

Eleven Principles For Creating Health

April 2016



The
Creating Health
Collaborative

Exploring health beyond health care

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Summary

Most countries are struggling to meet the growing demand for care.

The Creating Health Collaborative believes that at the heart of this struggle is our inability to define health as more than just ‘the absence of disease’, a definition derived from the bio-medical model.

When people and communities are asked what makes them *feel* healthy their answers encompass things like safety, physical functioning, financial security, emotional security, nourishing relationships, control over one’s life, and a sense of meaning. Embracing these broader definitions of health – which we call ‘health beyond the lens of health care’ – may make it possible to create it and, in turn, reduce the demand for care.

We are a group of entrepreneurs and intrapreneurs working individually to understand and create health beyond the lens of health care. We share our work and struggles, and collectively work out the principles for this work, as well as the key questions we need to answer next.

This is the report of our July 2015 meeting, entitled ‘Creating Health: Refining The Principles To Catalyze Practice’. The members of the meeting are listed in Appendix 1, the timetable of the meeting is in Appendix 2, and abstracts describing the work of the members are in Appendix 3. By listening to the members share their work and struggles we not only identified new principles (over and above those gleaned from our [July 2014 meeting](#) and in producing our [eBook](#)) but also clarified existing ones.

The refined principles are:

- 1. Embrace An Inclusive Definition Of Community**
- 2. Acknowledge Power Imbalances**
- 3. Share Power**
- 4. Let The Community Define What Matters**
- 5. Measure What Matters**
- 6. Operate At Individual And Community Levels**
- 7. Embrace Complexity**
- 8. Acknowledge That No One Can Do It Alone**
- 9. Accept That It’s Going To Take Time**
- 10. Build The Right Team**
- 11. Search For Sustainability**

Our aim is to catalyze practice. The principles are a list of things to bear in mind when trying to create health beyond the lens of health care. They are not a set of instructions and there is nothing to read into their order. We are aware that the principles share common ground with good processes for community change and systems change. Given that 70% of our health is derived from our social circumstances and the environment, this is not a coincidence. How the principles have evolved is in Appendix 4.



Summary (cont)

The five key questions seemingly common to all were:

- 1. How do we reconceive and describe health as something plural, culture-specific, and not professionally-provided?**
- 2. How does a community see itself as one, including acknowledging shared interests and showing equal respect to all?**
- 3. How do we manage the tension between the health care system's approach to health and residents' understanding of their health?**
- 4. How do we reconcile the differences between reductionist and holistic approaches to measurement in health?**
- 5. And, given the 'local' nature of this work, what does 'scale' mean?**

Our hope is that the refined principles can be leveraged to help more people try to create health beyond the lens of health care. But, as Ollie Smith, a member of the Executive of the Collaborative, shares in his commentary, “we must do better than just producing a list of principles”.

While we hope you enjoy the report what we really hope is that you start trying to do this kind of work. There is no road map; we have to learn by trying. So just start – and if we can help, [let us know](#).

What makes people feel healthy are things like safety, financial security, nourishing relationships, and a sense control over one's life



Introduction

Most countries are struggling to meet the growing demand for care.

We believe that at the heart of this struggle is our inability to define health as more than just ‘the absence of disease’, a definition derived from the bio-medical model, which underpins our current health care system. The system’s dominance of the health debate fails to allow for alternative definitions of health.

When people and communities are asked what makes them *feel* healthy their answers encompass things like safety, physical functioning, financial security, emotional security, nourishing relationships, control over one’s life, and a sense of meaning. Embracing these broader definitions of health – which we call ‘health beyond the lens of health care’ – may make it possible to create it and, in turn, reduce the demand for care.

The [Creating Health Collaborative](#) is a group of entrepreneurs and intrapreneurs working individually to understand and create health beyond the lens of health care. Community members share their experiences and offer each other assistance, whether formally or informally. Collectively, they contribute to developing and promoting new approaches to health and to demonstrating the value of those approaches. The Collaborative is run by an Executive (see below).

At the heart of the Collaborative is the belief that we cannot talk ourselves into a new way of doing, we have to do ourselves into a new way of talking. That’s why our work is all about finding those trying to operate beyond the bio-medical model, asking them to share their work and their struggles, and together working out what the principles for creating ‘health beyond health care’ are – as well as the key questions we need to answer next.

The Executive of the Creating Health Collaborative

Bridget B Kelly, Former Interim Director, Board on Children, Youth, and Families, National Academies of Sciences, Engineering, and Medicine, USA

Jamie Harvie, Executive Director, Institute for a Sustainable Future, USA

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Ollie Smith, Director of Strategy & Innovation, Guy’s and St Thomas’ Charity, UK

Pritpal S Tamber, Founder, The Creating Health Collaborative

Scott Liebman, FDA Regulatory & Compliance Partner, Loeb & Loeb LLP, USA



Introduction (cont)

Refining The Principles

This is the report of our July 2015 meeting, entitled 'Creating Health: Refining The Principles To Catalyze Practice'. The members of the meeting are listed in Appendix 1 and we thank them not only for their participation but also for their courageous work. The meeting – the timetable of which is in Appendix 2 – was framed by the principles we had gleaned by then, largely from our [July 2014 meeting](#) but also from our broader work, including a [series](#) published in *Stanford Social Innovation Review*, which is now an [eBook](#).

Much of what we discussed in July 2014 was on how communities are complex systems making it difficult to apply the kind of linear approaches that predominate in health care. The series/eBook and the discussions at the July 2015 meeting built on that and shifted towards what it really means for communities to have a voice.

By listening to the members share their work and struggles, we not only identified new principles but also clarified existing ones, including unpacking some that were either too broad or too vague. The refined set of principles follow, after which we share the key questions that seemed common to all. Abstracts describing the work of the members are in Appendix 3 and how the principles have evolved is in Appendix 4.

We are aware that the emerging set of principles share common ground with good processes for community change and systems change. Given that 70% of our health is derived from our social circumstances and the environment, this is clearly not a coincidence.

Catalyzing Practice

As the title of our July 2015 meeting makes clear our aim is to catalyze practice. The principles are a list of things to bear in mind when trying to create health beyond the lens of health care. They are not a set of instructions, however, and there is nothing to read into their order.

As part of a [webinar](#) that we held in October 2015, we asked over 1100 leaders in health care, public health, community, and social change what surprised them about the priorities of the communities they serve and what is preventing them from responding to such priorities. We're analyzing their answers to better understand their day-to-day challenges and hence work out how to help them broaden their health-related work so that it encompasses creation, as well as treatment and prevention.

