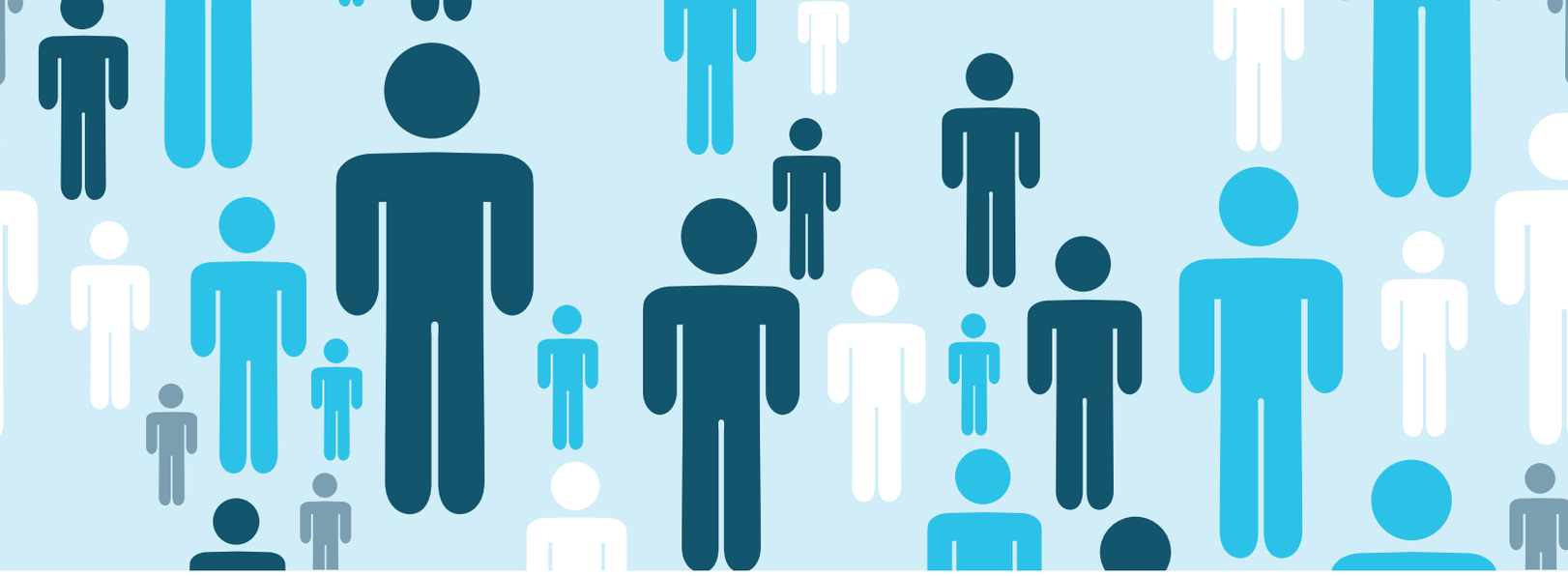

COMMUNITIES CREATING HEALTH

What would happen if the design, implementation, and evaluation of health interventions became something we do *with* communities rather than *to* them?

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Creating Health Collaborative

Stanford SOCIAL INNOVATION Review

About This Book

This collection of articles was first published as a blog series in *Stanford Social Innovation Review*, an award-winning magazine and website that covers cross-sector solutions to global problems. It was commissioned by the Creating Health Collaborative, an international collective aiming to understand health beyond health care.

People want to lead satisfying lives, and that includes feeling well. Health as defined by medicine is only part of feeling well, and yet the overwhelming majority of our society's health investments go to the health care sector for clinical services or public health interventions. While these services are important, their dominance detracts from supporting other things that have the potential to *create* health.

Medicine's narrow definition of health reinforces this dominance, which determines what we value, how we design interventions, and what we measure to determine success or failure. This is all too apparent in the requirements of funders, the experiences of implementers, and the perspectives of evaluators.

There is a large gap between what society provides to improve health and what communities want. What would happen if the design, implementation, and evaluation of health interventions became something we do *with* communities rather than *to* them? Understanding the goals that communities see for themselves, and pursuing those along with medically defined ones, has the potential to create lasting improvements in health.

Co-edited by Pritpal S. Tamber, Bridget B. Kelly, and Leigh Carroll on behalf of the Creating Health Collaborative and Jenifer Morgan of *Stanford Social Innovation Review*, this series brings together the voices of community members, implementers, evaluators, and funders, and builds on a meeting hosted by the Institute of Medicine in August 2014 on how evaluations in health can align more closely with what communities value.

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Foreword

By Sir Harry Burns

I used to be a surgeon in Glasgow, Scotland. For 15 years, I operated on people with cancer and abdominal trauma in the city's largest teaching hospital—a hospital that served the poorest and most socially deprived community in the UK. Working with people from this community challenged my perceptions of my role as a doctor.

At the time, health care's focus was primarily on risk factors—such as smoking, alcohol consumption, and poor diet—as the cause of poor health. Rich people were less likely to indulge in such unhealthy habits so, the profession deduced, the bad health of socially deprived people was due to these behaviors. Conventional public health assumed that once people were given information about how these risk factors were ruining their health, they would stop. Improving health was simply a matter of "getting the message across."

I was never convinced. The hospital rescued people from the brink of death, but when doctors told them their lives were at risk if they didn't change their ways, they invariably replied: "Why should I care? What have I got to live for? Life's tough; booze and cigarettes are the only pleasures I get."

To me, the idea that health was mostly about avoiding things that might make you ill didn't explain what was happening to the health of those living in poor and socially deprived areas. Eventually, I stopped trying to *treat illness* and started trying to understand how to *create health*—or foster what some think of as wellness or well-being.

Twenty-five years later, the evidence is compelling. We are *well* when we feel we have a sense of mastery over our lives, when our lives have meaning and purpose, and when we're part of a community that can support us in times of difficulty. The way we organize society, and look after and support each other creates the capacity for well-being within individuals. Failure to provide nurturing and supportive environments has psychological and biological consequences that increase risk of ill health and premature death.

International agencies and governments are increasingly recognizing the importance of taking action across society to promote well-being. However, we don't fully understand how to achieve well-being. Too often we see society as a machine; if only we could find the correct button to press, everything would work properly. We need to realize that society—and the communities within it—are complex environments that top-down, isolated projects are unlikely to change. The well-being of any community depends on the extent to which its members feel they can influence the decisions that affect them. Rather than do things *to* people we have to learn how to do things *with* them.

The chapters in this book propose a number of perspectives and approaches, from health professionals and community leaders, on how communities can create health. Borne of real-world experience, they illustrate new ways of thinking about health and discovering what communities themselves value most. People living in difficult and chaotic neighborhoods understand their problems better than anyone. They are more likely, when acting collectively, to find and implement the solutions to their problems. This important and timely book suggests resources, tools, and steps to take on the path from provoked thought to inspired action.

I applaud the Creating Health Collaborative (CHC)—an informal, international collective aiming to understand health beyond the lens of health care—and *Stanford Social Innovation Review (SSIR)* for their efforts to support the cohesion of an increasingly vocal group of people working to generate health in their own communities, through their own social networks and values. By documenting the perspectives of "health creators" and those who support them, the CHC and *SSIR* are bringing attention to a new type of health leader in a space currently dominated by the traditional health-care industry.

The challenge for my city, and probably most communities, is to find ways in which citizens can co-produce the solutions to their problems. From that point, they will create health for themselves.

Sir Harry Burns is professor of global public health at the University of Strathclyde, Scotland, and the nation's former chief medical officer.

Communities Creating Health: An Introduction

It's time we looked beyond health care for insights on how to build community-based, health-creating systems.

By Pritpal S. Tamber, Leigh Carroll, & Bridget B. Kelly

Health is the product of many behaviors, influences, and relationships that lie in the settings of everyday life, and yet most of our health spending goes to a health care industry narrowly focused on avoiding or treating disease. Given the rising cost of care, combined with ageing populations with multiple chronic conditions, this narrow focus has created an increasingly expensive and inaccessible health care system that demands sustenance at all costs but is ultimately unsustainable.

We need to take a long, hard look at whether the well-intentioned quest to support health through the lens of disease has detracted from supporting other activities that have the potential to *create* health in the settings of everyday life.

People do not see their health solely through the lens of disease. Health is a means to other things: caring for family, enjoying friends and hobbies, succeeding at a job, living long enough to see grandchildren grow, or concentrating in a classroom. How, then, do we understand and value the health of a community based not just on exercise rates or prevalence of diabetes, but on its ability to help people attain what matters to them?

Clearly the first step is to understand what communities want—something that is possible only when we prevent top-down strategies for reaching disease-based outcomes from dominating the discussion. In one neighborhood, this might lead to programs to support volunteers who visit the elderly twice a week. In another, it might require that communities install more garbage cans to promote cleaner, safer-feeling streets, as a first step to building walkable, active neighborhoods.

A growing number of people in professions both inside and outside of health care are beginning to ask how we can make this shift. One group of people has evolved into the Creating Health Collaborative, a collective that aims to understand health beyond the lens of health care. Each participant shares their work to surface and embrace broader definitions of and approaches to health, and to share learning, seed debate, receive feedback, and ultimately further their work.

The Collaborative published its first report on the emerging principles for creating health in November 2014, and also contributed to a meeting hosted by the Institute of Medicine (IOM) on designing evaluations for what communities really value. At the meeting, participants discussed how using evaluation methodologies designed for disease-based thinking limits our understanding of value—a discussion that has since broadened to include how we might incorporate a community's priorities and values into the design, implementation, and evaluation of interventions.

This broader discussion has inspired the forthcoming series, "Communities Creating Health." It brings together a collection of voices offering a diversity of perspectives on how to create health through community by framing the challenge, making the case for what's needed, sharing real world examples of approaches, and illustrating the possible benefits.

A community-based, health-creating system will require a broader cohort of people than we traditionally see in health care; parents who cook nutritious meals, people who shovel snow for neighbors with back problems, postal carriers who routinely check in on their clients, and business owners who pay a living wage all need as much support as health care professionals. As the series will make clear, it is time we called upon them to offer insights on how that can happen.

In the weeks to come, a variety of voices will contribute to this discussion, including: a local barber passionate about realizing his neighborhood's greatest potential, a council member who wants to see data help rather than hinder her community's progress, innovative researchers in service delivery, and leading practitioners of evaluation science. From these voices emerge eloquent illustrations of what is ultimately incredibly hard work: how to responsibly and effectively approach building new systems *with* communities; how to listen and be heard; and how to approach a process of change that is by its very nature complex, nonlinear, and highly dependent on the context in which it happens.

We hope that this series will provoke a snowball effect among those working in the health sector, recruiting more and more of them to consider new ways of thinking about how they can create health while also making the changes that communities themselves value most. At the same time, we aim for the series to offer resources, tools, and steps to take on the path from provoked thought to inspired action.

Pritpal S. Tamber (@pstamber) is an innovation consultant, the founder of the Creating Health Collaborative, and a public speaker. A physician by training, he has worked in academic publishing and clinical improvement, and his clients include established organizations like the NEJM Group, TEDMED, and WHO, as well as startups such as My Clinical Outcomes, Thicket, and Raremark.

Leigh Carroll is the special assistant to the president of the Institute of Medicine (IOM), and previously worked on IOM projects related to chronic disease and global health. Before working at the IOM, she taught high school science in rural Tanzania through the Peace Corps, and is interested in how neighborhoods can support formal and informal education. She was born and raised in Pittsburgh, Pa.

Bridget B. Kelly is a senior program officer at the Institute of Medicine, working on projects that cover a wide range of topics in health and education, using a diverse array of processes for convening, information gathering, and analysis and interpretation. She is also a dancer and choreographer with many years of experience in grassroots arts organizing.

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The Future of Health Is Giving Communities a Voice

The role of community in well-being has always been a part of life, but the health sector's efforts to support that role needs more development.

By Pritpal S. Tamber

Modern humanity is cursed by longevity.

Homo sapiens aren't designed to live until 85; we evolved to last until maybe 40, at which point lions would eat us. By sticking around for as long as we now do, we're experiencing often chronic, age-related conditions that hinder our quality of life. Compounding this are our increasingly sedentary lifestyles and poor diets. Is it any wonder that enduring ill health has become the normal human experience?

Health care as we know it today is predicated on the "bio-medical model"—it views us as individuals and suggests treating any disease, pain, or defect. But our health status is very much based on our life circumstances, making it social as well as individual. And not all disease, pain, or defects have treatments that people want.

