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Proem

I call myself a patient-caregiver activist, a change agent, always gravitating toward action. I look for what works for me, for you and our communities. For you and me, individuals, we set our goals, try stuff, learn, adjust, and try again. Hopefully, we can measure our goals. You've heard mine ad nauseam: progress as slowly as possible, don't fall, maintain my pathological optimism, and keep playing my bari sax. I measure each of these easily: Expanded Disability Scale (EDSS) I've gone from 2.0 to 6.5 out of ten in twelve years and steps walked per day (decreased from 4500 to 3000); no falls recently; occasional despondence, mostly upbeat; minutes per day playing my sax reduced from 60 to 5. See, measurable, easy, immediate feedback for action. Change over time, try stuff, and adjust. Rinse and repeat.

In contrast, I serve on panels measuring cost and quality of care. Complicated measures costing millions to develop, calculate, and disseminate. Often, usually, I find it impossible to see how the measures could or do drive action, especially for patients, caregivers, and communities. We will examine this deeper in subsequent episodes.

Introducing Tania Dutta and Uma Kotagal 02:44

My dear friend and colleague in the patient engagement and measurement world and previous guest on this podcast, Ellen Schultz, introduced me to a project called, Aligning Systems with Communities to Advance Equity through Shared Measurement. Quite a mouthful. I'm drawn because it's community action with measurement. My guest are Tania Dutta and Uma Kotagal.

Tania Dutta currently serves as a Senior Researcher at the American Institutes for Research (A.I.R.). She designs, manages, and directs projects on patient and stakeholder engagement, evidence-based policy, comparative effectiveness research, quality measurement, and health equity.

Dr. Uma Raman Kotagal currently serves as Senior Fellow at Cincinnati Children's Hospital Medical Center and Professor of Pediatrics Obstetrics and Gynecology at the University of Cincinnati. A neonatologist and Health Services Researcher by training, Dr. Kotagal previously served as Executive Lead for Community and Population Health and launched a community-based Learning Network (All Children's Thrive Learning Network). The Network focused on improving the lives of children in poverty through cross-sector partnerships, including health and education and social sectors.

Health Hats: Good afternoon. Thank you so much for joining me. I appreciate it. Would you please introduce yourself? How would you introduce yourselves in a social situation or a business situation that our listeners know who they're hearing?

Uma Kotagal: I'm Uma Kotagal. I'm a pediatrician, and I have been working, caring for children and especially sick children, for a very long time. I'm a neonatologist by background, which means that I work with very premature babies. But over the last ten-plus years, I have shifted my focus from directly taking care of kids and sick kids to looking at the whole system. I understand what works, why it works, why it doesn't work. Since 2001, I have been leading healthcare transformation, starting first at Cincinnati Children's but across the world. And my focus is really to make sure healthcare is more effective, safer, more reliable, more patient-centered. That's what I've been working on. But I began from my work and taking care of kids. I began to think that bigger issues needed to be tackled that probably required broader work. So, I started with myself and my work, then my hospitals, then work across other hospitals. But I recognized that health care by itself could not impact total health and that while healthcare could do a lot of things, surgery, fix a problem, orthopedics, a lot of different things, the health of a whole person required a community. I began to shift my thinking from simply saying making healthcare better to seeing if kids in our city, especially kids in poverty or kids in difficult circumstances, could advance their health. And we can talk a little more about that, but that's my trajectory, thinking, and work. And so currently, I'm working with people across the community at Cincinnati to improve the lives of children across different sectors.

Tania Dutta: Hi, I'm Tania. I am a senior researcher at the American Institutes for Research. I've been at A.I.R. for about seven years. But overall, I have around ten years of experience in developing, implementing, and managing projects more around patient and family engagement, comparative effective research delivery system reform, and health equity. When I started doing this work, I was new to health equity, but what attracted me was this idea that we need to care for the entire person and not just look at healthcare because healthcare by itself will not solve all the problems. And we do need to partner with other systems or sectors like education to meet the needs of the individuals, and there are so many things happening in one's lives, which we often call these are all upstream factors, and these need to be addressed. As we start to look at the health and well-being of individuals.

Aligning systems, communities, equity, shared measurement 08:22

Health Hats: I met you guys because of this project that you were involved in aligning systems with communities to advance equity through share shared measurement, such a mouthful. There's so much just in that title. I'm wondering if you could break that down for us. What systems, which communities, what kind of equity, and what is shared measurement?

