Stakeholder Health

Insights from New Systems of Health

Leader's Guide

For Health System Executive Leadership
and Board Members

Leader's Guide

for

Stakeholder Health: Insights from New Systems of Health

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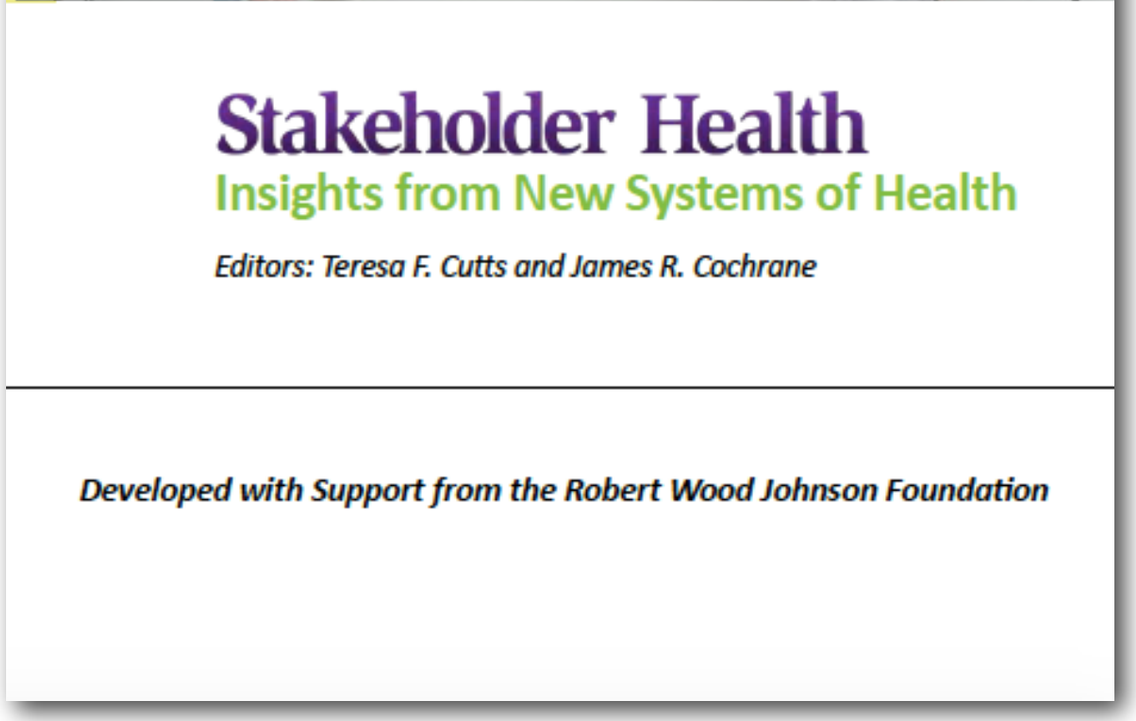

Leader's Guide

for Executive Leadership & Board Members

HOW TO USE THE LEADER'S GUIDE

This guide is designed for use with groups working on complex issues. It's for hospitals and health systems that see in the current policy environment the opportunity to address the underlying causes of poor health in their communities by strategically shifting existing resources and partnering with diverse stakeholders.

We understand that no group would have time to discuss all of these questions. We suggest that as discussion leader you go through the various chapters and questions to see which ones would lead to the most fruitful conversations for your particular situation.

If you are working on a specific chapter, you may want to download the pdf of that chapter at: www.stakeholderhealth.org/the-book/ and make copies for people to read ahead of time.

We've also included chapter summaries (thanks, Bonnie Condon!) for your convenience.

Chapter 2

Systems Thinking Approach to the Social Determinants of Health

Chapter Summary

Chapter 2 addresses the social determinants of health from a systems perspective. The World Health Organization states that the "social determinants of health" reflect the conditions in which people are born, grow, live, work and age. The authors remind readers that factors that have the greatest impact on health are not medical interventions or individual lifestyle choices, but instead arise from the environments in which we live, work, pray and play. The social determinants of health are best understood with a systems thinking paradigm of interrelationships rather than linear cause-effect chains, and longer-term processes of change rather than simply snapshots in time.

Research conducted by the Population Health Institute at the University of Wisconsin demonstrates that clinical medical care accounts for just 20 percent of health outcomes while health behaviors, socioeconomic factors and the physical environment account for the remaining 80 percent. Addressing health at the population level will require a new level of thinking and strategic partnerships with entities not traditionally aligned with the health system. At its most progressive, this

new thinking will push health care to partner with others to address food sufficiency, housing, education and workforce development as well as the built environment. Health system leaders can begin addressing social determinants of health through supporting public policies that enhance health, leveraging partnerships in the community, engaging local residents, playing a role in innovative payment system reform pilots and implementing best practices in community health prevention and interventions.