Our unquestioning belief in the bio-medical model has created an over-reliance on a health care system that incurs wildly unsustainable costs. The United States is said to spend 18 percent of its GDP on health care—a staggering $3.8 trillion according to some calculations. The situation is just as acute in Canada and across Europe: Health care in these areas demands between 9-11 percent of GDP. This spending is slowly but surely crippling economies, and crowding out other important public services such as education and housing.

Something clearly has to change.

Let's imagine for a moment that we *don't* change. The health care industry will consolidate its position as one of the most important sectors of the economy, especially when it comes to job creation. This will make it "too big to fail," and it will then be in our collective economic interest to ensure that the sector has enough ill health to treat. Do we really want societies that create sickness to drive job creation?

This is the mother of all catch-22s. In ageing societies, there is more demand than ever for care, and yet the unsustainability of health care systems means they cannot meet that demand.

When trying to think about health beyond health care, it's useful to acknowledge that access to and quality of health care accounts for only 10-20 percent of premature mortality. The rest comes down to our genes, behaviours, social factors, and the environment. While genetics entrepreneurs convince venture capitalists that their field is the new panacea, calmer voices question its value. So the question becomes whether it's possible to influence behaviors, social factors, and the environment to *create* health.

To start answering this, we need to adopt broader definitions of health—broader than the bio-medical model suggests. Ask the man on the street what he thinks about when it comes to his health, and you'll hear public health messages learnt by rote: eat more fruit and veg, stop smoking, exercise more. But probe further into what makes people *feel* healthy, and a broader definition surfaces: financial security, a fulfilling career, the ability to function physically, emotional security, a sense of community, nourishing social interactions, and having meaning in life.

Some call this broader definition "subjective well-being," and evidence is emerging that well-being is associated with survival at older ages. But given its promise, who is responsible for delivering it? Look back at the broader definition, and you'll see that the answer is *everyone:* employers, government, friends, family, city planners, neighbors, and spiritual leaders. The problem with *everyone* being responsible is that

no one is.

Let's take a moment, though, and ask ourselves why we need health *delivered* to us. If well-being is subjective, who is better placed to devise interventions that create it than ourselves? It's time to question the assumption that outside expertise, ideas, technology, and resources that are often alien to our communities will bring health to us. It's time to believe that our communities have—or can nurture—what it takes to create health.

None of this is to say that we don't need external experts. Of course we do. When I herniated a spinal disc, I needed a neurosurgeon not my local baker (though my baker's handiness with a rolling pin contributes to my health and well-being in other ways). But these external experts have to see communities as experts in return, and they have to accept that the most important decision-makers are those who have to live with the consequences of decisions—community members themselves.

The role of community in well-being has always been a part of life, but currently, the health sector's efforts to support that role—with a view to making it more systematic, knowledge-generating, and, ultimately, valued—are in their infancy. We're still trying to refine how to devise interventions and evaluate whether they've worked. We don't even know how to measure "worked" when what we're creating is subjective and likely ever-changing. Nevertheless, it is critical that we develop a new discipline and approach to health so that one day any community can make informed choices about what health means to them and how they create it—whether that means funding a new MRI scanner or a local park.

If we don't, we may as well release the lions.

Pritpal S. Tamber (@pstamber) is an innovation consultant, the founder of the Creating Health Collaborative, and a public speaker. A physician by training, he has worked in academic publishing and clinical improvement, and his clients include established organizations like the NEJM Group, TEDMED, and WHO, as well as startups such as My Clinical Outcomes, Thicket, and Raremark.

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What Is Community Anyway?

Our understanding of community can help funders and evaluators identify, understand, and strengthen the communities they work with.

By David M. Chavis & Kien Lee

"Community" is so easy to say. The word itself connects us with each other. It describes an experience so common that we never really take time to explain it. It seems so simple, so natural, and so human. In the social sector, we often add it to the names of social innovations as a symbol of good intentions (for example, community mental health, community policing, community-based philanthropy, community economic development).

But the meaning of community is complex. And, unfortunately, insufficient understanding of what a community is and its role in the lives of people in diverse societies has led to the downfall of many well-intended "community" efforts.

Adding precision to our understanding of community can help funders and evaluators identify, understand, and strengthen the communities they work with. There has been a great deal of research in the social sciences about what a human community is (see for example, Chavis and Wandersman, 1990; Nesbit, 1953; Putnam, 2000). Here, we blend that research with our experience as evaluators and implementers of community change initiatives.

It's about people

First and foremost, community is not a place, a building, or an organization; nor is it an exchange of information over the Internet. Community is both a feeling and a set of relationships among people. People form and maintain communities to meet common needs.

Members of a community have a sense of trust, belonging, safety, and caring for each other. They have an individual and collective sense that they can, as part of that community, influence their environments and each other.

That treasured feeling of community comes from shared experiences and a sense of—not necessarily the actual experience of—shared history. As a result, people know who is and isn't part of their community. This feeling is fundamental to human existence.

Neighborhoods, companies, schools, and places of faith are context and environments for these communities, but they are not communities themselves.

People live in multiple communities

Since meeting common needs is the driving force behind the formation of communities, most people identify and participate in several of them, often based on neighborhood, nation, faith, politics, race or ethnicity, age, gender, hobby, or sexual orientation.

Most of us participate in multiple communities within a given day. The residential neighborhood remains especially important for single mothers, families living in poverty, and the elderly because their sense of community and relationships to people living near them are the basis for the support they need. But for many, community lies beyond. Technology and transportation have made community possible in ways that were unimaginable just a few decades ago.

Communities are nested within each other

Just like Russian Matryoshka dolls, communities often sit within other communities (Photo by Community Science)

Just like Russian Matryoshka dolls, communities often sit within other communities. For example, in a neighborhood—a community in and of itself—there may be ethnic or racial communities, communities based on people of different ages and with different needs, and communities based on common economic interests.

When a funder or evaluator looks at a neighborhood, they often struggle with its boundaries, as if streets can bind social relationships. Often they see a neighborhood as the community, when, in fact, many communities are likely to exist within it, and each likely extends well beyond the physical boundaries of the neighborhood.

Communities have formal and informal institutions

Communities form institutions—what we usually think of as large organizations and systems such as schools, government, faith, law enforcement, or the nonprofit sector—to more effectively fulfill their needs.

Equally important, however, are communities' informal institutions, such as the social or cultural networks of helpers and leaders (for example, council of elders, barbershops, rotating credit and savings associations, gardening clubs). Lower-income and immigrant communities, in particular, rely heavily on these informal institutions to help them make decisions, save money, solve family or intra-community problems, and link to more-formal institutions.

Communities are organized in different ways

Every community is organized to meet its members' needs, but they operate differently based on the cultures, religions, and other experiences of their members. For example, while the African American church is generally understood as playing an important role in promoting health education and social justice for that community, not all faith institutions such as the mosque or Buddhist temple are organized and operate in the same way.

Global migration has led to an assortment of communities based on people's needs and desire for that sense of trust, belonging, safety, and caring for each other. For example, one group of new immigrants may form a community around its need to advocate for better treatment by law enforcement. Another group may form a community around its need for spiritual guidance. The former may not look like a community, as we imagine them, while the latter likely will.

The meaning of community requires more thoughtfulness and deliberation than we typically give it. Going forward, researchers, practitioners, and policymakers must embrace this complexity—including the crucial impact communities have on health and well-being—as they strive to understand and create social change.

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Kien Lee, Ph.D, is the vice president and principal associate of Community Science where she specializes in issues affecting communities that are racially, ethnically, or culturally diverse. She brings more than 15 years of research and evaluation experience to this work, as well as expertise in the integration of immigrants, strategies, and programming for racial equity, the reduction of health disparities, and the development of cross-culturally competent organizations. See Kien's profile on LinkedIn.

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Giving Communities a Role to Play in Health

When people have a real voice in the decisions affecting their lives and health, they thrive in ways beyond measure.

By Tony Thomas

Our neighborhood, at its height, was 10 percent of the city's population. As economic opportunities disappeared and crime began to rise, people started to leave. Amenities soon followed, including our grocery stores. The Northside community of Spartanburg, South Carolina, was designated a food desert by US federal standards, due to the fact that there wasn't a grocer within a two-mile radius of its location. We had ice cream trucks canvassing the community all day long, but no healthy food choices.

Around this time, I came together with volunteers and community activists through Partners for Active Living, an organization that launched in 1996 after a study showed that cardiovascular disease and obesity were the greatest risks to our local community. One activist suggested that we create a "mobile market"—a truck that would drive through the area offering locally grown fruits and vegetables. It was a success, but we needed to do more.

Soon after, Former Mayor William Barnet embarked on a redevelopment plan for the area and fortunately determined that it would work best if the project happened *with* the community, not *to* them. To this end, he formed the Northside Development Group (NDG), a 501(c)3 nonprofit corporation whose role was to not only manage the process but encourage it, in part by ensuring that community leaders got involved. I was one of eight of these leaders.

To help us effectively participate in the redevelopment process, NDG sent the eight of us through a leadership course that spanned eight months. We met twice a month for three hours, with the aim of better understanding leadership principles and how we might use them in our work. When we finished, the course leader suggested that we formalize by giving ourselves a name. We decided on "Voyagers"; we knew that the journey ahead would last 10-15 years—a real voyage.

NDG presented a number of options for development during a three-day "charrette" (a fancy term for a public workshop) in a local Baptist church. The workshop included a number of seminars, and involved the project's developer and architect. But we also wanted to ensure that community members participated. The Voyagers were instrumental in making this happen. We went door to door, distributed flyers, arranged a small write-up in the local paper, and used Facebook to get the word out. We also reached out to Wofford College, the well-respected local liberal arts college, and encouraged students to help document the vast amount of information that emerged from the seminars. Despite the fact that over the years they'd been told to avoid our area for safety reasons, they came.

During the workshop, NDG set up images of each proposed development, gave each community member two green and two red stickers, and asked them to place the green stickers on what they wanted and the red on what they did not want. This feedback, and the feedback we gathered during the seminars and regular meetings, informed a master plan that the architect then drafted. It's important to note that this was not just about development; the participants also desired education, jobs, and safer streets, all while preserving the history of the community.

The redevelopment included demolishing a hotel that local residents abhorred for its tolerance of prostitution and drug activity. After its demolition, the community was even more optimistic that we were headed in the right direction. This gave the effort momentum, and served to build more trust between residents, the developers, and the Mayor's Office.

As part of the redevelopment, we've now managed to set up a local farmers' market with a cafe and fresh food store, providing both access to better food and jobs for local residents.

Thomas standing in front of local produce that is now available to residents in a fresh food market.

We also have plans for a new community center, where we'll build a database of local skills and talents to better understand what educational opportunities people are looking for and/or need. Although people wanted jobs, they also wanted to gain skills that will allow them to be more self-reliant. To meet this need, the community established the PowerHouse—a newly designated computer/Wi-Fi facility to assist children and adults with computer literacy, even if using a computer is not a part of what they currently do for a living. Having these broader skills is important to both how the community perceives itself and how others perceive them. Yet another resource we are creating is a planned early childhood development center, which will further assist our children with cradle-to-college educational opportunities. This will be very important to continuing the success of the local charter (elementary) school, which faces serious challenges but is now achieving like never before.

Along the way, a few things have surprised me. I was surprised that so many community members came out for the workshop. I've heard people talk about community apathy, but we've found that residents will come if you ask them and if you're sincere about listening to them. I was surprised to see so much student participation, despite the scare stories they'd heard over the years. The relationship between residents and law enforcement has greatly improved. We now have regular foot patrols, and our crime rate is currently the lowest in the city for the last three months. The police say to me, "We don't know what you all are doing but keep doing it."

But perhaps what surprised me most was hearing the elders in the community say they just wanted to go to bingo. Given all the issues we have in our area, it was such a simple request. They just wanted to go out and be with their friends without the threat of gun violence. I thought to myself, "We should be able to do that." And now we have.

From the beginning I knew that for this effort to succeed, we would need to see that the voice of our

community was being heard at each level of implementation. We were certain—and remain certain—that we all will make mistakes, but we will find the solutions together.

We're taking a different approach to overcoming blight; it's development on a humanitarian level, working with members of the community to understand their desires. We hope that other neighborhoods across the country will take a similar approach and, together, we'll become a network of communities learning from each other. What we, as Voyagers, have found most compelling is that when people have a role to play in change—a real voice in the decisions affecting their lives—they thrive in ways beyond measure. That's creating health!

Tony Thomas is a barber and cosmetologist with a passion and desire to bring his community to its greatest potential through a shared vision with other community leaders and supporters.

Conflicts of interest: None declared

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Between Listening and Doing

A "whole health" approach to improving access to food and food education.

