Mississauga Halton **LHIN**

To advance health system goals associated with Patients First regulation MHLHIN committed to work on behalf of patients, families, caregivers, individuals with lived experience, and citizens who access healthcare, to ensure a sustainable and responsive health system that is known for excellent health outcomes and patient experience. To this end, in January the MHLHIN shared their plans to embark upon a collaborative planning process to develop a shared vision for healthcare in the region and a six year roadmap for the Mississauga Halton LHIN health system.

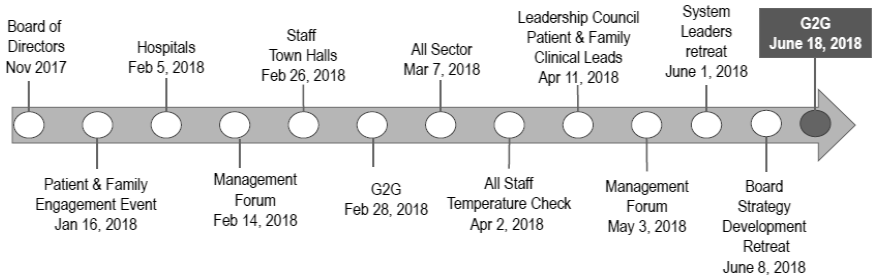
This collective planning initiative has required health service provider partnership and system collaboration to engage as full participation in the process to ensure the community is well-represented, and that the resulting plan reflects collective ownership.

A series of G2G sessions focussed on engagement to:

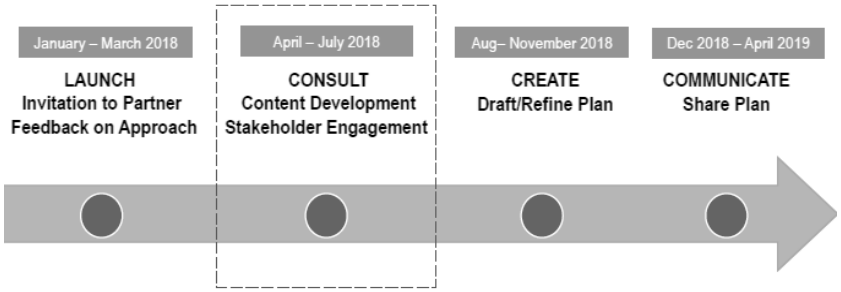
- Gather feedback on a proposed shared Vision and Mission
- Receive feedback on the proposed approach to develop a six year Strategic Plan for the MHLHIN
- Get input on the critical success factors for the MHLHIN to embrace a shared vision for health transformation
- Gain insights on how the 2019-2025 strategic plan can be a roadmap for the LHIN as an organization, and also for the system.

A schedule to ensure stakeholder engagement and four phases were identified to support the development and introduction of the 2019-2025 strategic plan.

**Engaged**:




**4 Phases**:




**6 Themes Identified:**

**Partnership & Collaboration** | **Population Health** | **System Capacity** | **Person Centred Health Care** | **People Who Serve (HHR)** | **Innovation / Best Practices**

<table>
<tr><th>June 18 Review</th><th>Stakeholder Feedback</th></tr>
<tr><td>Proposed Shared Vision:<br>Healthiest Community in Canada</td><td rowspan="2">Vision - The scope of the vision which did not reference person/client/patient and set a national rather than provincial. A shared vision needs to resonate with providers and stakeholders</td></tr>
<tr><td>Proposed Shared Mission:<br>Together, lead an innovative person-centred health system focused on quality care and well-being.</td></tr>
<tr><td colspan="2">Strategic Directions:<br>(at the June 18th meeting MHLHIN identified a number of Desired Outcomes defined at their Board Retreat. These were seen as tactical by Stakeholders - pg. 3)</td></tr>
<tr><td>Advancing Population Health<br>Improving the health and well-being of the MHLHIN community.</td><td rowspan="4">MHLHIN has set aside time and resources to develop a shared Vision, Mission and Strategic Directions. Specific translation of feedback and the addition of Board defined Desired Outcomes resulted in stakeholder concerns. The June 18th session resulted in general concern about the:<br><u>Strategic Plan</u><br>i. a 6 year planning strategy during a time of transition<br>ii. integration and expectation of the MHLHIN plan with sub-sector and organization strategic plans<br>iii. change in government<br><br>The advancement of the Strategic Directions to include Desired Outcomes defined by the MHLHIN Board caused concern among participating sector stakeholder organizations who in the lack of a coordinated Health System effort have been developing a number of associated outcomes within their individual areas. An important step in collaboration to review and define these Outcomes was missing in the process. Desired Outcomes need to be carefully reviewed by all providers and stakeholders to benefit from current and past initiatives and to maximize the effective use of resources.</td></tr>
<tr><td>Accelerating Innovative Practices<br>Moving the dial on scaling new technologies and initiatives, based on research and leading practices.</td></tr>
<tr><td>Investing in People Who Care<br>Ensuring that all carers – formal and informal –are connected, valued and supported.</td></tr>
<tr><td>Strengthening Person-Centred Care<br>Embracing the diverse and unique needs of our citizens – caring for today and the future.</td></tr>
</table>

**Defining PSL's Involvement in Next Step Engagement**:

MHLHIN, at the suggestion of stakeholders, is planning to hold an open house in the summer to discuss draft strategic directions and objectives. At the fall G2G MHLHIN will be asking for validation of the strategic direction and objectives and will ask provider agencies to sign a declaration of partnership and commitment in December 2018. Provider agencies have an opportunity to be further engaged to influence the strategic direction and objectives, and to acquire insights into and a better understanding of what the declaration of partnership will mean to their organizations.

Peel Senior Link's Board, together with Management, should identify next steps to be prepared to work with the MHLHIN to influence these documents, how they will be integrated into the Mississauga-Halton Health System, and to gain a better understanding of how this will impact our organization as a service provider.

**RECOMMENDATION: form an interim Committee to:**

1. **review, provide feedback, and support the ongoing evolution of MHLHIN's strategic plan that is best suited for MHLHIN**
2. **ensure PSL's Board is prepared to respond to, integrate with, and provide oversight for the MHLHIN Strategic Direction**
3. **provide insights regarding Directives and Desired Outcomes that engage and consider the ongoing efforts of providers to achieve the same.**

***Supporting Material*** **- Strategic Directive and Desired Outcomes:**

## Accelerating Innovative Practices

**Moving the dial on adopting and scaling new technologies, new knowledge and new analytics**

**Desired Outcomes**

- Increased integration and efficiency throughout the system
- Improved processes (e.g. increased access, seamless transitions and decreased errors)
- Increased research and knowledge mobilization
- Strong competencies and partnerships in AI, robotics, automation, and other emerging technologies
- Value-based care pathways and new care practices based on leading practice
- Accelerated spread and scale of pilots and leading practice
- Dedicated research strategy to test, spread and scale new knowledge
- Greater engagement in Public-Private Partnerships (leverage the presence of Canadian national subsidiaries)
- Regular consortia of thought leaders and lateral thinkers to ensure continuous implementation of new ideas
- Decreased barriers to growth (privacy and regulations)
- Proliferation of web based interactions and online medical assistance (through apps and emerging technologies)
- Recognition as a Patient-Centred Learning Health System


## Accelerating Innovative Practices

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- Recognition as a Patient-Centred Learning Health System


## Investing in People Who Care

**Ensuring that all carers – formal and informal – are connected, valued and supported.**

**Desired Outcomes**

- Centralized and standardized training
- training and education opportunities for all people who provide care, including family members
- All informal caregivers have the supports they need
- Enough physicians, personal support workers, specialists, etc. to meet the needs of the community
- Recruit across sectors and provide continuous development opportunities to encourage lateral thinking, and ensure required competencies among leaders and governors
- Strong desire to work in the Mississauga Halton LHIN system ('people are lining up')
- Joy and overall wellness in the workplace
- Increased integration of peer supports as a key resource in our system
- Standard menu of respite options available, with ability to customize
- Increased respect for and value of volunteers as part of the system
- Increased early and ongoing participation of caregivers in care plan design
- Team-based care as the standard
- Healthy turnover and cross-sectoral career-paths

## Strengthening Person-Centred Care

**Embracing the diverse and unique needs of our citizens – caring for today and the future.**

**Desired Outcomes**

- Programs are designed with consumers
- Increase access to health information (one phone call for services, access to health records, etc.)
- Increased care equity
- Access to community care providers with the right expertise for my needs
- Seamless patient experience
- Improved patient and caregiver feedback
- Increased person/self-directed care
- Holistic care that meets the needs of the whole person and not just treating the illness (e.g. physical, spiritual, cultural, etc.)
- Increased use of anticipatory care
- Adequate and appropriate investments and capacity within the system

# Mississauga Halton LHIN Values

*The vision of a person-centred health system is built on the foundation of our values*

*Quality is the framework from which we measure our success.*

**Respect through Compassion - *We honour people***

- Listening to understand
- Valuing differences
- Supporting the whole person – mind, body, spirit.
- Treating each other with empathy

**Innovative - *We think forward***

- Exploring and supporting new ideas
- Being open to what's possible
- Nuturing bold creativity and imaginative solutions
- Thinking beyond boundaries

**Collaboration - *We nurture partnerships***

- Building on our collective strengths
- Sharing our knowledge and ideas openly
- Engaging others to seek input and codesign solutions
- Investing in working relationships

**Accountable - *We take responsibility***

- Using actions and words which reflect honesty, integrity and good judgment
- Committed to being solution focused
- Responsibly manage resources entrusted to our care
- Navigating through changes and challenges

# Emerging Themes
# February G2G Engagement Session

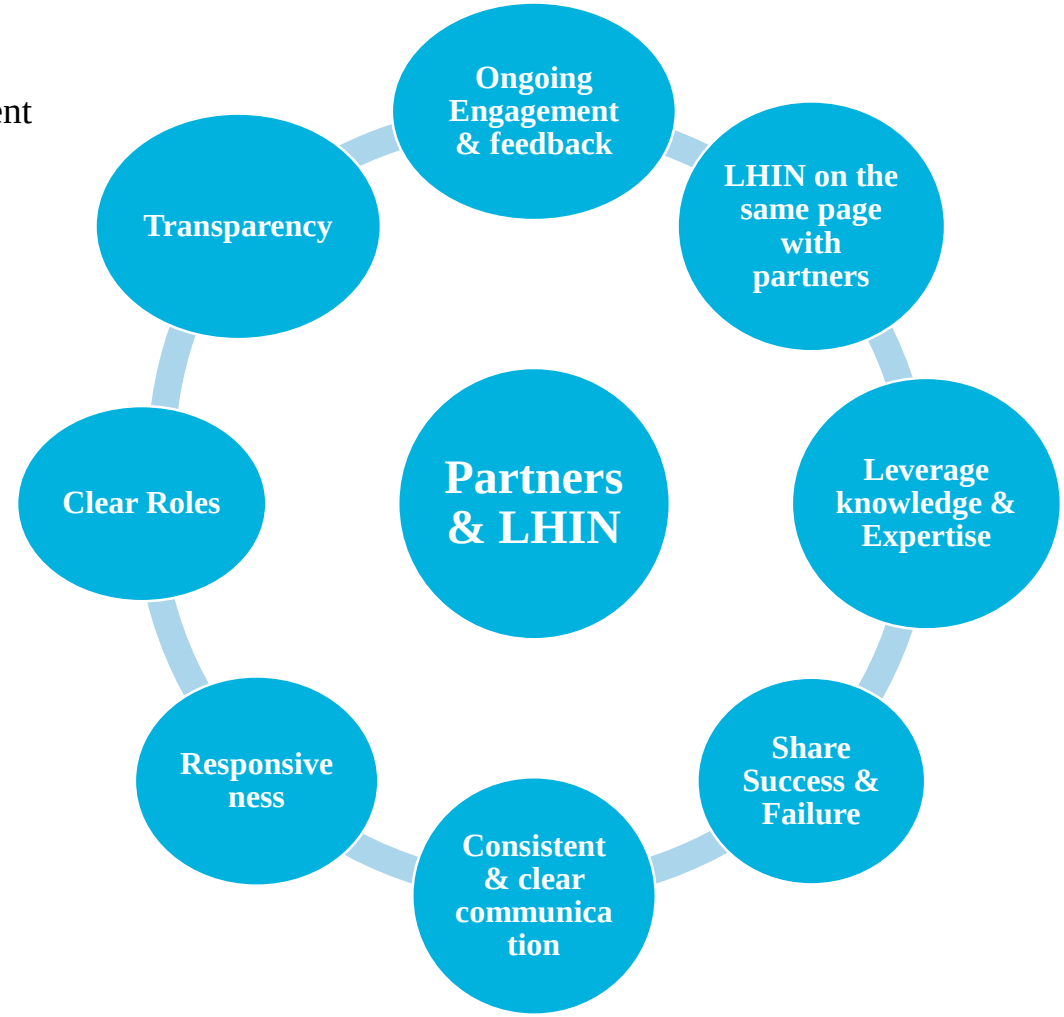
Strategic Planning Task Force Meeting
March 19, 2018

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

# Overall Themes from February 28, 2018 G2G Session

Be…

- Transparent
- Clear and consistent in the communication
- Clear on non negotiables
- Open to negative feedback
- Open to hearing about pressure points
- Responsive and timely
- Use simple language



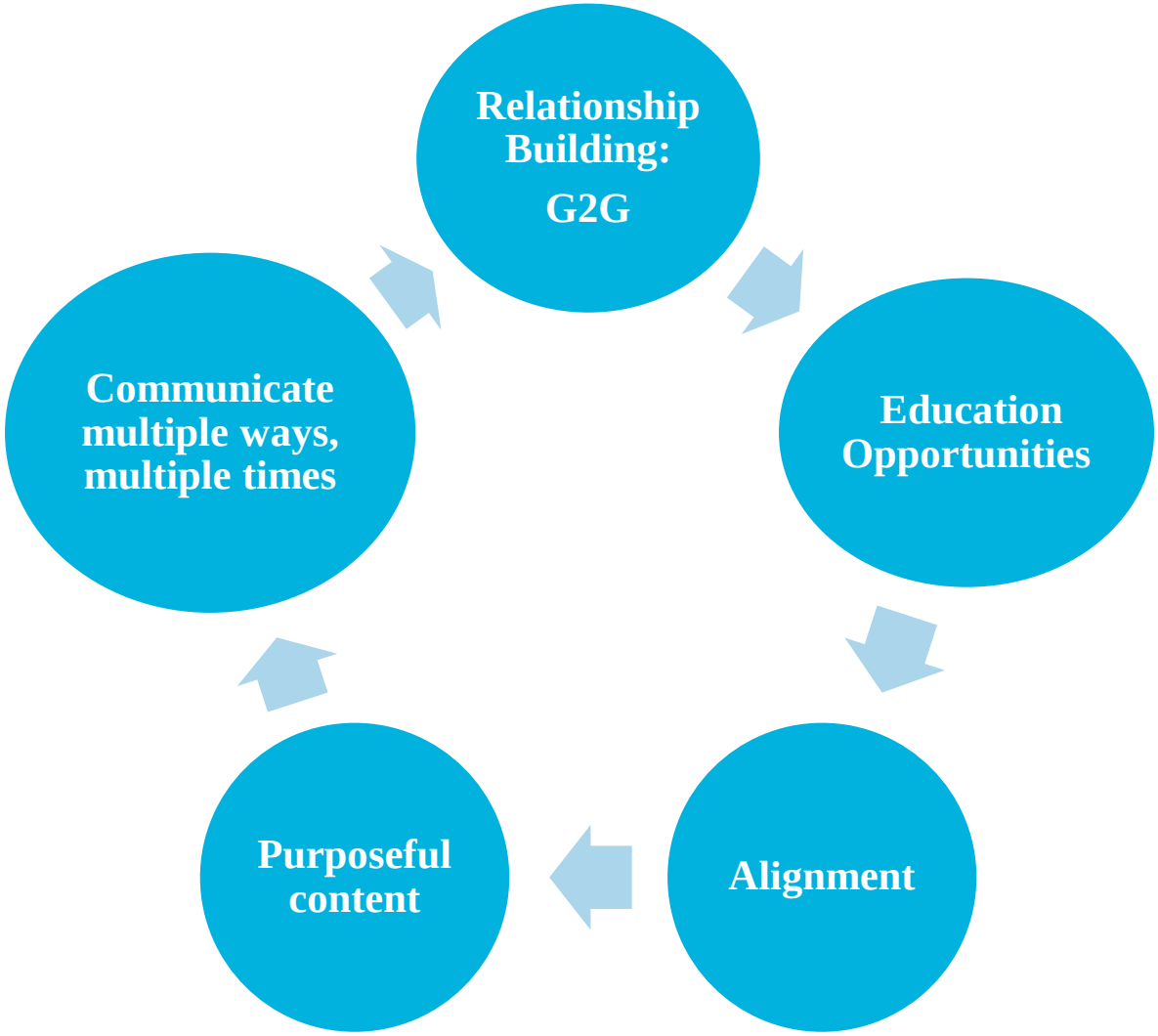

Other Points:

- Include advocates and frontline staff as partners
- Do more sector-sector meetings/focus groups

# Q1: What are the key success factors required to develop a strategic plan that reflects a shared vision for our local health system?