Discussion Questions

Q • The authors make the connections between poor housing, childhood asthma and school absenteeism. Pick a different clinical condition (for example, juvenile diabetes, COPD, HIV/AIDS) and create Mind Map by drawing circles for environmental factors, causes, treatments, special challenges. And draw lines between them showing the relationships between a disease and the related other aspects. How do these relationships impact our approaches to that disease?

Q • The authors point to studies that conclude that:

- One-fourth of the differences in health in mid-to late-life can be attributed to neighborhood differences during young adulthood,
- A person's zip code is far more important than their genetic code in determining health outcomes
- The most impoverished neighborhoods comprised predominantly of persons of color, have a life expectancy 15 to 25 years less than higher income and predominantly white neighborhoods.

How should this impact how you best address improving health in your community?

Q • List the different ways race issues overlap with determinants of health. Which of these do you think are the most important. Why?

Q • Funds for prevention versus medical care:

- Just 3-4 percent of our national health budget is dedicated to disease prevention; the rest is dedicated to medical care delivery,
- The nation's largest single investment in prevention, the Prevention and Public Health Fund provides $14 billion over the next 10 years while total health care spending for 2014 alone was $3 trillion,
- We are challenged to address 80 percent of the causative factors for preventable disease with a fraction of the national budget on health

The authors say that this "impossible ratio" is bound to lead to failure unless something is done that is dramatically different than the status quo. What are some things that can be done at a community level? At the national level?

Q • To improve community health hospitals can creatively leverage strategic partnerships in a number of sectors such as

business, economic development, education and faith. Describe an example you're aware of where this is happening. If you're not aware of one, think of a way this could be done.

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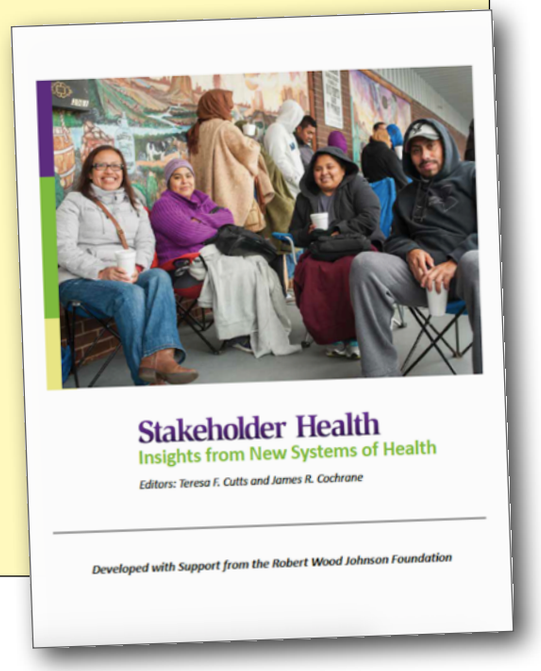

Chapter 3

Accountable Lives: Leading Complex Health Structures

Chapter Summary

Chapter 3 urges health care leaders to make three significant shifts in management. First is the shift of power dynamics among and between stakeholders or a "right side up" maneuver which begins to pay attention to the wisdom at all levels of the organization. While technology, connectivity, science, transparency and logic all unleash potential gains for the whole community, they may also strengthen roles of those formerly viewed as "lower" in the hierarchy. Teams of mutually empowered professionals are beginning to replace a single physician and the clinical space is growing to include retail clinics, homeless shelters, food pantries and places of worship.

A second shift related to where leaders spend their time will call for movement from time at the desk with internal constituents to time in the community with a broader range of stakeholders. The leadership move is essentially "inside out" where the leader and organization is connectable with the agents of health that surround the system. The population in this view is not an entity to be managed, but the thing doing the managing. Those "outside" are not passive consumers, but, rather, agents of their own health in a complex ecology of roles.

A third shift is a movement toward webs of trust. This moves leaders and organizations beyond high compliance to trusting that, within the future, are answers to today's best practices. High reliability will equal high adaptive capacity multiplied by the speed of trust divided by high compliance. Building trust within an organization must happen at a speed that exceeds decisions and behaviors that undermine trust. Trust becomes better or more efficient than mere control or managing by mandate.

The authors posit that, as soon as we became liable for long term health dynamics of the large fraction of the humans living around us, we became subject to shared power with many others. We have significant influence on the many other systems in our communities, often as the largest component of most communities, as long as we don't try to control or "manage" them.