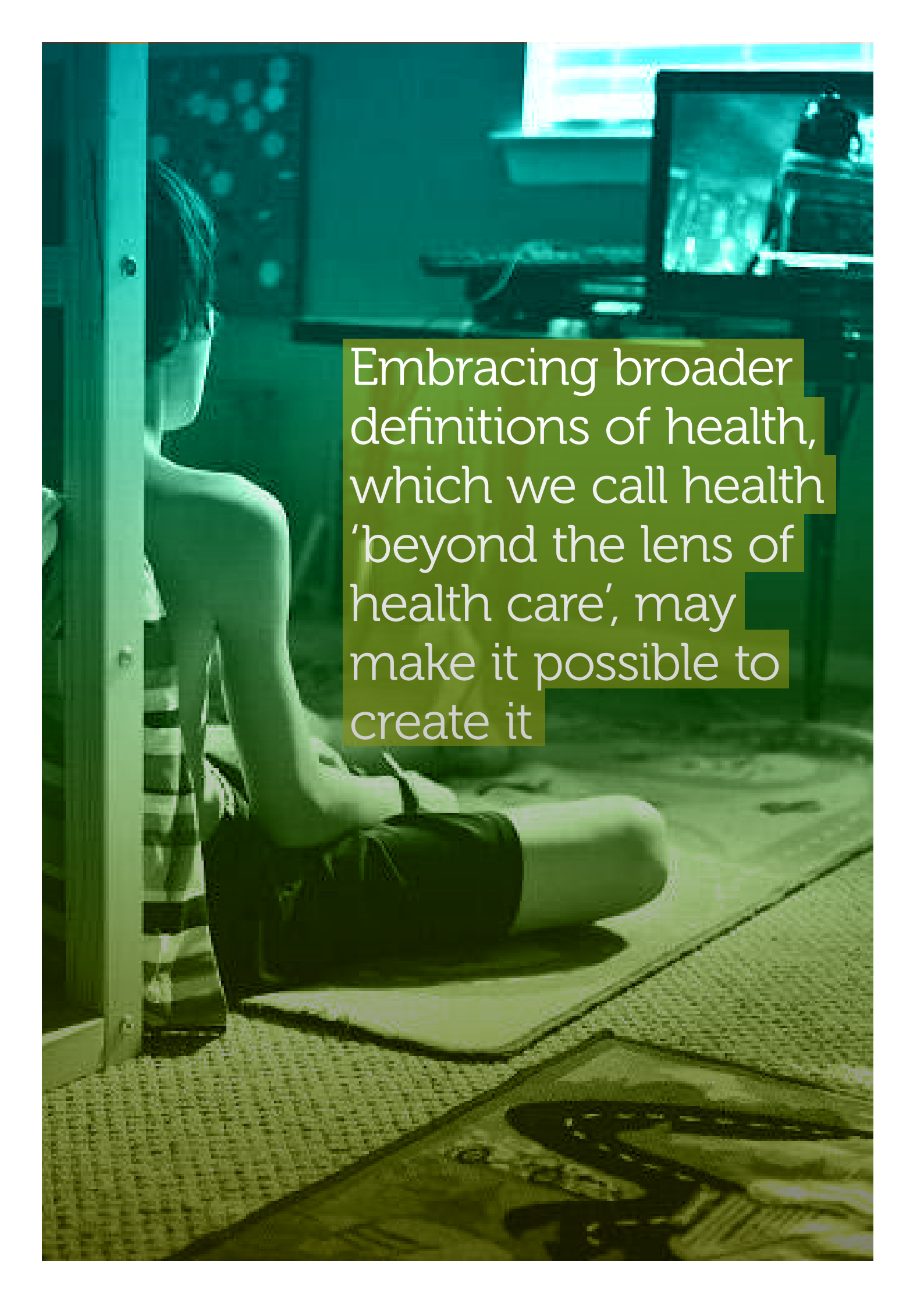
Our hope is that the refined principles, a better understanding of people's day-to-day challenges, and our growing network of entrepreneurs and intrapreneurs can be leveraged to help more people try to create health so as to reduce the demand for care. If we can help, [let us know](#).

Moving Forwards

While the Collaborative is – as the name suggests – a collective effort, we'd like to thank three people who were pivotal to the July 2015 meeting and this report. Scott Liebman was, as ever, a gracious and facilitative host. Lauren A Taylor ensured the agenda pushed our work forwards and took the notes from which this report emanates. And Pritpal S Tamber chaired the meeting as the Founder and driving force behind the Creating Health Collaborative.

While we hope you enjoy the report what we really hope is that you start trying to create health beyond the lens of health care. There is no road map, we have to learn by trying; we have to do ourselves into this new way of thinking.

Just start.

A person is sitting on a yoga mat in a living room, looking out a window. The scene is dimly lit with a teal tint. The person is wearing a dark tank top and shorts. The room contains a television, a window with blinds, and a patterned rug. The text is overlaid on the right side of the image.

Embracing broader definitions of health, which we call health 'beyond the lens of health care', may make it possible to create it

The eleven refined principles for creating health

By listening to the members share their work and struggles we not only identified new principles but also clarified and unpacked existing ones. To read abstracts describing the work of the members of the July 2015 meeting see Appendix 3. To see how the principles have evolved since our [July 2014 meeting](#) see Appendix 4.

Most of these principles share common ground with good processes for community change and systems change. Given that 70% of our health is derived from our social circumstances and the environment, this is not a coincidence. This particular combination of principles has been compiled from the experiences of those trying to operate beyond the bio-medical model and, as such, articulates a framework for creating health beyond the lens of health care.



The eleven refined principles for creating health (cont)

#1 Embrace An Inclusive Definition Of Community

Define community beyond those living in a locality (residents); those that work there and those that provide services to it are also constituents of the 'community'.

The work of the members embraced the idea that about 70% of our health is derived from our social circumstances and the environment (the rest coming from our genes and the health care system). To work in this 70%, however, means to work in communities and yet there was little agreement on how to define 'community'. Those based in the health care system tended towards those with health plans or disease-based understandings of community. There was a general recognition that neither were perfect, especially given the place-based nature of the determinants of health and increasing acceptance of the influence of social networks, which tend to transcend plan membership, disease status, and place.

The one point of agreement, however, was that to see 'community' only as those that live in a locality (residents) was to misrepresent its constituents. Those that work in a locality and those that provide services to its residents are equally important. To influence social circumstances and environment we have to embrace an inclusive definition of the people in a locality, and, in response, those that 'only' work or provide services to that locality have to see themselves as members of the community.

#2 Acknowledge Power Imbalances

Acknowledge the differences in power and influence between constituents of a community, including proactively seeking those usually not heard.

Many of the members witnessed how local conversations about health are dominated by health care and public health, despite their limited impact on health. This domination also tends to crowd out the priorities of the residents they purport to serve.

To have a genuine conversation about community health, members talked about the need to let people express themselves, which often meant understanding local power dynamics. There was a general acceptance that health is political and related to prevailing economic systems; shying away from that uncomfortable reality wasn't an option.

Some members talked about how local residents felt 'blamed' by health care for their poor health, while feeling both isolated and completely unable to affect their social circumstances. Those using techniques like community organizing said they saw a direct and immediate impact on health, even when those efforts were not specifically to improve bio-medical health.

All that said, there was caution from members that sometimes those that come to the table are not necessarily those that need to be at the table and so we should proactively seek to understand the constituents of a community and invite the under-represented into the conversation.



The eleven refined principles for creating health (cont)

#3 Share Power

Share power with all constituents; little is known about how to do this well so experiment, such as with the development of skills and capacities in those usually not heard.

The members described needing to help residents establish a sense of control over their lives. They talked about how social policies, such as racial zoning, impact negatively on whether people feel able to express agency. They also talked about how health care tends to see people as 'subjects' (especially when conducting research) or focuses on what they don't have (their so-called 'deficits'), ultimately reinforcing their role as supplicants. All this often happens while health care and public health claim to be 'co-creating' solutions with residents.

To genuinely share power means to genuinely share decision-making. Some members talked about how they co-own health data with local communities or share opportunities to present at scientific meetings usually reserved for 'professionals'. Others went further and said the need to share decision making was ultimately a need to revitalize democracy, the ultimate expression of agency. They talked about how it is being eroded by unacknowledged – and sometimes intentionally reinforced – power imbalances.

There was some debate on the influence of money when trying to influence social circumstances and the environment to impact health. Investment is clearly needed to do the work but if it comes with an agenda, whether it is the aims of research, the strategic focus of a foundation, or the desire for profit, does that mean the community is effectively working to someone else's agenda? If so, is power genuinely being shared? Likely not, but perhaps it could be, the members debated, with different approaches to finance that attribute returns to the community.

#4 Let The Community Define What Matters

Collaboratively explore and understand what matters to the constituents of the community and agree on what to focus on and how, including the development and implementation of interventions.

Some members talked about how professionals struggled with the consequences of shared power. For instance, when residents say their priorities are “dog shit and street lamps” health professionals tend to interpret that to mean they want cleaner sidewalks/pavements and a greater sense of safety so as to exercise more and tackle the consequences of sedentary lifestyles. This reinterpretation of what residents say is a form of power and needs to be resisted.

Other members talked about how letting residents genuinely participate in local decision-making is less about what they want to achieve and more about them realizing how they can go about achieving it. They saw this realization as an important part of their health. Some members described how, as residents and communities grow in confidence, they increasingly seek solutions locally, rather than believing help has to come from outside.



The eleven refined principles for creating health (cont)

#5 Measure What Matters

Agree what matters and figure out how to measure it (rather than assuming that what can be measured is what matters), including expanding what counts as knowledge.

All of the members talked about the tyranny of targets, metrics, outcomes, data, whatever terms we want to use for measurement. There was a general feeling that how we approach measurement has the potential to either undo or reinforce all the good work of defining community, acknowledging power differences, sharing power, and letting the community define what matters.