# Key Success Factors Outlined in Charter

# Q2: How would you like us to engage your Boards through the strategic planning process?



# Success factors in developing plan

Patient Centred:

- More “real” patients’ feedback, journey, contribute to plan (7x), Seniors, Parent councils in schools, mental health – reach vulnerable populations, go to them, 60 not enough (PFAC session)
- Seamless Transition points (2x), no wait times (2x)

Resources:

- People (8x), space, knowledge, expertise, dollars, technology, leadership
- Work force planning: Aging workforce, attract immigrants
- Equity of compensation

Capacity analysis and Patient Flow:

- Address access by way of capacity (4x) – through moving “well” people to another service
- Eliminates/reduces “silos” to address patient flow (3x)
- Stability of system & priorities
- Consideration of workforce implication and stratification of peak volumes and down times
- Coordination of various service levels

System Wide Analysis (3x)

- Work with other Ministries
- HSPs may not know how other HSPs are doing and what their services are

Evidence based/Data driven:

- Evidence regarding effectiveness (2x), data driven and fact based
- Need access to date
- Data/quantification of measures to show gaps and evaluation mechanisms, outcomes, wait times (2x)

Technology:

- Leverage technology (7x) for capacity management, mobile technology, throughout development of the plan, need secure electronic record, sustainable
- Partner with Apple /Private Sector

Population Health/ Social determinants:

- System view: It’s not a senior care issue, or ED hospital issue, or mental health team
- Need to have different conversation on continuum of care i.e. prevention of chronic conditions (4x), Health promotion
- Health system need to have courage or otherwise always be at risk
- All programming addresses health equity, knowledge of programs, overcome barriers to access
- Funding of Services needs to be directed more efficiently (2x), Social determinants of health , 90% goes to medical intervention

# The plan should be…

**Action Oriented:**

- Move beyond shared vision (3x), tangible action oriented plan
- A strategy that defines what "integrator" means
- Clear incentives (3x) – value to the organization

**Innovative & Bold:**

- Be bold, Incubate innovation (5x) - break the mold
- Scalable and spreadable concepts
- Find new voices and what they think
- Open communication and open to ideas
- Having clear accountability for risk taking
- Go big - what is possible? - Don't want it to be the same after six years – be flexible and not just stick to the plan
- Look at other provinces/sectors/countries E.g. Albert/BC

**Holistic**

- Increased partnerships across the system
- Mental Health = physical health – put a mental health lens on it – look at individuals as a whole

**Measurable:**

- Define goals clearly, Definitive quantifiable and measurable outcomes (4x)

**Comprehensive/Broad:**

- Sufficiently broad to encompass all of us represented here, reflective of all stakeholders (2x), but also find a focal point to unify our focus around patient and population needs.
- The Team – all teams are to share the responsibility for success or failure
- Collaboration with other LHINs on strategy (2x) i.e. how to ensure continuity where reflects/is needed and acknowledge local variation

**Agile & Flexible**

- Consider ensuring a "resilient" system, an agile system (5x)
- Strategic planning should be a dynamic document; continuously reflect
- Adoptive design principles so we can adjust and be agile
- Hypothesis testing – process

**Aligned with Values**

- Ensure strategic direction aligns with the values
- Access and Equity – value for money – equitable access for all parts of our LHIN

**Sustainable:**

- Appropriate funding models – sustainability (4x), Create viable solutions
- 6-year plan – 6 year model of $$ support, viable solutions, predictable funding

# Engaging boards

**Relationship Building:**

- Board to Board
- Attend AGMs
- Include organizational front line as well (top – down and bottom - up approach)
- Move from “funder relationship” to partnering relationship

**Education Opportunities for HSP Boards:**

- Slide deck for board chairs and management
- LHIN board members and/or senior staff come to board meeting
- Help focus on external system vs. internal focus (individual and collective focus)
- LHIN Board/Staff review HSP/CSS Vision & Strategic Plans (alignment)

**Method: Multiple way, multiple times**

- Common portal for information
- Test ‘draft’ through website or survey, e.g. HHC
- Face to face, board to board, senior management to senior management
- Multiple communication channels: Survey, bulletin, in person, reconvene G2G, webinars, town halls
- Engage at a regional level for national organizations
- Collaborative forum vs. knowledge sharing forum

**G2G Opportunities:**

- Share information in advance so G2G members can come prepared
- Smaller governance engagements that are sector specific or sub region or neighbourhood level
- Model other LHINs approach e.g. CW LHIN Governance Agreement
- Reconvene with smaller sector specific G2G to get into more specific content

**Content/Approach:**

- Have facts, dashboard, data available along with values, vision to set the stage
- Engage other LHINs on shared priorities
- Validate content and feedback regularly
- Include Primary Care

**Active listening to patients/partners**

- As strategy unfolds and being implemented “Give us Feedback”, and keep us engaged

# Memorandum

**TO:** Board Members, Chief Executive Officers and Executive Directors

**FROM:** Mary Davies, Acting Chair – Mississauga Halton LHIN

**DATE:** April 18, 2018

**SUBJECT:** **June Governance to Governance Date**
**February 28 G2G Strategic Plan Feedback**

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Dear Board Members, Chief Executive Officers and Executive Directors,

Thank you for your participation at the Governance to Governance session on February 28, 2018. Our key objectives for the session were to receive input on key success factors and Board engagement opportunities in developing the six year Strategic Plan for the Mississauga Halton LHIN that reflects a shared vision for our local health system.

We are pleased to report that there were over 115 participants at the session represented by 58 Board members and 57 senior leaders. Your feedback validated the input received on our System Partner Survey in the fall – that there is keen interest among you in collaborative planning, strengthened partnerships and developing a shared vision and collective accountability for our local health system as we transform together.

Attached, we are sharing a summary of the themes that emerged from the G2G session. We highly value your feedback and thank for your continued partnership and participation in Board to Board level engagement sessions.

Our next Governance to Governance session in mid-June will focus on content of the six year Strategic Plan itself. We will be seeking input on key themes that we will need to focus on together to become a high performing integrated health system and the strategic priorities that will guide our efforts. We understand June to be a busy time of year for many. **In an effort to ensure the greatest participation possible, please provide us with your availability by clicking this Doodle Poll.** A meeting invite will follow shortly after the poll closes on Wednesday April 25th.

We highly encourage Board Chairs and other Board members, along with senior executives, to attend. In response to a theme arising from the feedback, we are planning to hold smaller sub-region governance forums in late summer/early fall. This will allow for thoughtful and focused dialogue around future governance opportunities as we move forward together. Please let us know if you have additional recommendations for these Governance to Governance engagements.

On behalf of the Board, we look forward to your continued partnership as we continue along out Patients First journey together.

Sincerely,

Mary Davies
Acting Chair, Mississauga Halton LHIN Board of Directors

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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# Memorandum

**TO:** Mississauga Halton LHIN Health Service Providers and Health System Partners

**FROM:** Angie Burden, Vice President, Health System Strategy, Integration and Planning

**DATE:** April 24, 2018

**SUBJECT:** **Mississauga Halton LHIN Strategic Plan Update**

---

In January 2018, the Mississauga Halton LHIN embarked upon a collaborative planning process to develop a six-year Strategic Plan (2019 -2025) that will consider the future needs of our local health system and inform two successive three-year Integrated Health Service Plans. A six-year strategic plan ensures a longer planning horizon, and helps us prepare for the future.

The strategic plan will be a strong, collective voice of our health system providers, partners and local community, and reflect a shared vision for our local health system.

The Mississauga Halton LHIN strategic plan will also align with the four strategic priorities of the Ministry of Health and Long-Term Care's Action Plan: Patients First and the key supporting pillars of the Patients First Act, the Minister's mandate letter and the principles endorsed by the Mississauga Halton LHIN Board of Directors to guide the process.

I wanted to give you an update of the progress we've made in developing the strategic plan as we conclude the launch phase, and move into the consultation phase.

The initial or launch phase of our strategic plan included internal and external engagement to obtain support for a shared vision and collaborative approach to transforming the health system within our LHIN and to understand how we can best develop a strategic plan that will serve as a shared vision for a high-performing, person-centred, local health system. We also asked for help from stakeholders to assess strengths and opportunities for the Mississauga Halton LHIN.

These engagements demonstrated that our health system belongs to all of us.

We are now in the broader consultation phase, which will take us into the early summer months. As one of the opportunities to provide input, we are asking you to complete an online survey to help us understand the health care priorities in our region.

One vital component of our work is to hear from individuals we serve across the system as their voice must guide our efforts as we co-create our plan. We are asking you to **please share this link https://www.surveymonkey.com/r/Together2025 broadly with your patients, families, caregivers, clients and residents** along with your staff so that our plan reflective accurately reflects the views and priorities of those who live in our region.


You can access the survey by clicking on the image here or by visiting our website www.mhlhin.on.ca. The **Together 2025** online survey will extend until May 7, 2018.

The Mississauga Halton LHIN recognizes that when it comes to building healthy communities, everyone has a role to play – patients, families, caregivers and residents, primary care, health service providers, service provider organizations, municipalities, public health units, social services, child and youth services, French language service providers, Indigenous communities, faith-based organizations, the volunteer sector, and other partners.

As we move forward, we continue to build on the great planning and engagement efforts that our partners have undertaken in the spirit of partnership for which our LHIN is known. Together, we have a strong track record within our LHIN for collaboration and caring for those we serve. Together, we have the expertise and experience that can help shape our health system for the years to come.

We thank you for your partnership and your engagement in collectively and strategically thinking about the needs of our health system, opportunities for local innovation and transformation, and a future where together we achieve the promises of Patients First.

Sincerely,

Angie Burden, Vice President, Health System Strategy, Integration and Planning
Mississauga Halton LHIN

# Mississauga Halton LHIN Strategic Planning Process

## Preliminary Strategic Directions

*(Post June Governance-to-Governance Engagement)*

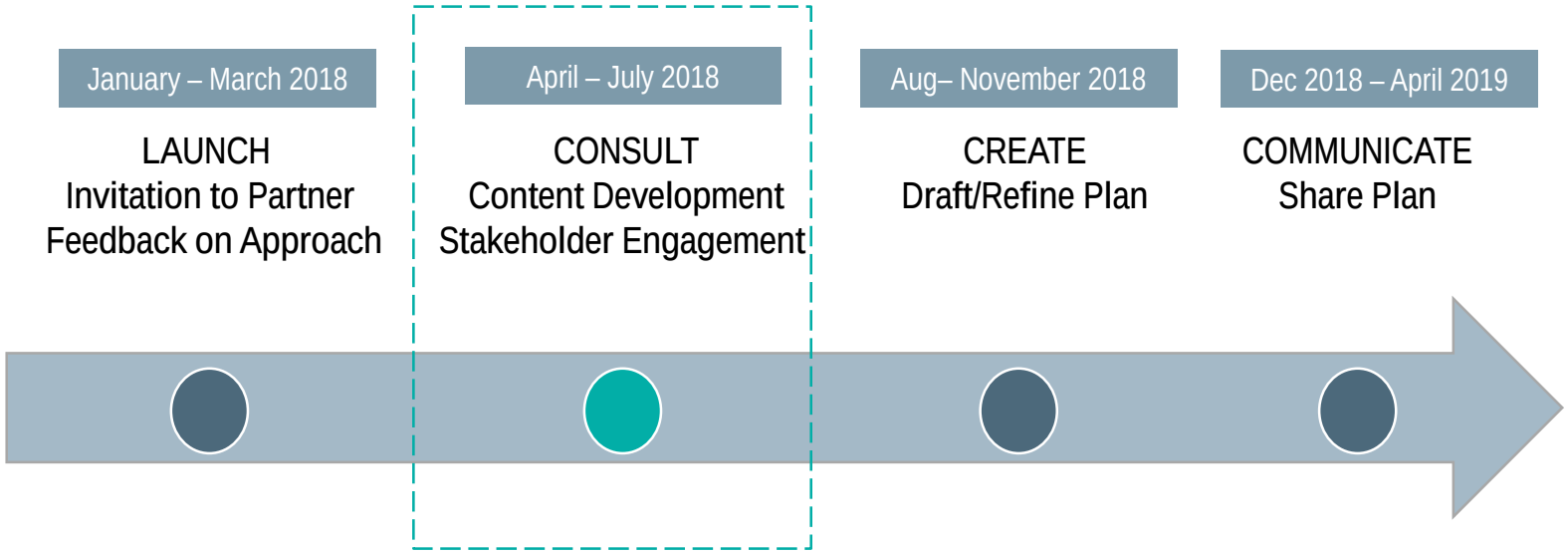
June 21, 2018

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

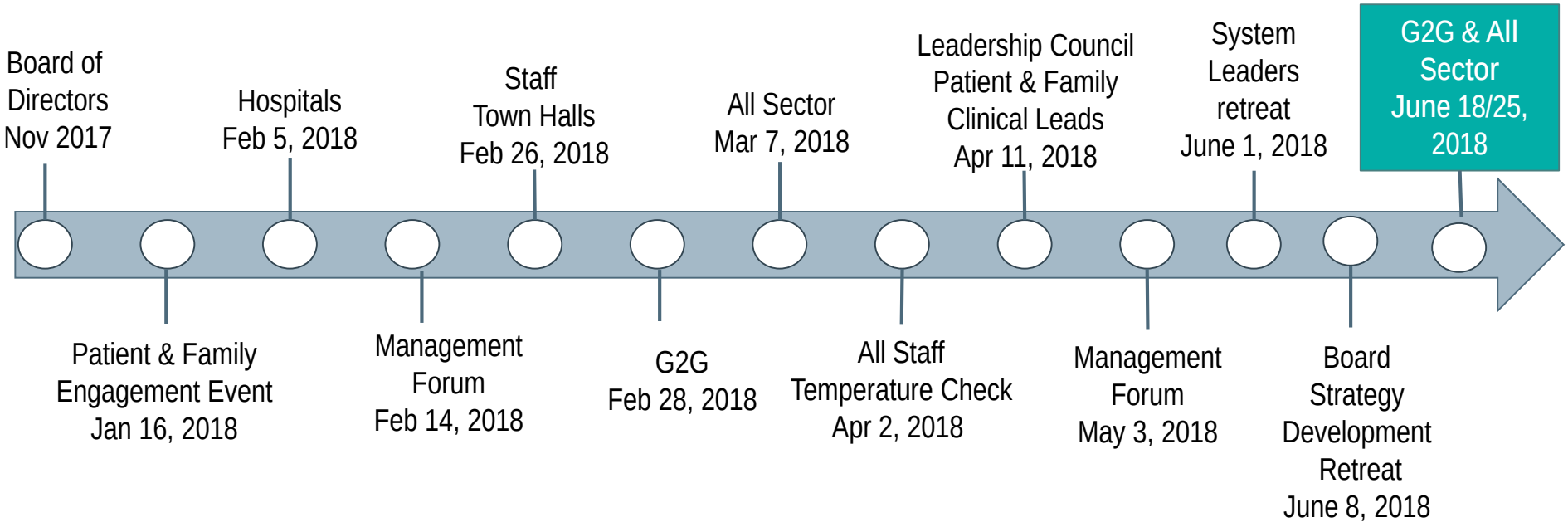
# Our Planning Journey for the Mississauga Halton LHIN 6-Year Strategic Plan