Discussion Questions

Q • The authors say that emerging models of health will require health system leaders to shift some of their time in the executive suite with "internal" constituencies to spend more time on the streets listening, blending, finding common alignment, especially with those who got little attention in the past. Integrating the blended intelligence of everyone from the surgeon to the community health worker. What kinds of new voices will we need to hear more? What challenges do you think this transition will present?

Q • Health leaders live in the tension and stresses of spending a great deal of energy with compliance to laws and professional "guild" requirements on one hand and the challenges and opportunities emerging from shifts in science, technology and public policy. What are some ways they can find the balance to more effectively improve community health?

Q • Stakeholder Health authors say that to improve community health, hospital need to do three things: 1) Move toward social complexity, 2) Move in partnerships, 3) Invest resources proactively. If you agree, what is one example you're aware for that represents each?

Q • Inside Out. By connecting with the "agents of health" that surround the hospital, leaders can form a new community that works in partnership. Those outside are not to be managed but are, through networks and relationships, agents of their own health. One example is when a hospital teamed up with hundreds of congregations around Memphis. Another possibility: the many clergy who are already visiting your patients every day. Can you think of other inside out relationships? What opportunities could this present? What challenges come with such a shift in thinking?

Q • Right-Side Up. This focuses on creating space and roles for the power and intelligence of those who populate the base of the organization, who live in the neighborhoods with the greatest health challenges. Not choosing the knowledge of the janitor over the surgeon, for example, but blending the intelligence of both for improved population health at scale. This leads to a vastly greater teachable institution. What kinds of attitudes and skills would it take for a leader to create a right-side up environment?

Q • Webs of Trust. Trust is better and more efficient than mere control. Stakeholder Health believes partnerships between hospitals and their communities will move at the speed of trust. What can leaders do to build that trust?

Chapter 4

Optimizing the Patient Encounter: Relational Technology that Integrates Social and Spiritual Domains into the Electronic Health Record

Chapter Summary

Chapter 4 advocates for relational technology within the information technologies employed by health care systems. According to the WHO, the US has the highest health care spending costs, but the poorest health outcomes when compared to other industrialized countries. Other industrialized countries spend much more on community based social services than on acute health care services. In our fragmented health care system, information technology has a strong role to play in bridging the gap in population health management. With 80% of poor health due to behavioral and social determinants, it becomes even more crucial that each patient encounter be optimized.

The authors believe that asking patients about socioeconomic factors, recording them in the electronic health record and navigating patients to resources to address those needs will begin to align US practices with the practices in industrialized countries that have better health outcomes. There is a growing body of research calling for the integration of socioeconomic information and environmental risk factors into the Electronic Health Record as an important aspect of improving community and patient health, and achieving health equity.

The authors also advocate for intentional inclusion of spiritual needs and resources into the patient information platform. While a standardized IT platform including socioeconomic information becomes a best practice, there is an emerging need for bi-directional communication between clinical providers, non-clinical caregivers and community based organizations that provide services to address socioeconomic needs. As systems are developed to better track patient needs and resources, the authors also advocate for the use of geo-coding/mapping of patients and community based resources to support population health management and development of critically placed community services.

Discussion Questions

Q • The authors say that redesigned IT systems need to understand and connect a person's health and his/her environment. What are some examples of information that could be helpful to optimize patient care for the healthcare professional, and what information would be relevant to community providers of care?

Q • In an integrated system (question above) who owns the information? How can it be democratized in a way that protects the privacy of a person's health record while sharing relevant information to those providing support or care in the community. What ethical issues must be addressed for this to work? What privacy issues? What practical issues?

Q • Health Information Exchanges (HIEs) could serve as sources of both patient data and community intelligence. How could that improve the health of people in your community? How are HIE's being used in your community? What changes or partnerships need to be made with HIE's to improve effectiveness? (Please give examples if possible.)

Q • How can data platforms be used to promote cross-sector health improvement initiatives in communities?

Q • To align the efforts of the individual caregiver and community to assure appropriate health interventions are happening, there is a need for bi-directional communication between community-based organizations, clinical providers and non-clinical caregivers. Describe, as well as you can, what the ideal for this kind of communication would look like. List the components on a flip chart or board.

Q • It would seem that private physicians, especially primary care providers, are crucial to the success of such a model. What would motivate them to get involved in this?

Q • Who are the best people to design information systems that "create alignment" between public health, hospitals and the community? What would such a process need to include?

Q • Users of Electronic Health Records in countries like Denmark, Sweden and New Zealand have benefitted from the interoperable (platforms that can talk to each other) patient data systems. Who are key stakeholders in your community who would work together to advance initiatives advocating for integrated platforms?

