Foundations of a Community of Solutions

SCALE 1.0 Synthesis Report
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How to Cite This Report:
About the SCALE Series

From January 2015 to January 2017, with the generous support of the Robert Wood Johnson Foundation, four 100 Million Healthier Lives partner organizations (Institute for Healthcare Improvement [IHI], Communities Joined in Action [CJA], Community Solutions [CS], and Network for Regional Healthcare Improvement [NRHI]) began learning how to support communities across a wide range of contexts to accelerate their journeys toward a Culture of Health. Each partner brought complementary expertise to the table. The Institute for Healthcare Improvement (which serves as the convening partner for both 100 Million Healthier Lives and SCALE) brought a wealth of experience as a leading innovator in helping organizations and communities worldwide apply improvement science to solve complex problems at scale (100,000 Lives, Project Fives Alive). Community Solutions brought expertise in applying improvement science to create practical solutions in the social sector to address challenges such as homelessness at scale in the 100,000 Homes campaign. Communities Joined in Action brought its experience in convening communities across the country in pursuit of 100% access and 0 disparities. The Network for Regional Healthcare Improvement brought its experience in Aligning Forces for Quality and in applying technology to create community connection.

Through the Spreading Community Accelerators through Learning and Evaluation (SCALE) initiative, three of these partners (IHI, CJA, CS) co-developed a strengths-based model of community transformation, called Community of Solutions, in partnership with communities. A fourth partner (NRHI) learned how to support community transformation virtually. A formative evaluation, led by Dr. Abraham Wandersman, provided a rich context and an opportunity to rapidly understand what worked and to refine the model with communities. This paper is part of a series of synthesis reports commissioned by the Robert Wood Johnson Foundation to harvest the key lessons learned from the SCALE initiative as a practical offering to the field. The papers in this series include:

1) Overview of SCALE and a Community of Solutions
2) Foundations of a Community of Solutions
3) SCALE: Using Improvement Methods and Design Thinking to Guide Action
4) Engaging Community Residents with Lived Experience in SCALE
5) Leading for Abundance: Approach to Generative Sustainability
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SCALE Communities
Introduction

For decades, communities throughout the United States and the world have been engaged in transformation toward achieving increased health and well-being for all. The most recent efforts aim to achieve what is called a Culture of Health (so termed by the Robert Wood Johnson Foundation, RWJF; 2017), which emphasizes health as a shared value, cross-sectoral partnerships, integration of health and health care, and healthy, equitable communities. Hundreds of communities have joined this journey either through initiatives directly funded by RWJF or through independent alignment with the Culture of Health vision. However, to date, these proposed outcomes have proven challenging for communities to achieve, requiring a complex community transformation that has been rarely observed.

The continuum between incremental improvement and complex, community-based transformational improvement (Hawe, Shiell, & Riley, 2009) is noteworthy. Incremental improvement seeks to make adjustments to an existing process. It leverages evidence-based interventions through a change package and implements it with fidelity and at growing scale. Transformational improvement might leverage many incremental improvement processes, but also takes a socio-ecological approach that introduces changes to relationships, networks, culture, mindset and complex dynamic systems in order to yield sustained, system-wide improvement (Hawe, Shiell, & Riley, 2009).

For the last 20 months, members of the 100 Million Healthier Lives SCALE (Spreading Community Accelerators through Learning & Evaluation) initiative have been engaged in intensive learning about how to unleash community transformations that can create sustained improvements in population health, well-being, and equity. In the first phase of SCALE, the SCALE Implementation Team, together with communities and the evaluation team, identified a core set of skills (Community of Solutions skills). These skills lead to a core set of behaviors, systems, and processes that appear to catalyze transformational change in communities (Community of Solutions behaviors, systems and processes). Over time, these promise, in turn, to lead to a sustainable transformation in communities toward a Culture of Health (Culture of Health outcomes). This report lays out the conceptual underpinnings and empirical evidence that underlies the Community of Solutions model developed in SCALE; the companion report, “Overview of SCALE & a Community of Solutions,” details the elements of the Community of Solutions model.

Overview of Community Transformation Literature

Early Framing of a Community of Solutions

The Folsom Report (NCCHS, 1967) was commissioned between 1963 and 1966 by the National Commission on Community Health Services and sponsored by the American Public Health Association and the National Health Council. It sought to recommend a system for the provision of more comprehensive health care, improvement in housing and transportation, and overall enhancement of urban and rural life. The authors described a community as a “dynamic network of interacting actors, structures, and processes comprising a territory or space, a group, or a set of social structures and organizations” (NCCHS, 1967). They presciently proposed that in a community of solutions, the citizenry needed to be actively engaged in community transformation and the creation of healthy environments. Furthermore, they promoted a broad view of the environmental contributors to health. They recommended that community members engage in community partnerships and enhance the health literacy of the population. They cited the need for a health workforce that better served the needs of U.S. communities, and for integrated health services across the continuum, bridging public health and medicine and incorporating health information technology (NCCHS, 1967).
The Folsom Report authors described this concept as a community of solutions. Yet their initial framing of the model left out key elements: place-based framing, understanding of system and policy contexts; a recognition of the importance of social determinants of health and well-being; and a place-based mapping of community actors, assets, structures, and needs (The Folsom Group, 2012; Griswold, Lesko, & Westfall, 2013; Westfall, 2013). The Folsom report, moreover, described an ideal state but did not propose an implementation plan or a system by which such communities of solutions could be developed.

Fifty years later, after decades of experience in fostering community transformation, much has been learned about both key success factors in community transformation and opportunities for improvement. In the next sections, we will review these key success factors and opportunities for improvement in community transformation based on the literature, which focuses heavily on the work of community coalitions seeking to drive transformation. We will then identify potential ways we might design community work differently based on key implementation lessons gleaned from large scale initiatives that have achieved outcomes at scale. Finally, we will identify how these elements worked together to create the SCALE community of solutions model.

Key Success Factors and Opportunities for Improvement

The study of the effectiveness of community coalitions has been complicated by the reality that coalitions can be at very different stages of readiness. In the ACEs and Resilience Collective Community Capacity (ARC)³ framework, Hargreaves and colleagues (2016) suggest four different levels of coalition general capacity — coalition capacity, network capacity, community-based solutions, and community-wide impact — which lead to different levels of potential impact (Scaccia et al., 2016). The work of Scaccia, Wandersman and colleagues offers ways to approach this challenge, by further defining the readiness of community coalitions based on general capacity, innovation capacity, and motivation. Their theory is that as communities develop their readiness, they increase their ability to achieve higher levels of community change and population health and well-being outcomes.