At the heart of the challenge seems to be to expand what counts as knowledge. Some members talked about going to residents with a pre-set list of targets only to be told to “go to hell”. They watched residents change the list, almost always making it shorter, although they often retained some of the original. Others talked about creating a process to agree shared measures and how it was often iterative as initial data is gathered. They also talked about how whoever runs the process for agreeing shared measures has to be careful not to introduce their own biases through the process.

The members also talked about the need to tolerate failure, both in figuring out what to measure as much as trying to do what matters. Some of the things that matter to residents and communities can be hard to measure – such as better relationships or feeling well – so there is a need to experiment with measurement as much as intervention. What seemed clear to all members was that, contrary to the general health dialogue, what matters and what should be measured are local and dynamic and we need processes to handle this.

There was a love-hate relationship with economic measures. While some used them to make the case for working differently, such as by showing how the cost of obesity is twice the locality’s budget, others feared that the economic lens reduced people’s lives to solely being about economic growth. Community value was generally considered to be harder to measure than economic value but the members felt it was a problem that needed to be proactively tackled.

#6 Operate At Individual And Community Levels

Operate at the individual and community level at all times (individual agency comes from collective agency and collectively agency is made up of individual agency).

There was only a weak signal for this one amongst the members of the 2015 meeting but it echoed much of what was discussed in the [2014 meeting](#), which at the time we called the community ‘scaffold’.

One member in the 2015 meeting talked about how teaching residents to be more critical of the advice they get from health care professionals gave them confidence but only when they shared their new insights with their peer group. When that happened, they become more vocal, together.

Using a geographic definition of community, some members talked about the need to invest in people and place. If you invest only in people, they’ll eventually move to a better place, effectively impoverishing where they started from. If you invest only in place, there is every chance that the original residents will slowly be squeezed out as new people move in.

In the report of the [2014 meeting](#) we felt that interventions aimed at individuals would always fail if the interconnectedness between people – the ‘scaffold’ – was not also invested in. We advised to bake this understanding into everything that is done so that any intervention aimed at individuals is either matched by an intervention to bolster the ‘scaffold’ or used as a way to better understand the ‘scaffold’.



The eleven refined principles for creating health (cont)

#7 Embrace Complexity

Embrace complexity, including the need to experiment and to learn from emergent outcomes, irrespective of whether they're considered successes or failures.

Having discussed communities as complex systems at length [in 2014](#), this one felt like received wisdom at the 2015 meeting. However, there were some useful further insights.

One member talked about how health care prioritizes a highly replicable process and bristles at unwarranted variations, which is partly why it struggles with the more exploratory nature of operating in complex environments. Another member talked about how these differing world views made it hard for well-meaning professionals in health care to act; their belief in more pre-defined approaches effectively diminished their comfort with real-time experimentation.

Fundamental to working in the context of complexity is to meticulously document everything. Keep a record of what was done, how it was done, and why it was done, including how and why changes were made along the way. The process is essential to understanding and interpreting what succeeded or failed, and why. It is also critical as a means of accountability to the different constituents and stakeholders involved.

In the principles created in [July 2014](#) 'meticulously record processes' was one. However, we now feel it's part of what one would need to do to embrace complexity. We also think it underpins many of the other principles, such as measuring what matters (#5), accepting that it's going to take time (#9), and searching for sustainability (#7). We have removed 'meticulously record processes' as one of the principles.

#8 Acknowledge That No One Can Do It Alone

Acknowledge that our success depends on each other, including embracing group attribution.

Some members talked about how, as professionals in health care organizations, they were increasingly accepting that they have little to no influence over some of the most important determinants of health. They were, however, thinking about how they might 'score' themselves on these determinants, and what the consequences of such scores might be to how they operate.

Another member talked about how the rhetoric on co-creation was always framed around specific outcomes and yet what probably matters more is 'co-ownership of process' so that there is a shared sense of achievement, whether the emergent outcome is deemed positive or negative.

There was a strong sense that residents know what they need but they do not have access to, or influence over, local resources. There was significant debate as to whether the solution was simply to give residents more resources; while some thought yes others felt they'd need assistance on how to marshal such resources. This one was left unresolved, although the solution may well lie in using our more inclusive definition of 'community' (see #1).

Another unresolved topic was whether the health care industry could ever productively participate in attempts to create health beyond health care. There were strong opinions in both directions, all of which were based on experience, likely illustrating the dangers of stereotyping the people in what is a huge and heterogeneous industry.

One member described how difficult the communication between local residents and the local hospital had been. While the residents wanted to engage the hospital, and the hospital wanted to engage the residents, their differing cultures made it hard for them to connect with one another. Residents tend to operate through collaborative networks, often mediated through multiple community-based organizations, whereas the hospital tend to be more hierarchical; this dissonance proved almost impossible to reconcile.



The eleven refined principles for creating health (cont)

#9 Accept That It's Going To Take Time

Accept that it's going to take time, likely 5-10 years, but remember that quick wins can galvanize commitment.

The members were clear that there are no shortcuts; things take time and there's no way around that. Indeed, looking at these principles, it's obvious that operationalizing ideas like sharing power, expanding what counts as knowledge, experimenting and learning from emergent outcomes, and exploring group attribution is not going to happen over night. And yet there was general frustration that observers are looking for quick wins, especially in terms of bio-medical health outcomes.

That said, many members talked about having an over-arching theory of change and then establishing short term milestones, often of a formative nature. Some members called this the 'small wins' approach, a technique designed to create a sense of accomplishment so as to maintain enthusiasm and momentum.

Some members talked about how, although initiatives might not have taken hold in some localities, the process of encouraging communities to "get organized" led to other positive benefits.

#10 Build The Right Team

Build a resilient and generative team to enable this work and accept that, eventually, it must operate at the behest of the community.

This is another one that the members did not explicitly talk about and yet it's clear that 'creating health' is difficult work. As we said in our [2014 report](#), "uncertainty will be the norm, failure will be common, and doubts will surface repeatedly". Team cohesion will likely be an important formative metric.

Perhaps the greatest contribution to this principle was an article in our SSIR-published series, [Cultivating And Sustaining Generative Teams](#). The concluding paragraph reads: "People can make or break initiatives for change. Those looking to create health should work to suspend assumptions, agendas, and bias while engaging with the communities they aim to support. They should ask and deeply listen for both emerging needs and solutions from the community, and then continuously prototype, evaluate, and evolve these solutions together with the community. The resulting generative teams will create a system for learning and innovation that has the potential for great transformation."

One member reinforced this by saying that you fund people, not processes. Another talked about starting with a small group of people and then layering in additional folks as you go. Another talked about finding people for the work who were not resident in the locality, suggesting that this would give them a much-needed neutrality. One member increasingly felt that the key people to influence were wealthy philanthropists because government just wasn't listening to residents.

While most people are yet to start this kind of work, one member talked about the need to find the kind of people who accept that their success would essentially mean they "go out of business" and that such people would more readily find ways to replicate and sustain their work.



The eleven refined principles for creating health (cont)

#11 Search For Sustainability

Search for sustainability, including business model discovery.

The members were well aware of the sharp-tusked elephant in the room – how to sustain initiatives that try to create health beyond the lens of health care, including its financing.

There was general agreement that the economic model for health is too tied to sickness (and its prevention), which limits our ability – and perhaps desire – to understand health more broadly. Parallels were drawn with the industrial food system which, according to some members, has consolidated in such a way that locally-owned, neighborhood stores are rarely viable giving rise to so-called ‘food deserts’.

Some members hypothesized that for-profit companies might find ‘organized communities’ of value, although there was discomfort around the idea that a community was being primed for possible commercial exploitation. It also seemed

hard to find a model for the potential return on investment other than saved health care costs, which, although of value, restricts us to the bio-medical view of health.

One member is building on research that suggests that the more walkable a locality is, the more people want to live there, and hence the greater the value of the real estate. The group discussed how, despite the potential in this approach, there is always the danger that people on low-incomes will no longer be able to afford to live in such areas, which may, in fact, worsen their health.

