How To: Truly Engage Your Community
And What It Means For Your Organization

Dr Pritpal S Tamber, Bridging Health & Community
Dunia Faulx, Jefferson Healthcare
Lori Peterson, Collaborative Consulting
Finding the 12 Principles

Pritpal S Tamber
CEO, Bridging Health & Community, WA
The Inverse Care Law

“The availability of good medical care tends to vary inversely with the need for it in the population served.”

Dr Julian Tudor Hart

Feb 27, 1971
BEING THE WORKING POOR HURTS
What Does It Take?

“As a practical matter, there's no evidence these algorithms actually predict riskier populations and little evidence on what interventions would change the course for these patients.”

– Dr Ashish Jha, Harvard Global Health Institute
Discovering What It Takes

- Start from a community’s understanding of its health
- Learn from the doers
- Only engage those that’ll share their struggles
- Almost 100 practitioners to date
Discovering health care, not sick care

It’s becoming fashionable to say that health care is really ‘sick care’ but who is really trying to work out what caring for health means? One group in the Nijmegen Area of the Netherlands is leading the change and I was lucky enough to speak with its chief organiser, Chantal Walg.

Pritpal S. Tambe: Hi, Chantal. We probably should start with how you’re defining ‘health’ seeing as it’s at the core of what you’re doing.

Chantal Walg: Hi Pritpal. We use the idea of ‘positive health’, as described by Michiel Huber in a 2011 article in the BMJ. She argued that WHO’s definition of health as ‘a complete state of physical, mental and social well being’ was no longer fit for purpose given the rise of chronic diseases, especially in the elderly. She proposed an alternative: the ability to adapt and to self manage in the face of social, physical and emotional challenges. It has six domains: physical functioning, mental well-being, social participation, daily functioning, meaningfulness and quality of life. She called it ‘positive health’.

PST: Ok. So how far have you got with this alternative definition?
Diet

• Access to real food
• Affordable
• ‘Food deserts’
• Phil Sambol, Good Food Markets Inc.
• Diagnosis: lack of viable retail models
• Local stores are too small for regional grocery suppliers
• As a result, customers pay more per-unit
• Consumers perceive new stores as harbingers of displacement
• Lack of social coherence
Exercise

- Get more exercise!
- Normal part of life
- Walk more
- Maggie Super Church, Healthy Neighborhoods Equity Fund
- Capital Band A: Public money; no return
- Capital Band B: Philanthropy; modest return
- Capital Band C: Commercial capital; 10% return (i.e., hospitals)
- Hospitals typically invest without regard to mission alignment
- Safety and connectedness
Include in a community’s collective effort those who live there, those who work there, and those who deliver or support services there.

Spend time understanding differences in context, goals and power.

Appreciate the arc of local history as part of the story of a place.

Elicit, value and respond to what matters to community residents.

Facilitate and support the sharing of power, including building the capacity to use it and acknowledging existing imbalances.

Operate at four levels at the same time: individual, community, institutional and policy.

Accept that this is long-term, iterative work.

Embrace uncertainty, tension and missteps as sources of success.

Measure what matters, including the process and experience of the work.

Build a vehicle buffered from the constraints of existing systems and able to respond to what happens, as it happens.

Build a team capable of working in a collaborative, iterative way, including being able to navigate the tensions inherent in this work.

Pursue sustainability creatively; it’s as much about narrative, process and relationships as it is about resources.
Making Sense of the 12

- S Leonard Syme
- Inclusive, participatory and responsive process
- Fosters ‘agency’ – the ability to make purposeful choices
- Agency underpins having a sense of control
• Mastery; Self-Efficacy; Locus of Control; Learned Helplessness; Resilience

• Control as an integrating concept

• "Parsimonious integration of many seemingly unrelated concepts"

• Control enabled him to understand why higher rates of disease are found among people in lower socio-economic positions (50%)

• "I came to this conclusion grudgingly and reluctantly"
Fostering Agency to Improve Health

A tool to apply 12 principles key to health in your community

Version 1.0.0 (electronic) | May 2017

Creative Commons

Bringing Purpose to Community Engagement

A Tool for Reconceiving Health Care’s Relationship with Communities

www.healthandcommunity.org
11. Build a team capable of working in a collaborative, iterative way, to include navigating the tensions inherent in this work

Discuss where on this continuum you think your work lies

Participants in the community health effort acknowledge and embrace the value of an interdependent collaborative team.

Participants in the community health effort accept that the explorative, implicitly uncertain, and iterative nature of the work will surface tensions and insecurities, and that it is important to have support in building the capacity to navigate this.

Participants in the community health effort intentionally dedicate time to ongoing self-reflection on their purpose, motivations, assumptions, and insecurities in order to practice authenticity with their team.

Participants in the community health effort intentionally dedicate time to team building and co-reflection to make sense of situations they face together, including sharing motivations, assumptions, tensions and insecurities that arise.

The community health effort operates in an environment where motivations, assumptions, tensions and insecurities are routinely unearthed and understood through self and collective reflection, and the resulting cohesion of the team draws out insights and results not individually attainable.

