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Stewarding Regional Health Transformation

A Guide for Changemakers

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Transforming our regional health means whole-scale redesign and integration of all the forces that support health and wellbeing. To truly redesign local systems for radically better health, care, and economic prosperity in their regions, members of collaborative leadership teams must establish high aspirations and steward a change effort through distinct phases of transformation. They must create the long-term structures for active engagement of all the relevant participants—including residents—in stewarding shared resources. This Stewardship Guide is meant to help individual leaders and multi-sector collaborations create and sustain successful stewardship structures and change processes to lead regional transformation. It is meant for those who are looking to redesign their systems of health for radically better performance—creating and achieving a *transformed system* that will help individuals, families, and neighborhoods thrive with better health, lower costs, increased access to care, and improved equity and productivity for all.

Stewardship teams are groups of well-positioned leaders who are willing and able to take responsibility for improving their whole health system, and who lead together on behalf of that system, not just their own organizations. They look different in every community, and often include leaders from health care, public health, community organizations, business, insurers, philanthropy and nonprofits, social services, transportation, housing, and education.

This Guide will help you:

- Bring to the table the right kind and mix of leaders to act together as stewards of a change process
- Establish shared values and elevate aspirations for better health
- Engage residents in stewardship functions for the long run
- Encourage individuals to step outside their own organizational boundaries
- Design and lead stewardship teams that develop the legitimate authority to steer the system
- Build stewardship structures for the long haul and adapt them over time as the effort progresses
- Anticipate the challenges that will arise from progress and act collaboratively to address them

This Guide contains:

- Video presentations that explain how regional transformation efforts make progress (available online)
- Tools for individuals and stewardship teams to build and sustain momentum over time
- Case studies and video examples (available online) of leaders and regional stewardship groups who are leading change in their systems

- Common challenges—pitfalls—that leaders encounter in stewarding transformational change
- Momentum builders that help leaders avoid or move past these common pitfalls

The interactive Guide is available online at rethinkhealth.org/stewardship and includes videos, presentations, and web-based tools. This narrative version includes all written components available on the web, with a number of expanded sections.

How to Use the Guide

The Guide begins with an introduction to the core idea of stewardship and its central place in transforming regional systems of health. The Guide is then is divided into five sections that represent the key phases along the path that leaders must travel to build stewardship processes that can advance system-wide change. We call this the *Pathway for Transforming Regional Health*.

Phase Components

Each of the sections on the five phases begins with a short video presentation that you can find online. After watching the video, read through the phase description, which characterizes the main work and the most common pitfalls that arise. The phase description also identifies critical momentum builders—steps that are needed to enable and sustain progress, achieve the critical accomplishments of the phase, and continue building and adapting stewardship toward a transformed system. You will then want to explore the practical tools included in each section. These tools will help you assess progress and overcome hurdles in each phase of the *Pathway*. Lastly, dive into both the video and written case studies, which share lessons learned from stewardship groups that have traveled this journey and overcome key pitfalls and sustained momentum along the way.

Learning Partner

We recommend that you choose a learning partner for your progress through the Guide. That person might be someone who shares your aspirations for a radically better health system in your region, someone you work with closely in leading change, or someone you see as a champion or catalyst, whether in your own community or in another. The purpose of a learning partner is to explore ways to test and apply these materials in your own context and to help you sharpen your own effectiveness in leading transformation.

Your Feedback

At ReThink Health, we are committed to co-learning and co-creating with leaders in regions. We value your feedback on the content included in this Guide, which is an evolving and iterative resource. In the landing page of the Guide, and within every tool, you will see a feedback link through which you may provide comments. We look forward to hearing from you!

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Stewardship and the Pathway

What is Stewardship?

When regional stakeholders align around priorities and strategies and act on behalf of their system of health as stewards, they can enable successful redesign efforts. A system of health takes into consideration the full range of interconnecting forces—the social, behavioral, economic, and environmental conditions—that affect our health. These components include and extend far beyond hospital walls. Collaborative, legitimate leadership groups that bring together key, broad-based stakeholders across multiple sectors who can set priorities for change to their system of health are critical for success.

The research of economist and Nobel Laureate Elinor Ostrom inspires much of ReThink Health's thinking about stewardship of health systems. Learn more[1] about the power of leaders coming together across organizations to steward local resources on behalf of their communities. (See Appendix A).

Stewardship teams are groups of well-positioned leaders who are willing and able to take responsibility for improving their system of health broadly, and who lead together on behalf of that system, not just their own organizations. They look different in every community. Participants often include leaders from health care, public health, business, insurers, philanthropy and nonprofits, social services, transportation, housing, and education.

Some of the key functions stewardship teams fulfill over time are:

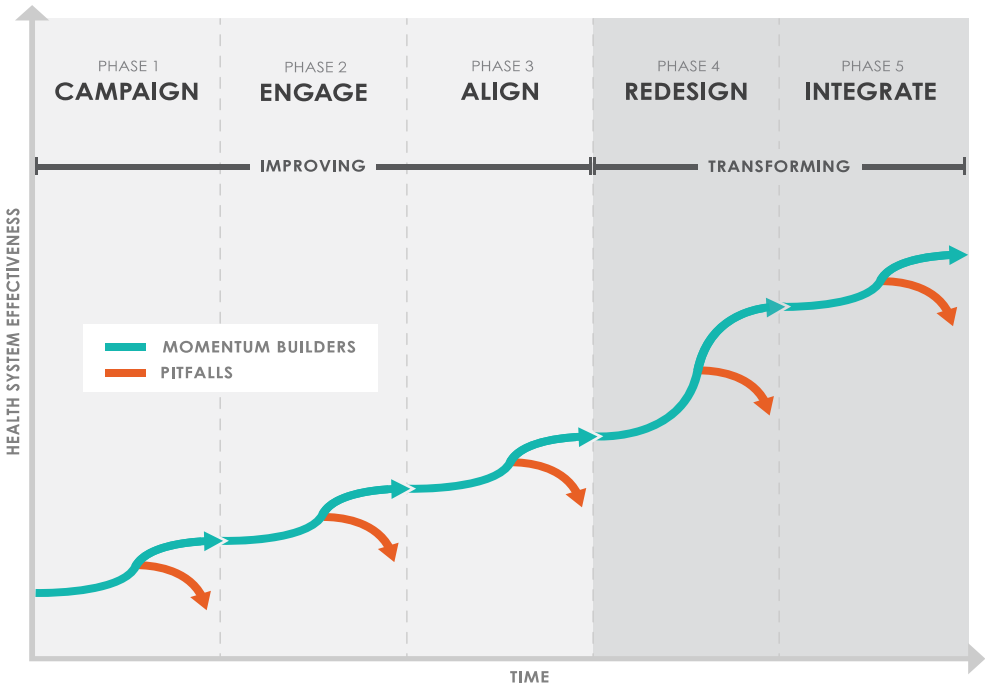
- Establishing opportunities to empower community voices and surface their priorities;
- Creating conditions to identify and sustain a shared vision for the future;
- Building critical relationships across sectors;
- Setting priorities for action;
- Identifying and pursuing strategies that will have significant impact; and
- Guiding resources into smarter more sustained investments.

[1] http://www.rethinkhealth.org/resources-list/stewardship-of-health-system-transformation/stewarding-shared-resources/

The *Pathway*

We developed the *Pathway for Transforming Regional Health* as a visual compass for leaders who are working to move from their currently fragmented regional systems of health to ones that are fully integrated and providing the results envisioned by residents. The *Pathway* begins when leaders step outside of their own organizations and work in collaboration with others to improve health and health care. Using the *Pathway*, leaders working toward a transformed system can assess where their effort is on the journey, what pitfalls to avoid, and what steps they should be considering to accelerate progress. The Pathway is represented as a crooked line rather than a linear roadmap because we know that regional efforts may cycle between phases for a while, move back into prior phases as they address pitfalls, or make occasional exponential progress.

Pathway for Transforming Regional Health



Through our partnerships with leaders in regions across the country, and drawing on research from many sectors beyond health and health care, at ReThink Health we have found that ambitious transformation efforts require three key ingredients. These are the three core pillars of the *Pathway*:

- **Broad-based Stewardship:** Leadership teams that work across boundaries
- **Sound Strategy:** A plan for focused action on high-leverage opportunities
- **Sustainable Financing:** New kinds of investment approaches to alter long-term trends

Significant improvements may be achieved in each domain of stewardship, strategy, and financing, but there are limits to each alone and they promise to be far stronger together. This Guide focuses on bolstering the stewardship function of regional change efforts. With active and broad-based

stewardship, groups will be better equipped to advance along the *Pathway* by developing sound strategies and successfully tackling ways to finance their ambitious visions.

You can learn more about the imperative of sustainable financing in our companion resource *ReThink Health Financing Primer*[2], and explore how leaders in regions can create sound strategy with the *ReThink Health System Dynamics Model*.[3]

Pitfalls on the Pathway

Often, successes in earlier stages of transformation create predictable pitfalls in later stages. For example, collaboratives that succeed in solving the key problem they came together to address can wind up stopping there—precisely because the results were satisfying and participants feel no need to do more. Pitfalls can derail progress, lead to missed opportunities for greater accomplishment, and keep a collaborative effort from achieving a bigger vision. These pitfalls can occur in communities of any size and demographic composition and with any array of health resources.

Momentum Builders

Momentum builders help leaders of stewardship teams avoid or move past common pitfalls. These are critical actions that help an effort to continue on an upward trajectory, protect against further reversals, and enable the transition to the next phase.

Introduction Tools

Tool 1: The Pathway Self-Diagnostic Tool

The Pathway Self-Diagnostic Tool[4] helps leaders address the questions:

Where do I believe our region is on the *Pathway*?
What pitfalls have we (successfully) navigated so far?
What pitfalls do we anticipate?
What momentum builders are well established, and where might we focus our work next?
(See Appendix B).

Tool 2: Leading Change Reflection Tool

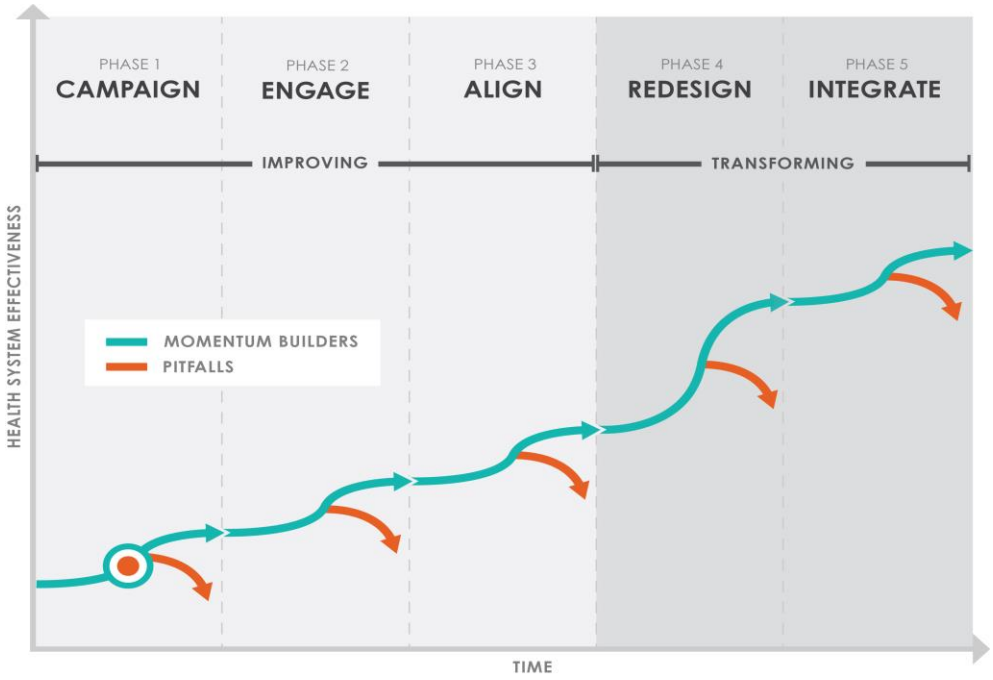
The Reflection Tool[5] is designed to enable leaders using the Stewardship Guide to address:

Where do I see my **own role** (leader, facilitator of other leaders, champion, participant) in the change effort of our system?
What are my personal aspirations for impact?
Who do I want as my learning partner(s) as I explore this material?
(See Appendix

[2] http://www.rethinkhealth.org/tools/financing-primer/
[3] http://www.rethinkhealth.org/our-work/dynamic-modeling-strategy/
[4] http://www.rethinkhealth.org/resources/stewardship-field-guide-pathway-diagnostic-tool/
[5] http://www.rethinkhealth.org/resources/reflection-tool-for-leadership/

Campaign

Phase 1



What is the Campaign Phase?

The first step on the *Pathway* often involves the launch of a cross-organizational collaboration to address a specific issue that necessitates coordination from multiple organizations. This coordination usually takes the shape of a "campaign," a focused, time-limited effort to align resources toward a shared goal that is implemented by a diverse group of stakeholders across a region. Phase 1 collaborations attack a specific issue or crisis, often for a subset of the residents in the community, and for a limited time.

For example, a successful Campaign Phase effort in Shelby County, Tennessee[6] was launched by a coalition of hospitals and other care providers, social service organizations, local businesses, and the faith community. This collaboration began by focusing on improving end-of-life care, reaching 100,000

[6] http://www.rethinkhealth.org/resources/phase-i-case-study-shelby-county-tennessee/

people in the region to promote use of advanced directives and advanced care planning for residents. Another example of a Phase 1 collaboration is the Community Solutions: Northeast Hartford Partnership—it is bringing together neighbors, businesses, public and private nonprofits, and government agencies to transform an abandoned factory into a center for community wellness, safety, and economic prosperity. (See Appendix C for a case study of the Community Solutions effort.)

A successful Phase 1 campaign is characterized by new, cooperative relationships being forged among leaders from diverse organizations that play a critical role in shaping health and care within that region. One of the critical challenges to overcome is forging trust with peer leaders who bring a different mindset and series of motivations to the table. Frequently, leaders who come from different organizations within a collaborative have a hard time connecting or getting past perceived barriers to cooperation. For example, it is hard to break down obstacles and work toward a common goal when leaders of competing hospital systems in a region have not had a history of collaborating.

A key accomplishment for Phase 1, then, is successfully meeting people where they are and building bridges to understanding roles, perspectives, and what it will take to work together. The joint work in this phase may be designed to limit risk to any one organization, and convened around a narrow purpose that has clear benefits for each of the participating organizations. Funding sources are mainly external grants targeted toward accomplishing campaign goals.

The Community Solutions: Northeast Hartford Partnership is pursuing audacious goals through campaigns, and disrupting the status quo with a sense of urgency to promote improvement. Learn more in a narrative[8] *and* video[9] *case study.*

The critical stewardship features of Phase 1 that make it a distinct step at the beginning of the *Pathway* are that:

1. leaders from a diverse set of organizations, including public health, healthcare providers, and/or community organizations convene with cooperative intentions; and
2. they focus on accomplishing a piece of work jointly.

Campaigns can play a critical role throughout the *Pathway*, serving to create momentum around key initiatives for any ongoing collaborative. However, whether an initial campaign is poised to move a collaborative to Phase 1l on the *Pathway* depends on whether the stakeholders involved define their initial campaign as a starting point for further collaboration or see it as a limited effort. If the coalition was formed to address a specific problem, little collaborative capacity was created to foster more efforts to improve health. Therefore, senior leaders involved in the initial work, often step away from the campaign once it has been launched, transitioning leadership to the hands of operational managers

[7] http://www.rethinkhealth.org/resources/case-study-phase-i/
[8] http://www.rethinkhealth.org/resources/phase-i-video-case-study/

who lack the power to do more. Transition to Phase 1I also depends on whether a cadre of well-positioned leaders begins developing a system perspective and a long-term view.

Common Pitfalls of Phase 1

- **Temporary and time-bounded purpose.** Campaigns involve the rapid rallying of resources to solve a problem that matters to several organizations in a region. By their nature, they are typically short-term collaborations. While a campaign might result in a new entity being formed (for example, a new clinic), the purpose of the collaboration is to get that solution in place—not to create a forum for more dialogue and joint work. As a consequence, collaborative capacity built by a campaign—relationships between senior leaders, infrastructure to support joint efforts, funding for the initiative—is directed at solving the problem, rather than building capacity for further accomplishment together.
- **Project leadership, not stewardship.** The leadership group that conceives and ratifies the purposes of a campaign often is composed of the senior leaders of the key organizations. These individuals have the authority to make a shared problem a priority, and deploy resources toward solving it. But ongoing leadership of anything created by a campaign typically involves capable project managers—not necessarily strong champions or those with the power to inspire bolder shared actions to change the system.
- **"We've done enough."** Campaigns demand a lot of energy and resources. A successful campaign involves mustering considerable determination to work together and build the capacity to solve an important problem. By their nature, campaigns—with the rhythm of "peak" moments accumulating toward a stable solution—call upon participants to invest surges of energy. Once the problem is solved, it is common for participants to feel they have met their goal with little motivation to do more together.
- **Narrow scope, restricted vision.** Because it is focused on a particular problem, a targeted campaign often brings together only a subset of the system stakeholders—many of the healthcare providers with a particular community group, for example. This restricted composition limits the chances that the group will develop the ability to see and understand the whole health system and what could be radically better about it. This limited vision of what is possible narrows the scope of a collaborative effort for a future change agenda. Moreover, any efforts to broaden the purposes or goals often are experienced by existing players as a "bait-and switch."

<u>Consequences</u>: One problem solved, no broader system impact.

Phase 1 Momentum Builders

- **Conduct a common needs assessment.** One effective way to turn a short-term joint effort into a platform for long-term collaboration is when regional health care providers conduct the required community needs assessment together, rather than separately. This kind of campaign is a natural platform for building *collaborative capacity* in the community, and can be a springboard to launching combined action projects with many other players who will be essential to addressing

those needs. Moreover, a common needs assessment often motivates joint investment in infrastructure to support additional collaboration over time and across projects.

- **Convene and launch a team of multi-sector champions.** The hard work of sustained collaboration requires committed champions, and changing a complex system requires diverse champions who represent all the parts. Leverage the engagement created by a focused campaign, sponsored by well-positioned leaders to call others to the table for a dialogue about what else is possible. Keep the most senior leaders engaged in dialogue about the ways in which the system could be working so much better for all the constituents they serve. Invite them to become the public faces and vocal proponents of a larger vision and inspiring possibilities.
- **Surface dissatisfaction with the status quo.** Change is motivated both by the sense that something better is possible *and* by the shared conviction that the status quo is untenable, unsatisfactory, or both. Build urgency and vision around a broad definition of success that includes a wide range of shared values: health, prosperity, sustainable costs, and excellent care for all. Name the aspirations held in the community that can be the focus of collaborative work across organizations, and spotlight the ways in which the current state fails to live up to what residents need. Visibly promote joint work that matters to residents and that no one organization was able to solve working alone. Harvest the lessons of initial campaigns to underscore what is possible, and celebrate accomplishments.
- **Develop systems thinking among a broad cadre of leaders.** Changing all of the facets that make up the health system requires a group of people who collectively can "see the whole," appreciate the way that different parts of the system—from the features of communities that enable health to the way that care is made available and paid for—affect each other. Use the wide variety of tools and conversations that can build understanding of the many facets that drive the health system and the role others play in it, to engage and motivate many influential members of the region to sharpen their understanding, build more empathic relationships with other leaders, and begin to see the importance of pursuing a system-wide strategy for change.

<u>Consequences</u>: Well-positioned leaders experience increasing urgency to do more together; initial accomplishments result in determination to do more together.

Phase 1 Tools

Tool 1: Developmental Assessment – What conditions have you created for transforming your regional health system? (Individual online measure and group facilitation guide)

This tool[9] measures progress on 11 conditions which, collectively, accelerate and sustain progress toward a transformed system of regional health. It is available as an online measure completed by individuals (and provides feedback to the user about their region's relative standing on the 11

[9] http://www.rethinkhealth.org/resources/stewardship-field-guide-developmental-assessment/

conditions, compared to other regions). The Developmental Assessment is also available as a facilitated group discussion guide. (See Appendix B).

Tool 2: Story of Now

This tool[10] guides leaders in the development of an urgent narrative of why broad change is needed… now. Using imaging, creative writing, and other generative techniques, the Story of Now tool results in a vividly painted picture of the Nightmare (what will happen if we don't work together toward change) and the Dream (what is genuinely possible if we do). (See Appendix B).

Tool 3: Mapping the Scope of Your Effort—Who is involved in your effort so far?

This tool[11] guides leaders in considering who the major stakeholders are that care about the health system, that are positioned to lead change and mobilize resources within it, and which are — and are not — actively engaged in collaborative efforts to move the system. It invites users to strategize about ways of engaging a broader and better-positioned set of champions in a change effort. (See Appendix B).

Tool 4: Leading Change Reflection Tool

The Reflection Tool[12] is designed to enable leaders using the Stewardship Guide to address:

Where do I see my **own role** (leader, facilitator of other leaders, champion, participant) in the change effort of our system?
What are my personal aspirations for impact?
Who do I want as my learning partner(s) as I explore this material?
(See Appendix B).

[10] http://www.rethinkhealth.org/resources/public-narrative-story-of-now/
[11] http://www.rethinkhealth.org/resources/mapping-the-scope-of-your-effort/
[12] http://www.rethinkhealth.org/resources/reflection-tool-for-leadership/

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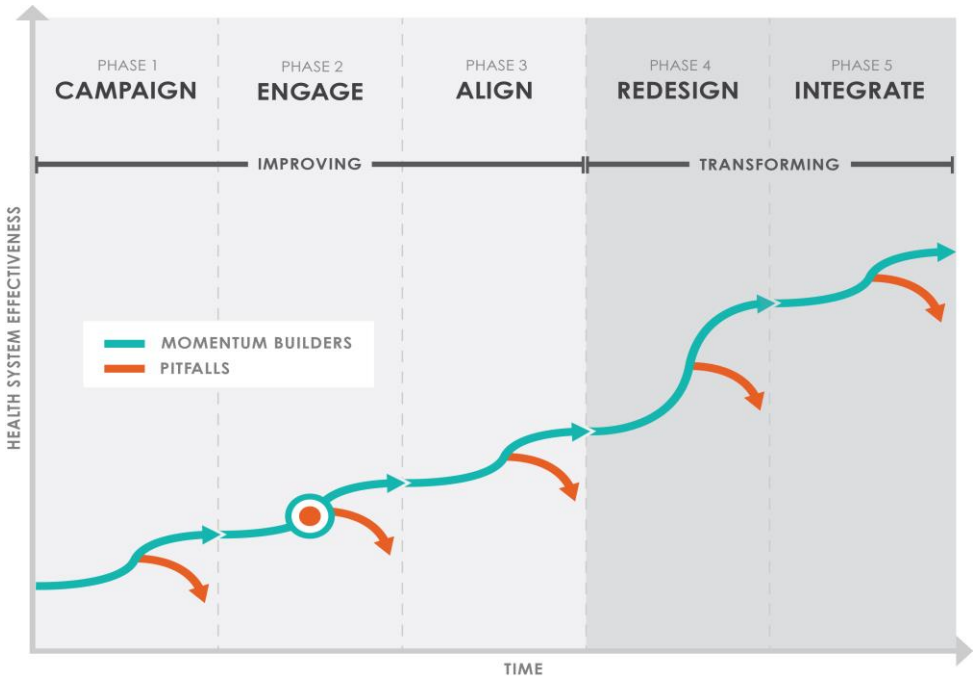
Engage

Phase 2



What is the Engage Phase?

The *Pathway's* second Phase 2 characterized by leaders of key regional institutions building an enduring collaboration around shared goals that cannot be achieved by any single organization acting alone. The critical features of Phase 2 that distinguish it from Phase 1 are:

1. a diverse group of leaders begins to think and act on behalf of the region, with the intention of continuing the collaboration over time; and
2. the group begins committing funds or hiring staff to make ongoing collaboration possible and productive.

In this phase, members of the collaboration identify and launch experiments and initiatives together, coordinating resources to anchor their efforts, even if it is primarily a forum for group dialogue.

Although leaders of a Phase 2 effort may define the collaboration's purpose as solving a particular problem for residents of the region, their joint initiatives ideally will lay the foundation for a broader scope of work going forward. Often, these collaborations become actual entities, hiring staff and investing in the creation of a shared infrastructure that makes joint initiatives across separate organizations possible—for example, systems for sharing data across institutions to solve a systemic problem.

There are many ongoing collaborative efforts that promote health and provide care in regions around the U.S. that sit squarely and successfully in Phase 2. One example is the ReThink Health-Upper Connecticut River Valley stewardship group in Vermont and New Hampshire. It represents regional employers, the social service sector, members of the Upper Valley community, Dartmouth College, and Dartmouth-Hitchcock Medical Center, and has the ultimate goal of building a healthy and sustainable local economy. Together, the group's members have worked to develop a long-term stewardship structure, even securing a permanent office and key staff to enable ongoing collaboration. (See Appendix C for a case study about the Upper Connecticut River Valley project).

Leaders of the ReThink Health-Upper Connecticut River Valley effort of Vermont and New Hampshire used narrative and informal and formal gatherings to recruit a team of champions, engage a broad set of residents in defining a vision, and build a cadre of highly engaged volunteers to launch initiatives. Learn more in a narrative[14] *and* video[15] *case study.*

The ability of Phase 2 efforts to progress to Phase 3 on the *Pathway*, however, depends on whether those involved have both the authority and capacity to commit their organizations to additional joint work. Transition to Phase 3 also depends on whether leaders are actively building trust rooted in shared values and aspirations as well as developing the capacity to identify a bolder, broader vision for a radically better, financially sustainable system that will help people lead healthier lives and access better, more affordable care where and when they need it.

Common Pitfalls of Phase 2

- **The "wrong" people are convening.** When organizations first decide to pursue an ongoing collaboration with each other, the process is a delicate dance. Often one key champion succeeds in convening the senior-most leaders to focus on one shared problem. Sometimes, once these leaders agree to commit resources to a shared project, they send delegates to take on management of the work. Leadership groups therefore wind up composed of people who have little authority to commit further resources or define additional purposes for the collaboration; they may not have been selected for the ability to work collaboratively, and they often see their responsibilities as

[13] http://www.rethinkhealth.org/resources/narrative-case-study-phase-ii/
[14] http://www.rethinkhealth.org/resources/video-case-study-phase-ii/

primarily or even solely to exercise influence on behalf of their own organizations. This leadership group composition inevitably keeps an effort stuck in a focus on a narrow task that has already been agreed upon, and unable or unwilling to tackle something harder.

- **Over-focus on early wins.** Building trust takes time, and leadership groups naturally tend to start with purposes that are easy to agree on—such as a small joint health-improvement project—that don't challenge anyone's core business. They also may invest a few resources and staff to get something started, but arrange matters so that people from different organizations work separately. Without working closely together over time, no collaborative "muscle" results even from successes.
- **Meetings are a waste of time**. In the early tentative dance of ongoing engagement, meetings of the leadership group can be mainly about discussion of shared issues, and certainly touch nothing controversial. It's a natural error—take it slow, don't ask too much too soon. The costs of that approach are that, rather than real collaborative work and decision making, leaders are merely having conversations that don't land anywhere. Eventually, any busy leader with significant responsibilities will lose commitment to the group—because the real leadership work is happening elsewhere.
- **Conflict undermines shared purpose.** Other leadership groups escape the "waste of time" trap but controversial subjects, such as competition between hospitals for key markets, are raised too soon in the process for the relatively limited collaborative capacity that has been built. In fact, the potential for unpleasant conflict may be one reason why members wind up spending their time on more trivial matters that are unlikely to become fraught with negative emotion. But existing conflicts between key institutions can erupt unexpectedly and evidence shows that mending damaged relationships takes far longer than breaking them.
- **Volunteer burnout.** Early ongoing collaborations rely heavily on the goodwill of participants; leaders, staff, and residents all typically donate time well beyond their "day jobs" to keep shared projects rolling, because investment in enough people and other resources to support a young initiative lag the amount of effort it takes to keep it going.

Consequences: Trust breaks down, momentum is lost, and/or the effort disbands; narrow focus results in limited system impact.

Phase 2 Momentum Builders

- **Build a real leadership team composed of the right people.** Effective Phase 2 collaborations create real leadership teams, composed of well-positioned leaders able to commit resources to a broad effort. It won't be the last such leadership team to form, but it plays a crucial role in building collaborative capacity to get things started. Rather than accepting delegates from organizations without scrutiny, with little sense of what those delegates bring to a leadership teams, champions building an ongoing effort can invite leaders to the table to take on a stewardship role. The "ask" to those who join is willingness to take responsibility to create broad involvement in a change effort over the long haul. Moreover, we know that people who contribute effectively to stewardship

groups have certain characteristics (see "Job Description for Stewards"[15]-Appendix B). It is important to identify a group of stewards who are willing and able to work together on behalf of the whole.

- **Experiment and learn.** Easy wins do build momentum, but successful efforts treat even early wins as opportunities for experimentation and learning. Identifying a handful of things that could be accomplished together and asking "what is possible for this collaboration?" make each experiment a basis for learning how to do more—and bigger—things together over time. Because later efforts can hit a wall when the easy wins are all harvested, early expectations that "we will fail at some things, and learn something from that," can inoculate against the pitfall of seeing only continued success as a sign that the collaboration is worth pursuing.
- **Share narratives to build values-based relationships.** Strongly shared purposes among key champions grow from shared values. Relationships that can endure hard conversations come from recognizing that the relationship is, in itself, something to be valued. One of the most powerful ways to discover shared values and build collaborative purposes is to engage in narrative. We find that engaging individual leaders in sharing their public narratives (see "Story of Self"[16] Appendix B) allows groups of leaders to articulate to themselves and to others what calls them, personally, to take on leadership of the challenges before them. Drawing on choice points in their personal histories, participants illustrate what values drive them as people, not just as representatives of their institutions, and why this leadership team's purposes may be consequential for them. Leaders can then readily identify shared themes and experience a genuine connection of purpose with each other that will serve them well when the challenge of dealing with different interests among their institutions inevitably arises.
- **Build capacity to discuss tough issues**. Choosing people with a demonstrated ability to work effectively with other leaders is one critical basis for building the team capacity to address the potentially competing interests among members' responsibilities over time. The second is defining the team's purpose and the invitation to leaders as leading on behalf of the whole. Conflicts in leadership teams often stem from members' views that their main responsibilities are to maximize the effectiveness of the unit or institution they lead. They will hold that assumption in the absence of any other "ask." But effective leadership teams also have clearly specified norms of conduct, established from the beginning and revisited repeatedly over time, that promote candor supported by empathy for each other's concerns. (see "(Re)Launching a Great Stewardship Team"[17] Appendix B).
- **Initiate joint investment.** Ongoing collaborations between organizations can rapidly outstrip the infrastructure needed to support them. Successful efforts are characterized by an early recognition that shared work will need shared structures— staff, funding, information systems—that will enable ongoing collaboration. And when leaders from different organizations invest in something shared,

[15] http://www.rethinkhealth.org/resources/relaunching-a-great-stewardship-team-job-description-for-stewards/
[16] http://www.rethinkhealth.org/resources/narrative-story-of-self/
[17] http://www.rethinkhealth.org/resources/relaunching-a-great-stewardship-team-job-description-for-stewards/

that investment itself builds the conviction about shared purposes and shared fates that keep a group together through challenging moments.

<u>Consequences</u>: Leaders build trust and deepening commitment to larger aims and a broader scope of action.

Phase 2 Tools

Tool 1: Developmental Assessment – What conditions have you created for transforming your regional health system? (Individual online measure and group facilitation guide)

This tool[18] measures progress on 11 conditions which, collectively, accelerate and sustain progress toward a transformed system of regional health. It is available as an online measure completed by individuals (and provides feedback to the user about their region's relative standing on the 11 conditions, compared to other regions). The Developmental Assessment is also available as a facilitated group discussion guide. (See Appendix B).

Tool 2: Story of Self

This tool[19] shows how developing and using a Story of Self can help develop leaders' calls to action and advance a coalition's motivational vision. Its purpose is to explain how to tell stories and share experiences in a way that inspires new leaders, shows a sense of urgency, and builds shared values and trust. (See Appendix B).

Tool 3: Stewardship Team Diagnostic Checklist

The Stewardship Team Diagnostic Checklist[20] for Leadership Teams was created to help stewards build effective leadership teams. It will help you to think through what features of your stewardship team most need some work to help improve the effectiveness of the team for guiding this phase of system change. (See Appendix B).

Tool 4: (Re)Launching a Stewardship Team & Job Description for Stewards

This tool[21] is intended to support the effective launch of a leadership team. It also can be adapted to re-launch a team that is not working effectively. Its principles can be applied to a coalition launch and ongoing team meeting agendas.

Included in this tool is a job description (modifiable by users and based on our work in many regions) outlining the skills needed to be an effective steward. It specifies the kinds of collaborative capacities and attitudes needed, as well as the typical time and task expectations of those serving the role. It can

[18] http://www.rethinkhealth.org/resources/stewardship-field-guide-developmental-assessment/
[19] http://www.rethinkhealth.org/resources/narrative-story-of-self/
[20] http://www.rethinkhealth.org/resources/stewardship-team-diagnostic-checklist/
[21] http://www.rethinkhealth.org/resources/relaunching-a-great-stewardship-team-job-description-for-stewards/

be used in recruiting stewards to the effort, and rethinking the composition of an existing leadership group. (See Appendix B).