Not unsurprisingly, there were no off-the-shelf solutions but there was a general acceptance that it’s time to experiment, that philanthropic capital was needed, and that the people behind such capital needed to understand the challenges associated with working in complex systems.



Key questions

By listening to the members share their work and struggles we identified five key questions seemingly common to all as well as some 'other considerations'.

#1

Getting the story right

How do we reconceive and describe health as something plural, culture-specific, and not solely professionally-provided? And how do we do this while also reassuring the current health care system (including public health) that we're in this together? In general, the members were keen to avoid introducing a competitive tone and approach, something that has served health care poorly by generating short-term incentives that are often to our collective long-term disadvantage.

#2

Being genuinely inclusive

What is the process by which a community sees itself as a community, including acknowledging shared interests, and how can it express itself as a community in a way that shows equal respect to all those at the table? Given the health care systems' successes in health how can it be part of a health-focused community endeavor without imposing its values, language and power?

#3

Managing the tension with the bio-medical

Building on #2, how do we manage the tension between the health care system's approach to health (treating the sick and managing risk) and residents' understanding of their health? This implicitly means proactively managing the tension between reductionist and holistic understandings of health, as well as enterprise-level approaches to service delivery versus localism.



Key questions (cont)

#4

Measurement

How do we reconcile the differences between reductionist and holistic approaches to measurement in health? Part of this has to be to establish understanding and respect for complex, rigorous, multiple-method measurement approaches among the many disciplines and sectors who need to be engaged in this work.

#5

Scale, replication, and sustainability

Given the 'local' nature of this work, what does 'scale' mean? The assumption of a one-size-fits-all approach may be 'wrong' but what is 'right' and how do we garner sufficient runway to find out? Is replication a form of scaling and, if so, can it be potentiated by how programs are structured and delivered? And is it possible to find long-term capital willing to fuel experimentation and business model discovery, whether that means tweaking the models in existing industries or finding new models specifically for creating health beyond the lens of health care?

Other considerations

How do we balance the need for longer-range work designed to discover new approaches and business models while reporting on shorter-range milestones that can galvanize commitment but have the potential to be distracting? A corollary to that is how do we acknowledge locally-specific crises, such as violence and poverty, without being distracted from the longer-range aims? The same question would apply to political ideologies, such as income inequality; is it possible to focus on the longer-range aims without being distracted by global political issues?



It'll take more than a list to climb this mountain

A COMMENTARY BY OLLIE SMITH

Director of Strategy and Innovation, Guy's and St Thomas' Charity
Member of the Executive of the Creating Health Collaborative

Reading through the principles and questions that arose from our 2015 meeting I am reminded of that moment on a hike when you reach what you think is the peak of the hill only to see the rest of the mountain loom large over you. It's a moment of brief elation swiftly followed by disappointment and then, with luck, steely determination to carry on. As I take advantage of this reflective moment I find myself wondering how helpful our efforts are to those who seek to follow us. We are, after all, hoping to catalyze practice.

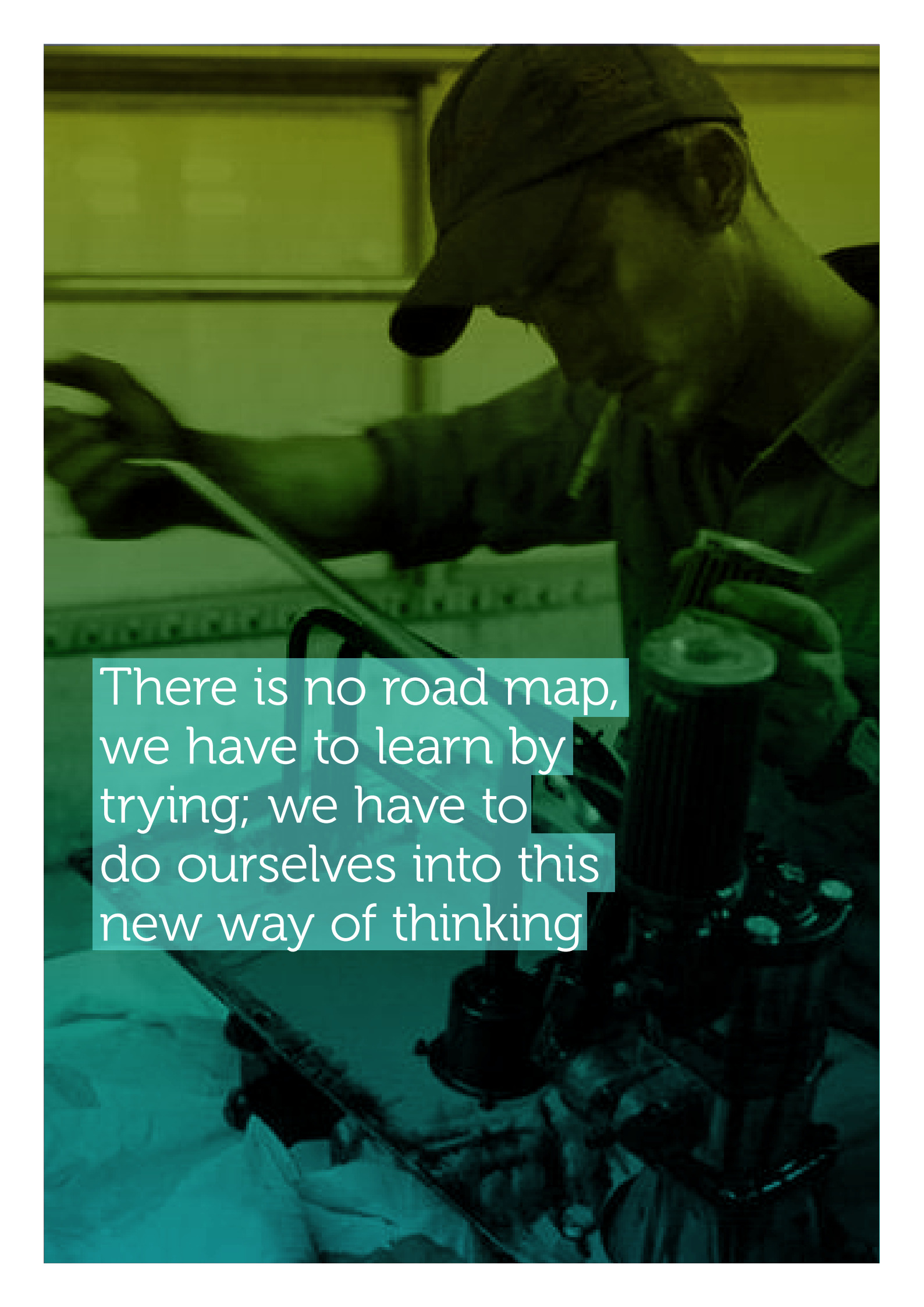
Since our 2015 meeting I have commissioned, on behalf of Guy's and St Thomas' Charity of which I am Director of Strategy and Innovation, an assessment of what a programme to enable communities to create health might look like. This work is being delivered by Pritpal S Tamber, the Founder of the Collaborative, and as part of it, I asked him to find UK-based entrepreneurs and intrapreneurs to attend an event in London inspired by our meetings. The Charity hosted the event in mid-December 2015 and the aim was to share, learn, and work out how to apply our shared experiences in the service of communities.

As part of briefing for the event, the participants were given the emerging principles for creating health as developed by the Collaborative at our [July 2014 meeting](#). The discussion was rich and wide-ranging. We covered similar ground in London to

the discussions in New York that led to this report; the challenges of language, evaluation, and balancing citizen versus professional leadership. But could I honestly say that sharing the principles sped up or facilitated the conversation? No, I could not.

This isn't an easy thing to admit but just refining principles, as was done at the 2015 meeting and shared in this report, is not going to be enough to catalyze practice. Knowing that some group has generated a list of things to bear in mind when trying to create health beyond the lens of health care doesn't mean that people will follow. My hypothesis for this is that everyone has to start the journey – from bio-medical health to community-defined health – in their own way, airing their own prejudices and hang-ups and arguing about meaning until a common language, understanding, and resolve is reached.

