest Need**

Your zip code can be more important than your genetic code. Profound health disparities exist depending on where you live.



WHO **Collaborate with Others to Maximize Efforts**

HOW **Use a Balanced Portfolio of Interventions for Greatest Impact**

- Action in one area may produce positive outcomes in another.
- Start by using interventions that work across all four action areas.
- Over time, increase investment in socioeconomic factors for the greatest impact on health and well-being for all.

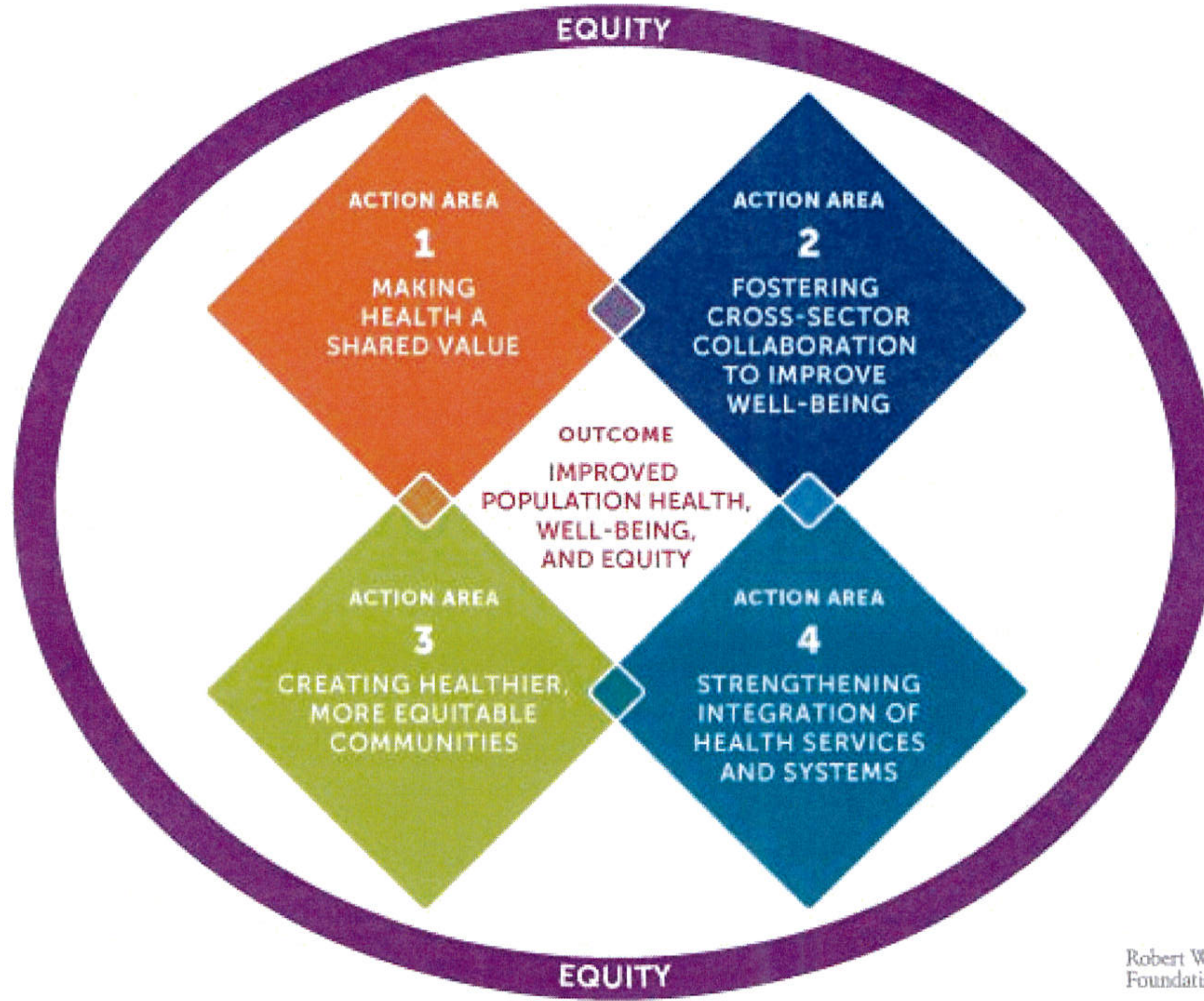
Four ACTION Areas

VISIT **www.cdc.gov/CHInav** FOR TOOLS AND RESOURCES TO IMPROVE YOUR COMMUNITY'S HEALTH AND WELL-BEING

NATIONAL PREVENTION STRATEGY

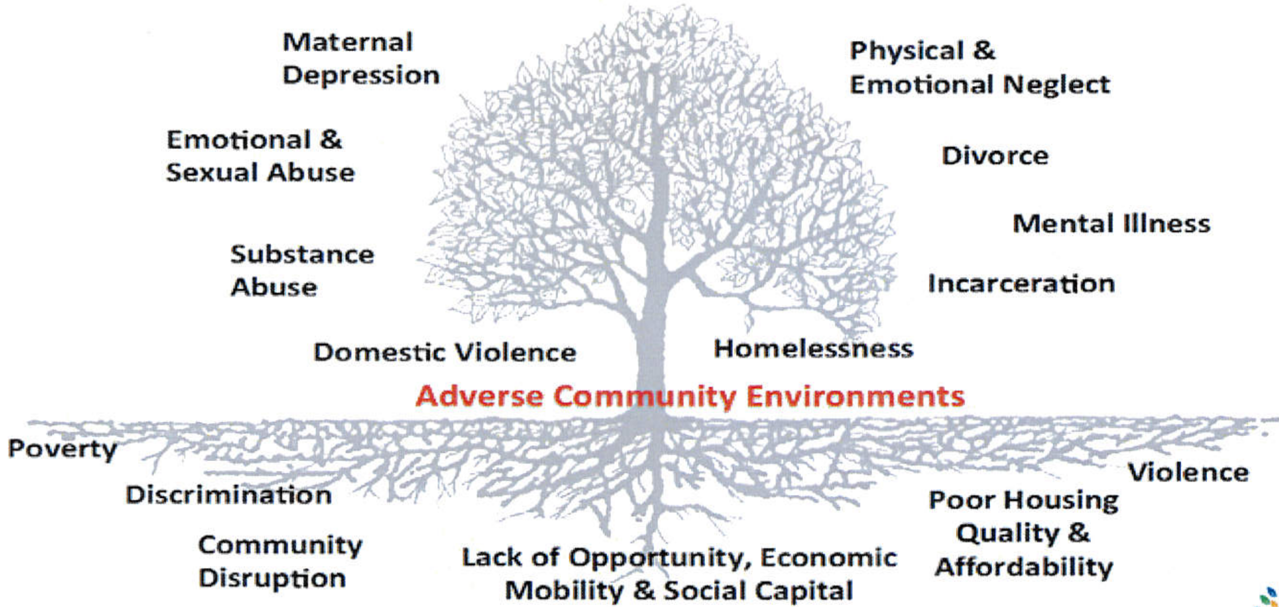
Robert Wood Johnson Foundation

Robert Wood Johnson Foundation's Culture of Health



Robert Wood Johnson Foundation

The Pair of ACEs



Ellis W., Dietz W. BCR Framework *Academic Peds* (2017)

CDC

https://www.cdc.gov/chinav/tools/index.html

To help increase your chances of success, the framework below can serve as a template for your Community Health Improvement (CHI) efforts.

- **Key Concepts :** Actionable descriptions intended to guide execution in each part of the CHI process
- **Tools for Getting Started:** Select tools including "how-to" descriptions, templates, and checklists to achieve the key concepts

ReThink Health
ReSearch • ReConnect • ReDesign

Financing Along the Pathway

Which Financing Tasks are Most Prominent in Each Phase?

Phase 1: Campaign

The financing objective is to secure funding for the chosen initiative. Typically, this funding is: one-time only; to be used only for the specific initiative; sought from outside sources such as foundation or governmental grants, although some funding may be contributed by the organizations involved, such as in-kind support or Community Benefit dollars, with the understanding that there is little or no risk involved.

Phase 2: Engage

The financing objective is to develop multi-year funding that can be used for a portfolio of initiatives, including start-up funding for backbone organizations. This may involve repurposing existing funds, such as Community Benefits or health plans' grant funds, as well as expanded use of grant funds.

Phase 3: Align

The financing objective is to institutionalize and align resources towards strategic goals across organizations and sectors. This requires more financial commitment and risk-taking on behalf of the organizations involved, as moves are made to reposition the way existing funding streams are utilized, such as with global payments, gain-sharing agreements, social impact bonds, purchasing, and investment portfolios. Backbone organizations are fully funded.