By Philip Sambol

I grew up working in my father's restaurant. My father grew up working in his father's restaurant. Food and food service are in my blood; it's an intergenerational passion, and it has led me to spend the last few years trying to work out why food deserts exist. The more I have looked into it, the more incomprehensible it has become. There are people crying out for local grocery stores—or *any* store selling fresh food—and yet not enough is happening. I thought it was because no one was listening to communities, but I have come to realize that listening is not enough; we must *do*. But doing is tough, and requires that we constantly ask new questions and find new solutions.

If you're going to think about food in the United States, there's no better place than New Orleans; "the Big Easy," as it's known, is a food lover's paradise. I arrived there in late 2012, with some savings and an income stream of royalties from my previous life. I spent the latter part of that year and early 2013 volunteering with various "food access" nonprofits, and meeting with long-time food and social justice activists to understand the problems. These conversations kept leading me back to the Lower Ninth Ward, an area devastated by Hurricane Katrina in 2005—80 percent of homes were destroyed or demolished. Many of the buildings remained in a state of disrepair, gutted and without electricity, and many of the former residents were still looking for a way to get back home.

But there was also another problem: Over the years, ideas for rebuilding that had little chance of success had sapped the community's strength. After Katrina, academics swamped the city, now left with half its population and a third of its grocery stores, wanting to use the opportunity—a veritable clean slate—to understand how to develop interventions that would improve food access. With dozens of food deserts around the city, it was easy to latch onto the desire for a grocery store. These academics conducted surveys, created artists renderings, and submitted reports to funders, but their recommendations failed to recognize that the grocery industry has well-established metrics for the size and density a neighborhood must reach to sustain a supermarket. After hundreds of community members dedicated years of time and energy to getting access to fresh food, they were left with the cold fiscal realities not considered in the surveys, renderings, and reports.

What the community wanted was clear, so the question became: How do you operate a grocery in a less-affluent community? It needs to be large enough to meet demand but small enough to avoid the costs of a large operation. While trying to answer this, I learned the role that grocery stores play in community development beyond access to food. Groceries also serve as meeting places, sources of informal credit, and places where kids get their first jobs and learn the responsibilities of work. I packaged what I learned into an approach that I developed with the help of dozens of individuals and organizations. I called it Health Education Center, Kitchen, Organic Farm, and Neighborhood Grocery, or HECK OF A Neighborhood Grocery for short.

With a plan in mind, and, more importantly, on paper, I began meeting with potential funders. Many were quick to pat me on the back and applaud the work I'd done to truly understand the problems—but the funding never came. In truth, we were asking for a lot, because we needed to renovate a building to house the store. But investment size aside, many funders had simply given up on the people of the Lower Ninth Ward.

I took all of the objections from funders as fodder for new ideas. I was warned that I'd be training local people in the basics: simple mathematics, turning up on time, and food handling. In response, we built a job-training program into the grocery operations. I was warned that we would never be able to offer prices to compete with big-box retailers. In response, we incorporated nonprofit functions into each aspect of the business to subsidize prices for members of low-income communities. I was warned that I would never

be able to secure proper distribution. In response, we built a strong relationship with a major grocery supplier, and designed an urban teaching and production farm to supply the store and foster knowledge about nutrition and growing food. And yet it was still difficult to convince most people that it was possible to help the area.

Once we developed these three components—grocery store, urban farm, and health education center—I needed to better understand them. I did an apprenticeship at the Center for Environmental Farming Systems in North Carolina, which helped me understand how to run an urban farm. Now I am operating a grocery store in the Woodridge neighborhood of Washington, DC, with Good Food Markets. Together, we're learning what it takes to make a local grocery economically viable. One similarity between the Lower Ninth Ward and Woodridge is that both communities are spending about $16 million a year on groceries and related shopping, but somehow it is still difficult to sustain a small store. How can that be so? We're working to learn why right now in DC.

Philip talks with local farmer Myeasha Taylor at Good Food Markets' pilot store in Washington, DC. (Photo by Sarah McLaughlin)

In my head, though, I'm always working on HECK OF A Neighborhood Grocery. I realized that we might have been asking for too much money back in New Orleans, even with the costs of renovating a building. Now I've worked out how to start smaller, learn along the way, and build from there—and eventually, hopefully, foster all three elements of the approach. I see it as a "whole health" model—healthy planet, healthy communities, and healthy people—for an ecological, economical, and educational space where people can access food, and nurture those informal relationships and trades that hold a community together and enable it to thrive.

Philip Sambol (@GoodFoodDC) was born in Chicago and has lived throughout the Western hemisphere. He currently resides in Washington, DC, where he is the vice president of operations for Good Food Markets, a mission-driven business committed to finding solutions to issues of food access and health

disparities in underserved communities.

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Building Trust with Communities of Color

Strategies for engaging communities of color in local health initiatives.

By Nayeli Y. Chavez-Dueñas & Hector Y. Adames

Culture-centered design, implementation, and evaluation of programs can be an arduous and complex task for health professionals who are outside of, but working in, communities different from their own. The consequences of not doing this well can be profound; the long-standing history of institutional discrimination against communities of color, for example, has resulted in distrust of governmental and health agencies. In addition, barriers such as language and cultural differences, lack of transportation, and inflexible working schedules may prevent communities of color from participating in health-related initiatives.

These factors may help explain the overall underrepresentation of communities of color in health-related programs. This lack of representation often results in programs that do not adequately meet the health needs of these communities, which can lead to adverse outcomes. There is a need for comprehensive and participatory approaches that establish collaborative partnerships with communities of color. Such collaborations would invite and welcome people of color as strategic decision makers in every step of the design, implementation, and evaluation of health initiatives for their community.

The diverse communities of Mexico City, circa 2013; building connections is critical to trust and outcomes. (Photo by Nayeli Y. Chavez-Dueñas and Hector Y. Adames)

We offer the following strategies, organized into three domains, for engaging communities of color in local health initiatives.

Domain 1: Building Empathy

To effectively engage communities of color, it is paramount that health professionals build empathy for how culture, racism, and history influence initiatives and their evaluation by:

- Recognizing both universal and culture-specific factors that influence participation in health initiatives and evaluations, perhaps by using the approach outlined in the *Multiracial, Multiethnic, Multicultural Competency Building Model,* which requires thoughtful action at four levels: intellectual, emotional, behavioral, and practical.
- Understanding how racism and ethnocentrism operate with the aim of developing evaluation methodologies that are respectful of diverse communities
- Appreciating the historical context in which evaluations have taken place, paying close attention to the negative affect on communities of color and their resulting loss of trust in agencies
- Developing an understanding of the interface between individuals' ethnic and racial experiences and their health beliefs; such knowledge may strengthen both the design of interventions and evaluation approaches.

A number of continuing-education programs focus on meeting the above-mentioned criteria. The Winter Roundtable at Columbia University's Teachers College, for example, focuses on cultural issues in psychology and education. The One America in the 21st Century: The President's Initiative on Race initiative has also issued a helpful tool for organizing and conducting a community discussion on race.

Domain 2: Nurturing Self-Awareness

To effectively engage communities of color, we encourage health professionals to:

- Become aware of their attitudes, biases, prejudices, and resulting stereotypes; failing to do so may detrimentally affect the establishment of trust with the communities they wish to engage
- Develop the ability to see and understand the cultures of people of color as sources of strength and resilience
- Gain awareness of the racial and cultural socialization of individuals in communities of color, as it may assist in finding culturally congruent ways to connect and build trust
- Be mindful of similarities and differences between how health professionals view and conceptualize health and healing practices, and how communities of color view them

A tool that can help health providers assess biases and attitudes is the Implicit Association Test, a multi-university collaboration that started in 1998 and has led to a substantial web-based infrastructure for supporting behavioral research and education on implicit bias, diversity, and inclusion, with a view to applying the science to practice.

Domain 3: Developing Skills

To effectively engage communities of color, we invite health professionals to demonstrate their commitment to promoting health among those communities by:

- Participating in training programs to learn cultural nuances, including ways to communicate and interpret verbal and nonverbal messages appropriately
- Assisting community members to develop an understanding about the process of evaluation, its rationale, and its expectations; such understanding may facilitate their engagement in health initiatives
- Developing partnerships with local agencies and providers of health services that are respected by the community, as a way to facilitate establishing trust between the community members and evaluators
- Implementing a strategic decision-making approach, where the voices of the community are included in every step of the evaluation process.

The Patient-Centered Outcomes Research Institute (PCORI) funds health programs that exemplify effective community engagement in health-related initiatives.

Overall, we invite health professionals to start—or continue—to learn how to strategically engage

communities of color in collaborative partnerships. Such engagement may serve to promote health behaviors that affirm the humanity of racially and ethnically minoritized communities. A commitment from health professionals to behave in ways that demonstrate that they have the community's best interest in mind is pivotal for engaging communities of color. Furthermore, many of these strategies are important best practices for all community work, which inevitably brings together community members and health professionals with diverse backgrounds. Ultimately, the design of health initiatives and their evaluations will reach their optimal potential when all individuals are invested in establishing relationships based on reciprocal trust.

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Connecting Big-Picture Theories with Community Experience

Blending practices and theory to improve health outcomes outside the clinical setting.

By Nancy Knopf

I am a social worker with more than 20 years of experience working in different communities and am now involved in helping a health care payer engage with communities. I have always tried to understand "where people are at" and build from there, and at a recent meeting hosted by the Institute of Medicine (IOM), titled "Designing Evaluations for What Communities Value," I realized that my instinctual way of working and the approaches I bring to the health sector from my social work background map to theories on how communities operate.

For example, taking the time to speak in depth with individuals to understand their needs falls under the formally developed approach of *narrative methodology*. The process of considering how people's many different affiliations affect their actions and decisions is closely related to theories and approaches about *systems thinking*—the idea that multiple things can influence multiple things within a system. Realizing this connection between the practices social workers use, and the theoretical work that informs and strengthens those practices, has helped me think through how my organization can further support the communities we serve to improve health outcomes outside of the clinical setting.

Graphic recording of community response to questions about what would make a healthier county; recorded at the Way to Wellville town hall in the city of Seaside, Clatsop County Oregon, January 2015. (Image courtesy of Danielle Olson)

I work for Columbia Pacific Coordinated Care Organization (CPCCO), a nonprofit health care plan for Medicaid-enrolled individuals and families in three counties of northwest Oregon. A coordinated care organization (CCO) enables people to get all of their care—physical, behavioral, or dental—through

the same plan, which includes things like transportation to health services, disease prevention, and help managing chronic health issues. The overall idea is to create more-integrated care and engage the community in the improvement of health.

CPCCO works with communities through community advisory councils. There is one per county, and members reflect the diversity of each county's community. The council mandates that 51 percent of the membership must be currently enrolled in Medicaid; the other 49 percent either work closely with people enrolled in Medicaid or reside in a community served by CPCCO. My job involves coordinating these councils, ensuring community engagement, and developing community health partnerships outside of the clinical setting. All three community councils report to a regional one.

CPCCO believes that eliciting the voices of the community and meeting them "where they are at" is critical to improving health outcomes. Working this way acknowledges that 90 percent of factors that influence our health occur outside the clinical setting. In 2013, we conducted a community health assessment in each county. The information from the assessments helped inform the process of choosing three health priorities to focus on, across the region, over the next five years. As part of the community health assessment CPCCO created a survey that asked residents' opinions of the health and health care needs of the communities in which they live—and then discussed the results with each of the affiliated community advisory councils. We also presented the data to the regional advisory council, which prioritized three areas to address over the following three years: obesity, mental health, and substance abuse.

Meanwhile, we piloted a narrative methodology approach provided by Cognitive Edge, in which participants—prompted with a question—share a story and then give the story a title. After that, the moderator asks each person a series of other questions that measure the effect their story has had on their life. The idea is that, in effect, the participant rates the importance of the story, rather than a researcher.

This approach aims to help everyone—citizens *and* providers of care—find a deeper understanding of how communities perceive themselves—in our case, how they see health and health care needs. We used it to understand more about the challenges people face in trying to be healthy, and the types of collaborative programs or activities that we could undertake to positively impact health in the communities we serve.

Using this approach made me realize that I have always used a narrative methodology—I just never called it that. Although my work has been largely clinical, I have been collecting stories (narratives) for a long time with the goal of understanding what people need from social services.

This narrative methodology approach is also powerful because community members formulate all of the questions. Making the approach participatory engages community members in both the collection and interpretation of the narratives to find solutions.

We found that the narratives we collected provided a rich context that we didn't get from the community survey, and that there are many reasons why conditions or problems exist. This enabled us to see new patterns and explore more potential solutions. People's actions and decision-making processes are flexible, and depend on ever-changing internal and external circumstances; they are continuous works-in-progress. The narratives also helped us see that a small action to address an issue can have a big effect—something much harder to glean from our survey data.