Tania Dutta: Yes. I agree. There's a lot in that title. And we, too, defined a lot of these terms when we started working on this project. But the idea at its base is that we can't advance equity well without working with the people you're seeking to serve because there's no substitute for their perspective. So, in terms of defining communities, we intentionally kept it very broad. So that the work that we complete can be applicable in different settings. Community can be either at the neighborhood level, the city level, or in some cases, we've seen even at the national level. And the people in these communities have different needs and priorities. And systems or sectors, as we know in healthcare, are organizations that directly influence the health and well-being of the community members. So, everything from healthcare, human, and social services, public health, education, transportation, our justice system. All of these are systems. We saw that these systems often operate in silos when we started this work, creating fragmentation and community service delivery. And this fragmentation often makes it more likely that community members' needs can go unmet and that they may experience worse health outcomes as a result. So, when we're thinking of the whole health of community members, we want the systems to align to meet their needs. Sometimes systems align for different reasons, but not all ways to advance equity. In some cases, what we've also seen as the alignment efforts have exacerbated the existing inequities.

Our goal from the very beginning was that we wanted these organizations to align to advance equity. Now, the other piece of this is the use of shared measurement. That's what makes this project unique. The systems have traditionally used measurement to set their goals and define what success should look like. And measurement in these cases is often linked to dollars because it can determine how resources are allocated. It can also be used to create checks and balances on how those dollars are spent. To promote equity, we must identify how these inequities are built into our use of measurement. And then, we must be intentional about dismantling those inequities. So, we need to ask questions, like what measures or measurement systems are we using? Where did those measures come from? What biases

may be built into that data? What important information do we need from those measurement systems that the existing measures cannot tell us? Through this work, what we've seen as an essential part of changing systems is how those systems use shared measurement. Measurement can either reinforce the status quo of systemic racism and structural inequities that exist within systems. Or we can use it as a force to advance equity. That's what this work is about. I'll go into a little more detail and talk about shared measurement because everyone doesn't understand it similarly. Our project, funded by the Robert Wood Johnson Foundation, focuses on using shared measurement as a strategy to advance equity. So shared measurement means using a common set of measurable goals that reflect shared priorities across systems and with community members. So, when talking about shared measurement, we mean the whole process of measuring, not just individual metrics or data. Does It include what we need to measure? Why is it important to choose how to measure it, including the data sources we should use? It's not just about quantitative or numeric data, but it's also about the qualitative stories or the narratives that come with it. It's also about making sense of what the data means, including interpreting it and telling the story about it. Then finally, shared measurement is also about sharing that information in ways that are easy to understand that help those different stakeholders monitor progress toward collective goals that they've established and support learning. And also can be used to inform policy decisions. So, I'm going to pause there and see if you have any other questions. I know there was a lot, but that's how we broke it down the different pieces.

That was a lot. Delivering services, creating devices and products, learning through research all require the participation of the people affected and using the output: engagement, participation, partnering, co-production. Sound familiar? Changing systems-public health, acute care, neighborhood services, whatever-needs attention paid to the boundaries between their inevitable structured silos and inequities. Finally, measurement done well that makes sense to users and communities, can be impacted by collective action, and is worth the effort.

Scientific, valid, meaningful, and warm 14:51

Health Hats: Uma, why did you get involved specifically in this project?

Uma Kotagal: When I think about children, which is what I think about most of the time, I think about their well-being. I think about no harm to them. I think about are they going to thrive? Will they be on the trajectory that gets them to a place where they could be strong, healthy adults. And I am a systems person, and I have an improvement person. In both categories, my view of the world is not just about people talking about what they do, but the impact? As an improvement expert, my fundamental bias is that people talk a lot and do a lot, but we don't change the system. So, to change the system, we have to start from a systems perspective. And as Tania said, the number one issue is what are we talking about? So, in my case, we're talking about children in poverty, children between the ages of zero to nine. Children entering kindergarten. Children being able to graduate from third grade, let's think about that. And as we think about that, I have to talk to different people about what I can't be gobbledygook, and it can't be complex measurement because we are working with a community, for that community to be engaged because we're thinking about populations. So, its work has to be scientific, valid, and sound,

but it also has to be meaningful and warm and encourage people to be curious and say, oh, I didn't know that. Tell me more about it. So what Tania is describing, the systems view, what does a system look like? Why does it work a certain way? Why does it act the way it does? Why does this system produce good results, and that system does not produce good results? It comes down to both measurement and your theory of what's going on.