This is one of my struggles and something that I'll share at our 2016 meeting. It's all very well us declaring a principle that "it's going to take time" but I would like us to aim to reduce that time. As a Collaborative we know that we must do better than just producing a list of principles. In our steely determination to climb the mountain we mustn't forget our duty to make the journey easier for all those who are only just starting.

A person wearing a dark cap and a dark jacket is working with a large, complex industrial machine. The person is holding a long, thin rod or pipe that is part of the machine. The machine has various components, including a large cylindrical part and a smaller cylindrical part. The background is a plain, light-colored wall. The entire image is overlaid with a teal gradient, and a semi-transparent teal box contains white text.

There is no road map,
we have to learn by
trying; we have to
do ourselves into this
new way of thinking

Appendix 1: The members of the meeting



Bridget Kelly



David Citrin



Elizabeth Slade



Lauren A Taylor



Leigh Carroll



Marvin Avilez



Prabhjot Singh



Pritpal S Tamber



Scott Liebman

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Catalina Denman
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Prabhjot Singh
Director, Arnhold Global
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Pritpal S Tamber
Founder, The Creating
Health Collaborative

Scott Liebman
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Compliance Partner, Loeb
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Thomas Kottke
Medical Director For
Population Health,
HealthPartners, USA

Tony Barrueta
SVP, Government
Relations, Kaiser
Foundation Health Plan,
USA



Appendix 2: The timetable of the meeting

Thursday July 16th, 2015

12.00 noon	-	12:45 pm	Arrival and buffet lunch	Please arrive on time to meet your colleagues
12:45 pm	-	13:30 pm	Introduction	- Greeting from Scott, our host - Logistics from Lauren - Two line bios from all - Framing from Pritpal
1.30 pm	-	2.30 pm	Session 1: Incubating the idea of change (part 1)	- Thomas Kottke - Ollie Smith
2.30 pm	-	3.00 pm	Break	Kindly provided by Loeb & Loeb LLC
3.00 pm	-	4.30 pm	Session 2: Learning from each other (part 1)	- Anthony Iton - Catalina Denman - Margaret Aimer
4.30 pm	-	5.00 pm	Break	Kindly provided by Loeb & Loeb LLC
5.00 pm	-	6.00 pm	Session 3: Learning from each other (part 2)	- Marvin Avilez - Maggie Super Church
6.00 pm	-	7.00 pm	Retire to hotels	
7.00 pm	-	7.30 pm	Reconvene for dinner	The Sea Fire Grill
7.30 pm	-	9.30 pm	Dinner	Kindly provided by Loeb & Loeb LLC

Friday July 17th, 2015

8.00 am	-	8.30 am	Breakfast	Kindly provided by Loeb & Loeb LLC
08:30	-	08:45	Easing into the day	- Jamie Harvie to facilitate
08:45	-	10:15	Session 4: Learning from the broader landscape	- Jeff Cohen - David Zuckerman - Alina Baciu
10:15	-	10:45	Break	Kindly provided by Loeb & Loeb LLC
10:45	-	11:45	Session 5: Learning from each other (part 3)	- Mark L Wieland - Onil Bhattacharyya
11:45	-	12:30	Where do we go from here?	- Bridget Kelly to facilitate
12:30	-	13:15	Lunch including photographs	Kindly provided by Loeb & Loeb LLC
13:15	-	14:45	Session 6: Incubating the idea of change (part 2)	- Prabhjot Singh - Tony Barraeta - Jamie Harvie
14:45	-	15:15	Break	Kindly provided by Loeb & Loeb LLC
15:15	-	16:45	Session 7: Wrapping up	- Jeff Cohen to facilitate

Appendix 3: Abstracts from the presenters

SESSION 1: Incubating The Idea Of Change (Part 1)

TOM KOTTKE

Medical Director for Population Health, HealthPartners, Minneapolis, MN, USA



In order to focus our initiatives where they can have the greatest impact, we at HealthPartners have developed summary measures of health and well-being for adults. These measures comprise two components of health – current health and prospects for future health – and one component of subjective well-being.

Our measure of current health is disability-adjusted life years (DALYs). DALYs comprise years of potential life lost (YLL) to death and years lived with disability (YLD). Prospects for future health comprises member/patient reports of six behaviors associated with health – tobacco use, diet, physical activity, alcohol use, sleep patterns, and healthy thinking – plus an estimated probability that the member/patient is up to date with their indicated clinical preventive services.

Our measure of subjective well-being is ‘life satisfaction’ but since 2015 we have also collected survey data about meaning and purpose and six domains of subjective well-being: emotional/mental,

physical, career, financial, social/interpersonal, and community. We survey stratified random samples of 1,400 adults per month. While the current survey is limited to English, we plan to translate it into Spanish, Somali, Hmong, and Vietnamese.

We will use the [County Health Rankings framework](#) to assess the elements in the social, economic and physical environment that affect health and well-being. The social and economic factors that we will assess will include high school graduation rates and rates of individuals with some college education; unemployment rates; percent of children who live in poverty; adequacy of social support; children in single-parent households; violent crime rates; and, rates of deaths from injury. The physical environment elements that we will assess will include stability and quality of housing; time spent commuting to work and whether commuting alone; air pollution; and, drinking water violations. Our data sources will be a combination of surveys and administrative data. When possible, we will align our metrics with the recommendations of the report Vital Signs: Core Metrics for Health and Health Care Progress (National Academies of Sciences, Engineering, and Medicine, 2015)..

While the above program description only applies to adults, we plan to develop summary measures of health and well-being for infants, children and adolescents over the next 3 to 5 years.

Our key concerns relate to survey response rates and we are testing several survey strategies. This concern applies both to our members/patients who do not speak English and to native English speakers. We are also thinking about whether and how we measure the impact of our work in those places where we do not have direct influence, such as transportation and housing, how we assess well-being in people whose world view differs from English-speaking Americans, and how to communicate our metrics with various stakeholders.

Visit our [web site](#) to learn more about our work.

Appendix 3: Abstracts from the presenters (cont)

OLLIE SMITH

Director of Strategy & Innovation, Guys and St Thomas' Charity, UK



[Guy's and St Thomas' Charity](#) (GSTC) is an independent charitable foundation that is committed to radical innovation in health and health care for the people living in two boroughs of South London, Lambeth and Southwark. We've been around since the 16th century, and in that time we've largely supported the local hospitals with whom we share our name.

Just as the hospitals have changed dramatically in the past 500 years, so has GSTC. Our current strategy seeks to work beyond the hospitals' walls, supporting projects that are community-focused and that bring together many different elements of health. As a result, we're in the early stages of developing our own community-led health programme to sit alongside our support for the hospitals.

Our journey to considering a community-led programme began by undertaking a small piece of [public insight research](#) that sought to understand what people prioritize in their lives and how health relates to that. Results showed that people wanted a fulfilling life that is financially secure and includes nourishing relationships.

The research also demonstrated that discussions about health can quickly elide into a focus on avoiding illness. To some extent, this is understandable; illness, or fear of it, can have such a dramatic impact on life that avoiding or treating it can become a person's sole focus. However, this propensity to conflate health and avoiding illness can dominate thinking and lead to services that, while valuable, neglect what people truly prioritize—a fulfilling life, with prevention of ill-health and care as means to it.

We joined the Creating Health Collaborative to understand how others were approaching this issue. At the last meeting we brought three challenges to the table that we were wrestling with:

1. How big should our scope be? In focusing on a fulfilling life is there a danger that we try to do too much?
2. How can we introduce our existing health care partners into this work without undermining what is different about it?
3. Given that the Charity does not provide ongoing funding, is it possible to exit such a programme and have the benefits sustain?

Following the 2015 meeting we commissioned further work to help us to answer these, and other questions, and to propose what a GSTC-funded community-led health programme might look like. This work will be completed soon and we look forward to sharing it.

Appendix 3: Abstracts from the presenters (cont)

SESSION 2: Learning From Each Other (Part 1)

ANTHONY ITON

Senior Vice President for Healthy Communities,
The California Endowment, USA



The California Endowment's [Building Healthy Communities](#) (BHC) Initiative is a ten year, billion dollar, 14-site, place-based, health improvement effort targeting comprehensive local and statewide policy and systems change. BHC is based on the recognition that the legacy of racial and economic segregation, anti-immigrant policy, and a host of other historical “isms” has left many California residents mired in environments that conspire to injure their health. These environments lack basic health protective amenities like grocery stores and decent schools. Community residents must navigate multiple risks without the benefit of significant health protective resources. These neighborhood environments are manmade, and can be unmade.