Using the Cognitive Edge approach was also my first exposure to systems thinking. I have always understood individuals as a collection of affiliations: cultural, religious, geographic, familial, professional, etc. Each of these affiliations influence individuals—both their development and behavior, and the choices they make with regard to their health. It made me realize that we need to embrace systems thinking to create strategies that resonate with individuals.

Another "aha!" moment I had at the IOM meeting—alongside narrative methodologies and systems thinking—came with my introduction to *collective impact*, the idea that a group of actors from different sectors can create a common agenda to solve a specific social problem. I am now using all three of these big-picture theories to help me think through how we might do more for our communities. Understanding that these theories not only exist, but also align with my instinctual way of working gives me great confidence and furthers my resolve to improve health outcomes at the community level.

Nancy Knopf is a social worker with more than 20 years of experience, working in the community with people who are low-income and who experience long-term health conditions. Currently she works for Columbia Pacific Coordinated Care Organization as a community health partnership manger in three counties in northwest Oregon.

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Emerging Tools for Community-Driven Evaluations

Eight tools for building inclusive, community programs to address health and other social issues.

By Deepthi Welaratna

Too often, the process of building shared knowledge excludes the very people expected to act on that knowledge. Many scientific studies treat people as subjects, rather than participants. Resulting discoveries are locked away from the public—in technical jargon, expensive journals, customized software, and patented procedures. As a result, communities have become increasingly uninformed and unwilling to participate in science.

Another roadblock to community-based work is the fact that it is becoming harder to establish common understanding as the world becomes more interconnected. Culture, socioeconomic class, and lived experience all contribute to divergent perspectives that impede alignment on priorities and decisions.

We can re-engage people in the process of discovery, but we must rebuild trust and find common understanding. When we design collaborations in a truly inclusive manner, trust and alignment are natural outcomes. Researchers and practitioners must work with communities to establish common goals, transparent practices, and shared criteria for evaluation.

Here, I suggest tools for building inclusive, community-driven programs through the establishment of shared frameworks, the use of process-based collaborations, and new ways of framing and analyzing data. Many of these suggestions come from human-centered design, organizational theory, or systems design.

Establishing Shared Frameworks

A shared framework helps clarify how everyone involved sees pathways to change and the criteria for how an evaluation might assess those changes. Participatory activities engage people from different backgrounds and disciplines to establish common understanding of complex factors, and hence a shared framework. The following activities facilitate productive group discussions that align rather than fragment.

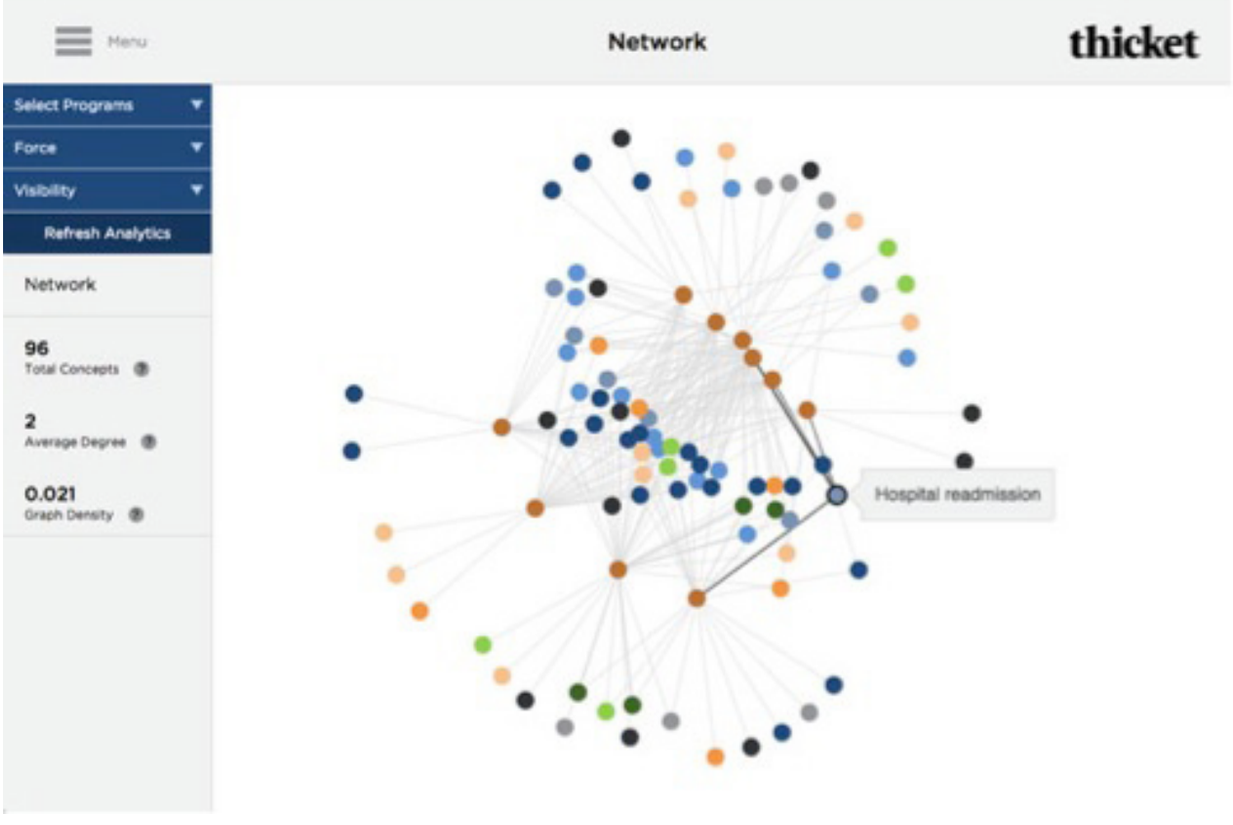
- Cognitive maps are simple visuals documenting an individual's thought process about a topic or system; they use lines and arrows to show how concepts relate to each other. Comparing cognitive maps can identify points of alignment and divergence within groups of people. Examples of cognitive maps include process, system, and stakeholder maps, often used in strategic planning.
- Card sorting is an activity to design taxonomies for large amounts of information. An individual or group document categories that make up a complex system on index cards, using one card per category. They then spread them out on a table and organize them into different classification systems. Website designers use card sorting to organize information for multiple audiences; it can also facilitate the design of an intervention.
- Ranking and prioritization activities can help align people around decisions. They require participants to prioritize competing alternatives and explain their choices. Human-centered designers use these activities to bring diverse stakeholders toward agreement.

Process-Based Collaborations

Scientists and designers share an open secret: A strong process is a critical element of success in both research and development programs. Whether building shared knowledge using the scientific method or by designing a new program using human-centered design, the steps are very similar. Prioritizing process over outputs can positively affect productivity, creativity, and social cohesion.

- Hackathons are intensive events where small teams brainstorm and prototype technology-based solutions around a theme. The constraints of having to work fast in deep collaboration can bond teams that might never become tight-knit under more relaxed conditions. They can also produce solutions that surpass typical levels of creative innovation. Health care organizations have used hackathons to break down cultural boundaries between health care professionals and technology developers.
- Social innovation labs don't impose the strict time constraints of hackathons, but they also convene small teams to rapidly prototype and pressure-test solutions for real-world problems. Typically a week or longer, social innovation labs encourage a systems view to create social cohesion among diverse groups, and have addressed problems such as literacy and youth unemployment.

Finding New Ways to Frame and Analyze Data



Network maps organize complex sets of data and examine factors like influence within a network. (Photo courtesy of Thicket Labs)

We have generated much of the world's data in just the last few years. But big data is no cure-all. We must leverage emerging tools to make sense of all this information, particularly if we want our evaluations to account for multiple factors impacting at once, as in complex systems. The tools below help frame and analyze big data.

- Infographics are everywhere today because they combine two powerful tools for sharing information: visuals and storytelling. Research tells us that visuals help people glean more information at a glance. And contextualizing data through stories that connect insights to their real-world utility helps people make sense of data more readily.
- Network analysis is a new way to distill large datasets for easier analysis, resulting in what's called a network map. Network maps add new dimensions to our traditional analysis of data by representing the influence of multiple factors on each other. One example application is how social network analysis has visualized the spread of loneliness through social networks.
- Simulations are network maps turned into dynamic models. By setting hypothetical scenarios, it's possible to test how systems behave and hence identify meaningful patters. Simulations can help validate hypotheses quickly and cost-effectively before moving on to more-costly trials in the real world. Simulations are used regularly in behavior research.

The tools presented here can help reduce roadblocks resulting from differing agendas, slow processes, and poor communication. We can and should make our decision-making more inclusive.

Deepthi Welaratna (@deepthiw) is the founder of Thicket, a design lab and consultancy that helps improve the way people share knowledge and work together. She has spent the last 12 years influencing complex systems by developing public policy campaigns, cultivating creative leaders, and building movements around a range of social and economic issues.

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Health Services and Designing for Uncertainty

How a "lean startup" approach can help create an effective community-based program.

By Onil Bhattacharyya, Leigh Hayden, & Jennifer Hensel

We don't quite have it right with health care. We know that. It's too costly, too impersonal, too inefficient, and too ineffective. It also continues to focus on managing sickness at the expense of promoting health. Given the need for change, our group is looking outside of health care for inspiration. The tech industry is making increasingly complex applications both intuitive and empowering for end users, and might provide some novel approaches to meeting the needs of patients and communities—not just providers.

Beyond the "Waterfall" Approach

Biomedical research often informs health services research. Possible solutions start with safety and efficacy trials, and then move to implementation trials. In this latter stage, each step is based on hypotheses about causality, which researchers test in a pre-defined manner, but it does not allow for modifications based on what researchers learn during implementation. For example, if you are testing the effectiveness of a new diabetes education program on patients' knowledge of diabetes and their outcomes (as compared to regular care), and partway through you learn that participants need and want support rather than education, you can't modify your intervention.

In the tech world, this kind of approach is called "waterfall"—each step occurs in sequence: gathering requirements, designing the solution, implementing it, verifying its implementation, and then maintaining it. But it's recently fallen out of favor with start-ups, since you can spend a lot of time developing something that nobody wants, which is very common for early-stage products and services. In the diabetes program example above, a waterfall approach would tell you whether your pre-determined intervention was better or worse than regular care, but it wouldn't help you land on the best possible intervention for the people you're looking to help.

In response to this, many start-ups are using a more iterative approach that incorporates adaptive planning, earlier delivery of smaller parts, and constant testing with end users. These new approaches are called "agile"—and the best-known is the "lean startup."

Going Lean

Our group applies the agile approach to helping health care professionals design models of care for people with complex needs—an area where there is a lot of uncertainty about what works and how to measure it.

For instance, we recently worked with one team on developing a community-based program to reduce readmissions of patients discharged from an in-patient psychiatric service. Prior to our first meeting, the team did a literature review to find effective interventions, and outlined the proposed service and implementation process.

Together we decided to draw on the lean startup approach to test the "minimum viable service" before building an entire program. We described eight critical components, including care coordination for community resources, support for family doctors, medication review and education, and urgent access to psychiatric care. We then followed a small number of patients through the program to see how much these components *really* mattered to users and whether they affected readmissions rates.

One month of data showed that three of the eight components were neither relevant nor effective. For instance, we found that the care co-ordinator had limited knowledge of community resources and several patients had no family doctor. Those who *did* have a doctor had little or no recent contact and no interest

in reconnecting.

So we modified our components. Because engagement with the family doctor was important but challenging, for example, we developed one approach for engaged patients and another for disengaged patients. And in addition to trying to improve the program, we are working with the in-patient psychiatric service to fundamentally improve the discharge process, rather than just put a Band-Aid on it.

Our initial approach took three months to develop, but just one month of data collection revealed its flaws. We learned that while it may take a trial to determine that something *does* work, rapid testing of rough versions of a service can convincingly show that it *doesn't*. Now we look for problems and are already thinking about alternate solutions before problems surface. For our psychiatric project, we are reconceptualizing and taking what we have learned to better plan services, including adding family physician support service to an existing platform for family doctors with complex patients.

Lessons

We think this approach is well-suited to circumstances where the intervention, appropriate target group, and outcomes are unclear. It's hard work, with few eureka moments, and so we'd like to share our tips for other teams considering the same approach:

1. **Assume it isn't going to work**. This will do two things: keep your emotions and motivation intact and encourage you to test multiple things at once to maintain your momentum.

2. **Pace yourself**. Constant iteration isn't about working like crazy until you kill yourself; it's about creating simple tests that help you see whether things are working or whether they need to change.

3. **Document your journey**. It's easy to get discouraged, and it's easy to forget the things you have already learned if they aren't visible. We made several tweaks to the program (such as with physician communications), and recording the changes was helpful and motivating.