Minus nine to nine 16:53

Uma Kotagal: If my goal is children thriving. I know that third grade is a significant factor for advancement. So, the measurements for All Children Thrive Network relate to minus nine to nine. Minus nine is starting pregnancy and in nine is nine years. Our measures have to be meaningful for teachers, meaningful for parents. They have to be meaningful for the providers and the physicians and nurses taking care of kids. And we want them to be simple logical, understandable, not so complex that I don't know if I'm doing better or not because measurement is really about, am I going in that direction? Is that direction the right direction? Am I making progress? So, I think about measurement probably not only what the measurement is, but why do we measure this?

Healthy births to graduation from third grade 17:51

Health Hats: Can we shift a little from the theoretical to the like, so give me some examples, like out of all this work, where did you end up?

Uma Kotagal: We focused on 66,000 children in Cincinnati, 40% of whom live in poverty. Our focus is for all our children to thrive, and we decided to start from pregnancy, so early gestation till third grade. Believing that early space is where mental health, physical health, confidence, trajectories matter. We said, okay, from minus nine to nine, that's our measurement system. So, we started with healthy births. And there we're looking at prematurity and infant mortality, children dying before the age of one, either from primary or secondary causes. But then we also recognize that graduating third grade sets you on a trajectory of success. Whereas if you failed third grade, the likelihood is that you would not be able to do well. In third grade, it becomes a good marker. At the other end of the spectrum, our marker is third-grade graduation. It's not necessarily a traditional research-oriented model. It's a child's trajectory model. And there were asking the question, what do I need to know for you by one year? What did we need to know when you were born? What does it look like when you enter school? What does it look like when you're nine years old when you were in third grade?

Health Hats: So, when you say you, you want to know what it looks like. What are you looking at? Are you looking at food, or you're looking at the family? Say more.

Infant mortality, prematurity, poverty, inequities 19:51

Uma Kotagal: Let's take infant mortality as surviving to age one. We know that infant mortality in blacks is significantly higher than infant mortality in whites. We know that for people with excellent income and good socioeconomic status, infant mortality is very low. In contrast, for people of lower socioeconomic status and African Americans, infant mortality is high. Our goal here is that you're going to survive your first birthday. Once we say that is right, the theory that infant mortality is what we're

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going to measure. Then we have our theory about why. Sometimes it's because of multiple pregnancies, meaning I have quadruplets. Sometimes it's because my risk of pregnancy is very high, and the likelihood that I will have a baby, a full-term baby, is low. So, once you take the big measure, which in our case is infant mortality, then we've got to build a theory about why that doesn't work. Prematurity is the number one cause of infant mortality, with children being born too premature. And the factors related to prematurity related to maternal stress to poverty, economic status. Predominantly infant mortality is higher in blacks than whites. So now, if we want to address infant mortality, what we have found is that we have to find mothers very early. We have to mothers, pregnant women, very early. We have to build their confidence. We have to have a community group that supports them. They have to have stable housing. They have to be supported and cared for during their pregnancy. And if we do all of that, we have good data to show that our prematurity rates are low and our infant mortality rates are low. So that's the pregestational starting pre gestation to age one.

Scientists, clinicians, and community members together plus deep design work 21:40

Health Hats: I understand that those are occurrences factors, situations that make a difference. Did this project start with what you knew already, and then you brought communities together to validate it? How were communities involved?

Uma Kotagal: It's both. The experts in the field, the people that have the scientific research knowledge to say what we must do to decrease prematurity or what we must do to decrease infant mortality, there's scientific evidence. They come to the table to synthesize the scientific evidence and say that we need to do these things to make this better. That's one. The second is that while the physicians and the scientists can say you need to do these things, some of the underlying factors are poverty, stress, unstable housing in single parents, and stuff like that. Then we must have those people at the table to hear their view. Not only what we're not doing right for them but what they need to be able to do to survive and have healthy children. It's not an either-or option. We set the table where the physicians are, the obstetricians are, and the pediatricians are there. The nurse-midwives are there. The community people are there, but we also explicitly do deep design work. Specifically, meeting with families, visiting their homes, understanding their context so that we're not making it up from our perspective, but we're looking at their perspective. So, for example, in the early premature, early pregnancy space, there's a lot of stuff we could do to prevent stillbirths or early prematurely. And some of that is activating women, creating a women's group that takes care of each other, making sure that the housing is safe and they're not evicted, things like that that contribute to poor outcomes. So sometimes, we're going beyond the medical space. Yeah, community space, which is where we have to do the work. And sometimes, we might only be in the medical space. And that depends on which goal we're tackling, what measurement work happened.