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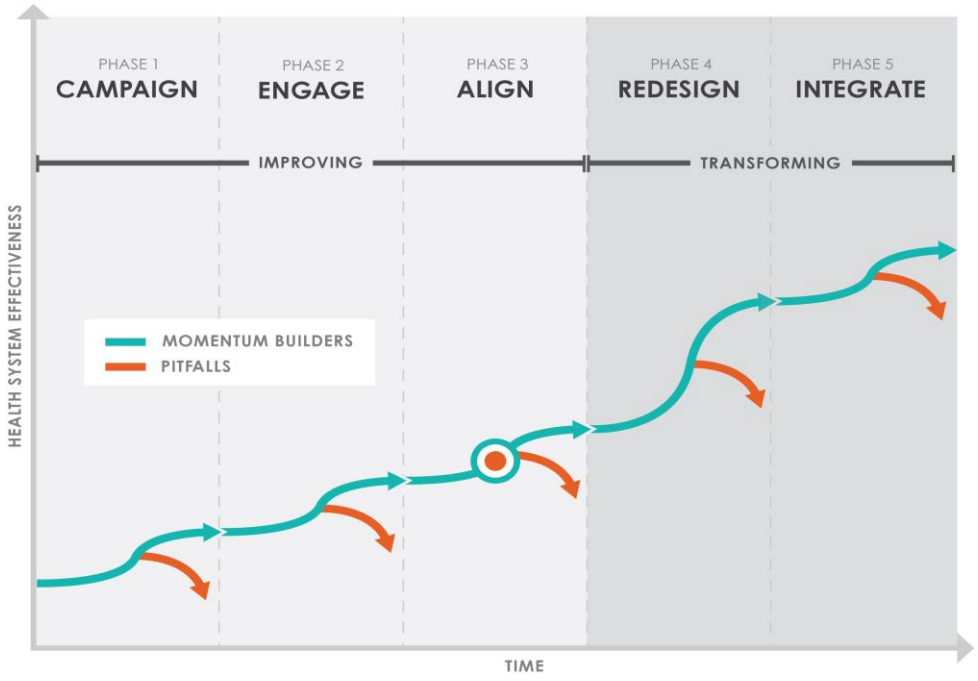
Align

Phase 3



What is the Align Phase?

The third phase of the *Pathway* focuses on aligning multiple efforts across the region under a common vision. In this phase, collaborative relationships among a whole array of stakeholders are well established, and the collaboration has logged experience with multiple cooperative projects and accomplishments. Phase 3 is different from earlier phases because:

1. sturdy bridges have been built between health and health care;
2. there is a well-established system orientation among many key leaders; and
3. clearly articulated shared values are guiding serious efforts to pool resources, connect related innovations to each other, and hold key groups and organizations accountable to a set of shared measures.

A successful Align Phase of regional health system transformation is when leaders recognize that the impact of their efforts will be magnified if they are connected in meaningful ways. A well-established multi-stakeholder leadership team, carefully composed for adequate diversity and system perspective, organizes to link an array of health and healthcare improvement efforts. If a backbone organization was not launched in Phase 2, Phase 3 is typically the time when significant investment in collaborative infrastructure—especially the information technology to support shared measurement—becomes critical. Align Phase efforts also are characterized by growing recognition of the importance of involving local residents in devising shared aims and helping to bridge relationships with different groups. As a consequence, community forums, and convenings become more common.

In addition, the array of funding sources for community-based efforts broadens and there is more creative thinking about the deployment of things like hospital community benefit funding to deepen the impact of community-provider partnerships. The Atlanta Regional Collaborative for Health Improvement (ARCHI), representative of more than 90 organizations, is an example of a stewardship group in Phase 3. Together, its members were able to publish a regional Playbook[22] outlining the group's priorities, which include encouraging healthy behaviors, increasing pathways to advantage for families and students, increasing care coordination, and expanding health insurance coverage. (See Appendix C).

The ability to transition from Phase 3 to Phase 4 on the *Pathway* depends on whether the stakeholders involved can weather some failures in their shared tasks, are making investments in collaborative infrastructure that keeps pace with the scope of their efforts, and have the patience and attention to persist over time.

The Atlanta Regional Collaborative for Health Improvement (ARCHI) is "upping the ante" by setting audacious goals for a great leap forward in community health improvement by building on many earlier successes and picking low hanging fruit. Learn more in a narrative[24] *and video*[25] *case study.*

Transition to Phase 4 also depends on whether collaborations can take on more difficult topics and accept that there will be winners and losers moving forward. Because Phase 4 involves significant redesign of the system—including addressing competitive relations among organizations how providers are paid and resources distributed—the activities of Phase 3 must foster trusting relationships anchored in genuinely shared values to enable the next leap forward.

[22] http://www.archicollaborative.org/archi_playbook.pdf
[23] http://www.rethinkhealth.org/narrative-case-study-phase-iii/
[24] http://www.rethinkhealth.org/resources/video-case-study-phase-iii/

Common Pitfalls of Phase 3

- **"Easy wins" have already succeeded.** Safe topics, easy-funding streams, and low-hanging fruit are nearly exhausted; momentum and excitement are much more difficult to trigger and sustain. Win-wins are much harder to find; the inevitable challenges to organizational priorities and competitive relationships can no longer be ignored; and pressure to accept the status quo and to be satisfied with early gains intensifies.
- **The "backbone" is sagging.** At the same time, delayed impact, especially of health improvement efforts, requires patience, especially as perceptions of little progress can weaken some funding streams. Many Phase 3 efforts turn to new things in the temptation to create more "easy wins" — and as the scope of efforts broaden, the infrastructure struggles to keep up.
- **Unexpected departures erode shared purpose.** As safe topics are exhausted, or task accomplishments seem weak or delayed, attention wanes and members become distracted. Initial champions may depart for a wide range of reasons, including ordinary job turnover, leaving the effort and its purposes adrift.

Consequences: Early members drift away, funding gets tighter, and members give in to the temptation to redefine the effort and narrow it.

Phase 3 Momentum Builders

- **Up the ante**. Key leaders with significant moral authority and a reputation for neutrality can call for more audacious and transformative goals for the system. They can call others to step out of their organizational boundaries, act as stewards of the whole and not just be tied to the interests they bring to the table.
- **Invest and experiment.** Efforts at this stage benefit from creative thinking and exploration of many sources of unexplored funding. Create a group focused on financing[25] and broaden the sources of support. Rather than pick new projects that don't build additional capacity, design and launch complex joint experiments across organizations that tackle multiple challenges simultaneously. Collectively generate and commit to a system strategy with a handful of high-leverage initiatives. Embrace the notion that a core purpose of this effort is to learn together about what might work. Make learning a critical outcome needed for further radical improvement and celebrate new lessons learned.
- **Recruit new stewards.** Invest in relationships: Leaders and organizations will accept that not every joint effort results in gains for themselves or their organizations, or could even undermine their work. But they stay with the effort when they are able to trust that their concerns, the wellbeing of their organizations, and the larger shared benefit to the region are the core guiding principles.

[25] http://www.rethinkhealth.org/tools/financing-primer/

Consequences: Renewal of energy, enhancement of resources, and important learning that can feed a sharper, more systemic approach to moving the whole system.

Phase 3 Tools

Tool 1: Developmental Assessment – What conditions have you created for transforming your regional health system? (Individual online measure and group facilitation guide)

This tool[26] measures progress on 11 conditions which, collectively, accelerate and sustain progress toward a healthy health system. It is available as an online measure completed by individuals (and provides feedback to the user about their region's relative standing on the 11 conditions, compared to other regions). The Developmental Assessment is also available as a facilitated group discussion guide. (See Appendix B).

Tool 2: Building a Learning Practice: Before and After Action Reviews

Emergent Learning is literally about learning that *emerges* from the work itself. Its tools and practices[27] support surfacing, capturing, and employing those insights to inform future work.

The tools and practices include a Before Action Review (BAR) and an After Action Review (AAR), which are designed to help leaders engage with each other at the beginning of a project or initiative and during the work itself, as often as needed, to reflect and adjust their thinking along the way. (See Appendix B).

Tool 3: Creating and Sustaining Audacious Goals

The purpose of this tool[28] is first to invite users to assess the boldness of their current system aspirations. It then enables individuals and groups to enhance their abilities to articulate bold aspirations—aspirations that are clear enough to generate challenging but achievable goals, and goals that can both be sharpened and sustained over time. (See Appendix B).

Tool 4: An Agenda for Large Group Visioning

This tool[29] is a (modifiable) agenda for large group convenings (50 or more) that guides leaders of an effort to systematically invite, convene, and engage residents in contributing to a vision for the effort for the long term. (See Appendix B).

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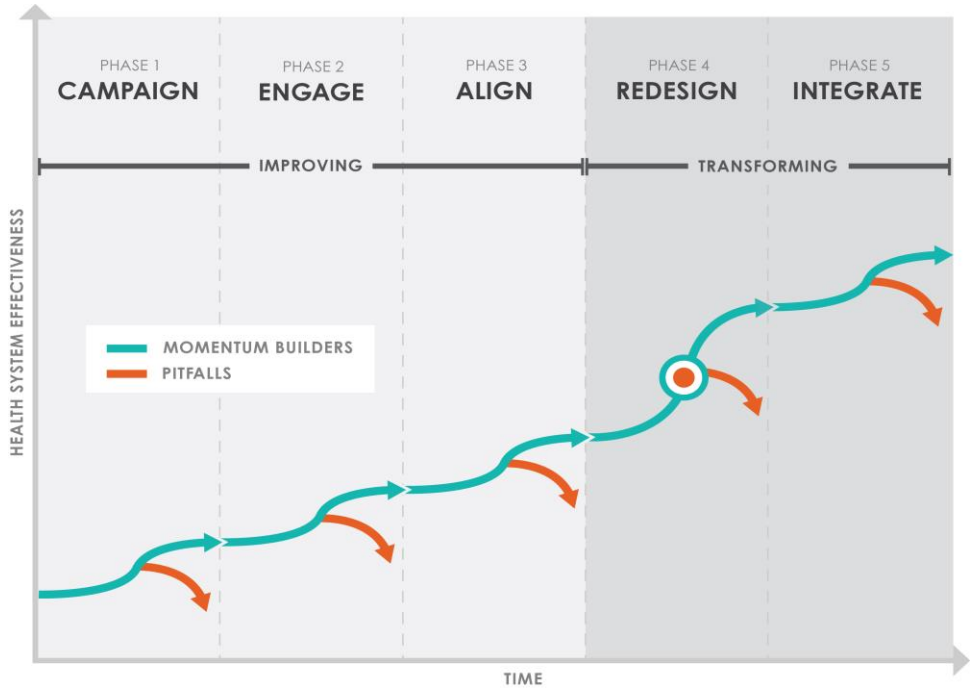
[26] http://www.rethinkhealth.org/resources/stewardship-field-guide-developmental-assessment/
[27] http://www.rethinkhealth.org/resources/building-a-learning-practice-to-rethink-health/
[28] http://www.rethinkhealth.org/resources/creating-and-sustaining-audacious-goals/
[29] http://www.rethinkhealth.org/resources/an-agenda-for-engaging-large-groups-in-establishing-vision/

Phase 4



What is the Redesign Phase?

The Redesign phase is a step-change from the Align phase in multiple ways. The work of the fourth phase of the *Pathway* is to redesign core structures and systems, and to seed and spread disruptive innovations that alter organizations in fundamental ways. Because the Redesign phase requires organizational leaders to change current business models, to partner with each other in new ways, and to design reward systems to provide incentives for new behavior, it represents a qualitative shift from the kind of improvement thinking prevalent in the Align phase to transformation thinking in the final two phases.

Progress in the Align phase occurs and accelerates through the activities of independent stakeholders making incremental shifts in their priorities over time toward shared goals and measurements. *By contrast, Redesign phase activities require high interdependence among organizations, including former competitors, and they call for discontinuous change in organizational strategies and a redeployment of their core competencies.* Like most discontinuous change efforts, the impetus for radically rethinking business models may come not from inside local organizations but from pressures outside the health

sector and the geographic region—such as changes in the policy environment, new entrants into the region, or initiatives of governmental entities to promote regional development beyond health and health care.

Through our work with stewardship groups across the country, we have observed that leaders face a barrier when they try to move beyond aligning efforts around shared goals (the third phase of the *Pathway*) toward whole-scale redesign and deliberate integration of the forces that support health and wellbeing in their regions (the fourth and fifth phases). Too often, we have seen that a group's enthusiasm wanes when win-wins are no longer possible, and resistance arises when fundamental questions about their organization's purposes and independence are at stake—making it harder to keep a collective effort going and growing. Yet discontinuous change is needed to make the transition from innovations that accumulate on the margins of the system to a truly new way of doing business.

Discontinuous change processes require:

1. a significantly different kind of *internal* organizational leadership in the regional health system, as well as
2. stewardship structures that stimulate, guide, and promote genuinely transformative change at the system level.

These two distinctions mean that the individuals and groups that guided change through the Align phase may not be the same as stewardship structures of the Redesign phase and beyond.

Leveraging Interdependence and Increasing Transformation Thinking

Internal organizational leadership in the Redesign phase requires more than willingness to shift priorities to a moderate degree in order to cooperate in promoting system-wide aims. It requires the vision and determination to re-conceptualize business models and to partner with other organizations in new ways. Redesign phase leadership groups must address and promote the taking on of controversial matters that strike at the heart of old organizational practice—and they must address the subsequent changes in organizational independence and power to act autonomously.

In the Redesign phase, multi-stakeholder stewardship forums therefore increase in complexity. While no single structural arrangement can address the stewardship needs of every regional context, we have seen that certain common features of the stewardship structure are needed to address critical Redesign phase challenges. First, multiple groups may serve different stewardship functions

Currently, even the most advanced stewardship groups known to ReThink Health inhabit Phase 3 on the Pathway, and there is a bottleneck of organizations moving into Phase IV. We have identified several key member organizations of regional stewardship groups that are moving forward, making progress toward Phase 4. Read on[31] *to learn more.*

that together promote transformative change. For example, councils may enable dialogue among like organizations, for dealing with controversial matters within a sector—a hospital forum for addressing competitive capital investments, for example, or a convening of social services providers and community organizations for addressing capacity. These groups allow negotiation and cooperative agreements and promote the development and enforcement of new intra-sector norms and standards of conduct. While multiple leadership groups serve different purposes, the need for an overarching stewardship structure remains. Redesign efforts require a stewardship group that is committed to a system-wide vision and strategy.

While earlier phases of the *Pathway* can be largely about harvesting improvements that are the result of aligning independent stakeholders and their investments and priorities, Redesign requires experimentation that focuses on blank-slate imagining of ideal designs, prototyping, and scaling major innovations in place. These experiments must address how and where care is provided; how people are paid; the role of residents in their health and care; which policies shape vulnerability and opportunity; the ways the system will be funded; and how transparency, information-sharing, and impact evaluation will be conducted for the whole region.

In one example, a local safety net health system and insurer launched a Redesign effort. Cambridge Health Alliance (CHA) experienced a significant change in state funding that threatened to put it out of business. Instead, CHA motivated its leaders to engage in a broadly inclusive, collective process to identify meaningful ways to restructure the enterprise and focus on providing needed services to its community. CHA is now continually experimenting and testing new global payment and incentive models, ways to reduce hospitalizations and improve care transitions and access to primary care, and innovative approaches to reinvesting savings in a much broader scope of primary care and preventive services that impact health. (See Appendix C for a case study about the Redesign phase.)

Council of Councils

The Redesign phase also ushers in the need for nested stewardship structures. For redesign efforts to bring about movement toward a system that produces radically better performance across multiple outcomes—health, cost, quality, equity, productivity—some stewardship forum must have the capacity for joint decision-making that articulates shared goals, deploys funding with legitimate authority, and holds members accountable to strongly shared norms across sectors. A successful Redesign phase requires leaders' recognition of the potential synergies that could be realized by redesigning key structural elements in response to external pressures. For example, leaders may perceive the impact of contingent global payments on efforts to improve care and reduce costs, the power of long-term upstream investments in the environment for radically reshaping what is possible in the health system, and other complex relationships that call for true redesign of the health economy of a region. The scope of initiatives and sources of funding in the Redesign phase are broad, but guided by a system strategy that recognizes the interdependencies among parts of the health system.

An overarching stewardship group may be formed or composed by representatives from sector-specific councils, or it may arise from broadly aimed regional efforts that are given authority to convene and influence other groups. It can derive authorization to steer a regional health effort either through

formal authority (e.g., a group of county-level elected officials, or a state-appointed coordinating body), or through the powerful informal authority that comes from being representative of all the key stakeholders and authorized by participating organizations. Regardless of how it is formed and authorized, such a stewardship structure must be viewed by organizations and residents as having the legitimate authority to set priorities and guide the investment of resources.

One example of a representative council is in Cincinnati, where collective impact processes focused on education and community development have been underway for years, and a "Council of Councils" is helping to coordinate and integrate a new regional planning effort around community health. The purpose of the Council of Councils is to bring the various sectors together, helping both the long-established and recently established find common ground and learn to work together effectively. (See Appendix C).

Moving to Phase 5

Whether a Redesign effort is poised to move to the Integrate phase on the *Pathway*, however, depends on whether the stewardship structure guiding the effort is prepared to make hard choices and affirm that organizations must redesign their current business models and hold members accountable to those standards. Transition to he fifth phase also depends on whether the intensive investment and energy of the Redesign phase has successfully involved engaging residents in defining how the health system will be led in the future. Because the Integrate phase involves the creation of collaborative long-term governance of the system, the activities of the redesign phase must result in a citizenry that is engaged and prepared to share responsibility for a long-term system vision and structure for making choices into the future.

Common Pitfalls of the Redesign Phase

- **Political resistance.** Even the hard-won and trusting relationships built up through the Align phase can be tested at this phase on the *Pathway*. Hard choices need to be made during the Redesign Phase, especially about competitive relationships, organizational priorities that are out of step with regional needs, capacity issues, and payment models. Resistance to addressing these choices escalates because all solutions are likely to create a different array of winners and losers than the current system.
- **Leaders mired in incremental change**. Leaders of major organizations who rose to power through prior eras, and with significant experience in old business models, can remain committed to enacting only minor changes to the status quo. As a consequence, many may lack the vision or the change leadership skills to envision discontinuous change or to build commitment to whole new business models. Boards of directors continue to evaluate and incent chief executives on their abilities to make only small changes and to take few risks while maintaining a healthy bottom line.
- **Successes don't replicate.** Innovative models that have been launched and tested are successful within their contexts, but prove difficult to replicate. At the same time, launching additional projects seems increasingly more exciting and motivating than creating conditions for spread and replication of models that have succeeded. The temptation to continue investing in small

improvements or in novel approaches that do not threaten powerful interests creates a risk of spreading resources over too many things.

<u>Consequences</u>: The sharp edges of regional purpose, focus, and strategy are sanded down; leaders return to "safe" topics under the strain of win-lose conditions.

Redesign Phase Momentum Builders

- **Take the long view.** Consider key scenarios beyond the tenure of current leaders. Key leaders, including hospital executives who are willing to say: "I can imagine that, in 25 years, there won't be a hospital in our community," trigger a survival response in others, leading to creative solutions that can only be achieved collaboratively.
- **Address institutional needs.** The key to navigating the tensions of win-lose circumstances and the need to reshape many business models is to respect the core needs of others' organizations and take them into account in collective decision-making. Develop and use a high-quality practice of integrative negotiation, and sustain empathy for the threats to organizational identity and existence that are experienced by members of the stewardship groups. Engage in well-structured joint decision-making about regional priorities.
- **Structure for stewardship.** Design a long-term stewardship structure, including strategies that result in stewardship groups holding the legitimate authority to establish priorities and hold the effort's feet to the fire about living up to those priorities. Recruit new champions among real change leaders who support the vision. Populate the long-term stewardship structure with those who actively embrace redesign as a principle necessary for bringing about a radically better system.
- **Redefine success.** Define success as the uptake and spread of successful discoveries and redesigned models that have been shown to move the system toward the future state. Enhance capacity for spread and scale of those redesigns that work and measure the impact of innovative redesign efforts on short and long-term outcomes. Implement new financing strategies that allow the effort to harvest investments and leverage the scale of the effort– and resulting savings – to stabilize funding streams (see: "ReThink Health Financing Primer"[30]).

<u>Consequences</u>: Re-generated momentum as high impact redesign innovations demonstrate visibly that a new future is possible.

Redesign Phase Tools

Tool 1: Developmental Assessment – What conditions have you created for transforming your regional health system? (Individual online measure and group facilitation guide)

This tool[31] measures progress on 11 conditions which, collectively, accelerate and sustain progress toward a healthy health system. It is available as an online measure completed by individuals (and

[30] http://www.rethinkhealth.org/tools/financing-primer/
[31] http://www.rethinkhealth.org/resources/stewardship-field-guide-developmental-assessment

provides feedback to the user about their region's relative standing on the 11 conditions, compared to other regions). The Developmental Assessment is also available as a facilitated group discussion guide. (See Appendix B).

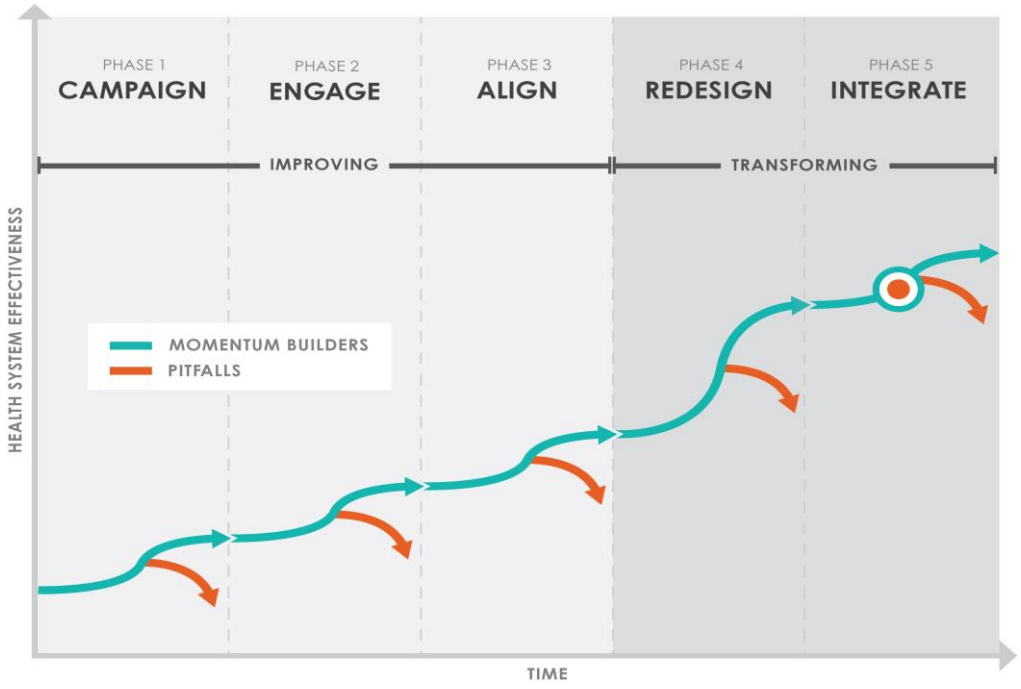
Tool 2: Understanding Accidental Adversaries

This tool[32] invites users to map key stakeholders and their interests, identify those likely to suffer as a consequence of intended initiatives, and anticipate resistance to a change effort. It invites users to consider an array of approaches to addressing potential resistance and to develop strategies for securing provisional commitment from key stakeholders to engage in joint experimentation and learning. (See Appendix B).

[32] http://www.rethinkhealth.org/resources/accidental-adversaries/

Integrate

Phase 5



What is the Integrate Phase?

The final phase of the *Pathway* represents the culmination of the work of the previous phases, when the redesign experiments and their lessons and results become integrated into the ongoing work of the health system and its stakeholder organizations. Efforts have reached this phase when there are established multi-stakeholder stewardship structure(s) that wield influence and hold authority for setting regional goals, for shaping and monitoring policies, for influencing and directing the allocation of resources and adjudicating conflicts among groups and organizations. The Integrate phase results in solidified partnerships and high levels of interdependence among formerly independent stakeholder organizations. This phase also institutionalizes the lessons of the prior phases in ways that facilitate ongoing learning and rethinking, enabling the system to adapt to changing conditions and to ever-heightened aspirations.

A successful Integrate Phase of the *Pathway* is characterized by stewardship groups that are widely viewed as legitimate authorities for identifying priorities and setting targeted goals consistent with a

long-term regional vision. In Phase 5, health system financing has been fully redesigned for value-based pay. As the ReThink Health System Dynamics Model shows, significant payment redesign toward value-based pay for health care, and increased integration of health and social budgets accelerate the cost savings and health improvements realized by regional transformation efforts. The groups' legitimacy derives, in part, from evidence of progress on health and care initiatives that show cost savings and health improvements across many initiatives. Transparency of data and shared metrics are critical underpinnings both to evidence of results and the continuing learning and resilience of the health system. At the same time, an Integrate phase effort has broad and active resident engagement in the system that may be part of the stewardship structure, and they certainly are the key voices establishing vision and priorities for the system.

A few regional efforts are showing certain aspects of Integrate phase stewardship properties (though we have yet to see any wholly transformed health systems producing the results that characterize Phase 5). In one advanced stewardship example, recognizing that "only through a collective effort can meaningful change be realized in such a large and diverse region," the County of San Diego Board of Supervisors launched Live Well San Diego in 2010 as a "long-term plan to advance the health, safety, and overall wellbeing of the region" that includes citizens, city and town governments, healthcare and other types of businesses, military and veterans organizations, schools, and community- and faith-based organizations. Today, every county department is involved in Live Well San Diego. This effort clearly derives its authority to steward the system from being an initiative of the county government in broad partnership with diverse stakeholders around the region. (See Appendix C.)

Currently, ReThink Health is not aware of a fully developed Integrate phase region. Even the most advanced known regional efforts inhabit the Align phase on the *Pathway, and there is a bottleneck of organizations moving into the Redesign phase. ReThink Health has, however,* identified two regional stewardship groups *that have established legitimate stewardship authority, a key characteristic of Integrate phase efforts.* Read on *to learn more.*

By contrast, the Whatcom Alliance for Health Advancement (WAHA), in Bellingham, Washington, derives its authority not from local government, but from the credibility and respect it has built since 1985 as a non-profit deeply engaged with the community. Governed by a leadership board that includes concerned citizens and representatives from healthcare, public health, business, and governmental organizations, WAHA is a backbone organization that works hard to engage the community in everything it does and seeks to serve as the true community voice on healthcare priorities in the region. (See Appendix C.)

Stewardship groups in the Integrate phase have well-developed norms and procedures both for holding members accountable to shared goals and for respecting the values and role of different institutions. In Phase 5, there is widespread transparency among the key players about their goals, and their

performance and contribution to collective aims. After the disruptive changes of the Redesign phase have resulted in viable partnerships and innovative business models, the core strategy of a Phase 5 effort is consolidation of learning aimed at producing better and better results, with joint projects launched as the effort identifies new challenges or ways in which the results of the current system could be still better. Integrate phase regions have broadly implemented practices of shared risk among stakeholders in the health system, with residents and providers alike holding responsibility for results.

Further, the funding streams of a Phase 5 region are sustainable, with adequate short- and long-term private and public investments both for the upstream drivers of health and economic prosperity in the region, and high-quality, affordable care for residents. The Live Well San Diego effort is an important example of global budgeting for health and other social services in the United States. The structure allows the region to invest its resources more efficiently while achieving better outcomes—much like many foreign nations that spend less than the U.S. on health, but whose people enjoy better health status than Americans overall.

The Integrate phase is only a stable equilibrium, however, if the stewardship of the health system in the region is attentive to ongoing changes in the environment, dexterous in in responding to those changes and attentive to influencing and sustaining a policy environment that promotes and protects a sound health system strategy over time.

Common Pitfalls of the Integrate Phase

- **Documenting success may be years away.** Even in the final phase of transformation, some high-leverage redesign efforts can be slow to deliver dramatic results and prove that the new system addresses all the shortcomings of the old; progress can be difficult to prove even though investment of resources and time has been significant. At the same time, the fun, excitement, and energy of earlier phases is difficult to sustain when leaders are seeking to anticipate and head off threats to a largely positive situation, rather than to proactively identify and solve existing and deeply felt problems in a troubled region.
- **Changing environment.** External conditions change, making a reevaluation of core strategies necessary to sustain progress. Re-negotiation of hard-won agreements and priorities causes strain and disruption in relationships among key stakeholders, threatening the stability of stewardship structures and cooperative agreements.
- **Disengaged stewardship.** A strong staff in the coordinating organization(s) causes key champions to disengage from active stewardship; planned changes in membership of the stewardship groups require significant energy to manage, as new members feel little of the urgency for change of earlier phases.
- **No known models for this phase.** We are aware of no existing models of truly transformed, integrated regional health systems in the U.S. Therefore, leaders are forging a new path with few models to follow. Without clear alternatives, key leaders struggle to perceive the long-term structures needed to maintain effectiveness and adaptiveness in the system.

<u>Consequences</u>: Complacency or distraction risks backsliding or failure to solidify hard-

learned lessons into lasting stewardship structures and processes.

Integrate Phase Momentum Builders

- **Share a broad definition of impact.** Celebrate successes. Impact on the health system manifests not just in the outcome measures of interest, such as health statistics, per capita costs of care, and the like (though outcome metrics are indeed essential). There also are signs of significant progress to celebrate as the conditions for further progress are put in place, such as citizen forums, an effective nested stewardship structure, alignment around vision for the future. Use rituals, ceremonies, and awards to celebrate and reinforce a new culture of health and of active involvement by residents (See "Developmental Assessment"[34] -Appendix B).
- **Exercise influence upward and outward.** Leverage successes and expanded resources and capacity to work on additional factors affecting the system, including policy. Develop the external influence capacities of the core stewardship team in the broader context, including at the state level.
- **Ensure a legitimate and authoritative stewardship group.** Sharpen core leadership functions. Draw clear distinctions among the leadership functions of different groups. Continue to engage a wide array of residents in the review and celebration of progress and in shaping and ratifying vision and goals. Enable the staff of the coordinating (backbone; integrator) organization to play network building and operational leadership roles effectively. Make priority setting, resource deployment, and championing the vision for the future into the core functions of the stewardship team(s).
- **Cast a wider net for inspiration.** In the absence of multiple models from U.S. regions, draw on the lessons and possibilities of transformed, sustainable systems in other contexts, such as energy sustainability or the health systems of other countries.

Consequences: Focused, adaptive, interdependent leadership of a resilient regional health economy.

Integrate Phase Tools

Tool 1: Developmental Assessment – What conditions have you created for transforming your regional health system? (Individual online measure and group facilitation guide)

This tool[35] measures progress on 11 conditions which, collectively, accelerate and sustain progress toward a healthy health system. It is available as an online measure completed by individuals (and provides feedback to the user about their region's relative standing on the 11 conditions, compared to other regions). The Developmental Assessment is also available as a facilitated group discussion guide. (See Appendix B).

[34] http://www.rethinkhealth.org/resources/stewardship-field-guide-developmental-assessment/
[35] http://www.rethinkhealth.org/resources/stewardship-field-guide-developmental-assessment/

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Annotated Bibliography

This list of readings and presentations presents the foundational research and practice upon which ReThink Health's Stewardship Guide is built. Each of these sources provides additional in-depth treatment of the challenges and practices of stewarding health system transformation.

Emerson, Kirk; Nabatchi, Tina; and Balogh, Stephen. (2012). An Integrative Framework for Collaborative Governance. Journal of Public Administration Research and Theory, 22, pp. 1-29. This article synthesizes and extends a suite of conceptual frameworks, research findings, and practice-based knowledge into an integrative framework for describing how collaborative governance structures operate. The framework specifies a set of nested dimensions that encompass a larger system context, a collaborative governance regime, and its internal collaborative dynamics and actions that can generate impacts and adaptations across systems. The article also offers 10 propositions about the dynamic interactions among components within the framework and concludes with a discussion about the implications of the framework for theory, research, evaluation, and practice.

Erickson, Jane; Branscomb, Jane; and Milstein, Bobby. (2015). Multi-sector Partnerships for Health: 2014 Pulse Check Findings. ReThink Health: Cambridge, MA. This report synthesizes the findings of ReThink Health's 2014 Pulse Check, which was conducted to sketch the national landscape of multi-sector, regional partnerships that are working to create healthier and more resilient communities. Using data from 133 multi-sector partnerships across the United States, the report shares insights into the scope, makeup, challenges, and accomplishments of these groups.

Ganz, Marshall. (2010). Leading change: Leadership, organization, and social movements. In N. Nohria & R. Khurana (Eds.), *Advancing Leadership,* Harvard Business School Press, Boston: MA. This chapter provides a theoretical and practical treatment of the core methods of organizing and community engagement. Rooted in 28 years of organizing experience, and informed by insights of social science and teaching at Harvard's Kennedy School of Government, *Leading Change* explores the practices necessary for strengthening the effectiveness of civic associations, community organizing, and social movement responses to the critical challenges of our time through continual learning, capacity building, and leadership development.

Hackman, J.Richard (2002). *Leading Teams: Setting the Stage for Great Performances*. Boston, MA: Harvard Business School Press. This book, written for leaders and team members, provides a comprehensive treatment of how to design and lead teams. It draws on five decades of teams research to illustrate the handful of conditions, which, when present, increase the chances of having great teamwork—and how to get those conditions in place for any kind of team.

Hirsch, Gary; Isaacs, Kathryn; and Wageman, Ruth. (2015). A Dynamic Model of Collaborative Capacity in Health Transformation efforts. Working paper. This study of 20 health transformation collaboratives around the U.S. explores what conditions, created by leaders, most enable these efforts to create collaborative capacity—the ability to enact more and greater changes over time. It identifies the key positive conditions that can create growth loops and strong upward trajectories, and the unintended ways that such efforts can get off course and hit reversals. The research offers more than just a checklist of conditions for success: it shows how collaborative capacity is a dynamic process and how leaders can act to prevent pitfalls and build momentum over time.