BHC enlists the very residents who have been excluded, stigmatized, and discriminated against in holding local, regional and state systems accountable for creating healthy and equitable community environments. The BHC theory of change is about

building community capacity (increasing social, political and economic power and changing the narrative about health), to change policy and systems, in order to create healthy environments, that will (over time) improve health status. The targeted policy and systems change is multi-level: local, regional, and statewide.

Fresno, California, is one of the 14 sites. City residents in the north part of town have access to five times as much parkland per resident than do residents of the south. Parks not only provide places to exercise and play, they are community gathering spaces where local issues are discussed and advocates are born. In 2013, local BHC partners secured the City of Fresno's commitment to develop a Parks Master Plan. However, the city continually delayed the plan update. To create urgency, in 2015 BHC partners attempted to purchase city bus wraps highlighting the park inequity. City officials rejected the BHC's ad, calling them too “political”, a move that BHC partners publicized through press conferences, ultimately garnering more exposure than the ads would have had on their own. The residents' voices were heard and the City is now putting the planning process in motion. More enduring than this win is the shift in the City's power structure, laying the groundwork for deeper success moving forward.

One of the challenges we face is telling our story. We must make order out of a complex effort in a way that inspires others, allows them to see themselves in the work, and motivates them to replicate it. Another challenge is ensuring the gains are sustained; this includes everything from laser focusing investments in those key capacities necessary for building community power to successfully transition from foundation to community-ownership.

Appendix 3: Abstracts from the presenters (cont)

CATALINA A. DENMAN

Profesora-Investigadora, Center for Health Promotion in Northern Mexico, Mexico



[Meta Salud](#) is a prevention program for non-communicable disease (NCD) implemented at the community level by community health workers (CHW). It was developed by the Center for Health Promotion in Northern Mexico at El Colegio de Sonora in Mexico with the University of Arizona. It involves thirteen sessions on individual health goals, group and team activities and physical activity, as well as informational sessions and critical thinking. The sessions are led by a CHW.

The program is based on knowledge about how people change, strategies to develop solidarity, gender perspectives and health, and the idea of salutogenesis, which focuses on the genesis of health and the sense of coherence (SOC). The overall idea is to move towards the creation of healthy individuals in healthy societies rather than focus solely on disease and risk factors.

The sense of coherence framework posits that when confronted with a stressor the individual or group with a strong SOC will: wish to, or will be motivated to, cope; believe that the stress or challenge is understood; and believe that resources to cope are available. Overall, our purpose is to develop ways in our programs to strengthen the individual and collective SOC.

We do this by: recognizing the internal and external resources people have for creating health; identifying how we care for ourselves and how we manage health care when we are not in optimum health; identifying the people of our families and community with resources to care for health; developing exercises to increase a sense of control, empowerment, self-esteem and exercises to create communicational skills; and advancing critical thinking to understand the meaning of personal experiences about health and health care and the resources at hand.

All the exercises in the program progress from simple to complex so to help people achieve a sense of control and meaningfulness and include motivational strategies to validate and affirm feelings and promote positive social interaction and strengthen family, cultural and community ties.

The main challenges we face are creating opportunities for community activities while individual survival and defense against violence places great pressure on people's lives; dealing with the constant crisis between chronic disease care and infectious disease; and the economy.

Appendix 3: Abstracts from the presenters (cont)

MARGARET AIMER

Development and Delivery Lead, Ko Awatea Health System Innovation and Improvement, Counties Manukau Health, New Zealand



Ko Awatea is a health innovation and improvement center within Counties Manukau Health (CMH), one of 20 district health boards that provide and fund public health services to New Zealand's population of 4.5 million people.

CMH serves a district of over 500,000 people living in urban and rural South Auckland. It is a district marked by rapid growth and high levels of social deprivation, with high numbers of Maori and Pacific peoples as well as Asian immigrants. Our district faces all the challenges familiar to public health providers in the developed world; high demand on hospital and specialist services that is not sustainable with the money available.

In thinking about how to address these challenges Ko Awatea's Director, Jonathon Gray, considered how the approach to change used in social and political movements, as taught by Marshall Ganz, might be applied to health. In other words, could we "organize" a population group to develop their own agency and take action to create health and keep themselves well?

Alexandra Nicholas and Margaret Aimer were trained in the practices of organizing and began to develop a campaign to put this theory into action. Alexandra started by recruiting a youth leadership team of five who initially launched a listening campaign to hear from Pacific youth across South Auckland about what mattered to them regarding their own mental health and wellbeing.

Youth described the pressure of 'living in two worlds' – one steeped in their faith, family and culture and the other influenced by opposing western values – which became the focus for the campaign. They named it 'Handle the Jandal' with the aim of building youth resilience to handle the pressures of living in these two worlds. Jandal is a slang term for a sandal or flip-flop, often used by parents of that community to discipline their children.

Over the next two years they engaged over 1000 Pacific youth, families, and community members in leadership action through youth trainings, a 'snowflake' team structure, and delivering a host of local youth-led community meetings and workshops providing practical skills to deal with distress. They also launched 3 sub-campaigns addressing Pacific youth tertiary education, bullying, and parent-youth relationships.

Our future challenges are:

1. Relationships – Outcomes tension: how do we build community engagement while also efficiently meeting organizational expectations?
2. Insider – Outsider tension: how can we strategically include other sectors to help us move towards our goal without losing youth ownership?
3. Long term – Short term tension: how do we tackle the more entrenched problems in our communities while also achieving early wins?

For further detail see our July 2015 paper in [Australasian Psychiatry](#) entitled, 'An Innovative Community Organizing Campaign To Improve Mental Health And Wellbeing Among Pacific Island Youth In South Auckland, New Zealand', [as well as our website](#).

Appendix 3: Abstracts from the presenters (cont)

SESSION 3: Learning From Each Other (Part 2)

MAGGIE SUPER CHURCH

Community Development and Sustainability Consultant,
Conservation Law Foundation, USA



Health outcomes – traditionally a concern of public health practitioners and policy makers – have begun to attract the interest of impact investors, who are recognizing that when it comes to health, your zip matters more than your genetic code. In Boston, Massachusetts, where life expectancy between census tracts varies by as much as 33 years, two organizations have teamed up to build a new investment fund aimed at addressing the place-based drivers of health. The [Healthy Neighborhoods Equity Fund](#) (HNEF), sponsored by the Conservation Law Foundation (CLF) and Massachusetts Housing Investment Corporation (MHIC) is a \$30million private equity fund investing in the building blocks of healthy neighborhoods.

The Fund makes long-term equity investments in large-scale housing and commercial projects near transit that contribute to safe, walkable, and connected communities.

HNEF has a [blended capital stack](#) that includes public, philanthropic, and private investors.

The public funds, which do not have any return requirements, make up 7% of the fund size (Class C). Philanthropic investments, including guarantees and Program-Related Investments (PRIs), make up 16% of the fund size and have modest return expectations (Class B). Together, the Class C and B investors provide substantial risk protection for Class A investors who make up the balance of the fund size and earn a higher rate of return.

HNEF also considers the community, environmental, and health benefits of potential projects, with a focus on neighborhoods in the early to mid-stages of transformational change where the market has not yet proven itself. As part of the investment review process, CLF uses a detailed scorecard that integrates over fifty quantitative and qualitative measures including demographics, community conditions, health outcomes, and project characteristics to evaluate the need and the opportunity for healthy development, and quantify the expected impact of the project. The scorecard also provides baseline data for monitoring a range of outcomes over the life of the investment. Unlike Social Impact Bonds, however, the payback to HNEF investors is not contingent on achieving a single pre-defined success measure.

As a proof-of-concept fund, HNEF has been a learning process for Fund sponsors, investors, and developers. We are continuing to explore a number of key questions, including the type of data and evidence that are needed to drive greater investment in healthy communities and the core principles that should guide place-based investments in health.