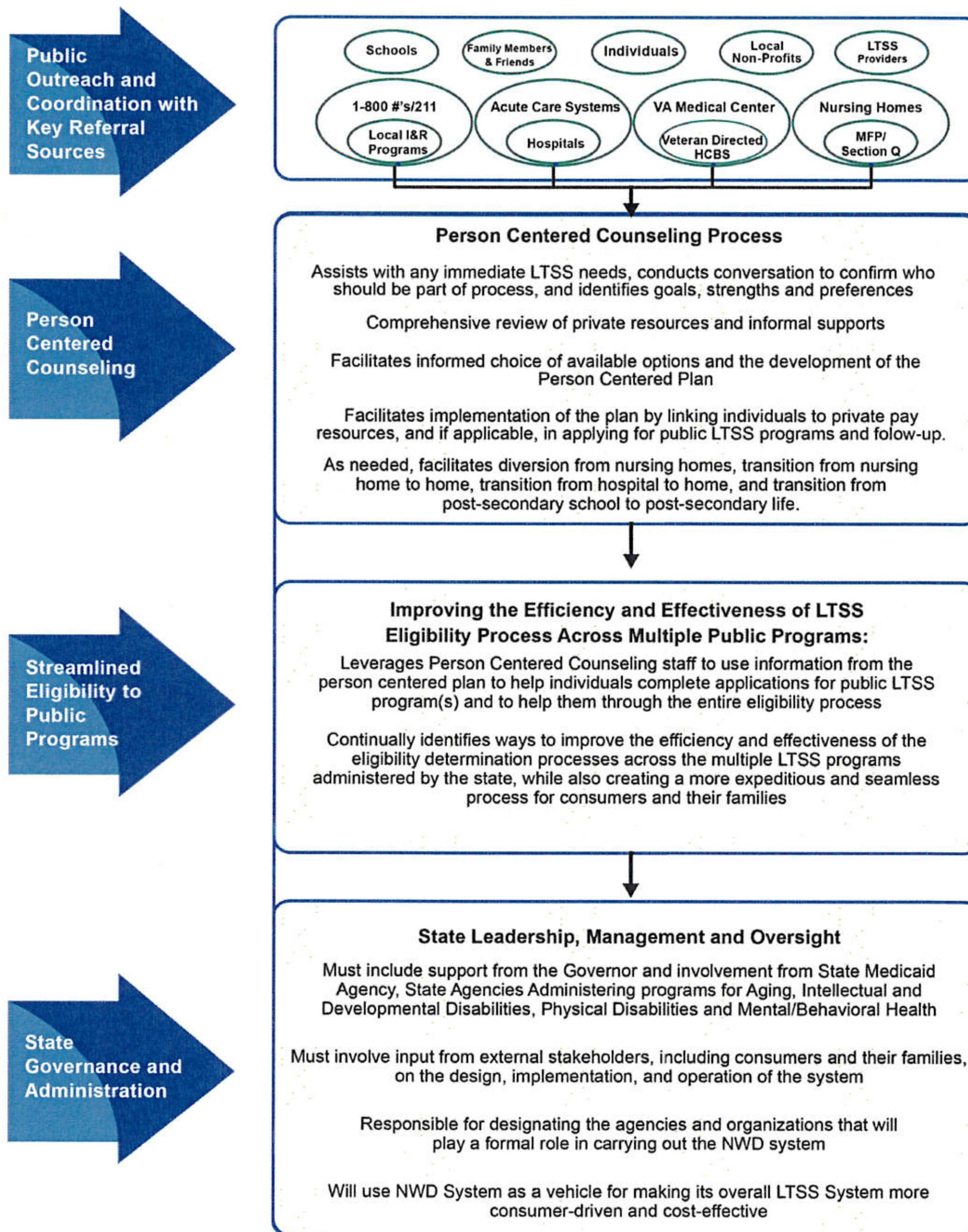
Phase 4: Redesign

The financing objective is to disrupt the existing system, shifting it toward greater sustainability and incentivizing the creation of health. Disruption might occur through new entrants with very different business models coming into the market; in any event it would entail new business models for existing players in the health arena, such as health plans, providers and public health agencies. It may involve new governance structures for accumulating and distributing funds that can be used broadly for a wide-ranging set of population health measures. In the public sector, it entails new policies about what is funded, an appetite for longer-term payback periods, and the installation of new budgeting structures that recognize and support linkages across sectors. This is a phase of considerable risk and turbulence; transition or risk management plans/mechanisms may be required.

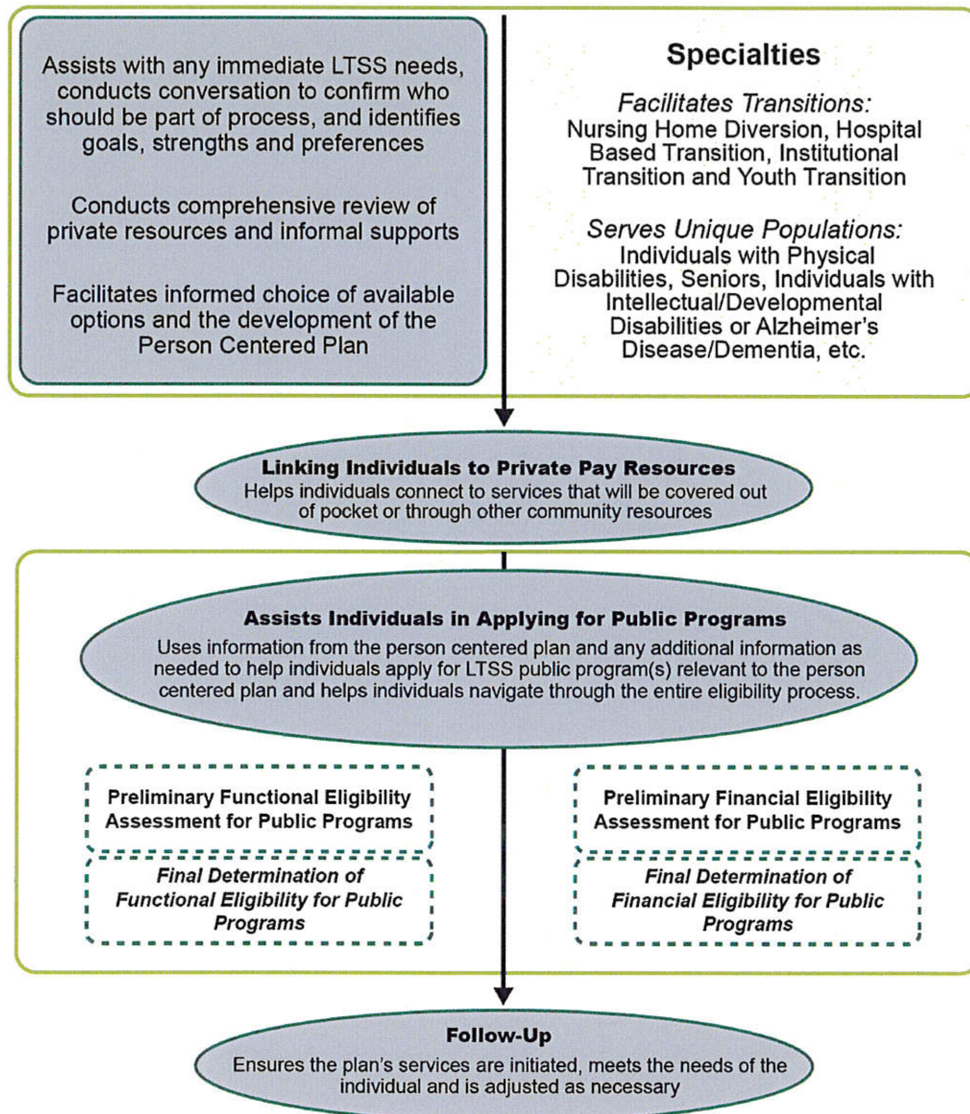
Phase 5: Integrate

The financing objective is to underpin and support a wider health system that creates healthy regions. In Phase V, new financing mechanisms (from Phase IV) have been adopted as routine procedures and functions of the system; they are sustainable; they adapt with changes and improvements in the system; they incentivize and reward the creation of health.

No Wrong Door Schematic



Person-Centered Counseling Schematic



Core Competencies: Required of all staff performing Person-Centered Counseling

Specialties: Performed by subsets of Person Centered Counselors who also have specialized knowledge and experience

Streamline Access: Some of these functions can be performed by Person Centered Counselors at the discretion of the state

It's Up To Us®

to Create a Healthy & Supportive San Diego

A special bulletin covering mental health topics for San Diegans

Edition Twenty

About the Campaign

The "It's Up to Us" campaign is designed to empower San Diegans to talk openly about mental illness, recognize symptoms, utilize local resources and seek help. By raising awareness and providing access to local resources, we aim to inspire wellness, reduce stigma and prevent suicide.

Recovery is possible and help is available. It's Up to Us to make a difference in the lives of San Diegans experiencing mental health challenges by offering support and providing opportunities.

This campaign is developed through the County of San Diego Health and Human Services Agency, and supports the County's *Live Well San Diego* vision to promote a community that is healthy, safe and thriving.