Hilton, Kate and Wageman, Ruth. (2015). Leadership in volunteer multistakeholder groups tackling complex problems. *Emerald Monographs in Leadership and Management Series: Leadership Lessons from Compelling Contexts*. S. Braun, C. Peus, and B. Schyns, Editors. London: Emerald Group. This chapter explores distributed leadership in volunteer multi-stakeholder groups tackling complex problems, focusing on community organizing practices to transform health and health care in Columbia, South Carolina. It brings to life many of the special challenges common to multi-stakeholder groups, including indistinct articulation of shared purposes, limited engagement and motivation, conflicting interests, lack of trust, limited authority, and decision-making dominated by institutional elites. It shows how the learning of organizing practices cross stakeholders—including public narrative, collective decision-making, and building team structure—can serve as shared leadership practice to systematically overcome those challenges.

Homer, Jack; Hirsch, Gary; Fisher, Elliott; and Milstein, Bobby. (2015). How the Right Combination of Local System Changes Could Substantially Improve Health and Lower Cost and Be Financially Self-Sustaining. Working paper, ReThink Health. Health reform in the U.S. is a national priority that requires concerted action in every region across the country. Knowing that health and health care are shaped strongly by local conditions, researchers examine several strategy choices that local planners may pursue to influence health system performance over time. This report concentrates on five strategies in particular: (1) delivering high-value preventive and chronic care; (2) reinvesting savings from lower health care costs; (3) shifting provider payment from fee-for-service to contingent global payments; (4) enabling healthier behaviors and safer environments; and (5) expanding socioeconomic pathways to advantage for families. Authors estimate the relative and combined effects of these strategies using simulated scenarios from the ReThink Health Dynamics Model, configured with national data to represent a prototypical mid-sized American city. Results show the likely influence on cumulative measures of deaths, health care costs, inequity, workforce productivity, and program spending from 2012-2040. These scenarios suggest that a carefully crafted mix of clinical and social change initiatives, together with value-based payment and sustainable financing could significantly transform local health system performance.

McGinnis, Michael D. (2013). Caring for the health commons: What is it and who's responsible for it. Working Paper. This research paper explores Elinor Ostrom's core concepts of the commons and their application to the idea of a health commons, stewardship, and common property. Examples from the case of Grand Junction, Colorado, are used to illustrate the relevance of these principles to shared

stewardship of a regional health commons. The paper concludes with a set of questions that can help assess a community's ability to more effectively manage their own system of healthcare delivery.

Milstein, Bobby; Homer, Jack; Briss, Peter; Burton, Deron; and Pechacek, Terry. (2011). Why Behavioral And Environmental Interventions Are Needed To Improve Health At Lower Cost. *Health Affairs, 30,* 823-832. A dynamic simulation model of the US health system is used to test three proposed strategies to reduce deaths and improve the cost-effectiveness of interventions: expanding health insurance coverage, delivering better preventive and chronic care, and protecting health by enabling healthier behavior and improving environmental conditions. We found that each alone could save lives and provide good economic value, but they are likely to be more effective in combination. Although coverage and care save lives quickly, they tend to increase costs. The impact of protection grows more gradually, but it is a critical ingredient over time for lowering both the number of deaths and reducing costs. Only protection slows the growth in the prevalence of disease and injury and thereby alleviates rather than exacerbates demand on limited primary care capacity. When added to a simulated scenario with coverage and care, protection could save 90 percent more lives and reduce costs by 30 percent in year 10; by year 25, that same investment in protection could save about 140 percent more lives and reduce costs by 62 percent.

Ostrom, Elinor. (2010). Beyond markets and states: Polycentric governance of complex economic systems. *The American Economic Review,* 100(3), 641–672. 2009 Nobel Prize lecture. The research of Elinor Ostrom, professor of political science at Indiana University and Nobel Laureate in Economics, inspires much of our thinking about stewardship of health systems. Her work vividly underscores the power of leaders coming together across organizations to steward local resources on behalf of their communities. Ostrom found that communities, left to themselves, can sort out their own ways of stewarding their resources to sustain them over time. Through cooperation, trust, and collective action, the users of those resources create sensible rules for themselves to avoid over-fishing, over-farming, and cutting down their forests. We see many parallels in her work for our efforts to transform our health systems to promote and sustain the health of our residents and to steward and invest our financial resources in health and care.

Senge, Peter. (2006). *The Fifth Discipline*. New York: Doubleday. The tools and writing in ReThink Health's Stewardship Guides that are focused on developing a learning practice and sharpening systems thinking are based in this work. This book teaches the core mindsets and practices of collective problem solving and using systems thinking to develop enterprises into learning organizations. The five disciplines represent approaches for developing three core learning capabilities: fostering aspiration, developing reflective conversation, and understanding complexity.

Siriani, Carmen. (2009). *Investing in Democracy: Engaging Citizens in Collaborative Governance.* Washington, D.C.: The Brookings Institution. The health of American democracy ultimately depends on our willingness and ability to work together as citizens and stakeholders in our republic. Growing numbers of policymakers across the country are figuring out how government can serve as a partner and catalyst for collaborative problem solving. This book details three such success stories: neighborhood planning in Seattle; youth civic engagement programs in Hampton, Virginia; and efforts

to develop civic environmentalism at the U.S. Environmental Protection Agency. The book explains what measures were taken and why they succeeded. It distills eight core design principles that characterize effective collaborative governance and concludes with concrete recommendations for federal policy.

Wageman, Ruth. (2013). Building great leadership teams for complex problems. Chapter 4 in *Developing and Enhancing High-Performance Teams in Organizations*. E. Salas, Editor. Malden, MA: Wiley. This chapter draws on a decade of research to identify the most common design problems of leadership teams that form across organizations to lead a complex change effort. It explains why those challenges—such as unclear purposes, the wrong people convening, and time-wasting or wheel-spinning—occur, and offers hands-on strategies for leadership team members, facilitator, and leaders to redesign their teams for momentum and excellence.

Meeting Summary: ReThink Health Roundtable on Leveraging Investments. (2014). ReThink Health: Cambridge, MA. In September 2014, ReThink Health convened 25 leaders of regional health collaboratives for an innovative roundtable in Chicago on leveraging investments to advance their health and health care. Together these leaders meaningfully explored barriers to their stewardship activities and approaches to sustainable investment and financing. Learn more about how ReThink Health catalyzed actionable dialogue and creative problem-solving with these change-makers.

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Appendices

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Appendix A

Resources

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Stewarding Shared Resources

Elinor Ostrom's Research and ReThink Health's Approach

The research of Elinor Ostrom, professor of political science at Indiana University and Nobel Laureate in Economics, inspires much of our thinking about stewardship of health systems. Her work vividly underscores the power of leaders coming together across organizations to steward local resources on behalf of their communities.

Ostrom studied many communities whose residents depended on critical public resources for their livelihoods: fishing grounds, forests, arable land, and water supplies. All of these resources are vulnerable to being overused, even used up, as people make independent decisions to harvest more and more to support their own families, groups, or organizations. That destructive pattern is typically called the "tragedy of the commons."

We see many parallels in Ostrom's work for our efforts to transform our health systems to promote and sustain the health of our residents and to steward and invest our financial resources in health and care. She found that communities, left to themselves, can sort out their own ways of stewarding their resources to sustain them over time. Through cooperation, trust, and collective action, the users of those resources create sensible rules for themselves to avoid over-fishing, over-farming, and cutting down their forests. She saw that:

- Some communities do fall prey to the "tragedy of the commons" – as families, companies, or groups each harvest as much as they can for their own gain.
- Some communities do not. Instead, they form local groups of leaders representing users of the resources.
- These self-governing groups act on behalf of a bounded group of residents.
- They form shared aspirations for sustaining the resource.
- They formulate rules and monitor each others' behavior.
- They create mechanisms to resolve inevitable disputes.

This kind of stewardship is neither a free-for-all nor does it rely on outsiders creating rules and governing local resources. It is a sometimes-fragile but ultimately powerful and flexible process of shared leadership and the balancing of individual, group, and community interests.

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Appendix B

Tools

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Accidental Adversaries

Are organizations in your effort caught in a harmful pattern of adversarial actions and feelings?

This tool will help you identify how partner organizations in your regional effort may be on a road to breakdown or collaboration failure—and how to get them back on a constructive path.

Learning Objectives:

- **To understand why partners can end up behaving as if they are adversaries**
- **To identify interventions or leverage points to improve collaboration among key participants in your effort**

Phase(s): This tool is best used by groups engaged in a Phase 2 effort along the Pathway for Regional Health Transformation

How to use this tool

The Accidental Adversaries tool introduces a core idea from systems thinking, and shows a common pattern of how relationships between partners can break down. It then invites you to consider a relationship breakdown in your own effort and consider its root causes. Finally, this tool offers interventions that you can undertake to improve the collaboration among key participants in your regional effort.

This tool is most effective when completed by people deeply engaged in the regional change effort and well-informed about its areas of activity, such as those who are part of the core stewardship team leading the effort, or part of the backbone or integrator organization.

Systems Archetypes: "Accidental Adversaries"

The Main Idea

Actual or potential partners behave as if they are adversaries because at least one party *unintentionally* takes action that undermines the success of their partner(s).

Accidental adversaries is one of ten archetypes used in system dynamics modeling. It occurs when two or more individuals, groups, or organizations cooperate for a common goal, but accidentally take action that undermine each others' success.

Generic Story of How it Works

Two parties have chosen to work together because they receive mutual benefit from the relationship. Each takes action to benefit the other in the belief that, if the alliance works, both parties will benefit.

The problem arises when one or both parties need to correct a performance gap (often precipitated by an external change or pressure). Action is taken to improve performance, but it accidentally undermines their partner's success.

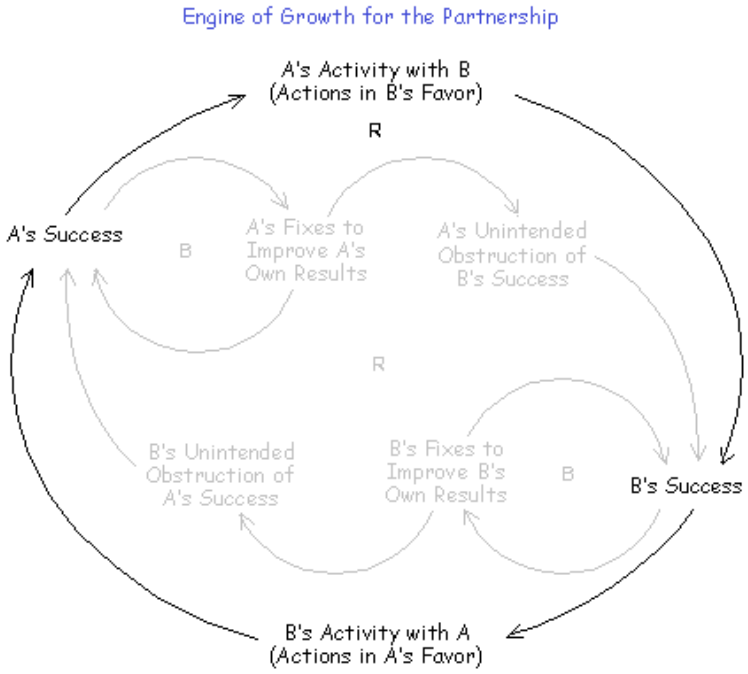
The impact of these harmful activities may simply create a sense of frustration and resentment between the parties, who remain partners, or it may actually reach the point of turning them into hostile adversaries.

Situations Ripe for Accidental Adversaries Breakdowns

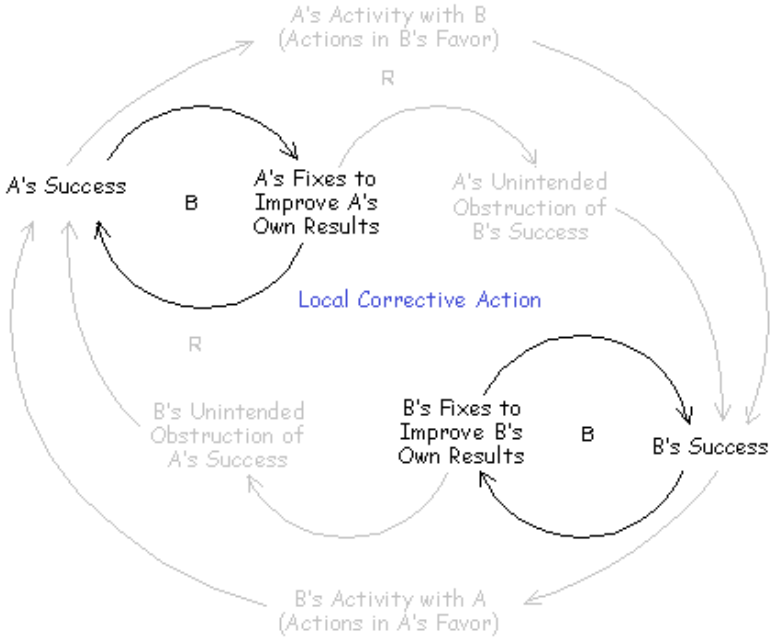
- Between departmental or process groups
- Between client groups and groups who provide support to them
- Between customers and suppliers
- Between field and headquarters
- Between organizations

The pattern explained in loops

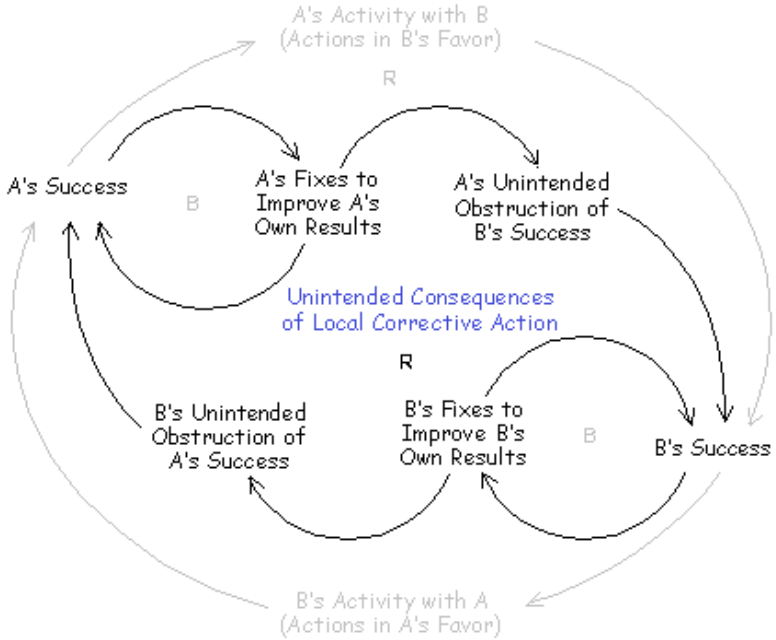
The pattern evolves in three stages. In the first stage, the partners form their alliance for mutual benefit. This is a virtuous reinforcing dynamic – we act in your favor, which creates success for you, and you are motivated to act in our favor, which creates success for us.



In the second stage, balancing dynamics arise as the partners take independent action to improve their own performance. This action is often precipitated by outside factors that are affecting success.



In third stage, the partners' local corrective actions unintentionally undermine the other partner's success. This is a negative reinforcing dynamic that reverses the first stage virtuous cycle into a vicious cycle. In other words, the interior reinforcing loop is the battlefront where accidents turn into intentional adversarial actions, and the exterior reinforcing loop becomes vicious because there is less and less incentive to engage in collaborative behaviors.



Typical Mental Models

Let's now look at how the typical mental models of people involved in these dynamics change over time.

First is the mental model that initiates and reinforces the partnership in the first place. It is rooted in self-interest, and open to mutual benefit:

- "It will benefit us to build a partnership/alliance/relationship with them, and they will benefit too."
- "If we help them, they will help us."

Second are the mental models that lead to "accidents" that create unintended negative consequences for each other:

- "To continue benefiting ourselves, we must take actions that are relevant to our own goals."
- "These actions don't have any connection to our partnership."

Third are the mental models that arise from the unintended consequences (the accidents) and that escalate into adversarial positioning:

- "They're causing problems for us, while we continue to support the partnership in good faith."
- "They're intentionally ignoring or hurting us. Why don't they realize what they're doing and stop?"

An Example: Working at Cross Purposes

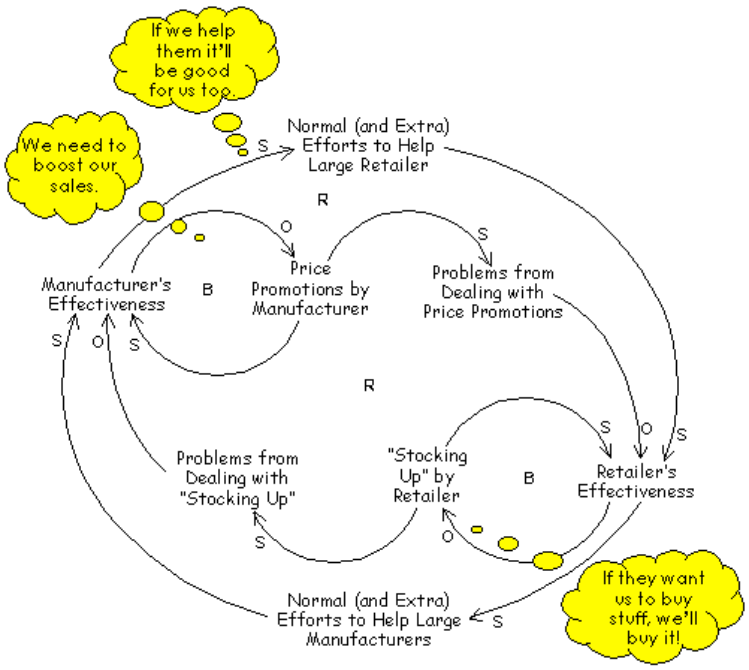
A large consumer products manufacturer and a major national retailer had a joint goal to improve the effectiveness of their combined production/distribution system. But each felt the other was acting in self-serving ways that damaged their relationship.

Starting in the 1970's, the manufacturer began to rely more heavily on price promotions to boost its market share and increase its profits. However, the promotions created enormous costs and other difficulties for the retailer. The retailer responded by stocking up, buying large quantities of a product when it was discounted, then selling it at regular prices when the promotion ended.

That extra revenue improved their margins.

This strategy caused great swings in volume for the manufacturer. It added to their costs and undermined their profitability because the retailer would not order product for months at a time. To improve its results, the manufacturer pushed even more heavily on promotions and blamed the retailer for its problems. The retailer countered by stocking up even more.

Eventually, the manufacturer found itself putting effort into promotions at the expense of new product development, while the retailer concentrated more on buying and storing promoted products than on improving basic operations. Many of the short-term profits from the promotions were drained away in long-term costs.



Implications & Leverage Points

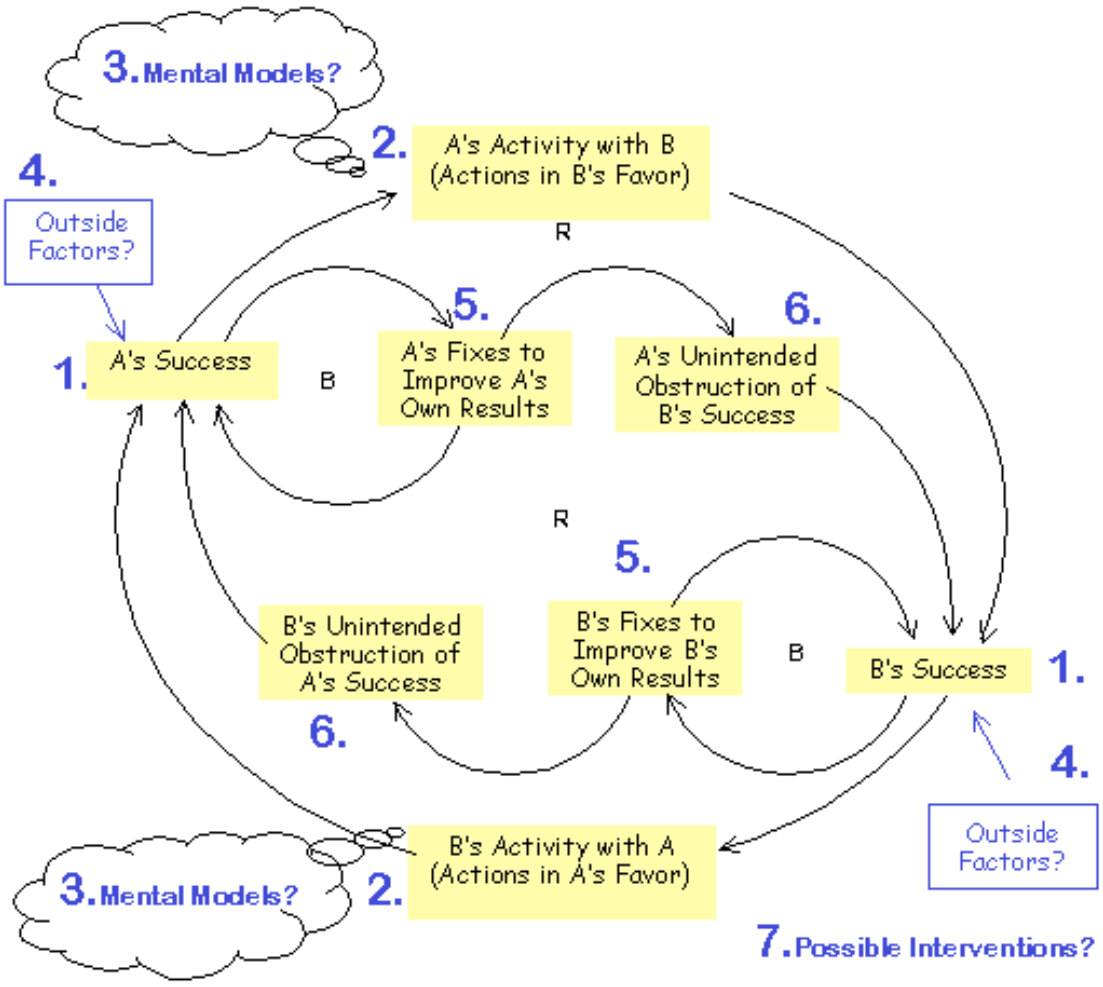
- Any local corrective action has the potential for creating an accident; in interdependent systems, what appear to be independent actions may have unforeseen effects on other parts of the system.
- In the absence of information, even an ally may assume negative motivations on the part of a friend or partner.
- For a partnership to work, the partners need to constantly inquire how local corrective actions might harm the other partner.
- No matter how well intended and structured an alliance is, without constant attention, it can become negative.
- What is required to maintain the success of both partners over time may look different from the actions envisioned during negotiations. A partner is most likely to assume that the other measures and values success in the same way, when pressures and circumstances are actually quite different.
- When a partnership falters, the partners may take on the roles of victim and oppressor. When allies feel threatened, they may protect their own interests—passively or aggressively.
- Fear, threat, frustration or unwillingness to deal with difficulties in the relationship may lead one or both partners to end the relationship.

Exercise

Create an Accidental Adversaries diagram of your own. Consider an important partner to you in your regional effort that is showing signs of strain and mutually negative thinking and action. Use this

generic diagram to guide you, remembering that your diagram may have more variables, more or fewer links, and external variables.

Begin with the origin of the partnership.



Part I: The Partnership

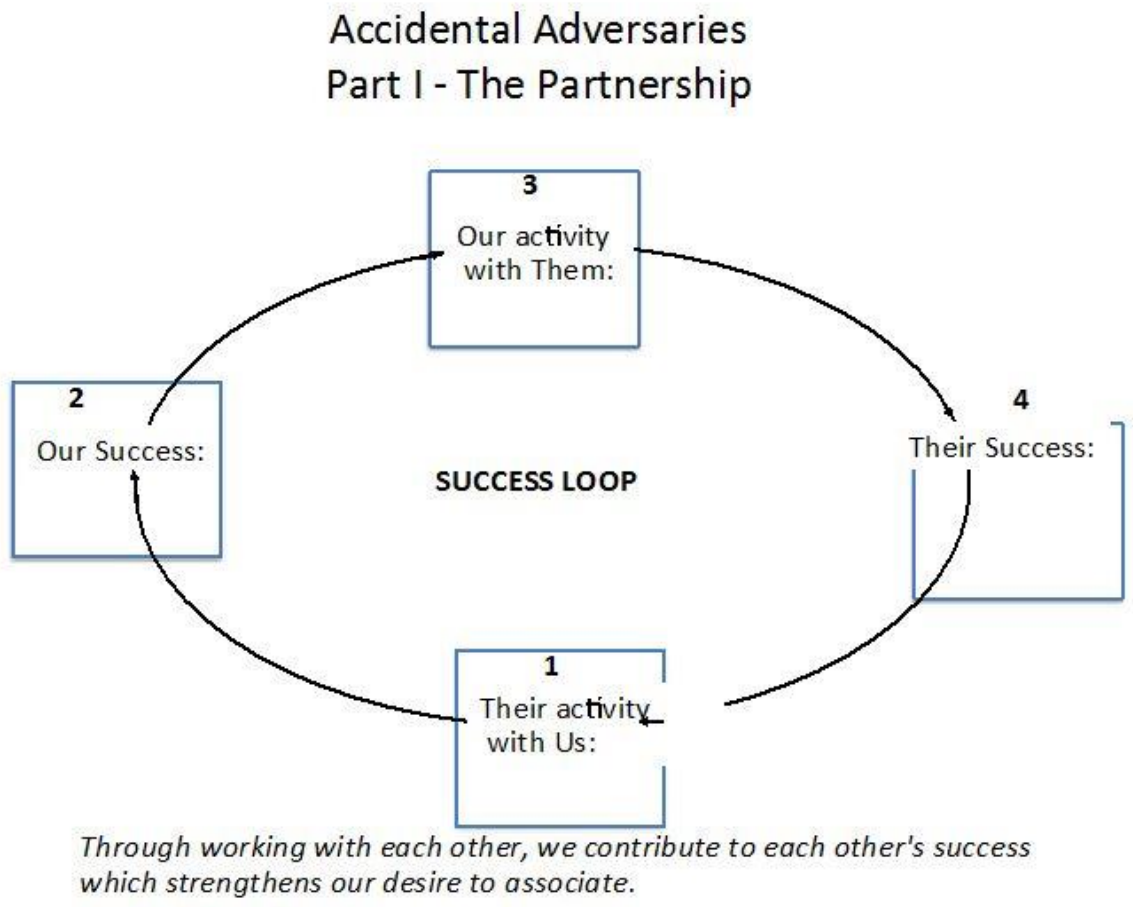
Draw the success loop of your relationship. These questions can help you fill in the boxes.

1. How does your partner contribute to your success? Specifically, what do they do that you value? What actions do you count on?

2. How do you benefit from the relationship? What gives you the incentive to continue the relationship? How do you measure your success?

3. What do you do that is critical to the success of your partner? What do you do that they value?

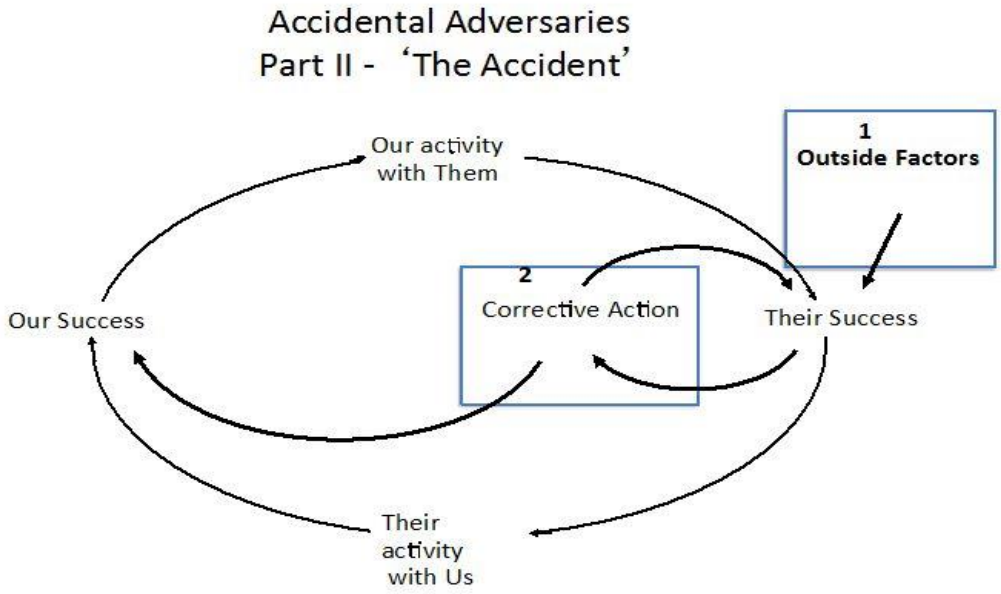
4. How does your partner benefit from the relationship? What gives them the incentive to continue the relationship? How do they measure their success?



Part II: The "Accident"(s)

Now add one or two accidents to your loop.

1. What does your partner do that hinders your success or makes your life difficult? How does their action affect your success?
2. When you experience your success as hindered, how do you respond?
3. How might your responses negatively affect your partner?



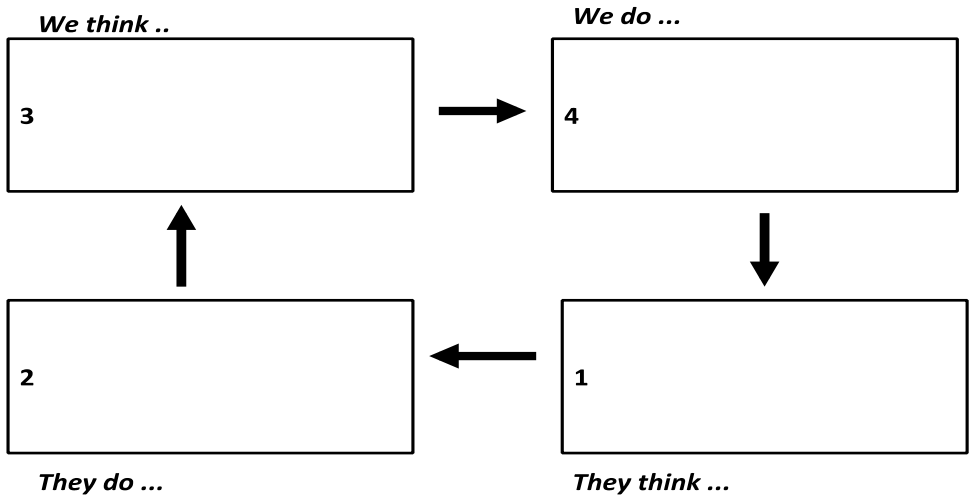
Due to some external factors, their success deteriorates. They attempt to increase their success by taking actions which make sense within their systems. However the action has an unintended detrimental impact on our results, which may diminish our desire to work with them.

Part III: The Defensive Routine

Use these questions to help you fill in the boxes of the defensive routine and the accidental adversaries develop in their thinking and actions.

1. What do we think they think about us? What do they believe about our relationship?
2. What do we see them doing (usually to us) that makes us think that?
3. How do we feel about what they do to us? What do we think about them? What are our beliefs about the relationship?
4. What do we do based on what we think about them? How does what we do confirm what they think about the situation and about us?

Part III: The Collapse of Collaboration - A Defensive Routine



Part IV: Re-establishing a Collaborative Relationship

It is helpful for the partners to name some of the problems (with as little blame as possible) and figure out alternative approaches while also rebuilding the partnership.

In the above case, the manufacturer actually committed to ending price promotions with this retail customer, and introduced a policy of "everyday low prices" that produced stable prices somewhere between the regular price and promotional price at all times. The retailer reciprocated by regularizing orders over the course of a year, allowing the manufacturer to engage in better production planning. Eventually, the manufacturer was able to establish similar partnerships with other major customers. An important intervention in cases of accidental adversaries is creating some mechanism for each partner to understand the other as behaving rationally and with good intent. This mental model makes it possible to give the partner feedback about the unintended consequences of their actions in a way that is not argumentative and accusatory. While there are still accidents, this process of correcting them becomes of one the actions that reinforce the partnership.

To manage or change the Accidental Adversaries dynamic:

1. Acknowledge the "accidents" and that damage was done, and build mechanisms for timely feedback. Begin the process by asking how your actions might be creating a problem for your partner.

    - "We judge others by their actions and ourselves by our intent."

- Do we have ways of giving feedback about the impact of the other's actions?
- Do we assume good intent on the part of our partner? What would we do differently if we did?

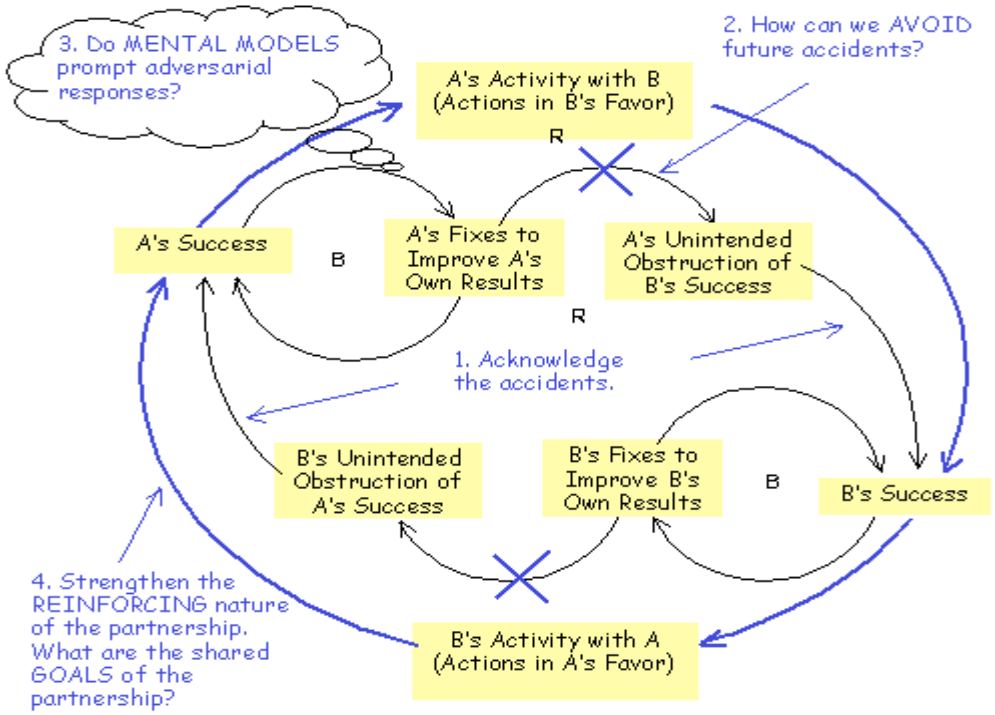
2. Develop mechanisms to avoid accidents. Learn more about your partner so that you can anticipate unintended consequences and/or allow your partner an opportunity for input prior to implementing significant changes.