Guiding principles 24:56

The A.I.R./Robert Woods Johnson initiative includes five other community projects: San Antonio 2020, Vermont Health in All Policies, Community Schools Initiative, Connect SoCal, LA County Homeless Initiative. Find more about each in the show notes. I asked Tania about the Guiding Principles learned by

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this collaboration of communities. Ellen Shultz telling me about these guiding principles first caught my attention and motivated me to devote an episode to the project. Again, more about the principles can be found in the show notes.

Tania Dutta: As we were exploring how shared measurement can be used as a tool, we developed a core set of five principles and accompanying guidance, practical guidance for community members, system leaders. And we decided to develop principles because these are the fundamental values that can shape and govern the policies and objectives of systems. What you heard from Uma is one of our use cases. So we had a process where we engaged stakeholders from various systems and community members to make sure that we include their input as we're developing the principles. We spoke to Uma's group and drafted a use case or a case study on the Cincinnati All Children Thrive initiative and how they use shared measurement to advance equity. And we did that for five more initiatives, so we selected different initiatives, some at the national level, some at the neighborhood level, and some at the state level. And we took all of that information, and we also conducted six listening sessions with various communities across the country to hear their needs. And we took all of this information to start like a Delphi process again, in which several experts, stakeholders, community members were engaged. And that's what led to the development of the principles and the practical guidance.

Health Hats: The principles are the upfront investment, co-creation, accountability, holistic and comprehensive view, and shared value. How is it that people that you're not connected with? That now you've done all this work. You've published these principles. Why should people care about this? What is it that this, how is this going to help people who are out in the community advocating for whatever they're advocating for that are not part of this project? How will this be generalized to other people and other groups?

Getting measurement right. Parsimonious, discrete, improvable 27:06

Uma Kotagal: I think that principals are clean and clear and offer information that allows people to be more successful at what they want to impact. Measurement as a key principle is vital to this kind of work because if people stay fuzzy about the measurement, then after a little while with the project, things are not going the right way. Then they begin to say it was this or it was that. Getting the measurement right is like the goalpost, right? I want to reduce infant mortality by 40%. I want to improve third-grade reading by 80%. By putting a stake in the ground, I'm seeing what I'm going to improve and how much I'm going to improve it. That's where the measurement system is essential.

Quite frequently, people try to put hundreds of measures or 50 measures or many measures, and then they don't quite know if what worked or what didn't work all their time on measurement when they should be spending their time on improvement. Getting that measurement right is very critical. And we say that you must have a parsimonious set of measures. You can't bring the whole kitten caboodle to the dance. You got to come with a discrete set of measures that you know how to measure. That is important. That you know how to improve because I can measure and keep on measuring, but not improving, it doesn't matter. In our case, our measures are related to the zero to nine age group, but

they're a small set of measures. So, we measure survival, right? Infant mortality. Days spent in the hospital. Are you sick and not able to do all the things you should do? This means, which is about prevention and supporting parents and so on. We went to third-grade reading as a measure because it's a predictor of long-term success for healthy children, but it's not in the healthcare space.

Health Hats: But it is.

Uma Kotagal: The measurement is that we had to go to whatever sector we had to go to figure out what the kids would need. Yeah. If you're looking at our measures, the commonality is that we can highlight exactly what we want to do. Then we build an improvement course to help people learn how to improve those measures. Then everybody in the community starts to use those measures and share those measures and learn. We begin to get population-level data using systems approaches that allow us to answer the question, does it work, or does it not work? So, the partners are important. But the measurement is what drives the focus.