Up2SD.org®

LINK UP FOR INFORMATION AND MENTAL HEALTH RESOURCES

Access & Crisis Line

(888) 724-7240

COMMUNITY RESOURCES

2-1-1

COUNTY OF SAN DIEGO

HHSA

HEALTH AND HUMAN SERVICES AGENCY

Funded by the Mental Health Services Act

Read Up: Live Well San Diego Encourages Us to Be Our Best, Healthiest Selves

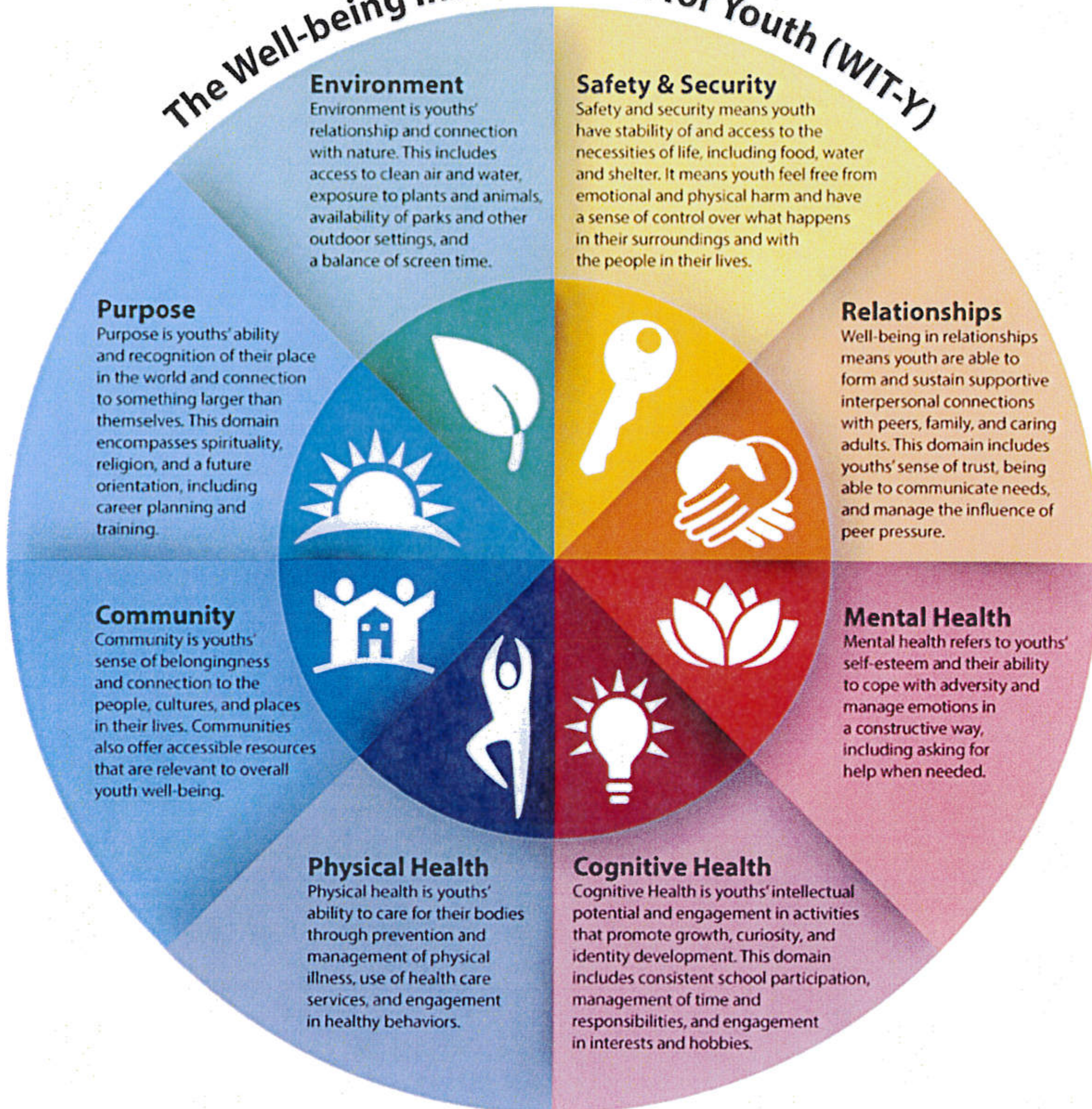
Live Well San Diego is the County of San Diego's vision to improve the health, safety and well-being of all of us living in America's finest city. As part of Live Well, San Diegans are encouraged to improve three behaviors that contribute to four chronic diseases that together account for more than half of deaths in San Diego. Modifying these behaviors—poor diet, physical inactivity and smoking—leads to decreased risk of cancer, heart disease and stroke, diabetes, and respiratory conditions. Changing our lifestyle does wonders for our mental health, too!

Felice Jacka, President of the International Society for Nutritional Psychiatry Research, says, "A very large body of evidence now exists that suggests diet is as important to mental health as it is to physical health. A healthy diet is protective and an unhealthy diet is a risk factor for depression and anxiety." Multiple studies have shown that exercise, in addition to helping with weight management and cardiovascular health, reduces stress and releases endorphins to help improve our moods. And last, but not least, the ingestion of nicotine causes a temporary sense of relaxation but overall can lead to increased anxiety and tension.

For more information on Live Well San Diego, visit www.livewellsd.org. For other tips to improve your mental health, visit Up2SD.org.

The Phases of Collective Impact

Over-arching Actions	Components of Success	Phase I *Assess Readiness*	Phase II *Initiate Action*	Phase III *Organize for Impact*	Phase IV *Begin Implementation*	Phase IV *Review and Renew*
		Pre start-up *Focus: Engagement and Exploration*	Start up *Focus: From Idea to Formation*	Growth *Focus: Early Experimentation*	Growth *Focus: Scaling efforts*	Maturity *Focus: Sustain and Renew*
		EARLY YEARS Key Question: *What needs to happen?*		MIDDLE YEARS Key Question: *How well is it working?*		LATER YEARS Key Question: *What difference are we making?*
			KEY ELEMENTS			
Design, Implement and Lead your CI Initiative	**Governance and Infrastructure** How decisions are made and responsibilities shared	Convene Community Stakeholders	Identify champions and form cross-sector Steering Committee (SC) to guide the effort	Develop infrastructure (backbone, leadership team, and working groups)	Launch work groups and formalize backbone infrastructure	Facilitate, refine and renew
	Strategic Planning What are we trying to do and how: Our Theory of Change	Hold dialogue about issue, community context and available resources	Map the landscape and use data to make the case	Create common agenda, clear problem definition, agreement on population level goals	Develop blueprint for implementation and identify quick wins	Refine strategies to mobilize for quick wins and to review progress
Understand Context	**Community Involvement** Who is involved? Who else's eyes need to be on this issue?	Determine community readiness; create a community engagement plan	Begin outreach to community leaders	Incorporate community voice, gain community perspective and input around issue	Engage community more broadly and build public will	Continue engagement and address policy change needs
Assess Progress, Outcomes, Impact and Learning	**Evaluation and Improvement** What are we learning and how are we changing culture, norms and systems?	Determine if there is consensus and urgency to move forward	Analyze baseline data to identify key issues and gaps	Establish shared metrics (indicators, measurement and approach)	Establish shared measures (indicators and approach at SC and WG levels	Collect, track, and report progress (process to learn, improve, and renew)



http://cascw.umn.edu/portfolio-items/well-being-indicator-tool-for-youth-wit-y/

Health Affairs Blog

Place Matters: Making The United States The Healthiest Nation, Community By Community

Garth Graham and Georges Benjamin

May 19, 2016

Our health is affected by more than what happens in the doctor's office. The factors that can make or break our health include the many societal conditions we face on a daily basis—determinants such as access to fresh foods, neighborhood walkability, and public safety. When our communities are built and governed with health in mind, we all inherit an opportunity to live longer, healthier lives. For us, healthy communities are economically competitive, inclusive, and equitable.

Fortunately, most Americans want a healthier future, too: According to a recent survey fielded by the Aetna Foundation, 94 percent of Americans say that they are willing to take action to make their communities healthier.

The survey results show that Americans believe they have an average of five healthy days per week, and more than 77 percent of respondents describe their health as good. This is encouraging news. However, global health data find that when we compare ourselves with our peers in other high-income nations, America comes up short. Despite spending more on health care than any other country in the world does, Americans live shorter, less healthy lives than our counterparts in other rich nations. We can and must do better.

But, first, we need to elevate a national dialogue about what it means to be healthy—not just to be free of disease. For example, according to the World Health Organization, health is much more than the absence of disease; health is also the presence of complete mental, physical, and social well-being. Transforming the way we think about and perceive good health is no easy task, but it's a critical ingredient for creating healthier communities and, eventually, a healthier nation.

We all have a role to play in improving health and wellness in our communities, and we know no single entity can make sufficient changes alone. And as our colleagues on the frontlines of medicine and public health know, those working outside of both sectors can be valuable partners in addressing the social determinants that shape our health and well-being.

If we can break down silos and galvanize the brightest minds across all sectors that influence our health, we can make an enormous difference in health outcomes across the country. Leaders in education, transportation, housing, and private business can combine their expertise to help ignite the change we need to make a sustainable impact in the communities facing the greatest disparities in the ability to live long, healthy lives.

That's why the Aetna Foundation, American Public Health Association, and National Association of Counties, in partnership with CEOs for Cities, have launched the **Healthiest Cities & Counties Challenge.** By working with small to mid-size cities, counties, and federally recognized tribes across the country, the Challenge will help build measurable improvements over time on key wellness metrics such as healthy behaviors; community safety; social and economic factors like access to high-quality jobs; environmental exposures like pollution; and the built environment, in which people can live, work, and play. As of today, several "Innovator Cities" have already signed on from communities across the country to be a part of the Challenge, with projects ranging from curbing secondhand smoke, to reducing violence, to increasing access to fresh fruits and vegetables.