Q • Are there funding opportunities that might exist if you have a data platform that is used across multiple sectors of a community? How could that improve the health systems opportunities to engage in improving aspects that really improve health?

Q • Do you agree with the authors that "systems thinkers" need to be involved in data development? If so, why is this important?

Q • What are the policy implications that will need to be addressed to improve collaboration and opportunities to share data?

Q • Who would be ideal individuals to help create our new data infrastructure for health? What would be their characteristics and competencies? How do we develop this new workforce?

Q • What do you need to keep in mind to assure that selected data from the various sources is "actionable"? How do you set it up so that it's usable in real time?

Q • What are some ways to work with IT vendors to bring existing and future systems up to current geographical data accuracy standards and be more inclusive of social determinants?

Q • What services do community partners provide?

Q • How do caregivers know what resources are available in the community?

Q • How can we access these resources to optimize the health of an individual?

Chapter 5

Navigating for Health

Chapter Summary

Chapter 5 explores the importance of navigation in health care today. As people seek care and community based resources in our nation's fragmented health care system, even people with comprehensive insurance often struggle to navigate the systems. Health care systems are developing roles to assist individuals with access and to connect them with social services necessary to truly optimize their health.

The authors describe an array of navigation roles that have been created and specifically focus on the community health worker (CHW) role. CHWs have made significant contributions to the Triple Aim and have also impacted what many consider a fourth aim of US health care reform—improved health equity. In many ways CHWs go 'beyond the compass' in their relationships with patients because they are not simply directing people to resources, but are establishing caring connections with patients while assisting patients in addressing socioeconomic needs as well. CHWs have been documented to improve utilization of preventative services, reduce ED usage, improve birth outcomes, improve care transitions, provide culturally appropriate health education, reduce infant mortality, improve asthma self-management and increase knowledge and use of community services. In addition to improving utilization of health care resources and improving health of individuals, CHWs are becoming a new pipeline for health care careers and community economic development.

Across the country, there are diverse models of training for CHWs. Some states are moving to a standardized training requirement with a certificate, while others are instituting a state licensure for CHWs. Currently, many CHW positions are funded by grants. Payment model reform, rewarding value and health equity, is helping CHW roles move from time-limited grants to stronger integration into care systems, workforce sustainability and increased opportunities to improve population health.

Discussion Questions

Q • Think of examples of cases you are aware of where someone needed help getting around a complicated health challenge. What did they have to navigate? Who helped them? Relatives? Friends? Professional navigators such as those listed in the chapter? How was their experience?

Q • In your experience, what tools do navigators use? Which ones work well and which don't? What gaps are there? What would be the most important to add or improve soon?

Q • Why is navigation important in health care today?

Q • How can Community Health Workers (CHWs) help your organization work toward achieving the Triple Aim?

Q • How would you find trained CHWs in your community?

Q • What steps to I need to take to send candidates for CHW training,?

Q • What are the other key considerations for starting a CHW program in your organization?

Q • How would you connect with other stakeholders who would like to see CHWs in our community?

Q • What are the benefits of making CHW programs sustainable over time?

Chapter 6

Community Asset Mapping: Integrating and Engaging Community and Health Systems

Chapter Summary

Chapter 6 discusses the important role of participatory community asset "mapping" methodologies in both building meaningful and useful partnerships between health systems and communities as well as augmenting data collected for hospital Community Health Needs assessments. This type of participatory mapping began in the 1970's and continues today. The history and specifications of select asset-based mapping methodologies are reviewed in the chapter with examples of processes, findings and outcomes. The reviewed methodologies include: Asset Based Community Development (ABCD); Mobilizing for Action Through Planning and Partnerships (MAPP); Participatory Inquiry into Religious Health Assets, Networks and Agency (PIRHANA); Community Health Assets Mapping Partnership (CHAMP); CHAMP Access to Care; Spiritual Capacities and Religious Assets for Transforming Community Health by Mobilization of Males for Peace and Safety (SCRATCH-MAPS); Communities of Shalom and Participatory Hotspotting. Existing mapping tools (Community Health Improvement Navigator, Community Commons, County Health Ranking Roadmaps' What Works for Health [WWFH]) are also reviewed.

While the above mentioned participatory community mapping methodologies can be viewed as specific forms of community engagement related to the federally mandated CHNAs, the authors caution that these mapping modalities should not be used as "an end unto itself," but rather as a springboard to developing partnerships with the community members to improve health. Additional considerations for mapping include addressing historical trauma to build trust, creating mutual accountability between health systems and community, as well as building a platform for Community-Based or Community-engaged Participatory Research and data gathering.