Many studies and reviews have explored contributors to community coalition capacity and effectiveness to better understand what types of factors contribute to the likelihood that a coalition will have the capacity to achieve sustained transformation, and eventually, outcomes. Table 1 overviews potential contributors from three large-scale reviews of the transformation literature cross-walked with elements from the SCALE Community of Solutions model.
Table 1. Potential contributing factors for sustained community transformation

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<td><strong># Factors Identified</strong></td>
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<td><strong>List of Factors</strong></td>
<td>1. Formal governance procedures*</td>
<td>1. Pluralistic leadership*</td>
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<td>2. Encourage strong [inclusive] leadership*</td>
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<td>2. Targeted vision and mission*</td>
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<td>3. Foster active participation of members*</td>
<td>3. Resource mobilization*</td>
<td>3. Paid staff working as community mobilizers**</td>
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<td>5. Promote collaborations among member agencies*</td>
<td>5. Connections with outside communities and institutions (the role of outside agents)*</td>
<td>5. An action plan*</td>
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<td>7. Community norms and values*</td>
<td>7. A documentation and feedback system**</td>
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<td>8. Commitment (willingness to convene for the common good)*</td>
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<td>9. Community power*</td>
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<td>10. Community knowledge and skills (problem assessment, critical assessment of causes of inequalities, including knowledge of existing prevention efforts, communication, and conflict accommodation)*</td>
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<td>*</td>
<td>Community of Solutions behaviors, systems, processes</td>
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* Community of Solutions behaviors, systems, processes  ** Additional elements integrated into SCALE design
Opportunities for Improvement in Community Health Improvement and Community Transformation

While the key success factors described above help to identify how community capacity might be evaluated, they do not describe how it can be generated.

Other elements of successful and sustainable community transformation — beyond coalition effectiveness — have been reported in the national and global community development literature but have not become a core part of how communities create improvement. For example, Emery and Flora (2006) identified social capital within and between groups as crucial, describing it as “the critical resource that reversed the downward spiral of loss to an upward spiral of hope in impoverished communities” (p. 19). Mathie and Cunningham (2003; 2005) promote asset-based community development, initially proposed by Kretzmann and McNight (1993), as a means of growing social capital, building on the strengths and contributions of people with lived experience of inequity. Unfortunately, few efforts at community health improvement integrate the development of social capital or the development of strength in those affected by inequity as a core element or build the trust needed to share assets across sectors.

In an effort to address a lack of effective collaboration across communities in a way that achieves results, Kania and Kramer (2011) described five elements of successful coalitions that had achieved large-scale collective action, which they termed “collective impact”: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and a backbone support organization. Kania and Kramer based their findings on a study of advanced community coalitions, a common and effective practice. They did not, however, describe or widely disseminate the genesis of these elements in the successful communities.

Collective impact took hold and spread across the country because of the simplicity and elegance of its model. Many community coalitions adopted collective impact principles without the deeper understanding of how these communities developed trust, created improvement, or shared leadership with those affected by inequity. As a result, a number of these coalitions were unable to be effective because they failed to develop the trust needed for shared governance or inadvertently institutionalized structural inequity in the community improvement process by only having resource or institutional leaders at the table when determining aims and measures. A number of subsequent leaders in the field have since critiqued the model based on “its failure to cite advocacy and systems change as core strategies, engage those most affected in the community as partners with equal power, and directly address the causes of social problems and their political, racial, and economic contexts” (Wolff, et al., 2017, p.43). Wolff et al. (2017) in turn identified six principles for community transformation:

1. Explicitly address issues of social and economic injustice and structural racism.
2. Employ a community development approach in which residents have equal power in determining the agenda and resource allocation of the coalition or collaborative agenda.
3. Employ community organizing as an intentional strategy and as part of the process. Work to build resident leadership and power.
4. Focus on policy, systems, and structural change.
5. Build on the extensive community-engaged scholarship, and then evaluate appropriately.
6. Construct core functions for the collaborative, based on equity and justice, that provide basic facilitating structures and build member ownership and leadership.
Finally, few communities were able to use the very useful framework of collective impact to drive change because they did not have core improvement skills to know how to do so. In fact, few efforts to improve community health over the last 30 years have yielded improvements in sustained health outcomes or community transformation outcomes. Mary Pittman, in her reflections on 25 years of the Healthy Cities, Healthy Communities movement as one of its co-founders, noted key challenges in program planning and implementation that affected long-term sustainability:

Leading public health organizations engaged their communities in the planning and implementation of projects that were usually grant funded and focused on building specific areas of program expertise. There were few metrics or methods for designing healthy communities in this early period. However, the leaders who were engaged in redefining community health realized that metrics were necessary to measure their progress in whatever focus they had identified. Few of the early pilots were sustained after grant funding ended, but those that did thrive created a strong leadership capacity that facilitated partnering across organizations and sectors and attracted strong local support from government, philanthropy, and business. (Pittman, 2013, p. 17)

A review of 48 community change initiatives by the Aspen Institute Roundtable on Community Change similarly concluded the following regarding challenges to achieving population-wide, community transformation in overall wellbeing or key related indicators:

The accomplishments of community-change efforts can be summarized as follows. Most can show improvements in the well-being of individual residents who participated in programs in their target neighborhoods. Some produced physical change in their neighborhoods through housing production and rehabilitation, some reduced crime, and a few also sparked commercial development. Most can demonstrate increased neighborhood capacity in the form of stronger leadership, networks, or organizations, or in improved connections between the neighborhood and external entities in the public, private, and nonprofit sectors. A few can point to accomplishments in policy and systems reform. While these are important, tangible outcomes, most of the interventions have not produced the degree of community transformation envisioned by their designers. For example, few (if any) have been able to demonstrate population-level changes in child and family well-being or rates of poverty. (Kubisch et al., 2011, p. 139)

Few studies have looked rigorously at community behaviors, processes, or systems; the skills or learning system needed to accelerate the development of such behaviors, processes, and systems; or their relationship with outcomes. A review of 58 interventions to address health disparities (Anderson et al., 2015) revealed some evidence of early health behavior change or health outcomes, but little evidence linking community coalition activities to these outcomes. Few community transformation systems have been rigorously evaluated and tested for their effectiveness in creating the wide range of pre-conditions needed to get to population level outcomes.

In summary, while key success factors have been identified for community transformation, there is little evidence currently that population health outcomes can be readily achieved in this context. To gain a better understanding for how community outcomes might be improved in the context of a transformative community change process, a look at the empiric literature derived from implementation is needed to understand the key implementation success factors that differentiate initiatives which achieve outcomes.
Lessons Learned from Implementation

To better ground itself on key implementation success factors, in addition to grounding itself in the literature of community transformation, SCALE also built on the experience of six large-scale initiatives that achieved sustained transformation and spread and scale. Three of these initiatives, which achieved measurable improvements and system change at scale, are then described in detail below the table: Project Fives Alive; the 100,000 Homes Campaign; and the Baha’i Community Health Partnership. Principles and lessons learned from all six initiatives are identified in Table 2.