One of the more telling results from the survey (mentioned above) was that nearly all Americans (94 percent) are willing to do something to have a healthier place to live. The responses ranged from growing fruits and vegetables in a garden, to taking public transportation, to even paying more in taxes.

The willingness to take part in bettering the health of where we live is apparent through the six Innovator Cities in the Healthiest Cities and Counties Challenge. These Innovator Cities have already shown great progress in their efforts to impact the health disparities facing their communities but are looking to the Challenge as a way to bring together new partners or gain greater awareness of the top health issues they face.

The city of Cleveland recently passed the Tobacco 21 law banning sales of tobacco products within the city proper to anyone under the age of twenty-one. The city is participating in the Challenge to develop a program to elevate the discussion they are having locally about tobacco control.

In Tulsa, Oklahoma, more than 80,000 residents live in areas considered "food deserts." While there have been many local nonprofits and faith-based organizations that have helped to address the issue, the Tulsa Department of Health is working to bring together all of the resources addressing food access to create one comprehensive program.

The Challenge is part of our three organizations' overall commitment to building healthy communities. We'll be awarding more than $1.5 million in prizes to participating cities, counties, and tribes that develop innovative models for health and wellness that can be tailored to other localities and replicated nationwide. We're not seeking to simply rank communities for the work they're already doing; our goal is actually to motivate cities, counties, and tribes to dive deeper into their communities to jumpstart sustainable changes toward better health for all.

Our goal is to inspire innovative, cross-sector, and community-driven solutions that can be used community by community, city by city, county by county, and tribe by tribe to address unique challenges where we live, work, and play.

Learn more about how your city, county, or federally recognized tribe can get involved by visiting www.HealthiestCities.org.

Health Affairs Blog

Unusual Community Partnerships Offer New Mental Health Interventions

Veronica Nieva, Whitney Bowman-Zatzkin, and Maurice Johnson

April 6, 2017

The landscape of health care innovation is complex and vast, and often leads to a global web of conversations that, very often, run parallel without ever intersecting to collaborate. That space where innovators are working at the fringe toward a similar outcome is where Scouting Health has stepped in to close the conversation gap.

Scouting Health, funded by the Robert Wood Johnson Foundation, is a partnership between Westat, a social science research, statistical analysis, and evidence-based communications firm, and Rare Dots, a health care consultancy focused on provoking connected communities to action. Scouting Health draws attention to these innovators—with a goal of inspiring more aware and capable communities by elevating the debate and highlighting advancements in various areas of health.

Making a community's resources, such as parks for exercise and police for public safety, easily available to people is the bedrock of ensuring that people have what they need to live healthy lives. When our lives at home, work, and school are focused on an expectation of health, we have the opportunity to achieve our desired health outcomes.

Scouting Health has looked past the traditional sources of care to seek out the unexpected partners and stakeholders within communities that are working to integrate care or advance health in some way. This search led Scouting Health over to Bexar County, Texas (where San Antonio is located), which used an approach from the criminal justice system to expand mental health interventions among youth.

Some Background

Prior to entering the field, law enforcement officials receive extensive training. They become adept at assessing situations and ensuring that public safety is at the forefront of their work each day. But what is the right course of action for an officer who encounters a person in the midst of a mental health crisis? In many instances, officers become the decision point between mental health treatment and entry to the criminal justice system.

In 2014, nearly 12 million Americans reported experiencing an unmet need for additional mental health services. When we drill down to the population of the criminal justice system, a staggering 1.2 million people across federal, state, and local prison systems reported current symptoms, or a recent history, of mental illness in 2005. Those with mental illness who are incarcerated are often recipients of inadequate care. According to surveys of inmates in 2002 and 2004, over one in three state prisoners and one in six jail inmates with a mental health problem received mental health services since admission to prison.

Foregoing treatment can have dire consequences for physical health. People living with an undiagnosed or untreated mental illness are at greater risk of developing a chronic medical condition and of dying earlier than others.

But this is only one side of the criminal justice system. Here is a more alarming fact: Research has shown that between 65 and 70 percent of youth in contact with the juvenile justice system have a diagnosable mental illness. Also, sometimes youth enter the juvenile justice system more than once.

While early treatment of mental health disorders is the key to decreasing the risk that the illness will become more difficult to treat, or become a life-long struggle, 75 to 80 percent of adolescents in general with a mental health diagnosis report that they do not receive appropriate services. When the cost of mental illness among the population under age twenty-four is tallied, including health care, use of services such as special education and juvenile justice, and decreased productivity, that cost is $247 billion each year, said a 2013 report from the Centers for Disease Control and Prevention.

Bexar County Initiative For Adults

One county in Texas, Bexar County, created a model for aligning its criminal justice system, hospital, mental health services, and community partners. Facing extreme overcrowding in the jail system, largely from people with severe mental illness, the Bexar County Jail, in San Antonio, began transforming its mental health system into a program focused on diverting people with serious mental illness from jail and into treatment.

Unveiled in 2004, the Bexar County Jail Diversion Program (BCJDP) is an initiative aimed at supporting and improving the lives of adults with mental health and behavioral health needs by partnering with nearly sixty community stakeholders, including public health departments, emergency medical services, hospitals, and businesses. This effort has successfully diverted more than 100,000 adults from jails and emergency departments and resulted in a cost savings of nearly $100 million over an eight-year period.

Model Expanded To Help Youth

Realizing the extreme gap in care within the juvenile system, Bexar County expanded its model to include the following two services focused on its youth.

The BCJDP team launched a parallel initiative focused on expanding services to address the mental health and behavioral health needs among county youth and their families to try to prevent future entry of youth into the criminal justice system. The team expanded the program to include educators and school system leaders. The youth initiative uses the BCJDP's adult-focused program as a guidepost in creating interventions focused on adolescent mental illness and behavioral health conditions. This was particularly challenging for the team, since early treatment is crucial to ensure that a child's brain does not consistently use disordered thinking, as such use decreases the likelihood of finding an appropriate treatment for a condition.

Bexar County also created and runs Bexar CARES (Coordinated Access to Resources Equals Success), a program that works in collaboration with police, health care providers, and community stakeholders to proactively screen children within the child welfare and public school systems for behavioral health conditions using a Pediatric Symptom Checklist. If a screening reveals the need for intervention, families receive a more extensive mental health assessment. An individualized plan detailing recommended ongoing care goals is also created in partnership with the child and family. Bexar CARES has reached many children and adolescents—with 741 having participated in the program.

For Bexar County, coordination among health providers, law enforcement officers, educators, and community stakeholders is the key to creating an environment of early intervention in mental

AcademyHealth

Toward Data-Driven, Cross-Sector, and Community-Led Transformation: An Environmental Scan of Select Programs

Executive Summary

The Community Health Peer Learning Program (CHP), a partnership of AcademyHealth and the Office of the National Coordinator for Health Information Technology (ONC), conducted an **environmental scan** of multisector initiatives driving toward population health improvement at the community level, many with a focus on capturing, sharing, integrating, and using data to support their work. The scan and ensuing report confirm the emergence and rapid expansion of such efforts, and reflect a growing recognition that local conditions often drive the environmental and social determinants of health. Many place-based population health improvement efforts, therefore, involve sectors outside of health care (e.g., housing, education, criminal justice), and this report profiles several different programs and strategies designed to build and sustain these cross-sector collaborations. The report also conveys the scale, scope, and diversity of ongoing efforts, and offers insights into common challenges, emerging strategies, and promising practices to accelerate progress. Ultimately, the scan and associated report reveal the emergence of a movement—a convergence of programs and people connecting across traditional and non-traditional boundaries, and working together to improve community health.

What we found

THE WHO:

- Seventeen programs supporting nearly 450 locally-driven, population health improvement efforts
- Supported by over 16 different public and private funders
- Most common partners include health care, behavioral and social services, housing, and public health

THE WHAT:

- Specific aims and objectives differ, but nearly all working to build community capacity and to affect health outcomes
- Diverse range of focus populations and conditions—many with a justice and/or equity layer
- Early stages in terms of collaborative maturity; most are focused on individual and local community improvement; not (yet) policy impact

THE HOW:

- **Peer learning:** All programs include a peer learning component. These differ based on project resourcing and needs, but are built upon the common knowledge that local projects face similar challenges (e.g., inexperience with community engagement, limited resources, siloed data and functions) and the promise that collective action can address these problems in a deeper way than any one program or project can on its own.
- **Technical Assistance (TA):** TA is offered across all programs, but structured in different ways, delivered via diverse media, and focused on a range of topics—some relevant to only a subset (e.g., data governance) and others broadly applicable (e.g., strategic and sustainability planning).

The 17 Programs

Accountable Health Communities (AHC)

Alignment for Health Equity and Development (AHEAD)

Bridging for Health

BUILD Health Challenge

CA Accountable Communities for Health Initiative (CACHI)

Community Health Peer Learning Program (CHP)

Community Interoperability and HIE Cooperative Agreement Program (Community Interoperability and HIE Program)

Connecting Communities and Care Funding Opportunity

Data Across Sectors for Health (DASH)

Health Impact Project

Invest Health

MacArthur Foundation Safety and Justice Challenge

ReThink Health Ventures

Spreading Community Accelerators through Learning and Evaluation (SCALE)

Transforming Communities Initiative

What Works Cities

White House Data-Driven Justice Initiative*

As of January 23, 2017, the Arnold Foundation is also supporting this work.