# 2019-2025 Strategic Plan Development

## 4 Phases:



# Engagements Thus Far



# Guiding Principles for Strategic Planning

- The plan will serve as a roadmap for ***both the LHIN as an organization and the broader health system***.
- The plan will be based on a ***population health*** framework, and incorporate the ***social determinants of health*** and their impact on ***community health and wellbeing***.
- ***Innovation, transformation, quality, and patient/citizen activation*** will be central themes that guide the development of the plan in order to fully deliver on the Patient First vision in Mississauga Halton.
- The plan will be developed with broad ***engagement*** (patient, family, citizen, health service provider and system partner), in order to develop a ***shared vision*** for ***integrated health system*** leadership, and ***collective ownership*** for improved outcomes and experience.
- The plan will position the Mississauga Halton LHIN to deliver on its leadership mandate to plan, fund and integrate the local health system, and ***provide quality patient-centred care***.

**Proposed Organizing Framework**

The Quadruple Aim: improved health; improved care; reduced cost; thriving carers.

# Our Strategic Directions – Generating Ideas on Possible Objectives

# The Strategic Continuum

**Mission**
"Why do we exist? For whom?"

**Values**
"What is it important to us?"

**Vision**
"What we want to be true about our organization?"

**Strategic Areas of Focus**
"What will we focus on? Where do we want to see progress?"

**Strategic Objectives / Outcomes**
"How will we define success?"

**Balanced Scorecard**
"What will we measure to determine progress?"

**Targets & Initiatives**
"What pace do we need to set and how will we achieve it?"

**Personal Objectives**
"What do individuals need to do to contribute?"

Strategic Outcomes

| Satisfied Funders | Delighted Customers | Efficient & Effective Processes | Motivated and Prepared Workforce |
|---|---|---|---|

# Preliminary Thinking - Strategic Directions

Informed by the engagement to-date, the Mississauga Halton LHIN Board and Executive Team met on June 8, followed by a session attended by system governors on June 18, to do some preliminary thinking strategic directions.

## Promoting Population Health

Improving the health and well-being of the Mississauga Halton LHIN community.

## Advancing System Integration

Collaborating across the health and social care system to create new relationships, achieve common goals and drive collective impact.

## Accelerating Innovative Practices

Rapid adoption, adaptation, and scaling of new technologies and knowledge through a culture of agile transformation.

## Investing in People Who Care

Ensuring that all carers - formal and informal - are connected, valued and supported.

## Strengthening Person-Centred Care

Embracing the diverse and unique needs of our citizens through a health equity lens – caring for today and the future.

For each of these Strategic Directions, preliminary ideas on <u>desired outcomes</u> were identified to help think about what we want to achieve together in 6 years.

# Promoting Population Health

Improving the health and well-being of the Mississauga Halton LHIN community.

## Desired Outcomes

### Prioritizing the Social Determinants of Health

- **Focus on advancing progress on select socio-economic indicators** such as: low unemployment, progress on child poverty and poverty in general, increased access to affordable housing and mental health supports, and food security.
- **Decreased social isolation**, supported by neighbourhood networks of care and healthy environments.

### Addressing the Needs of all Populations

- **Organizations work together across systems** to improve health outcomes, addressing the health needs of the entire population, and targets vulnerable groups to improve health disparities and inequities.
- **A range of approaches are leveraged to target segments of the population** and there is clear acknowledgement that different segments require different approaches and involvement from different system partners to be effective.
- **Significant enablement from population-based data and analytics** (including segmentations of the population and analysis of local needs) and shared budgets.

# Advancing System Integration

Collaborating across the health and social care system to create new relationships, achieve common goals and drive collective impact.

## Desired Outcomes

### Building communities and partnerships

- **A fully integrated system**; aligned governance, goals and outcomes; the prioritization of current opportunities; and further development of existing assets.
- **Collaboration and trust at a higher level across the health and social care system**; working together in new ways; strong connections of our diverse community to our system and outreach to those not currently engaged in or connected.
- **System leaders serve as facilitators** to break down silos and foster increased alignment and creative solutions between the individual parts of the health and social care system, including health and social service providers, LHIN, primary care, public health, municipalities/regions, community resources, and non-traditional partners.
- **Integration of primary care;** physicians are full partners at the system level and with the people the provide care for.

### Driving integration trough an increased focus on public health

- **The care continuum is seamless between health promotion, prevention and intervention,** with an increased focus on health and social literacy, healthy behaviours, and well-being, to truly help people 'live a life worth living'.
- **A health metric is adopted and a data baseline is developed** to track and demonstrate progress on the health outcomes of communities.

# Accelerating Innovative Practices

Rapid adoption, adaptation, and scaling of new technologies and knowledge through a culture of agile transformation.

## Desired Outcomes

### Encouraging courageous thinking, and action

- **Continuous consumption and generation of evidence and new ideas**, while also leveraging existing assets and knowledge,
- **Creating a culture where it is OK to fail fast**, in which returning to the 'drawing board' to address issues is encouraged.
- **Increased application of agile processes** (e.g. increased access, seamless transitions and decreased errors); increased research and knowledge mobilization; and a proliferation in technological solutions enhance collaboration.
- **Regular convening of innovation consortium of Mississauga Halton LHIN thought leaders** that is recognized throughout the province and drives the application of leading innovations.

### Exploring a fresh take on partnerships

- **Private-public sector partnerships** that lead the way in Artificial Intelligence, automation, and other emerging technologies.
- **Digital strategy fully supported** and advancing across the system.
- **Dedicated research strategy** to test and scale new knowledge, and decreased barriers to growth (e.g. privacy/regulatory issues).
- **Understanding of innovations in other sectors and jurisdictions** that could be applied in the Ontario healthcare context.

### Leveraging leading practice

- **Creation of value-based care pathways and new care practices** based on leading practice; spread and scale of successful pilots; and increased tech-enabled interactions (e.g. virtual, cloud-based, Blockchain, apps etc.) – 'learning from digital natives''.
- **Recognition as a person-centred learning health system** co-designed to support research to improve care in ways meaningful to patients, their families, and providers.

# Investing in People Who Care

Ensuring that all carers – formal and informal – are connected, valued and supported.

## Desired Outcomes

### Helping people grow

- **Centralized and standardized training** opportunities for all people who provide care, including family members.
- **Exceptional talent and leadership** with core competencies to lead transformation (e.g. lateral thinkers, ecosystem design, adaptability); enhanced business acumen across the system supported by cross-sectoral recruiting.

### Ensuring adequate resources and supports

- **Enough physicians, nurses, personal support workers, allied health professionals, and specialists**, with team-based care as the standard.
- **Integration of peer supports** as a key resource in our system to meet the needs of the community
- **Caregivers who have the supports they need** to achieve economic stability while providing care through the development of a capacity/compensation structure, and a customizable menu of respite options.
- **Increased early and ongoing participation of caregivers** in care planning and system co-design.

### Fostering a healthy workplace and culture

- **Strong desire to work in the Mississauga Halton LHIN system** ('people are lining up'), while recognizing that the workforce may not be able to afford to live here.
- **Joy and overall wellness** in the workplace.
- **Increased respect for and value of volunteers** as part of the system.

# Strengthening Person-Centred Care

Embracing the diverse and unique needs of our citizens through a health equity lens – caring for today and the future.

## Desired Outcomes

### Responding to evolving consumer expectations:

- **Recognition of, and reaction to, consumers** with rapidly evolving expectations (e.g. access to services on mobile.)
- **Seamless patient experience**; access to care when you need it, how you need it, where you need it.
- **Exceptional patient experience** with continuous feedback loops enable by mechanisms that are easy to access and use.
- **Holistic care that meets the needs of the whole person** and not just treating the illness (e.g. physical, spiritual, cultural, etc.), and the increased use of anticipatory care.
- **Strong foundation in primary care** and connected pathways to specialist care.
- **A system designed with enough foresight** to meet the needs of future patients.

### Activating all citizens

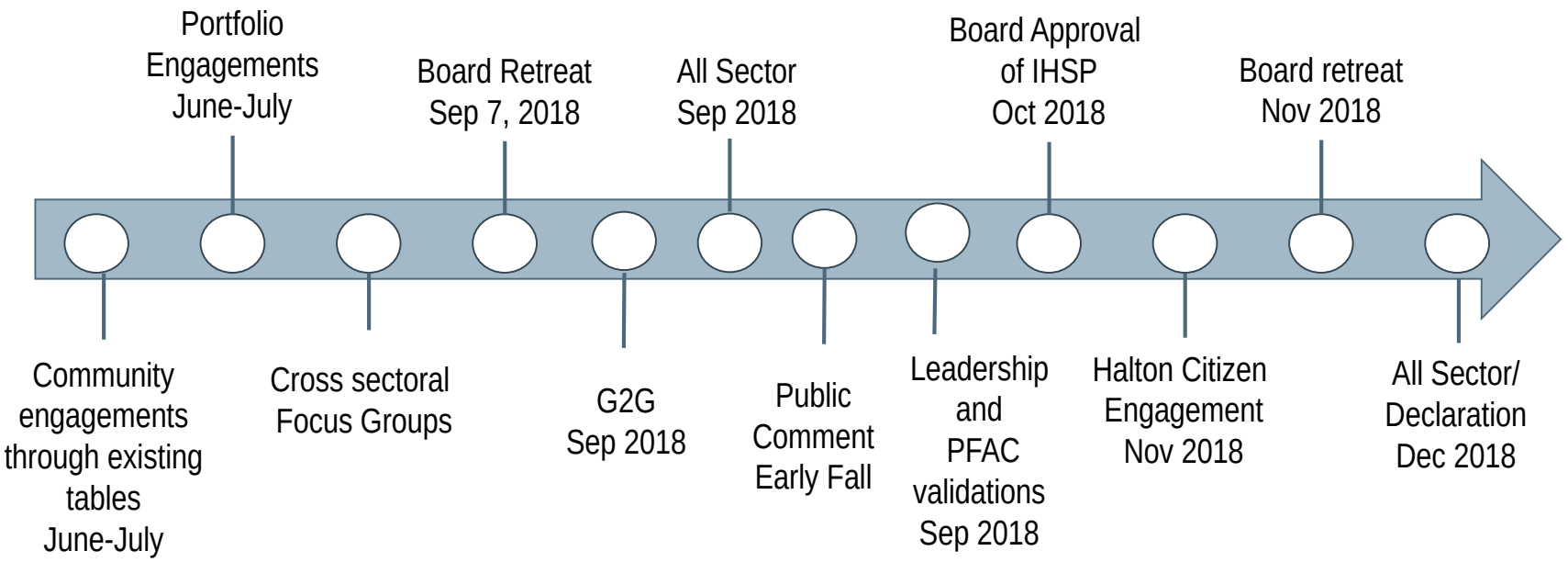
- **All citizens, across generations** (current and future system users) are seen as co-producers of their own health outcomes, health system partners, educated early, and are actively involved in the design stages of service and program development.
- **Increased care equity**, self directed care, and access to health information ('one call' for all services and health information).

### Uplifting diverse views and experiences

- **Broad diversity in feedback** that allows for the inclusion of marginalized populations who may not always have access to feedback channels.

# Next Steps

# Our Engagement Journey Moving Forward



KPMG

# Plotting the course

## Ten crucial conversations about system change

November 2017

kpmg.ca/healthcare

# Introduction

**We wouldn't start from where we are, knowing what we now know. Health system and political leadership has never been more important.**

–Dr. Mark Britnell, Chairman and Partner, Global Healthcare, KPMG International

KPMG in Canada co-authored this paper in collaboration with health system leaders from the former* Toronto Central Community Care Access Centre (TC CCAC) to reflect on the transformation of the Ontario healthcare system and to provide insights based on global and local learned experiences.

Together we took a 'virtual tour' around the world to consider emerging approaches to improve population health and create more integrated systems of care – two of the most consistent elements of health system transformation in the jurisdictions we visited. We took snapshots of some of the most interesting practices that we saw in our journey, and along the way we learned from some of Canada's own top healthcare leaders who are at the forefront of disruptive change. In this paper, we share some of the highlights from our expedition to help other leaders plot a course for health system transformation.

Every global jurisdiction that we reviewed is undergoing transformation. Governments are testing ways to signifi improve quality and value while shifting to community-based care, improving integration with primary care, limiting growth in healthcare spending through performance-based funding models and moving upstream to focus on population health. These transformations include both micro and macro level change, creating integrated systems across health and social care.

While integrated business models are not new, the desperate lack of resources for healthcare delivery and rising expectations of consumers present ripe conditions for more rapid cycle implementation to achieve sustainable transformation. The path forward, however, requires signifi planning and effort, with each actor playing their part. In a recent assessment of the UK's Sustainability and Transformation Plans (STPs), to integrate at a local level and move care to the community, Nuffield Trust[1] found that expectations amongst funders and providers were too optimistic on the cost savings potential of their plans, potentially impacting future sustainability. The conditions for success require us to engage with funders, providers, front-line staff and patients and families in ways that are a departure from the status quo.

Our paper highlights ten crucial conversations we need to have to make rapid, sustainable transformation a reality.

## Ten crucial conversations about systems change

Here are ten critical conversations that can help drive success in transformation, driven by our global review and our own experiences with change.