   - Do we share a common picture of the "success loop" of our partnership?
   - Are we clear about our respective measures of success and priorities?
   - Do we know what actions are expected and valued in the relationship?

3. Identify mental models that may contribute to an adversarial relationship. Begin by assuming that harmful actions were taken to correct a performance problem.

4. Reaffirm the intent and benefit of the partnership; strengthen mutual understanding of each other's needs and of the criteria by which each partner defines success. Establish shared goals. Do the actions taken by each party really help the other? Are others needed? What behavior must stop? Based on our understanding of the structures undermining collaboration, what can we do differently immediately?

Generic Leverage Points



This tool was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

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Establishing a Shared Vision

Agenda for Engaging Large Groups in Transforming Regional Systems of Health

There are many tough challenges when creating a clear, audacious, and broadly shared vision. We know that individuals and organizations can be skilled at articulating a bold vision that is germane to their specific goals. But a vision that enables buy-in from stakeholders and community members involved in a stewardship group requires that participants feel their voices and values are represented.

Successfully arriving at an enduring, representative vision takes hard, deliberate work, and often is not intuitive. Participants in stewardship efforts tend to compromise with others ("Yes, it matters that our oldest citizens have great end-of-life care, but it also matters that our children get a great healthy start to their lives. Let's say "health across the lifespan."). This reduces clarity and tends to create a long list of good things—which is not a vision.

Learning Objectives:

- **To create a shared vision for a transformed system of health for your region**
- **To extend and strengthen relationships**
- **To learn from and build on work already in process**
- **To generate positive images of what is possible and desirable**
- **To create alignment without sanding down the sharp edges of great images**

Phase(s): This tool is best used by groups engaged in a Phase 3 effort along the Pathway for Transforming Regional Health

How to use this tool

The Establishing a Shared Vision tool is an agenda for a convening of 50 or more members of a stewardship effort to work together toward a BIG VISION for the future of the health of the region.

Large groups need some structured help to generate the images of the things that most represent a thriving future community, and they need structure that will keep that vision sharp even through the inevitable conflicts or compromises that occur—and to land the vision at a point of agreement where most can commit to pursue. To that end, this tool proposes a detailed agenda and small-group session agendas during which these comprehensive discussions can occur.

The tool begins with a detailed proposed agenda for the initial session, lasting approximately five hours. The second agenda is for the first small-group breakout session, "Beginning to Build a Shared Vision," to help participants articulate their visions for health and a healthy system of health in their region. The third agenda is for the second small-group breakout session, "Activities & Actions Connected to the Vision," to help participants develop new ideas about how they can help make their vision a reality.

Agenda

Total Time: 5.5 Hours

Steps	Description	Minutes	Purpose
1.	Welcome, Goals & Agenda Review • *Share the story of the effort to date* • *Articulate goals for the gathering & review the agenda*	20	• To create a hospitable space as if welcoming everyone into your home • To set the tone around our values and culture we are building • To reinforce a sense of abundance in the room, draw on all the wonderful people and resources and efforts present, demonstrate an attitude of gratitude • To ensure that everyone knows the who/what/where/when/why of the effort: cultivate transparency by clearly articulating where we've been where we are now, and where we are headed • To articulate the goals for the gathering • To review the agenda • To articulate the purpose and interconnections between this gathering and upcoming gatherings • To make an "ask": To commit to "bringing your best self and thinking" into the room today • To prep them for an ask at the end: To come to future meetings and join us along the way

2.	Introductions & Ground Rules • *Introduce ourselves and get to know each other better* • *Draw on our collective wisdom to enable genuine, engaged dialogue*	60	• To identify everyone in the room and begin building relationships • To create a shared set of rules, drawing on the collective wisdom in the room, to enable genuine, engaged, dialogue
3.	Beginning to Build a Shared Vision • *Offer a starting point based on learning to date*	20	• To offer a starting point to build a shared vision for a healthy health system
4.	*Small-Group Work:* • *Articulate our visions for health and a healthy health system in our region – from our own points of view and from those of other stakeholders*	30	• To invite others to build a shared vision—see agenda below
5.	Report Back • *Weave together the threads of our shared vision*	30	• To hear threads of a shared vision and to raise learning around empathy
6.	BREAK	10	• To move! To eat! To honor our bodies and health! To connect informally
7.	Activities & Actions Connected to the Vision • *Offer examples of innovation and stewardship – those already in process and those that we may be able to set in motion*	20	• To raise examples of innovation and stewardship
8.	Small-Group Work • *Identify what engages us about the vision* • *Consider what will be required to be successful*	30	• See agenda below
9.	LUNCH	30	

10.	Report Back • *Gather our commitments, expected challenges, and lessons learned*	30	• To generate public personal commitments to begin bringing the shared vision to life; to acknowledge the genuine challenges we face and begin compiling lessons about how to address them
11.	Next Steps in the Journey • *Offer descriptions about plans this year*	20	• To provide an additional opportunity for questions and to offer clear next steps about where we are headed
12.	Naming the Effort • *Brainstorm ideas about a name for the effort*	10	• To begin a collective decision making process to create a name; to develop shared ownership in the effort
13.	Invitation for Feedback • *Learn and improve our processes of collaboration* • *Make the next gatherings even more effective*	10	• To hear feedback. To learn and improve our processes of collaboration, and make the next gatherings even more effective
14.	Closing Words • *Celebrate and honor what we have achieved together*	10	• To celebrate what we've achieved together and honor how we are feeling as a result
15.	CLOSING & GOODBYES		
16.	Evaluation of the Gathering	40	• To review what came out of today and how it influences next steps • Time for this is not included in the 5 hour suggested agenda; this is additional for the planning team.

Agenda for First Small-Group Discussion: Beginning to Build a Shared Vision

Goals:

1. To articulate our visions for health and a healthy system of health in our region – from our individual points of view and from the perspectives of other stakeholder groups
2. To listen to each other with curiosity and appreciation so that we create a rich picture that acknowledges what we care about most

Guidelines:

- Please make use of the paper on top of your table to draw pictures and jot down ideas as you reflect on the questions.
- To hear from everyone during discussion, please ensure that everyone speaks once (for no more than 2 minutes each) before anyone talks a second time.
- When someone else is speaking, please listen. If you disagree, still listen. At this point, we need to hear all ideas, we don't need to agree.

Total Time: 30 minutes

Steps	Description	Minutes
1.	Review the agenda	2
2.	Select a note taker who will take notes on the conversation. Select a reporter who will report out at the end. Select a timekeeper who will help the group manage its time.	1
3.	Reflect on the visions described in the large group. Silently jot down responses in words or images. Consider: 1. What do I care about in these visions? 2. What facet(s) would I add?	2
4.	Share your responses. (2 minutes each)	10
5.	Imagine that you are a member of the constituency assigned to your group. Take a moment to reflect on the presentations and conversation so far. Silently jot down responses in words or images. Consider: 1. What would I care about in these visions? 2. What facet(s) would I add?	2
6.	Share your responses. (2 minutes each)	10
7.	Prepare to report on: 1. Key elements of the vision from individuals at the table 2. Your stakeholder group – and key elements of the vision from that vantage point	3

Agenda for Second Small-Group Discussion:

Activities and Actions Connected to the Vision

Goals:

- To reflect on and identify what engages us about the vision so that we each might walk away with one new idea about how we can help make the vision a reality
- To consider what will be required to be successful
- To listen to each other with curiosity and appreciation

Guidelines:

- Please make use of the paper on top of your table to draw pictures and jot down ideas as you reflect on the questions.
- To hear from everyone during discussion, please ensure that everyone speaks once (for no more than 2 minutes each) before anyone talks a second time.
- When someone else is speaking, please listen

Total time: 30 minutes

Steps	Description	Minutes
1.	Review the agenda	2
2.	Select a note taker who will take notes on the conversation. Select a reporter who will report out at the end. Select a timekeeper who will help the group manage its time.	1
3.	Reflect on the vision generated this morning. Silently jot down responses in words or images. Consider: 1. What am I most drawn to/energized by? 2. What would it look like if I brought that to life in my personal, work and/or community life?	1
4.	Share your responses. (2 minutes each)	10
5.	Pause to consider these questions (reflect quietly) If we start working together toward this vision: 1. What challenges will we face? 2. What have we learned from past efforts that can help us? 3. What are our keys to success?	1
6.	Address these three questions as a group. (3 minutes each)	10
7.	Prepare to report on: 1. One personal commitment that someone at the table made 2. Key themes about the challenges we will face 3. Key themes from what we have learned from past efforts that can help us	5

This tool was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

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Creating and Sustaining Audacious Goals

How do we set and maintain stretch goals?

The purpose of this tool is to enhance your ability to articulate bold aspirations—aspirations that are clear enough to generate challenging but achievable goals that promote creativity and action, and that can be sharpened and sustained over time.

Learning Goals:

- **Capturing aspiration using "creative tension"**
- **Identifying and overcoming pitfalls that surface when articulating audacious goals**

Phase(s): This tool is best used by groups and individuals engaged in a Phase 3 effort along the Pathway for Transforming Regional Health

How to use this tool

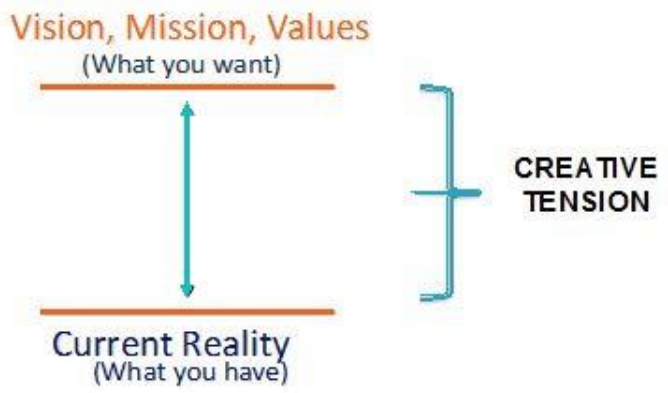
This tool focuses on establishing and maintaining creative tension—knowing simultaneously what you want and what you have. This can lead to "out of the box" thinking and audacious goal setting based on what really matters to you. When you can see creative tension as distinct from psychological tension, that is, how you feel in the face of creative tension, you can more consciously choose to act out of creative tension and manage psychological tension. Otherwise, rather than you having your emotions, they have you and they run the show.

The last section of this tool includes discussion questions for your leadership team that can be used to help plan and facilitate creating audacious goals within your organization and/or regional collaborative.

This tool is most effective when completed by people deeply engaged in the regional change effort and well-informed about all its areas activity, such as those who are part of the core stewardship team leading the effort, or part of the backbone or integrator organization.

Establishing Creative Tension & Managing Psychological Tension

The idea of creative tension is a core part of the practice of Personal Mastery[1]—a discipline of being generative vs. predominantly reactive.



Sustaining creative tension involves learning to keep both vision and a clear picture of current reality before us. Tension, by its nature, seeks resolution. It's as if we have set up a rubber band between the two poles of our vision and current reality.

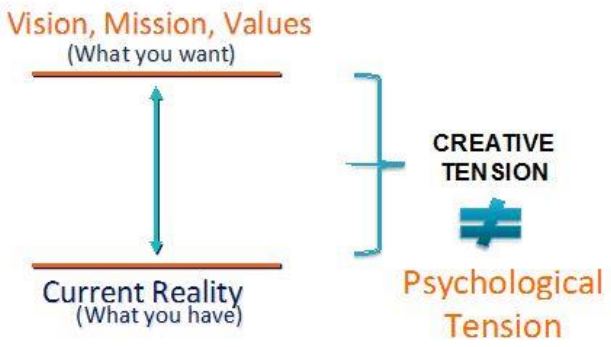
Source: www.solonline.org

Tension can resolve itself in two basic ways: in favor of our vision or in favor of reality.

Holding the vision resolves tension in favor of what we want. There are many great examples, from landing a man on the moon to sinking a putt on the golf course. And you may have examples about access to care or every child healthy at their first birthday.

Resolving tension in favor of reality means we let go of the vision, usually because we experience discomfort with the difficulty (or even seeming impossibility) of the vision, some concern about actually succeeding, or even thoughts that we don't deserve it. So we keep things the way they are.

[1] See Senge, Peter. *The Fifth Discipline: The Art and Practice of the Learning Organization* (Doubleday, 1990; 2006) and the Fifth Discipline Fieldbook series.



How do we cope with emotional or psychological tension? Some of us have elaborate strategies – organizations often seek to motivate action through crisis to persuade us that we simply can't keep things as they are. Looking closely and clearly at current reality is one of the most difficult tasks of the discipline of holding a vision.

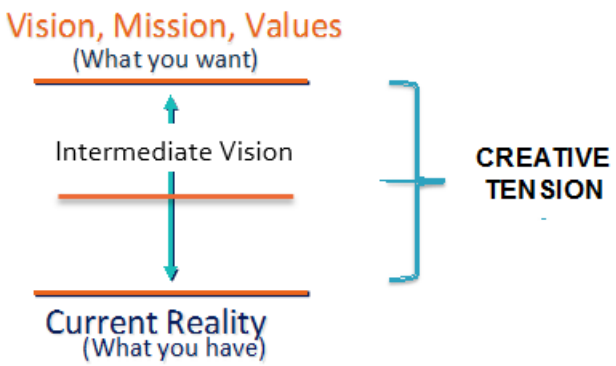
For now, notice where your energy flows—toward holding the tension, or lessening it—and recognize that the tendency is also just part of current reality.

One way to think of your leadership job is therefore about establishing and maintaining tension.

How to establish healthy, generative tension? The Goldilocks challenge!

There's an art to establishing the right amount of healthy tension.

- TOO LITTLE: Not much happens; you settle for what you have because it's close enough; other things are more important and generative (e.g., losing the last few pounds; reducing smoking by 1%).
- TOO MUCH: Psychological tension dominates because the tension "breaks"—the vision seems out of reach (e.g., going from 100% volume payment for healthcare to 100% based on value; zero infant mortality).
- JUST RIGHT: A stretch that can be managed, and vision is reset as progress is made; those who can hold a greater tension should, but meet people where they are (e.g., switch 250,000 people [in a major metropolitan area] from being smokers to being non-smokers)!



One way many organizations and communities manage tension is to have some people serve as the visionaries and others become the pragmatists. This does allow a group collectively to hold creative tension, but it's not the best case. Better is when everyone can simultaneously hold vision and reality. So you not only want to build shared vision, you want to build shared reality, too.

Some reflections on healthy creative tension[2]

1. When you set *annual* (short-term) goals, you tend to think small and/or incrementally. So set longer-term goals, and then short-term goals.
2. Setting longer-term goals allows you to put some tension in the system, tell stories about challenges, opportunities, good years and bad years. People might not know how they're going to get there, but at least they know the direction they're headed.
3. Regional health transformation initiatives do not just happen. They are often a result of setting big, hairy, audacious goals that participants really were not sure how to achieve. Holding the vision encourages experiments and innovation.
4. When others don't take action when you expected them too, be sure to ask them about how they see reality as well as revisiting vision. What you may see as a big aspiration, they may see as a minor improvement because you aren't starting from the same place.

Visioning Guidelines – How to tune up your vision?[3]

Some goal formats are better than others in terms of achieving results. There are just two basic guidelines: tell the truth about what you want and focus on the result. No one wants to invest in a

[2] Adapted from "Using Creative Tension to Reach Big Goals," an interview by Nina Kruschwitz with Dave Stangis (of Campbell's Soup) in the *MIT Sloan Management Review*, November 10, 2011. http://sloanreview.mit.edu/article/using-creative-tension-to-reach-big-goals/

[3] Based on the work of Robert Fritz and Charlie Kiefer.

compromise. The World Health Organization and The World Bank regularly articulate global goals (e.g., the millennium development goal to improve maternal health). Use the following guidelines to test and refine elements of your vision.

1. Focus on what you want

- put yourself and those affected in the picture
- whether or not you think it's possible

ASK: Is it what I/we want? If I/we had it, would I/we keep it?

"In the case of maternal health globally, maternal deaths dropped 45% between 1990 and 2013 . . . While substantial progress has been achieved in almost all regions, many countries, particularly in sub-Saharan Africa, will fail to reach the Goal 5 target of reducing maternal mortality by 75% from 1990 to 2015. Every day, nearly 800 women across the globe die due to complications during pregnancy and childbirth, and 99% of these deaths occur in developing countries . . . Investing in better maternal health not only improves a mother's health and that of her family, but also increases the number of women in the workforce and promotes the economic wellbeing of communities and countries. Untreated pregnancy and birth complications mean that 10-20 million women become disabled every year, undermining their ability to support their families."

2. Focus on the result

- see it in the positive (vs. getting rid of something you don't want)
- check that you are clear about the ends (vs. focus only on the means)

ASK: Is it a result? If I had it, what result would it bring me? (Do I want to add that result to my vision?)

The maternal health example highlights a challenge: how do we state the result in the positive? For example, the vision is to increase reproductive choice and planning, the number of intact families, and women in the workforce. Negative vision is often motivating, but successful endeavors often shift from reacting to a problem to achieving a positive result. In many cases, asking what you want really helps. For example, reducing teen pregnancy is often about helping young women make good life choices. It is best to say you want both these things to strengthen your vision. As an example: "If young Nigerian women had the same employment rate as young men, the country would add $13.9 billion to GDP annually."

Similarly, it is very helpful to clearly name both ends and the means. A group has a goal to draft a business plan. That's great, and we know how many plans end up and drawers and virtual file cabinets. If we had the plan, what result do we want that to bring us? Name that goal too.

These are great coaching questions to help test and refine your vision.

Summary: Discussion Questions for Stewardship Teams

1. Creative tension: What do we really care about creating? What is reality relative to what we care about—the good, the bad, the ugly?
2. Vision tune-up: How can we restate our vision to make it more specific, positive, and real? (Also see guidelines for "story of now" in the Phase 1I page of the Stewardship Guides) If we are wildly successful, what would that lead to? Are there any other things we should be considering to get to those results?
3. Psychological tension: What beliefs or feelings might be getting in our way? How can we use what's useful about them to learn and proceed?

This tool was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

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Conditions for Progress on the Pathway

Developmental Assessment Tool

This assessment captures 11 key conditions that, together and over time, build momentum toward a transformed regional health system.

Learning Objectives:

- **To understand the 11 conditions necessary for transforming systems of health**
- **To assess where your effort is on each of the 11 conditions**
- **To identify areas of strength, improvement, and opportunity**

Phase(s): This tool can be used by groups and individuals engaged in an effort in any Phase (1-5) along the Pathway for Transforming Regional Health.

How this tool helps along the Pathway

The 11 conditions assessed here are the aspects of your regional effort that powerfully promote progress and momentum. Each of them is built over time throughout the Phases of the Pathway. We find that regional efforts avoid pitfalls and sustain progress by attending to each of these conditions repeatedly over time.

For each of these conditions, we characterize five levels of development, roughly equivalent to the five Phases of the *Pathway for Transforming Regional Health*. It will help your effort to move along the Pathway by identifying which conditions are relatively strong already and which you are poised to develop next.

You are aiming for *balance* among these conditions, not overweighting on one or more and inattention to others—they should be roughly equal. Weaker ones can drag back the strengths you have developed.

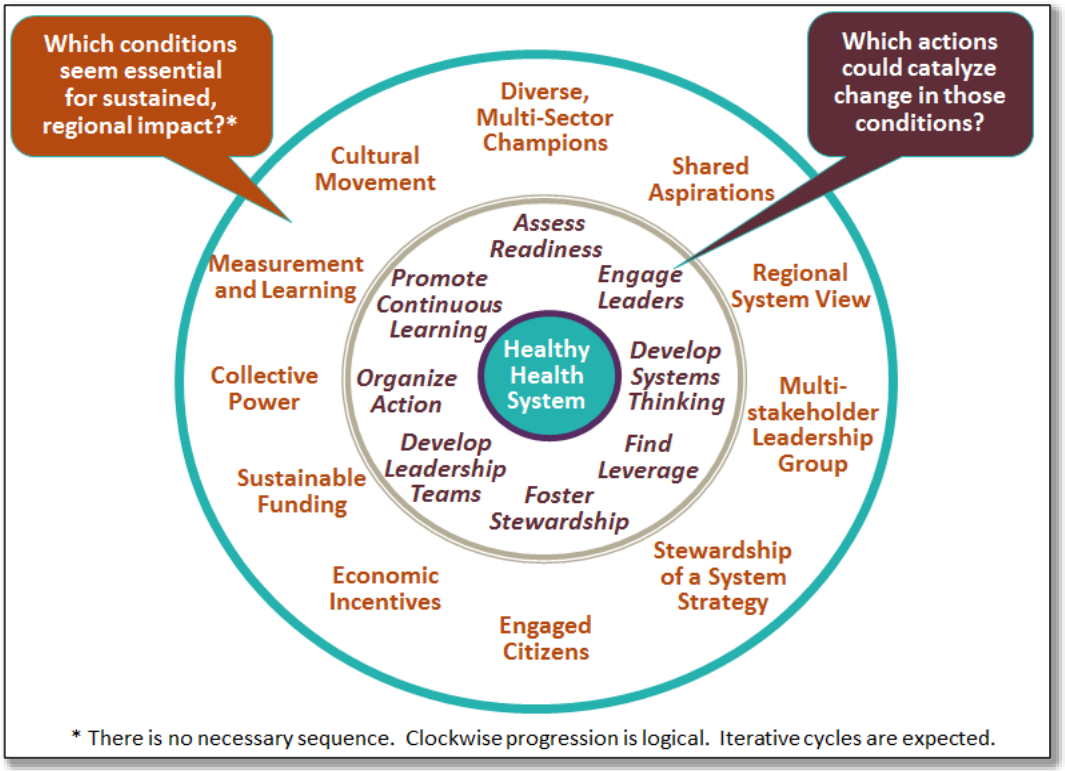
How to use it

This tool is most effective when completed by people deeply engaged in the regional change effort and well-informed about all its areas activity, such as those who are members of the core stewardship team leading the effort, or part of any backbone or integrator organization.

To use it as a team: (1) invite individuals to complete the assessment on their own, (2) capture the range of team member responses for each characteristic described below (on a flipchart or whiteboard); (3) discuss the conditions where responses are widely different, and develop a shared view of progress of your effort on the conditions for progress. It also can be completed by individuals knowledgeable about the effort as a means of assessing progress and engaging others around areas needing attention.

When you or your team has completed the assessment, identify which three or four conditions most need attention (for example, those scoring a 1 or 2 when your effort aspires to be moving securely through Phase 3 of the Pathway). These conditions can serve as strategic priorities for your effort in the next year or so. Attention to the movement of these conditions over time, by reassessing them periodically using this tool, can help you identify and celebrate progress, and target conditions needing attention in the next stages of your work. Regional efforts sustain momentum by making progress on each of the conditions in each phase, maintaining a balanced scorecard among them over time.

Conditions and Catalysts for a Healthy System of Health



Conditions for Progress on the Pathway for Transforming Regional Health

Instructions

There are three parts to each condition listed below: (1) definition of the condition; (2) what to consider when rating your local effort; and (3) descriptions of each level for the condition being rated. You may find it helpful to go through the assessment as follows.

1. Respond to each of the 11 conditions in sequence. For each condition, read the overall definition.
2. The notes for rating your local effort provide additional information about what observations or data you should consider when making your assessment.
3. Choose your rating (1 - 5) based on the level that most closely aligns with what is happening in your local context for that particular condition. Level 1 is just beginning, whereas level 5 represents an effort significantly advanced on that condition.
4. Please feel free to offer comments on why you rated each condition as you did.

Condition 1

MULTI-SECTOR CHAMPIONS: Well-positioned leaders from cross-sector stakeholders have committed themselves publicly to aims that will benefit not just their institutions, but the whole health system.

- Identify any major voices in the region speaking publicly about what is needed for the future of health and health care locally (if any).
- Are these individuals from multiple sectors: e.g., local government, healthcare providers, public health, academia, other institutions?
- Is the work they undertake aimed at positive outcomes for the population of the region, and key institutions other than their own? Or are they working on aims primarily good for their organization but better achieved by working with others?
- Do these leaders take leadership responsibility for bringing about a future that is better for all residents?

1. Well-positioned leaders of key institutions participate in the collaborative to benefit and strengthen their institutions, and they express themselves as leading primarily on behalf of their own organizations' interests.

2. Some well-positioned leaders are beginning to call for identifying ways to work together to benefit the whole region.

3. Well-positioned leaders have committed themselves to a few aims that benefit the region, beyond their own institutions.

4. Well-positioned leaders have committed themselves to aims that benefit the region and actively week ways for their organizations to contribute.

5. Well-positioned leaders publicly articulate aims that benefit the whole system and characterize themselves as feeling responsible for leading on behalf of the entire region.

Condition 2

ASPIRATIONS: A key leadership group has articulated audacious goals about transforming the whole system of health for all regional participants.

- Consider the publicly recorded goals and vision for whatever multi-stakeholder initiative(s) exist in the region.
  - Are the initiatives about solving a specific problem that affects a sub-population (e.g., care for the uninsured; better support for residents with diabetes)?
  - Or are they about more than one outcome and more than one sub-population (e.g., charity care for the uninsured and childhood asthma, low birth rate initiatives) in a move toward more widespread impact?
- "Audacious" goals are those of multi-stakeholder initiatives whose vision explicitly is about making the whole system work better for everyone, both "upstream" aims to improve population health and "downstream" aims to radically improve the system of care. Are the publicly recorded goals about making the whole system better for all?

1. The local emphasis is primarily on a specific project or sub-population.

2. Some health goals or care goals have been identified the majority of the population of the region.

3. The focus of innovation of the collaborative is impact across multiple spheres such as how care is provided and which risks are addressed for certain sub-groups.

4. The focus of innovation includes some radical redesign of systems like incentives and information that affect the whole region.

5. The focus of innovation is at the regional level, to create a sustainable health and care system radically better than the status quo.

Condition 3

REGIONAL SYSTEM VIEW: **Many well-positioned leaders across sectors have invested in developing the ability to understand the system of health as a complex system, including how upstream factors influence health, how key institutions influence each others' actions and incentives, and how a long-term view should shape action in the short term.**

- How do key leaders talk about the system of health, especially those that are engaged in cross-sector dialogue or partnerships? Is the perspective they express focused on how their organization influences and is influenced by others (rather than as an independent actor)?
- Has there been any intervention or activity offered to groups of stakeholders that is explicitly aimed at broadening their understanding of the system of health as a whole?

1. Well-positioned leaders in the region generally understand only their own narrow, isolated parts of the system.

2. A few well-positioned leaders understand how other parts of the system affect their core businesses.

3. Some well-positioned leaders are beginning to articulate understanding of the interconnections between certain parts of the health system, such as health care and public health, but leave others out (such as education, transportation).

4. Well-positioned leaders are actively engaged in building widespread understanding of how the whole system works.

5. Well-positioned leaders are able to see the whole system of health, and can articulate the relationships among key sectors and their activities, and how they collectively produce outcomes.

Condition 4

MULTI-STAKEHOLDER LEADERSHIP TEAM: A leadership group is composed of the key stakeholders, it operates as a real leadership team, and it makes decisions together that affect the whole health system (they exercise legitimate authority).

- Identify the key leadership group that is the closest to a multi-stakeholder governing body or stewardship team in your region. Some examples to consider: a steering group, a board of a multi-stakeholder organization, an executive team of a collaborative, or all three (or none).
- In assessing that team, consider the diversity of membership of the group, including involvement of payers, employers, public health, providers, and residents.
- Consider the degree of authority this group has to make decisions together that affect many stakeholders in the region. What does this leadership team do when it convenes (e.g., make decisions, or just exchange information; establish priorities for the system, or only for small parts of it)?

1. There is no recognizable multi-stakeholder group that operates as a leadership team for health system transformation.

2. The leadership groups that convene across organizations operate largely within their own sectors.

3. There is a multi-sector group of leaders convening, but key stakeholders in the system of health (such as payers or employers or public health officials) are not at the table, and the group has authority to act only for parts of the regional system.

4. There is a multi-sector group convening, and it represents stakeholders from most relevant sectors; its authority to make decisions is emerging but not fully authorized.

5. There is a multi-sector group convening, and it represents all relevant sectors of the regional system of health. It is recognized by residents to have legitimate authority for making collective decisions that affect the whole system of health of the region.

Condition 5

STEWARDSHIP OF A SYSTEM STRATEGY: A key leadership group has formulated a high-leverage strategy that proposes a coherent set of initiatives to be undertaken in a coordinated way among stakeholders of the whole system of health of a region.

- Considering the same group(s) as above, what do their strategizing processes consider? Is there a multi-sector strategy? Does it show consistency and coherence across all the initiatives that the leadership team guides? Do the initiatives fit together to move multiple outcomes?
- Does the strategy that is formulated rely primarily on individual organizations and actors pursuing their own projects, or does it call for multiple stakeholders to coordinate their actions and attend to timing and sequencing of their initiatives over time?

1. Major stakeholder organizations establish their own change priorities independently of one another and are not guided by a coherent regional strategy.

2. Some major stakeholder organizations have slightly shifted their own strategies to take shared aims into account.

3. A multi-sector group has established shared goals and priorities for the region; most change initiatives are undertaken independently by key stakeholders based on their own strategic priorities rather than as a coordinated effort with other stakeholder institutions.

4. A multi-sector group has established shared goals and priorities for the region, and a few change initiatives are undertaken by new partnerships across organizations directly to address those goals and priorities.

5 A multi-sector group has established shared goals and priorities for the region and has created a shared strategy of high-leverage initiatives for the whole system. Change efforts are sequenced and integrated among key stakeholder organizations.

Condition 6

ENGAGED CITIZENS: The general population, individually and collectively, exercises responsibility and ownership for its own health system.

- Considering the same leadership group(s) as above, are community members (and not just high-level leaders from community organizations) represented on the governing bodies? Do residents have more than an advisory voice? Are they part of making decisions for the future of the system?
- Considering change initiatives in the system: Are residents involved in shaping the vision of the future system? Are they providing advice and feedback about aims and priorities? Are they active participants in leading the implementation of change efforts? Are they members of open forums where the main collaborative efforts report results?

1. Citizen involvement is largely pro forma: Residents are mainly clients and no mechanisms exist for them to be meaningful decision makers in the design and priorities of their health system.

2. Residents have been involved in dialogue about needs but not in deciding overall vision or making decisions about strategies and resource allocations

3 Residents have been meaningful decision makers in establishing the vision for the future system; but key institutions decide strategy and resources without citizen engagement.

4 Residents have been meaningful decision makers in establishing the vision for the future system and there are deliberate recruitment and outreach strategies by key institutions to involve them in strategy and innovation; there is no formal role for residents in governance.

5 There are well-established and meaningful mechanisms in place for engaged residents to get involved in shaping the system, as well as active involvement in governance by residents that makes the system accountable to the public.

Condition 7

ECONOMIC INCENTIVES: Positive financial consequences accrue to individuals, groups, and institutions contingent on system-level performance outcomes, and incentives do not reward undesired behavior.

- Do incentives for all key stakeholders depend on population health status?
- How are providers paid? Is there some form of payment in place in the region that moves providers away from fee for service?
- Are cost savings and patient well-being rewarded?

1. Misaligned incentives dominate and efforts to change are stalled.

2. A few key organizations have altered incentives away from paying for volume.

3. A handful of important organizations have incorporated population health into their performance measures and pay systems.

4. Many key groups have launched experiments that change incentives toward aligned accountability for health status of the population.

5. Key actors are guided by incentives that now encourage mutual accountability for the outcomes and health status of the population.

Condition 8

SUSTAINABLE FINANCING: **The health transformation strategy is supported by a financing strategy that is designed to be self-sustaining; its survival is not dependent on any one main funding stream or outside grants; the region actively invests more in promoting health than in providing sickness care.**

- Consider what you know about where the funding comes from to support the initiatives that are part of the change effort, and the infrastructure for cross-sector collaboration (i.e., the organization(s) that supports implementing shared strategy). How diverse and intentional is the array of funding? Are participants investing jointly in the effort?
- Does an agreement exist among key stakeholders in a regional system of health to identify funds that might be saved as a consequence of one initiative, and to invest those funds in initiatives to improve population health over time?

1. Joint initiatives are funded with external funding or short-term investments.

2. An ongoing collaboration of stakeholders has begun to invest in staff or infrastructure to support ongoing coordination.

3. Stakeholders provide financial resources for supporting a backbone or integrator organization and for implementing joint initiatives, but a long-term financing strategy for health promotion is yet to be developed.

4. Stakeholders are implementing new business models and harvesting the resulting savings to stabilize the funding of long-term strategies.

5. Stable funding comes from diverse sources, including reinvestment of savings, to drive improvements over time in the health of the population of the region.

Condition 9

COLLECTIVE POWER: Organizations are partnering with each other, increasing interdependence, and combining resources in ways that integrate parts of the health system that used to function in silos.