Discussion Questions

Q • The authors say that a mapping assessment that centers not on a community's needs but on its assets can better and more sustainably empower community members and instill hope. Do you agree with this? What difference does this shift make?

Q • How could identifying a community's health assets in partnership with your health system be of value?

Q • Community asset mapping can be seen as a form of community engagement, even as a first step or springboard for partnerships that integrate both hospital and community assets. Can you identify some ways in which the very process of community asset mapping can add value toward the goal of community health?

Q • The authors note that mapping processes that focus on harvesting and "using" community intelligence without a commitment to building genuine and trustworthy partnership can damage fledgling collaborative efforts. How important is trust in community asset mapping? How can trust best be developed? What ingredients are needed?

Q • The authors suggest that community asset mapping is useful in exploring "historical trauma," where psychological wounding and unresolved grief cross generations. It is present in almost all communities and health systems have, sadly, sometimes been either complicit or actively engaged in the traumatic events. Asset mapping can be useful in beginning to address this through truth telling, reconciliation and community healing and trust building. Can you think of any historical trauma in your community? What would it take to address it?

Q • Community asset mapping can make grassroots "voices" audible to those who influence health policy. How do you see this happening? What difference can this make?

Chapter 7

Integrating Care to Improve Health Outcomes: Trauma, Resilience and Mental Health

Chapter Summary

Chapter 7 delves further into the importance of understanding and treating the whole person, particularly related to the emerging field of trauma and resilience or the science around how social conditions impact our bodies even at the genetic and cellular levels. Health care systems are quickly realizing that engaging the patient in their whole life context is critical if they are to meet requirements of government and commercial payers regarding health outcomes and cost savings. Seminal studies related to Adverse Childhood Experiences (ACE) have identified correlated health outcomes for individuals who have experienced multiple traumatic experiences.

Historical trauma describes the condition in which an entire population is subjugated over an extended period of time. Historical trauma studies that cross historical periods have found an increased disease burden in those with immediate experience, but, even more critically, the trans-generational transmission of poorer health outcomes. Perhaps the most hopeful thing about individual or community trauma is that resilience or the process of adapting well during times of trauma or stress "trumps trauma." In other words, if trauma is fundamentally caused by dysfunctional or toxic relationships and systems, one of the most critical protective and healing factors for both individuals and communities is strong social relationships or social cohesion.

The authors document the cost of ACEs in terms of correlated health outcomes and financial impact. They also describe the financial and personal cost of mental illness and substance abuse, particularly focusing on ED utilization costs. Evidence-based practices can be implemented at the community level and individual level to offset or prevent some types of mental illness and substance abuse. For instance, in preventing depression, such practices include strength-based and resiliency training, cognitive behavioral programs, web-based programs, the targeting of high risk populations (post-partum, elderly, college students, etc.) as well as addressing poverty and ACEs in children and youth.

Finally, the authors advocate for increased integration of behavioral health and trauma screenings and services into care of the whole patient. Screening tools and evidence based practices which are emerging to address trauma, mental health, substance abuse and stigma are summarized for both individual and community interventions.

Discussion Questions

Q • What likely possible or likely causes of community trauma are in your community? How would your health system go about getting a deeper understanding of this?

Q • Clusters of people with Adverse Childhood Events (or ACEs) are found in places with the highest percentages of poverty and low-education levels. And studies have found that those with more ACEs have higher risks of certain diseases and unhealthy behavioral practices. This has led some hospitals to include ACE questions in their Community Health Needs Assessment. How might a high ACE score impact a patient's wellness?

Q • Trauma is not destiny, say the authors. Healing can occur and health outcomes improve when ACEs are addressed. Resilience, our ability to modulate the stress response, is teachable. Because trauma is fundamentally a phenomenon of dysfunctional or toxic relationships, one of the most protective healing factors for both individuals and communities is strong social relationships. What sorts of efforts can hospitals and communities take to strengthen these social relationships? What challenges will they likely find? What resources are available for this? What resources could your system make available?

Q • The authors point to a study that concluded that it was not the quantity of services that were provided to people suffering with stress, but the quality of relationships between an adult service provider and the stressed person that was most predictive of how well a child was able to make use of the services. In what ways should this impact how we design our service programs?

Q • Many people who work daily with patients, families and others who suffer with trauma can themselves suffer from secondary, or vicarious, trauma. Some hospitals and service providers offer resiliency training for them. How can this be of value? What other approaches can be taken to support these staff?