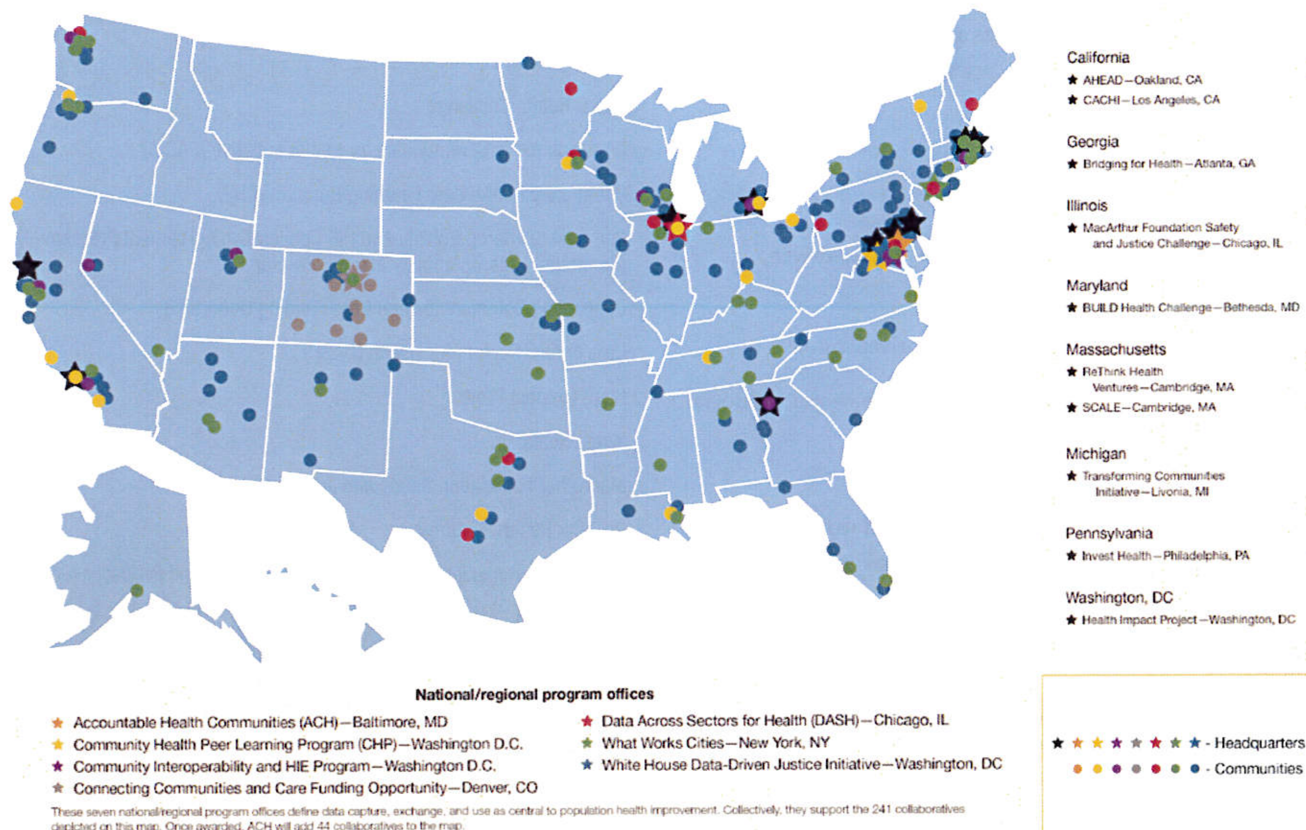
- **Evaluation:** Programs are taking varied approaches to evaluation, and at multiple levels (e.g., program office performance, community progress). All confirm they have much to learn, and expressed interest in a further discussion of metrics and measurement strategies for assessing both community capacity and health improvement impact over time.
- **Financing models and sustainability:** Ten programs are exploring alternative financing models (e.g., pay-for-success, social impact bonds, Wellness Funds), but all programs expressed concern about building the capacity of local collaboratives to sustain and extend progress beyond funding terms.
- **Data capture, exchange, and use:** Nearly half of the profiled programs are working with partners and local communities to enhance existing or build new data infrastructure to support community health improvement objectives. Efforts are diverse, and focus on a range of use cases, including individual care coordination, and population-based detection and intervention planning. The geographic coverage and scale of these local projects is highlighted in the map below.

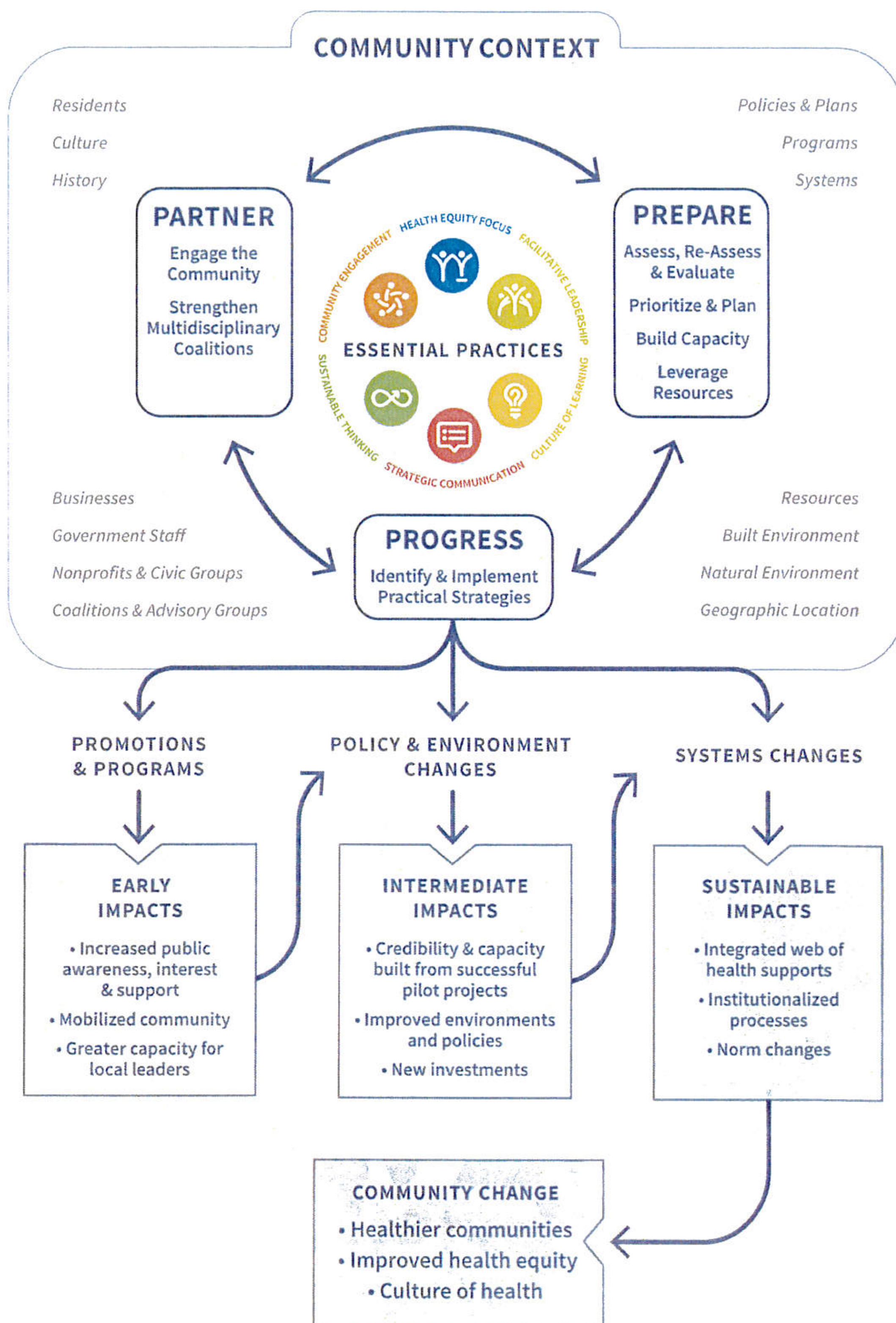
Much work remains: Future opportunities for research and investment

- **Supporting "aspirational" community collaboratives:** Though 400+ local initiatives represented in the scan receive financial support, many more remain unfunded, or underfunded, and may need external financial and other support to gain traction and sustain progress.
- **Capturing and shamelessly sharing what does and does not work:** Those aspiring to this level of collaboration for community health need both cautionary tales and bright spots; programs are working hard to both advance progress and document lessons for the benefit of the field.
- **Supporting a multigenerational workforce:** Programs see their investment as supporting local infrastructure development and empowering newly engaged community partners to play more active roles toward population health improvement.
- **Developing measures of progress and building the evidence base:** Progress at scale will require the development and application of meaningful metrics; these will help to assess impact at the individual community level, and to signal a path forward for other communities working with similar constraints, attributes, resources, and aims.
- **Creating mechanisms to support meaningful connections:** Program leaders, funders, and local projects share a common interest in connecting and coordinating to learn as much and as quickly as possible. The establishment and recent growth of All In: Data for Community Health, which seeks to build capacity, accelerate learning, and enhance collective impact, reflects this need for networked learning at scale.