4. **Keep reaching**. Most things we do in health care make only a marginal difference. If we want major insights, we need to expect more and change strategies (while keeping the same vision) until we find them.

Getting stuck is inevitable. Great teams with strong members take turns leading each other through the hard times. Getting unstuck could be a matter of revisiting what you have learned or conducting a few radical experiments. Maybe you need to all go out for ice cream. Regardless, working in an iterative and critical way is hard work and takes focus and determination.

The uncertainty we face in treating sickness will only increase as we move toward creating health by working across sectors to support people's aspirations. But honing agile and iterative approaches in the former domain will increase our success in the latter. And we hope that by sharing our frustrations and our journey, it will help you in yours.

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Jennifer Hensel is an outpatient psychiatrist at Women's College Hospital and assistant professor in the Department of Psychiatry at the University of Toronto. She is a WIHV Fellow and the psychiatric lead for the model described.

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which make the flaws in everything obvious and brings us closer to real solutions. Thanks also to Simone Vigod and Valerie Taylor for their work on the initial design, and to Catharine Fox, clinical manager, for her work on the model.

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Cultivating and Sustaining Generative Teams

Four practices that can help people establish common intent; sense emerging needs and solutions; and collectively prototype, create, and evolve innovative heath models and relationships.

By Margaret A. Hawthorne

Fundamental to successful health-creating initiatives are people—people who collect and interpret data, facilitate town-hall meetings, strive to understand community politics and culture, implement and interact with the initiative, and of course make up the community the initiative aims to serve. Each person comes with their own cares, stresses, and interests, and yet all must work together to successfully implement, evaluate, and evolve new programs.

These people come together to form teams. These teams, such as initiative evaluation teams like my former team at the Institute of Medicine, are most successful and transformative when they are diverse in expertise, skills, perspective, and culture, and include both program implementers and community members. With diversity, however, comes the potential for power struggles, bias, and misunderstanding. We have all been in situations where relationships with colleagues make or break success. Thus teams have the power to either unlock deep potential and creativity, or keep us stuck, insecure, and reacting to patterns of the past.

In his book *The Fifth Discipline*, systems scientist Peter Senge notes: “When you ask people about what it is like being part of a great team, what is most striking is the meaningfulness of the experience. People talk about being part of something larger than themselves, of being connected, of being generative.”

Great teams are *generative*. They identify and evolve ideas and relationships using a continuous process of deep listening, collective inquiry, dialogue, prototyping, and reflection to maintain learning and innovation. Teams that can do this produce and test potential solutions more quickly and—by engaging with each other and the community they are working with—can adapt more efficiently

Generative teams are transformative at both the individual and systemic level. They extend each members’ capacity to understand and create, allowing them to perform better collectively than they could individually. Applied to community partnerships and partnership evaluation, this approach creates a shared commitment to creative solutions and responses that are deeply grounded in community values.

A generative team engaging around common intent. (Photo by Berly Laycox)

Generative teams don't just happen. Groups must cultivate them by design and pay attention to creating, monitoring, and maintaining them; team development should be as intentional and important as sound financial procedures. Through my experience working on a generative team, training as a qualitative researcher, and studying the work of Senge and his colleague, economist Otto Scharmer, I've gleaned four practices for cultivating these kinds of teams. Continually engaging in these practices helps build and sustain teams that can initiate with common intent; sense emerging needs and solutions; and collectively prototype, create, and evolve innovative heath models and relationships.

1. Practicing authenticity: Individuals must develop an ongoing self-reflection practice of understanding their true self and purpose, and then operate from that more-honest place. By contrast, inauthenticity, which favors self-promotion and preservation, involves hiding thoughts and opinions to support what individuals think others want to hear. Author and lecturer Bren Brown, notes the difficulty of this "daily practice of supposed to be and embracing who we are." As team members become more and more themselves, and foster genuine relationships, stronger connections emerge between them, fear and power dynamics lessen, creativity flourishes, and the collective potential of the team improves.

2. Engaging in deep listening: Generative teams practice deep listening as they focus on their common intent. Qualitative researchers learn the same: to authentically listen and observe. Part of the reason is so that they can tune their mind as a research instrument for objective, disciplined inquiry; it also helps them recognize, monitor, and understand the deeply entrenched assumptions and biases that they and others bring to situations. Routine can enhance listening—practice, listening-quality check-ins, and bias reflection through journaling can all help. Once team members can recognize and understand assumptions and judgments, they can suspend them, be fully open to contributing to the team's collective insight, and immerse themselves in the people and places they are trying to effect.

3. Creating spaces for collective reflection and dialogue: Generative teams create spaces conducive to reflection, gaining insight, and engaging with each other to act collectively on those insights; they intentionally commit time, space, and energy to participate in co-reflection to make sense of situations

they face. Entering these spaces, participants try to practice authenticity, deeply listen, remove titles and hierarchies, let go of positions and views, see themselves in others, and value the contribution of each individual. This way, teams enter into dialogue or "thinking together" that draws out insights not individually attainable and that crystalizes action that emerges from these insights.

4. Aligning and acting on shared vision: From a shared vision grounded in collective insight and intent, generative teams move ideas to action through prototyping, quickly trying out ways to collectively take next steps toward the vision they hope to create. For example, if a team formed around the common intent of increasing a sense of community through the use of public spaces, and the idea emerged that more trash cans would create cleaner and more-inviting public spaces, then a prototype would be to place a trash can in a community space, observe how the community uses it, and then feed insight from that test into the next prototype. The prototype—a single trash can—is to inform future action; it is not meant to determine the exact placement of all trash cans in the area, raise funding, or explore possible models and vendors of trash cans before action. The prototype creates the potential for continuous feedback and learning between the team and community members using the preceding principles of deep listening, collective inquiry, dialogue, and reflection.

How can we give generative team cultivation the attention it deserves? Initiative leaders can:

- Give someone on the team the role of "team-builder"—someone responsible for designing, implementing, and monitoring activities and spaces aimed at enhancing listening, reflection, and collective dialogue. This could be the same person throughout the course of a project, or people could rotate every few months. Establishing this role will better ensure that team development doesn't fall through the cracks.
- Schedule consistent activities for improving team skills. This includes traditional, fun, team-building activities, but it's imperative to the success of your project that you set aside time to hone listening skills and discuss the future you hope to attain together.
- Set agreed-on principles for team meetings that facilitate entering into dialogue. For example, you could decide that before anyone responds to someone else's comment or instantly critiques their viewpoint, they must either first take a brief moment of silence to reflect on their reactions, or ask a follow-up question or build on the previous person's comment ("yes, and …"). These challenges help habitualize good listening and empathy skills.

In addition, we need to create more opportunities and spaces for communities, implementers, funders, and evaluators to come together, listen together, and together explore the future they hope to create. Imagine setting up regular formal and informal listening sessions, workshops, forums, interviews, or site visits for dialogue between communities, implementers, and funders.

People can make or break initiatives for change. Those looking to create health should work to suspend assumptions, agendas, and bias while engaging with the communities they aim to support. They should ask and deeply listen for both emerging needs and solutions *from* the community, and then continuously prototype, evaluate, and evolve these solutions together *with* the community. The resulting generative teams will create a system for learning and innovation that has the potential for great transformation.

Margaret A. Hawthorne (@MaggieHawthorne) serves as the associate director of planning and performance improvement for the Camden Coalition of Healthcare Providers, where she works with diverse stakeholder groups to design, evaluate, and transform operational processes and care delivery systems. She is passionate about utilizing a mix of both qualitative and quantitative methods to understand, design, implement, and evolve relationships and systems that will lead to profound impact and change.

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Undercover Solutions

Solutions to social problems are often hidden in the most obvious places, masquerading as problems.

By Meghan Williamson

As changemakers and service providers, we come from a culture that trains us to identify problems: obesity rates, percentages of impoverishment, degrees of blight. This lens of scarcity exposes harsh and important realities, but it is also a distancing lens. When we see only problems, too often our response is to marshal non-local resources and top-down interventions. Worse, our own history and experience frames our understanding of these problems. We may assume, for example, that vacant storefronts are merely indicators of economic failing, rather than seeking the views of people who sleep in them or the members of youth bands that practice in them.

To create systems of change that act *with* communities rather than *to* them, we must see the potential solutions that are already embedded in communities—solutions often hidden in the most obvious places, masquerading as problems.

In fact, some imposed solutions can be harmful, and what we consider harmful can be transformative. Permaculture, a design system focused on building interconnected and sustainable systems, holds that any resource in excess becomes a pollutant. In an agricultural context, excess animal waste destroys streams in runoff proportions, but in proper and integrated doses, it is vital to maintaining soil fertility and a regenerative ecosystem. In a social setting, "pollutants" such as unemployment or vacant buildings can indeed cause harm, but they may also hold hidden potential and assets for local communities.

My own community, Staunton, Virginia, had a familiar problem. After several decades of focused downtown revitalization efforts, this small southern city with a rural heritage began seeing a proliferation of entrepreneurial small businesses that had incredible talent—web-designers, accountants, massage therapists, nutritionists, and bike mechanics—but lacked the cash necessary to procure each other's services. The potential seemed great, and the problem seemed obvious: While time and talent were plentiful, the businesses needed more money.

In response, the local government—in partnership with a new nonprofit community development agency, the Staunton Creative Community Fund—launched micro-lending programs funded with public and non-local dollars; the programs provided loans to support start-up and working capital for the local businesses. For several years, I served as the executive director of the agency, and to a degree it worked. Today, data shows that the initiative supported hundreds of thousands of dollars in microloans, and that there were strong rates of repayment over the lifetime of the portfolios.

Yet while these measures capture the outputs of a *microloan program*, they don't necessarily capture the true extent of local exchange or business health. Are businesses better off after loan repayment? Did the microloans actually help local entrepreneurs and their businesses become happier, healthier, and more vibrant? Perhaps most to the point of this article, how could we achieve the original goals using local resources and talent, rather than relying on outside funding?

The microloan program continues to provide a valuable tool to the local entrepreneurial community, but several years ago a coalition of local residents, businesses, and the community development organization that originally launched the microloan program decided to begin a complementary initiative—this time less reliant on outside financing, and more accessible to residents and entrepreneurs who aren't necessarily good candidates for loans. Focusing on local solutions, the new initiative began with what was abundant (time and talent) rather than focusing on what was scarce (money). These local businesses had the services to meet each other needs, but they didn't always have the means to unlock those services. Our preconceived notion said that money was the only way to catalyze this exchange—but was it?

Rather than trading dollars, member residents and businesses can now pay each other in hours. We call this hOUR Economy, and it operates as a local time bank. The hours circulate throughout the community, allowing a nutritionist to access videography, a videographer to get gardening help, a gardener to earn a much-needed massage, and so on. The resource these businesses had in greatest excess—time and talent—became their currency of exchange. In the time bank, everyone's hour is equal, and services that are often undervalued in the traditional monetary economy (childcare, elder care, and cooking, for example) are more formally recognized and rewarded.

A local nutritionist, Anne Buzzelli, works for hOURs in a market garden. (Photo by Meghan Williamson)

Elsewhere, access to health care has become a cornerstone of a more-developed time bank, Hour Exchange Portland, located in Portland, Maine. Working with both traditional and non-traditional health and wellness providers, time bank members can access healthcare using hours rather than dollars. Rather than seeing recipients of this care simply as "uninsured" or "poor," the program recognizes them for their other contributions—again, measured in hours rather than dollars.

What other overlooked resources could we incorporate into community renewal and health? Abandoned lots can transform into urban gardens. Vacant buildings can become experimental spaces for pop-up stores and entrepreneurs. Artists can spark much-needed community conversations and collective visioning. What knowledge, compassion, and resources do those who most need services already have, and how can we collaborate to build more-vibrant communities?

Good program design begins with understanding the problems—as the community itself experiences them—and then identifies local assets that the community can deploy as solutions. Good program evaluations embody these insights, step by step.

Inverting our "solution" paradigm should not become an excuse to remain blind to external harms that programs can inflict on communities. But as we work to remove these external causes of harm, we must also work with communities; we must listen to and recognize communities as whole, complex system capable of great self-agency and even greater self-healing.

Meghan Williamson (@doghousenotes) is a local economist in the original sense of the term: one who is a steward of their home. Located in the Shenandoah Valley of Virginia, she works to build local systems that celebrate sustainability, community, and openness for all.

Conflicts of interest: Meghan previously served as the executive director of the Staunton Creative Community Fund, mentioned in this article, for several years. She is a member and volunteer for the local hOUR Economy.

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Operating When You Can't See the Full Picture

Three principles for solving complex, systemic problems like improving community health.