Q • Many super-utilizers of emergency services have mental illness/substance abuse issues. Meanwhile, experiments in care for people covered under Medicaid and other programs for the under-served show that incorporating any level of mental health screening, care and treatment can save money for health plans, hospitals, individuals and other stakeholders—and more importantly, improve the quality of life for individuals and their families. So why are we not using strategies that are known to work (as well as reduce costs) to improve the mental health, resiliency and well-being of all people?

Q • The authors suggest a broader view of integrated health that more and more encompasses care in the community. They suggest that providers (such as physicians, social workers, psychologists, nutritionists, etc.) leave the clinic and base their efforts in places where those who need the help the most are. What does this look like today? What could bring services more into places that could help the most?

Chapter 8

Financial Accounting that Produces Health

Chapter Summary

Chapter 8 discusses current dynamics and emerging financial trends in the context of health reform with a focus on implications related to the shift from fee-for-service to value-based reimbursement. While the United States (US) is the wealthiest nation on our planet, it ranks last among 11 peer countries related to health care access, efficiency and equity. The US spends only 60 cents on social services per $1 spent on health care compared to countries with better health outcomes that spend $2 for social services for every $1 for health care. The US approach to social service provision including childcare, housing, transportation and education seems to be a causal factor of our current state of health.

Additionally, the authors posit that the history and legacy of discrimination has created pockets of extreme poverty, social dysfunction, and persistent health problems in communities across the country, highlighting the need for focused attention and investment, not just by health care organizations, but by a broad spectrum of stakeholders across sectors in order to produce meaningful and sustainable improvement. The following emerging models are highlighted as possible solutions to the issues that have created health inequity: federal support of state innovations, CMS programs supporting housing-related activities, federal waivers for housing, increased education funding, Pay for Success and local "collective impact" collaborations. Additional innovative possibilities for health care systems include leveraging funds with Community Development Funding Institutions (CDFIs) and partnering with employers to engage in health promotion.

Discussion Questions

Q • Stir things up! Project the chart (page 126) up on a screen or hand it out to participants. What would happen if the U.S. were not an outlier among industrialized counties? What if it shifted about 5 percent of its GDP spending from health services to social services? What would that look like? How would it impact your health system? How would such a shift impact various stakeholders? How might it impact overall community health?

Q • Fee-for-service (FFS) reimbursement has long been the predominant form for health care payment. It rewards the producers of increasingly costly procedures, equipment, pharmaceuticals and treatment facilities. Many health care leaders increasingly recognize that the FFS model is unsustainable. How would shifting away from conducting procedures and filling beds and towards keeping people healthy and out of clinical care settings impact the cost of health care? How would it impact the quality of health?

Q • One recent innovative model with promise for health care institutions is the Pay for Success, or PFS. The authors cited

three examples of PFS in early childhood intervention, reducing asthma and reducing recidivism. What areas in your community show promise for the PFS model of intervention? Which organizations may be interested in such an approach?

Q • Giving more focus to the social determinants of health and to geographic areas where health inequities are concentrated represents a shift for health care organizations from the question "Who is at greater risk for disease?" to the question "Why are some people at greater risk of preventable illness, injury and death than others?" The next, even more critical question, however, is "What are we going to do about it?" How can leaders of health systems help their institutions make this shift?

Q • A number of health systems are directing a portion of their investment portfolios to support development of physical infrastructure that improve health in their communities — especially those needed to reverse the negative health impacts associated with decades of red-lining and disinvestment. Can you identify in your community areas that could use such investment? What kinds of infrastructure do you imagine could be needed? What would it take for investments to be made in this manner?

Q • U.S. employers provide coverage for about 54 percent of the population. Nearly 80 percent of these employers offer workplace wellness programs. The authors say that the next frontier for employers to support wellness and reducing health care costs involves expanding this engagement beyond employees to their families and surrounding communities. How can health systems and other institutions partner to make this happen? What would such collaboration take? What would be the first steps?

Chapter 9

Philanthropy

Chapter Summary

Chapter 9 begins by acknowledging the reality, that, given the broad and complex range of factors that determine health, any single institution or sector, including health care, has a limited scope of influence. As noted in previous chapters, there is a need for shared partnerships to address the social structures and conditions that impact health, and the authors for this chapter suggest that foundations are a natural partner in the work of health improvement. While there are many types of foundations, two specific types are particularly relevant to health care: hospital or health system foundations and health conversion foundations (formed when a nonprofit hospital or system converts to, or is acquired by, a for profit entity). In addition to funding planning for programs (planning grant) and implementing programs (implementation grant), foundations also engage strategically in building the capacity of organizations, provide leadership development opportunities, introduce innovations, raise public awareness of key issues and advocate for policy change. Foundations also can fund individual hospital or health systems or community collaborative work. In fact, many foundations require partnerships as a component of a funding proposal. An additional role that foundations are well positioned to play is as a convener of cross-sectoral partners within a community.