Consider these prompt questions to help you assess and deepen your alignment with the Principle

- How do participants in your community health effort view the role of the team and of the individual?
- How do you build, monitor, and maintain the functioning and cohesion of your team?
- How are tensions acknowledged, discussed, and addressed?
- How are self-reflection and assessment of motivations, judgments, and assumptions incorporated into your work?
- How is self-care encouraged and supported?
- In what areas is the team excelling? In what areas is the team struggling?
- How is working as a collaborative team deepening engagement in the other principles?
- What barriers exist to developing a team capable of working in a collaborative and iterative manner? Why do you think these barriers exist?
- What steps could you take to create a more collaborative, iterative, and high-functioning team?
Build a team capable of working in a collaborative, iterative way, including being able to navigate the tensions inherent in this work.

Participants in the community health effort acknowledge and embrace the value of an interdependent collaborative team. The community health effort operates in an environment where motivations, assumptions, tensions and insecurities are routinely unearthed and understood through self and collective reflection, and the resulting cohesion of the team draws out insights and results not individually attainable.

**How are tensions acknowledged, discussed and addressed?**
Applying the Principles at a Rural Hospital in Washington State

Dunia Faulx
Population Health Department, Jefferson Healthcare, Port Townsend WA
A 25 bed, full service, fully accredited critical access hospital meeting the healthcare needs of 27,000 residents of east Jefferson county.

The owner and operator of Jefferson Healthcare Home Health and Hospice Services.

The largest employer in Jefferson County, employing 465 FTE’s and generating over $45 million in annual payroll.

The healthcare system of East Jefferson County.
The Community We Serve

- Population 30,333 (ACS 2016)
- Washington State’s oldest population;
  - Median age of 56.2 years;
  - 18 years above the median age of the U.S.;
  - 9,598 people are 65 years old and older; this is 32% of the total population.
- 51.2% Female (ACS 2016)
Jefferson Healthcare: Transitioning From Fee For Service To Value

Fee for service → Community Health Partnerships → Value-Based Care Contracts → Population Health
Value Based Care

#Focusingonthehealthinhealthcare

Clinical Care (20%)
- Quality of Care
- Access to Care

Health Behaviors (30%)
- Tobacco Use
- Diet & Exercise
- Alcohol and drug use
- Sexual activity

Social & Economic Factors (40%)
- Education
- Employment
- Income
- Family & Social Support
- Community Safety
- Food Insecurity

Physical Environment (10%)
- Housing
- Air and water quality
- Transportation
2018-2019 Population Health Strategies

- Food
- Housing
- Friends

Jefferson Healthcare
Population Health
2018 - 2019

- Coordinate community-wide projects to improve health.
- Characterize population needs.
- Promote a data-driven culture.

Brief Introduction
Brinnon is located in south Jefferson County. With a population of 778 in 2016, Brinnon has a median age of 59.4, which is higher than the median age for Jefferson County (56.2). The region is economically suppressed, with 25% of families with children under the age of 18 living below the poverty level. In the entire zip code of 1,211 individuals, 42% currently have a primary care provider at Jefferson Healthcare.

Brinnon Fast Facts
- Current population: 778 in Brinnon (53.5% male; 46.5% female), 1,211 in zip code 58320.
- Median housing income: $52,042.
- Mean travel time to work: 42.

Brinnon Community Profile

<table>
<thead>
<tr>
<th>Brinnon Fast Facts</th>
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<tbody>
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<td>Median housing income: $52,042.</td>
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<td>Mean travel time to work: 42.</td>
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Educational Attainment
- 28% College graduate
- 65% High school graduate or some college
- 15% Less than high school

Income
<table>
<thead>
<tr>
<th>2000</th>
<th>2016</th>
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<tbody>
<tr>
<td>Median housing income (in 2016-dollars)</td>
<td>37,380</td>
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</tbody>
</table>

Education
<table>
<thead>
<tr>
<th>2000</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 9th grade</td>
<td>34 (28%)</td>
</tr>
<tr>
<td>9th to 12th grade, no diploma</td>
<td>131 (29%)</td>
</tr>
<tr>
<td>High school graduate</td>
<td>248 (55%)</td>
</tr>
<tr>
<td>Some college</td>
<td>165 (9%)</td>
</tr>
<tr>
<td>College degree, including associate, bachelor and graduate</td>
<td>18 (10%)</td>
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Housing
<table>
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<tr>
<th>2000</th>
<th>2016</th>
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<tbody>
<tr>
<td>Total housing units</td>
<td>912</td>
</tr>
<tr>
<td>Occupied housing units</td>
<td>815 (89%)</td>
</tr>
<tr>
<td>Vacant housing units</td>
<td>97 (11%)</td>
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7. Accept that this is long-term, iterative work

Where on this continuum you think your community health effort lies

Participants in the community health effort acknowledge that they do not have all the knowledge or answers and that this is long-term work.

Participants in the community health effort develop and communicate a shared vision that signals its long-term (10-20 year) commitment to the community while also allowing for flexibility.

Participants in the community health effort practice using flexible approaches and prototypes in all key functions of the community health effort that allows for emergent needs, changing reality, and new insight.