By Jeff Cohen

Problems can be simple, complicated, or complex. Building a hospital is an example of a relatively simple challenge; given the necessary resources and expertise, we can generally predict the cost, timeline, and end result. Developing a vaccine represents a more-complicated challenge—it may take many attempts before a group develops a successful formula, but once it does, it can reproduce the vaccine and expect to see consistent results.

Complex problems are quite different, because they involve systems—ever-changing, non-linear environments. Making progress on complex problems requires that we understand the interplay between multiple independent factors that influence each other in dynamic ways. While constructing the hospital itself might be relatively straightforward, when you factor in raising the money for the project, getting buy-in from the community, staffing, and other factors, it becomes more complex. Similarly, the complicated science of developing a vaccine evolves into a complex problem when you add in the challenges of investing in R&D for a product that meets a public need but does not feed an ongoing market, or convincing some communities that taking up the vaccine is a good idea.

Improving the health of a community is a complex problem. Availability and quality of health care are important, but so are economic conditions, social norms, and myriad other factors. The interplay and interrelatedness of these factors creates a kaleidoscope of causes and effects that we can easily capture in one "full picture"—and that can shift the momentum of a system in one direction or another in unpredictable ways. In these circumstances, each intervention is unique; programs that are successful at one point or in one place will not necessarily be successful elsewhere. Past efforts can provide guideposts, but replication is not a feasible goal, and fidelity will prove quite elusive.

Complex problems require an emergent strategy—strategy that evolves over time as initial intentions and plans collide with, and accommodate, an ever-changing reality. Using this approach, organizations learn what works in practice and accept that the strategy will change in unpredictable ways over time.

There is no systemic procedure or formula for how to figure out, or evaluate, what is going on within a complex system or emergent strategy. However, there are a few principles that can help guide practitioners as they take steps into this strange new world of evaluating complexity. We have recently laid out nine of these principles—here's a brief look at three that are particularly critical:

1. Continuous learning. Constant learning allows organizations to adapt and evolve as they implement strategies and activities. The regular flow of data and information is important to running a "learning engine," and enabling adaptation and innovation. Information can also provide positive and negative feedback that reinforces desired patterns or dampens unproductive ones. For example, the more information a teacher has about exactly where each of his students is struggling or attaining mastery, the more he can differentiate his instruction to each of those student's needs. He could also assess which instructional approaches worked best for helping students grasp particular concepts. New technologies are emerging that give teachers access to this kind of granular data on student performance, but differentiation also requires that teachers adopt a continuous improvement mindset, in which they see data less as an accountability mechanism, and more as a way to gain insight into what is happening in their classrooms and to inform their pedagogical strategies. Evaluations of emergent strategies can help improve and strengthen capacity for continuous learning through the collection and analysis of data, and through interpreting that data to make sense of what it means in ways that are timely and actionable.

2. Attention to context. Context matters in most evaluations, but it's particularly important to understand the nature and influence of context in emergent strategy. Because emergent strategies tend to involve many actors and organizations, unfold over a number of years, and naturally adapt in response to changing conditions, evaluations need to capture information on how the initiative and its context are "co-evolving." In other words, the evaluation should not only study the nature of the context and its influence, but also measure the ways in which the initiative affects it.

3. Focus on relationships. A defining characteristic of complex systems is that they contain a web of relationships and interdependencies. This "interstitial tissue" is what often makes or breaks a strategy, either by amplifying the power of the strategy or by getting in its way. In the context of complex problems, the relationships among people and organizations are often as important, if not more so, than the people and organizations themselves. With each relationship, it is important to understand its nature, strength, and longevity. It's also important to know the levels of relational trust, the quality of the relationship, and how entities work together within the relationships, such as the ways and extent to which they share information, plan together, and co-construct solutions. Launching an effort to clean up a watershed, for instance, is much easier if the farmers, companies, government agencies, and other stakeholders involved have some history of productive collaboration with each other, rather than a legacy of mistrust and competition for resources.

Evaluating complexity is itself complex, and it requires an emergent strategy. Over time, as we carry out more and more evaluations of this kind, we will no doubt add clarity and depth to the propositions for how to do it well. But even today it is clear that continuous learning, attention to context, and a focus on relationships are important to the success of any strategy to improve the health of a community.

Jeff Cohen is a director in FSG's Seattle office (@fsgtweets). He works extensively on strategy development and collective impact in US education and health care.

This article draws on the white paper, Evaluating Complexity: Propositions for Improving Practice. *Thanks to its authors: Hallie Preskill, Srik Gopal, Katelyn Mack, and Joelle Cook.*

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The Promise and Peril of Community Evaluation

Four ways to improve community evaluation so that it helps build, rather than erode, social progress.

By Kimberley Sims

I see evaluations and data as tools. Used correctly, they can help us effectively analyze social change programs, services, and communities. They can also create transparency and accountability. But I've become more and more frustrated by them. People often consume evaluations as if they represent the absolute truth, without context, and this can hinder initial improvements and future developments. They also paint only part of the picture; they scratch the surface of how a person thinks or a community operates, but few get to the *why*. An evaluation may show us that a program is not meeting its goals but offer no insight as to the underlying reasons.

Unfortunately, data on Muskegon Heights, Michigan—my community, my home—paints a picture that doesn't attract people, businesses, or investment. It does quite the opposite. In recent months, for example, my city has made statewide news as one of the most violent in the state. Examined closely, the violence rates relate to murders mainly among young black males; they're not "random acts of violence" that would affect the average person. Nevertheless, these types of headlines deter businesses, which means fewer jobs—and yet jobs are precisely what the poverty-stricken population needs. The data essentially deprives the next generation in our community of even a glimpse of what the world has to offer. Data on Muskegon Heights also says that we live in a "food desert" and *need* a grocery store, but it does not tell you that we *want* jobs, which have the potential to build self-esteem and restore hope.

Essentially, in using evaluations, we risk exposing only the problems within our current systems and structures, instead of questioning the systems and structures themselves.

Part of why this happens—and one powerful thing to keep in mind—is that systems and structures are never neutral; public policies and services, private practices, and people with power all have built-in biases. We can see this in the glaring similarities of most urban communities in the United States; while geographically distinct, they operate from the same blueprint, influenced by the same biases from established systems. These biases flow through every aspect of the evaluation process and greatly affect the three main groups involved in evaluations:

1. *Evaluators* are part of "the system" and develop their approaches within the prevailing perspective. In essence, the evaluator's mind is skewed toward valuing particular outcomes that are determined by the requirements of the system.

2. *Those who are evaluated* are "measured" for how they perform within the system's framework, using tools that evaluators develop in response to built-in system biases.

3. *Those who read and use the evaluation results*, while reading consciously, will have subconscious biases based on the current system, its perspective, and the framework it exerts.

But what about the things that happen outside of that prevailing framework? Data cannot tell you about the lady who had a stroke but bakes cookies for volunteers when they come together to clean her yard. Data cannot tell you about the 86-year-old farmer who teaches children in his neighborhood to farm and who sells produce to pay for his medication. For me, this is real "data" about my community—people surviving outside of "the system" and untouched by "the structures." How do we capture *these* "facts"?

There are a few ways to make community evaluations more effective:

1. Leaders of initiatives can develop the tool to simultaneously measure outcomes and the program itself. Start with the end in mind: What is the desired outcome? And, using the ideas below, remove potential bias from the beginning.

2. Evaluators can spend time with people from the community they are evaluating, allowing for more context-sensitive results. The members of the community can ensure that evaluators understand the community before deciding what data to collect. They can also act as interpreters to ensure that the data translates in a way that considers local context.

3. Evaluators can go back to good, old-fashioned conversation. In the technology age, we tend to stare at screens and data, and shy away from the realities of the people we engage. Knowing the community and building relationships should be a component of program evaluation, as it encourages evaluators to become vested in the information they share.

4. Evaluators should compare the mindsets and behaviors of the community before, during, and after a program. I believe this is the only way to measure the true effectiveness of a program. Observation of this kind needs to occur over time. It can be time-consuming, but it's likely important to creating *sustainable* outcomes.

5. When evaluators and organizations communicate results, they should do so in partnership with agents of the community and include a history of its people. This context can help minimize misinterpretation and negative consequences.

How we approach and report data can mean life or death for communities like mine. It can empower or further marginalize; it can help build or erode. We should consider evaluations as tools, or weapons, and recognize the powerful effects they can have on communities.

Kimberley Sims (@kimdsims) is a wife, mother of three, and avid homeschooler. She holds a bachelor's in communication and has proudly served her community as councilwoman for the last 11 years. Sims sees her position as one of service and gives a platform for voices that would otherwise go unheard. She believes strongly in the empowerment of people at the grassroots level.

I'd like to thank my community for entrusting me with the opportunity to share their hearts.

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How Evaluation Can Strengthen Communities

Including community members in decisions about evaluation can improve the community's capacity to effectively manage and control change.

By Kien Lee & David M. Chavis

Evaluation isn't just good for creating knowledge or informing investments; at its best, it's a tool for strengthening the community itself. Including community members in decisions about an evaluation—such as measures of success, culturally appropriate ways to collect data, and meaning and implications of findings—can improve the community's capacity to effectively manage and control change.

In our work at Community Science, a research and development organization dedicated to building healthy, just, and equitable communities, we see how evaluation:

1. Supports evaluative thinking

2. Generates information for decision-making

3. Builds capacity for using data for advocacy

4. Upholds accountability

5. Promotes and monitors progress towards social justice and equity

Supporting evaluative thinking

Evaluation provides the opportunity for all members of the community, regardless of power or status, to build a learning community that works to collectively solve problems. This is formally known as evaluative thinking: the cognitive process of asking questions, explicating beliefs and assumptions, learning and reflecting, and developing new understanding to make informed decisions and prepare for action. When a group of people repeatedly apply and practice this cognitive process, it provides the opportunity for establishing shared understanding, developing relationships, transforming disagreements and conflicts, engaging in mutual learning, and working together toward a common goal—all ingredients for creating a sense of community.

Generating information for decision-making

Evaluation generates information that we can use in decision-making, including how we can improve a strategy or program, or what new programs or services the community needs. Evaluation also can identify training or technical-assistance needs. For example, findings may reveal that a nonprofit has difficulty reaching the desired number of beneficiaries, because of its limited knowledge and skills in strategic communications or because of culturally inappropriate outreach methods. These kinds of information can help funders enhance the capacity of nonprofits in a community, which in turn can strengthen that community.

Building capacity for using information for advocacy

Communities can use information produced by evaluation to advocate for change. For instance, one community survey we used in a community-building project showed that families were concerned about their children's safety when walking to school, because there were no sidewalks in a certain area. Community members mobilized and organized around this information, and petitioned their district representative to advocate for constructing a sidewalk. This process requires that community members work together to make joint decisions; pool their expertise and resources; conduct a power analysis to uncover and make known the policies, procedures, and practices that perpetuate injustice in institutional

structures and systems; and act collectively to advocate for the change. In another example (see "All in Favor: Using Data in Advocacy Work"), an evaluation used data to show the link between out-of-school time and juvenile offenses, and to advocate for after-school programs.

Upholding accountability

Data can also be a powerful tool for holding program managers, community leaders, decision makers, and policymakers to account. For example, communities can use state report cards on health disparities to hold elected officials to their promise of better health outcomes. Philanthropic organizations similarly use dashboards to hold program staff accountable for achieving desired grant outcomes. Evaluation contributes to generating the information that forms the basis for these types of tools, and in the use of these tools, encourages linkages between people and institutions, and between formal and informal institutions.

Promoting progress towards social justice

Community members working together to discuss and interpret information generated by evaluation. (Photo courtesy of Community Science)

Evaluation plays a role in promoting social justice and equity. This means accounting for the political, economic, social, and cultural factors that contribute to the inequities—the unfair and avoidable conditions—that prevent people in a community from achieving their best. Evaluators can help prevent harm and the perpetuation of inequity by convening stakeholders (such as funders, policymakers, community leaders, and residents) to contextualize and discuss the data. These gatherings provide the opportunity for people to listen to one another, understand what they can and cannot conclude from the data, and work together to promote social justice and equity.

These five observations from our work are very much aligned with the five guiding principles of the American Evaluation Association. While we believe evaluation undoubtedly plays a role in strengthening communities, it is important to note that its success in doing so is inherently tied to the strategy it's evaluating. Evaluations strengthen communities when they are part of community change initiatives that

share a similarly strong commitment to learning, using knowledge, and practicing evaluative thinking in its planning, operations, and stakeholder engagement.

Kien Lee, Ph.D, is the vice president and principal associate of Community Science where she specializes in issues affecting communities that are racially, ethnically, or culturally diverse. She brings more than 15 years of research and evaluation experience to this work, as well as expertise in the integration of immigrants, strategies, and programming for racial equity, the reduction of health disparities, and the development of cross-culturally competent organizations. See Kien's profile on LinkedIn.