**Payers are becoming 'activist'**

**Consumers are becoming activated**

**Leading through change: from 'sage on a stage' to 'guide on the side'**

**Stop referring to them as 'soft skills'**

**Creating a social movement for change: a thousand points of light vs a supernova**

**Accelerating disruption through technology**

**You cannot plot a course forward by measuring backward**

**Inspiring a workforce to thrive**

**Ensuring a creative space for transformation**

**Pathways to 'population health'**

**The Community Care Access Centres of Ontario, which were responsible for the delivery of publicly-funded home care, were restructured as part of Ontario's health system transformation plan in 2017.*

# Payers are becoming 'activist'

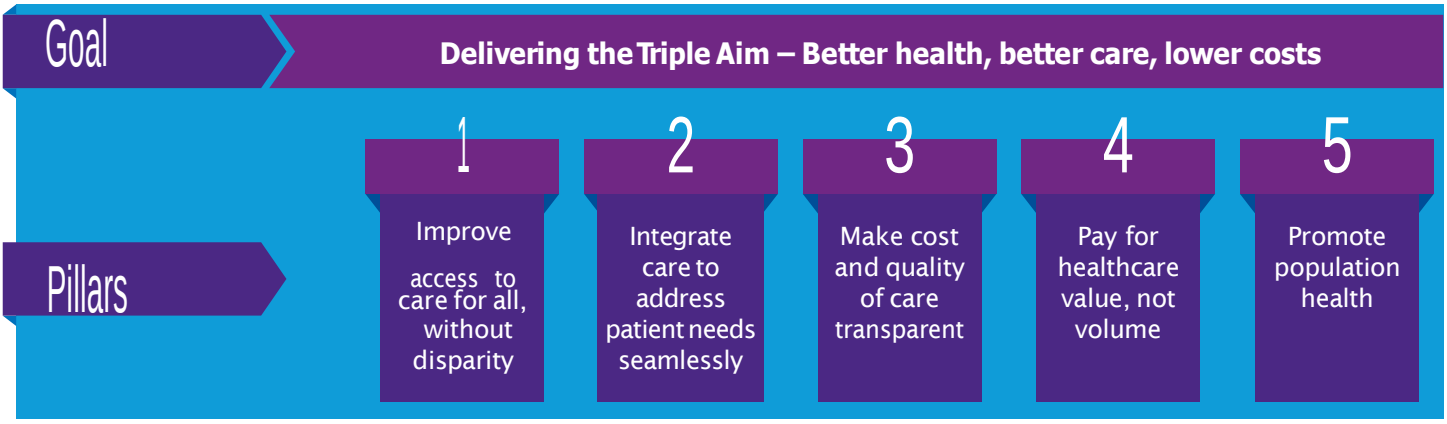
In response to financial pressures, governments are using payment models to incentivize change in practice, behaviours and outcomes. There is a shift from volume-based payments to incentives and payments based on value (outcomes and quality). In the US, if Medicaid reforms continue under the new Administration, 50% of Medicare payments will be value-based by 2018, and 75% by 2020.[2]

There is a general acknowledgment and understanding among providers that payment systems will focus more on quality, value and risk.[3] This is creating a new challenge for health providers and forcing them to replace traditional care delivery with innovative partnerships and new perspectives. Overall, providers do not feel well-equipped to respond to these changes, including bundled payments, increased risk sharing and value-based purchasing.[4] However, providers do feel that reduced costs and improved outcomes can be achieved through truly integrated care.

The State of New York is taking the lead in the US through the transformation of its Medicaid system. As part of a wider system transformation, New York State is reforming payment models to pay for value instead of volume. Provider networks are incentivized to work together to realize shared savings and are entitled to keep the savings, depending on the risk-sharing model they sign up for. The payment model is a graduated system with four levels that increases the risk and rewards for provider networks as they mature and agree to take on more responsibility for the outcomes and health of the population. This funding reform was implemented through thoughtful tailored design, with a range of funding options to suit the maturity of providers and their readiness to take on risk. It was part of a significant investment by the State to implement, test and revise and deploying rapid cycle improvement to continuously improve outcomes.

In Ontario, Canada, the Ministry of Health and Long-Term Care has commissioned six integrated and bundled care pilots where payment models were tested – some based on payment for outcomes. A recently published review identified key success factors for bundled reimbursement programs.[5] If we look to other jurisdictions we can extrapolate what shape things will take and what we can learn from those experiences – both success and failure – as well as from our own experience in moving to a future of population-based integrated care in Ontario.

Where Quality is the outcomes as defi by the patient, e.g., Safe, Effective, Patient-Centered


*Source:* KPMG in Canada

## Our insight

Payment reform is not a panacea but has been successful in many jurisdictions around the world. These reforms are creating incentives to build formal, sustainable partnerships that through additional, purpose-built support, bring front-line providers together to address the health needs of the population. Although these funding models have been in the implementation phase for several years, it will be several more before we can say they have been completed at scale. These endeavors are long-term journeys that require investment and support to test, improve and spread what works.

# Consumers are becoming activated

There is a growing trend with consumerism amongst health "citizens" and patient populations. The proliferation of apps is having a spillover effect in healthcare. Consumers are increasingly interacting with their health and social care providers and organizations through business models that did not exist five or ten years ago.

Disruption continues to spill over into healthcare and will create a greater expectation, especially from a younger generation, that options exist for them to engage in the management of their own healthcare. As an example, Heal is an app that provides on-demand doctor house calls. According to Heal, the company has raised USD $52 million in funding and plans to grow its doctor visits exponentially as it expands its availability across key US locations by the end of 2017.[6]

With the strong presence of social media, the growing popularity of rating websites for healthcare providers, and the increasingly strong voice of patient organizations comes an increased demand for transparency as patients want to understand where they can go for the service they want. Increasing transparency naturally leads to choice, which creates competition for healthcare providers that has not existed on this scale in the past.

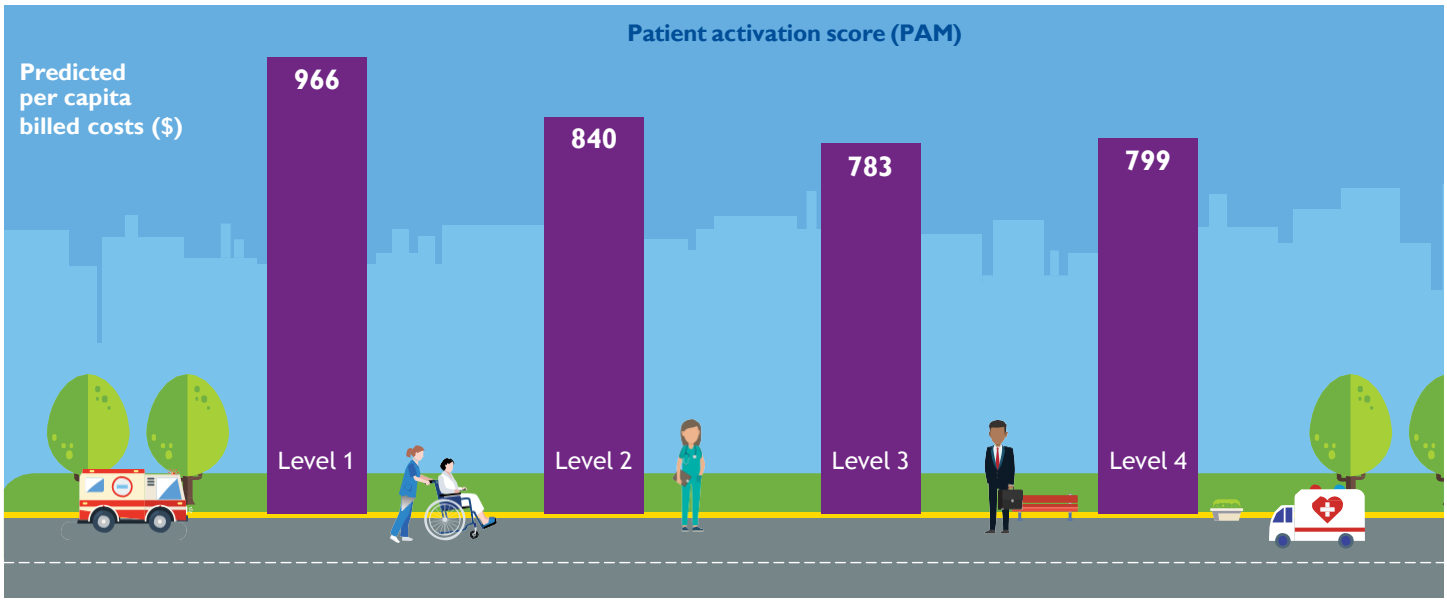
The same tools that are disrupting traditional care models and methods for engaging with providers are enabling a new activated patient. These patients are fully engaged in their own self-management in partnership with clinicians, however take a more educated and active role in managing their health than traditional patient-clinician interactions.

Research has demonstrated that patients who are activated have better health outcomes at lower costs.[†] As shown in the chart, it is clear that the activated patient is an unmatched source of value for health care systems – the key is to carefully and purposely respond to their expectations and ensure the system is sensitive to their needs.This can be achieved through active participation of patients in the co-design of processes, care pathways and systems that directly respond to their needs, enhancing their ability to provide an active role in their own care.

Discovery, a health insurer in South Africa, has adopted an innovative wellness program called 'Vitality' that has demonstrated the link between activation and the outcomes it provides, including lower hospital admit rates, lower costs per patient and reduced mortality.[7] Members are rewarded for making healthy lifestyle choices, including preventive screening, purchasing healthy food, participating in exercise programs and nutritional counselling. Participants set goals using an online portal or mobile app and are rewarded for reaching their goals. Their members are being incentivized to be active participants in their health.

[†] *KPMG Global Healthcare Conference Survey 2014: 28% agree, 44% strongly agree that 'with the right support and empowerment, patients actively managing their own care creates better value care.*

> “Activated patients have better outcomes at lower cost.”




As patients become more engaged in their own care (e.g. their patient activation scores (PAM) increase), outcomes improve and total costs to provide care go down.[8]

## Our insight

Individuals are the most important factor in their own health. We now have the tools to enable full participation in one’s own care. We need to enable clinicians to catch up to their patients so they can meet them where they are. Activating patients and delivering on what patients expect, we need equipped clinicians to engage differently and meaningfully.

# Leading through change: from 'sage on a stage' to 'guide on the side'

## Transformation requires that we move from a focus on the organization to the system.

This requires the ability to work with multiple players and organizations across the system. The healthcare "system" is a *complex adaptive system* that requires a system leadership approach relying on relationships to drive transformation – where leaders have traditionally relied on hierarchical approaches to drive change.[9] Provider incentives within the system are not always aligned and therefore require a different approach, for example the differing and sometimes competing payment models for physicians and provider organizations.

This means transitioning from hierarchical management ('sage on a stage') to collaborative leadership ('guide on the side'). Here, leaders cannot dictate change because systems of care challenge positional authority. Instead, success is built through collaboration and relationships. What is it going to take to build collaborative leaders? It requires retraining leaders in collaborative approaches, often referred to as *adaptive leadership*. It means that those high performers may be different than the people currently holding leadership roles. Traditional leadership uses technical and hierarchical tools, however, it is adaptive leadership skills that are needed to make transformation successful.[10] Current leaders often use technical and hierarchical tools to approach transformation whereas is the adaptive leaders who will set transformation on the road to success.

When the rubber hits the road and the pressure is on to transform, the gravest risk is that we revert to traditional leadership tools when an adaptive leadership tool kit is what is most critical. Adaptive leadership comes into play when the answer to the dilemma is not clear and new learning is required. On the front line, it is hearts and minds and not just behaviours that need to change. It requires actively managing multiple perspectives, where progress requires trial and error. Adaptive leadership often make smart people feel incompetent, disorients and scares people and it also takes time to lead adaptively and to produce meaningful progress on complex issues. A common cause of leadership failure is using a technical fix for an adaptive problem.

In Canterbury, New Zealand, the integration of primary care providers and secondary care was a clear demonstration of taking a systems approach utilizing collaborative leadership. Primary care providers came together with hospital-based physicians and administrators to create hundreds of standardized care pathways for integrating care between primary and secondary care.[11] The success of this approach – improving patient flow and communication amongst providers around the needs of patients – has quickly spread to 28 health regions across Australia and New Zealand.

## Our insight

The leadership model required to support healthcare transformation requires a complete rethink of the leadership principles and skills needed to lead this change. Leaders will need support and retraining on the system and collaborative leadership to create sustainable change and forge enduring relationships beyond their organizational boundaries.

# Stop referring to them as 'soft skills'

## How often do we hear about the soft skills as "nice to haves" rather than the "must have" skills?

Currently, the competencies that are most usually associated with leadership and organizational management – which are those skills that are knowledge and logic-based – are referred to as the 'hard skills'. However, for the kind of transformation required in health and social care around the world – to create integrated systems of care – this needs to change.

Leaders with highly evolved soft skills have the ability to capture the hearts and minds of people, understand what is most important to patients and their families, build trust, have difficult conversations, create a shared purpose and guide people along a transformation journey. These soft skills are *not* the "nice to haves", rather, they are the *required* skills for transformation; leading, designing and implementing integrated systems of care requires a strong soft skill base; these are the key competencies that will differentiate technical leaders from adaptive, system leaders.

System leaders build relationships based on deep listening, allowing networks of trust and collaboration to flourish. Short-term reactive problem solving becomes more balanced with long-term value creation.[12] These are the soft skills that will be required to win the hearts and minds of front- line staff and those managing them; to equip them with the capabilities to extend beyond their siloed clinical training to work in teams and build relationships outside their organizations, sometimes with individual primary care providers who are not used to working in this way.

These core capabilities include being able to see the larger system and the whole needs of the individual; Building and sustaining teams, and inspiring staff through generative conversations and time for reflection where teams are co-creating solutions in partnerships with clients and their families.[13] This creates a system of continuous improvement towards the vision of integrated care and a more engaged workforce that takes ownership of integrated care delivery.

**"The soft skills are not the 'nice to have' they are the 'must have' in order to create change on this scale."**

## Moving from leadership to 'leaderful'

The creation and ongoing nurturing of integrated care teams require us to move from leadership to 'leaderful'; everyone must be empowered to lead and make recommendations and decisions for how the team works.[14] There is a concurrent and collective shared responsibility for leadership. This is a complete cultural and philosophical shift, where front-line staff become empowered to lead care. It is the responsibility of good managers to enable and facilitate a 'leaderful environment', where individual team members feel safe and supported in making decisions.

The effort and capability required to build integrated systems of care cannot be understated. Relationship building is a core competency required to work across divergent providers. Building and sustaining relationships, particularly with individual primary care physicians, requires significant investment in time, and a skillset that is not part of the health professional curriculum. Building teams is also hard work and the core competencies known as soft skills: relationship building, establishing and maintaining trust, having integrity – are critical competencies to move to a population-based integrated service delivery model.[15]

Furthermore, when health system leaders see that change is not happening at the pace and scale they need, traditional leadership can slide into habits of 'shaming and blaming' as a way to incentivize higher performance and 'command and control' behaviours to drive change. Neither of these actions creates sustainable change because the people on the front-lines are disempowered by these leadership behaviours. Adaptive leaders do the opposite, they seek to understand the best way to unleash the potential of people, drawing on the strengths and skills of different teams and individuals while shoring up areas where capacity is lacking.[16]

## Our insight

We need to acknowledge the soft skills as essential competencies for the next generation of health system leadership (and the current leaders) and we need to re-train and re-tool our leaders and our leadership programs accordingly. We also need to recognize that using 'command and control' and 'shame and blame' tactics will neither facilitate nor incentivize a culture of improvement. Instead, we need to focus on how best to build our people power to reach our goals.

# Building a social movement: a thousand points of light vs a supernova

System change does not happen top down. It also does not happen through a thousand pilot projects. For real change in the system we need to inspire a social movement across consumers, carers, front-line staff and managers.

We have learnt through Helen Bevan, Chief Transformation Officer for the National Health Service (NHS), and others, not only do you need to activate all the players to create a social movement but you also need to inspire them to innovate and lead the change. Some of the most impactful change is generated from consumers and front line staff. We believe creating a social movement is a critical enabler to drive and hard wire transformation.