Our hope is that this report will both clarify the current state of this dynamic and rapidly growing movement and illuminate possible opportunities at all levels to hasten progress toward greater connectivity and collective action toward improving population health.

Mapping (part) of the national movement



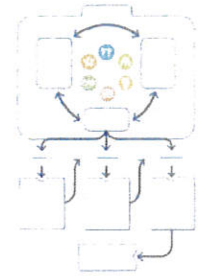


Community Action Model

ACTIVE LIVING BY DESIGN
Catalyst for a culture of health

This model is an evidence-informed framework for creating healthier communities through comprehensive and integrated strategies. It serves as the basis for Active Living By Design's work with communities and funders and can be useful to community coalitions and local leaders seeking a collaborative approach to creating healthier places and to funders seeking tested strategies for local investments. For more information, visit activelivingbydesign.org

© 2016 Active Living By Design



COMMUNITY CONTEXT

HEALTH EQUITY FOCUS

Use an intentional, inclusive, and reciprocal process to address the community's history of social and structural injustices and to help build trust and mutual understanding.

FACILITATIVE LEADERSHIP

Broaden your definition of leadership. Look for leaders outside of the usual health and government sectors, such as youth, educators, and faith, immigrant, and business communities.

CULTURE OF LEARNING

Listen to the lived experiences of community members and partners. Share what you learn broadly and collaboratively.

STRATEGIC COMMUNICATION

Seek to understand the current conversation around health in the community. Identify and learn about your audience's values, culture, and perspectives.

SUSTAINABLE THINKING

Assess the community's social, environmental, policy, systems, and economic resources to identify opportunities to leverage and sustain your work.

COMMUNITY ENGAGEMENT

Build in opportunities for residents to share their perspectives about the community. Incorporate their understanding of community context into your work.

Essential Practice Wheels

The Essential Practices of Active Living By Design's Community Action Model are interwoven within all stages of the model, including community context and the 3P Action Cycle. These wheels explore what form that might take in your community change work. For more information, visit activelivingbydesign.org.

© 2016 Active Living By Design

Core Characteristics and Related Indicators of Successful Partnerships Involving Hospitals, Public Health Departments, and Other Parties

http://www.uky.edu/publichealth/CoreCharacteristicsSuccessfulPartners.php

Click here for the study final report.

CORE CHARACTERISTICS AND KEY INDICATORS

1. **Vision, Mission, and Values – The partnership's vision, mission, and values are clearly stated, reflect a strong focus on improving community health, and are firmly supported by the partners**
   - Vision, mission, and values are set forth in a written document and shared with key stakeholders, including the community the partnership serves
   - Partners are committed to support the partnership's vision, mission, and values
   - A board, a steering committee, or other body has the responsibility and authority to adopt policies and approve initiatives that support the partnership's mission
2. **Partners – The partners demonstrate a culture of collaboration with other parties, understand the challenges in forming and operating partnerships, and enjoy mutual respect and trust**
   - Partners have a history and tradition of participating in collaborative arrangements
   - Partners share mutual respect and trust for one another
   - Partners are open and transparent with one another
   - Partners focus on developing programs in which they have expertise and/or can secure external talent readily and efficiently
3. **Goals and Objectives – The goals and objectives of the partnership are clearly stated, widely communicated, and strongly supported by the partners and the partnership staff**
   - The partnership's goals, objectives, and programs are based on community needs with substantial community input
   - The partnership's goals and objectives are set forth in a written document and shared with key stakeholders, including the community the partnership serves
   - The goals and objectives should include meaningful and measurable outcomes and a timeline for achievement
   - Information regarding progress towards the partnership's goals and objectives is regularly provided to the partners, the community, and other key stakeholders
4. **Organizational Structure – A durable structure is in place to carry out the mission and goals of the collaborative arrangement. This can take the form of a legal entity, affiliation agreement, memorandum of understanding, or other less formal arrangements such as community coalitions**

- Organizational documents recite the key features of the partnership including its mission, goals, and core policies
- The partnership's board, or other body with governance responsibility, is comprised of persons with the capability needed to effectively provide direction, monitor progress, and adopt action plans as required to ensure continued progress
- Tax-exempt status is preferred but not required

5. **Leadership – The partners jointly have designated highly-qualified and dedicated persons to manage the partnership and its programs**

   - Leadership roles, responsibilities and decision-making authority are defined in writing, honored by key parties, and updated on a regular basis
   - Members of the partnership's staff have mutual respect for each other, compatible values, and dedication to build and maintain a successful, trust-based partnership
   - The partners and members of the partnership's staff share "ownership" of the partnership and demonstrate commitment to its long-term success

6. **Partnership operations – The partnership institutes programs and operates them effectively**

   - Partners identify resource requirements (human and financial), build capital and operating budgets that are sufficient, and successfully secures those resources
   - Communication channels among the partners, staff, the community, and other stakeholders are clear, transparent, and effective
   - Mechanisms to identify and resolve conflicts or issues are well-established and used proactively

7. **Program Success and Sustainability – The partnership is operational and clearly has demonstrated successful performance**

   - The partnership has been in operation for at least two years
   - The partnership assesses community health needs, prioritizes those needs, and develops evidence-based programs and strategies to address them
   - There is solid evidence of community engagement and support
   - There is solid evidence of successful operating performance, including clear potential to have long-term impact on community health

8. **Performance Evaluation and Improvement – The partnership monitors and measures its performance periodically against agreed upon goals, objectives, and metrics**

   - The partners and staff are deeply committed to on-going evaluation and continuous improvement
   - Measurable outcomes, metrics, and scorecards that enable evidence-based assessment of the partnership's performance are employed consistently
   - The partnership's goals, objectives, and programs are assessed regularly, findings are reported to the governing body, and actions are taken to improve the partnership and its performance

Principles for Making Health Care Measurement Patient-Centered

April 2017

American Institutes for Research

AMERICAN INSTITUTES FOR RESEARCH®

1000 Thomas Jefferson Street NW
Washington, DC 20007-3835
202.403.5000

www.air.org

Copyright © 2017 American Institutes for Research. All rights reserved.

Executive Summary

Patient-centered measurement involves partnering with patients in a meaningful way to decide what we measure, how we measure it, and how we report and use the results of measurement. It also requires that the needs and concerns of other key stakeholders such as health care providers, health care organizations, payers, insurers, and policymakers are considered, allowing for increased information flow between stakeholders; improved partnership; and shared responsibility and accountability for outcomes.

Five principles for patient-centered measurement were developed with input from a multidisciplinary group of stakeholders that included patients. These principles describe the essential elements and characteristics of patient-centered measurement. As a group, the principles augment and complement each other to inform a vision of measurement that reflects what patients say they need and want. The principles require that patient-centered measurement be: patient-driven, holistic, transparent, comprehensible and timely, and co-created with patients. Adhering to these five principles of patient-centeredness will improve the ability of measurement to drive meaningful change toward better health, better care, and lower costs.

Five Principles for Patient-Centered Measurement

Patient-centered measurement is:

1. **Patient-driven:** Patients' goals, preferences, and priorities drive what is measured and how performance is assessed.
2. **Holistic:** Measurement recognizes that patients are whole people and considers their circumstances, life and health histories, and experiences within and outside of the health care system.
3. **Transparent:** Patients have access to the same data as other stakeholders and understand how data is used to inform decision-making around care practices and policies.
4. **Comprehensible and timely:** Patients and other stakeholders get timely, easy-to-understand data to inform decision-making and quality improvement.
5. **Co-created:** Patients are equal partners in measure development and have decision-making authority about how data is collected, reported, and used.

VIEWPOINT

Era 3 for Medicine and Health Care

Donald M. Berwick, MD, MPP
Institute for Healthcare Improvement, Cambridge, Massachusetts.

Editorial page 1339

Viewpoints pages 1331, 1333, and 1335

Corresponding Author: Donald M. Berwick, MD, MPP, Institute for Healthcare Improvement, 20 University Rd, Cambridge, MA 02138 (donberwick@gmail.com).

Constant conflict roils the health care landscape, including issues related to the Affordable Care Act, electronic health records, payment changes, and consolidation of hospitals and health plans. The morale of physicians and other clinicians is in jeopardy.[1]

One foundational cause of the discord is an epic collision of 2 eras with incompatible beliefs.

Era 1

Era 1 was the ascendancy of the profession, with roots millennia deep—back to Hippocrates. Its norms include these: the profession of medicine is noble; it has special knowledge, inaccessible to laity; it is beneficent; and it will self-regulate. In return, society conceded to the medical profession a privilege most other work groups do not get: the authority to judge the quality of its own work.[2]

However, the idealism of era 1 was shaken when researchers examining the system of care found problems, such as enormous unexplained variation in practice, rates of injury from errors in care high enough to make health care a public health menace, indignities, injustice related to race and social class, and profiteering. They also reported that some of the soaring costs of care were wasteful—not producing better outcomes.

These findings made a pure reliance on trusted professionalism seem naive. If medical professionals were scientific, why was there so much variation? If they were beneficent, how could they permit so much harm? If they self-regulate, how could they waste so much?