David M. Chavis, Ph.D. is the Principal Associate and CEO of Community Science and is internationally recognized for his work in the implementation, support, and evaluation of community and systems change initiatives. The primary focus of his work has been the relationship between community development and the prevention of poverty, violence, substance abuse, and other social problems, as well as the design and implementation of community capacity building systems. See David's profile on LinkedIn and follow him on Twitter.

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Investing in Community-led Health

The case for investing in the long-term health and well-being of communities, based on what those communities value.

By Ollie Smith

Guy's and St Thomas' Charity (GSTC) is a an independent charitable foundation that is committed to radical innovation in health and health care for the people living in two boroughs of South London, Lambeth and Southwark.

We've been around since the 16th century, and in that time we've largely supported the local hospitals with whom we share our name. But just as the hospitals have changed dramatically in the past 500 years, so has GSTC. As a result, we're in the early stages of developing our own *community-led* health intervention to sit alongside our support for the hospitals. Our current strategy seeks to work beyond the hospitals' walls, supporting projects that are community-focused and that bring together many different elements of health.

The regular income generated from our endowment means that we have the capital to make long-term bets that potentially have big pay-offs—the kind of bets that are too risky for other sources of capital. This usually manifests as support for clinical science, but we've found that we have an equally valuable role in investing in the long-term health and well-being of communities, based on what those communities value, rather than what medical professionals prioritize. At present, few foundations invest in health this way, and we hope that our story will inspire others to embark on a similar journey.

The Limits of Health Care

GSTC works as a catalyst for innovation, and is currently in year three of a five-year, $149 million spending cycle in Lambeth and Southwark. These boroughs have a population of 600,000—with all of the diversity and inequality typically associated with large urban areas.

Over the last five years, we have supported health care providers to deliver a wide range of projects to improve the health of these communities. The Diabetes Modernisation Initiative, for example, brought together hospital and family physicians to improve the diagnosis and treatment of people with diabetes. Another example is Southwark and Lambeth Integrated Care, an ongoing effort in which health and social care professionals work to improve the care for older people by applying models similar to accountable-care organizations. While these have delivered a lot of benefits, they have also exposed limitations of what traditional health care providers can achieve. Two barriers are most apparent: 1) It is hard for existing organizations to break out of established ways of working, and 2) we understand very little about what is important to citizens, and how this affects their behavior and engagement with the health care system.

Essentially, we've realized that the issue we face is that health care is structured around institutions rather than individuals. This is not a unique problem for Lambeth and Southwark; it is true across England and perhaps the world.

This realization led us to invest in trying to understand what a different approach to improving health might look like. We undertook a small piece of public insight research that sought to understand what people prioritize in their lives and how health relates to that. Results showed that people wanted a fulfilling life that is financially secure and includes nourishing relationships.

But the research also demonstrated that people didn't contextualize what they wanted from health care in terms of life fulfilment; instead, they focused on wanting to avoid or treat illness, such that it became the end in itself. To some extent, this is understandable; illness, or fear of it, can have such a dramatic impact on life that evading or treating it can become a person's sole focus. However, this propensity for health care to dominate thinking can lead to services that, while valuable, neglect what people truly prioritize—a fulfilling life, with health care as only one means to it.

To understand how others were approaching this problem, we invested in Wellthcare, an exploration of new ways to create and value health, specifically with a view to create a meeting of like-minded organizations. The group that formed evolved into the Creating Health Collaborative, which looks to understand health beyond health care (and which co-curated this series).

The Special Nature of Place-based Capital

"Place-based" capital has a special license to prioritize the people of the locality rather than its organizations. (Photo by Lena Vasiljeva)

Reflecting on our journey, I am struck by how important our roots in Lambeth and Southwark have been in driving our thinking. If our organization were focused on a particular disease, I'm not convinced that we would be going as far in challenging the institution-dominated definition and approach to health.

To me this suggests that there is a special role that "place-based capital"—capital that is inextricably tied to a particular location, often because of limitations placed on the original endowment—can play. While organizations with place-based capital can and must continue to work closely with health-care institutions, an approach that has roots in a particular place also gives it special license to prioritize the people of the locality rather than the organizations that currently serve them. This creates space to discover and suggest new approaches to improving the health and well-being of local residents.

The critical step for any place-based investor is to have conversations with the people who live there. It is easy for local professionals to mediate and organization's understanding of local need. But while that perspective is important, it is only one perspective. You can only truly prioritize the health and well-being of local residents when you know what that means to them.

As a result of our experiences, GSTC is in the early stages of developing an approach to community-led interventions for the people of Lambeth and Southwark, based on their priorities. We are only in the foothills of our journey, but we encourage other foundations that can make long-term bets—especially those with a place-based mandate—to join us.

Ollie Smith (@olliewsmith) joined Guy's and St Thomas' Charity in 2010 as director of strategy and innovation. He was previously a deputy director at England's Department of Health, where he led a diverse range of health and health care policy and strategy initiatives. His earlier experience includes working in the Prime Minister's Strategy Unit.

Thanks to my colleagues Peter Hewitt and Gayle Willis for their helpful suggestions and edits.

Conflicts of interest: Guy's and St Thomas' Charity provided funding to Wellthcare, which evolved into the Creating Health Collaborative, co-curator of this series.

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Making the Money Work

How funders can best support place-based initiatives.

Anthony B. Iton

Health happens in communities.

Many people living in low-income communities in the United States are mired in a constant and unremitting fog of stress. This chronic stress is driven by housing insecurity, food insecurity, fear of crime, unemployment, exposure to pollution, and poor education. These things lead to poor community health and are often collectively conceptualized as social determinants of health.

The good news is that this situation is largely manmade and thus can be unmade. Our initiative, Building Healthy Communities (BHC), is a holistic attempt to help reweave the fraying fabric of low-income communities by harnessing the latent power and potential of their residents. Launched in 2010, it is a 10-year, $1 billion, place-based initiative that aims to transform 14 communities by building *power* (social, political, and economic), implementing proven health-protective *policy*, and changing the *narrative* about what produces health (beyond health insurance and individual behavior). BHC's strategy is grounded in the belief that health is fundamentally political. The idea is to revitalize local democracy to transform these environments into places where everyone has the opportunity to thrive.

The BHC model envisions these communities as proving grounds for community-driven policy and practice innovations that, in turn, advance statewide policy and systems change. It creates unprecedented space for community organizing, leadership development, and sustained multi-sector collaboration by enabling residents, community groups, and institutional leaders to work together across all sorts of boundaries, including different races and ethnicities, personal experiences, legacies of discriminatory treatment, and differential levels of power.

While the approach is the same across all sites—build power, change narrative and policy/systems—it manifests differently depending on local circumstances. In Fresno, California, for instance, the work is taking the form of unlikely alliances between community and environmental groups interested in ensuring that the city grows sustainably for both people and the environment. In East Salinas, California, the community is coming together with public servants to heal and put racial equity at the forefront of all city policies, practices, and procedures.

At a community festival in San Diego school children illustrate the benefit of investing in schools rather than prisons; our San Diego Organizing Project sponsored the festival. (Photo by JoAnn Fields)

The problems facing each of these communities are old and deep. There are numerous strategic challenges in deciding how to use the money that BHC provides—challenges that surface regardless of investment size and fit into the following six broad categories:

1. Seeking alignment. A community is not a vacuum. When a foundation like ours enters into a community, there is a lot of other work happening already. There are prominent leaders and other natural leaders who have been creating change at various levels in the community. How foundations identify and align their efforts with pre-existing work is critical to building trust and acceptance.

2. Synchronizing with residents. Fostering collaboration between residents, community-based organizations, and system leaders means overcoming profound cultural differences, linguistic barriers, acronyms and other insider jargon, and enormous power imbalances. Each of these constituencies has different learning curves. Foundations may need to sequence and synchronize their work in a way that gives residents the time and opportunity to train and prepare so that they can come to the collaborative table ready to engage in meaningful dialogue and not feel intimidated. At the same time, system leaders may feel ambushed if foundations don't properly introduce them to the initiative's approach.

3. Setting goals. Foundations come to the work with a point of view. Communities, by definition, have multiple points of view. All must negotiate these competing perspectives to develop trust. Thus foundations should neither hold too tight to a set of goals, nor be opaque about what it wants to accomplish. Short-term, medium-term, and long-term goals must be explicit but open to negotiation and renegotiation—no rigid agendas and no hidden agendas. Ownership of multi-year initiatives should transition to the community and its leadership over time, and understanding and supporting this maturation process is essential.

4. Making it sustainable. It is unusual for foundation-funded, community-driven initiatives to achieve their goals quickly or even within a timeframe defined by their board. Initiatives usually need to establish

proxy goals that are harbingers of longer-term goals. With the achievement of proxy goals and the development of community leadership and collaborative capacity, foundations and community partners must create and implement sustainability strategies—a major challenge for foundation-funded initiatives.

In low-income communities, often the only available source of sustainable funding is government, and enlisting government support for community initiatives requires significant political buy-in. The process for developing that buy-in has to begin very early. A significant challenge in this is that government is often reticent to support—through participation or funding—initiatives that focus on shifting policies through building power. There are many reasons for this, not least of which is the necessary tension between government and the community groups that want to hold it to account.

Achieving government buy-in for an initiative might require shifting investment away from community organizing. This is potentially very high cost and could risk the longer-term success of the initiative. For the time-being, we are continuing to experiment with sustainability strategy designs that defend and maintain the initiative's goal to build resident voice and power.

5. Avoiding fatigue. Foundations are notorious for being dilettantish and unaccountable, and boards get bored. At the same time, it is essential that foundation boards understand the need for an appropriate initiative length and commitment. A proactive strategy to ensure that boards are deep engaged is essential. With BHC, we matched board members to sites, asking them to visit the sites and regularly connect with program managers at those sites. This deepens their commitment and their understanding of the overall strategy.

6. Evaluating our efforts. Given that BHC sees these 14 communities as proving grounds, evaluating our efforts is a critical component of everything we do. Our organization is grounded in the spirit of ongoing and continuous learning, and so developing the BHC evaluation questions and methodology has been iterative. Each site has a learning and evaluation team that serves as the bridge between the community partners, and the foundation's learning and evaluation staff. Together, they've designed surveys that measure collaboration strength, the efficacy of policy advocacy, and much more. The point is not so much to uncover weaknesses; it's to find what is working, and share learning within and across the sites so that everyone benefits.

Building Health Communities has taught us many things, perhaps none as significant as the importance of power in our democracy - the stronger our local democracies, the healthier our communities. We believe that the biggest challenge to the health of communities is encouraging continuous investment in the great venture that is American democracy. The biggest threat to democracy is the tendency of power to concentrate in the hands of the few. Community organizing is the strongest antidote to this, but it's also controversial and usually underfunded. In as much as government works at the behest of the public, it must work to foster a civically engaged, well-informed populace. The government sector must embrace the vital role that community organizing plays in creating a functioning democracy and invest in organizations and opportunities that build power in the most under-represented communities. This will bring it closer to the ideal of a government of the people, for the people, and by the people—*all* the people.

Anthony B. Iton is senior vice president of Healthy Communities at the California Endowment (@CalEndow), the state's largest private health foundation. He focuses on the foundation's 10-year Building Healthy Communities initiative, which aims to create communities where children are healthy, safe, and ready to learn. Previously, Iton served as both the director and county health officer for the Alameda County Public Health Department.

This article was written with the assistance of Alexandra Desautels, program Manager, the California Endowment.

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Tomorrow's Health Relies on New Relationships

Imagining a healthier future doesn't start with how to pay for it. Communities must first develop a shared view of what a healthier life could be.

By Prabhjot Singh

Imagine that it is five years from now, and your neighborhood is a measurably healthier place to live—kids start life with the support they needed to succeed, and when people experience life challenges, neighbors make themselves available to help. As community members celebrate what they have achieved together, people from surrounding areas clamor to know how it happened, especially since your neighborhood did not receive any special concessions. When they visit, they see the same things they have in their own neighborhood: schools, social services, hospitals and clinics, banks, businesses, housing developments, and places of worship. They see that the political leadership is competent, but no more so than their own. However, they also notice that people and organizations have completely different beliefs about and intuitions for effectively interacting with each other.

So, what changed, and is it sustainable?

The secret behind your neighborhood's transformation was, in some ways, simple. Five years ago, your neighborhood was many things, including an informal organization that held the pieces of everyone's health. Except, when you looked at it, you saw the pieces were scattered and needed assembly. Posed this way, it was clear that the quality of connections between parts of the neighborhood made a difference. Homeless services, housing support, and job-training programs were not linked, for example, and there was no support for caregivers when they felt overwhelmed. Where connections were poor, health suffered and healthcare spending was higher. And yet, there was no mechanism or sense of accountability to help establish better connections, and it was impossible to see how the neighborhood might improve the health of its people.