Project Fives Alive! in Ghana

Adapted from (Sodzi-Tettey, et al., 2015)

Project Fives Alive! (PFA) was a five-year initiative launched in 2008 by the Institute for Healthcare Improvement (IHI) and the National Catholic Health Service (NCHS) to accelerate Ghana’s efforts to achieve Millennium Development Goal (MDG) 4 of reducing under-age 5 mortality by two-thirds — from its 1990 baseline of 110 deaths per 1,000 live births to fewer than 40 deaths per 1,000 live births by 2015. The project used quality improvement (QI) methods to implement an evidence-based package of clinical interventions developed by the Ghana Health Service (GHS), working closely with communities, front-line workers, and health system leaders.

Over the course of the initiative, results from the 2015 Ghana Demographic Health Survey (DHS) showed a reduction in under-5 mortality from 80 to 60 per 1,000 live births; child mortality (by age 12 months) from 31 to 19 per 1,000 live births; infant mortality from 50 to 41 per 1,000 live births; and neonatal mortality from 33 to 29 per 1,000 live births.

The project applied a scale-up approach (Barker, Reid, & Schall, 2016), beginning with work in three of the nation’s least-resourced northern regions, and then expanding to the remaining seven regions of the country in a series of four phases, or “waves” (Figure 1). Each district management team trained local managers and staff, thereby building the QI capability to support the work at the district and sub-district levels. As the project expanded from the initial three districts to 38 districts in Wave 2, the project required significant redesign in building local capability among the district and regional supervisors and high-level leaders.

The Health Ministry and the GHS were not deeply involved in the design from the outset, which made it difficult to work on sustainability mechanisms (e.g., a national plan to replenish QI mentors lost through turnover). The team learned from this and quickly made it a priority going forward. However, toward the end of the project, an improvement in maternal and infant outcomes (e.g., a reduction in hospital-based deaths) attracted the interest and support of regional and national leaders.

Figure 1. Project Fives Alive! Phased Scale-Up “Waves”
national leaders.

The first wave involved testing process changes in three innovative districts in the northern region of the country. Wave 2 further refined and documented the process changes developed during Wave 1 and created a set of improvements in early antenatal care (ANC), skilled delivery (SD), and postnatal care (PNC) in 38 districts. These improvements were then used in additional regions in subsequent waves. Wave 3 focused on improving safety and reliability specifically of hospital-based care process in nine NCHS hospitals that were then scaled up to all hospitals in Ghana.

Wave 4 began the final phase of the national scale-up, which eventually reached 55 percent of all districts, including 80 percent of all public-sector hospitals in Ghana.

**PFA PROJECT DESIGN**

The project design included using QI to test how the districts and sub-districts could best apply the evidence-based changes for reducing maternal and infant mortality, the use of Prototype Collaboratives (i.e., a structured way for improvement teams to learn from each other and track their progress), and deep engagement of district staff and community members.

**PFA KEY LESSONS**

The project team identified several factors that contributed to the success of the project, including adaptive design, engaging community partners, forming effective stakeholder partnerships, developing improvement skills at multiple levels, and building for sustainability.

**Use Adaptive Design**

Adaptive design means tailoring plans to the context and to respond to learning as the project progresses. For example, while the project initially focused on addressing the causes of under-5 mortality (i.e., diarrhea, pneumonia, and malaria), the team soon learned, from talking with local health providers, that they also needed to address newborn and maternal health, since so many of the under-5 deaths occurred in childbirth and during the first week of life.

**Engage Community Partners**

In order to effectively address all the contributing factors to under-5 mortality, the project team learned that the improvements could not be solely focused on care in hospitals and health facilities. For example, one major contributor to child mortality was delay in seeking care. The project team adjusted their work to include engaging community leaders and community-based services to remove the barriers to timely access. Another pressing issue was ensuring safe, timely, and effective referrals of pregnant women and newborns from communities to health facilities and between health facilities. This effort required the active engagement and cooperation of community members, including traditional birth attendants (TBAs), licensed chemical sellers, local government officials, traditional authorities (chiefs and Queen Mothers), and other local stakeholders.

**Form Effective Stakeholder Partnerships**

The relationships between the partners — IHI, the NCHS, and the GHS — were important factors in the project’s success. The GHS and the NCHS together provide approximately 95 percent of the health care in Ghana. In addition, the GHS provided reach, size, staff, and infrastructure at
the district and sub-district levels as well as way for the project staff to connect with the key players at the local and regional levels. The NCHS had a national network of hospitals and clinics that provided a natural infrastructure for the health facility-based work. IHI provided the quality improvement know-how and approach to improvement, spread, and scale-up. Understanding and leveraging the relationships between these stakeholders enabled the project team to move forward with key pieces of the project, including the development of a national data system and testing of new guidelines for newborn care that were introduced during the project. The project team also partnered with other NGOs and academic institutions that were working to address under-5 mortality and related issues in Ghana.

**Develop Improvement Skills at Multiple Levels**

The Model for Improvement (i.e., setting aims, identifying measures to track progress, and developing and testing changes) was a foundational element of the design of the project and led to the integration of improvement science methods and principles throughout the country. This required capacity building at multiple levels and in multiple organizations. Project staff trained the initial set of district managers and staff in Wave 1, but they realized that they needed help to do all the training needed to scale the improvements across the country. Training of the partnership organizations (including leaders) was then built into their project design, enabling the partners to support training of local staff as the project expanded.

**Build for Sustainability and Scale**

The project design, which included planning for the end of the project from the outset, included:

- Building QI skills at all levels of the partner organizations and at the district and sub-district levels to ensure the ability to address challenges and issues beyond the formal end of the project;
- Establishing systems to collect data and monitor progress;
- Implementing protocols, tools, and training programs;
- Packaging the recommended changes developed during the project into “how-to guides;” and
- Ensuring that national organizations are prepared to serve as the permanent home for continued improvements in under-5 mortality as well as other improvement efforts.
100,000 Homes Campaign

In July 2010, Community Solutions, a SCALE partner, launched the 100,000 Homes Campaign. The campaign had an ambitious goal of providing permanent housing to 100,000 of the most chronic and vulnerable homeless Americans and, in doing so, forever changing how communities address homelessness. This segment of the homeless population represented 20 percent of the total, but consumed more than 70 percent of the resources allocated for homelessness, and were least likely to be able to access existing permanent housing options designed for people experiencing homelessness (Culhane & Metraux, 2008).