Social movements directed at health and care issues have been gaining increased attention.They take aim at a broad array of social, cultural and political changes such as promoting healthy lifestyles, de-stigmatizing mental health, experimenting with new approaches to knowledge creation, innovation, and policymaking. In the UK, a key component of the transformation of NHS England is the identifi support and spreading of effective social movements. As part of the support for the *Five Year Forward View*, the NHS launched a three-year program to support social movements in health and social care. Social movements are seen as one approach to system-level transformation that is so urgently needed in health and social care.[17]

Social movements can increase civic engagement in healthcare, and foster new thinking on many health and social care issues, such as the way we engage with primary care, breaking down siloes in health and social care, and identifying new models of care including digital and on-line access to care.

In Japan, it was a social movement that supported the creation of legislated policies that placed accountability for the care of the elderly on their children. This has translated to programs developed by Japan Post that offers the *Post Office Watch* system. For a monthly fee, post office employees check on elderly clients once or twice a month, using a standard checklist to confirm the person is safe and well. The result is

> **“ Without a social movement that drives change at scale you can have a thousand points of light but no supernova. ”**

mailed back to the person who purchased the service. The service helps reduce social isolation and identify potential safety issues before they arise.[18]

Driving a social movement for change requires creating platforms to engage patients, carers, teams and providers, so that the system can drive a conversation and change behaviour to reach goals at scale. The traditional approach of creating change (e.g. through 'power', 'command' and 'control') is less useful for driving complex change towards a new future state model. As Greg Satell states in *What Successful Movements Have In Common*,[19]

> "It's no longer enough to capture the trappings of power, because movements made up of small groups are able to synchronize their actions through networks. So if you want to effect lasting change today, it's no longer enough to merely command resources, you have to inspire opponents to join your cause."

Social movements are used to inspire massive change. Two examples in creating social movements for change in health care include: *NHS Social Movement for Health and Social Care Radicals* and the social movement for improved AIDS treatment in the 1980s, and outside of healthcare include the women's movement in the developed world.

## Our insight

The recent experience in the UK to create a sustaining social movement in healthcare serves as an example for all systems to create networks which support and realize the benefit of social movements in order to affect wider-scale system change.

# Accelerating disruption through technology


## Increasingly, regions with reduced resources have been developing innovative and creative ways to deliver care and serve patient needs that often exceed developed countries models in efficiency and effectiveness.

For example, regions in Asia and Africa are using mobile phones to support care delivery and health promotion in remarkable ways. Although telemedicine has been around for decades – the US Navy has been using it to support medical field operations since 1995 – this traditionally involved primarily physician-to-physician transactions. Today, there is a growing use of telecare, direct from provider-to-patient in their home, or on their phone with the use of at-home diagnostics and wearables.

In the Netherlands, Focus Cura has demonstrated the benefits of home health monitoring in partnership with Slingeland Ziekenhuis. Patients are being supported in their homes through the use of wearables and telemedicine that create a direct connection to care coordinators and the care team, helping patients manage with Chronic Obstructive Pulmonary Disease (COPD), heart failure and other chronic conditions. What truly makes this model work is an integrated care team at the point of care, allowing all to have access to the patient's care record as well as an awareness of their expressed goals for treatment. Additionally, these patients are activated and engaged in their own care, thereby actively contributing to their own outcomes and the attainment of goals. In many healthcare systems today, you might typically find this type of patient in a Complex Continuing Care unit, or in an acute setting waiting to be discharged to long-term care.

Telemedicine is only one example of technology creating new and improved care model. Israel is an example of a leader in the adoption of technology for the betterment of patients and care pathways; they have a fully integrated health record with patient and family applications that allow them to access their own information from hand held devices, where patients can communicate directly with members of their care team.

## Our insight

Significant opportunities exist around the world – with demonstrated benefits – to leverage cost-effective digital health solutions as a means to improve the patient experience and support the activation of patients. Next generation applications that disrupt current care models could have a profound impact on transforming the way we interact with care teams. Health leaders should consider the application of virtual care where it has demonstrated a continued contribution to creating value.

# You cannot plot a course forward by measuring backward

## We cannot use existing measures to measure the system of care for the future; we need metrics for new systems and new metrics for health outcomes, as well as new expectations for delivery.

Few health systems track real measures for integrated systems of care, patient reported outcomes and experience measures. We therefore evaluate quality of care, patient experience and health outcomes based on existing and easy to access data – which was never designed for the purposes we are using them for. We need to step back and ask:

- What are our goals?
- How do we measure them?
- What metrics do we need? If they are new metrics, how do we develop them?

While these questions may seem obvious, it is important to note most system transformation does not consider this line of questioning. We are therefore attempting to design a forward-looking design by measuring success looking backward through pre-existing metrics.

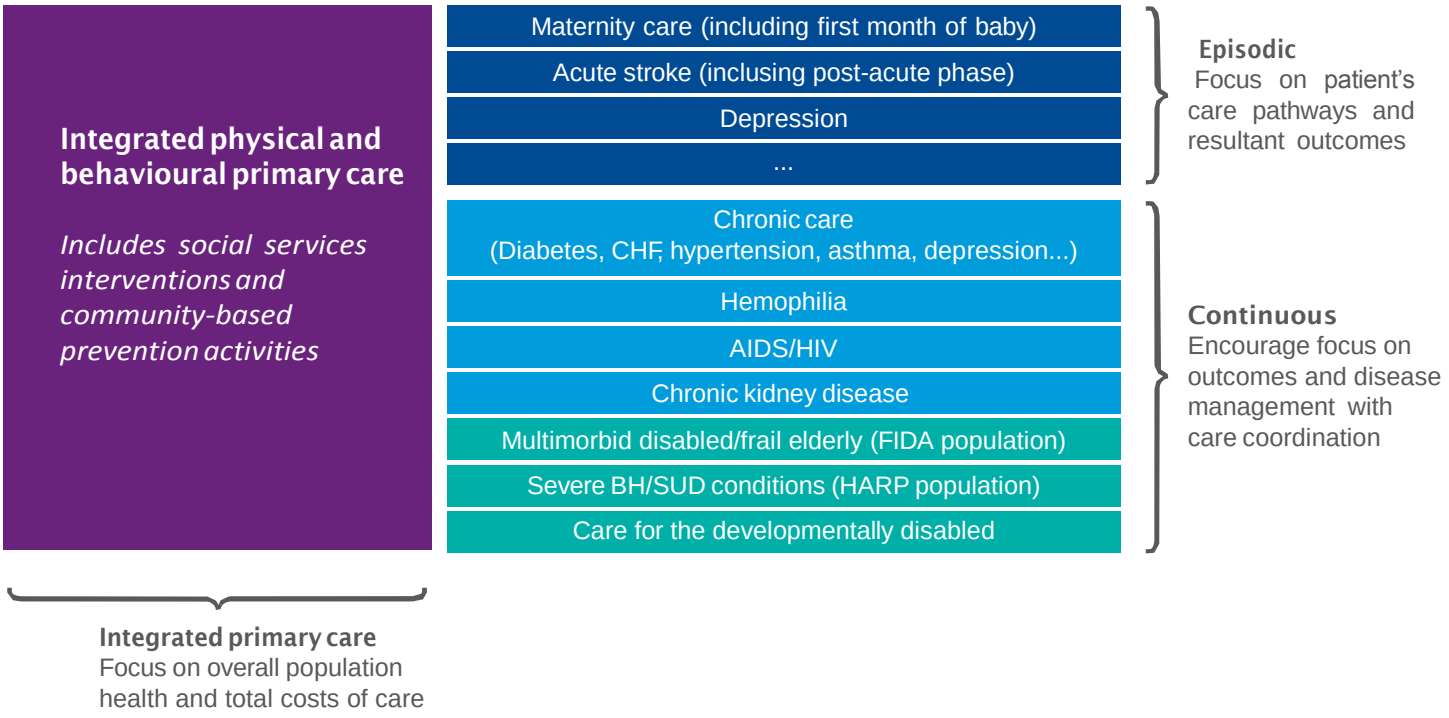
One possible solution is moving to an integrated, population-based model of care through the development of outcome measures that incentivize the right behaviours. This requires investments in data and analytics to measure outcomes that are important to clients/patients. In the State of New York, over 90 care bundles were mapped, grouping related activity to provide the foundation for payment reform based on the pertinent outcomes as shown in the graphic on the next page. Using a population-based approach, healthcare administrators can also map disparities and areas of health need based on outcomes. Achieving this level of sophistication requires building systems that can track client/patient goals and their progress in meeting those goals.

## Our insight

One of the key gaps in the transformation agenda in many jurisdictions is the lack of alignment between strategy, performance, quality metrics and public reporting. A data and analytics strategy is therefore essential to build the knowledge system required to shift outcomes. Forward thinking and new approaches to measurement of KPIs can facilitate and help incentivize the new patterns of behaviour.

> “If you want to build a world class health system, you need to defi what that looks like, and the measures to track when you’ve arrived. ”

## Care pathways developed for bundled payments in the State of New York




*Source:* KPMG in Canada

# Inspiring a workforce to thrive

## There are two main components to creating a workforce that thrives: engaging providers in caring for a 'whole' person, and partnering with patients and carers to achieve better health outcomes.

The health and social care system we want will not function on the traditional learned skills of most healthcare practitioners; the educational systems to support the development of healthcare providers has traditionally been very siloed, learning a discreet set of skills with the expectations that in practice things will operate very differently. Additionally, providers have learned skills to treat the immediate episodic needs of the patient – to drive system change and really address the needs of the client/patient, all providers will need to engage in team-based approaches to address the needs of the whole person.

This holistic and collaborative approach includes preparing the health workforce to focus on chronic disease management and care coordination, thereby addressing the underlying health issues that may be improved by addressing the social determinants of health. This will require a broadening of skill sets and enable providers to work to their full scope of practice. To provide a holistic patient experience, the workforce of tomorrow also needs to be able to take a systems view. This requires a workforce with a skill set emphasizing leadership, financial management, service improvement, taking a systems approach and strategic insight.

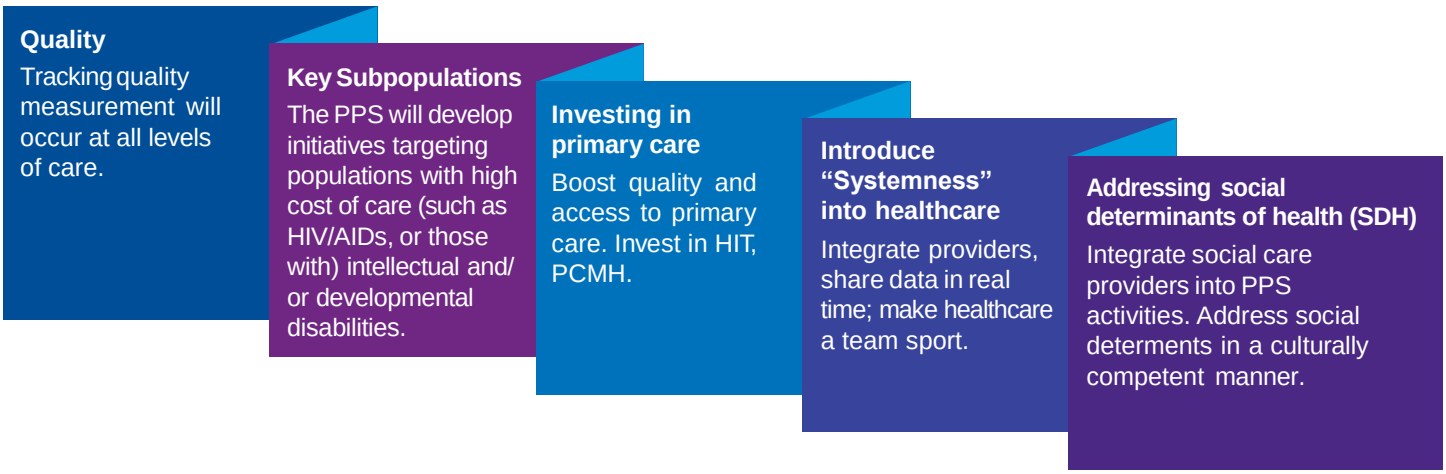
Building an integrated team of disparate providers, used to working in solo practices, can be diffi as it challenges the traditional ways that clinicians have been trained. This change requires a reorientation to understand and respond to the needs of citizens, to create a real and meaningful difference for patients and their caregivers. Moreover, it requires a full spectrum of traditional and non-traditional leadership skills that creates the conditions to inspire people and create an environment where they love coming to work every day. We have observed that when individuals work as a team and focus on the needs of clients, they become energized.

In the UK, 'the Vanguards' are new care models that are being implemented to transform patient care and the way providers across organizations work together. By investing in team-based care, these care models work to anticipate the needs of patients and carers instead of being reactive; this proactivity empowers clinicians and gives more voice to patients to play an active role in their own care.[20] Additionally, the outcomes have resulted in reductions in avoidable hospital use.

In the State of New York, the 25 Performing Provider Systems (PPS) are creating care teams that stretch across multiple organizations, coalescing around the needs of patients. Through rapid cycle improvement, integrated care teams have been identifying the needs of high user patients to identify what patients need to keep them healthy. These interventions have included buying and installing air conditioners for COPD or diabetes patients during the hot summer months, or aiding in improving home air quality for children with asthma.[21] In one PPS, upon completing a home health assessment, patients were offered air conditioners to help them cope with the extreme heat. The result was a signifi drop in Emergency Department (ED) visits in the population, allowing providers across the network to share in the savings achieved from this intervention as a result of reduced emergency department visits.

> **“ The health workforce of today requires a skill set that emphasizes leadership, fi management, service improvement, taking a systems approach to problem solving and strategic insight. ”**

### PPS holistic approach to system transformation




*Source:* Medicaid Redesign and Delivery System Reform: New York’s Story, New York State Department of Health

## Our insight

Changing the way providers think about the needs of patients will require fundamental changes to the way clinicians are trained. Expectations around outcomes will also change the conversation with patients, engaging them in discussions about their goals and how the system can support them in achieving it.

# Ensuring a creative space for transformation

## It is said that health system transformation is like changing a Boeing 747 into a stealth bomber in mid-air. This kind of complex system redesign requires infrastructure and industry expertise.

How is it possible that we expect existing health system providers and leaders to transform the system while they are fully employed and over capacity? Health system redesign needs a collective effort; we need to build in the space and capacity for change to happen and we need to ensure that people have the right skills to design and implement change.

Health system transformation requires people to adapt and change. This requires self-reflection and understanding of how our own behaviours and work habits need to change, regardless of role or position. Entrenched patterns of behaviour and ways of working can be significant barriers to transformation.

Globally, significant transformation efforts are already underway, with many being supported with dedicated infrastructure and financial support systems – thereby achieving the escape velocity required to launch sustainable system change. In the State of New York, an entire program of support has been developed to aid health system transformation focused on support for provider integration, workforce transformation, and payment reform. The State has been granted $8 billion USD from the federal Centers for Medicare & Medicaid Services (CMS) to invest in the transformation to 2020; The system serves a population less than half that of the Province of Ontario's (6.2 million) with a spend of $62 billion USD in 2016.