So you set about envisioning a future together. You identified kindred citizens— neighborhood leaders, and people from local healthcare systems and community development institutions—who also saw the neighborhood as a health-producing organization, and asked how health would change under different circumstances. Using tools to model future scenarios, you all saw that acting collectively to confront tensions that were holding you back could lead to better outcomes for everyone. To move forward, you needed a common set of aims, including ones that could help healthcare systems shift toward more neighborhood-based care. In the past decade, the positive feedback loop between better health and community development had been getting stronger, but you needed to organize your neighborhood to understand how to assemble a healthy environment from their perspective.

As your neighborhood meetings yielded new relationships and opportunities, they also revealed gaps in infrastructure. For example, your growing group didn't realize how challenging it was to get help from a scatter of organizations after being sick and how this could worsen chronic cycles of illness. The health care system shared this challenge, so you pooled together a small amount of money designated for community benefit so that neighbors could dedicate themselves to making sure that people didn't get lost on the pathway out of illness.

You also recognized that some neighbors had a much harder time than others and that the health care system was concerned about many of the same people, given their focus on high-need patients. So you to made the case for neighborhood organizations to participate in the value chain of improving health. This helped redirect some of the financial incentives created for the health care system and establish the neighborhood's voice and expertise as an integral, rather than *ad hoc*, part of the system.

As you worked together, your neighborhood's modest achievements instilled confidence in aiming higher. Some business-savvy neighbors realized that if the community invested in revitalizing dilapidated housing and cleared a nearby junkyard to build a new park, the value of that area and areas surrounding it might rise. It would also be safer and more walkable. Together, the experience of planning small projects enabled you to adaptively design more complex ones. As the projects became more complex, local business leaders and regional planners took note of your progress, as they did in places like Atlanta. Because you communicated your successes, the local healthcare system became more active, recognizing that their independent community benefit programs could be better spent on the neighborhood's work.

As more people in the neighborhood heard about the success of your growing group, they wanted to join, because:

1. You recognized that people assemble health where they live, which means that healthcare organizations and neighborhood-based services need to work together.

2. Through shared experiences, people trusted each other more and felt capable of confronting tensions that previously pulled the neighborhood apart.

3. Your local healthcare organizations started to shift their center of gravity away from hospitals into neighborhoods.

4. Your entire community embraced adaptive problem solving, which brought new skillsets to hard problems.

As your neighborhood's reputation grew, more opportunities came its way, and you had the confidence to make bolder investments in your shared future.

Imagining a healthier future doesn't start with how to pay for it. What comes first is the neighborhood developing an understanding of what is happening right now, including understanding the connections that matter and developing a shared view of what a healthier life could be. Only then can communities know how to get the most from every dollar spent to improve health. What's important is imagining it out loud.

Today health care systems command the lion's share of health spending, because we can see their devotion to evidence, efficiency, and improvement. Tomorrow, local experience, efficacy at the neighborhood level, and intrinsic motivation will make for a better value proposition—one that attracts social investors, regional planners, and politicians, who play an integral role in ensuring that the benefits are equitably shared.

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Conflict of interest: I'm an unpaid founding technical advisor for City Health Works.

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Time To Return to the Whole

Only by finding a new narrative that embraces the whole, rather than the parts, can we build the health-creating systems we need.

By Jamie Harvie

As we settle into the 21st century, we are learning that many of the systems and institutions on which we've depended are in flux and crisis. In the United States, we are at or near the bottom of a variety of important national well-being indicators—including relative poverty, education, and social mobility—while the burdens of chronic disease and climate change spiral out of control.

It is in this context that this timely collection of articles about communities creating health arrives. At one level, the lessons various contributors have shared are deeply intuitive; they remind us that we humans are complex, deeply social beings with a shared need for love, belonging, respect, and connection. At another level, they force us to take a hard look and ask ourselves: How—despite many modern societies' well-intended quest to support health and be caring—have we gone so far astray?

One misstep occurred when we traveled down the narrow path of measuring health only in terms of disease. As a linear approach, the bio-medical model has created an emphasis on mechanistic interventions, such as pharmaceuticals and medical devices. Clearly, these play an important role, yet over-reliance on these technologies has come at the expense of the "whole person" and their context—their communities and the planet.

We have sacrificed the whole for the parts.

We have become increasingly aware that the bio-medical model does not fully reflect the complexity of human experience—a particularly discomforting realization for the health care sector (which commands an increasingly crippling proportion of many countries' GDP), because it suggests the need for fundamental change in the narrative of where and how we derive health.

We need a new narrative that shifts the focus of health from disease control and treatment, to the individual as a whole. With this shift will come the understanding that health is intimately local. Community assets such as parks, clean water, healthy food access, livable jobs, quality education, and affordable housing will become central pillars of a new health system. And given that these assets are the responsibility of many institutions—government, community, business, and education—these shared resources will become a shared community responsibility. Thus, this new narrative is also an uncomfortable wake-up call to society; it necessitates greater shared responsibility for health and means that we can no longer outsource "health" to health care.

Shifting to this new narrative necessarily requires that we emphasize and attend to relationships and individuals as systems, within systems. As physicist Fritjof Capra suggests, there is a unique quality to the connections between objects that deserves elevated attention beyond what we give to each object individually. By paying more attention to relationships, we build a new operating system—one characterized by networks and approaches such as collaboration, empathy, narrative, teamwork, empowerment, and connection, rather than linearity, hierarchies, and control. It is no surprise, then, that the articles in this series highlight these vital attributes and the importance of a new social architecture of health creation.

All of this points to the intimate connection between the strength of our local democracies and the health of our communities. The late Nobel Prize-winning economist Elinor Ostrom showed how ordinary people can develop principles to successfully manage their "commons"—shared resources such as water rights and fisheries that are central to the health of populations. At its core, management of the commons offers a guide to how we could develop community-driven health systems, with a fair set of rules, a means for equal say, and the right to well-being.

This series is an important clarion call to chart a new path—one that we ignore at our peril. Together, the articles demand a shift in our approach to health that reflects the needs and voices of people and their communities.

Thankfully, there are efforts that we can build on and that offer powerful glimmers of hope. CureTogether and Community Commons are exciting examples of health care-oriented social platforms. Tools and practices such as Art of Hosting are helping harness community wisdom through the application of complexity science, which allows for the natural emergence of solutions and strategies in complex adaptive systems—citizens and communities. The ecological, whole-person approach of "integrative medicine" is becoming an established part of the US healthcare system, and the Academy of Integrative Health & Medicine (AIHM) launched just last year. A recent report by the Institute of Medicine found that we will need systemic approaches to meet US food system challenges in the 21st century; Fresno, Calif., already offers a viable example of a food commons—a fully integrated, community-owned food system. In communities such as Cleveland and Springfield, Ill., hospitals and universities have worked to support the worker-owned collaborative business model. States and cities across the United States are adopting strategies, such as ranked-choice voting (RCV), to revitalize democracy. RCV allows voters to rank candidates in order of preference. This permits like-minded voters to elect candidates in proportion to their share of the vote in multi-member constituencies (avoiding split votes) and allows voters in a minority to win a fair share of representation. These are some of the many powerful threads of a new health narrative.

We have a limited window to act. Let us hope that we can build on these emerging examples to co-create the health-creating systems of the future.

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Conflicts of interest: Harvie has provided pro bono support for a number of the organizations mentioned in this article. This includes authorship of the introduction to the Democracy Collaborative's "Hospitals Building Healthier Communities: Embracing the Anchor Mission"; strategic consulting on ecological and community health for the AIHM, where he holds the title of director of community and ecological health; and health-narrative framing and consultation for the Food Commons. He is the co-author of a chapter in the textbook Integrative Medicine 3rd ed *and added his name on petitions in support of RCV. His wife, Nancy Sudak, is a physician and executive director of the AIHM.*

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Creating Health in the 21st Century

Five principles to guide how communities can develop new pathways to health, plus concrete steps toward contributing to a culture that values connections and relationships as much as treatments and health campaigns.

By Leigh Carroll & Bridget B. Kelly

This series has explored what it means to create health, sketching a collective path to new systems that can contribute to health in the 21st century. The overarching message is that we in the health sector need to take community—people's connections to each other and their places, and everything that arises from these connections—more seriously, and that all types of professionals can do this, whether in hospitals or philanthropies or grocery stores.

If we really take community and connectedness seriously, we will be vigilant about the extent to which we strengthen or disrupt it when developing health interventions. We will value the knowledge and assets that all people have to offer from their unique relationships with people and place. And ultimately, we will commit to building the power that communities have to create health themselves, beyond clinical services and public health interventions.

Unfortunately, the systems we have created, rather than the solutions we now need, often drive current approaches to improving health. We have garnered from contributors to the series a number of principles to guide us as we develop new ways of doing things, as well as concrete steps toward contributing to a culture that values connections and relationships as much as treatments and health campaigns.

GUIDING PRINCIPLES

1. **Acknowledge that our success depends on each other.** Creating health will happen among individuals and institutions, so we must set aside ego, trust others, and recognize that our individual knowledge is limited and our progress is collective.

2. **Bring more voices to the table.** It is vital to understand the dynamics and relationships within a given community. To do that, we must ensure that all who may be affected by and involved in carrying out an intervention have the opportunity to comfortably share their visions and concerns.

3. **Expand what counts as knowledge.** The insights that communities share often play second fiddle to what professionals and academics typically deem valuable. Putting them on a more equal footing influences what to implement, how to allocate resources, and conclusions about whether something "worked."

4. **Embrace emergence, including unpredictability.** We must abandon the linear approach favored by traditional health care and embrace the unpredictable nature of community-driven interventions. We must learn and adapt in real time, and remember that unexpected outcomes are one way an intervention can succeed.

5. **Value what people value.** All too often we decide what to aim for and evaluate based on what we can easily measure. It is essential to flip this—to identify goals and then figure out ways of measuring progress toward them.

NEXT STEPS

1. **Invest in community organizing.** Drawing on community requires hard work that needs supportive infrastructure. The health sector can contribute to building shared infrastructure with other efforts that in many cases have a longer history of community-driven approaches, such as housing and economic development.

2. **Invest in community learning systems.** We must develop information-sharing collaboratives

and build the capacity of local organizations to use information for decision-making and performance improvement.

3. **Experiment.** We must try new ways to develop, implement, and assess interventions. People who research, evaluate, and run community health programs can carry this out, but it is possible only with the support of funders willing to embrace a new form of experimentation.

4. **Build the capacity of professionals.** Doing something in a new way requires that program managers, community leaders, evaluators, investors, and other professionals understand the reasons for change and have the skills to operate in ways that strengthen community.

5. **Incorporate processes for good teamwork.** We must take listening and team-building seriously in every part of the process, including how we design meetings, develop collaborative projects, and engage neighbors.

6. **Share and hold each other accountable.** We must develop resources and regular meetings to connect implementers, researchers, evaluators, funders, and community leaders so that everyone can share information and tools, and so that accountability becomes the norm.

7. **Expand opportunities to document knowledge.** Journals and other venues need to commit to curating information from community health initiatives, just as they do for cardiology or pediatrics. This will mean embracing different types of insights from all nooks of society and giving thoughtful consideration to what constitutes evidence.

8. **Promote the tangible impact of community.** Building on the other steps listed here will make it possible to find new ways to communicate the value of community, and to understand why we need to review policies for their impact on human and community development, much like environmental or health impact assessments.

9. **Transform what drives funding decisions.** More funders need to commit to doing what emerges as best for local communities, rather than focusing on a narrowly defined disease outcome or what one discipline or advocacy group suggests.

Finally, there are things those of us working in the health sector can do daily to take community more seriously. We can abandon the comfort of smart-sounding insider lingo, invite feedback on what we do from those whose ideas we can't safely predict, and have the courage to challenge colleagues to reevaluate whether a project is truly getting us closer to meaningful "well-being." We can be more open and vulnerable in how we write about our work, which many of the authors in this series bravely did. And we can certainly get out and spend more time building relationships in our own neighborhoods. The better we get to know our own people and places, the less reasonable it will seem to leave "community" in the fringes.

We are grateful to the authors of this series, who stepped forward to document how to take community seriously. We hope their voices will catalyze an expanding cohort of professionals dedicated to embracing the potential of each place to create health in its own way. We thank the authors for their honesty, willingness to articulate personal experiences in a public forum, and commitment to moving this conversation into action.

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The views expressed in this article do not necessarily represent the views of the Institute of Medicine.

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