As stated in its manifesto, the Campaign was based on the following core principles:

- Knowing the names of every person living on the streets and in shelters along with their health and housing needs, to prioritize permanent housing to those with the greatest needs;
- Using a “Housing First” philosophy of offering permanent housing immediately and unconditionally, rather than conditioning housing on sobriety, treatment, employment, or other milestones;
- Regular (monthly) reporting on the number of vulnerable and chronically homeless people communities had placed into permanent housing; and
- Improving local homeless systems to target resources to the most vulnerable individuals and families quickly and predictably. (Leopold & Ho, 2015, p. 7)

CAMPAIGN RESULTS

In July 2014, Community Solutions concluded its Campaign, having helped 186 communities provide permanent housing to nearly 106,000 people. In addition to exceeding its 100,000 goal, according to an independent, third-party evaluation conducted by the Urban Institute:

The 100,000 Homes Campaign has had a major impact on national efforts to end homelessness, particularly chronic homelessness and homelessness among veterans, despite its modest staffing and budget. Qualitative data suggests that the Campaign helped bring new energy and partnerships to the work of ending homelessness. One of the defining themes that emerged from stakeholder interviews with local and national groups was the uncommon joy that Community Solutions brought to the work of addressing homelessness. Another defining theme was the Campaign's ability to bring diverse community stakeholders together around ambitious, data-driven goals. The Campaign has also helped to establish the credibility of the Housing First approach by demonstrating both the severity of the public health needs of people experiencing homelessness and the positive impact permanent housing can have on peoples' lives. (Leopold & Ho, 2015, p. 46)

While Campaign communities viewed the goal of housing 100,000 individuals as inspiring, responsibility for achieving it was initially too diffuse. As a result, the Campaign was on track to place just 30,000 vulnerable and chronically homeless people into housing (less than 1/3 of its goal). To put the Campaign back on track to meet its goal and provide greater ownership to communities, the Campaign made the difficult decision to assign a goal (a target monthly housing placement rate) to each participating community. Using the best data available at the time, the Campaign asked each community to place 2.5 percent of their chronic and vulnerable homeless population into permanent housing each month. To put
this placement rate into perspective, the average monthly housing placement at the time this target was set was just 0.6 percent each month, meaning that a four-fold improvement, on average, would be needed for communities to meet the new target.

While these daunting targets could have driven communities from the Campaign, after a series of intense conversations, all but one decided to continue. In striving to meet these audacious goals, communities unleashed their creativity, shared successful ideas with one another, and began to move toward designing a more coordinated housing placement system across communities. This work, in turn, led to a dramatic improvement in housing placement rates by Campaign communities — from an average of 0.6 percent monthly housing placement rate of their vulnerable and chronic population to an average of nearly 3.5 percent — and dramatic improvements in aggregate placements (Figure 2).

**Cumulative Permanent Housing Placements of Chronically or Vulnerable Homeless People**

*By Campaign communities, July 2010-June 2014*

![Cumulative Permanent Housing Placements of Chronically or Vulnerable Homeless People](image)

**Figure 2.** Cumulative Monthly Permanent Housing Placements by 100,000 Homes Campaign Communities. *Source: (Leopold & Ho, 2015, p. 3)*
KEY LEARNING AND THE CAMPAIGN “SECRET SAUCE”

It is impossible to know (or note) all the factors that contributed to the Campaign’s success, and the sum of these factors undoubtedly equaled more than their individual parts. But according to the Urban Institute—the Campaign’s third-party evaluator—from their conversations with Campaign communities and Campaign staff, core factors included (Leopold & Ho, 2015):

- Establishing an audacious, time-bound goal that required communities to improve their homelessness systems (not just work a bit harder).
- Using “Switch thinking” principles to help communities feel like an integral part of a national movement and to spur regular reporting of housing placement and other data (Heath & Heath, 2010).
- A communications strategy that emphasized movement building, an “in this together” mentality, which kept spirits high and made ending homelessness for this population a visceral, emotional call to action.
- Understanding and strategic use of the “Diffusion of Innovation” curve to engage communities, report data, and participate in Campaign activities (Katz, 1961).
- The early recognition that innovation would more often come from the ground level (from programs within the Campaign communities) rather than from the top-down.
- Establishing a “sharing economy” for inter-community spread in which communities felt compelled to freely share their successes (bright spots), ask each other questions, and work together to address common challenges.
- Setting targets not just at the national level, but at the local level, including interim targets, since most communities needed time to make the leap to placing 2.5 percent of their chronic and vulnerable population each month.
- Placing an emphasis on data, improving data (reporting) over time, and making everyone (not just “data geeks”) comfortable with using data for decision making and improvement.
- Harvesting bright spots and making them easy for other Campaign communities to adopt/adapt.
- Helping communities embrace the concept of “failing forward,” in which mistakes are not only tolerated but viewed as a critical part of any improvement effort as long as they lead to learning.
- The introduction of Action Labs (then known as Boot Camps) as a mechanism for rapid planning and improvement cycles that mobilize key stakeholders and result in system-level improvements in about 100 days.
- A focus on making the work joyful and celebrating the milestones along the way to the 100,000 goal.
Baha’i Community Health Partnership, Guyana

The Baha’i Community Health Partnership in the Rupununi Region of Guyana, run by the Varqa Foundation and Guyana Office of Social & Economic Development from 1990 to 2000, offers an example of sustainable structural and community transformation that illustrates many of the concepts of a Community of Solutions. Based in the second-poorest region in the second-poorest country in the Western Hemisphere, this program began with a plan to phase itself out within ten years. Despite the absence of an infrastructure for transportation, education (a fifth-grade education was the highest level available in the region), communication, or health care, the program leaders saw untapped potential and believed in the ability of the Amerindian community to develop the capacity to take over the process of development for themselves.

Initially, the 15,845 residents of the Rupununi, who were clustered in 36 villages across the 33,000-square-mile region, were largely isolated in their villages. Because of challenges in transportation (dirt roads, and bullock carts and bicycles as primary vehicles) and communication (CB radios used to communicate only for emergencies between villages), there was very little sharing of insight or resources between villages. Only 10 percent of elected village officials were women. Every year there was, if the region was lucky, a Regional Health Officer assigned to administer the health of the region. However, because schools reached only the fifth grade, the Regional Health Officer was invariably an outsider who often didn’t want to be there, didn’t know the region well, and didn’t have trusting relationships with the local indigenous community (Saha, 1996).

The Guyana Office of Social and Economic Development (GOSED) was asked by the country’s Ministry of Health to place a doctor in the region, as there was no trained medical professional. When Dr. Jamshid Aidun (the physician lead for the program) arrived, he found a regional hospital with eight beds but little else — no blood bank, laboratory, or anesthesia. He began to rehabilitate the hospital with the support of Health for Humanity, a US-based nonprofit partner that connected low income countries with volunteer resources and contributions from high income countries. It quickly became apparent that most people couldn’t get to the hospital — for the residential population served, the trip took six to 24 hours by bullock cart. At the time, upper respiratory infections, diarrhea, childbirth, and malaria were the leading causes of death and disability.

The program began with a strength-based approach to the community; they believed that the Amerindian people in the region had inherent wisdom and leadership capabilities to offer which could contribute in the short-term and which, if developed, could help them take over the process of development in the long term.
This deep respect for local communities and the belief in their ability to create their own futures was demonstrated in different ways throughout the project. With prevention in mind, the program team brought together existing assets—a nurse midwife who administered the vaccines and family planning for the region, a malaria control worker, and a physician. They also obtained funding for a vehicle to travel from village to village, using a public health approach to educate villagers through local health fairs, immunize children, and detect and treat malaria. They also supported the 36 community health workers (who had three months of training from the government and were sent out to care for their communities), with additional education in diagnosing and treating disease.