The community health effort operates in an overall environment of emergent learning, with a process for continuous adaptation and evolution of strategy and solutions in response to ever-changing needs, reality, and insight.

Consider these prompt questions to help you deepen your practice of fostering community agency:

- What is the time horizon for the goals of your community health effort?
- How often are you assessing progress, context, and direction?
- How do you use information to influence strategies, activities, and direction? How responsive is your community health effort to new insight?
- What has been the effect when responding to emergent needs and insight?
- What barriers exist to being more flexible and responsive to emergent needs and insight? Why do you think these barriers exist?
- What steps could you take to become more flexible, iterative, and responsive?
- What barriers exist to working on a longer time horizon? Why do you think these barriers exist?
- What steps could you take to integrate working on a longer time horizon?
We have asked all the questions, we’ve reached out to all of the stakeholders.

Let’s address social isolation in South Jefferson County!
Is social isolation a problem that stands alone?

social isolation entwined with all other health factors
We have asked all the questions we needed to and have reached out to all of the stakeholders. Let’s address social isolation in South Jefferson County!
A Community Health Improvement Plan is a long-term, systematic effort to address the community’s most important health problems.

It is community-driven, rooted in data, and used to define a vision for health in a community.
Community Health Improvement Process

Community Health Assessment

Top Issues Identified

Final Priorities

Morbidity and Access

Behaviors

Morbidity and mortality

Safety and Access

Social Outcomes

Mental Health

Healthy Eating/Active Living

Substance Abuse

Clinical Care

Morbidity

Mental Health and Chemical Dependency

Chronic Disease Prevention

Access to Care

Immunizations

BRINNON
12 Principles: Top 3 For Me

• **Principle 1**: Include in a community’s collective effort those who live there, those who work there, and those who deliver or support services provided there.

• **Principle 3**: Appreciate the arc of local history as part of the story of a place.

• **Principle 6**: Operate at four levels at the same time: individual, community, institutional and policy.
Community & Cross-Sector Work

Lori Peterson
CEO, Collaborative Consulting, CA
Views from the Field

Learnings that Have Emerged from Our Cross-Sector Partnership Work
No Playbook

• Moving from complicated to complex
• No system or market is the same
• Multiple variables, dynamics, and desires will be involved
But, Some Considerations

- Leadership
- Financing
- Market Conditions
- Capacity Across Sectors
- **Design**
- Results-Oriented
Intermountain Healthcare to put $12M toward issues like housing, food insecurity

How Payer Philanthropy Can Address Social Determinants of Health

Kaiser Permanente Announces $200 Million Impact Investment, Partners With U.S. Mayors and CEOs to Address Housing Stability
Phases of Design

1. **Assess Internally**
   - Understand self – build capacities – change - organize

2. **Assess Externally**
   - Scan – identify - select

3. **Engagement and Relationship Building**
   - Listen – understand – inspire – common ground alignment

4. **Develop the Partnership Structure**
   - Design – integrate – manage - experiment

5. **Incorporate Mechanisms for Monitoring and Evolving Partnership**
   - Sustain (or terminate) – measure - refine

6. **Expand What Is Working**
   - Grow – replicate – new populations – new partners
Good Design & Notable Results

A hospital implemented a community care network
- .8 Day Reduction in Average Length of Stay for SNF Patients
- Over $2.2 Million in Savings from Initial LOS Reduction Alone
- Improved Efficiency in Door-to-Bed Times for Admitted Patients

A hospital partnered with a CBO on a short-term respite program
- 85% Readmission Reduction for Respite Participants
- 2 Week Reduction in Average Length of Stay for Participants
- Serving over 300 Homeless Patients Annually

A health plan engaged a CBO and Housing Provider to develop a community care program
- 50% Reduction in Total Cost of Care per Member per Month
- 60% Reduction in Hospital Average Length of Stay
- 95% Retention Rate in Community Placement at 6 Months
Community as a Design Partner
Not an After-Thought

• Partnership Intervention: Transition individuals from long-term custodial care to community settings with community-based care support

• Goals: Lower cost per member and improve member satisfaction

• Challenge: Member satisfaction lower than expected, individuals lacked social and daily living support

• Learned: Ask individuals directly what support they envision needing (not just about what the health plan envisioned as the needs) to thrive in the community and the “fix” was relatively simple
Another Example

- Partnership Focus: Create, standardize, and test a screening process for social needs in the four different clinical settings and refer individuals to CBO partners for services.
- Goals: Identify needs, enhance communication between sectors, better address the social needs.
- Challenge: Screening identified need but many individuals declined support from CBOs.
- Learned: Include community perspective early in the process and as part of the advisory/design team in screening tool development and seek community input on effective location and environment to screen for needs.
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What Next?

• Prospective testing of the 12 Principles
• Experimentation and learn
• Five sites (urban, suburban, semi-rural, rural, etc)
• Invest in both the work and sharing the learning
• Build a corpus of knowledge – partly for others to use
• If interested: contact@healthandcommunity.org

Please Do Ask Questions?
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