Everybody meets. Everybody talks. 30:00

Uma Kotagal: I go to a lot of sessions, and everybody meets, and everybody talks and then six months later you go back, and everybody meets, and everybody talks and that's that there's so much money and time wasted that if we started with, so for instance, we, our four goals are pretty tough to move. But they're working hard to move them. So, at third-grade reading measure, we have to partner with the schools, right? So, to partner with the schools, we have to build improvement capability in the schools themselves, which means we have to build relationships and trust because the superintendent of schools was asking, who the hell are you? Why are you coming into my space and telling me that I should improve third-grade reading? So, I have to go into that space with humility, trust, and a shared belief that she and I are interested in children's well-being because we would not be where we were. And then I can introduce how you want to know if we were successful, that's measurement, right? And she says if my third-grade kids move from 45% to 70%, that will be a total success. The measurement comes into the dialogue all the time. It comes in many ways, and there's no way you can change the system without coming to terms with that.

Health Hats: You need a barometer. Yes.

Uma Kotagal: You did something good.

Health Hats: Yes, of course. That's helpful. Thank you for that.

Co-creation 30:43

Uma Kotagal: That's the first principle. We got to solve problems. And then, for us to be able to align the communities, they have to be co-created by the communities. It can't be us going in and saying, I got the measure, don't worry about it. We got to sit down with the superintendent, and she says, if it's this, how will I measure that? We're looking at mental health in schools as an essential thing for children to learn. Cause to be literate, you gotta be present and to be present. Then we'll have measures around disruptions in the classroom and understand that the classrooms' working well. The measure of third-

grade reading was a partnership between Cincinnati public schools and us. It wasn't my measurement asking the questions. It was their measurement. And because the evidence is very clear about that third-grade goal, then we could unify around it. And once we take that measurement and break it down, we know that the kids have to be in school. We know that if there's a gap, the teacher has to know that she's got 15 kids that don't understand what's going on. You got to have reading specialists that come in and help those kids. But now we can design the system because we said that we're going to move our third-grade goals from X to Y. And they know what it's going to take to do it. It's just, don't do it systematically, but by measurement and quarterly measurement, and then looking at the kids that aren't doing well, we build more theories and improve. So, without measurement, and so many people across the country do this work with no measurement, just conversations and musing and writing about it. But to do that, you have to engage the people.

Health Hats: Yeah. Thank you. That was very helpful.

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San Antonio 2020 33:59

Tania Dutta: I just wanted to give a different example. Our principle about co-creation is about co-creating to center the values, needs, and priorities of communities. Another use case that we worked on was on the San Antonio 2020 initiative. And this is a citywide initiative wherein 2010, the city government partnered with community representatives. And they had established a citywide goal to improve the health, education, and economic opportunity of people in San Antonio. And it was a very broad goal, but the way they did it was they engaged community members from 11 different neighborhoods and brought them together. And along with that, city leaders and other stakeholders came up with 62 measures that were of relevance to the community. The community was not involved in the technical aspects of the measurement. But they said, okay, this is what we need to do. These are our priority areas, and this is what we want to improve. So, they took that information and then figured out, okay, how can we make this work? How can we meet the goal of this initiative? And not only did they record all of this information and share it back with the communities, but periodically every year, they shared it with more than 150 local organizations. Then they adopted their priorities to meet this community vision. So after doing all of this work for ten years, and last year, so in 2020, they went back to the community and talked to them. Okay, this is where we started ten years ago. This is what we've achieved. Should we continue down this path, or do we need to change our priorities in some manner? So that's another example that struck me because the community was involved from the beginning throughout the process.

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Lessons learned for other communities 36:11

Health Hats: The use cases gathered for this project sounded like they were already mature community efforts, and this project was drawing on their expertise. How is it that now that the project has been completed and you've published something, how will the word get out to other communities and other initiatives that can use this roadmap or these guidelines? What can we learn that we could share with other communities about how to go about doing this?

Tania Dutta: We have currently worked on a lot of those dissemination activities. We are presenting at conferences, which are attended by yes. And we are doing things with community-based organizations, presenting at conferences that they attend. In addition, we are doing two listening sessions. This month, we're again inviting like practitioners. There may be initiatives that are not as advanced as Cincinnati's All Children Thrive. But they want to hear about this work and see what principles they can take and how to move. That'll help them move this work forward. So the listening sessions again involve community members. If you're going to hear from them, what do you want to see system leaders do? What do you want funders to do for them? Or we may hear some barriers that are our barriers and if you're not able to do these things because of XYZ. So those are the listening sessions that will happen.