As time went on, the program continued to evolve—supporting public health, health literacy, and arts campaigns, and engaging thousands of people in the region in their own health and preventive care. Water wells got covered, latrines built, and children vaccinated. Over time, the people in the region began to see the development of health and well-being as something that required local ownership of health as a shared value across sectors. They elected local health assemblies and formed teams that engaged community health workers, teachers, and local villagers to assess and improve the well-being of their communities. They defined health based on the World Health Organization (1946) definition of “complete mental, physical, social, and spiritual well-being” and began training local health assemblies to facilitate the development of a common vision, to build on existing assets in creative ways, to measure the impact of their efforts, and to change their approach as needed.

Innovations blossomed and went to scale using solutions that could only have been developed and implemented by local people because they had the trust to share assets across sectors. In one village, the local health assembly, in assessing their community, figured out that widows were malnourished because they could not produce enough food from farming to make it through the winter; in the same village, 80 percent of villagers suffered from malaria every year. They knew that they could prevent malaria with mosquito nets, but couldn’t afford these in a subsistence economy. The local health assembly spoke with the widows and convinced them to stop farming and instead to form a sewing cooperative to weave mosquito nets that they could barter for food with local villagers. Within a year, the incidence of malaria had dropped by 90 percent and malnutrition among widows was eliminated (Saha, 1996).

Another community health worker noted that children in the region were exhibiting a developmental delay by the time they were five years old. The worker realized that most babies were being carried on their parents’ back while families were farming, a two-person job. In addition, playing or talking with infants was not seen as valuable in the Amerindian culture. The community health worker developed a parent-child nursery school and taught mothers to play with their kids, using locally available resources to build...
puppets and playgrounds. These ideas spread throughout the region, and within three years, they had nearly eliminated acquired developmental delay (Saha, 1996).

Over time, as the local health assemblies gained confidence, they began taking on structural change. They realized, with some support from the Varqa Foundation and evaluators, that the limited available educational opportunities substantially impeded their ability to control the fate of their health system. The local health assemblies (which by this time had elected a regional health assembly) decided to invest in building a secondary school program with a strong science curriculum. Within ten years, they increased the number of physicians, nurses, midwives, science workers, etc. within the region. People in the region learned to prospectively tell grantors interested in investing in the region to support local initiatives and priorities. They worked with eco-tourism and development agencies to build roads to help address economic isolation. Because they had strong community and regional leadership involved in the decisions, they were able to do this in a way that promoted local leadership, culture, and economy.

Throughout this period, the Varqa Foundation team continued to accompany the local health assemblies, building capacity, helping them to step back and reflect, and supporting the teams to overcome barriers and spread good ideas. They described this model of providing assistance as “accompaniment” — walking alongside a group, trusting in their growth in leadership and capacity over time, providing the support needed during different phases as the relationship evolves to one of full partnership and eventually full leadership by local people. Varqa transitioned out of the region within about ten years, but continued to provide remote coaching and training as needed.

The following key principles from the Baha’i Community Health Partnership approach were adopted in the SCALE Community of Solutions approach:

- A broad, shared vision of health and well-being that is owned as everyone’s responsibility within the community;
- A deep belief in the ability of local communities to create their own future and solutions;
- Viewing the process of development as unlocking the trapped and untapped potential of local people and communities to create the solutions they need, and believing in their ability to create effective solutions;
- A focus on partnership as core to success, valuing unity in diversity for what each partner contributes;
- An instilled belief in the interconnectedness of people within and across communities and a focus on building culture as well as technical skills;
- Embracing the concept of “failing forward” and learning what is really needed as the community progresses on the journey, changing the program as needed to adapt to newly identified priorities;
- An accompaniment model of support by the technical assistance provider, which required significant reinvention of support to provide “just-in-time” skills and support to match what the community was trying to accomplish;
- The belief that community members, even with a fifth-grade education, could acquire the skills to assess their community’s needs, identify the its strengths, develop improvements, and test them in measurable ways; and
- Embracing system transformation in practical ways.

The elements of these three programs and several others are summarized below in Table 2. The core concepts and principles developed for the Community of Solutions model derive from core concepts in each of these programs and based on a review of the literature and are summarized in Table 3.
Table 2. Principles and Lessons of Community Health Improvement Initiatives that Achieved Spread and Scale

<table>
<thead>
<tr>
<th>Project Fives Alive! (Ghana)</th>
<th>100,000 Homes Campaign</th>
<th>Institute for Healthcare Improvement (IHI) Triple Aim</th>
<th>Urban Health Initiative</th>
<th>Baha’i Community Health Partnership (Guyana)</th>
<th>Safety Net Medical Home Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Audacious, time-bound goal</td>
<td>• An audacious, time-bound goal</td>
<td>• Understand your population</td>
<td>• Emphasis on systems</td>
<td>• Align around a vision created together</td>
<td>• Attitude of hope</td>
</tr>
<tr>
<td>• Use of adaptive design (change design as needed to address emerging needs)</td>
<td>• Placing an emphasis on data ownership and improvement</td>
<td>• Develop leadership and governance structures, and engage leaders at all levels of your effort</td>
<td>• Guiding values and principles of trust, joy, unity in diversity, empowerment of women, the inherent value of people</td>
<td>• Approach as cultural transformation rather than structural or service transformation</td>
<td></td>
</tr>
<tr>
<td>• Engagement of community partners</td>
<td>• Build motivation and make change easier</td>
<td>• Articulate a purpose that will hold your stakeholders together</td>
<td>• Believe that change is possible and that the communities (even those in historic poverty) have the capacity to transform</td>
<td>• Harness the power of meaning</td>
<td></td>
</tr>
<tr>
<td>• Breadth and depth of local stakeholder engagement</td>
<td>• Movement building and an “in this together” mentality</td>
<td>• Establish population-level measures based on the community’s goals</td>
<td>• Civic elite and public share understanding of issues and what needs to happen</td>
<td>• Engage front-line staff and patients in the change, with a focus on building leadership capability</td>
<td></td>
</tr>
<tr>
<td>• Wide adoption of improvement science methods and widespread capacity building at multiple levels and in multiple organizations</td>
<td>• The recognition that innovation would more often come from the ground level rather than from the top-down.</td>
<td>• Harness current portfolio (group) of community interventions or projects that together will move the population-level measures and reach community goals</td>
<td>• City as area of focus</td>
<td>• Develop capability of community leaders to take over the change, with training in leadership and improvement</td>
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<tr>
<td>• Plan for sustainability and scale-up from the beginning. This included generation and adaptation of a set of key changes to improve maternal and child health that are relevant to a variety of local contexts while adhering to an overall national program. Successful scale-up of QI intervention to approximately 25% of the country’s districts in three years</td>
<td>• Establishing a “sharing economy” for inter-community spread, willingness to help each other succeed, trust</td>
<td>• Develop an explicit theory or rationale for community changes</td>
<td>• Particular attention to upstream changes</td>
<td>• Develop leadership capabilities to lead the challenge</td>
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<tr>
<td>• Helping communities embrace the concept of “failing forward”</td>
<td>• Harvesting bright spots and making them easy to adopt/adopt.</td>
<td>• Learn by an iterative quality improvement approach (including iterative planning for going to scale)</td>
<td>• Dialogue between academics studying change and practitioners implementing change</td>
<td>• Consider sustainability from the outset</td>
<td></td>
</tr>
<tr>
<td>• Making the work joyful and celebrating milestones along the way.</td>
<td>• Helping communities embrace the concept of “failing forward”</td>
<td>• Engage individuals in the design and implementation of changes</td>
<td>• Assess regularly and change program course as needed, evolving over time</td>
<td>• Cultivate champions at every level</td>
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</tbody>
</table>
Table 3. Core Concepts and Principles of a Community of Solutions