Discussion Questions

Q • Foundations can provide significant support to community-wide efforts to improve health. Many of the strategies can be applied to the work of health systems. Take a few minutes to look over the following list from the chapter and identify the one you think shows the most promise in your community. Write down which you picked.

- Provide targeted funding for key projects
- Support the development of organizational capacity
- Support the development of needed leadership skills
- Sponsor community assessments and other research
- Support awareness raising, agenda setting and policy advocacy
- Other (please describe)

After this task has been completed by individuals, have each participant describe which they chose and why.

Q • How could your health system partner with a foundation to accomplish any of these tasks?

Q • How can foundations and health systems work together to create a community health strategy?

Q • Convening. Foundations are well positioned in a community to convene cross-sectoral partnerships around improving health. This is especially true where there are turf-issues, competing interests, and a variety of stakeholders. How could your health system partner with a foundation to play this critical convening role? What do you need to keep in mind to do this? [Use the LS Social Network Webbing or an exercise from Health Asset Mapping]

Q • Healthcare systems can play a key role in improving their community's health but don't need to (and can't) go it alone. Instead they will need to strategically align their resources and efforts with other partners. And foundations are especially natural partners. Ask participants to identify the foundations that are or could be relevant in their geographic or other area.

Q • What has your institutions' history with foundations been? How has it changed over the years? How have you engaged with foundations in improving the health of your community in the past? Do you have any initiatives going now? Any conversations about the future? How would you characterize them?

Q • "Given that hospitals and foundations have mutually reinforcing interests, how can we encourage productive partnering?" Three options: Advise hospitals and foundations to take a second look at one another, and 1) a deeper look at one another's assets. 2) encourage leaders of hospitals and foundations to reach out to one another on a periodic basis to explore their respective and shared interests and 3) use the Stakeholder Health's perspective as a guide for developing a shared strategy, that is, bringing the public health paradigm squarely into heathcare organizations, framing health improvement as a partnership among multiple organizations that complement one another. Discuss these three options and the pros and cons of each.

Q • The authors say that the Stakeholder Health "movement" is intentionally disruptive, calling for hospitals to re-imagine their role in advancing health. Beyond just diagnosing and treating patients one at a time, healthcare organizations are being challenged to also intervene in ways that improve the health of entire populations. This means an expanded perspective, seeing the whole person rather than a specific illness and looking more upstream — to the social and economic determinants that either undermine or enhance health. Meanwhile foundations typically seek to advance the health and wellbeing of populations rather than individual patients, clients or customers. Do you agree or disagree with these assumptions. Why or why not?

Chapter 10

Global Dynamics at Home

Chapter Summary

Chapter 10 encourages people to open their experience and imagination to the increasingly rich, dynamic interactions that are occurring between local and global health systems. Health care applies international standards in diagnosing and treating certain diseases and epidemics. Professional exchanges with other countries and international health providers are occurring every day. While global health was equated in the past with international health and focused primarily on controlling the spread of epidemics, global health today is shifting from disease-control to a vision of health for all. This shift considers questions of human dignity and health equity, and views all human beings as agents able to jointly achieve better health outcomes. The redressing of systemic disadvantages and the promotion of inclusion and social justice become critical dimensions of any healthy community.

Global health perspectives across boundaries consider how to prioritize health care spending; how to engage market pressures for increasingly expensive drugs and treatments; how to address the social demand for access to health and well-being for all; and how to balance the tension between the historically powerful technical medical field and the complex, socially formed self-directed person that human beings are.

While global health exhibits its own "pathologies"--including silo mentalities, over-reliance on technological solutions, unfulfilled promises, and over-confidence, many new shifts in policy and practice have opened up the possibility of major positive gains if the requisite intelligence and will are applied. This is a time where the promise of a better, more just future is within our grasp; where the possibility of reducing infections and maternal and child mortality to low rates universally, and of tackling chronic diseases and the impoverishing effects of health expenses, are realistic. The authors cite six strategies for addressing global health in the future including a systems approach that is people centric rather than market centric.

Discussion Questions

Q • The authors say that the hospital, clinic or dispensary – "formal health facilities" – are only some of the nodes that matter and that they offer only limited pathways to health with their most important role being largely at critical or acute moments (probably the great majority of health matters being chronic). They suggest that a broader, more inclusive view of health provision and health care is vital. If you agree, what are other nodes? How do these nodes connect to improve community health? Where do they not connect to the detriment of a person's health?