Era 2

The inconsistency helped birth era 2, which dominates the present. Exponents of era 1 believe in professional trust and prerogative; those of era 2 believe in accountability, scrutiny, measurement, incentives, and markets. The machinery of era 2 is the manipulation of contingencies: rewards, punishments, and pay for performance.

The collision of norms from these 2 eras—between the romance of professional autonomy on the one hand, and the various tools of external accountability on the other—leads to discomfort and self-protective reactions. Physicians, other clinicians, and many health care managers feel angry, misunderstood, and overcontrolled. Payers, governments, and consumer groups feel suspicious, resisted, and often helpless. Champions of era 1 circle the wagons to defend professional prerogatives. Champions of era 2 invest in more and more ravenous inspection and control.

This conflict impedes the pursuit of the social goals of fundamentally better care, better health, and lower cost. The best route to these goals is the continual design and redesign of health care as a system. When the ethos of professionalism clashes with the ethos of markets and accountability, immense resources get diverted from the crucial and difficult enterprise of re-creating care.

The tactics of eras 1 and 2 reflect deeply held beliefs. The clash will continue unless and until those beliefs change and stakeholders act differently as a result.

Era 3

It is time for era 3—guided by updated beliefs that reject both the protectionism of era 1 and the reductionism of era 2. Era 3 requires 9 changes, at least.

First, Reduce Mandatory Measurement

Era 2 has brought with it excessive measurement, much of which is useless but nonetheless mandated. Intemperate measurement is as unwise and irresponsible as is intemperate health care. Purveyors of measurement, including the Centers for Medicare & Medicaid Services (CMS), commercial insurers, and regulators, working with the National Quality Forum, should commit to reducing (by 50% in 3 years and by 75% in 6 years) the volume and total cost of measurements currently being used and enforced in health care. The aim should be to measure only what matters, and mainly for learning.

With that focus, all health care stakeholders could know what they need to know with 25% of the cost and burden of today's measurements enterprise. The CMS has, to its credit, removed many process measures from programs, but progress toward a much smaller set of outcome measures needs to be faster. Such discipline would restore to care providers an enormous amount of time wasted now on generating and responding to reports that help no one at all.

Second, Stop Complex Individual Incentives

Aligning payment systems and incentives with triple aim goals for organizations makes sense, but payers and health care executives should declare a moratorium on complex incentive programs for individual clinicians, which are confusing, unstable, and invite gaming. The CMS should confine value-based payment models for clinicians to large groups. A moratorium would require placing more trust in the intrinsic motivation of the health care workforce and putting more effort into learning and less into managing carrots and sticks. For many, if not all, clinicians, the best form of individual payment to support a focus on need is, simply, salaried practice in patient-focused organizations.

Third, Shift the Business Strategy From Revenue to Quality

Maximizing revenue continues too much to dominate the business models of health care organizations. That reflects short-term thinking. A better, more sustainable route to financial success is improving quality. This requires mastering the theory and methods of improvement as a core competence for health care leaders. It also requires that the CMS and other payers continue to un-

Copyright 2016 American Medical Association. All rights reserved.

Downloaded From: http://jamanetwork.com/pdfaccess.ashx?url=/data/journals/jama/935156/ by a San Diego State University User on 04/04/2017

link incomes from input metrics, such as "relative value units" for specialists' incomes, which are not associated with quality and drive volume constantly upward.

Fourth, Give Up Professional Prerogative When It Hurts the Whole

From era 1, clinicians inherit the trump card of prerogative over the needs and interests of others. "It's my operating room time." "I give the orders." "Only a doctor can...." "Only a nurse can...." These habits and beliefs do harm. Although most clinicians richly deserve respect and gratitude, the romantic image of the totally self-sufficient physician no longer serves professionals or patients well. The most important question a modern professional can ask is not "What do I do?" but "What am I part of?" Those who prepare young professionals should nurture that redirection from prerogative to citizenship. Physician guilds should reconsider their self-protective rhetoric and policies.

Fifth, Use Improvement Science

Modern quality sciences offer a sterling alternative to the hostility and misunderstanding that inspection, reward, and punishment create. For those methods to work, they have to be used, but for the most part, health care still does not use them. Four decades into the quality movement, few in health care have studied the work of Deming, can recognize a process control chart, or have mastered the power of tests ("plan-do-study-act" cycles) as tools for substantial improvement. Yet, proof of concept is apparent in leading organizations that are using quality improvement strategically. Academicians should make mastery of improvement sciences part of the core curriculum for the preparation of clinicians and managers.

Sixth, Ensure Complete Transparency

Although measurement has become excessive and needs to be streamlined, transparency is nonetheless essential. The right rule is: "Anything professionals know about their work, the people and communities they serve can know, too, without delay, cost, or smokescreens." Congress should provide further resources and direction to the CMS to make its vast trove of data much more readily available at much lower cost to clinicians, organizations, communities, and patients who can use that information to improve care. Commercial insurers should do the same with their data, and regulators should remove barriers like gag clauses and Employee Retirement Income Security Act (ERISA) ambiguity about who owns claims to allow data on value and quality to be widely accessible, even while raising the bar on privacy and security. All states should adopt all-payer claims databases. Professional societies and clinicians should abandon traditional opposition to absolute transparency.

Seventh, Protect Civility

The rhetoric of era 1 can slide into self-importance; that of era 2, into the tone of a sports arena. Neither supports authentic dialogue. Medicine should not, as happens too often in Washington, DC, substitute accusation for conversation. Proponents of era 3 should heed the advice of Waller, who noted, "Everything possible begins in civility" (Robert Waller, MD, former president and CEO of Mayo Clinic, written communication, January 31, 2016).

Eighth, Hear the Voices of the People Served

The more patients and families become empowered, shaping their care, the better that care becomes, and the lower the costs. Clinicians, and those who train them, should learn how to ask less, "What is the matter with you?" and more, "What matters to you?" "Coproduction,"[3] "co-design," and "person-centered care" are among the new watchwords, and professionals, and those who train them, should master those ideas and embrace the transfer of control over people's lives to the people. That includes paying special attention to the needs of the poor, the disadvantaged, and the marginalized, and firmly defending health care as a universal human right.

Ninth, Reject Greed

Health care has slipped into tolerance of greed and it has to stop, through volunteerism when possible, through strong regulation when not. Rapacious pharmaceutical pricing, hospitals' exploiting market leverage to increase prices, profiteering physicians, and billing processes that deteriorate into games with consultants coaching on how to squeeze out more profit all hurt patients and impair trust. Era 3 needs much more restraint. For starters, willing pharmaceutical companies, equipment manufacturers, hospitals, physicians' organizations, nursing leaders, and consumer groups should convene to define and promulgate a new set of forceful principles for "fair profit and fair pricing," with severe consequences for violators. Professional organizations and, importantly, academic medical centers should articulate, model, and fiercely protect moral values intolerant of individual or institutional greed in health care.

Conclusion

Era 1 is the era of professional dominance. Era 2 is the era of accountability and market theory. Let era 3 be the moral era. Era 1 enthusiasts will find that prescription abrasive. Era 2 devotees will find it naive. But the discord is not helping clinicians, communities, or patients. Without a new moral ethos, there will be no winners.

ARTICLE INFORMATION

Published Online: March 3, 2016. doi:10.1001/jama.2016.1509.

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Berwick reported serving as president emeritus and senior fellow at the Institute for Healthcare Improvement, as a visiting fellow of the King's Fund (London, England), and a member of the board of directors for NRC Inc. All 3 organizations have projects in the field of quality of care improvement and measurement. The first 2 are not-for-profit organizations and the last is for-profit.

Additional Information: This article is based on a keynote address given at the 27th Annual National Forum on Quality Improvement in Health Care; December 9, 2015; Orlando, Florida. The full speech is available at https://www.youtube.com/watch?v=DKK-yFn7e_0.

REFERENCES

1. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc*. 2015;90(12):1600-1613.

2. Freidson EL. *Profession of Medicine: A Study in the Sociology of Applied Knowledge*. Chicago, IL: University of Chicago Press; 1970.

3. Batalden M, Batalden P, Margolis P, et al. Coproduction of healthcare service [published online September 16, 2015]. *BMJ Qual Saf*. doi:10.1136/bmjqs-2015-004315.

Copyright 2016 American Medical Association. All rights reserved.