<table>
<thead>
<tr>
<th>How people relate to themselves, each other, and those most affected by inequity:</th>
<th>How the community creates abundance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The community is seen as an interconnected network; the improvement work reflects this perception and leadership is distributed within the network.</td>
<td>7. Stewards across sectors coordinate and leverage their assets in usual and unusual ways to address the priority needs of the community.</td>
</tr>
<tr>
<td>2. People with lived experience of inequity work together with community connectors and resource stewards to co-design and drive change.</td>
<td>8. Leaders at all levels have the trust and governance processes in place to share resources and accountability.</td>
</tr>
<tr>
<td>3. A critical mass of people see themselves as stewards of the community’s well-being, with the agency and capacity to create change.</td>
<td>9. Leaders prioritize the unlocking of untapped potential in people and organizations as a pathway to abundance.</td>
</tr>
<tr>
<td>4. Leaders across the community work together strategically to create the improvements, systems, and policies needed to sustain long-term change.</td>
<td>10. Leaders support the development of other leaders who contribute to solutions at every level of the community.</td>
</tr>
<tr>
<td>5. Community leaders prioritize equity and create a change process that offers greater ownership to those with lived experience of inequity.</td>
<td>11. Leaders invest in a change process that is dynamic and enhances engagement, relationship, capacity, and the will for change.</td>
</tr>
<tr>
<td>6. People reflect, ask open and honest questions, address and resolve conflicts, and embrace differences in a constructive way.</td>
<td>12. Leaders invest in the development of social change in a way that gives a wide range of people increasing agency in the change process for themselves and for their communities.</td>
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<table>
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<tr>
<th>How the community approaches the change process:</th>
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<tbody>
<tr>
<td>13. Believe change is possible and define a tangible, motivating vision with concrete aims.</td>
</tr>
<tr>
<td>14. Co-design change with the person, place or population.</td>
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<tr>
<td>15. Recognize that solutions can come from anywhere — and create the space and process for their emergence, through the application of effective facilitation and design methods.</td>
</tr>
<tr>
<td>16. Focus on getting to meaningful outcomes, with a clear theory of change and measurement aligned with the theory.</td>
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<tr>
<td>17. Approach change in a dynamic way — community members learn, adapt, and “fail forward” as a normal part of creating change in small and big ways.</td>
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<tr>
<td>18. Use data and stories to drive improvement and monitor impact.</td>
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<tr>
<td>19. Adapt aims and measures as the community learns.</td>
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<td>20. Embrace the opportunity to learn from others.</td>
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<tr>
<td>21. Display humility and a willingness to adopt solutions generated by others.</td>
</tr>
<tr>
<td>22. Focus on community strengths and bright spots, approaching challenges as opportunities.</td>
</tr>
<tr>
<td>23. Understand and prioritize the growth of trust, joy, meaning, motivation, and relationship in the change process.</td>
</tr>
<tr>
<td>24. Understand the system of the community from multiple perspectives.</td>
</tr>
<tr>
<td>25. Prioritize people and places that aren’t thriving.</td>
</tr>
<tr>
<td>26. Address equity in a way that builds trust, resilience, and unity.</td>
</tr>
<tr>
<td>27. Unapologetically and pragmatically address structural racism and inequity in processes and systems.</td>
</tr>
<tr>
<td>28. Plan for sustainability, spread, and scale from the beginning.</td>
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</tbody>
</table>
Conclusion

The Community of Solutions model developed for the 100 Million Healthier Lives SCALE initiative builds on the theory, practice, lessons, and opportunities from both the literature and on-the-ground work of community transformation around the globe. This paper has described some of the key conceptual elements of scholarship on community transformation that have informed the development, implementation, and evaluation of SCALE 1.0. The accompanying report in this series, “Overview of SCALE and a Community of Solutions,” provides an in-depth description of the Community of Solutions model as well examples of the model in practice from SCALE communities.