Other jurisdictions have taken similar approaches, creating public and provider facing agencies to drive system level transformation, including Vancouver Coastal Health regional authority's Clinical and System Transformation (CST) project to improve system reliability and sustainability; the public launch of the Five Year Forward View to support transformation in the UK; and the NHS' development of more regional Sustainability and Transformation Plans – in addition to system-wide leadership training through the NHS Leadership Academy.

## Our insight

Many jurisdictions around the world are launching significant transformation efforts of health and social care. Success requires a clearly articulated vision and support for front-line providers and leaders. Every ecosystem needs a clear roadmap (including expectations, milestones, and endpoints) which provides support for providers throughout the journey. We believe this strategic investment will reap dividends for years.

# Pathways to 'population health'

## Changing the health of an entire population requires a shift in thinking and consensus on what we mean by 'population health'.

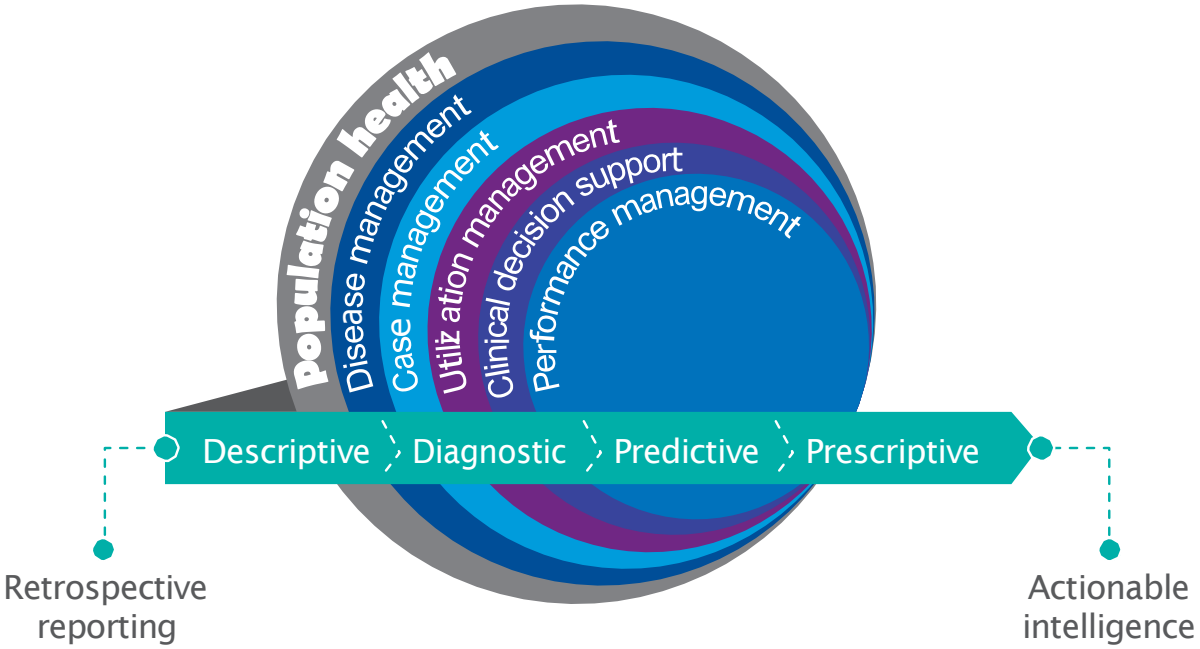
The Public Health Agency of Canada (PHAC) defines population health as "an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups." Core to this approach is the recognition that there are multiple determinants of health, many of which lie beyond the traditional scope of the health system. Equally important is the focus on the distribution of health across populations and the socio-economic gradient.[22] A population health approach recognizes the importance of intersectoral partnerships at the community level, across and among different levels of government, and between health care providers and other professionals who have a role in influencing health.

The leadership in the US, by organizations such as Kaiser Permanente, and the Institute for Healthcare Improvement, with a focus on improving the health of populations, has developed approaches now used by accountable care organizations. These approaches aim to make provider networks and organizations responsible for the health of the population and take on some of the risks of managing that population by compensating providers for outcomes. For example, some of these systems are self-selecting populations, capable of selecting a typically healthier population to manage. Regardless of how populations are selected, the approach to population health is similar:

- Organizations must work together across systems to improve health outcomes for a defined population. This addresses the health needs of the entire population, not just those that show up at Physician offices or Emergency Departments, and targets vulnerable groups to improve health disparities and inequities.
- Different approaches are used to target segments of the population to meet health needs and address specific health risks. This recognizes that different segments of the population require different approaches and involvement from different system partners to be effective.
- Improving the health of the population requires a range of interventions at the individual level, addressing the broader determinants of health and may include: housing support, education, employment services, wellness and exercise, smoking cessation, etc.[23]

Moving towards a population health approach requires significant enablement from population-based data and analytics (including segmentations of the population and an analysis of local needs) and shared budgets. Moreover, system

## Paths to population health




*Source:* What Works: Paths to Population Health, KPMG International

leadership which draws on the skills and experience from a range of organizations and sectors is required when developing the overall vision and strategy, including shared goals based on the analysis of local needs and evidence-based interventions. Community engagement and incentives are also needed to encourage collaboration between people and providers.

An example of how to best approach population health is The Robert Wood Foundation, which has significant investments in creating a culture of health with the creation of a Culture of Health Action Framework. The framework sets a national agenda for the US to improve health, well-being, and equity, articulating ten principles to guide all large scale change and improve the health of diverse communities. Exemplars of how best to approach population health or healthy communities exist. It is our opportunity to actualize these to improve the health of diverse communities.

## Our insight

A population health approach will require breaking down the silos between health and social care… and beyond. New ways of thinking are required if funders and policy makers are to lead this effort – including a new set of rules for determining who they can fund to support health and equity amongst the population. Our goal is to ensure and improve the health of diverse communities, as well as collectively understand what we mean by population health, what our goals are and how to actualize the associated approaches.

# Conclusion

Health systems all over the world are undergoing significant change to address issues of sustainability, building fit-for-purpose systems. The developed world's healthcare systems evolved slowly over the last century, now requiring a transformational shift around the needs of the patient. Over the next decade, the voice of the patient will become prominent in defining care choices and system design.

This paper addresses ten critical issues and recommendations required to support this transformation. To get us there, health systems need to move beyond "patient-centered" and focus on activating patients in their care, building systems around empowered citizens. There is a need to recognize and equip the healthcare workforce with the necessary leadership skills to enable a more decentralized system, to enable decision-making at the front line and within teams. We will need to empower systems managers to lead in this environment, adopting more coaching-oriented styles of leadership. There is much to learn from the successes and failures of others, particularly where technological innovation can support the needs of patients. Lastly, system managers should be mindful of the space required for transformation to take place and the recognition of the effort required to get there. We must remember the health system is for all our benefit and requires a collective effort to build anew.

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> **“We must remember the health system is for all our benefit and requires a collective effort to build anew. ”**


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ARTICLE
POLICY

# The Innovation Health Care Really Needs: Help People Manage Their Own Health

*by Clayton M. Christensen, Andrew Waldeck and Rebecca Fogg*

Harvard Business Review

POLICY

# The Innovation Health Care Really Needs: Help People Manage Their Own Health

by Clayton M. Christensen, Andrew Waldeck and Rebecca Fogg

OCTOBER 30, 2017 UPDATED NOVEMBER 06, 2017

jennifer maravillas for hbr

Finally, health care, which has been largely immune to the forces of disruptive innovation, is beginning to change. Seeing the potential to improve health with simple primary-care strategies,

some of the biggest incumbent players are inviting new entrants focused on empowering consumers into their highly regulated ecosystems, bringing down costs.

This shift is long overdue. Whereas new technologies, competitors, and business models have made products and services more affordable and accessible in media, finance, retail, and other sectors, U.S. health care keeps getting costlier. It is now by far the world's most expensive system per capita, about twice that of the UK, Canada, and Australia, with chronic conditions such as diabetes and heart disease now accounting for more than 80% of total spending.

These astronomical costs are largely due to the way competition works in American health care. Employers and insurance companies — not end consumers — call the shots on what kind of care they will pay for. Large hospitals and physician practices, in turn, compete as if they're in an arms race to attract payers, adding advanced diagnostic gear or new surgical wings to differentiate, driving up costs.

In most industries, disruption comes from startups. Yet almost all health care innovation funded since 2000 has been for sustaining the industry's business model rather than disrupting it. Our analysis of Pitchbook Data shows that more than $200 billion has been poured into health care venture capital, mostly in biotech, pharma, and devices where advances typically make health care more sophisticated — and expensive. Less than 1% of those investments have focused on helping consumers to play a more active role in managing their own health, an area ripe for disruptive approaches.

## The Whole-Person Approach

One big incumbent that has become more receptive to disruptive innovation is the insurance giant Humana. It has partnered with Boston-based startup Iora Health. Created by physician-entrepreneur Rushika Fernandopulle, Iora has advanced a disruptive primary-care model that uses relatively inexpensive, nonphysician health coaches to identify patients' unhealthy habits and life styles and guide them toward better choices, before health problems arise or become serious. Since its founding in 2010, Iora has attracted more than $123 million in funding and now operates 37 practices serving 40,000 patients in 11 states. Iora trains health coaches to become the consumer's advocate, acting as the quarterback of an extended care team that includes a physician. When visiting an Iora clinic, the patient meets with the coach to establish a health agenda before seeing the doctor. After the patient sees the physician, the health coach and patient debrief to ensure the patient can confidently pursue the agreed-upon health goals — for example, by adopting new health habits. The coach then serves as the patient's connection with the Iora team, and creates accountability.

Another feature of the Iora model is the morning huddle, when the entire care team invests an hour discussing the health status of the clinic's population. Because Iora assumes full financial risk for its patients — it is paid a set fee per patient for a given period — the huddle prioritizes those who require the most attention and directs care around their needs.

To that end, Iora has developed a "worry score" methodology, which rates each patient on a 1-to-4 scale according to their health status and needs. Patients scoring a 4 require a specific action, such as immediate outreach from a health coach. If the patient's outlook turns for the better, their worry score is lowered, a development celebrated by the team.

The Iora model has produced dramatic results in the management of chronic conditions. For example, an unpublished Iora study found that inpatient hospital admissions among a cohort of 1,176 Iora Medicare enrollees over an 18-month period decreased by 50%, emergency department visits decreased by 20%, and the total medical spend declined by 12% — this despite the cohort being sicker than average Medicare patients.

Iora is not alone in this approach to focusing on health rather than health care: Oak Street, Omada, Docent, ChenMed, WellMed, Mosaic, Aledade and others have gained traction with disruptive care-team models. What makes the models disruptive — and able to get a foothold among mammoth incumbent provider organizations — is the combination of delivery and payment schemes (capitation is the predominant model); either alone would be unlikely to succeed.

## Encouraging Disruption

Payers and other innovative delivery organizations have employed similar strategies for years. A range of programs — by Aetna, CareMore, Dignity Health, Humana, Kaiser Permanente, and the Medicare Advantage program — are using coaches and home visits to substantially improve health and lower costs. One study found that providers participating in Medicare's Independence at Home Demonstration saved $1,010 per beneficiary on average in the second year of the program, primarily by reducing hospital use.

Another care-team-based pilot, the Diabetes Prevention Program, reduced patients' risk of developing the disease and saved Medicare an estimated $2,650 per beneficiary over a 15-month period by helping patients lose an average 5% of their body weight through changes in diet and exercise. The program is delivered through primary care groups, hospitals, YMCAs, and telehealth networks, and patients are supported by weekly, hourlong "maintenance sessions" with coaches.

While this care model has proved powerful at a small scale, to have significant impact on costs and outcomes nationally it must serve millions more consumers. To achieve that scale, we recommend the following strategies:

**For care providers:** Embrace the business model of extended care teams that include health coaches. We recommend starting with pilot programs under which hospitals and clinics take on financial risk for patients' health. This way, care teams are incentivized to help patients stay healthy.

**For payers and insurers:** Private-public partnerships like Medicare Advantage (under which for-profit insurers administer plans paid for by the government) have become successful marketplaces that

allow disruptive models. We recommend extending programs modeled on pilots like Independence at Home and the Diabetes Prevention Program across privately-funded insurance markets.

**For legislators:** Work to enable new models of care that lower costs by incenting individuals, payers, and providers to improve wellness, rather than treat disease after it manifests. This requires fostering a robust individual insurance market in which payers reward providers for helping patients stay healthy.

*Editors' note: We have updated this article to clarify that many provider organizations in addition to Iora have historically used care-team models.*

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Stanford SOCIAL INNOVATION REVIEW

# Channeling Change: Making Collective Impact Work

By Fay Hanleybrown, John Kania, & Mark Kramer

Stanford Social Innovation Review
2012

# Channeling Change: Making Collective Impact Work

*An in-depth look at how organizations of all types, acting in diverse settings, are implementing a collective impact approach to solve large-scale social problems.*

By Fay HanleyBrown, JoHn Kania, & MarK KraMer

What does a global effort to reduce malnutrition have in common with a program to reduce teenage substance abuse in a small rural Massachusetts county? Both have achieved significant progress toward their goals: the Global Alliance for Improved Nutrition (GAIN) has helped reduce nutritional deficiencies among 530 million poor people across the globe, while the Communities That Care Coalition of Franklin County and the North Quabbin (Communities That Care) has made equally impressive progress toward its much more local goals, reducing teenage binge drinking by 31 percent. Surprisingly, neither organization owes its impact to a new previously untested intervention, nor to scaling up a high-performing nonprofi organization. Despite their dramatic differences in focus and scope, both succeeded by using a collective impact approach.

In the winter 2011 issue of *Stanford Social Innovation Review* we introduced the concept of "collective impact" by describing several examples of highly structured collaborative efforts that had achieved substantial impact on a large scale social problem, such as The Strive Partnership[1] educational initiative in Cincinnati, the environmental cleanup of the Elizabeth River in Virginia, and the Shape Up Somerville campaign against childhood obesity in Somerville, Mass. All of these initiatives share the five key conditions that distinguish collective impact from other types of collaboration: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and the presence of a backbone organization. (See "The Five Conditions of Collective Impact" below.)

We hypothesized that these five conditions offered a more powerful and realistic paradigm for social progress than the prevailing model of isolated impact in which countless nonprofit, business, and government organizations each work to address social problems independently. The complex nature of most social problems belies the idea that any single program or organization, however well managed and funded, can singlehandedly create lasting large-scale change. (See "Isolated Impact vs. Collective Impact" on page 2.)

Response to that article was overwhelming. Hundreds of organizations and indi-

## The Five Conditions of Collective Impact

| | |
|---|---|
| **Common Agenda** | All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions. |
| **Shared Measurement** | Collecting data and measuring results consistently across all participants ensures eff remain aligned and participants hold each other accountable. |
| **Mutually Reinforcing Activities** | Participant activities must be diff entiated while still being coordinated through a mutually reinforcing plan of action. |
| **Continuous Communication** | Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and create common motivation. |
| **Backbone Support** | Creating and managing collective impact requires a separate organization(s) with staff and a specifi set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies. |

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## Isolated Impact vs. Collective Impact

| Isolated Impact | Collective Impact |
|---|---|
| S Funders select individual grantees that off the most promising solutions. | S Funders and implementers understand that social problems, and their solutions, arise from the interaction of many organizations within a larger system. |
| S Nonprofi work separately and compete to produce the greatest independent impact. | S Progress depends on working toward the same goal and measuring the same things. |
| S Evaluation attempts to isolate a particular organization's impact. | S Large scale impact depends on increasing cross-sector alignment and learning among many organizations. |
| S Large scale change is assumed to depend on scaling a single organization. | S Corporate and government sectors are essential partners. |
| S Corporate and government sectors are often disconnected from the eff of foundations and nonprofi . | S Organizations actively coordinate their action and share lessons learned. |

viduals from every continent in the world, even including the White House, have reached out to describe their efforts to use collective impact and to ask for more guidance on how to implement these principles.