- When redesign efforts are undertaken (in the health delivery system, in how social services or other services are provided) are those efforts designed jointly by different stakeholder organizations from different sectors, and are they implemented with personnel working interdependently across organizations?
- Have stakeholder organizations merged, created strategic alliances, adopted new partnerships and business models together?
- Consider who is providing resources, personnel, leadership, and other capacities to projects. Is each innovation or improvement effort managed by a single stakeholder, or are efforts combined and aligned across organizations and sectors?

1. Different stakeholders pursue mostly their own initiatives; collaborations are time bounded and project focused.

2. Key organizations are conducting ongoing joint initiatives but mostly within sector.

3. Key organizations have launched a few initiatives that are designed, conducted, and resourced in ways that bring together sectors.

4. Distinct groups and organizations work together on many innovations across sectors and jointly deploy resources—their "collaborative muscle"—to achieve shared aims.

5. Key organizations have created formal partnerships to do their core work in radically more integrated ways.

Condition 10

MEASUREMENT AND LEARNING: **A coordinated effort exists to collect and use data to measure impact across a range of key outcomes to enable learning about the impact of initiatives, and for altering course based on findings.**

- Consider the core collaborative of the region and the ways in which information systems, evaluation practices, and measurement are incorporated into initiatives.
- What key metrics (if any) is the group tracking, and for what populations? Do those metrics represent a diverse dashboard, covering the range of outcomes that define an effective system of health?
- To what degree are measures used to test progress? Are these measures used to suggest course corrections and do they serve as a source of collective reflection by key leaders engaged in implementing the strategy?
- Are measures of impact shared in public forums and do those forums result in new initiatives or alterations of strategy and priorities?

1. The effort measures key outcomes mainly at the specific project level and the results are not shared beyond the immediate participants.

2. The effort measures and publicizes key project outcomes but they are not attached to regional population goals.

3. The regional effort has developed a handful of shared metrics to assess project outcomes, including project-level contributions to shared priorities.

4. The regional effort has developed shared measures at the population level for health, care, and costs, and findings are made public.

5. The regional effort integrates rigorous measures into a dashboard assessing movement toward true regional goals, including excellent population health, high-quality care, and sustainable costs; performance is reported publicly.

Condition 11

CULTURAL MOVEMENT: Different stakeholders consistently express similar strong values about the characteristics of transformed regional health, and their norms of behavior and organizational priorities support promotion of those values.

- Consider the stories key leaders tell and what gets celebrated as accomplishment in the local effort: Are there consistent themes across stakeholders that are widely shared?
- If there are surveys in use as part of the local effort, consider questions about what respondents value in their system of health. Do residents as well as well-positioned leaders express a set of shared values about health, access, equity, sustainability, and other key attributes of a common vision?

1. Values about a transformed health system vary widely among institutions and groups, and are not strongly shared.

2. Some institutions and groups are beginning to coalesce around certain shared values for a better health system, but others hold competing values.

3. Values about a better health system are strongly shared among groups and institutions actively involved in the change effort, but not beyond the insiders.

4. Values about a transformed health system are strongly shared among those actively involved in a change effort, and are being promoted and publicly celebrated beyond the insiders.

5. Values for transformed regional health are strongly shared and actively pursued by a powerful movement in the whole community.

This tool was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

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Building a Learning Practice

Before and After Action Review Tools

If learning is fundamentally about continually expanding our capacity to create the future to which we aspire, then by definition our learning must evolve as that future emerges.

Emergent Learning is about designing a process to enable groups to continue to learn from their experiences, as that experience unfolds.

Learning Objectives:

- **To understand how emergent learning is used for continuous learning that *emerges* from the work itself**
- **To develop an emergent learning practice for your effort using the Before Action Review (BAR) and After Action Review (AAR) tools**

Phase(s): This tool can be used by groups and individuals engaged in an effort in any Phase (1-5) along the Pathway for Transforming Regional Health, and is particularly poignant for those engaged in a Phase 3 effort

How to use this tool

This tool leads you through the core principles of emergent learning, how to use framing questions to focus your learning, followed by two tools: (1) the Before Action Review (BAR), which begins by asking what our intended outcome is and what success will look like and ends with a plan to produce it; and (2) the After Action Review (AAR), which stops to ask if you got there and what insights you plan to take forward. It turns work into a deliberate learning experiment.

This tool is most effective when completed by people deeply engaged in the regional change effort and well-informed about all its areas activity, such as those who are part of the core stewardship team leading the effort, or part of the backbone or integrator organization.

Emergent Learning

Emergent Learning is learning that *emerges* from the work itself. Its tools and practices support surfacing, capturing, and employing those insights to inform future work. These things help train our thinking process so that we make decisions and take action based on deeper and more robust hypotheses about what it will take to achieve the future to which we aspire.

In ReThink Health, we have explored ways to deepen our reflection and understanding about health care and the complex and dynamic environment in which it operates, in order to ask better questions, gain a more systemic, more sustainable perspective, and take more robust action. But it would be a mistake to think that "deep reflection" equates with "right answers" that simply need to be implemented. All of us aim to create change in a dynamic environment with partners and stakeholders who view the world through their own eyes and use their own experience and thinking to make their own informed decisions; and so they should and always will. Their thinking will be different from yours and will evolve based on their own experience, as will yours.

Therefore, it is not enough to gather once, or even once a year, to reflect together. The tools and practices of emergent learning are designed to help people who have different perspectives engage with each other at the beginning of a project or initiative and during the work itself, as often as needed, in ways that are as simple as possible, to reflect and adjust their thinking as the situation unfolds.

Framing the Learning Practice

In a complex environment, there is quite literally too much to learn. We begin an emergent learning practice by identifying a handful of learning priorities—a fundamental, pernicious challenge; a high-leverage opportunity; a critical link in a logic model or theory of change—and build a plan to learn from the work itself. The question to ask is this:

> *If we could master only one thing this year, what would make the greatest contribution to creating the change to which we aspire?*

Testing Out Assumptions and Theories of Change

A great place to start is by exploring your own strategic plan, logic model, or theory of change, and the underlying assumptions.

One simple way to look at logic models, theories of change, or strategy documents is that they all consist of a series of "if/then" *hypotheses*: "**IF** we make (this) decision or take (this) action, **THEN** we expect to achieve (that) result." In a sense, every hypothesis – whether part of a grand strategic plan or a two- hour meeting design – breeds another hypothesis: "Well, what would it take to do that?"

Thinking in this way makes it easier to test out hypotheses in practice. The "if" is the decision or action; the "then" is how you would recognize success. The Before Action Review (BAR) described below begins by asking what our intended outcome is and what success will look like and ends with a plan to

produce it. The After Action Review (AAR) stops to ask if you got there and what insights you plan to take forward. It turns work into a deliberate learning experiment.

Using Framing Questions to Train Your Focus

A ***framing question*** translates a learning priority (challenge, opportunity, or hypothesis) into a question that keeps people's attention focused on it as they work. It encourages people to explore new ideas. It also helps bring a community of partners together to think together in an attitude of inquiry. Lastly, repeating it at the beginning of a BAR or AAR (see below) helps focus reflection.

Selecting an effective framing question is a bit of an art. The best framing questions typically take the form of "What would it take to . . . ?" or "How can we . . . ?" Let's say, for instance, that a community health initiative is continually running into roadblocks and delays because of disagreements among key community stakeholders.

Problem Question	Why	Better Question
Why don't our stakeholders support this approach?	Retrospective and analytical questions result in debate and fault-finding, but no movement forward.	What will it take on our part to get our stakeholders to support this initiative?
How do you build stakeholder alignment?	Big, abstract questions tend to lead to big, abstract conversations.	How can we help our stakeholders agree on a common goal for this initiative?
What will it take to get the clinic director and the mayor to kiss and make up?	Questions with embedded assumptions about the cause of a problem limit the group's focus and options.	What will it take on our part to help key stakeholders listen to and understand each other's needs?
How can we develop a good briefing document for the community?	Questions with embedded solutions limit the team's options and may be seen as trivial or irrelevant.	How can we ensure that we are communicating effectively with the community on an ongoing basis?
How can we communicate our message, get buy in, and build momentum on our schedule so that slips do not impact ultimate deliverables?	Compound questions make the team learning process unnecessarily complex.	How can we ensure that delays caused by external circumstances do not impact our ultimate deliverables?

Turning Work Into a Learning Experiment

We attend a thought-provoking workshop or read a book that challenges our thinking. Then we leave and turn our attention back to our "to do" list. Without a concrete way to experiment with new ideas in our real work, learning becomes theoretical. Increased awareness + no improvement = frustration.

It is in the doing of the things that we do on an everyday basis that we either: (1) learn and improve; or (2) just move through the motions on the way to the next deadline. Making decisions, meeting with stakeholders, conducting routine health procedures, rotating shifts, etc., etc. These routine events can be seen as an opportunity to conduct a learning experiment.

Think about your framing question(s): what events or activities in your regular work would lend themselves to your trying new ideas?

Look for especially important upcoming events. These events offer great opportunities to help a group where it will matter most *to them*. (This is in contrast to starting with a post-mortem of a one-time project when everyone in the room just wants to get on to their next project.)

Look for repeated events. These provide a built-in opportunity to test out a group's thinking, see how it works, refine its approach, and try again. If you can improve something your group does on a repeated basis, the group will quickly see the benefit of a learning practice for themselves and start to look for other opportunities to try out new thinking deliberately.

Putting It All Together to Improve Practice

To summarize, an emergent learning practice identifies a learning priority, frames it as a question, identifies opportunities to test out ideas, and employs simple tools like Before Action Reviews and After Action Reviews to test out ideas in practice. Over time, it helps a group deepen its understanding of what causes a persistent challenge or how to best take advantage of an important opportunity, and how to work together to learn and improve.

You can even use BARs and AARs to track the progress of the practice itself. You can bring the group together in a more intensive BAR as you get started, in order to get everyone's thoughts on the table. Periodically, you can use these tools to step back and reflect on what you have learned over the past month or quarter, and cast forward for the next month or quarter to what you want to focus on learning and what the opportunities are to test out new ideas.

Convening Stakeholders to Learn Together from Everyone's Experience

Too often, a meeting intended to bring stakeholders together to learn from each other's experiences translates into a series of PowerPoint presentations with no real effort being made to create deeper insight or to think about what it would take to apply ideas to your own work.

What would it take to turn these gatherings into true peer learning sessions that help the whole community get better at achieving the outcomes they share? Emergent learning tools and practices can help bring participants together as "experts in equal measure."

A framing question can create a theme for the meeting and a tone of mutual inquiry. It helps participants decide which stories to share. It increases the potential to deepen insight by comparing and contrasting stories in dialogue. In what ways are our experiences similar? How are they different? What meaning do we make of these similarities and differences? What other ideas do these comparisons suggest?

Participants can use the AAR format to prepare to reflect on their experience around the framing question – the story *behind* their success or their failure. They can use the BAR format to think about how what they have heard might apply to their own situation.

What if…

. . . a whole network of stakeholders working together to achieve a shared outcome were to create their own emergent learning practice—to go from N to N+1, all at the same time—and come together on a regular basis to share what they were learning? What if improvements and innovations accumulated more quickly? What impact could that have on the rate of change…in creating the future to which we aspire?

(See "Growing Knowledge Together: Using Emergent Learning and EL Maps for Better Results," *Reflections: The SoL Journal of Knowledge, Learning and Change,* Vol. 8, No. 1.)

TOOL: Before and After Action Reviews (BARs and AARs)

Overview

Before Action Reviews (BARs) were created to replicate some of the behind-the-scenes preparation the U.S. Army uses to set the stage for effective learning. **After Action Reviews (AARs) were** developed by the U.S. Army after the humbling experience of Vietnam to involve every soldier in the process of reshaping the Army into a more skillful, adaptive organization. It has helped them prepare for new kinds of missions – conducting peacekeeping in Haiti; offering humanitarian assistance in Rwanda. It has been used extensively in both Iraq and Afghanistan.

The BAR/AAR tool is so simple and flexible that it has been adopted by many public agencies to learn from major crises, by corporations to improve performance, and by foundations and nonprofits to improve social outcomes. But like so many things that look impossibly simple on the surface, there is an art to using BAR/AARs well. Fourth Quadrant Partners has intensively studied the masters who created and refined this simple tool over the past 25 years.

Before Action Reviews

Purposes and Outcomes

The primary goals of the BAR is to make sure that everyone is on the same page with regard to intent; is thinking actively about how to affect outcomes; is taking into account past lessons and ideas; and is aware that there will be an AAR to reflect on results. The BAR goes beyond the "plan on paper" and asks "what *else* will it take?" and "what *else* can we try?"

A BAR asks group members to:

1. Declare their intended outcome and how they will recognize success;
2. Think together about what challenges they predict and draw on insights from their past experiences; and
3. Develop a plan for achieving their outcome in the face of predicted challenges.

Time

Both BARs and AARs should be "fit for purpose," depending on the complexity of the work and the number of actors involved. If preparing for a large event with a number of people who are involved in different aspects of the work or who represent different organizations, a BAR may take up to two hours. If there are several elements to an event or activity, consider breaking the BAR into smaller pieces, with one wrap-up BAR to "rehearse" how the parts fit together. These more complex BARs would benefit from skilled facilitation.

For most events and activities, however, a BAR should take from 10 to 30 minutes, and can and should be self-facilitated.

Participants

A BAR should involve those people who "have their hands on the task." If not everyone can attend, it is more valuable to hold a BAR with the people who can be there than to cancel it.

Preparation

In most cases, the only preparation required is a flip chart or a notepad for taking notes. An optional template has been provided below. For large or complex events and activities, any planning documents, including goals, schedules, and metrics, should be available. If a theory of change or logic model has been created, that should also be available. A visual timeline of the plan may be a valuable coordinating tool.

Conducting a BAR

While a BAR may take ten minutes or two hours, the same basic steps apply:

Step 1: What is our intended result?

This may be as simple as reviewing the goals for an initiative launch, a stakeholder meeting, etc. Without clear, shared intent, it will be difficult to compare intent with actual results.

Step 2: What are our success measures?

In your AAR (detailed below), you will use your success measures to compare intended versus actual results – a very important part of the learning conversation. Your measures may be quantitative (meeting deadlines, budgets, quality standards; receiving funding; performing to standard) or qualitative (having every voice heard; having a clear idea of who will do what by when; gaining stakeholder commitment). But the more concrete the metric, the easier it will be to compare intent and results in your AAR.

Step 3: What challenges will we face?

This is the last chance to get real—to use the group's past experience to *predict* what is likely to get in the way and to plan for it. Are there predictable scheduling bottlenecks to plan for? Is there a point in your process where you always seem to fall behind schedule? Are you likely to experience resistance from a particular stakeholder? Do you typically forget to keep certain key people in the loop? Your framing questions may guide you to focus on one particular dynamic that you want to work on changing.

Step 4: What did we learn from last time?

If any lessons exist from past activities conducted by this group, or from similar activities conducted by other organizations, this is the time to bring them into the conversation. The goal is not to exhaustively replicate every idea proposed by someone in the past but to realistically plan for stumbling blocks you might face and to **identify *one* good idea** that you can try.

Consider this step to be a requirement. In every organization we have worked with, the weak link in the learning process is between reflection and planning. Being rigorous about looking back helps to strengthen the link and ensure that you don't keep learning the same lessons over and over.

Step 5: What do we think will make us successful this time?

Taking Steps 1–4 into account, what is the one thing the group could do that you predict will make the biggest difference in its results? **Create an experiment**. Think through any additional plans it will take to try this out. Because you will be conducting an AAR afterward, you will have a perfect opportunity to ask yourselves, "Did it work?"

After Action Reviews

Purpose and Outcomes

In practice, many organizations only hold an "AAR" at the end of a project or initiative. These intensive AARs are seen as stand-alone events whose purpose is to extract and document all of the possible "lessons learned." These are actually "postmortems" and serve a different purpose than a true AAR.

The primary purpose of an AAR is to work together to consciously test out and refine a group's thinking and actions in a timely way within the work itself, while there is still an opportunity to correct course and improve the outcomes of a project or initiative.

An AAR is conducted after an event or a small piece of action. It asks those who had their hands on the action to get together to:

1. Compare what they intended to accomplish and what actually happened
2. To reflect on what caused their results
3. To identify "sustains and improves" for next time

Time

As with BARs, AARs should be fit-for-purpose. They may last anywhere from a quick ten-minute debrief to an extensive four-hour deep dive into causes and insights.

When deciding how long to plan for, do a cost/benefit analysis from the perspective of participants. Does the time spent result in visible improvement? ***Remember that the goal of a single AAR is to get better, not to thoroughly review every aspect of an event or activity***. The goal is to go from *N* to *N+1*. Because you are building a practice rather than holding a single event, you will be able to come back and address other issues next time. It is better to come away with one good, actionable insight and idea than a whole report full of recommendations that will sit on the shelf.

As with BARs, longer, more complex AARs will benefit from skilled facilitation. Shorter AARs can and should be self-facilitated, especially if the availability of a facilitator complicates scheduling.

Participants

An AAR should generally involve the same people who conducted the BAR – the people who had their hands on the work itself. Organizational leaders who did not participate in the activity may request to participate in the AAR. If and how they participate should depend on the culture and level of trust in the group. (See Facilitation Tips Below.)

Preparation

For simple AARs, nothing more than a flip chart or a pad of paper is needed for taking notes. An optional template has been provided below.

Using Visual Aids

At the beginning of an AAR at the Army's premiere National Training Center (NTC), where the AAR was born, the facilitator shows a "hero tape"—video clips from the day's battle, followed by a series of charts that review the intent they covered in preparation for the battle, actual results at the battle's end, and maps that illustrate their position, strength, and movement at decisive moments as the battle unfolded. In addition to establishing the "ground truth" for an honest learning conversation, this rich set of video clips, charts, and maps also serves to help the soldiers ***step back into the experience in time***. This helps them unravel, by the end of the battle, what has become a very complex set of interactions and reflect on how and when specific actions affected the outcome.

For AARs of complex work or involving many participants, preparing visual aids will help participants step back through decisive moments. It will help them come away with a much more accurate understanding and a much more targeted and high-leverage set of insights to apply next time.

Effective visual aids might include any of the following:

- Charts of agreed-upon intent or goals for the activity
- Key metrics and performance against them
- A logic model
- A timeline of key events and milestones over the course of the activity
- Responsibility charts mapping out who was involved in what decisions when
- A process map for how the activity was designed to flow
- Group snapshots or video clips of the activity
- Products produced by the group along the way
- Anything else that might draw people back into what happened

Remember that the amount of preparation should be fit-for-purpose. If the preparation burden is too great, the group may experience one great AAR but resist committing to doing them on a regular basis.

Conducting an AAR

Whether an AAR takes ten minutes or four hours, the same basic steps apply:

Step 1: What was our intended result?

If you did a BAR, it should take very little time to restate what you agreed to in advance. If a participant questions the intent, rather than debating it here, include that as a topic for Step 3.

Step 2: What were our actual results?

If you have been able to document this prior to the AAR and prepare a chart or other visual record, this step will also not take very long, though participants should be encouraged to challenge your assessment of the results. Discussion about results should always reference intent and success

measures. "We said we were going to do X. Did we do it?" If a discussion does get started, it will invariably drift into the question of "why?," which should be deferred to Step 3.

Step 3: What caused our results?

This is the meat of the reflection process. Depending on how much time you have, you can go deep into understanding causes, or you can focus on top-of-mind highlights. (See **Facilitation Tips,** below, for suggestions about facilitating for deep understanding.)

Sometimes the answer is that the group did not get a chance to try out its thinking. This is not uncommon. But ***everything feeds back into the AAR process***, so it is perfectly valid to ask "Why not? What would it have taken to try that out and how could we make sure that we try it out next time?"

Use a timeline to help move from generalizations to specifics. For more complex AARs, if you have a prepared timeline, it can be helpful to hand out sticky notes and ask participants to take a moment to write down their own thoughts about what happened when and why, and to get up one at a time and place it on the timeline. Even if you are reviewing a simple event, it can be useful to break your reflection down into sections (before/during/after, morning/afternoon, etc.). Some key insights may come from thinking about what happened (or didn't) before you stepped into the room.

Step 4: What lessons should we take forward for next time?

The ideal outcome of this step is to find up to three of the most powerful insights or ideas that this group could take forward to improve its performance in its next opportunity. Consciously looking forward to the next opportunity helps to strengthen the weak link between reflection and planning.

There are a number of different ways to answer this question. One of the Army's favorite techniques is "Three Ups/Three Downs" (three things that worked that should be sustained; three things that we need to improve). You can identify "Sustains and Improves"; "Key Lessons" or "Insights; and "Ideas and Experiments."

AAR Facilitation Tips

Good preparation and good meeting management is the first step. Everything you already know about running an effective meeting applies here. Beyond that, here are a few basic rules to keep in mind:

- There is no more powerful way to set the tone before the AAR than to counsel the leader of the group to acknowledge something that she or he could have done better.
- Remember that this is the group's meeting, not yours. Stay focused on what they want to understand and improve, not what you think they should.
- Help the group stay focused on their own responsibilities, rather than shifting the blame to people not present. Register complaints in a parking lot and shift the focus back to what they

can address themselves. Finish the meeting with a plan to address issues outside of their scope of responsibility.

- Design and facilitate the meeting so that participants do most of the talking. Your goal is not to teach the team but to help them learn themselves.
- When the conversation strays, use the visuals you've prepared to bring the team back to its intent and the ground truth.
- Ask the team to identify what worked as well as what didn't.
- Help the group to avoid generalizations and to get as specific as possible. When a participant makes a broad assessment (such as "leadership is to blame"), ask for an example.
- When the conversation turns into advocacy for different points of view, ask each party to "ground" his or her point of view with the data. Focus on the next opportunity and get the team to choose one alternative to test out. Because it is part of a learning practice, you can always try out another alternative next time.

Ground Rules

You may choose to write your own ground rules. Here are some that have worked for us:

- Everyone is on equal footing. Everyone participates . . . and everyone listens to each other.
- No one here has the "right" answers. It is okay to disagree.
- There is no success or failure here. There is always room to learn and improve.
- There are the facts and then there is your thinking about those facts. Try to speak about them separately.
- The goal is for us to understand and improve together . . . as a team. No thin skins . . . and no blame!
- This is a place for candid discussion. This has two implications:
- What gets said stays in the room, unless we decide to share what we've learned with others.
- Nothing that gets said in this room gets used against anyone, whether present or not.
- Take notes . . . take ownership for tomorrow's results.

BAR / AAR Planning Tool

Organization or Team:

Framing Question:

Event or Activity:

Before Action Review (BAR)
Date:
What is our intended result?
What are our success measures?
What challenges will we face? (Predictions)
What did we learn from last time? (REQUIRED FIELD: Lessons/plans from last AAR, if available)
What do we think will make us successful this time? (Hypotheses and Experiments)

After Action Review (AAR)
Date:
What was our intended result?
What were our actual results?
What caused our results?
What is our next opportunity?
What should we take forward for next time? (Sustains/Improves/Insights/Experiments)
Special notes: (Who we should copy this to; other action items; etc.)

This tool was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

Leading Change Reflection Tool

What is my role as a change leader?

This tool will help you to reflect on what role you can effectively play in leading change toward a transformed health system for your community.

Learning Objectives:

- **To reflect on your vision for change**
- **To understand what role you can effectively play in leading change**

Phase(s): This tool can be used by groups and individuals engaged in an effort in any phase (1-5) along the Pathway for Transforming Regional Health

How to use this tool

This tool can be used as a private exercise, but also invites exchange with a learning partner about a few key insights into how you see yourself and your vision for a healthy system of health. It also can be used as the basis for a leadership group discussion on the array of change leadership roles represented within the group.

The first section will lead you through articulating your own vision for your change effort. The second section will ask you to consider a set of statements to determine the degree to which you see yourself as an organizational leader, a facilitator, a steward, or an innovator. In the last section, you will be asked to share your reflections with a learning partner and think about opportunities for action.

Leading Change

Your Vision

Create some quiet space to reflect on the following three questions. Note in words and/or draw pictures that help you imagine a compelling future for your region's health. What *should* it look like?

Continue until a complete picture of what you want is reflected in your notes here.

1. Imagine the community in which you live and work. How does it look when it is genuinely thriving? What signs or images do you see that reflect a genuinely healthy community?

2. Imagine the way that people receive health care when they need it. What is great about it?

3. Now paint yourself into the picture. What are the ways you participate in sustaining that community, that system of care? When someone asks you what you are proud of having contributed to that vision, what will your future self say?

Your Role

Consider the following statement.

"I view myself as a leader in our health system—someone who **accepts responsibility for influencing the future in a radically better direction**."

_____ No or not yet ____ To some degree/I'd like to be ____ Yes, definitely

If you responded "Yes" or "To some degree," this tool will help you explore the several important *kinds* of leadership roles that you might play as you take on this challenging work.

Consider the sets of statements below. Which set of statements comes closest to describing YOUR aspirations for what you want to contribute? (Note: there will be overlap, but for purposes of this exercise, consider which comes closest to how you imagine your ideal role).

1. I want to lead change primarily to make the future brighter for my organization and those it serves.
I want to collaborate with peers *within* my organization to bring about change.
I have a vision for the future of my organization and its role in the larger community.
I see my main role as to deliver important results for my organization and its constituents.

2. I see myself creating conditions for others to be effective in leading a regional effort.
One of my main strengths is enabling other leaders to work together effectively.
I love to engage others in imagining a better future.
I can see myself working to create a strategic leadership structure to enable change to happen across many stakeholders.

3. I think I can and should influence more than just my own organization.
I want to work with leaders outside of my sector to build something together.
I aspire to call other leaders to be their better selves.
I have a long time horizon for my aspirations.
I see myself as a steward, a leader who takes responsibility for moving the whole system.

4. I am energized by inventing/designing new approaches and finding ways to bring them to life.
I love getting things done.
I am good at connecting with others who are working on related things and aligning our work.
I am energized by innovative experiments and learning from them.

All four of these leadership roles are critical in moving toward a better health system.

Leading change in a health system is demanding work. Below we characterize each leadership role, and offer some questions you might want to address to build your effectiveness as you lead change. These are all matters that can be found throughout ReThink Health's Stewardship Guide.

If you chose the first set of statements, we'll refer to that role as "organizational leader."

If you see yourself acting primarily within the responsibilities of your organizational role, among the questions that may help you to act more effectively are:

- How can I help my organization be part of articulating vision and goals that benefit all residents?
- How can I serve my organization while also moving it toward greater alignment with collective priorities?
- How can I participate effectively in dialogue across key organizations?
- How can I bring resources to shared purposes?

If you chose the second set of statements, we'll refer to that role as "facilitator."
Stewardship teams—the main leadership team of a regional effort—need careful attention to their design and structure as well as wise facilitation and support to enable their effectiveness. If you are in such a role, perhaps as part of a backbone organization or other collaborative entity, addressing these questions may improve your effectiveness:

- How can I support a key leadership group to develop into a superb stewardship team?
- How can I effectively design and shape the agendas and conversations among well-positioned leaders in the region?
- How can I anticipate and address the challenges ahead, and the inevitable turnover of key leaders that will happen over time?
- How can I promote a habit of experimentation and learning among those who lead change? How can that be part of my own practice?

If you chose the third set, we'll call that role a "steward." If you are a well-positioned leader working closely with other leaders from key organizations across sectors to transform your health system, addressing these questions may improve your effectiveness:

- How can I expand the network of well-positioned leaders in our region who are part of leading system-wide change?
- How can I build values-based relationships with other key leaders, including competitors?
- How can I more effectively champion change and engage others in that process?
- How can I anticipate and recognize when the stewardship of needs of this effort change? What different actions will be needed from me over time?

If you chose the fourth set, we'll call that role "innovator." If you love working with others to develop, implement, and test new approaches to enabling better health, providing better care, changing how incentives are designed, and other critical processes in the health system, you may enhance your effectiveness by addressing the following questions:

- What do I need to understand about the whole system that can enable my work to have more strategic impact?
- How can I connect the work I'm doing with other, similar efforts, and speed up our learning and performance?
- What kinds of relationships and alignment will I need in different phases of the change effort in my region?
- How can I contribute to shared goals and priorities and participate in the larger vision?

Shared Reflections

With a learning partner, take 15 minutes *each* to describe to each other your major reflections from this exercise about:

1. Key elements of your vision about which you feel most committed to act.

2. Which leadership role you most identify with in bringing about change in your region.

3. What 2 or 3 questions you most want to address (from the above) as you expand your leadership capacities? In what aspects of the work do you feel most vulnerable? What kind of support do you need?

This tool was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

ReThink Health
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Mapping the Scope of Your Effort

To what degree are you pursuing regional health system transformation? Who else needs to be involved?

Learning Objectives:

- **To understand who is currently involved in your effort**
- **To understand what aspects of your system of health are currently being addressed by your effort**
- **To identify opportunities to increase the scope of participants and areas of emphasis**

Phase(s): This tool is best used by groups and individuals engaged in a Phase 1 effort along the Pathway for Transforming Regional Health

How to use this tool

Are you part of a multi-sector partnership that is investing in building a healthier, more resilient community? "Multi-sector partnership" here means any organized effort that spans health, health care, and other sectors like social services or local government that is collaborating on a single endeavor or multiple ones. This tool aims to help partnerships identify opportunities to increase the scope of participants in their effort, and expand their areas of emphasis.

There are two sections to this tool: (1) mapping your effort, and (2) reflecting on the scope of your effort. In the first section, you will be asked to think about the overall purposes of your effort, how long it has been active, your geographic breadth, and what sectors are represented in the leadership of your initiative. It will also invite you to rate your efforts' level of emphasis across the spectrum of downstream (health care) and upstream (drivers of health) factors and on sustainably financing your health system.

In the second section, you will be guided through reflection questions about the scope of your effort. These questions will help you think about who—individuals, organizations, sectors, or geographic regions—might be missing from your effort, what areas of emphasis are not being addressed, and what

opportunities there might be to make connections to broaden your scope and work toward transforming your system of health.

Mapping Your Effort

Initiative or Partnership Overview

Name of initiative or partnership: _____

Year collaborative efforts began: _____

Geographic level of your effort:

	Geographic Level
	Census tract
	Zip Code(s)
	Neighborhood/Community
	Town
	City
	County
	Health care service area
	National
	Other
	We do not have a geographic approach

Sectors

Results from ReThink Health's initial studies suggest that collaborative efforts to create healthier communities are broadly distributed across the U.S. and that their formation has accelerated in recent years. While many of these groups engage diverse sectors in order to address change on multiple fronts, there are still many lacking partners who might be valuable, if not essential, to their success.

Sectors included in your initiative or partnership (check all that apply)

	Sectors:
	Hospital, Health Care, Primary Care
	Health Insurance
	Public Health
	Government & Elected Officials
	Social Service

	Academia & Research
	Education
	Mental Health
	Community Planning & Transportation
	Business
	Faith-Based Institutions
	Housing & Economic Development
	Philanthropy
	Media

_____ Number of sectors (above) represented in your partnership

_____ Number of sectors (above) not represented in your partnership

Areas of Emphasis

How strong is your emphasis on radically improving or redesigning the following areas as a core purpose of your partnership (check all that apply)?

Areas of Emphasis	Strength of Emphasis				
	Minimal		Moderate		Strong
	1	2	3	4	5
Health behaviors and risk factors	○	○	○	○	○
Health care access, quality, and cost	○	○	○	○	○
Social, economic, educational conditions or services	○	○	○	○	○
Physical environments	○	○	○	○	○
New ways to finance and sustain initiatives over time	○	○	○	○	○

Reflecting on the scope of your effort

Our observations of regional health transformation efforts are that successful ones that maintain momentum and progress along the *Pathway* are broad in scope on all the above dimensions: (1) they involve all or nearly all sectors in significant leadership of the effort and have built dense networks of relationships of joint activity across the sectors; (2) the purposes and activities of the regional effort

overall include all the areas of emphasis identified above, and (3) they do so for a large population, typically multiple communities and often counties or larger.

We want to underscore that the stewardship structures that support that kind of scope vary widely—there may be some groups in the region focused primarily on implementing health improvement initiatives and securing financing for them, while others address downstream redesign. But in successful regional efforts in Phases II and beyond, each of these elements of the regional effort are tied together through stewardship structures that align their activities with shared visions and goals for the region.

1. Look back at how you described the sectors involved in your effort.

Who is missing from the network of leaders engaged in the transformation? What role might they play in enabling system change?

_____
_____
_____
_____

Who is well represented or even over represented, potentially dominating the purposes and priorities of the effort?

_____
_____
_____
_____

What do these gaps in membership suggest about who might be needed at the stewardship table in the future?

_____
_____
_____
_____

2. Look back at how you characterized the areas of emphasis in your effort.

What aspects of the regional health system are absent or underemphasized (scoring as moderate to minimal in emphasis) in how you define your purposes or the activities you undertake?

Are there others in the region focusing on those areas? How might you connect with them, and what synergies might arise from connecting disparate efforts with similar long-term visions?

3. Finally, consider the geographic scope of your effort.

What are the reasons for the geography you have chosen? Are there potential benefits to broadening the population you serve?

Who within a larger region has particular capabilities in aspects of health system transformation not presently part of your initiative? How might you connect your effort with theirs?

This tool was developed with support from the Robert Wood Johnson Foundation and the Fannie E.Rippel Foundation.

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Pathway Self-Diagnostic Tool: Where Are We on the Pathway?