Appendix 3: Abstracts from the presenters (cont)

SESSION 4: Learning From The Broader Landscape

JEFF COHEN

Managing Director, FSG, USA



Some communities seeking to create health have chosen to do so through a structured collaborative process known as collective impact. FSG [defines collective impact](#) as “long-term commitments by a group of important actors from different sectors to a common agenda for solving a specific social problem.” The term “collective impact” has gained currency in the past few years, and many communities have put some elements of collective impact into place, but the efforts that have been most effective have committed to all five elements of the approach: a common agenda; shared measurement; mutually reinforcing activities; continuous communication; and, backbone support.

FSG supports collective impact initiatives around the world in a number of ways, including short-term technical assistance, serving as an interim backbone until a permanent backbone organization is established, and managing a learning community for practitioners. Through both direct support and research, we’ve seen the approach applied to many different types of complex social challenges, from cleaning up a river’s catchment basin to improving nutrition in developing countries.

Some collective impact efforts have attained remarkable success, but, as the approach gains favor, one of the biggest challenges that practitioners confront is how to make an initiative sustainable. To try to gain some insight into what allows a collective impact effort to be sustained we looked at some initiatives that have lasted more than four years to glean the characteristics that seem to favor sustainability:

- 1. Institutional adaptability:**
 - a. For funders, this means flexibility to work outside of traditional grant cycles and established processes
 - b. For all participants, this entails a willingness to learn new skill sets required, including partnering, facilitation, communication, community engagement, and convening
- 2. Culture shifts:**
 - a. Participants show comfort with uncertainty and have the adaptability required for co-creation of strategy, ongoing learning orientation, and openness to shifting strategy as the context and community needs change
 - b. Participants are aware of, and are able to openly acknowledge and navigate, power dynamics among various stakeholders
- 3. A long-term orientation:**
 - a. There is a general understanding amongst participants of the timespan required for systemic change and the need to make a long-term commitment
 - b. Participants are increasingly comfortable with the idea of shifting to contribution rather than attribution as part of achieving progress
 - c. Participants are comfortable with measuring progress using interim milestones and process measures

This is a very preliminary set of observations based on the small sample we analyzed for the 2015 meeting of the Creating Health Collaborative. We continue to learn and share our insights through our [webpage on collective impact](#) and the [Collective Impact Forum](#).

Appendix 3: Abstracts from the presenters (cont)

DAVID ZUCKERMAN

Manager, Healthcare Engagement, Anchor Institution Initiative, The Democracy Collaborative, USA



A non-profit founded in 1999, The Democracy Collaborative is a national leader in community wealth building and works to create a new economy anchored in democratic ownership, to generate inclusive and equitable outcomes, foster ecological sustainability, and promote flourishing democracy and community life.

[Community wealth building](#) is an inclusive, placed-based approach to economic development that focuses on leveraging existing assets to expand community ownership for under-served residents. The Democracy Collaborative seeks to change the paradigm of economic development in the United States by encouraging anchor institutions — nonprofit and public employers, such as hospitals, universities, community foundations, and local governments — to adopt community wealth building practices to support their local economies.

To achieve these goals, the Collaborative sustains a wide range of advisory, research and field building activities designed to transform the practice of community economic development in the United States. It has significant experience convening cross-sector stakeholders, such as nonprofits, public sector, financial institutions, healthcare institutions, and philanthropy, and has published extensive research on the role of many of these sectors in community wealth building. The Collaborative also hosts the [Next System Project](#), intellectual work designed to connect community wealth building to the larger context of systemic economic transformation.

This work has many challenges. As we all work to improve the economic, social and physical health and well-being of low-income communities, how do we create the conditions to allow individuals to flourish and thrive? Some important questions we're considering are:

1. Can building community capacity be scaled? How do we go from project-ism to system change?
2. What is the role of healthcare and philanthropy in tackling income inequality in the United States? If they have a role, are they capable of succeeding?
3. If we cannot reduce income inequality and eliminate poverty, can communities and individuals flourish?

Appendix 3: Abstracts from the presenters (cont)

ALINA BACIU

Senior Program Officer, Board on Population Health and Public Health Practice, National Academies of Sciences, Engineering, and Medicine, USA



The [Roundtable on Population Health Improvement](#) brings together stakeholders from a range of sectors and perspectives to discuss, showcase, and catalyze action related to the multiple factors that influence the public's health. The Roundtable's work propagates key concepts, and identifies and shares important strategies, case studies, evidence, and good practices related to metrics, relationships, resources, research, policy, and communication.

As part of their activities, Roundtable members have examined the meaning of community and of social movements, and have engaged in public dialogue on these topics with multiple stakeholders. The Roundtable has learned that communities are resourceful, knowledgeable, and powerful. Its members have reflected on examples and lessons from the environmental justice movement, faith-driven community organizing, and young community organizers.

Themes that surfaced at the Roundtable's public workshops included techniques for community organizing, relationship-building to address historic asymmetries of power, deliberate policies of exclusion (in finance, land use, and employment), the need for both treetops and grassroots engagement, that a movement cannot be from above, and the need for infrastructure for sustained movement that is not merely grant-driven, and for building organizations, not merely mobilizing.

One of the recurrent themes is the idea of "community readiness"—a community's ability to launch a program of health improvement. There is general recognition that it requires some infrastructure and capacity, such as an integrator or backbone organization, and a leader, so a central question seems to be "how do we help the most disadvantaged communities get to 'ready'?" Other questions that have emerged include who are the members of a community—is it the residents alone, or also organizations and businesses operating in the community? Also, what does it mean to view communities as full partners (e.g., with researchers, business, health care providers) and not merely as consumers, patients, service recipients?

While we consider these questions, we also ask questions of our own work that include:

Given where the Roundtable is situated, how could it engage at the community level so as to complement the academic dialogue with community perspectives and real-life local applications and meaning? How could the Roundtable interface with the community, which is not the typical audience for Academies' work?

Appendix 3: Abstracts from the presenters (cont)

SESSION 5: Learning From Each Other (Part 3)

MARK WIELAND

Assistant Professor of Medicine, Primary Care Internal Medicine, Mayo Clinic, USA



[Rochester Healthy Community Partnership](#) aims to promote healthy living for every member of the Rochester, MN, community through community-based participatory research (CBPR), education, and civic engagement. A key challenge to this work is that the existing funding environment requires community health interventions to walk the line between being bio-medical by name and social by structure.

Socially-structured community health interventions, such as forming authentic partnerships, require the ability to respond to emergent ideas, sometimes with major conceptual pivots, which can be stifled by traditional funding requirements that are reductionist and linear in nature. It requires innovative thinking by community-academic partnerships to sustain momentum while maintaining the focus on processes necessary for the emergence of health.

CBPR gets at the inherent complexity of this work, through participatory intervention development and co-creation of health, in a way that the traditional reductionist approach cannot.

Through our research we have funded partnership that has led to: a community response to the disruption of active tuberculosis among socially marginalized groups, culminating in an effective, sustainable, community-owned TB prevention and control program; co-creation of a childhood obesity prevention program among at-risk youth in after-school programs; digital storytelling for chronic disease management among immigrants and refugees as a mechanism for community informing healthcare practice (rather than the other way around); and, through community-led work, the attenuation of risk of cardiovascular disease among immigrants and refugee families in Minnesota who are living in poverty.

As co-lead of this partnership, I observe community and academic partners grapple with maintaining momentum in the context of rigid funding requirements. There is acknowledgment of the power of data to impact social change but there is also a tension between the pace of research versus the pace of social action. This tension extends to the range of metrics that define success for funding agencies versus those that speak to community partners.

I also observe tremendous opportunities for communities engaged in health creation through research. This engagement underpins whether and how the success of the partnership leads to sustainable change. Likewise, authentic partnerships have greater potential to promote wider dissemination of community health interventions and lead to policy change.

Appendix 3: Abstracts from the presenters (cont)

ONIL BHATTACHARYYA

Frigon Blau Chair in Family Medicine Research, Women's College Hospital, Canada



Developing novel approaches for communities to create health will require robust approaches to managing uncertainty. Testing risky but promising ideas is challenging for small, tightly knit groups like a startup company. A successful venture usually starts with a peak of inflated expectations when they launch, a trough of disillusionment when initial approaches fail to work, followed by a series of pivots (changes in the product/service or the target group) until they find a fit between a product and a market. Navigating this journey for innovations that involve multiple stakeholders with varying interests and levels of engagement is much more challenging.