Downloaded From: http://jamanetwork.com/pdfaccess.ashx?url=/data/journals/jama/935156/ by a San Diego State University User on 04/04/2017

STRONG FOUNDATIONS: THE ECONOMIC FUTURES OF KIDS AND COMMUNITIES

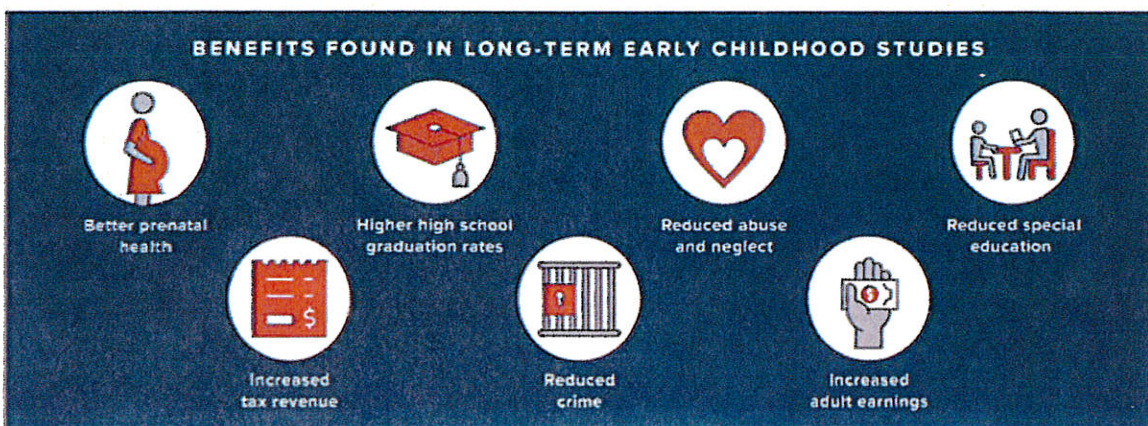
By Lecia Imbery APRIL 14, 2017
HTTP://WWW.CHN.ORG/2017/04/14/STRONG-FOUNDATIONS-THE-ECONOMIC-FUTURES-OF-KIDS-AND-COMMUNITIES/#.WPEN6NLYS2X

"Our young people are the future, and we all want them to have the support they need for successful and fulfilling lives. As a central banker, I recognize the benefits to the broader economy when more people are better prepared for work and for managing their finances. In short, ensuring that all of our kids have 'strong foundations' will help build a similarly strong foundation for the U.S. economy." – Janet Yellen, Chair of the Board of Governors of the Federal Reserve System

Last month, I attended a conference convened by the Federal Reserve System titled, "Strong Foundations: The Economic Futures of Kids and Communities." Over the course of two days, academics, public servants, policy wonks, and on-the-ground advocates presented research and debated policies related to developmental and environmental factors that influence children and communities. Why would the Fed, an institution that most of us only think about only in terms of interest rates and monetary policy, care about things such as a child's education or the environment he or she grows up in? The above quote by Federal Reserve Chair Yellen, taken from her opening remarks at the conference, says it all when kids have strong foundations for success, our economy as a whole will be more successful.

Early Investment in Kids Can Pay Off

Inflation-adjusted rates of return estimated to reach 10 percent or higher*

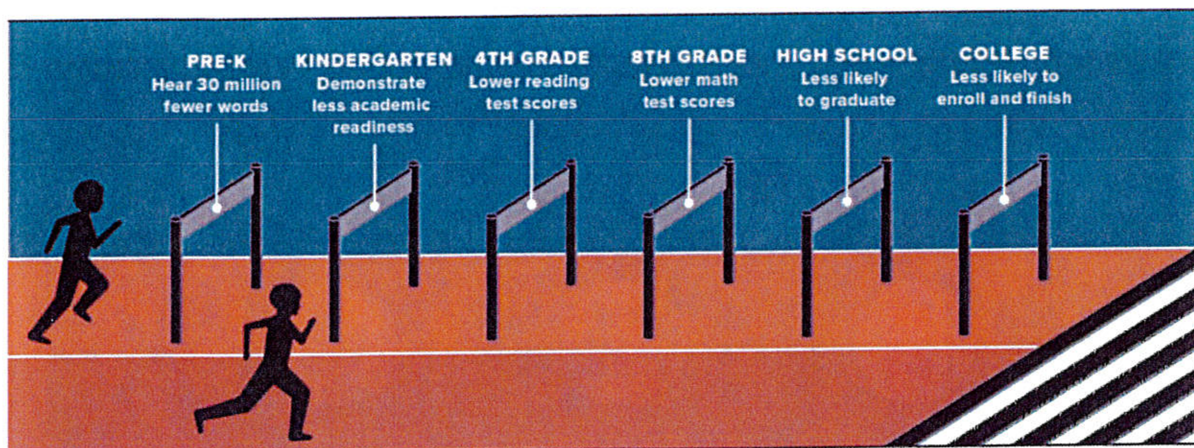


minneapolisfed.org/2017FRSConference

Several speakers throughout the conference noted that the Federal Reserve has two goals as it relates to monetary policy: stable prices and maximum sustainable employment. The Fed believes that community development and these conferences (the conference last month was the 10th such conference they have convened) support the goal of maximum sustainable employment. The better kids are prepared to get and keep good jobs, they closer the economy gets to this goal. In fact, as Chair Yellen pointed out, "The conference is cosponsored by, and includes substantive contributions from, the community development offices of all 12 Federal Reserve Banks as well as the Board of Governors. That united effort and level of commitment reflects how consequential we consider these issues to be."

Throughout the three different tracks of the conference – early childhood development, community conditions, and education and workforce development – several reoccurring themes appeared:

- **Early childhood experiences** (neighborhood environment, parents' income, school quality and other factors) **have a huge impact** on the development of kids and their health and success later in life. Investing in early childhood development is one of the best possible investments we can make, and attention to childhood development should begin very early on with things like prenatal care, home visiting programs, and cash supports for parents such as the Earned Income Tax Credit and child care subsidies.

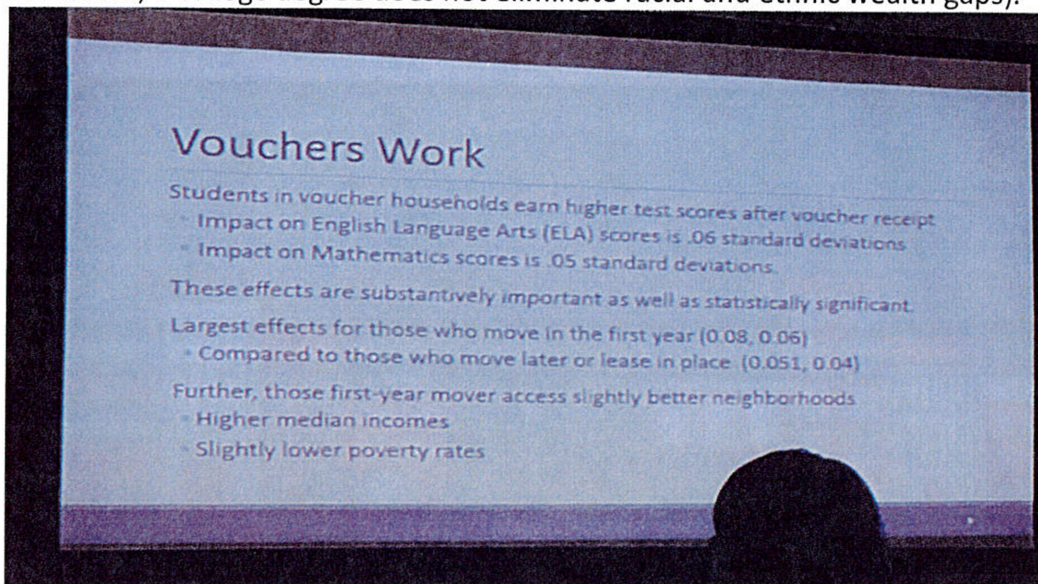


- Early childhood education is not an inoculation. **Kids need positive "booster shots"** along the way – especially in adolescence, which is a critical time for development and growth.
- Policies need to **improve opportunities for ALL low-income** children and be racially and ethnically conscious.
- We need to both **support and build the capabilities of adults** who care for kids, and **strengthen communities** to support families raising kids under difficult circumstances.

A plethora of resources that were presented throughout the two-day event can be helpful to advocates in a number of different fields:

- FedCommunities.org has hundreds of community development resources from all 12 Federal Reserve Banks and the Board of Governors. Resources include free webinars, a podcast series, papers presented at the last two conferences on economic mobility and strengthening the financial futures of families, and more.

- All of the papers and presentations from this year's conference can be found here. A few of the highlights include papers showing the positive impact of housing vouchers on school performance (see one slide from the presentation below), the negative effect of distressed housing on kindergarten readiness, the positive effect of the EITC on lowering childhood obesity, and the relationship between higher education and racial and ethnic wealth gaps (while increased education is related to increased wealth for all races and ethnicities, a college degree does not eliminate racial and ethnic wealth gaps).



- DiversityDataKids.org, a product of Brandeis' Heller School for Social Policy and Management, allows you to "explore hundreds of measures of child wellbeing and policy analysis from a unique information source that documents diversity, opportunity and equity among US children."

More resources, including videos of the keynote and plenary speakers and downloadable versions of the infographics produced by the Fed used in this piece, are expected to be added to the conference website soon, so check back for these.

According to a sneak preview from Dr. Yellen, the Federal Reserve Board's latest Survey of Household Economics and Decisionmaking (SHED), to be published in May, shows the strong connection between the experiences of poverty in childhood and economic challenges later as an adult. Also in May, we expect to see a more detailed version of President Trump's FY18 budget proposal, the "skinny" version of which eliminates Community Development Block Grants, Community Services Block Grants, afterschool programs and others, and slashes education, rental assistance, the Women, Infants and Children nutrition program and so many more programs that fight childhood poverty. While it's unlikely that President Trump will use the resources mentioned above from the Fed, we as advocates can use these resources to push back against the cuts. We'll continue updating our FY18 budget resource page with other useful resources, too, to empower you in the fight ahead. The success of our children – and of our economy – depends on it.