Q • A dominant harmful assumption exists that positional power – the level of authority and control a person has – is the only form of power that matters in an organization. Leaders using a "living systems" approach, in contrast, will humbly seek out those who understand and wield differing kinds of power and reinforce the learning needed to support, encourage and realign practices. The authors say that a living systems approach is crucial to the long-term, sustainable, and equitable health of individuals and their communities. This requires hospitals to flip the power dynamics, ceding power to those typically marginalized both within the hospital and outside in the community, valuing and honoring the intelligence of those people and communities. Do you agree? What would this look like in your community?

Q • The authors talk about three worlds. In World One all the tools and practices for improving health are competent, efficient and available to all. This is basic but not enough. In World Two important gains are made by integrating and aligning the many tools, procedure and techniques to detect, prevent, treat and manage disease conditions (most population management focuses on illness and disease). In World Three, essentially a projection of what is required (and possible) but not yet in place, the focus is on the causes of life of the individual and society as a whole. How do these differ in approach and in how they manifest themselves?

Q • The authors suggest that people working in hospital systems have three kinds of accountability that must be made far more congruent:

- Internal accountability — answerable for skills or expertise
- Bureaucratic accountability — answerable between different levels of the formal health system
- External accountability — answerable between health provider and community

The dominant emphasis in health systems is on internal and bureaucratic accountability, with accountability to those being served ("communities of individuals") either very limited or determined by the provider alone and, hence, significantly limited in what can be achieved to deal with the most intractable health challenges we face, including chronic illnesses and those that are a direct and ongoing expression of underlying social factors. Another, "deep accountability" could be developed with stronger two-way citizen engagement and involvement with the population hospitals serve. What might this look like? What is your community doing in this area?

Chapter 11

Mission and the Heart of Healthy Communities

Chapter Summary

Chapter 11 calls faith based and mission driven organizations to reconnect and strengthen the heritage of whole person care that has deep roots in religious faith. The authors caution that faith based and charitable health care systems are facing challenges to their founding missions as the current national climate of mergers and acquisitions is often creating large bureaucratized and commoditized systems where identities of whole person care and care of the poor may be fading. In addition to reciting some of the history and theology of faith rooted health care, the authors speak about a change of language that arose in the second half of the 19th century where terms of war replaced terms of mission. In health care, we speak in language of fighting disease with batteries of tests, giving shots, utilizing arsenals of drugs, physician orders and discharging patients.

The emerging language for health care in our current century is market focused and filled with references to customers, market share, productivity and product lines. The authors fully understand that finance and accountability and safety are important considerations, but raise the possibility that today's health care increasingly runs the danger of losing its charitable soul, devolving into yet another commoditized industry. It is incumbent on faith rooted and mission driven health care to move beyond the preservation of nostalgic language while still expressing commitment to charitable and meaningful service in a world with all of its rich cultural and religious diversity. In today's complex world, the moral vision of Stakeholder Health continues to call all toward creating a beloved community of life, health and hope in partnership with others, utilizing both the growing scientific knowledge of addressing disease, and the faith based knowledge of healing and whole person care. The vision of the beloved community of health is the yearning expression of faithful people to create better health for all people.

Discussion Questions

Q • Look for faith and heart in the history and mission of your health system. For advance work, ask someone to find the original history of your health system. If founded by a faith community, what were their original faith statements then and what are their faith or mission statements today? What are the faith and health statements of the larger body that founded it?

Q • How do you see the trajectory of hospitals that were started, usually long ago, out of a faith tradition? Is there any reference to faith aspects of the work? What faith or religious language appears? What heart language? What are the moral/heart/faith statements in the mission or vision statements of your health system?

Q • Is there strong connection or disconnection between "mission" and clinical operations of your hospital?

Q • People and their own faith journeys and motivations. Take time to reflect on your own motivations (as it relates to faith or heart) for working in the area of improving health. What are the key reasons? Why, from an inner personal motivation do you work in the field of health or social services? Does the institution you work with reflect these motivations?

Q • What can a health system do to better tie into the heart/faith motivations of their staff?

Q • The authors say that creating a culture of health for communities will require collaborative networks, including those of faith. What are some ways hospitals and faith groups can work together in your community to improve health for the underserved. How does this system relate to the faith community of the larger community?

Q • What would be the first steps for your health system to more intentionally engage with the faith communities in your area?

Q • What important trends do you see in the area of faith and health? What about this particular point in the conversation of health in the U.S. should you be noticing and paying attention to? In an increasingly secular industry, how is heart or faith relevant to health care? What difference can it make?

Q • What are the most hopeful trends you all see in the area of faith communities and healthcare systems collaborating to improve public health?

Q • What are some of the best examples where hospitals and faith institutions have joined together to improve the health of their community.