SCALE seeks to understand how communities can go beyond an understanding of principles to catalyze a living practice of community transformation that leads to meaningful improvement in the lives of its residents and achieves a Culture of Health. The synthesis papers that follow, one on integrating people with lived experience of inequity into community transformation processes, and one on approaching sustainability in communities differently and one on integrating improvement and design principles in communities, all explore different elements of the Community of Solutions model in implementation. By sharing the details of implementation, what worked and what didn't, as well as a wealth of examples from communities at all stages of readiness, the authors of this series hope to contribute to the rich and growing knowledge base of community based improvement and transformation they have been privileged to draw from, joining countless others across the country who are discovering and describing how to make a Culture of Health in communities a living reality.
# Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>100 Million Healthier Lives Well-Being Survey</strong></td>
<td>A short survey used by 100 Million Healthier Lives to measure the different dimensions of well-being, including physical and mental health, and social and spiritual well-being.</td>
</tr>
<tr>
<td><strong>Aim</strong></td>
<td>A statement of what an improvement team intends to accomplish. It is time-specific and measurable, defining how much, by when, and for whom a community is working. The aim helps everyone in the community understand what the community is trying to do, sets a pathway for the choices of which projects and interventions can achieve that aim, and builds will among community stakeholders to join the effort.</td>
</tr>
<tr>
<td><strong>Bright Spot</strong></td>
<td>A set of activities, an intervention, or a program that a community is working on to improve health, well-being, and equity. It is scalable and shows evidence of the impact of the work on the population or subpopulation in the community.</td>
</tr>
<tr>
<td><strong>Change Idea</strong></td>
<td>A change idea is an actionable, specific idea for changing a process. It can come from a review of the evidence from research; from best practice; or from talking to those with lived experience of the issues, or with other teams, organizations, or communities that have tested changes and demonstrated improvement on a specific issue.</td>
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<tr>
<td><strong>Change Sustainability</strong></td>
<td>Refers to the sustainability of the change process itself. There are three components of change sustainability: program sustainability, outcome sustainability, and process sustainability.</td>
</tr>
<tr>
<td><strong>CHILA</strong></td>
<td>Community Health Improvement and Leadership Academy (CHILA) is the series of in-person leadership training sessions for the SCALE local improvement advisors (definition below) and other members of the pacesetter and mentor communities. There were four CHILA sessions over the 20-month time period for SCALE 1.0.</td>
</tr>
<tr>
<td><strong>CHILA Faculty</strong></td>
<td>Faculty for CHILA have deep experience in a skill or topic that matters for community health improvement. Together with members of the SCALE Implementation Team, they lead sessions during CHILA and the monthly SCALE webinars.</td>
</tr>
<tr>
<td><strong>CHIP</strong></td>
<td>Community Health Improvement Plan (CHIP) is a comprehensive guide used by SCALE communities to guide their journey to improving health, well-being, and equity.</td>
</tr>
<tr>
<td><strong>Co-design and Co-production</strong></td>
<td>Co-design is the process of engaging community members directly in identifying and planning changes that are needed in their community to achieve health, well-being, and equity. Co-production is the process by which community members directly carry out the changes created during the co-design.</td>
</tr>
<tr>
<td><strong>Community Champion</strong></td>
<td>A community champion is a community resident with lived experience who works as a member of the core transformation team in the SCALE community. This person is a community member who has “lived experience” with the health issues in the community (e.g., a woman who was formerly or is currently experiencing homelessness who can offer insight into that experience) and is ready to be actively involved in efforts to improve the health of the community.</td>
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<tr>
<td><strong>Community Leader</strong></td>
<td>A community leader guides and organizes people, resources, and processes within a community to improve health, well-being, and equity. A community leader may be an elected or appointed governmental or agency official or someone who has been elected to a leadership position within a partnership or coalition or within their organization or community group.</td>
</tr>
<tr>
<td><strong>Community of Solutions</strong></td>
<td>Community of Solutions is a framework that supports communities in cultivating behaviors, processes, and systems that, over time, results in a Culture of Health and sustainable improvements in health, well-being, and equity.</td>
</tr>
<tr>
<td><strong>Community Resident with Lived Experience</strong></td>
<td>Someone who has lived (or is currently living) with the issues the community is focusing on and who may have insight to offer about the system as it is experienced by consumers (e.g., a woman who was formerly or is currently experiencing homelessness who can offer insight into that experience).</td>
</tr>
<tr>
<td><strong>Design Principles and Methods</strong></td>
<td>A set of approaches and tools to better understand the experience of community members with programs (e.g., an employment program or a diabetes prevention program), systems (e.g., the homelessness system or the child welfare system), or places (e.g., a neighborhood with poor health outcomes), and then to use this understanding to improve their design and effectiveness.</td>
</tr>
<tr>
<td><strong>Driver Diagram</strong></td>
<td>A driver diagram is an illustration of the structures, processes, and norms that are believed to require change in the system; this is one way to illustrate the team’s shared theory of change.</td>
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<tr>
<td><strong>Emerging Bright Spot</strong></td>
<td>A set of practices, programs, or policies that show some initial evidence of far better outcomes than the norm; however, it may not yet have been replicated in other contexts.</td>
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<tr>
<td><strong>Empathy Mapping</strong></td>
<td>Empathy Mapping allows a program, system, or community to better understand the people they work with by “walking a mile in their shoes” and going beyond surveys, interviews, and focus groups. By more fully understanding the wants, needs, fears, and frustrations of community members, it is possible to gain insights that can result in effective change ideas.</td>
</tr>
<tr>
<td><strong>Environmental Sustainability</strong></td>
<td>Refers to the stability and possibility for growth in the physical, political, social/cultural, financial, and technology/innovation environment.</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td>Conditions in which all people have the opportunity to attain their highest possible level of health and well-being, without barriers that prevent them from doing so.</td>
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<tr>
<td><strong>Equity Action Lab</strong></td>
<td>Equity Action Lab uses a structured set of activities to bring together a diverse group of community stakeholders to set a goal that is important to them and to design and take action over a 100-day period to make progress toward that goal. (Community Solutions, Designing an Action Lab, 2016)</td>
</tr>
<tr>
<td><strong>Failing Forward</strong></td>
<td>The notion that mistakes are not only to be accepted as an occasional occurrence in improvement projects, but should be viewed as critical parts of the learning and improvement process. It embraces the belief that teams that fail forward quickly learn faster, reach higher levels of performance, and create a safe environment for a wide variety of ideas to be suggested and tried.</td>
</tr>
<tr>
<td><strong>Formative Evaluation</strong></td>
<td>Evaluation that is intended to assess and improve the project design during the course of the initiative (in this case, SCALE) while it is happening. Using diverse methods including direct observation, surveys, interviews, and feedback from the project Implementation Team, the formative evaluation seeks to collaboratively learn what it takes to accelerate progress within and among communities.</td>
</tr>
<tr>
<td><strong>Generative Sustainability</strong></td>
<td>A set of practices and conditions that enables a change process to grow and scale.</td>
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<tr>
<td><strong>Habits of the Heart</strong></td>
<td>Habits of the Heart are a set of practices developed by the Center for Courage and Renewal that enable community members to openly and honestly engage with one another, to develop shared understanding, and to be able to take action together based on that understanding.</td>
</tr>
<tr>
<td><strong>HealthDoers</strong></td>
<td>HealthDoers is the online platform supported by the Network for Regional Health Improvement (NHRI). It connects SCALE communities as well as individuals, initiatives, and organizations across the country, including those involved in the 100MLives movement, who are forging local solutions to advance health and well-being.</td>
</tr>
<tr>
<td><strong>Improvement Science</strong></td>
<td>An applied, multidisciplinary science that emphasizes innovation, rapid-cycle testing in the field, and spread in order to generate learning about which changes, in which contexts, produce improvements. It is characterized by the combination of expert subject knowledge with improvement methods and tools.</td>
</tr>
<tr>
<td><strong>Jargon Card</strong></td>
<td>A small posterboard card with the work &quot;jargon&quot; on it; during CHILAs, any person could raise a jargon card at any time when an unfamiliar term was used without being defined, so that everyone could fully understand the remarks.</td>
</tr>
<tr>
<td><strong>Leading for Equity</strong></td>
<td>Refers to the application of Leading from Within, Leading Together, and Leading for Outcomes to address equity at a population and structural level.</td>
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<tr>
<td><strong>Leading for Outcomes</strong></td>
<td>Includes the skills of innovation, improvement, implementation, and systems change and refers to the application of design skills to co-create a theory of change, identify measures, test the theory, and then plan for both implementation and scaling up in a way that makes these tasks easier.</td>
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<tr>
<td><strong>Leading for Sustainability</strong></td>
<td>The development of a continuing process of transformation in a community (generative sustainability) as opposed to maintaining programs as they are.</td>
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<tr>
<td><strong>Leading for Abundance</strong></td>
<td>A set of practices and key concepts that the SCALE partners tested together related to: reflective practice in leadership (Leading from Within), collaboration (Leading Together), design thinking and improvement science (Leading for Outcomes), equity (Leading for Equity) and generative sustainability (Leading for Sustainability); taken together, these elements make up the Community of Solutions skills.</td>
</tr>
<tr>
<td><strong>Framework = Community of Solutions Skills</strong></td>
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</tr>
<tr>
<td><strong>Leading from Within</strong></td>
<td>The inner and reflective work of leadership and one's inner journey as a leader.</td>
</tr>
<tr>
<td><strong>Leading Together</strong></td>
<td>The skills of working together, grounded in seeing the community as a dynamic network of interacting people, organizations, structures, and systems that are related to a place. It is necessary to lead together with others in a community to create effective, equitable change.</td>
</tr>
<tr>
<td><strong>Local Improvement Advisor (LIA)</strong></td>
<td>A person from a SCALE community with the knowledge and skills to facilitate both the development of relationships across community stakeholders and the improvement process of the community.</td>
</tr>
<tr>
<td><strong>Mentor Community</strong></td>
<td>A community committed to health and equity that has made significant progress in addressing multiple determinants of health across sectors (e.g., health care, education, public health, business, social services, etc.); agrees to provide an experienced change agent who can share learning; and is willing to support others in the SCALE network. While mentor communities have made progress, they also want to continue to learn from others and make even more progress in their own journey toward a healthier community. There were four mentor communities in SCALE 1.0.</td>
</tr>
<tr>
<td><strong>Model for Improvement</strong></td>
<td>Developed by Associates in Process Improvement, the Model for Improvement is a simple tool for accelerating improvement. It contains three questions that help to create an aim, measures, and a set of changes together with a structured way to test changes in practice (Plan-Do-Study-Act, or PDSA cycles).</td>
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<tr>
<td><strong>Massive Open Online Course (MOOC)</strong></td>
<td>A free online course offered to a large number of people.</td>
</tr>
<tr>
<td><strong>Mr. Potato Head Exercise</strong></td>
<td>An exercise that engages participants in testing ideas as a way to illustrate the importance of each step in the PDSA cycle.</td>
</tr>
<tr>
<td><strong>Pacesetter Community</strong></td>
<td>A pacesetter community is a community committed to health and equity with at least three partnering organizations capable of addressing the determinants of health across sectors (e.g., education, public health, social services, health care, etc.). Pacesetter communities have at least some experience in improving the health of their communities, and have the hunger and passion to do more, to learn from others, and to contribute to a vibrant shared learning community. There were 20 pacesetter communities in SCALE 1.0.</td>
</tr>
<tr>
<td><strong>Pathway to Pacesetters (P2P)</strong></td>
<td>A virtual capacity-building program that grew out of SCALE 1.0. It supports communities in accelerating their improvement journey, no matter where they are. The goals of Pathway to Pacesetter are:</td>
</tr>
</tbody>
</table>
1. Support local leaders working together across sectors to be effective in achieving their goals for improving health, well-being, and equity in their communities.