Pathway for Transforming Regional Health

This tool will help you determine where your regional, multi-stakeholder collaboration sits on the *Pathway for Transforming Regional Health.*

Learning Objectives:

- **To understand the five phases of the Pathway for Transforming Regional Health**
- **To assess in which phase of the Pathway your effort currently sits**
- **To identify areas of strength, improvement, and opportunity**

Phase(s): This tool can be used by groups and individuals engaged in an effort in any Phase (1-5) along the Pathway for Regional Health Transformation

How to use this tool

The *Pathway* begins when leaders step outside of their own organizational boundaries to work collaboratively with other organizations and groups in the region. This worksheet is a diagnostic tool that provides definitions and characteristics of each of the *Pathway's* five phases, along with key questions that will aid you in determining which phase most closely characterizes your work. If helpful, refer back to the *Pathway* diagram (figure 1) as you complete the self-diagnostic. Once you have located where your region is on the *Pathway*, the last section of the tool will guide you in considering what particular features of your health transformation effort need attention, what will be key to moving into later phases, and what pitfalls may be around the corner.

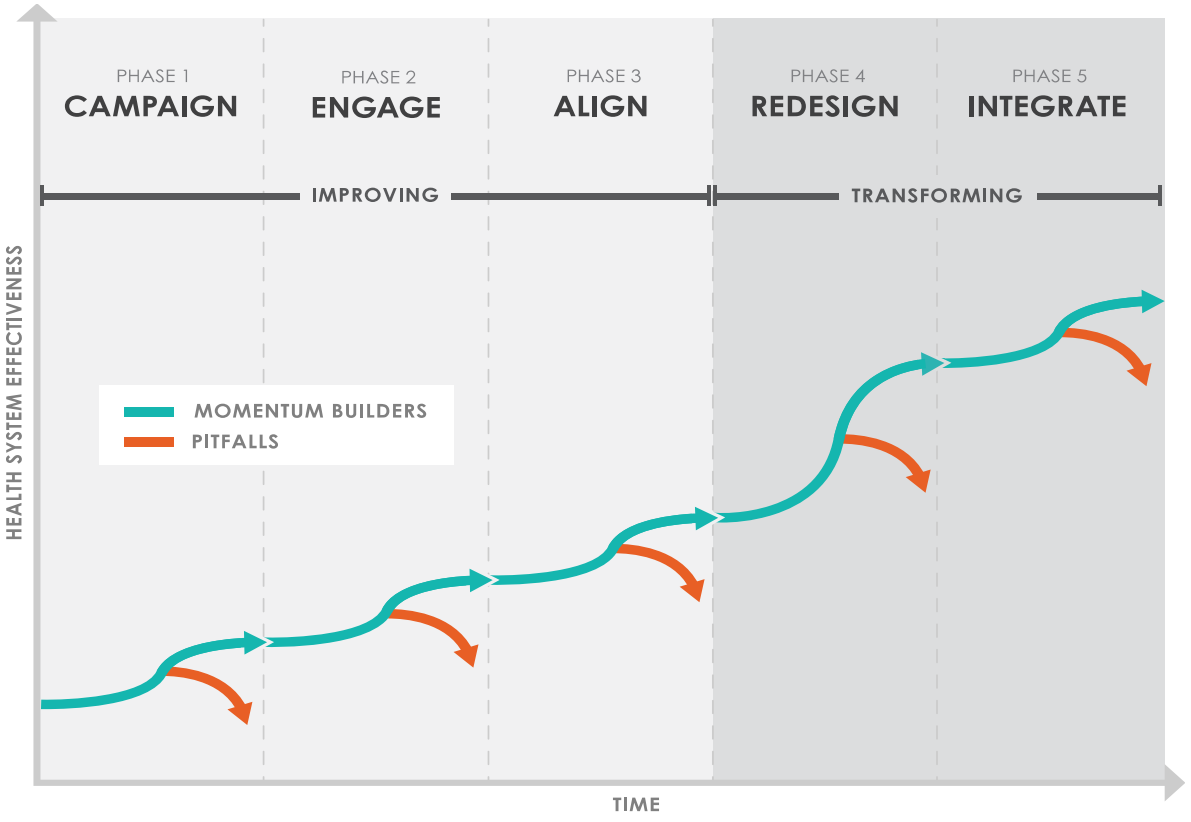
This tool is most effective when completed by people who are deeply engaged in the regional change effort and well informed about all its areas of activity. This includes those who are part of the core stewardship team leading the effort, and those who are part of the backbone or integrator organization. It also may be completed by individuals knowledgeable about the effort.

To complete it as a team: (1) invite individuals to complete their own *Pathway* self-diagnostic, (2) capture the range of team members' responses for each characteristic described below; (3) discuss the

conditions where responses are widely different, and (4) develop a shared view of progress of your effort on the *Pathway*.

Identifying where you are on the Pathway

Figure 1: ReThink Health Pathway for Regional Health Transformation



As you respond to the questions in each phase below, focus on the main collaborative effort to bring about large-scale changes in the health system, and the leadership group guiding this effort.

Phase 1: Campaign

Definition. Organizations conduct a focused, time-limited effort to combine resources and take action on a specific issue or crisis, often around a subpopulation rather than the whole population of a region.

Characteristics. High-energy, exciting, collaborative effort focused toward a single shared goal.

Example. In one region, public health workers, doctors, social services agencies, and community organizations worked together to reduce hospitalization of children with asthma and create a new way of supporting home care.

Phase 1 Key Questions	No	Yes
1. Is the health system change effort mainly led by one organization?*		
2. Is the collaborative effort intended to be time-limited?		
3. Is the effort funded through a specific program, initiative, or grant (private or government) that has a finite amount of support and timeframe?		
4. Is the effort focused around a narrow problem (e.g., disease or sub-population specific)?		
5. Is the effort focused on addressing just one aspect of the health system (e.g., care coordination or access to care)?		

***If your answer to question 1 is YES, representing little collaboration across stakeholder organizations, your effort may not yet be on the Pathway**.

Phase 2: Engage

Definition. A diverse set of stakeholders engages in an on-going dialogue focused on mutual understanding and coordination around a few initiatives.

Characteristics. Focused leadership and growing diversity of relationships across sectors; leaders across organizations commit to on-going engagement; leaders are beginning to think at the system level; innovations are largely within institutions; coordinated initiatives are focused on win-win results.

Example. In one region, public health leaders, CEOs from the regional hospitals, and three community organizations invented new places for health care for the underinsured at low costs; these leaders then began meeting regularly to decide what else might be done together.

Phase 2 Key Questions	Yes	No
1. Is the effort engaging a diverse set of leaders in ongoing dialogue about further improvements to the health system to work on together?		
2. Is the effort launching and coordinating initiatives that are intended to build capacity and trust for continued collaboration?		
3. Does the effort have goals framed around collectively identified needs?		
4. Is the effort beginning to invest resources and money to hire staff or create structure for more coordination?		

Phase 3: Align

Definition. The collaborative is focused on aligning many efforts around shared goals for the region.

Characteristics. Sturdy bridges built between health and health care; agreement on shared measures; growing community engagement and collaboration; key leaders have a system view.

Example. In one region, a diverse group of stakeholders has together addressed "hot spots," (geographies where hospital utilization is especially high), reduced hospital readmissions, and launched initiatives to support aging in place, generating real successes on multiple health outcomes. They have jointly invested in hired staff to support these shared efforts and have crafted a handful of shared priorities around health outcomes to pursue over the next 5 years.

Phase 3 Key Questions	Yes	No
1. Have stakeholders created a handful of clear, measurable, and high-priority goals for the region?		
2. Are stakeholder organizations aligned around the goals?		
3. Is infrastructure in place for managing shared initiatives?		
4. Are community forums being held to develop common vision?		
5. Have organizations shifted their funding priorities to align with the common goals?		

Phase 4: Redesign

Definition. The regional effort is engaged in high-impact system redesign efforts, and is seeding and spreading disruptive innovations that alter key structures and processes (such as pay systems) in fundamental rather than incremental ways.

Characteristics. Stakeholder organizations partner in new ways and create new business models; redesign replaces improvement thinking; discontinuous change and disruptors of the status quo help provoke major movement and are steered toward collective aims; high interdependence among participating organizations, including former competitors.

Example. A hospital system faced with state funding reductions that threatened its survival engaged its leaders to enact a broadly inclusive, collective process to identify meaningful ways to restructure and focus on providing needed services to its community. This regional effort is testing new global payment and incentive models as well as ways to reduce hospitalizations, improve care transitions and access to

primary care, and innovative approaches to reinvesting savings in an array of preventive services that impact health.

Phase 4 Key Questions	Yes	No
1. Are organizations working toward clear, region-level goals, using shared measures, and drawing on pooled resources they have invested together?		
2. Are organizational leaders redesigning key processes, including incentives, to align with regional aspirations?		
3. Are stakeholder organizations merging, partnering, and testing new models for how they provide value to residents?		
4. Are there multiple groups serving distinct, aligned, and legitimate leadership roles in stewarding the system transformation?		

Phase 5: Integrate

Definition. The regional effort and its stakeholder organizations are working to integrate the successful innovations of the redesign phase into the "new normal." A stable system is emerging that is design to produce health. Stable stewardship structures facilitate learning and enable a resilient system.

Characteristics. A regional governance structure has widespread legitimacy to steer the system; broad and active citizen engagement in vision and accountability; sustainable financing that invests in health.

Example. In one region, a non-profit organization has been created and is vested with authority to guide meaningful change in the health system and create a healthier region. It is tasked with convening forums, enabling collective decision making, identifying priorities, staffing key initiatives, and fostering public participation in the process. Its leaders include elected residents, representatives from public health, business leaders, as well as the healthcare provider community.

Phase 5 Key Questions	Yes	No
1. Are incentives aligned across stakeholder organizations to encourage quality care and invest in excellent health?		
2. Are measures institutionalized that hold stakeholders accountable to residents' expectations?		

3. Is there an established and sturdy multi-stakeholder structure that steers the whole health system by setting priorities and making mindful choices about how resources are invested for health and health care?		
4. Is the regional leadership structure oriented to the future needs of residents and focusing on learning and adaptation for sustained effectiveness?		

Locating your effort on the Pathway.

Now that you have answered this series of questions, look back at the sequence of responses. Where are there checkmarks in the left-hand "yes" column? If the entire left column for a Phase is checked, your effort is solidly in—or through—the work of that phase of the *Pathway*.

If the checkmarks in the left "yes" column stop or taper off at a particular point, (e.g., there is only one check mark in the left "yes" column in the Phase 3 questions), this indicates your effort is actively engaged in the work of that phase of the Pathway (or has only just entered it).

Now that you have identified where your effort is on the Pathway, you are poised to consider what particular features of your regional effort need attention, what will be key to moving into later phases, and what pitfalls may be around the corner.

As you reflect on where you see yourselves on the *Pathway*, consider and identify:

1. What do you see as the key strengths that have been built by your effort so far? Where, especially with respect to stewardship, strategy, and financing, do you see your region holding real strengths for movement into the future?

2. What do you see as the main risks or potential pitfalls that face your effort? Would you characterize these as threats to stewardship, strategy, or financing and in what ways?

This tool was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

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Stewardship Team (Re)Launch Tool

The purpose of the Stewardship Team (Re)Launch Tool is to get a newly formed stewardship team off to a maximally effective start. It also is a guide for conducting a formal re-launch of a stewardship team at a critical transition points.

Learning Objectives:

- **To understand the goals and core principles of (re)launching an effective stewardship team**
- **To develop an agenda for a high-quality stewardship team (re)launch**
- **To understand the role of members of the stewardship team**

Phase(s): This tool is best used by groups and individuals engaged in a Phase 1 or 2 effort along the Pathway for Transforming Regional Health.

How to use this tool

The core principles involved in giving a team a strong start can be applied to any coalition launch (or re-launch) and to startups for any kind of task-performing team. The team (re)launch tool should be given about three and a half to four hours of dedicated time to do effectively.

This tool is composed of four sections: (1) stewardship team (re)launch goals; (2) pillars of a great team launch; (3) stewardship team (re)launch agenda; and (4) a job description for stewards. The first section offers eight guiding goals to clarify the intent of the team (re)launch. The second section outlines four pillars of a high-quality team launch: creating a "real" team, articulating a compelling purpose, specifying core norms of conduct, and designing initial roles and work processes. Last, is a draft job description outlining key capacities and expectations for individuals participating in your stewardship team.

This tool is most effective when completed by people engaged in the regional change effort, such as those who are part of the core stewardship team leading the effort, or part of the backbone or integrator organization.

Stewardship Team (Re)Launch Goals

1. Build relationships and shared aspirations among members. Relationships built on trust and shared values are the "glue" that will enable leadership groups to navigate their way through hard questions together.
2. Identify shared values. Shared values are the most critical underpinning of a compelling team purpose that is meaningful to all the members.
3. Clarify the team's purpose; establish a compelling direction. Any team needs clarity of purpose, and that clarity must be established at the beginning of the life of a group.
4. Explore definitions and measures of success for the whole initiative. Success that is defined in terms of achieving high aspirations (rather than solving problems) keeps leaders and participants engaged and determined through difficult times.
5. Ensure the right people. Decide how or whether to expand, reduce, or alter the composition of the team (to ensure that all members have the appropriate system focus, teamwork skills, and legitimacy to lead on behalf of the community).
6. Capture lessons from experience about conditions for success and for a great startup; use the breadth of experience around the table to anticipate the challenges ahead.
7. Develop initial norms and work practices that will enable the team to work together effectively and lead on behalf the whole region.
8. Surface key strategic questions to guide the work of the group in its upcoming meetings and build interdependence through joint decisions.

Pillars of a great team launch

There are four core pillars of a high-quality team launch, and this agenda is designed to get all four in place:

1. Create a *real team*: A real team is bounded (it is clear who is and is not in the team), stable (intact as a team for some significant period of time), and interdependent (working on decisions and tasks together that cannot be achieved effectively working independently)
2. Articulate compelling *purposes*: Making sure the team's purposes are clear, challenging, and consequential
3. Specify core *norms* of conduct: a handful of rules of engagement that support the work of the team and help to avoid pitfalls
4. Design initial work *processes* and *roles*

Stewardship Team (Re)Launch Meeting Agenda

1. Engage in Story of Self (3 minutes per person)

Each team member shares a story from his or her own history that will help the rest of the team to understand why s/he wants to be part of this stewardship team, and to lead health system change:

- Prepare for this segment with 5 minutes of silent reflection on:
    - Why you aspire to lead this change; what leading this change means for you given your personal values and commitment
    - Some part of your history, a challenge you faced and a choice you made, that illustrates what this purpose means to you

There are several ways this part of the stewardship team launch can be conducted. Each individual can share his or her story, one at a time around the table. Alternatively, leaders can share stories in pairs, and then introduce each other to the rest of the group. Finally, the larger team can split into two small subgroups to hear stories. In all cases, a facilitator should capture the themes that are shared across leaders' stories as critical input into articulating shared purposes (next).

2. Clarify team purpose (30-45 minutes)

This section of the agenda addresses: What are the overall purposes that this team exists to accomplish? What is the unique added value of this stewardship team that no other group can accomplish for this effort?

There are two options for this aspect of the team launch: (1) If there is a key champion of the effort (or a facilitator who has worked with the team members), that individual can prepare a statement of team purpose and then offer it to the team, taking 10 minutes or so to get clarification and reactions; or (2) the team can discuss together the main objectives that make up its overall purposes given their answers to the above questions.

3. Conduct a Before Action Review (BAR) (45 minutes)

What have we learned from prior efforts? The primary goal of the BAR is to make sure that everyone is on the same page with regard to intent for the team and the effort, is thinking actively about how to affect outcomes, and is taking into account past lessons and ideas.

Ask the group members to:

1) Name their intended outcome and how they will recognize success;
2) Think together about what challenges they predict and draw on insights from their past experience; and

3) Develop a plan for achieving their outcome in the face of predicted challenges.

4. Member Resources (40 minutes total)

The purpose of this part of the launch agenda is to identify the special capabilities, experiences, and relationships that are available to draw on in the team in accomplishing their shared purpose.

Identifying resources. Split into pairs composed of members from different organizations and parts of the health system. Each individual in the pair is to spend 10 minutes interviewing his/her counterpart to elicit the relevant experiences, passions, activities, and relationships that may be important for this effort. After 10 minutes, interviewers should switch to being interviewees (and vice versa) for another 10 minutes. Capture what you learn to report back to the rest of the group. **(20 minutes)**

Summarizing team resources. Each member of each pair should report back what was learned about a colleague that can be an important resource for the team. Once you have captured that list as a group, identify any key capabilities you think you may need as a team that are not yet represented in this group and that you may need to seek from other sources. **(20 minutes)**

5. Team Roles and Norms (30 minutes)

Given what the team has just identified as its array of resources and its main objectives, what are (1) particular roles that individuals will be deployed to play on behalf of the team; and (2) a few essential norms of conduct (what must be done/never be done) about the way that this team will operate that are needed to support the work.

Typical Roles of Stewardship Team Members. This list of roles is a useful checklist for making sure the right people are at the stewardship table. It can be used by the team's convener, champion, or facilitator when inviting others to join the team.

- Exhibit clarity about and share the effort's aspirations
- Be willing and able to lead on behalf of the whole, not just one's own organization's or constituency's interests
- Be willing and demonstrably able to hear and take into account the concerns of others
- Have excellent conceptual thinking skills, including ability to understand complex systems
- If representing an organization, have CEO endorsement
- Be willing and able to commit sufficient time: (approximately)
    - One monthly meeting of 3 hours
    - Weekly 30 minute alignment call
    - Visible leadership role in community engagement events
    - Participation in committees, projects, and alignment activities

Norms of conduct. Some suggestions include:

- Candor about concerns
- Give others the benefit of the doubt (ask clarifying questions rather than making assumptions or especially if you are dumfounded by a stated position)
- Confidentiality within the group
- Prioritizing the team's meeting time
- Clarity about decision rules (e.g., consensus, majority)
- Amendments? Additional proposals?

6. Priorities and Next Steps (15 minutes)

Clarify upcoming priorities and immediate next steps for the team as a whole as well as individual tasks for team members.

7. Questions, Observations, and Meeting Evaluation (15 minutes)

Take a few minutes to identify 2-3 questions, observations, and lessons from the meeting. Meeting evaluation should include: (1) key insights; (2) what went well; and (3) what can be improved for the next meeting.

Sample Agenda

AGENDA ITEM	TIME
Review agenda and recruit note taker and timekeeper	3 minutes
Tell personal stories: Each team member will share a story from their own history that will teach us something about them: • Why you aspire to lead this change • What leading this change means for you given your personal values and commitment	3 minutes per person
Establish team's shared purpose	45 minutes
Conduct before action review (BAR) • What have we learned from prior efforts?	45 minutes
Review the key relationships and capabilities members bring • Consider who is not at the table and may be needed	40 minutes
Establish roles and structure to support the work of the group	30 minutes

Establish norms of conduct Make sure to establish a norm (ground rules) for decision making and a way to hold the team accountable (to be revisited)	15 minutes
Clarify upcoming priorities and immediate next steps	5 minutes
Dig into key strategic priorities	as much time as needed
Evaluate the meeting: • Key insights • What went well • What we will improve	15 minutes

Job Description for Stewards

Effective stewardship team members have particular characteristics and capabilities. The job description for stewards outlines a set of key capacities and expectations for individuals participating in a stewardship team. It is meant to help identify good candidates to join the team as well as give team members some basic expectations for being a fully engaged and productive participant in the group.

The convener or champion of the effort can use this list of characteristics to recruit initial team members, or to help key stakeholder organizations identify an appropriate individual to take the place of a departing member of the stewardship team.

Key capacities of stewards include:

- Exhibit clarity about and share the effort's aspirations
- Be willing and able to lead on behalf of the whole, not just own organization's or constituency's interests
- Be willing and demonstrably able to hear and take into account the concerns of others
- Have excellent conceptual thinking skills, including ability to understand complex systems
- If representing an organization, have CEO endorsement

Key expectations include:

- Be willing and able to commit sufficient time:
    - One monthly meeting of 3 hours
    - Weekly 30 minute alignment call
- Visible leadership role in community engagement events
- Participation in committees, projects, and alignment activities

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Stewardship Team Diagnostic Checklist

Assessing Stewardship Teams

This checklist was created to help you think through features of your stewardship team that may need improvement to more effectively navigate your current phase of health system transformation.

Learning Objectives:

- **To understand the three conditions of effective stewardship teams:**
  - **Compelling Purpose;**
  - **The Right People; and**
  - **Enabling Structure**
- **To assess your stewardship team based on these conditions**
- **To identify opportunities for improvement within these conditions**

Phase(s): This tool is best used by groups and individuals engaged in a Phase 2 effort along the Pathway for Transforming Regional Health.

How to use this tool

This tool can be used by leaders and stewardship teams to assess: (1) your stewardship team's purpose and aspirations; (2) the people involved in your stewardship team; and (3) the structure in place for effective stewardship.

Section 1 of the checklist assesses the degree to which the team's purpose engages members' motivation to work with others toward shared aspirations, and the extent to which that purpose orients them in an aligned direction. Section 2 asks you to look at the leaders who are presently involved in the main stewardship team of the effort, and evaluate the composition of the team, including members' willingness to lead on behalf of the whole system, not just their own institutions. Section 3 evaluates the structures in place for how the group makes decisions and supports core norms of conduct.

Move through the tool by grading your team on each of the three conditions on the checklist, assigning grades for various criteria within each condition as well as an overall grade for each. Then identify steps

for improvement within each condition. The last part of the tool focuses on working with a peer or learning partner to discuss the strengths and weaknesses of your steps for improvement.

Assessing Stewardship Teams

Assess the stewardship team's design

Move through the checklist on the next page by starting in the **middle** column of each section. For each statement give your team a grade, from A (really superb, needs no work at all) to F (We fail completely. This condition is in poor shape for us.) For example, you might assign an "A" to the first statement, "The team has a shared purpose that is clear to all members."

Assign an overall grade.

Combine the grades to give the condition (i.e., "Compelling Purpose") an overall grade.

Identify and write out steps for improvement

Identify the aspects of the stewardship team that you see as most in need of improvement. In the column to the right, sketch some thoughts about how you might go about improving those dimensions of team design. Consider:

- What strategies might you use to influence this aspect of the team?
- What allies will you need?

This part should take about 30 minutes

Assess Your Stewardship Team

	How is this stewardship team's design? *A B C D F*	*How might we improve our design?*
Compelling Purpose  Grade Overall	—— The team has a shared purpose that is clear to all members. —— The shared purpose is seriously consequential for health and health care in our community. —— The shared purpose poses a significant challenge that will demand people's best efforts.	
The Right People  Grade Overall	—— Members are people who see themselves as leading for a *community* (not just their home institutions). —— All team members have collaborative skills such as empathy and integrity that are necessary for working well with peers. —— Members have the diversity of roles and perspectives to lead with legitimacy in the eyes of stakeholders. —— The group has a high level of systems thinking.	
Enabling Structure  Grade Overall	—— The tasks the team performs are real leadership activities involving important joint decisions. —— The group has explicit norms of conduct that specify acceptable and unacceptable behavior in the team.	

Improving Stewardship Teams

Peer Consultation

Pair up with a colleague with whom you would welcome the chance to try out your view of the strengths and weaknesses of your stewardship team and your thoughts about how to improve it.

Each of you should spend about 10 minutes briefing your colleague about your views of the following:

1. Key strengths of the stewardship team that you want to be sure to protect.
2. The aspects of the team that you view as most need of improvement and your best understanding of the reasons for those challenges.
3. Try out your ideas about how to improve the stewardship team's design with your colleague.

You should spend about 15 minutes discussing your diagnosis and action ideas. After 15 minutes, reverse the relationship and hear your colleague's diagnosis and action strategies.

Discussion

Here are some suggestions for how you might be helpful to each other:

1. Reflect back your understanding of what challenges the stewardship team faces.

2. Ask questions about upcoming opportunities to reshape the team in positive ways.

3. Propose alternative paths to improving the team's design, some of which may need to be collaborative (i.e., engaging the team itself in the redesign) and some of which may be best accomplished by an individual (i.e., a team leader or champion of the effort who can reconvene or relaunch the team).

This tool was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

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Public Narrative: Story of Now Individual Tool

Using Narrative to Call Others to Action

This tool offers guidance about how to develop a stewardship team's shared purposes and to build values-based relationships among individual leaders through public narrative. Its purpose is to explain how to use narrative as a sustainable leadership practice to motivate others to work together effectively.

Learning Objectives:

- **To explain why narrative matters**
- **To understand how the leadership practice of public narrative works**
- **To develop your own public narrative and to coach others in theirs**
- **To identify opportunities to apply narrative in your leadership work**

Phase(s): This tool is best used by individuals who are a part of a group engaged in a Phase 1 effort along the Pathway for Transforming Regional Health

How to use this tool

This tool is most effective when completed by people engaged in the regional change effort, such as those who are part of the core stewardship team leading the effort, or part of the backbone or integrator organization.

We introduce the core ideas behind the power of narrative and the purposes of a Story of Now, and then offer a tool to help you to develop your personal own Story of Now. This tool is geared towards individuals. For a process that enables the development of a shared narrative in a stewardship team, see the Tool: "Story of Now: Stewardship Team Crafting a Shared Vision."

The Story of Now tool begins with an overview of narrative and its three components: (1) story of self, (2) story of now, and (3) story of us. The overview defines narrative, explains why it can be a powerful tool, and offers guidelines for when to use narrative in practice. This tool focuses specifically on the second narrative component, "Story of Now," and the last section offers a step-by-step guide to develop your own story.

Why Narrative?

One of the challenges facing multi-stakeholder stewardship teams is forming relationships, sometimes in a context of little existing trust, with other leaders from other organizations—relationships that can withstand challenging and difficult subjects and the hard work of leading change over time. A second key challenge is arriving at a compelling shared purpose that is genuinely motivating for leaders who work together, and that can supersede individual and potentially competing interests. That purpose must be clear and shared to guide collective work.

Narrative provides a method to identify the shared values of a diverse set of stakeholders. It offers a framework for developing a clear and collective vision guided by those values. It invites and inspires new leaders to join in action. Narrative builds a values-based culture around the effort. It identifies and sustains stakeholders' intrinsic motivations to steward shared resources over time. Using narrative recalls leaders to their core values, which are sustaining in the face of differences, conflict, and complex decision-making. It reminds leaders of what unites them as equals, and how together they can make a difference.

What Is Narrative?

Narrative is the skill of creating a shared story around our common values to motivate others to join us in action.[1] It involves three core components: personal stories that illustrate our own values ("story of self"); collective stories that illustrate shared values ("story of us"); and stories that illustrate both the challenges a group faces and the hopeful actions groups can take to address those challenges ("story of now"). In this tool, we focus specifically on the third narrative: Story of Now.

How Does It Work?

Narrative establishes a foundation on which to: (1) lead; (2) collaborate with others; and (3) discover common purpose and vision to take action.

Narrative is how individual leaders learn to access their own moral resources—and courage—to make choices in the face of urgent challenges. Because it connects leaders to their individual motivations to act ("story of self"), it is critical to sustaining voluntary commitments in change efforts.

Hearing one another's stories allows leaders to build empathetic connections and collective capacity. Stories have the power to move others because they allow leaders to express values through their lived experiences.

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[1] Ganz, Marshall. (2010). Leading change: Leadership, organization, and social movements. In N. Nohria & R. Khurana (Eds.), *Advancing Leadership,* Harvard Business School Press, Boston: MA.

Narrative allows leaders to discover common purpose, or a motivating vision, to act on. Leaders tell stories to motivate others to join them *in action*. As one coalition leader stated, "It's not just telling a story for a story's sake; you are trying to accomplish something with it." In other words, narrative is a motivational "call to action," through which leaders describe the urgent challenges they face, a hopeful vision of what is possible, and the specific choices that they have made to move toward that vision.

Using Narrative in Practice to Build Values-Based Relationships and Call Others to Action

Leaders can use narrative to develop a team's shared purpose. To engage leaders in narrative with each other, ask them to tell a brief story to the group that illustrates:

- **Challenge:** What challenges, obstacles, or difficulties did you experience in your history that can teach us something about why you feel called to lead change toward a healthy health system?
- **Choices:** What choices did you make that illustrate that calling?
- **Outcomes:** What happened as a consequence of your choices? What might happen if we work together toward some shared purpose? Why are you hopeful that it is possible?

These stories allow members of stewardship groups to understand each other's aspirations as people and to begin to construct a collective vision around the values that will motivate their choices.

Leaders often share stories about loved ones who experienced harm in hospitals (for example). They describe personal trials navigating the health system themselves, or as children of elderly parents, or as parents of young children. They tell stories about patients whose lives could have been saved by population health efforts, whose families went bankrupt paying for care, and whose surviving caregivers suffered secondary mental and physical health problems. They share personal, yet universal, moments of grief and loss—and how those moments transformed them as human beings and as professionals.

In using narrative, leaders view their peers differently. With an emphasis on values, narrative provides a way to connect on equal footing with others from very different groups and constituencies. As one leader remarked, "Different people [in our coalition] are motivated to participate for a range of reasons—a belief in the Triple Aim, a market motivation, a population health mandate. But it is the use of narrative that connects us around a shared moral purpose, and everyone is united by that."

Story of Now (Individual Tool)

Individual Practice

A "Story of Now" Illustrates the Challenge We are Called to Face Now

The story of now focuses on an urgent challenge that requires action, a hopeful vision for a better future, and the choice we are calling upon others to make. In a story of now you call on others to join you in action.

Learning Objectives:

- To identify the urgent challenge
- To call others to action
- To coach your learning partner(s) in telling theirs

Telling the Story

A Story is Lived and Breathed in the Details

Stories are specific and visual. They evoke a time, place, setting, and mood as well as colors, sounds, textures, and tastes. The more you can communicate this visual specificity, the more power your story will have to engage others. This may seem like a paradox, but like a poem or a painting or a piece of music, it is the specificity of the experience that can give us access to the universal values or insight they contain.

The Craft of Narrative Involves Being Authentic and Speaking from the Heart

Learning the craft of public narrative is not learning a script, developing a message, or creating a brand. It is not a formula, but a framework. Our public narrative changes as our lives, communities, and challenges evolve.

Once Again: Why Stories?

You may think that your story doesn't matter, that people aren't interested, that you shouldn't be talking about yourself. But when you do public work, you have a responsibility to offer a public accounting of yourself—who you are, why you do what you do, and where you hope to lead. If you do not author your public story, others will, and they may not tell it in a way that you like.

A good public story is drawn from the series of "choice points" that have structured the "plot" of your life—the challenges you faced, choices you made, and outcomes you experienced. Your story gives others emotional and intellectual insight into your values, why you have chosen to act on them in this way, what they can expect from you, and what they can learn from you.

By telling our stories, we also become more mindful of our own moral resources. And because stories enable us to communicate our values not as abstract principles but as lived experience, they have the power to move others to join us in action now.

Story of Now Example

Please watch the first 10 minutes of this TED talk by Dr. Mark Hyman from 2012 TED MED. Think about the following elements of **NOW** that you hear in his story.

VIDEO REVIEW: https://www.youtube.com/watch?v=IhkLcpJTV9M

Consider the Story of Now you just heard and answer the following questions. These are some key ideas that can help you think about creating your own Story.

1. What are the values that underscore Dr. Hyman's "now"? Are these values shared?

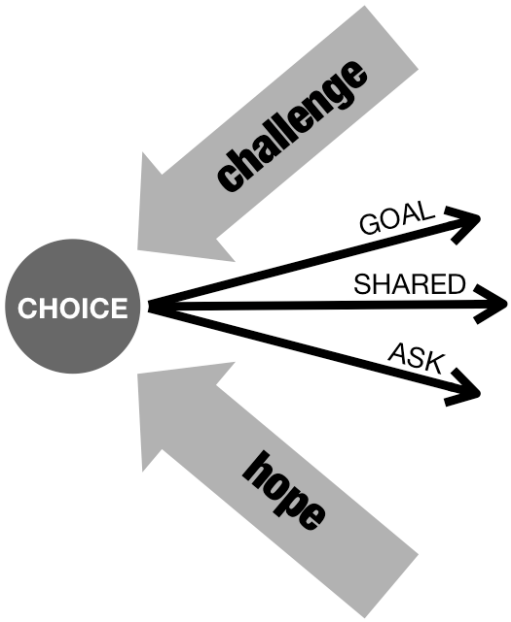
2. How does he make the "threat" real? Do you remember specific images?

3. Think about what Dr. Hyman asks of the crowd. Is it something doable? Also, does this "ask" seem significant? Will it make a difference?

4. Think about how Dr. Hyman weaves together his own story of self. Does he own his authority? How does he put himself on the same level as the group? How does his story connect to the cause he is calling for action around?

The Elements of a Story of Now

The "character" in a story of now is you, the people in the room with you, and the broader community you hope to engage in action.



- **Challenge** (or "nightmare") – A vivid image of what the future could be if we fail to act now (made real through stories not just statistics)
- **Outcome** (or "dream") – A vivid image of what the future could be if we do act
- **Choice** – A strategic "hopeful" choice that each person in your audience can make right now

Why it Matters

The choice we're called on to make is a choice to take strategic action now. Leaders who only describe problems, but fail to identify a way to act and bring others together to address the problem, aren't very good leaders. If you are called to address a real challenge, a challenge so urgent you have motivated us to face it as well, then you also have a responsibility to invite us to join you in action that has some chance of success. A "story of now" is not simply a call to make a choice to act—it is a call to **hopeful** action.

Develop Your Call to Action and Coach Others

TOOL: Draft A One-Page Motivating Vision for Your Region (If possible, email it to another leader for feedback)

WHAT URGENT "CHALLENGE" FACES US?

WHAT VISION COULD WE ACHIEVE IF WE ACT TOGETHER?

WHAT "ACTION" MIGHT YOU CALL UPON US TO JOIN YOU IN TAKING?

Narrative is an exercise of leadership that motivates others to join you in action on behalf of a shared purpose. The goal in this tool is to identify the challenge you will call upon others to join you in action to

address (Story of Now). A Story of Now is urgent. Its urgency is based on threat or opportunity; it is meant to inspire others to drop other things and pay attention.