Even more surprising than the level of interest is the number of collective impact efforts we have seen that report substantial progress in addressing their chosen issues. In addition to GAIN and Communities That Care, Opportunity Chicago placed 6,000 public housing residents in new jobs, surpassing its goal by 20 percent; Memphis Fast Forward reduced violent crime and created more than 14,000 new jobs in Memphis, Tenn.; the Calgary Homeless Foundation housed more than 3,300 men, women, and children and contributed to stopping what had been the fastest growing rate of homelessness in Canada; and Vibrant Communities significantly reduced poverty levels in several Canadian cities.

The initiatives we cited in our initial article have also gained tremendous traction: Shape Up Somerville's approach has now been adapted in 14 communities through subsequent research projects and influenced a national cross-sector collaborative. The Strive Partnership recently released its fourth annual report card, showing that 81 percent of its 34 measures of student achievement are trending in the right direction versus 74 percent last year and 68 percent two years ago.[2] Its planned expansion to five cities when the article came out has since been vastly expanded as more than 80 communities (including as far away as the Ruhr Valley in Germany) have expressed interest in building on The Strive Partnership's success.

Part of this momentum is no doubt due to the economic recession and the shortage of government funding that has forced the social sector to find new ways to do more with less—pressures that show no signs of abating. The appeal of collective impact may also be due to a broad disillusionment in the ability of governments around the world to solve society's problems, causing people to look more closely at alternative models of change.

More and more people, however, have come to believe that collective impact is not just a fancy name for collaboration, but represents a fundamentally different, more disciplined, and higher performing approach to achieving large-scale social impact. Even the attempt to use these ideas seems to stimulate renewed energy and optimism. FSG has been asked to help launch more than one dozen collective impact initiatives, and other organizations focused on social sector capacity building such as the Bridgespan Group, Monitor Institute, and the Tamarack Institute in Canada, have also developed tools to implement collective impact initiatives in diverse settings.

As examples of collective impact have continued to surface, it has become apparent that this approach can be applied against a wide range of issues at local, national, and even global levels. In fact, we believe that there is no other way society will achieve large-scale progress against the urgent and complex problems of our time, unless a collective impact approach becomes the accepted way of doing business.

At the same time, our continued research has provided a clearer sense of what it takes for collective impact to succeed. The purpose of this article, therefore, is to expand the understanding of collective impact and provide greater guidance for those who seek to initiate and lead collective impact initiatives around the world. In particular, we will focus on answering the questions we hear most often: How do we begin? How do we create alignment? And, How do we sustain the initiative?

### aWaKening tHe PoWer oF ColleCtive iMPaCt

Of all the collective impact examples we have studied, few are as different in scale as GAIN and Communities That Care, yet both of these efforts embody the principles of collective impact, and both have demonstrated substantial and consistent progress toward their goals.

GAIN, created in 2002 at a special session of the United Nations General Assembly, is focused on the goal of reducing malnutrition by improving the health and nutrition of nearly 1 billion at risk people in the developing world. The development of GAIN was predicated on two assumptions: first, that there were proven interventions that could be employed at scale to improve nutrition of the poor in developing countries, and second, that the private sector had a much greater role to play in improving the nutrition even for the very poor. GAIN is now coordinated by a Swiss Foundation with offices in eight cities around the world and more planned to open soon. In less than a decade, GAIN has created and coordinated the activity of 36 large-scale collaborations that include governments, NGOs, multilateral organizations, universities, and more than 600 companies in more than 30 countries. GAIN's work has enabled more than 530 million people worldwide to obtain nutritionally enhanced food and significantly reduced the prevalence of micronutrient deficiencies in a number of countries. In China, South Africa, and Kenya, for example, micronutrient deficiencies dropped between 11 and 30 percent among those who consumed GAIN's fortified products. During that time, GAIN has also raised $322 million in new financial commitments and leveraged many times more from its private sector and government partners.

At the other end of the spectrum, the Franklin County/North Quabbin Region

of Western Massachusetts has a population of only 88,000 people dispersed across 30 different municipalities and 844 square miles. When two local social service agencies—the Community Coalition for Teens and the Community Action of the Franklin, Hampshire, and North Quabbin Regions—first called a meeting to discuss teenage drinking and drug use, they were astonished that 60 people showed up. From that first meeting, coincidentally also in 2002, grew Communities That Care, that now includes more than 200 representatives from human service agencies, district attorney's offices, schools, police departments, youth serving agencies, faith-based organizations, local elected officials, local businesses, media, parents, and youth. Overseen by a central coordinating council, the initiative operates through three working groups that meet monthly to address parent education, youth recognition, and community laws and norms. In addition, a school health task force links these work groups to the 10 public school districts in the region. Over an eight-year time frame, the work of Communities That Care has resulted not only in reducing binge drinking, but also in reducing teen cigarette smoking by 32 percent and teen marijuana use by 18 percent. The coalition has also raised more than $5 million of new public money in support of their efforts.

Different as they may be, these two initiatives demonstrate the versatility of a collective impact approach and offer broad insights into how to begin, manage, and structure collective impact initiatives.

### tHe PreConditions For ColleCtive iMPaCt

Three conditions must be in place before launching a collective impact initiative: an *infl ential champion*, *adequate financial resources*, and a sense of *urgency for change*. Together, these preconditions create the opportunity and motivation necessary to bring people who have never before worked together into a collective impact initiative and hold them in place until the initiative's own momentum takes over.

The most critical factor by far is an *influential champion* (or small group of champions) who commands the respect necessary to bring CEO-level cross-sector leaders together and keep their active engagement over time. We have consistently seen the importance of dynamic leadership in catalyzing and sustaining collective impact efforts. It requires a very special type of leader, however, one who is passionately focused on solving a problem but willing to let the participants figure out the answers for themselves, rather than promoting his or her particular point of view.[3] In the case of GAIN, four individuals with deep experience in the development field—Bill Foege, the former director of the US Centers for Disease Control who is largely credited with eradicating small pox, Kul Gautam, a senior official at UNICEF, Duff Gillespie, head of the Office of Population and Nutrition at US Agency for International Development (USAID), and Sally Stansfield, one of the original directors at The Bill & Melinda Gates Foundation—came together to look at large scale opportunities to address malnutrition in populations at risk in the developing world. Together they galvanized the 2002 UN General Assembly special session that led to the creation of GAIN and to the subsequent engagement of hundreds of government, corporate, and nonprofit participants.

Second, there must be adequate *fi ancial resources* to last for at least two to three years, generally in the form of at least one anchor funder who is engaged from the beginning and can support and mobilize other resources to pay for the needed infrastructure and planning processes. The Gates Foundation, the Canadian International Development Agency, and the USAID played this role in the case of GAIN. For Communities That Care, a federal grant provided the necessary multi-year support.

The final factor is the *urgency for change* around an issue. Has a crisis created a breaking point to convince people that an entirely new approach is needed? Is there the potential for substantial funding that might entice people to work together, as was the case in Franklin County? Is there a fundamentally new approach, such as using the production, distribution, and demand creation capacities of the private sector to reach millions of people efficiently and sustainably, as was the case for GAIN? Conducting research and publicizing a report that captures media attention and highlights the severity of the problem is another way to create the necessary sense of urgency to persuade people to come together.

### bringing ColleCtive iMPaCt to liFe

Once the preconditions are in place, our research suggests that there are three distinct phases of getting a collective impact effort up and running.

Phase I, *Initiate Action*, requires an understanding of the landscape of key players and the existing work underway, baseline data on the social problem to develop the case for change, and an initial governance structure that includes strong and credible champions.

Phase II, *Organize for Impact*, requires that stakeholders work together to establish common goals and shared measures, create a supporting backbone infrastructure, and begin the process of aligning the many organizations involved against the shared goals and measures.

Phase III, *Sustain Action and Impact*, requires that stakeholders pursue prioritized areas for action in a coordinated way, systematically collect data, and put in place sustainable processes that enable active learning and course correcting as they track progress toward their common goals. (See "Phases of Collective Impact" on page 4.)

It is important to recognize that the initiative must build on any existing collaborative efforts already underway to address the issue. Collective impact efforts are most effective when they build from what already exists; honoring current efforts and engaging established organizations, rather than creating an entirely new

> The appeal of collective impact may be due to a broad disillusionment in the ability of governments to solve society's problems, causing people to look at alternative models of change.

solution from scratch.

Being realistic about the time it will take to get through these initial organizing stages is equally important. It takes time to create an effective infrastructure that allows stakeholders to work together and that truly can ameliorate a broken system. The first two phases alone can take between six months and two years. The scope of the problem to be addressed, the degree of existing collaboration, and the breadth of community engagement all influence the time required. Conducting a readiness assessment based on the preconditions listed above can help to anticipate the likely time required.

Once the initiative is established, Phase III can last a decade or more. Collective impact is a marathon, not a sprint. There is no shortcut in the long-term process of social change. Fortunately, progress happens along the way. In fact, early wins that demonstrate the value of working together are essential to hold the collaborative together. In a collective impact education initiative FSG is supporting in Seattle, for example, collaboration in the first year of the initiative led to a dramatic increase in students signing up for College Bound scholarships; not the ultimate goal, but an encouraging sign. Merely agreeing on a common agenda and shared measurement system during Phase II often feels like an important early win to participants.

### Setting the Common Agenda

Developing a well-defined but practical common agenda might seem like a straightforward task. Yet we find that regardless of the issue and geography, practitioners struggle to agree on an agenda with sufficient clarity to support a shared measurement system and shape mutually reinforcing activities. Setting a common agenda actually requires two steps: creating the boundaries of the system or issue to be addressed, and developing a strategic action framework to guide the activities of the initiative.

***Creating Boundaries.*** Establishing the boundaries of the issue is a judgment call based on each situation. For example, in another collective impact initiative that focused on teen substance abuse, a cross sector set of stakeholders in Staten Island, N.Y. drew their boundaries to include key factors such as parental and youth social norms as well as prevention and treatment activities. They could as easily have included many other related "root causes" of substance abuse such as youth unemployment or domestic violence. While these issues undoubtedly contribute to substance abuse, the group felt less able to impact these areas, and therefore left these issues outside the boundaries of their efforts. On the other hand, working with retailers to limit the availability of alcohol to minors, although outside the social sector, was determined to be an issue inside the boundary of what the group felt they could take on.

Or consider the boundaries drawn by Opportunity Chicago, a collective impact effort that included foundations, government agencies, nonprofits, and employers working to connect low-skilled public housing residents to employment in connection with the city's sweeping plan to transform public housing. The initiative's leaders realized that new housing would not help if the residents could not meet the work requirement established to qualify for residency. As a result, they included workforce development within the housing initiative's boundaries and established Opportunity Chicago, the collective impact initiative that ultimately placed 6,000 residents in jobs.

Boundaries can and do change over time. After nearly a decade of addressing teen substance abuse prevention, Communities That Care is launching a second initiative to address youth nutrition and physical activity, applying the existing structure and stakeholders to a closely related but new topic area within their mission of improving youth health in their region.

Determining geographic boundaries requires the same type of judgment in balancing the local context and stakeholder aspirations. While Shape Up Somerville chose a city-wide focus to tackle childhood obesity, Livewell Colorado addressed the same issue for the entire state by bringing together a more widely dispersed group of representatives from businesses, government, nonprofi s, healthcare, schools, and the transportation sector.

Although it is important to create clarity on what is and what is not part of the collective efforts, most boundaries are loosely defined and flexible. Subsequent analysis and activity may draw in other issues, players, and geographies that were initially excluded. Communities That Care, for example, began by serving only Franklin County, and expanded their geographic boundaries in their seventh year to include North Quabbin.

***Developing the Strategic Action Framework.*** Once the initial system boundaries have been established, the task of creating a common agenda must shift to developing a strategic framework for action. This should not be an elaborate plan or a rigid theory of change. The Strive Partnership's "roadmap" for example, fi s on a single page and was originally developed in just a few weeks. The strategic framework must balance the necessity of simplicity with the need to create a comprehensive understanding of the issue that encompasses the activities of all stakeholders, and the flexibility to allow for the organic learning

## Phases of Collective Impact

| Components for Success | Phase I Initiate Action | Phase II Organize for Impact | Phase III Sustain Action and Impact |
|---|---|---|---|
| ***Governance and Infrastructure*** | Identify champions and form cross-sector group | Create infrastructure (backbone and processes) | Facilitate and refi |
| ***Strategic Planning*** | Map the landscape and use data to make case | Create common agenda (goals and strategy) | Support implementation (alignment to goals and strategies) |
| ***Community Involvement*** | Facilitate community outreach | Engage community and build public will | Continue engagement and conduct advocacy |
| ***Evaluation and Improvement*** | Analyze baseline data to identify key issues and gaps | Establish shared metrics (indicators, measurement, and approach) | Collect, track, and report progress (process to learn and improve) |

process of collective impact to unfold. This framework for action can serve a critical role in building a shared agenda. As Chad Wick, one of the early champions of The Strive Partnership explains, "Our map got everyone to suspend their own view of the world and got us on a common page from which to work. It allowed others to suspend their preconceived views and be open minded about what was and what could be."

Hundreds of organizations and individuals from every continent in the world, even including the White House, have reached out to describe their eff to use collective impact.

Successful frameworks include a number of key components: a description of the problem informed by solid research; a clear goal for the desired change; a portfolio of key strategies to drive large scale change; a set of principles that guide the group's behavior; and an approach to evaluation that lays out how the collective impact initiative will obtain and judge the feedback on its efforts.

Since 2002, the Tamarack Institute has been guiding Canada's approach to fighting poverty through the Vibrant Communities initiative in a dozen Canadian cities. The Tamarack Institute refers to their strategic action frameworks as "frameworks-for-change," and cogently describes their value as follows: "A strong framework for change, based on strong research and input from local players, shapes the strategic thinking of the group, helps them make tough choices about where to spend their time and energy, and guides their efforts at monitoring and evaluating their work. Ask anyone involved in the effort about where they are going and their road map for getting there, and they will tell you."[4]

We believe their description applies equally well to any strategic action framework that guides a common agenda. Our experience also suggests that it may not always make sense to start off by implementing every single strategy identified in the common agenda. It is also important to pursue a portfolio of strategies that offer a combination of easy but substantive short-term wins to sustain early momentum for the initiative, as well as more ambitious, long-term systemic strategies that may not show impact for several years.

Importantly, strategic action frameworks are not static. Tamarack goes on to note: "They are working hypotheses of how the group believes it can [achieve its goals], hypotheses that are constantly tested through a process of trial and error and updated to reflect new learnings, endless changes in the local context, and the arrival of new actors with new insights and priorities."

FSG research bears out this need for continuous adaptation. The Strive Partnership has evolved their roadmap three times in the last five years. GAIN has built in a robust feedback loop from its programming, and over the past eight years has incorporated best practices and lessons learned as a fundamental component of its fourth annual strategic action framework. And Communities That Care has revised its community action plan three times in the last eight years.

Implementing a collective impact approach with this type of fluid agenda requires new types of collaborative structures, such as shared measurement systems and backbone organizations.