Listening sessions 37:58

Health Hats: Oh, I so like that. I'm on the Board of Governors of PCORI, the Patient-Centered Outcomes Research Institute. The question I asked at the last meeting was if one of the things we're trying to do is healthcare communication. Communication is not just unidirectional. We did this work. Here it is. It's listening. And what is the science of listening to communities? And I will be very interested in a month or so; if you don't mind, I'd love to hear from you again about what you learned in those listening sessions and how you did those listening sessions. I think we suck at listening. It's hard for people who are experts, I believe, often to listen. And how does that happen? So, I'll be very interested in what's working for you in your listening sessions and what isn't? These kinds of projects are often you publish a paper, and it's the endpoint, you did the research, you did whatever it's, that's it. That isn't it., it's only the beginning. It's who's going to use it, not what are they going to use it? And how did it work? And, maybe it worked for these five inspiring community initiatives, but who's to say it's going to work everywhere.

Brilliant ideas insufficient. Roll up our sleeves. Trust and humility. 39:22

Uma Kotagal: I wanted to say I think that, when we are thinking about improvement and measurement and impact, we are intentionally designing for it, and so when we are thinking, so when we're saying let's take the city of Cincinnati, and it's home to 66,000 children, more than 40% of whom live in poverty. And our goal is to transform their trajectory. And we believe that third-grade reading is the first space to do that work. If we start with that premise, that's just the first step. And the second step was to engage the people whose work it is to say, I think you can do better. Here's how we could help you. Huh? So that you build the will, Cincinnati public schools say, I want to get all my kids graduated. I don't want to have a 63% rate of third-grade literacy. Let's talk about that. When we do that, we, as improvement experts, but not content experts, have to be humble, collaborative, and collegial and learn

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to build that partnership. The work of transforming community it's not going to come simply from brilliant ideas. It's going to come from rolling up our sleeves and working together, understanding how you work. Oh my God, if you do it this way, here is an opportunity that I could leverage. And so when we are working with teachers to change how they teach, when we measure literacy changes every two weeks to see what's happening, we begin to not think about a monolithic process but an engaged process in which everybody works. And without the community, co-designing work, it can't just be three nerdy pediatricians from Cincinnati Children's coming in to say I got the answer, right? It's their work. We bring some tools that have been very helpful for us to transform the healthcare that we're known for across the country. So, the measurement matters. The alignment matters. The principles that Tania's described have to be actuated in the context of the work. But at the end of the day, to actuate those principles, it's about trust. It's about collaboration. It's about learning. It's about humility, and importantly, it is about the people who know more than you, telling you what's going on. In our case, in the hospital, it's parents telling us, Hey, I don't know why you do it this way. It doesn't work for us. And I was listening and saying something different for kids in schools. It's the people learning how to do that, so looking at the system, understanding it, and agreeing to the measurement. Without that, you can't proceed, but once you do that and build the collaborations, you can transform systems. And there's a fair amount of evidence and a reasonable amount of research and experience in doing that. Because it's by setting the goals and doing the necessary work, the systems will change, but maybe they looked at the data only once every three months. But if they look at the data every two weeks, you might pick up some seriously important things that they could use. So that's the work, the trust-building the generosity, that's the soft side, the decency building the capacity.

Technical side of improvement 42:37

Uma Kotagal: Then there's the technical side of teaching improvement. How you measure? How do you keep a run chart? How do you run a PDSA that allows you to know if your theory is working or not? When both of those parts. Plan Study Do Act. Exactly. When both of those Plan Do Study Act, so when both of those come together, I think then we see, we have the compassion and the understanding and the learning and the trust and the collaboration. But then we have the methods that enable people to try and test and learn to change systems. And when people get activated in that way, because, oh my God, I didn't know, I could do that. Wow. Here's my chart on this little kid. Do you want to see this little kid's chart? Last year he looked like this year, look at this chart. All kinds of causes happen, and that is what kind of systems change requires both the soft and the technical sides.

A seat at the table, not on the menu 43:39

Health Hats: Before we end. I want to ask you what should we have talked about that we didn't Tania what didn't we talk about that we should have around this?

Tania Dutta: I just wanted to reiterate the importance of equal partnership with community members. So when we were talking to community members and community-based organizations in this work, they express the importance of systems working with the community. And one community member said That we need to have a seat at the table, not on the menu. Yeah.

Health Hats: I saw that. That was great. I liked that I'm not on the menu.