Accelerate the spread of good ideas and practices between communities through the development of relationships, peer-to-peer networks, and an effective learning system for spread.

**PDSA Cycle**

A *Plan-Do-Study-Act (PDSA) cycle* is a structured way of testing a change in the real world — by planning it, trying it, observing the results, and acting on what is learned.

**Peer Community Team**

A Peer Community Team is composed of the following: the SCALE Coach, a mentor community, and five selected pacesetter communities that have a common focus, community type (e.g., urban, rural, etc.) and/or some other identified affinity. There were four Peer Community Teams in SCALE 1.0.

**Readiness**

The general capacity, innovation capacity, and motivation of a community to do a particular task. Readiness was formally assessed throughout SCALE by the evaluation team and used to guide curriculum development and coaching.

**SCALE 1.0**

Spreading Community Accelerators through Learning and Evaluation (SCALE) 1.0 was a 20-month intensive “learning and doing” program made possible by the generous support of the Robert Wood Johnson Foundation. It was designed to assist communities to achieve unprecedented results in improving the health and well-being of people, populations, and the community at large. SCALE 1.0 was the first time this program was funded (SCALE 2.0, also supported by the Robert Wood Johnson Foundation, began in May 2017). SCALE supports communities in their efforts to address factors that contribute to health, to lead complex change, and to advance equity.

**SCALE Coaches**

Individuals experienced in leading improvement efforts in community health and in coaching teams to develop and carry out plans to improve the health and vitality of their communities. The SCALE coaches are nominated by SCALE Community Partners and lead the Peer Community Teams.

**SCALE Community Partners**

The four SCALE 1.0 Community Partners are Community Solutions (CS), Communities Joined in Action (CJA), the Network for Regional Healthcare Improvement (NRHI), and the Institute for Healthcare Improvement (IHI).

**SCALE Communities**

The communities participating in the SCALE Initiative. In SCALE 1.0, there were 24 SCALE communities (see beginning of this report for a list).

**SCALE Community Improvement Team**

The improvement or transformation team in each community.

**SCALE Tripod Leadership Team**

A leadership structure, encouraged for SCALE Communities, which combines formal institutional leaders, community connectors, and community residents with lived experience.
**Switch Thinking**

A concept from the work of Dan and Chip Heath in the book, *Switch: How to Change Things When Change Is Hard*. The idea is that by understanding how to motivate the emotional brain (the Elephant) using the rational brain (the Rider), it is possible to provide direction and make the environment for change (the Path) as hospitable as possible. Individuals, groups, and entire communities can thereby make and sustain changes.

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**Theory of Change**

A tool that helps to describe a group’s belief (theory) about how a concrete goal (aim) will be achieved, including its primary contributors (primary drivers), possible secondary contributors (secondary drivers), and often, possible changes that could be tried (change ideas).
References


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SCALE Communities

- **Atlanta Regional Collaborative for Health Improvement**: Atlanta, Georgia
- **Bernalillo County Community Health Council**: Albuquerque, New Mexico
- **Brooklyn Park**: Minneapolis, Minnesota
- **BuckeyeHEAL**: Cleveland, Ohio
- **Ethnic Community-based Organization for Refugees**: Salt Lake City, Utah
- **Healthy Livable Communities Consortium of Cattaraugus County**: Salamanca, New York
- **Healthy in the Hills**: Williamson, West Virginia
- **Healthy Monadnock**: Keene, New Hampshire
- **Healthy Waterville**: Waterville, Maine
- **Health Improvement Partnership of Maricopa County**: Phoenix, Arizona
- **Jackson Collaborative Council**: Jackson, Michigan
- **Laramie County Community Partnership**: Cheyenne, Wyoming
- **Live Algoma**: Algoma, Wisconsin
- **North Colorado Health Alliance**: Evans, Colorado
- **Proviso Partners for Health**: Chicago, Illinois
- **Pueblo Triple Aim Corporation**: Pueblo, Colorado
- **San Gabriel Valley Healthy Cities Collaborative**: Los Angeles, California
Southeast Raleigh YMCA: Raleigh, North Carolina  
Sitka Health Summit Coalition: Sitka, Alaska  
Summit County: Akron, Ohio  
Tenderloin Health Improvement Partnership: San Francisco, California  
Vital Village Network: Boston, Massachusetts  
Wellness Now: Oklahoma City, Oklahoma  
Women of Skid Row: Los Angeles, California