### sHared MeasureMent systeMs

Practitioners consistently report that one of the most challenging aspects to achieving collective impact is shared measurement—the use of a common set of measures to monitor performance, track progress toward goals, and learn what is or is not working. The traditional paradigm of evaluation, which focuses on isolating the impact of a single organization or grant, is not easily transposed to measure the impact of multiple organizations working together in real time to solve a common problem. Competing priorities among stakeholders and fears about being judged as underperforming make it very hard to agree on common measures. Organizations have few resources with which to measure their own performance, let alone develop and maintain a shared measurement system among multiple organizations.

Yet shared measurement is essential, and collaborative efforts will remain superficial without it. Having a small but comprehensive set of indicators establishes a common language that supports the action framework, measures progress along the common agenda, enables greater alignment among the goals of different organizations, encourages more collaborative problem-solving, and becomes the platform for an ongoing learning community that gradually increases the effectiveness of all participants.[5] Mutually reinforcing activities become very clear once the work of many different organizations can be mapped out against the same set of indicators and outcomes.

Consider the collective impact effort to reduce homelessness in Calgary, Canada, supported by the Calgary Homeless Foundation (CHF). When stakeholders first came together to define common measures of homelessness, they were shocked to discover that the many agencies, providers, and funders in Calgary were using thousands of separate measures relating to homelessness. They also found that providers had very different definitions of key terms, such as the "chronic" versus "transitional" homeless, and that their services were not always aligned to the needs of the individuals served. Merely developing a limited set of eight common measures with clear definitions led to improved services and increased coordination. Even privacy issues, a major legal obstacle to sharing data, were resolved in ways that permitted sharing while actually increasing confidentiality. As Alina Turner, vice president of strategy at CHF put it, "Putting shared measures in place is a way to start the deeper systems change in a way that people can get their heads around . . . starting from a common framework to get alignment across a whole system of care."

Developing an effective shared measurement system requires broad engagement by many organizations in the field together with clear expectations about confidentiality and transparency. The Calgary homelessness initiative worked with both

a cross-sector advisory committee and a service provider committee to develop common measures from evidence-based research. The measures were then refined through iterative meetings with dozens of stakeholders before being finalized.

Shared measurement systems also require strong leadership, substantial funding, and ongoing staffing support from the backbone organization to provide training, facilitation, and to review the accuracy of data. In CHF's case, the foundation funded and staffed the development of the homelessness management information system (HMIS) and the process of developing shared measures.

Developments in web-based technology permit huge numbers of stakeholders to use shared measurement inexpensively in ways that would have been impossible even a few years ago. CHF has adopted a sophisticated HMIS system with different levels of secure data access for providers, government agencies, and funders. The Strive Partnership, in collaboration with Cincinnati Public Schools, Procter & Gamble, and Microsoft, has made major advances in shared measurement by introducing the "Learning Partner Dashboard," a web-based system that allows schools and nonprofit providers to access data including the performance of individual students and the specific services they receive. Memphis Fast Forward's Operation, Safe Community, built a tool for tracking and publicizing county-wide crime data and facilitated the memorandum of understanding that resulted in data sharing and participation by all five local municipal police departments and the Sheriff's office.

Having shared measures is just the first step. Participants must gather regularly to share results, learn from each other, and refine their individual and collective work based on their learning. Many initiatives use standardized continuous improvement processes, such as General Electric's Six Sigma process or the Model for Improvement. In the case of GAIN, the initiative has both a performance framework and rigorous monitoring and evaluation criteria which feed into an organization-wide learning agenda. Their Partnership Council, comprised of world experts in the fields of nutrition, agriculture, economics, and business, advises the board of directors on the learning agenda, reviews the data to ensure its integrity, and recommends programmatic and management improvements.

Regardless of the continuous improvement approach chosen, the backbone organization plays a critical role in supporting the process of learning and improving throughout the life of the collaborative.

**KeePing ColleCtive iMPaCt alive**

Two key structural elements enable collective impact initiatives to withstand the overwhelming challenges of bringing so many different organizations into alignment and holding them together for so long: the *backbone organization* and *cascading levels of linked collaboration*.

***Backbone Organization.*** In our initial article we wrote that "creating and managing collective impact requires a separate organization and staff with a very specific set of skills to serve as the backbone for the entire initiative." We also cautioned, "Coordinating large groups in a collective impact initiative takes time and resources, and too often, the expectation that collaboration can occur without a supporting infrastructure is one of the most frequent reasons why it fails."

Our subsequent research has confirmed that backbone organizations serve six essential functions: providing overall strategic direction, facilitating dialogue between partners, managing data collection and analysis, handling communications, coordinating community outreach, and mobilizing funding.

Although the core backbone functions are consistent across all of the collective impact initiatives we have studied, they can be accomplished through a variety of different organizational structures. (See "Backbone Organizations" on page 7.) Funders, new or existing nonprofi s, intermediaries like community foundations, United Ways, and government agencies, can all fill the backbone role. Backbone functions can also be shared across multiple organizations. The Magnolia Place Community Initiative in Los Angeles, for example, strives to optimize family functioning, health and well-being, school readiness, and economic stability for a population of 100,000. The Initiative has a small, dedicated staff that drives the work. Multiple partner organizations from the 70 organizations in the network fulfill different backbone functions, such as collecting and analyzing data, and maintaining a coherent strategic vision through communications.

Each structure has pros and cons, and the best structure will be situation-specific, depending on the issue and geography, the ability to secure funding, the highly important perceived neutrality of the organization, and the ability to mobilize stakeholders. Backbone organizations also face two distinct challenges in their leadership and funding. No collective impact effort can survive unless the backbone organization is led by an executive possessing strong adaptive leadership skills; the ability to mobilize people without imposing a predetermined agenda or taking credit for success. Backbone organizations must maintain a delicate balance between the strong leadership needed to keep all parties together and the invisible "behind the scenes" role that lets the other stakeholders own the initiative's success.

Backbone organizations must also be sufficiently well resourced. Despite the growing interest in collective impact, few funders are yet stepping up to support backbones associated with the issues they care about. Adopting a collective impact approach requires a fundamental shift in the mindset of many funders who are used to receiving credit for supporting specific short-term interventions. Collective impact offers no silver bullets. It works through many gradual improvements over time as stakeholders learn for themselves how to become more aligned and effec-

There is no other way society will achieve large-scale progress against urgent and complex problems, unless a collective impact approach becomes the accepted way of doing business.

tive. Funders must be willing to support an open-ended process over many years, satisfied in knowing that they are contributing to large scale and sustainable social impact, without being able to take credit for any specific result that is directly attributable to their funding.

Worse, backbone organizations are sometimes seen as the kind of overhead that funders so assiduously avoid. Yet effective backbone organizations provide extraordinary leverage. A backbone's funding is typically less than 1 percent of the total budgets of the organizations it coordinates, and it can dramatically increase the effectiveness of the other 99 percent of expenditures. Backbone organizations can also attract new funds. As mentioned above, both GAIN and Communities That Care have raised substantial new funding for their work.

Even the best backbone organization, however, cannot single-handedly manage the work of the hundreds of stakeholders engaged in a collective impact initiative. Instead, different levels of linked collaboration are required.

***Cascading Levels of Linked Collaboration.*** We have observed markedly similar patterns in the way successful collective impact efforts are structured across many different issues and geographies. Each begins with the establishment of an oversight group, often called a steering committee or executive committee, which consists of cross-sector CEO level individuals from key organizations engaged with the issue. Under the best circumstances, the oversight group also includes representatives of the individuals touched by the issue. This steering committee works to create the common agenda that defines the boundaries of the effort and sets a strategic action framework. Thereafter, the committee meets regularly to oversee the progress of the entire initiative.

Once the strategic action framework is agreed upon, different working groups are formed around each of its primary leverage points or strategies. GAIN, for example, is overseen by a board of directors, with a 100-person secretariat that operates through four program initiatives: large-scale fortification, multi-nutrient supplements, nutritious foods during pregnancy and early childhood, and enhancing the nutritional content of agriculture products. These programs are supported by 15 working groups on both technical and programmatic topics like salt iodization, infant and child nutrition, and advocacy, as well as functional working groups on evaluation and research, communications, and donor relations. Livewell Colorado operates with 22 cross-sector coalitions that reinforce the state's common agenda within individual communities. Communities That Care has three working groups focused on parent education, youth recognition, and community norms, and a school health task force. More complicated initiatives may have subgroups that take on specific objectives within the prioritized strategies.

Although each working group meets separately, they communicate and coordinate with each other in cascading levels of linked collaboration. Effective coordination by the backbone can create aligned and coordinated action among hundreds of organizations that simultaneously tackle many different dimensions of a complex issue. The

## Backbone Organizations

| Types of Backbones | Description | examples | Pros | Cons |
|---|---|---|---|---|
| ***Funder-Based*** | One funder initiates CI strategy as planner, fi , and convener | Calgary Homeless Foundation | S Ability to secure start-up funding and recurring resources<br>S Ability to bring others to the table and leverage other funders | S Lack of broad buy-in if CI eff seen as driven by one funder<br>S Lack of perceived neutrality |
| ***New Nonprofit*** | New entity is created, often by private funding, to serve as backbone | Community Center for Education Results | S Perceived neutrality as facilitator and convener<br>S Potential lack of baggage<br>S Clarity of focus | S Lack of sustainable funding stream and potential questions about funding priorities<br>S Potential competition with local nonprofi |
| ***Existing Nonprofit*** | Established nonprofi takes the lead in coordinating CI strategy | Opportunity Chicago | S Credibility, clear ownership, and strong understanding of issue<br>S Existing infrastructure in place if properly resourced | S Potential "baggage" and lack of perceived neutrality<br>S Lack of attention if poorly funded |
| ***Government*** | Government entity, either at local or state level, drives CI eff | Shape Up Somerville | S Public sector "seal of approval"<br>S Existing infrastructure in place if properly resourced | S Bureaucracy may slow progress<br>S Public funding may not be dependable |
| ***Shared Across Multiple Organizations*** | Numerous organizations take ownership of CI wins | Magnolia Place | S Lower resource requirements if shared across multiple organizations<br>S Broad buy-in, expertise | S Lack of clear accountability with multiple voices at the table<br>S Coordination challenges, leading to potential ineffi |
| ***Steering Committee Driven*** | Senior-level committee with ultimate decision-making power | Memphis Fast Forward | S Broad buy-in from senior leaders across public, private, and nonprofi sectors | S Lack of clear accountability with multiple voices |

Channeling Change: Making Collective Impact Work

real work of the collective impact initiative takes place in these targeted groups through a continuous process of "planning and doing," grounded in constant evidence-based feedback about what is or is not working.

The working groups typically develop their own plans for action organized around "moving the needle" on specific shared measures. Once plans are developed, the working groups are then responsible for coming together on a regular basis to share data and stories about progress being made, and for communicating their activities more broadly with other organizations and individuals affected by the issue so that the circle of alignment can grow. This confers an additional benefi of collective impact: as the common agenda's center of gravity becomes more apparent to all those working on the issue, even people and organizations who have not been directly engaged as a formal part of the initiative start doing things in ways more aligned to the effort. Brenda Ranum, a leader within The Northeast Iowa Food & Fitness Initiative that has brought five rural counties together to improve access to healthy, locally grown foods and to create opportunities for physical activity, refers to this benefi in alignment as getting "order for free." In our own consulting work supporting collective impact initiatives for issues as varied as juvenile justice reform, sustainable fishing, education reform, youth development, and agricultural development, we have also observed the benefi s of this "order for free" phenomenon.

The backbone organization provides periodic and systematic assessments of progress attained by the various work groups, and then synthesizes the results and presents them back to the oversight committee that carries the sustaining flame of the common agenda.

The number of working groups and the cascading layers of collaboration may also change over time. As working group strategies are modified based on an examination of what is working, some groups may end and new ones begin to pursue newly identified strategies defined by the common agenda. What is critically important is that all strategies pursued clearly link back to the common agenda and shared measures, as well as link to each other.

Memphis Fast Forward illustrates how one community can address multiple complex issues through this multi-level cascading structure. The work of Memphis Fast Forward is overseen by a 20-person cross-sector steering committee with the goal of making Memphis one of the most successful economic centers in the southern United States. They developed a common agenda focused on four key levers: public safety, education, jobs, and government efficiency. Each lever constitutes its own sub-initiative and is overseen by its own cross-sector steering committee and supported by a dedicated backbone organization. Each sub-initiative then cascades into linked working groups focused around the strategic levers unique to each of the four selected areas. Public Safety, for example, has developed its own strategic action framework that has 15 strategies, each with lead partners and cross-sector representation. The combined efforts of these linked work groups has led to a decrease in violent and property crimes of 26 percent and 32 percent respectively over the last five years.

One of the lead individuals associated with Memphis Fast Forward characterizes both the challenges and the value of this approach: "By using a decentralized but linked approach, each effort has its own governance and unique structure but all efforts come together to share learnings. It took us a while to realize the value in formally bringing the backbone organization leaders together for sharing and problem solving. Initially, the different initiatives were only loosely communicating, but then we realized that we had a great opportunity to all learn from each other and should do so more intentionally and proactively." Now leaders from the four initiatives meet monthly.

## tHe essential intangibles oF ColleCtive iMPaCt

Our guidance here on implementing collective impact has said little about the "softer" dimensions of any successful change effort, such as relationship and trust building among diverse stakeholders, leadership identification and development, and creating a culture of learning. These dimensions are essential to successfully achieving collective impact. We, as well as others, have written extensively about the profound impact that getting the soft stuff right has on social change efforts. And indeed, all of the successful collective impact practitioners we've observed can cite numerous instances when skillful implementation of these intangible dimensions was essential to their collective efforts.

One such intangible ingredient is, of all things, food. Ask Marjorie Mayfield Jackson, founder of the Elizabeth River Project, what the secret of her success was in building a common agenda among diverse and antagonistic stakeholders, including aggressive environmental activists and hard-nosed businessmen. She'll answer, "Clam bakes and beer." So too, The Tamarack Institute has a dedicated "Recipes Section" on its website that recognizes "how food has been that special leaven in bringing people together." In attempting collective impact, never underestimate the power and need to return to essential activities that can help clear away the burdens of past wounds and provide connections between people who thought they could never possibly work together.

As much as we have tried to describe clear steps to implement collective impact, it remains a messy and fragile process. Many attempts will no doubt fail, although the many examples we have studied demonstrate that it can also succeed. Yet even the attempt itself brings one important intangible benefit that is in short supply nowadays: hope. Despite the difficulty of getting collective impact efforts off the ground, those involved report a new sense of optimism that dawns early on in the process. Developing the common agenda alone has produced remarkable changes in people's belief that the future can be different and better even before many changes have been made. For many who are searching for a reason to hope in these difficult times, this alone may be purpose enough to embrace collective impact. S

1 Originally named Strive when the earlier article appeared.

2 http://www.strivetogether.org/wp-content/uploads/2011/11/2011-Strive-Partnership-Report.pdf.

3 We described the qualities of such a leader as Adaptive Leadership, in Ronald Heifetz, John Kania, and Mark Kramer, "Leading Boldly," *Stanford Social Innovation Review*, winter 2004.

4 *Cities Reducing Poverty: How Vibrant Communities Are Creating Comprehensive Solutions to the Most Complex Problems of Our Times*, The Tamarack Institute, 2011: 137.

5 Mark Kramer, Marcie Parkhurst, and Lalitha Vaidyanathan, *Breakthroughs in Shared Measurement and Social impact*, FSG, 2009.