Leaders need to do more than describe a problem; they need to inspire us to act together to try to solve the problem. What, precisely, are you asking us to do? Offering a list of "100 things you can do to make the world better" is a cop-out because it trivializes each action. Suggesting that everyone work in their own way ignores the importance of strategic focus in overcoming resistance to change. If you are called to face a real challenge, a challenge so urgent that we are motivated to face it as well, you have a responsibility to invite us to join you in plausible action. A Story of Now is not simply a call to be for or against something—that's "exhortation"—it is a call to take hopeful action. A Story of Now offers clarity as to what will happen if we don't act, what could happen if we do, and action each of us could commit to take that could start us in a clear direction right here, now, in this place.

What urgent challenge do you hope to inspire others to take action on? How can we act together to achieve a better outcome? What choice will you call on others to make now, as a first step? How can you connect with others to experience the sources of the values that move you not only to act, but also to lead? Identify key choice points that set you on your path.

A Story of Now works if people join you in action – specific action.

Important note: This tool is not about answering the above questions in order. However, it helps to start with the "ask" in your Story of Now. What you are going to ask of others in joining you in this leadership work? Then develop stories to motivate other to join you in this action. You will almost always end with the ask itself: "Will you join me in_____?"

Also remember that learning public narrative is a process, and it is iterative. This is not about writing a script that will fit all situations. It can be learned only by telling, listening, reflecting, and telling again—over, over, and over. This work will be a beginning.

Complete the Story of Now worksheet below. Email it to your learning partner.

Take a moment to reflect on a challenge in the long-term system of health in your region. What makes that challenge urgent to you, to other leaders, and to residents? On what must you take collective action now?

Use these questions, the introduction to Story of Now, and Dr. Hyman's TED clip to help you put together a Story of Now for your effort.

Why is it important to act together now? What is the urgent challenge or opportunity that faces residents of this region? What specific stories can you tell that make the challenge real for your listeners?
What's the vision of a hopeful future? What would the world look like if you were to succeed? Make it as concrete as you can; use images.
What *choice* are you asking people to make? Be specific. When? Where?

Coaching Each Other

Listening to and coaching stories is just as important (if not more) as telling your own. It is important to ask sharpening questions that can guide the storyteller to consider the effect of their narrative and the values it expresses. And, as you help in another's learning process, you in turn fine-tune your own story.

Below are some coaching tips. Read carefully through the kind of reflective and probing questions that can help bring clarity to someone else's story.

When giving feedback to your learning partner, remember to be curious and genuinely interested. Offer constructive advice where a story needs sharpening, and be positive about what connects you to their story. The purpose of coaching is to listen to the way stories are told and think of ways that the storytelling could be improved.

- **The Challenge:** What were the specific challenges the storyteller identified? Did the storyteller paint a vivid picture of those challenges? Is the challenge clear? Is there a sense of urgency around that challenge, not just for the speaker, but also for us?

  "When you described _____, I got a clear picture of the challenge."

  "I understood the challenge to be _____. Is that what you intended?"

  "The challenge wasn't clear. How would you describe _____?"

- **The Ask:** Was there a clear choice being asked of us in response to the challenge? How does the choice make you feel? (hopeful? angry?) Does it seem significant and doable?

  "To me, the choice you are asking of us is _____, and it made me feel _____."

- **The Possible Future:** What is the positive vision of a possible future that the story describes? Is it hopeful? Does the action we are being asked to take together make that vision more possible?

  "I understood the vision to be _____. But how does it relate to our work now?"

- **The Values:** Can you identify what the storyteller's values are and where they came from? How? How did the story make you feel? What shared value does the narrative animate? How?

  "Your story made me feel _____ because _____."

  "It's clear from your story that you value _____ "

- **Details:** Were there sections of the story that had especially good details or images (e.g., sights, sounds, smells, or emotions of the moment)? Did you feel like the moment was captured vividly? Or, did the speaker merely explain the circumstances from a certain angle of remove?

  "The image of _____ really helped me identify with what you were feeling."

  "Try telling more details about _____ so we can imagine what you were experiencing."

Originally adapted from the works of Marshall Ganz, Harvard University; adapted by Ruth Wageman

This tool was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

Story of Now (Group Tool)

Group Practice: Stewardship Teams Crafting a Shared Vision

The purpose of this one-hour group agenda is to enable a stewardship team to envision a broad purpose for their collaborative work in transforming the regional health system.

Learning Objectives:

- **To understand the core ideas behind the power of narrative and the purposes of a Story of Now**
- **To develop a shared narrative in a stewardship team**

Phase(s): This tool is best used by groups engaged in a Phase 1 effort along the Pathway for Transforming Regional Health. We recommend that a facilitator lead the group through the tool.

How to use this tool

This tool is most effective when completed by people engaged in the regional change effort, such as those who are part of the core stewardship team leading the effort, or part of the backbone or integrator organization.

We introduce the core ideas behind the power of narrative and the purposes of a Story of Now, and then offer a tool that enables the development of a shared narrative in a stewardship team.

The tool proceeds through four phases: (1) hearing a "Story of Now" as an example of how images of the "nightmare" and the "dream" can motivate a desire for change; (2) individually reflecting on a positive vision for the future and the consequences of not changing the status quo; (3) group members articulating to their colleagues their images of both the positive possibilities and the negative consequences of not changing the health system; and (4) harvesting themes and imagery from the group that can form the basis of a shared vision for the launching and momentum of a broad collaborative effort.

The facilitator should ensure that all group members have blank paper and drawing materials. The facilitator will need a blackboard, whiteboard, or flipchart for capturing themes and images, and a projector or computer for showing the focal video, "The Girl Effect." (https://www.youtube.com/watch?v=1e8xgFoJtVg)

Agenda

Example Story of Now **(15 minutes)**

Show the video, "The Girl Effect." Invite members of the group to describe what effects the video has on them and why it works as a call to action.

- Does the film motivate us to act? Why? What about the way this story is told is especially compelling (details, imagery, characters—the elements of story)?
- Do we see why a negative future is likely without action? What is the *challenge* that we face?
- Do we see an action we can take to bring about a more positive future? What is the *choice* that we are asked to make?
-Did the story and imagery help viewers see *why* there might be plausible action that could be taken to bring about a radically more positive future? What is the possible *outcome* that can happen if we make that choice?

Explain to team members: The purpose of a Story of Now is to begin articulating a vision to which this group feels committed and is willing to take responsibility to create conditions for others to work together to make that vision possible. It is a vision, rooted in shared values, that others can help to shape and sharpen in the future.

A Story of Now illustrates:

- What will happen if we do not take action together? Why is that negative future likely if we do not act? (The Challenge)
- What positive vision is possible if we do work together? (The Outcome)
- Why are we hopeful that this positive future is possible? What are we being asked to do? (The Choice)

Individual reflection: The Nightmare and the Dream **(5 minutes)**

Each member of the group takes a blank paper and drawing materials and sketches an image (using words as well where helpful) of the Nightmare.

The facilitator should say "The nightmare is your image of what negative possible future awaits us as a community if we do not act together to change the course of our health system. Try using pictures and imagery that describe concretely what our region will be like, for those of us around the table and

people not in the room, if we continue on our current path. Who are the characters in the nightmare? What are they doing? What are they experiencing?"

Each member of the group then sketches an image (using words as well where helpful) of the Dream.

The facilitator should say "The Dream is your image of what positive future can arise for us as a community if we start acting together now to change the course of our health system. Try using pictures and imagery that describe concretely what our region will be like, for those of us around the table and people not in the room, if we work together to change our current path. Who are the characters in the Dream? What are they doing? What are they experiencing?"

Finally, what is the choice that you are asking each other to make? What are you calling others to do?

Group imagery

(30 minutes)

Each member of the team shows or explains his or her images of the Nightmare and Dream, and makes the "ask" of team members.

The facilitator captures key ideas on a central whiteboard/flip chart for the group to see. The ideas should include key outcomes—unsustainable costs, poor health, difficulty accessing care, etc.—that are represented in the Nightmare and Dream, as well as the key constituents (children, care providers, teachers, the elderly, etc.) who are central characters in the story.

Group themes and priorities

(10 minutes)

Once all group members have articulated their Story of Now, the facilitator should lead them in a discussion of what images of the possible futures—negative and positive—they find especially powerful and relevant for this regional health system effort. (A weighted voting technique, inviting members to post votes for their most strongly preferred image, may be useful for identifying an emerging consensus)

- Which images help members of the team to see themselves leading the work?
- Which images will motivate others to join in working together?
- Which best represent a bold vision for what might be possible?
- Which help people see that a different future is possible?

The facilitator may then ask for a volunteer from the team to craft a Story of Now that represents the team as a whole. Alternatively, the facilitator can take the images and messages generated from the team and, after the meeting, craft a single Story of Now for the team's comments and amendments.

This tool was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

Public Narrative: Story of Self

Using Narrative to Build Relationships and Shared Vision

This tool offers an overview of how to develop a stewardship group's shared purposes and to build values-based relationships among individual leaders through public narrative. Its purpose is to explain how to use narrative as a sustainable leadership practice to motivate others to work together effectively.

Learning Objectives:

- **To explain why narrative matters**
- **To understand how the leadership practice of public narrative works**
- **To develop your own public narrative and to coach others in theirs**
- **To identify opportunities to apply narrative in your leadership work**

Phase(s): This tool is best used by individuals who are a part of a group engaged in a Phase 2 effort along the Pathway for Transforming Regional Health.

How to use this tool

This tool is most effective when completed by people deeply engaged in the regional change effort, such as those who are part of the core stewardship team leading the effort, or part of the backbone or integrator organization.

Leaders can use narrative to develop a team's shared purpose by developing and sharing their personal stories of self to engage and motivate others to join in the effort and encouraging individuals to write their own stories of self to share and to build a shared view of your effort.

This tool begins with an overview of narrative and its three components: (1) story of self, (2) story of now, and (3) story of us. The overview defines narrative, explains why it can be a powerful tool and offers guidelines for when to use narrative in practice. This tool focuses specifically on the first narrative component, "Story of Self", and the last section offers a step-by-step guide to develop your own story.

Why Narrative?

One of the challenges facing multi-stakeholder stewardship teams is forming relationships, sometimes in a context of little existing trust, with other leaders from other organizations—relationships that can withstand challenging and difficult subjects and the hard work of leading change over time. A second key challenge is arriving at a compelling shared purpose that is genuinely motivating for leaders who work together, and that can supersede individual and potentially competing interests. That purpose must be clear and shared to guide collective work.

Narrative provides a method to identify the shared values of a diverse set of stakeholders. It offers a framework for developing a clear and collective vision guided by those values. It invites and inspires new leaders to join in action. It builds a values-based culture around the effort. It identifies and sustains stakeholders' intrinsic motivations to steward shared resources on an ongoing basis. It recalls leaders to their core values, which are sustaining in the face of differences, conflict, and complex decision-making. It reminds leaders of what unites them as equals, and how together they can make a difference.

What Is Narrative?

Narrative is the skill of creating a shared story around our common values to motivate others to join us in action.[40] It involves three core components: personal stories that illustrate our own values ("story of self"); collective stories that illustrate shared values ("story of us"); and stories that illustrate both the challenges a group faces and the hopeful actions groups can take to address those challenges ("story of now"). In this tool, we focus specifically on the first narrative: Story of Self.

How Does It Work?

Narrative establishes a foundation on which to: (1) lead; (2) collaborate with others; and (3) discover common purpose and vision to take action.

Narrative is how individual leaders learn to access their own moral resources—and courage—to make choices in the face of urgent challenges. Because it connects leaders to their individual motivations to act ("story of self"), it is critical to sustaining volunteer commitments in change efforts.

Hearing one another's stories allows leaders to build empathetic connections and a collective capacity. Stories have the power to move others because they allow leaders to express values through their lived experiences. And sharing them allows leaders to learn where they have shared experiences and shared values.

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[40] Ganz, Marshall. (2010). Leading change: Leadership, organization, and social movements. In N. Nohria & R. Khurana (Eds.), *Advancing Leadership,* Harvard Business School Press, Boston: MA.

Narrative allows leaders to discover common purpose, or a motivating vision, to act on. Leaders tell stories to motivate others to join them *in action*.. As one coalition leader stated, "It's not just telling a story for a story's sake; you are trying to accomplish something with it." In other words, narrative is a motivational "call to action," through which leaders describe the urgent challenges they face, a hopeful vision of what life could be, and the specific choices that they have made to move toward that vision.

When Do We Use Narrative In Practice?

To Develop a Shared Purpose as a Stewardship Team

Leaders can use narrative to develop a team's shared purpose. When we ask leaders to engage in narrative with each other, we ask them to tell a brief story to the group that illustrates:

- **Challenges:** What challenges, obstacles, or difficulties did you experience in your history that can teach us something about why you feel called to lead change toward a healthy health system?
- **Choices:** What choices did you make that illustrate that calling?
- **Outcomes:** What happened as a consequence of your choices? What might happen if we work together toward some shared purpose? Why are you hopeful that it is possible?

This discursive process allows stakeholder groups to envision the future collectively, make choices to move toward that vision, and construct an identity around the values that motivate their choices.

Leaders often share stories about loved ones who experienced harm in hospitals (for example). They describe personal trials navigating the health system themselves, or as children of elderly parents, and as parents of young children. They tell stories about patients whose lives could have been saved by population health efforts, whose families went bankrupt paying for care, and whose surviving caregivers suffered secondary mental and physical health problems. They share personal, yet universal, moments of grief and loss—and how those moments transformed them as human beings and as professionals.

In using narrative, leaders view their peers differently. With an emphasis on values, narrative provides a way to connect on equal footing with others from very different groups and constituencies. As one leader remarked, "Different people [in our coalition] are motivated to participate for a range of reasons—a belief in the Triple Aim, a market motivation, a population health mandate. But it is the use of narrative that connects us around a shared moral purpose, and everyone is united by that."

Story of Self

A "Story of Self" Illustrates Why You Have Been Called To Act

Everyone has a compelling story to tell. We all have stories of pain, or we wouldn't think the world needs changing. We all have stories of hope, or we wouldn't think we could change it. We all have made choices that shaped our life's path—how we responded to challenges, whether to take leadership positions, where we found courage to take risks. In a story of self, we focus on choice points, moments in our lives when our values become real and we exercised agency in the face of uncertainty. When did you first care about health and health care? Why? When did you feel you had to do something? Why did you feel you could? What were the circumstances? The power in a story of self is to reveal something of yourself and your values—not your deepest secrets, but the key moments in your life.

Telling the Story

A Story Is Lived and Breathed in the Details

Stories are specific and visual. They evoke a time, place, setting, and mood as well as colors, sounds, textures, and tastes. The more you can communicate this visual specificity, the more power your story will have to engage others. This may seem like a paradox, but like a poem or a painting or a piece of music, it is the specificity of the experience that can give us access to the universal values or insight they contain.

The Craft of Narrative Involves Being Authentic and Speaking from the Heart

Learning the craft of public narrative is not learning a script, developing a message, or creating a brand. It is not a formula, but a framework. Our public narrative changes as our lives, communities, and challenges evolve. But each narrative we tell should be a genuine reflection of real choices that define who we are.

Once Again: Why Stories?

You may think that your story doesn't matter, that people aren't interested, that you shouldn't be talking about yourself. But when you do public work, you have a responsibility to offer a public accounting of yourself—who you are, why you do what you do, and where you hope to lead. If you do not author your public story, others will, and they may not tell it in a way that you like.

A good public story is drawn from the series of "choice points" that have structured the "plot" of your life—the challenges you faced, choices you made, and outcomes you experienced. Your story gives others emotional and intellectual insight into your values, why you have chosen to act on them in this way, what they can expect from you, and what they can learn from you.

By telling our stories, we also become more mindful of our own moral resources. And because stories enable us to communicate our values not as abstract principles but as lived experience, they have the power to move others to join us in action now.

Example: Dr. Elliott Fisher's Narrative

Listen to Dr. Elliott Fisher tell his Story of Self, by clicking the audio review link. If you are not able to listen to the audio, please read the transcript on the next page.

Audio Review: Dr. Elliott Fisher's Story of Self

Think about the elements of personal history and choice that you hear in his story. ***Please use the space below to take notes.***

1. **What was Elliott Fisher's purpose in telling these stories? What was he asking people to do?**

2. **What values did his narrative convey?**

3. **What details or images in particular reflected those values?**

4. **What were the challenges, choices, and outcomes in his story? What values do these convey?**

Dr. Elliott Fisher Story of Self Video Transcript

Elliott S. Fisher, MD, MPH
Director, Dartmouth Institute for Health Policy and Clinical Practice

"I grew up, you know, the son of a very prominent Harvard law professor who had been a meteorologist in World War II, flying over Japan back and forth, doing weather forecasts. After the war, he discovered that those lone flights up over Japan in a B29 had taught the residents of Hiroshima that they could ignore that first early morning flight of a lone B29 in the morning. So many thousands of additional people died in Hiroshima thanks to those morning flights. He came back from World War II having lost many of his friends, thinking that violence and war were no way to solve problems. And so devoted his life to reducing the risk of conflict, focusing on nuclear war, establishing the field of conflict resolution, and devoted really his life not just to the study of stuff, but to try and make a difference. So my brother and I grew up, you know, both feeling we knew we had to grow up and, you know, become people who were making a difference in the world, but with no clue how to do it. So I majored in mountaineering in college as I sometimes say, although that wasn't an approved major back in those days.

When I graduated, I still had no idea what I'd do in my life. So I decided to drive an ambulance in Somerville, Massachusetts, three miles from where I grew up in the fancy part of Cambridge. And where I was driving the ambulance, kids were getting diseases like diabetes and seizure disorders and that none of my classmates had, asthma. And so, seeing this sharp disparity between what I got to experience growing up and what was happening with, you know, basically neighbors, and seeing how terrible the health care they got was, led me to think, gosh, you know maybe there's something I could do, you know, at the interface between healthcare and public policy that would sort of where I could make a difference, and it would be far enough away from my father that I thought I'd have my own identity.

One of the things that I do go back to, as I think about my year and a half on the ambulance was this, was seeing really for the first time through the eyes of a patient, what it felt like to be, you know, a poor person of color going into a, you know, a hospital where they did not feel valued or respected and they felt fearful about what was going to happen to them there, just because of their social position. And then it was later in medical school where I learned that that happens all the time because most of the people who are sick actually are also poor. It's a much higher burden of illness among poor people in this country than among the rest of us. But everyone feels, feels vulnerable and scared, and the ambulance really let me come into the emergency room, with the eyes of a patient in ways that probably I wouldn't have otherwise had experienced."

Develop Your Call to Action and Coach Others

TOOL: Draft Your Story of Self

Draft a one-page narrative that conveys why you are called to being a change agent in health (and exchange it with your learning partner for feedback).

Narrative is an exercise in leadership that motivates others to join you in action on behalf of a shared purpose. The goal in this tool is to identify sources of your own calling (story of self). Use the guide below to help you create your draft.

Why are you called to being a change agent in health? What stories can you share that will enable other leaders to "get you?" How can you connect with others to experience the sources of the values that move you not only to act, but also to lead? Identify key choice points that set you on your path.

Important note: This tool is not about answering the above questions in order. However, it helps to start with what you imagine you are going to ask of others in joining you in this leadership work. That outcome toward which you would like others to join you in leading can help you identify the aspects of your own history and experiences that make that outcome important to you, personally.

Also remember that learning public narrative is a process, and it is iterative. This is not about writing a script that will fit all situations. It can be learned only by telling, listening, reflecting, and telling again—over, over, and over. This work will be a beginning.

1. Identify the challenge: What specific challenges have you faced in your life? Choose one that is relevant to the values you want to express about yourself in this context. What vivid details (characters, settings, images) will help a listener experience what it was like to face that challenge?

2. Identify the choice. What did you do in facing that challenge? How did it make you feel?

3. Describe the outcome. What happened as a consequence of your choice? Is the lesson for you positive (it offered a hopeful direction), or negative (it made you rethink your choices, aspire to something different)?

Coaching Each Other

Listening to and coaching stories is just as important (if not more) as telling your own. Public narrative is not a script that comes ready-made to take into the world. It is important to ask sharpening questions that will guide the storyteller to consider the effect of their narrative and the values it expresses. And, as you help in another's learning process, you in turn fine-tune your own story.

Below are some coaching tips. Read carefully through the kind of reflective and probing questions that can help bring clarity to someone else's story.

When giving feedback to your learning partner, be curious and genuinely interested! Probe where a story needs sharpening, and share what connects you to their story. The purpose of coaching is to listen to the way stories are told and think of ways that the storytelling could be improved.

- **The Challenge:** What were the specific challenges the storyteller faced? Did the storyteller paint a vivid picture of those challenges? Is there a sense of urgency around that challenge, not just for the speaker, but also for us?

  "When you described _____, I got a clear picture of the challenge."
  "I understood the challenge to be _____. Is that what you intended?"
  "The challenge wasn't clear. How would you describe _____?"

- **The Choice:** Was there a clear choice that was made in response to each challenge? How did the choice make you feel? (hopeful? angry?) Is the choice we are being asked to make clear? Does it seem significant and doable?

  "To me, the choice you made was _____, and it made me feel _____."
  "It would be helpful if you focused on the moment you made a choice."

- **The Outcome:** What was the specific outcome that resulted from each choice? What does that outcome teach us?

  "I understood the outcome to be _____, and it teaches me _____. But how does it relate to our work now?"

- **The Values:** Could you identify what this person's values are and where they came from? How? How did the story make you feel? Is the value claim about the choice we need to make clear? What shared value does the narrative animate? How?

  "Your story made me feel _____ because _____."
  "It's clear from your story that you value _____; but it could be even clearer if you told a story about where that value comes from."

- **Details:** Were there sections of the story that had especially good details or images (e.g., sights, sounds, smells, or emotions of the moment)? Did you feel like the moment was captured vividly? Or, did the speaker merely explain the circumstances from a certain angle of remove?

  "The image of _____ really helped me identify with what you were feeling."
  "Try telling more details about _____ so we can imagine what you were experiencing."

This tool was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

ReThink Health
ReSearch ◦ ReConnect ◦ ReDesign

Appendix C

Case Studies

ReThink Health
ReSearch ◦ ReConnect ◦ ReDesign

Phase 1 Case Study: Campaign

Community Solutions: Northeast Hartford Partnership

In Connecticut, the Northeast Hartford Partnership (NHP) got its start in 2010, when its parent organization, Community Solutions, a national non-profit focused on addressing the root causes of poverty, was gifted and invited to transform an abandoned factory in Northeast Hartford into a center for community wellness, safety, and economic prosperity. The neighborhood of nearly 11,000 people surrounding the defunct M. Swift & Sons gold leaf factory is one of the poorest in Connecticut—residents' average life expectancy is 10 years less than in neighboring communities and 40% of residents live in poverty.

Community Solutions, in the form of NHP, views itself as a backbone organization whose role is to coordinate, integrate, and align local efforts to help address this issue. NHP Director Gina Federico Muslim sees herself as a catalyst who helps to build relationships with everyone from the staff and clients of the smallest neighborhood non-profit to those who run St. Francis Hospital, Cigna Foundation, and the state Medicaid agency—all of whom need to be at the table. Muslim says the transformed Swift factory will serve as a community hub and will represent the best and most effective partners at work supporting residents.

NHP currently is in Phase 1—the Campaign Phase—on ReThink Health's *Pathway for Transforming Regional Health*. Phase 1 efforts typically address a specific issue or project—in this case transforming the Swift factory—that requires leaders from diverse organizations across a community to work together. NHP also is working hard to shift into Phase 1I by bringing together a wide variety of stakeholders to coordinate their efforts around a neighborhood sustainability plan, based on the findings of a community needs assessment, and leveraging the area's federal Promise Zone designation. Phase 1I efforts focus on building a collaborative team with well-positioned leaders from key organizations that affect the community's health. Because of this, group composition often expands from a Phase 1 to Phase 1I effort.

"I see the work we're doing to transform the Swift factory as one physical example of the work we're doing to transform the community," said NHP's Muslim.

Establishing a Stewardship Group

As a backbone organization, NHP is bringing together neighbors, businesses, public and private nonprofits, and government agencies around issues that affect everyone in the neighborhood. The factory is being transformed into a community hub where partners can work together and see the results of their partnership. The core components of the factory renovation will include a community

food center, a health delivery space that will include mental health and wrap-around services provided by community health workers from the neighborhood, and a potential public library branch that will focus on job training and placement and support resident-led problem solving.

So far, NHP's efforts are paying off. A nine-month care coordination project, for example, resulted in a dramatic reduction in emergency room usage among participants (down from average of nine visits per resident to four), which, in turn, resulted in a 57% reduction in costs.

Tackling Pitfalls

New campaigns focused on addressing a particular community problem are exciting and hold tremendous potential. But, while they bring together individuals and organizations that have not worked together before, they also can feel temporary—new partners come together to achieve a specific goal and often disband once the goal is met. The time-limited nature of campaign-style projects is a common pitfall in Phase 1 that makes it difficult to advance to Phase 1I.

A closely related pitfall is that, once the campaign goal is met, participants may be looking forward to moving on to something else—they are satisfied with a job well done and assume that the community will be returning to the old way of doing things, which required less consensus and collaboration and afforded them and their organizations more autonomy.

NHP is working to avoid these and other pitfalls by developing itself into a stewardship group that inspires project leaders to see beyond their specific efforts to how those efforts align with a broader, long-term vision for the community. When asked about NHP's role in the community, Muslim said: "When we first got here, there were a lot of folks focused on important objectives, but they weren't really talking to each other. We realized that a role that Community Solutions and the Northeast Hartford Partnership could play is bringing these folks together, not only for conversation but finding ways to align. The sum of our parts is more effective working together than any of us can do working side by side."

Building Momentum

Along the *Pathway*, strategies that help stewardship groups manage or avoid common pitfalls so that they may continue progressing toward the next phase are called momentum builders. In Hartford, the NHP is building momentum in several important ways.

- ***NHP and community stakeholders collaboratively conducted a common needs assessment***. NHP is using the factory transformation and other neighborhood projects as a jumping off point for a much bolder aspiration—to develop and implement, over the long term, a collective vision for a healthier, more prosperous community. To begin laying the groundwork for that vision, NHP, in partnership with the Cigna Foundation, a neighbor and major health insurer in Hartford, developed a health risk assessment (HRA)-style community survey (called Pulse Northeast) to take the pulse of the neighborhood. Conducted by neighborhood

residents, the survey takes stock of the health, social, and economic qualities of the neighborhood. It provides an opportunity for residents to explain to their neighbors the work that NHP is doing and how community members can contribute, as well as providing employment to those conducting the surveys.

- ***NHP has brought together a team of multi-sector champions who are beginning to think about broad systems change***. Community Solutions and NHP are laying a foundation and settling in for the long term. They are developing relationships with and partnering with a group of "systems champions"—a diverse group of local leaders who are willing to work hard toward systems change. The recent Promise Zone designation has accelerated these efforts and brought NHP into contact with other leaders, including the Mayor's Office, who are also working to improve the community.

  In addition to working together on the Pulse Northeast assessment, Community Solutions and Cigna proposed a partnership with the State of Connecticut that complements and supports the Connecticut Healthcare Innovation Plan by improving community health; alleviating health disparities; achieving better quality of care and care experience; and improving affordability by reducing healthcare costs. The State agreed to join the partnership and provides it with important insurance claims data that will help NHP identify health needs in the community and track changes over time.

  "We're coordinating efforts across challenges," said Cigna Foundation's David Figliuzzi. "Creating a shared vision and getting everyone to pull in the same direction is our greatest challenge, but if we can do that, then we can make progress."

Looking Ahead

The Northeast Hartford Partnership is always looking ahead. Once Community Solutions realized the needs were much greater than could be appropriately addressed by transforming an old factory into a central resource for the community, it began the process of networking and building relationships with key stakeholders—a process that will continue as it transitions the initial group of leaders into a more formal stewardship group in Phase 1I. "We can build a strong framework for true partnership—because people come and go—but a strong framework can be a profound engine for neighborhood change," said Muslim.

Watch the Phase 1 video about NHP's work:

http://www.rethinkhealth.org/resources/phase-i-video-case-study/

This case study was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

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Phase 2 Case Study: Engage

ReThink Health-Upper Connecticut River Valley

In 2013, a small group of leaders from across the Upper Connecticut River Valley challenged their communities to come together and collectively transform their systems of health. These leaders established ReThink Health-Upper Connecticut River Valley (RTH-UCRV), forming a stewardship group that took responsibility for developing their leadership structures, a coordinated cross-organization multi-intervention strategy, a sustainable funding model, and solid measures of success to ensure enduring regional transformation. The group's ultimate goal: build a healthy and sustainable local economy.

Today, RTH-UCRV has created the conditions for movement through Phase 2 on the *Pathway for Tranforming Regional Health*: diverse team of leaders thinking and acting on a regional level, continuing dialogue and increasing collaboration, and building infrastructure to make that ongoing shared work possible. The effort has put considerable work into developing a long-term stewardship structure and is actively aspiring to Phase 3.

Establishing Stewardship and Moving on the Pathway

An initial group representing regional employers, the social service sector, members of the Upper Valley community, Dartmouth College, and Dartmouth-Hitchcock Medical Center came together to get something started and create the conditions for many others to join in. The group's early goals included: fostering formation of an effective leadership team, inspiring a broad group of stakeholders to join, building shared understanding of local challenges and possibilities, forging strong new relationships among the many potential stewards who might play a role in the effort, building trust across groups and organizations, and framing a broadly shared vision and set of priorities that could engage the commitment of all.

These core stewardship functions enabled critical Phase 1I accomplishments for RTH-UCRV: a permanent office has been established to enable ongoing collaboration, key staff have been hired, and the group has devised a structure and process designed for the long-term stewardship of resources in the region, including mechanisms for citizens to be an active part of setting priorities and leading change. Further, a region-wide gathering in late 2013 resulted in the formation of three working groups—locally referred to as "Circles of Innovation"—charged with launching and leading efforts focused on three agreed upon priorities:

1. Coordinating care in the Upper Valley, including between medical care and social services;

2. Engaging citizens and workplaces in healthy behavior programs to improve population health; and
3. Altering the payment system in the region toward global payments, and creating a system for capturing savings from change efforts and reinvesting in upstream, health promoting activities.

These circles of innovation develop and implement new projects and also connect the many existing change efforts in the region.

Tackling Pitfalls

"We ask ourselves all the time why this [effort] is going to be of any more meaning than every other committee, panel, council, advisory group, etc. that has talked about health," said RTH-UCRV's Sara Kobylensky. "And the answer to that really is because we won't let it *not* be. [There is a] constant awareness that, if this is going to mean anything, it can't just be talk, there has to be change."

In fact, from the moment of its founding, RTH-UCRV sought to avoid potential pitfalls that can stymie efforts to transform health and health care in a region. Some of the potential sticking points that UCRV has deliberately worked to overcome included the need to:

- **Making sure meetings are not a waste of time.** Conceived as a team of stewards who took responsibility to "get something started," the diverse group of leaders in the initial planning team began their work together by sharing their personal stories and building their purpose as a leadership team around collective values. Their work when they convene has focused on real leadership activities: developing strategies to convene the broader community, creating conditions for shared vision, securing resources to launch and support cross-sector learning-focused initiatives consistent with their shared purpose.
- **Focus on big, shared priorities rather than narrow projects**. They aligned on shared priorities by ensuring broad and meaningful representation of stakeholders from across the entire region, creating priority-setting gatherings: large, town-hall-type meetings carefully structured to invite in many voices who were actively recruited to participate. The early work of these gatherings was to set aspirations high by imagining what bold goals might be achieved together.
- **Avoid volunteer burnout by attracting funding and by jointly investing**. The time commitment required to establish, implement, and maintain stewardship of a regional effort is daunting, and the initial RTH UCRV planning committee—senior leaders who had full-time jobs—made it a top priority to establish funding support and hire dedicated staff for the group early in the process to enable their effectiveness.

Building Momentum

Along the *Pathway*, strategies that help stewardship groups manage or avoid common pitfalls to continue progressing toward the next phase are called "momentum builders." RTH-UCRV has been adept at thoughtfully building momentum for its efforts from the very beginning. By maintaining a clear focus on developing strong relationships and networks among stakeholders, and by being inclusive and generating buy-in across the region for its leadership, they have created the conditions for many people to see themselves as stewards of their community's health. RTH-UCRV leaders have had unusually sharp focus on building a sturdy stewardship structure on two fronts: (1) deeply engaging citizens in guiding the effort, right from the very beginning, and (2) planning for the transition to a stable stewardship board, with elected members and careful onboarding processes that preserve the history and vision of the effort over time.

Engaged citizens

The first year of the RTH-UCRV effort involved convening three related gatherings, each one building on the last. The first focused on crafting a shared vision of a thriving region, the second on strategy and goals for working toward that vision, and the third on innovating and launching initiatives to bring the strategy to life. Each citizen gathering attracted back previous attendees and expanding the table ever further to engage more stakeholders and a wider geography.

Planful evolution of stewardship

Also significant is the effort's planfulness about how the leadership of the effort should focus on sustainable stewardship right from the start. While the initial planning team took responsibility for getting something started, it also had every intention of creating the conditions for others to step into leadership roles. The group designed a Stewardship Board that would at first contain members of

RTH-UCRV'S STEWARDSHIP STRUCTURE

Sectors involved: Hospital, health care, primary care; public health; community organizations; government & elected officials; social services; academia & research; education; mental health; community planning & transportation; business; faith-based institutions; housing & economic development; health insurance; philanthropy; and media.

How they are structured: Began as an initial planning team whose eight members also served on a handful of work groups, but has evolved over two years into a broader stewardship group whose 120+ members, in many small leadership teams, are focused on three priorities: healthy behaviors, care coordination, and financing and payment reform. The Stewardship Board serves as the steering committee of the effort and members are elected by the larger group of participants.