As co-lead of an incubator for new models of care at the University of Toronto called “Building Bridges to Integrate Care”, or BRIDGES, I observed this process first-hand several times. Though health service design is more straightforward than communities creating health, many of the challenges are similar.

While many groups in the incubator had difficulty changing course based on early findings, one project, called “Seamless Care Optimizing the Patient Experience”, was particularly agile. It was a partnership between several hospitals, a family practice and a community service agency, all of which were funded and operated separately. The program provided lone general practitioners (GP) direct telephone access to internal medicine specialists, nurse navigators and community case managers in order to reduce emergency department (ED) visits from their patients.

Based on early data showing many patients went straight to the ED, the group attempted to target patients directly but then abandoned this because of limited effect. They found that use by physician was highly variable, but individual docs fell into stable patterns of use by 10 weeks, so they shifted from an intensive focus on 30 doctors with high volumes of ED visits to low-intensity engagement with 120 GPs. Lastly, initial results failed to show a reduction in ED visits, but the service appeared to have a range of other benefits, and many specialty groups approached the team to offer their services. This prompted a shift from targeting a fixed group of doctors with a fixed set of services, to a platform that could easily add GPs and specialty services.

At each step, it became easier to collect and present compelling data, and the steering committee was more willing to consider the implications and make a change. The service is growing and the evaluation is still ongoing, but it is getting closer to matching their service to a public need. When funding projects with uncertain benefits, the funder needs to not only be open to grantees changing their approach based on early findings but also develop the trust and insight to be able to encourage them to do so.

Appendix 3: Abstracts from the presenters (cont)

SESSION 6: Incubating The Idea Of Change (Part 2)

TONY BARRUETA

SVP, Government Relations, Kaiser Permanente, USA



One of America's leading health care organizations, Kaiser Permanente (KP), is obligated as charitable, tax-exempt hospital and health plan to benefit society as a whole, and not only its enrolled population. KP's own mission – to provide high quality, affordable health care services and to improve the health of its members and the communities it serves – reflects and underscores this longstanding requirement.

The more recent Affordable Care Act also requires charitable hospital organizations to conduct community health needs assessments (CHNAs) to help ensure that community benefit activities are targeted at the greatest community needs.

Together, these provisions, generally beneficial and well intentioned, carry one notable disadvantage – by narrowing the definition of charitable activities and formalizing community health needs and planning, “community benefit” may come to be understood as a discrete and specialized field.

A nonprofit organization with the economic scope of Kaiser Permanente – the largest private employer in California, and a significant institution in its other localities – has an opportunity to leverage all its operations in advancing community health and community development. As an example, our Southern California regional leadership has posed a simple (and yet profound) question – if 4% of the organization's economic activity is allocated explicitly to community benefit, how much more powerful can the effect be if we are purposeful with the other 96%?

KP is working towards integrating business practices and community activism, and in Southern California this effort is referred to as CULTIVATE. The goal is to inspire the organization to fully realize Kaiser Permanente's mission of improving health in its communities. CULTIVATE seeks to find the intersection of good business and community strength – being responsive to market demands while at the same time improving the social, economic, and environmental conditions that drive health by clarifying that Kaiser Permanente is a critical part of the communities it serves.

Appendix 3: Abstracts from the presenters (cont)

JAMIE HARVIE

Executive Director, Institute for a Sustainable Future, USA



[Commons Health](#) is a connector and facilitator of place-based health creation models. We think of health creation as promoting and enhancing connection, healing, and resilience for which there are individual, community, and global approaches. We look to highlight, support and strengthen these approaches while advancing a new language of health.

Our work is formulated on a variety of needs that are profoundly shifting our views on health and care. These include the burden of chronic diseases and associated treatment costs, poverty, and inequity. Studies show a majority of primary care clinicians recognize that social factors are more important to their patients' health than medical factors and yet we've created a health care system that is treatment focused and in which hospitals at the local level compete for diminishing resources.

We aim to understand how place – where and how we work, live and play – influence health and how health care can work collaboratively with communities to strengthen the systems that support health. We incorporate the principles of integrative medicine, which uses a patient-centered, prevention-oriented model of health.

Our efforts have resulted in annual US-based conferences and a highly successful Minnesota-wide health care prevention initiative. What we have discovered is that people have a passionate resonance for this work, a willingness to engage, and a deep hunger for a way forward that is caring, compassionate and heart-centered. Nevertheless, there are challenges we wrestle with, including:

1. Finding a language for health that is not captured by the bio-medical model such that health, disease and treatments are conflated
2. Overcoming the sense that there is a hidden map for the way forward and we can't move forward without it
3. Limited tools and training to combat the deeply entrenched narrative that success is about competition and winning rather than collaborating for the collective good

Appendix 4: How the principles for creating health have evolved through our work

Principles From <u>The Report Of The 2014 Meeting</u>	Principle Suggested In <u>The Commentary For The Institute of Medicine</u>	Principles From <u>The Final Article In The SSIR-Published Series</u>	New Principles Suggested For <u>The 2015 Agenda</u>	The Refined Principles For <u>Creating Health (Numbers Refer To This Report)</u>
Let people define health	Ask people what they want, don't tell them what you think they need Agree on how you'll evaluate, ensuring that you use their sense of value Learn their language rather than impose technocratic approximations	Value what people value		1. Define community beyond those living there (residents); those that work there and those that provide services to it are also constituents of the community
				2. Acknowledge the differences in power and influence between constituents of a community, including proactively seeking those usually not heard
				3. Share power with all constituents; little is known about how to do this well so experiment, such as with the development of skills and capacities in those usually not heard
				4. Collaboratively explore and understand what matters to the constituents of the community and agree on what to focus on and how, including the development and implementation of interventions
				5. Agree what matters and figure out how to measure it (rather than assuming that what can be measured is what matters), including expanding what counts as knowledge
Embrace complexity		Embrace emergence, including unpredictability (see also below)		7. Embrace complexity, including the need to experiment and to learn from emergent outcomes, irrespective of whether they're considered successes or failures
Set a long lead time				9. Accept that it's going to take time, likely 5-10 years, but remember that quick wins can galvanize commitment
Give the community control	"Help them define and deliver the interventions that make sense to them"	Bring more voices to the table	Lean into the need for local democracy	See 1-4 & 6

Appendix 4: How the principles for creating health have evolved through our work (cont)

Principles From The Report Of The 2014 Meeting	Principle Suggested In The Commentary For The Institute of Medicine	Principles From The Final Article In The SSIR-Published Series	New Principles Suggested For The 2015 Agenda	The Refined Principles For Creating Health (Numbers Refer To This Report)
	Shield them from prescriptive academic theories born of dispassionate observation and aggregation; let them own their experience			
Agree value before metrics				See 5
Operate at the individual and community level				6. Operate at the individual and community level at all times; individual agency comes from collective agency and collectively agency is made up of individual agency
Accept failure, but fail fast		Experiment (this wasn't a principle, as such, it was part of the suggested next steps; however, there is nothing in this list about the need to just try stuff so I have pulled it in)		See 7 & 9
Be open to unintended consequences		Embrace emergence, including unpredictability (see also above)		See 7 & 9
Baseline emerging concepts				Part of 'meticulously record processes', which is no longer a principle but underpins many of them, including 5, 7, 9 and 11 (see below)
Meticulously record processes				Underpins many of the principles, including 5, 7, 9 and 11
Build a resilient team				10. Build a resilient and generative team to enable this work and accept that, eventually, it must operate at the behest of the community
Invest carefully; err towards being lean			Search for sustainable business models	11. Search for sustainability, including business model discovery
Embrace group attribution				See 8
		Acknowledge that our success depends on each other		8. Acknowledge that our success depends on each other, including embracing group attribution
		Expand what counts as knowledge		See 5

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The views expressed in this report are those of the Executive of the Creating Health Collaborative and not necessarily of the members of the July 2015 meeting. The Executive asks the reader to keep in mind the exploratory nature of this work; the views are subject to change as we continue to learn.