Tania Dutta: Not on the menu, and that stayed with me. You're a good cook. Yes. So, I think that's what I want to do, and on, and I just wanted to make a note that this is just the start. And a lot of work still needs to be done as you're moving in this direction. And the work is messy. It won't happen overnight. As Uma said, we to be patient and humble as we embark on this journey and, it just needs a lot of work. It's just a start as you're moving towards achieving equitable outcomes for all.

Leadership. Willing to see and act. Build capacity. 44:55

Health Hats: I have to ask one more question. I'm thinking back to my career. I participated in stuff like this. And I'm thinking about how important the role of leadership is, community leadership. When stuff like this works, it's the CEO at a hospital cared, a town manager cared, a police chief cared, it was like, there was somebody that had either formal or informal authority and charisma, who cared and was willing to bring people together and then bring in skills that weren't present, that was needed. And then it what you, what do you think about that?

Uma Kotagal: Three things I think about the first I think about is learning to see. Learning to see, yeah. Cause there's a lot of times when it's all around us, but we're not willing to see, we're not willing to say third-grade literacy rates in Cincinnati are X. Why are they that low? Why is the gap between black and white? So, I think the learning to see part of it allows you to activate your, like suddenly, you notice now you say, oh my God, I saw this. The other day I noticed that this is real. I didn't realize it was real because I was in my little cocoon and doing my things and, I didn't know that black. So, the first one I think is learning to see that's true for anybody that wants to make improve of the time, the people who do improvement succeed in improvement is because they can see. And are willing to admit what's happening. I think the second is to be willing to act. Many times, people are writing papers, describing stuff and moving on, and writing the next paper. There are hundreds of papers written about a topic already, but nobody's doing anything about it or just re documenting and re documenting. Oh, it used to be 40% now it's 42%. Oh, so the second thing is being willing to act. The learning to see. Be willing to act. And the third thing is all about generosity, compassion, and sharing. It's not like I'm the boss, and I know what to do. So just listen to me. It's like giving the tools to everybody. Every teacher in the classroom can say, Hey, I ran this PDSA say, and here's what I learned. And tomorrow I'm going to do my class differently. To transform systems, I think you have to learn to see, be willing to act, and build that capacity of a hundred teachers. If you look at our children's hospitals were, 140 children's hospitals across the world participate in the last, I think week, previous ten years on reducing harm. And children's hospitals, you go to Australia, you go to the UK, you go to the app, or wherever you go, you'll see this happening. And we started that as a tiny thing in a single hospital. So those are the three things I think in addition to everything that Tania has talked about and that you have reflected on, I would say are important.

Health Hats: Thank you. This has been great. I learned something.

Uma Kotagal: Thank you. Thank you, Tania.

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Tania Dutta: Thank you so much.

Reflection 48:23

When I led Quality Management at St. Peter's Addiction Recovery Center (SPARC) early in this century (yes, I feel old, seasoned, whatever) we found ourselves seriously underwhelmed with the results of a HEDIS measure, <u>outpatient follow-up after inpatient discharge</u>. The idea: people discharged from behavioral health hospitalization (serious mental illness or detox), would fare better if they had a follow-up appointment in a clinic with a therapist within 30 days. SPARC sat at 25% follow-up - disappointing at best. Under the leadership of Bob Doherty, we convened a community initiative with people who had been discharged, inpatient clinicians, outpatient therapists, emergency medical personal, police, housing professionals, etc. The short story: this community collaboration resulted in improvement from 25% to 75% follow-up in about two years.   As Uma and Tania described: simple and frequent measurement, community participation and action, learning, and adjustment. On the other hand, I often found myself in other settings as Quality lead asking, why are we measuring all this stuff? They're not motivating or informative. We measure because we must. Most of our energy goes to deflecting blame, trying to look good, not improving anything - so discouraging. My experience with SPARC met many of the <u>Guiding Principles to Align Systems with Communities to Advance Equity through Shared Measurement</u>.

1. Requires up-front investment in communities to develop and sustain community partner capacity.
2. Is co-created by communities to center their values, needs, priorities, and actions.
3. Creates accountability to communities for addressing root causes of inequities and repairing harm.
4. Focuses on a holistic and comprehensive view of people and communities that highlights assets and historical context.
5. Reflects shared values and intentional, long-term efforts to build and sustain trust.

Thank you, Robert Woods Johnson Foundation, A.I.R., Uma Kotagal, and Tania Dutta for this fine work. I look forward to hearing and sharing more about your listening sessions. Onward.

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