For more information: RTH-UCRV is detailed more thoroughly in a white paper that it drafted and distributed across the Upper Valley region to help build greater interest in its work. To learn more, see http://rethinkhealthucrv.org/.

the initial planning team, but members would step out of the team in rotation over time, making room for new members to be elected by participants in the broader effort. They also invested considerable staff, energy, and resources into creating an "onboarding" process for newly arriving members, focused on relationship building, shared narratives and values, understanding the vision and history of the effort and its priorities. In this way, the effort would be protected from the kind of revisiting of decisions, loss of direction, or sanding down the edges of sharply defined purposes that plague so many collaborative groups as leadership changes over time.

"There has been a lot written about tipping points and momentum and those kinds of things, but they're real," said Kobylensky. "We are still in those early stages where we're doing a lot of uphill pushing with this, but it's really [about] pulling all this together so there will be sufficient energy going in the same direction, with a recognition of what it will look like if it gets to where it ought to be."

According to Kobylensky and other early leaders of the effort, the initial planning group began a tradition that has continued of meeting over meals—inviting each other to breakfast, lunch, or dinner; serving food at larger gatherings; and feeding the people who are taking the time to sit together, share their stories, build trust, and develop a shared vision.

Looking Ahead

Firmly established within Phase 2, RTH-UCRV has significant work to do before moving into Phase 3, but its stewardship group has cast its aspirations in that direction and is nurturing a long-term view of health and health care in the community. "[The work] is going to look messy along the way and there's going to be an act of faith required for a while until real, measurable, defined change can be observed," said Kobylensky. "But setting what those measures of change will be needs to come quite soon now, so that people can be watching to know that it is really on track and has been achieved."

In a recent Board meeting, members affirmed their determination to achieve the degree of alignment, strategically focused energy and cross-organizational accomplishment that characterize the Align phase of the *Pathway*.

This case study was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

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Phase 3 Case Study: Align

Atlanta Regional Collaborative for Health Improvement

In Georgia, the Atlanta Regional Collaborative for Health Improvement (ARCHI) is bringing leaders and residents of the Atlanta region together in support of a healthier population and a more vibrant local economy. Launched in 2011, ARCHI's members—representing a broad cross-section of local stakeholder institutions and organizations—were motivated to collaborate by the realization that a single, region-wide health needs assessment as well as collective, coordinated action to address those needs would better serve the area's residents than multiple assessments and initiatives carried out independently by various stakeholders.

Today, ARCHI—whose core partners include Centers for Disease Control and Prevention, Kaiser Permanente, Grady Health System, St. Joseph's Health System, Atlanta Regional Commission, Georgia Health Policy Center, and United Way of Greater Atlanta—is solidly in Phase 3 on ReThink Health's Pathway for Transforming Regional Health. Like other groups in Phase 3, also called the Align Phase, ARCHI's leaders share a long-term vision for the future, the area's residents are deeply engaged, and the organization, through regular meetings, is supporting the continual learning and development of its diverse membership. Another important characteristic of Phase 3 groups like ARCHI: leaders recognize that the impact of their efforts will be magnified if they are connected in meaningful ways.

"One of the things that has been a part of our work from our very first meeting is to think about not only what we're going to do, but how we're going to build our collaborative," said ARCHI Steering Committee Member Karen Minyard, who is also executive director of the Georgia Health Policy Center. "We have talked about collaboration, the characteristics of collaboration, who are the people that are going to be a part of our collaboration, how are we going to act together, at every single convening."

Establishing Stewardship

During a series of well-attended public meetings in 2012, ARCHI's members—today representing more than 90 organizations, including: hospitals, health centers, behavioral health, public health, education, insurance, business, local government, philanthropy, and faith communities—strategized around improving the health of their community and the quality of their health system. After deciding to focus ARCHI's efforts on Fulton and Dekalb counties, the group analyzed health system data and came to consensus around the region's challenges and potential solutions. ARCHI also worked with ReThink Health and its Dynamics Model[1] to compare and contrast the effects of different strategies and

[1] https://www.youtube.com/watch?v=YAmKs72wLK4

approaches that they might take together to change health and health care for the better in the region. During this process, the group, using instant polling technology at a meeting of more than 70 participants, reached 87% consensus around a clear set of priorities and financing strategies that make up the 28-year "Atlanta Transformation" plan.

In 2013, ARCHI published its regional Playbook[2], which serves as a toolkit for organizations around the region that are joining the transformation effort. The Playbook outlines the group's priorities, which include: encouraging healthy behaviors, increasing pathways to advantage for families and students, increasing care coordination, and expanding health insurance coverage. It also outlines the group's financing strategies: creating an innovation fund, increasing use of global payment, and capturing and reinvesting a portion of savings generated. ARCHI holds regular meetings to oversee the implementation of the work outlined in the Playbook and is now launching a place-based, concentrated pilot effort in the College Park community.

Tackling Pitfalls

Several pitfalls are common to organizations like ARCHI that are working at Phase 3 of the Pathway. One pervasive Phase 3 pitfall is the feeling that "it is all uphill from here"—meaning that the safe topics, obvious funding streams, and low-hanging fruit are nearly exhausted and momentum and enthusiasm are much harder to sustain. At this point, the group has been working hard together, often for many years, and is beginning to bump up against bigger challenges. It is an easy time for energy to wane, personnel to turn over, and ambitious efforts to stall. Other, similar pitfalls are the "sagging backbone"—referring to the temptation to broaden the organization's scope in order to turn toward new and exciting projects that may stretch the organization beyond its resources; and sudden, unexpected departures of former champions who had been deeply involved.

ARCHI is working to avoid these and other pitfalls by keeping the focus on building momentum via its stewardship group, which is

2 https://www.youtube.com/watch?v=YAmKs72wLK4
chi_playbook.pdf

ARCHI's Structure

The United Way, Atlanta Regional Commission, and Georgia Health Policy Center provide executive leadership to ARCHI's 15-member steering committee. The steering committee meets monthly while its broader general membership meets quarterly. Each meeting includes a formal presentation on research, data, and evidence on promising interventions that improve community health and equity. ARCHI laid out its vision for the future and a roadmap for achieving it in its published "Playbook," which serves as a toolkit for local communities that want to get involved.

responsible for keeping its eye on the long-term, region-wide vision for improved health. "When you're implementing a [specific] program, you're thinking about . . . here's what I have to do today to implement the program," said Minyard. "But when you're a group of people who are stewards of the whole system, then you're in a situation [where] you're having to say, 'what would it take for us to impact this whole system? How do we need to work together? Who needs to be a partner? How do we convince people to put their money in a different direction?' And so it's a different kind of question you're running on every day. It's a different level of relationship and it's a different kind of a partnership over time."

Building Momentum

Along the Pathway, strategies that help stewardship groups manage or avoid common pitfalls so that they may continue progressing toward the next phase are called momentum builders. ARCHI has been focused on generating and maintaining momentum from the start. In particular:

- ***ARCHI recruits new stewards and continually expands the stewardship table***. An important momentum builder for an ambitious Phase 3 organization like ARCHI is to keep bringing more diverse voices into the stewardship effort. This requires buy-in to a big vision from a broad swath of the region's residents, while keeping in mind that the group's leaders can't speak for everyone and that everyone's voice is important. ARCHI maintains an open call for members of the community at any level to join. Individuals may join by signing the membership agreement and can actively participate in any leadership gathering. Those that join on behalf of their organizations must have CEO endorsement. All sign a statement agreeing to become stewards of the ARCHI vision.

- ***ARCHI ups the ante on its efforts, creating and sustaining audacious goals.*** ARCHI's stewardship group not only involves large groups of citizens in its vision, but it works to generate positive images of what is possible and desirable and seeks to create alignment across the region. According to ARCHI's Evonne Yancy, when the group of more than 70 participants used polling technology to reach near consensus around a clear set of long-term priorities and financing strategies it "...was an eye-opening moment for everybody in the room because it allowed others to see, 'well, that person was thinking just like me.' So it gave ARCHI the foundation of priorities on which to focus." ARCHI took that mandate and upped the ante, creating a playbook of evidence-informed strategies that communities around the region could use to address the priorities outlined in the Atlanta transformation scenario—and formed the basis for the work now underway in the College Park community, which will serve as both testing ground and example for the region.

- ***ARCHI invests and experiments, exploring new sources of funding, resources, and ideas.*** According to Minyard, ARCHI is particularly focused on finding new sources of financial support for its infrastructure. "Assembling the resources to do this work in a sustainable way is one of the big challenges," said Minyard. "We're approaching the assembling of resources in

stages… One stage is getting the core resources that are needed just to staff the day-to-day work and keep us going, to work in the Tri-cities pilot, to align people, to have the meetings, to coordinate things, to have the website, just the basics."

Looking Ahead

Currently in the third year of its 28-year plan, ARCHI is working hard to move into Phase 4, the Redesign Phase, of the Pathway. But, given that transition to Phase 4 is, in many ways, a step-change from Phase 3, it will require significant concerted efforts that disrupt the status quo at the systems level. For its part, ARCHI is working toward implementing more of its financing strategy. Now that they are well on their way toward stable, long-term support for ARCHI's infrastructure, the next step, according to Minyard, is the innovation investment.

"That investment is one percent of the healthcare spending in the region per year for five years," Minyard said. That's a lot of money for us. The United Way has kicked us off by investing $3.5 million, but there are a lot more millions that we need, and we're going to be turning our attention to that next. The other part is for us to capture and reinvest. And that's when you implement things, where you save money and you do it in such a way that some of the savings are reinvested back into the efforts. And that's another part of the model that takes some negotiation and some change on people's parts."

For more information, visit:

http://www.archicollaborative.org

Watch the Phase 3 video about ARCHI's work:

http://www.rethinkhealth.org/resources/video-case-study-phase-iii/

This case study was developed with support from the Robert Wood Johnson Foundation and the Fannie E. Rippel Foundation.

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Phase 4 Case Study: Redesign

Organizations Exhibiting Characteristics of the Phase

On the *Pathway for Transforming Regional Health*, stewardship groups find that the tenor of the work changes significantly between the Align and Redesign Phases (Phases 3 and 4). At this crucial transition point, the many different stakeholder organizations that are participating in regional health transformation efforts must adopt new business models, change core practices and cultures, and create incentives for new behaviors. These changes can be precipitated by an internal or external crisis, or by a compelling "man on the moon" vision for the future that spells the end of business as usual.

Phase 4 stewardship groups must promote addressing controversial matters that strike at the heart of old organizational practice. Most critically, they must address the needed changes in organizational independence and the reduced power to act autonomously that results from new partnerships and increasing integration. In Phase 4, multi-stakeholder stewardship groups increase in complexity as they negotiate new working relationships among the players who recognize the "commons" they share. Examples include developing new community health plans to collectively maintain more local control of incentives and reinvestment; creating common health records and databases to manage population health; integrating processes and budgets across an array of services for those most at risk for poor health due to social determinants.

Currently, even the most advanced regional efforts in the U.S. known to ReThink Health inhabit Phase 3 on the *Pathway*, and organizations moving into Phase 4 encounter significant barriers. We believe that the Redesign Phase only becomes possible when key stakeholders embark on significant internal strategic realignment that catalyzes change elsewhere in the community. Cambridge Health Alliance in Cambridge, Massachusetts, and the Dartmouth Hitchcock Health System in New Hampshire are examples of stakeholder organizations where this type of realignment has happened. Other stewardship groups that illustrate some key characteristics of Phase 4 include The Community Technology Assessment Advisory Board in Rochester, New York; and The Health Collaborative in Cincinnati, Ohio. These groups collectively steward issues of capacity control and information exchange that would serve a regional stewardship group well in efforts to advance beyond Phase 3.

While no single structural arrangement can address the stewardship needs of every regional context, certain common features of the stewardship structure are needed to address critical Phase 4 challenges. Multiple groups may serve different stewardship functions that together promote transformative change. We offer these illustrations not as models to be copied but as examples of some key stewardship functions that are necessary in Phase 4.

Advancing Stewardship

Phase 4 activities require discontinuous change in organizational strategies, and a redeployment of their core competencies.

Discontinuous change processes require (1) organizational leadership within the stakeholder collaborative that leads the way in promoting transformative change (2) stewardship structures that stimulate, guide, and promote genuinely transformative change.

Leadership through discontinuous change and shifting financial resources

The Cambridge Health Alliance and the Dartmouth-Hitchcock Health System represent examples of organizations pursuing some of the discontinuous-change characteristics of an entity participating in a Phase 4 effort. They are changing their business practices based on regional conditions, anticipating that business-as-usual will no longer be possible in the future. Rather than resisting change or making only token incremental changes, these organizations are embracing discontinuous changes in their business models and in how they deploy their resources. They are pivoting in new, uncharted directions and investing money and other resources in new priorities informed by a novel vision for taking on a significant role in promoting regional health and what their organizations can contribute to that end.

The Cambridge Health Alliance

In 2008, the Cambridge Health Alliance (CHA), a local safety net health system and insurer, experienced a significant change in state funding that threatened to put it out of business. In response, the organization's leaders engaged in a broadly inclusive, collective process within the organization and beyond, to identify meaningful ways to restructure and focus more intently on providing needed services to its community.

They started by recognizing that their main value came from being a true community partner in promoting health, and that a new business model would require patient-centered health system redesign. They began by downsizing their footprint, closing one hospital and consolidating from 20 small community health centers to 15 mid-sized, robust ambulatory practices. CHA became a learning organization that is continually experimenting, assessing, and acting on results to improve quality of care and the health of community. Its innovations include: testing new global payment and incentive models; redesigning primary care to be team-based, accountable, and proactive in population management; integrating new IT systems across the healthcare delivery system; reducing hospitalizations and improving care transitions and access to primary care, and reinvesting savings more broadly into primary care, behavioral health, and social services that impact health.

When asked what advice she would give to other organizations facing similar challenges, Soma Stout, then vice president of patient-centered medical home development, said: "Start thinking about what creates health and what reduces costs, look at the numbers, and change and build from the person and population up. Include those people in the conversation as you're redesigning. And then really think about how you can structure your organization around high-functioning teams that can reliably, proactively meet the needs of a population along with community and public health partners."

Dartmouth-Hitchcock Medical Center

At Dartmouth-Hitchcock Health System (D-H)—a key stakeholder in the Phase 2 ReThink Health-Upper Connecticut River Valley regional stewardship group—a visionary CEO and innovative board of trustees are creating new business and financing models focused around high-value health care. Several years ago, CEO Dr. James Weinstein recognized that DHMC was struggling to compete financially because of a major disruption in Medicaid payments to the hospital. DHMC responded in part by creating its own health plan, and by focusing more intently on improving the health of its community. Because health-improvement services were not always reimbursable through standard agreements, Weinstein began investigating novel financing structures and strategies that would allow the health system to expand its focus on population health.

In addition to investing a portion of its hospital community benefit fund in population health, D-H's board also created a "Population Health Innovation Fund" to help support new and creative approaches to improving the community's health. This fund, which tops $11 million today, pulls from multiple streams, including savings that come from new payment models and a percentage of any windfall profits from the medical center's investment portfolio.

System leadership through complex stewardship structures

In Phase 4, many different stakeholder organizations within a region are simultaneously working on redesign, internally and within and across sectors. The collaborative landscape becomes increasingly complex. In some regions, sector-specific organizations may take on comparatively narrow and defined stewardship functions, such as creating a safe space for sensitive, business-related conversations and for setting standards and norms for the sector.

In other regions, cross-sector organizations may step up to serve important stewardship functions, such as an overarching stewardship group that is composed of representatives from sector-specific councils. In both cases, a stewardship organization arises with more complex structures and shared leadership functions as appropriate. Two examples of this emergent multi-group structure are Rochester's Community Technology Assessment Advisory Board and Cincinnati's Health Collaborative.

Note that an advanced Phase 4 effort must have a forum that is viewed by organizations and residents as having the legitimate authority to set priorities and guide the investment of resources. It should have the capacity for joint decision-making that articulates shared goals, and that holds member organizations accountable to strongly shared norms across sectors. The examples presented here illustrate important Phase 4 stewardship structure characteristics, and they may eventually become the overarching stewardship structure for the health system.

Rochester's Community Technology Assessment Advisory Board

In New York's Rochester and Finger Lakes region, which spans nine counties, the Finger Lakes Health Systems Agency (FLHSA) has become the primary convener of healthcare stakeholders in the region. One of the convening organizations it staffs is the Community Technology Assessment Advisory Board (CTAAB). Established in 1993 to augment the healthcare planning process, CTAAB is a neutral table around which healthcare stakeholders can gather and consider if and how potential technology and

capacity expansions align with the community's healthcare needs. CTAAB reflects the diversity of the Rochester community, with members representing the business and insurance communities, consumers, physician groups, health systems, and other community groups. CTAAB provides "an independent, evidence-based appraisal of community need for new or expanded medical services, technology, and major capital expenditures."

Going beyond the widely known "certificate of need" process for evaluating proposals for healthcare facilities, CTAAB's recommendations focus on assessing the need for and efficacy of new medical services, staffing, and technologies, which are among the biggest drivers of healthcare costs around the country. CTAAB advises the payers, the providers, and other interested parties—all of whom come together voluntarily—on the need for, or efficacy of, certain healthcare services and technologies on a community-wide basis. The payers, in turn, may use CTAAB's recommendations in the development of their reimbursement or network adequacy policies.

"The Rochester community has been involved in collaborative planning conversations around health for over half a century," said Albert Blankley, CTAAB's director of research and analytics. "CTAAB's legitimacy as a neutral resource is well established. Our recommendations are heeded because everyone who has a stake in these decisions is together at the table. Everyone agrees that our methodologies are fair and that all applications are given equal weight and decisions are made in the best interests of everyone as a whole."

As a result of its success with CTAAB and health planning, the FLHSA's mission has expanded and it has become a trusted, neutral advisor and convener of several Rochester coalitions focused around multiple health-related topics, including disparities, mental health, Medicaid, and poverty. The FLHSA also is responsible for bringing the community together around a healthcare vision and strategy for the entire region. Further, CTAAB is tackling newer capacity issues, such as pulling together recommendations around whether or not to make available an expensive, new specialty medication for treating Hepatitis C.

Another result: CTAAB is credited with helping to reduce healthcare spending in the region. According to a 2013 news article in the *Albany Times Union*: "A new study finds that the Rochester area has the lowest overall Medicare spending rate in the nation, a feat health officials attribute to aggressive regional planning that keeps a lid on unneeded hospital expansions and technology upgrades that the community ultimately pays for." While CTAAB's recommendations are non-binding, the governor is encouraging replication of the program around the state.

Cincinnati

Cincinnati is home to a number of multi-stakeholder stewardship efforts, including the StrivePartnership, a cradle-to-career collaboration that became an early example of collective impact to improve educational outcomes. A similar collective impact effort, The Health Collaborative, was formed in 1992—a time when the healthcare providers, employers, and health plans were experiencing great tension and conflict over issues related to cost. The organization began as a multi-stakeholder convener and successfully navigated the parties as they emerged from that initial storm. It went on to

become one of the Aligning Forces for Quality communities, delivering cross-sector solutions and health improvement pilot projects to the region.

In 2014, The Health Collaborative launched "Collective Impact on Health," which has convened about 75 local leaders to take accountability for achieving health goals articulated through other collective processes. The group currently is refining strategies and considering how these strategies can be funded sustainably.

And in 2015, The Health Collaborative merged with the Greater Cincinnati Health Council, which convenes 25+ hospitals and 100+ nursing home and primary care providers around sector-specific matters, and HealthBridge, the area's health information exchange. With the merger, Cincinnati has brought together convening, information, and delivery capacity in a way that can more effectively improve population health.

In addition, the separate collective impact initiatives meet regularly, functioning as a learning collaborative, with the support and leadership of the Greater Cincinnati Foundation. The leadership picture in Cincinnati—that of many groups playing distinct roles, coming increasingly together over time—illustrates the kind of structural complexity that is the opportunity and challenge of Phase 4.

Tackling Pitfalls and Building Momentum

While ReThink Health currently is not aware of a region with a fully realized Phase 4 stewardship structure, we see many groups on the verge. And numerous regional structures—like those described here—are embodying important elements of a Phase 4 effort. To help these organizations and efforts feel confident about reaching their ambitious visions for transformed systems of health, we have hypothesized—based on examples of multi-stakeholder regional efforts to transform other systems — important pitfalls that may be encountered once Phase 4 has been reached. These include:

- **Political resistance.** Hard choices need to be made during the redesign phase, especially about competitive relationships, organizational priorities that are out of step with regional needs, capacity issues, and payment models. Resistance to making these choices escalates because all solutions are likely to create winners and losers.
- **Leaders mired in incremental change.** Veteran leaders take very few risks, making only small changes to the status quo. As a consequence, many may lack the vision or the change leadership skills to envision discontinuous change or to build commitment to whole new business models.
- **Successes don't replicate.** Innovative models that have been launched and tested are successful within their context but prove difficult to replicate. At the same time, launching additional projects seems increasingly more exciting and motivating than creating conditions for spread and replication of models that have succeeded.

The consequences of these pitfalls may be that the sharp edges of regional purpose, focus, and strategy are sanded down and leaders return to "safe" topics under the strain of win-lose conditions.

To help overcome these pitfalls, efforts that reach the Redesign Phase may focus on a number of momentum builders to reach a fully transformed system of health in the Integrate Phase (Phase 5), including:

- **Take the long view.** Consider key scenarios beyond the tenure of current leaders. Key leaders, including hospital executives that are willing to say: "I can imagine that, in 25 years, there won't be a hospital in our community" trigger a survival response in others that in turn leads to creative solutions that can only be achieved collaboratively.
- **Address institutional needs.** Recognize and respect the core needs of other organizations and shape the stewardship process to take these into account in collective decision-making. To do this, develop and use a high-quality practice of integrative negotiation, and sustain empathy for the threats to organizational identity and existence that are experienced by members of the stewardship groups.
- **Structure for stewardship.** Design a long-term stewardship structure, including strategies that will result in stewardship groups holding the legitimate authority to establish priorities and hold the effort's feet to the fire about living up to those priorities.
- **Redefine success.** Define success as the uptake and spread of successful discoveries and redesigned models that have been shown to move the system toward the future state. And enhance the capacity for spread and scale of those redesigns that work.

These activities help to re-generate momentum as high-impact redesign innovations demonstrate that a new future is possible.

Looking Ahead

Stewarding the transformation of a regional health system is a complicated and challenging endeavor, regardless of what phase a stewardship group has reached on the Pathway. This is evident in Phases 1, 2, and 3, and becomes even more so during the transition to Phase 4. This is where the "rubber hits the road" in terms of implementing a regional, long-term vision. At this point, stakeholder organizations turn inward and begin the work of redesigning themselves to bring about a vision that spans outside of their organizational boundaries.

"We need an industrial revolution in health and health care in this country," said Dartmouth-Hitchcock's Jim Weinstein. "To have a population health strategy, you have to go beyond the normal business strategy of a healthcare system to be a health system. And until we change the incentives and align things around the patients and communities we serve, we're not going to change the system."

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Case Study Phase 5: Integrate

Regional Efforts Exhibiting Characteristics of the Phase

The Integrate Phase, or Phase 5, of ReThink Health's *Pathway for Transforming Regional Health* is the culmination of many years of visionary leadership, broad collaboration, and systems redesign. The primary work of this phase is integrating lessons learned in prior phases and establishing a "new normal"—a resilient system that is designed to produce health. The work of the Integrate Phase also is about facilitating the institutionalization of successful redesigns, and adapting efforts to changing conditions and ever-heightened aspirations. Reform efforts have reached the Integrate Phase when there are established multi-stakeholder stewardship structure(s) that wield influence and hold authority for setting regional goals, for shaping and monitoring policies, for influencing and directing the allocation of resources, and adjudicating conflicts among groups and organizations. Phase 5 regions feature a broadly representative and well-established stewardship structure and a deeply engaged citizenry.

ReThink Health has not found a Phase 5 effort that currently exists in the United States. We have, however, identified two regional efforts whose stewardship structures—Live Well San Diego, in California; and Whatcom Alliance for Health Advancement in Bellingham, Washington—have established legitimate stewardship authority, a key characteristic of Phase 5 groups. Because the two groups have approached their work differently and, therefore, offer distinct lessons for other regions, we offer both examples here. Legitimacy of stewardship of a Phase 5 effort can be achieved in multiple ways.

Advancing Stewardship

Stewardship efforts in Phase 5 are responsible for identifying priorities and setting goals consistent with the long-term regional vision. They have the right to shape organizational actions consistent with the will of residents. That legitimacy can arise because the convener of the effort already has authority to lead from its position in the region, as in our first example.

Live Well San Diego

In San Diego, public health leaders boiled down their health challenges to three numbers: 3-4-50. They know that three behaviors—no exercise, poor diet, and tobacco use—lead to four diseases—cancer, diabetes, heart disease, and lung disease—that cause more than 50% of deaths among residents. In response, the County Board of Supervisors launched, in 2010, a long-term plan to advance health,

safety, and the overall well-being of residents in the region. The collective impact effort, called Live Well San Diego, involves a wide range of stakeholders—including residents, city and county government agencies, health care, businesses, law enforcement, schools, and community- and faith-based organizations—working together to achieve a shared vision for the region, which they articulate as: "building better health, living safely, and thriving."

Initial planning for the effort began in 2008 within the County's integrated Health and Human Services Agency, which provides a broad range of family-focused, community-based health and social services to promote wellness, self-sufficiency, and a better quality of life for individuals and families. The Agency determined that the government could be an effective driver, convener, and coordinator for the effort. Today, every County department is involved in Live Well San Diego, which derives its authority from being adopted by the elected Board of Supervisors in broad partnership with key constituencies and stakeholders, including city governments, across the region.

According to the Live Well San Diego website: "Achieving this vision has required that the County go beyond what many would consider the typical scope of government. We have had to change the way we do our day-to-day work and redefine the role the entire County team plays as a steward of health, safety, and wellness. County leaders and staff have incorporated Live Well San Diego principles into our daily routines and integrated them into key policies."

Consistent with the characteristics of Phase 5 efforts, the engagement of residents is crucial to the continued success of Live Well San Diego. So much so that formal structures were created to encourage and support resident involvement in decision making and governance as well as in planning, implementing, and leading their own local projects. An example of a formal structure created for residents is the Resident Leadership Academy that helps them take on larger roles within the Live Well San Diego effort, which focuses on four strategic approaches: 1) building a better service delivery system; 2) supporting positive choices; 3) pursuing policy and environmental changes; and 4) improving the culture within.

And consistent with patterns in other countries, Live Well San Diego is an important example in the United States of global budgeting for health and other social services. Global budgeting for all such services allows the region to invest its resources more effectively across many sectors that impact health and well-being of residents.

The Whatcom Alliance for Health Advancement

The Whatcom Alliance for Health Advancement (WAHA), in Bellingham, Washington, derives its legitimate authority more informally: from the credibility and respect it has built over the years as a non-profit deeply engaged with community residents and organizations.

In 2002, the St. Luke's Foundation—now called the Chuckanut Health Foundation—convened more than 200 Whatcom County residents for a Healthcare Access Summit to increase awareness about eroding access to health coverage and care, and to identify potential strategies for developing a community-based response. The result was the creation of the Whatcom Alliance for Healthcare Access, which today is called the Whatcom Alliance for Health Advancement. Governed by a leadership

board that includes citizens and representatives from health care, public health, business, local tribes, and community-based and governmental organizations, WAHA is a backbone organization whose mission is "to connect people to health care and facilitate transformation of the current system into one that improves health, reduces cost and improves the experience of care."

The organization helps residents access all types of health care and other community-based services, and it works hard to engage the community in everything it does. WAHA serves as an authentic community voice on healthcare priorities in the region, always asking when it convenes groups of stakeholders around specific topics, "Do we have the right people at the table?"
Asked whether WAHA's legitimacy is the result of 20+ years of building trusting relationships with community, Elya Moore, WAHA's chief innovation officer, responded: "Collaboration happens at the speed of trust. Trust is essential to achieving anything."

She went on to explain that part of the organization's authenticity also derives from its direct service mission. "We are mission driven, everything else we do is grounded in what we learn from providing direct services to residents. We see for ourselves where the problems are," said Moore. She also identified transparency as critical to success, mentioning that WAHA is now moving into five more counties. "We don't have the same level of trust and connectivity outside of Whatcom County. We need to build that up, be open, and show who we are."

WAHA's role in the region is continuing to evolve as health care evolves, but there will always be a need for a convening organization. "There will always be value," said Moore, "in a neutral convener bringing people together and asking, 'What are we doing now? Where are we going next?' The need for that function will never go away."

Tackling Pitfalls and Building Momentum

As regions aspire toward Phase 5, they become vulnerable to certain pitfalls that are commonly encountered once it is reached, even just partially. These include:

- **Documenting success may be years away**. Progress is hard to demonstrate to a broad audience. The excitement of earlier phases is threatened—improvement in hard outcomes is difficult to prove even though investment of resources and time has been significant.
- **Changing environment**. External conditions shift, making a reevaluation of core strategy necessary, but re-negotiating hard-won agreements and priorities causes strain and disruption.
- **Disengaged stewardship**. A strong staff in the coordinating organization(s) causes key champions and the broader community to disengage from active stewardship.
- **No known models for this phase**. There are no models yet of truly transformed, integrated health systems in the US, which means leaders are forging a new path with few clear models to follow.

The consequences of these pitfalls may be complacency or distraction, which may cause backsliding or failure to solidify hard-learned lessons into lasting stewardship structures and processes.

To help overcome these pitfalls, organizations that reach Phase 5 may pursue a number of momentum builders, including:

- **Share a broad definition of impact**. Focus on impacts outside of health and cost outcome measures—use rituals, ceremonies and awards to celebrate and reinforce a new culture of health and of active involvement by residents.
- **Exercise influence upward and outward.** Leverage successes as well as expanded resources and capacity to work on additional factors affecting the system, including policy. Develop the external influence capacities of the core stewardship team.
- **Ensure a legitimate and authoritative stewardship group**. Sharpen core stewardship functions. Draw clear distinctions among the critical roles of different groups in the stewardship process, and continue to engage the community in shaping the vision.
- **Cast a wider net for inspiration**. In the absence of multiple models from U.S. regions, draw on the lessons and possibilities of transformed, sustainable systems in other contexts, such energy sustainability or the health systems of other countries.

These momentum builders can help create and sustain focused, adaptive, interdependent leadership of a resilient regional health economy.

Looking Ahead

In Phase 5, stewardship groups should provide focused, adaptive, distributed leadership of a resilient regional health economy. Currently, in the U.S., Phase 5 remains an aspiration for even the most innovative and advanced stewardship and stakeholder organizations on the *Pathway for Transforming Regional Health*. It is a goal that ReThink Health firmly believes can and must be achieved.

For more information, visit:

http://www.livewellsd.org/

http://whatcomalliance.org/

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Appendix D

Additional Resources

Additional Resources

On Stewardship and Regional Health Transformation

Catalyst organizations offering stewardship-related resources

County Health Rankings & Roadmaps

- http://www.countyhealthrankings.org/measuring-progress/poised-for-progress – A self-assessment tool focused on the critical skills necessary to create health and enhance community capacity.

Community Toolbox

- http://ctb.ku.edu/en/building-leadership -- Toolkit on building leadership
- http://ctb.ku.edu/en/creating-and-maintaining-partnerships -- Toolkit on creating and maintaining partnerships
- http://ctb.ku.edu/en/improve-organizational-management-and-development -- Toolkit on improving organizational management and development

The Civic Engagement in Action series of the American Democracy project

- http://www.aascu.org/programs/adp/civicagency -- Seminar on working collaboratively across differences, like partisan ideology, faith traditions, income, geography, and ethnicity to address common challenges, solve problems, and create common ground.

The Intersector Project

- http://intersector.com/toolkit/ -- Toolkit to help diagnose, design, implement, and assess successful intersector collaborations.

Society of Organizational Learning

- http://www.solonline.org/?page=CoursesProgram – Programs and workshops on stewardship (requires paid membership to log in).

Catalyst organizations and multi-sector collaborations to transform regional health

Georgia Health Policy Center

- http://ghpc.gsu.edu/our-services/signature-tools/strategic-alignment/ -- Tool that aids in strategic alignment of health policy agendas & investments across institutional & regional/national boundaries.
- http://ghpc.gsu.edu/system-mapping-models/ -- System mapping & models that allow users to see how everything is connected, the feedback loops, and where the boundaries are located.
- http://www.archicollaborative.org/resources.html -- Playbook outlining the priorities included in the Atlanta Transformation scenario.

Institute for Healthcare Improvement

- http://www.ihi.org/education/WebTraining/OnDemand/ImprovementModelIntro/Pages/default.aspx -- Video on creating change that results in improvement; includes the Plan-Do-Study-Act (PDSA)
- http://www.ihi.org/education/WebTraining/Webinars/LeadingQualityImprovement/2016leadingqualityimprovementessentialsformanagers/Pages/default.aspx -- Program for managers on improving organizational capacity and achieving strategic goals.

Kaiser Permanente

- http://share.kaiserpermanente.org/article/dose-creating-measuring-impact/ **-- Toolkit for boosting the impact of community health strategies.**

Kresge Foundation

- http://kresge.org/news/public-health-teams-around-us-chosen-for-projects-help-communities-enhance-leadership - 16-month leadership development program designed to help public health officers and their agencies thrive amid health reform.
- http://www.buildhealthchallenge.org/wp-content/uploads/2015/01/29700_Build_Health_IG_nocrops.pdf -- the BUILD health challenge encourages communities to build partnerships among hospitals and health systems, community-based organizations, local health departments, and others to improve the overall health of local residents.

Moving Health Care Upstream

- http://movinghealthcareupstream.org/ -- A national initiative to accelerate innovations that improve health at the community level.

Network for Regional Healthcare Improvement

- **http://www.nrhi.org --** Improving health and health care in U.S. communities through a network of member Regional Health Improvement Collaboratives.

Stakeholder Health

- **http://stakeholderhealth.org** -- Transforming health through community partnerships.