Health Commoning: Confronting the Polycentric Challenge in Bloomington, Indiana

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Revised April 25, 2014

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Prepared for presentation at the Spring 2014 Mini-Conference, The Vincent and Elinor Ostrom Workshop in Political Theory and Policy Analysis, Indiana University, Bloomington, May 5, 2014.

*Note: This paper was written by Joan Pong Linton and Michael D. McGinnis, but it builds extensively on a draft dated Jan. 2, 2013, co-authored by Linton and Carrie Ann Lawrence. Lawrence has not been able to comment on this particular version, but we felt it was essential to recognize her critical contribution to this research.

The authors acknowledge the generous support of The Fannie E. Rippel Foundation (of New Jersey) and The Vincent and Elinor Ostrom Workshop in Political Theory and Policy Analysis, and other units of Indiana University Bloomington (which are listed in the paper). However, none of these organizations bear any responsibility for the conclusions expressed in this paper, for which the authors are solely responsible.

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Abstract

Commoning is the process of collectively reconceptualizing and reorganizing an existing array of resources into a shared space, to be managed as a form of common property. This paper reports on our ongoing efforts to help catalyze such a transformation of the health and health care system around our home community of Bloomington, Indiana. An action research approach was applied in study of local health needs and the development of a web based community health information commons. Researchers from Indiana University along with community partners from city government, local agencies, public health professions and health care providers met to discuss common goals and collaborated to address key findings. The aims of the study were to identify and prioritize local social determinants and behaviors related to health outcomes and facilitate the development of a collective community based project. Using primarily qualitative methods, including in-depth interviews and discussion (focus) groups, the researchers assisted the community partners in identifying the components necessary to create, maintain and establish a way to gather and share community health information while promoting health. The results of this process have been disappointing, and this paper summarizes both positive and negative lessons that we have drawn from this experience. We hope this paper can inform other communities striving to facilitate collective action to improve their local health systems.

Keywords: action research, collaboration, collective action, commons, community health, health information technology, private-public partnerships, polycentricity, qualitative methods, stewardship

Bloomington hides a large poor segment that is underemployed, undereducated, with no insurance, preventive care, and transportation.

We need a movement to move the community on making behavior changes that are crucial to health.

Life gets in the way of people making the right choices.

The comments quoted above are taken from focus group meetings with health care professionals and community leaders from our home community of Bloomington, Indiana. These sentiments may come as a surprise to many students and faculty at the Indiana University campus, few of whom are fully aware of the significant pockets of poverty that remain in and around this otherwise prosperous college town. But we selected these focus groups to include people who deal with these problems on a regular basis, and who thus have a more complete understanding of the true nature of health and health care in this area. This paper reports on our ongoing efforts to help catalyze a community-wide conversation about how existing and potential new resources could be more effectively mobilized to address the health needs and concerns of all members of this community. This story remains incomplete, and we have experienced significant frustrations along the way. In this paper we attempt to draw lessons, both positive and negative, from our experiences in this action research project.

This project originally began when one of us (McGinnis) obtained grant funding from The Fannie E. Rippel Foundation (http://www.rippelfoundation.org/) as part of that foundation's long-standing support of innovative thinking in the area of health and health care. McGinnis was principal investigator of the Managing the Health Commons (MHC) research project, and he also became closely involved with the ReThink Health initiative (later recast as an alliance or learning community), a group of academics and leadership consultants involved in health care reform efforts in several communities around the U.S. For this MHC project the plan was to investigate regional collaboration, or the lack thereof, in three communities. Two of these communities (Grand Junction, Colorado, and Cedar Rapids, Iowa) were selected because they had been nationally recognized as exemplars of high-quality health care delivered to the citizens of their communities at an unusually low cost, as determined by the researchers involved in the *Dartmouth Atlas* project, which has demonstrated the surprising level of variation in quality, utilization, cost, and outcomes of health care in different regions in the U.S. Our intention was to learn more about how these two communities were able to achieve the status of being "positive deviants" within this distribution, by combining high quality and low cost.

Practically speaking, these two communities were selected because healthcare leaders from these two communities were already participating in an informal discussion group on these topics, a group in which Elinor Ostrom played a significant role. In those discussions we were exploring whether or not the implications of her Nobel Prize winning research on community-based management of natural resource systems might or might not be extended to help understand how leadership groups in some communities have come to realize better stewardship of their healthcare-related resource base.

Bloomington, Indiana, was also chosen as a case to be studied in the MHC project, basically because of its convenient location, as because of our intrinsic interest in learning more about our own local community. But we soon learned that the case of Bloomington was different in that the scope of community collaboration on health-related matters was primarily focused on questions of public health, and that the health care delivery system was instead dominated by competitive pressures and economic concerns. This system is dominated by Bloomington Hospital, which during the course of our study became affiliated with IU Health, a state-wide hospital and health care system that was engaged in more

competitive relationships with other hospital systems in Indianapolis and other metropolitan areas throughout the state of Indiana. Executives of IU-Health Bloomington see their facility as the core service unit for a ten-county area of south central Indiana, an urban and generally poor region.

Monroe Hospital, a newer, for profit hospital located just outside of Bloomington, specializes in certain kinds of medical care, and thus does not serve as a full-scale competitor for IU-Health Bloomington, and Monroe Hospital is not as well-connected to the community. Premier Healthcare (previously known as IMA) is an independent association of many of the physicians in the Bloomington area, has retained an arms-length relationship with IU-Health Bloomington, which has begun to hire more of its own physicians, including a new association that is directly affiliated with the IU Health system. The three largest local private employers are also in a strange relationship with the health care system: IU-Health Bloomington itself, Indiana University is connected, indirectly, to IU-Health through the IU Medical School on the Indianapolis campus, and Cook Group, Inc., is a self-insured corporation specializing in the production of stents and other medical devices.

Given this configuration of the major institutional stakeholders, the kind of top-down, CEO-driven cooperation found in Grand Junction and Cedar Rapids is simply not feasible in Bloomington. But there are problems with building the requisite level of cooperation from the bottom-up as well. In one sense, Bloomington might seem to be a great candidate for bottom-up efforts at health reform, given the strong tradition of community-wide cooperation on a wide range of public health issues, especially regarding recreational facilities, local food, and an early adopter of anti-smoking legislation.

But the more we looked at the programs extant in Bloomington, the more it looked like the syndrome of program-chasing that is so familiar to students of local economic development or international development assistance. Local community organizations have proven quite adept at obtaining funding from local, state, and national philanthropies. Our interview list included several members of the ACHIEVE team, which had been established a few years earlier and which had been successful at obtaining significant funding from several prominent sources. Their local programs included such things as its annual health and wellness assessment of the Bloomington/Monroe County community, with data and resources made available to community partners, as well as its disbursement of mini-grants to community on projects that address health policy and environmental and systems changes aimed at improving individual health choices and behaviors (ACHIEVE website).

Initial success can sometimes turn out to be self-limiting, and we were beginning to wonder if that might be the case in Bloomington. More generally, it is well established that most funding organizations, either private, philanthropic, or government agencies, tend to change their priorities frequently, always in the search for the newest thing that might generate the most buzz in the relevant populations. Most funders tend to lose interest in old programs, even successful ones, and are much more interested in developing new and innovative programs. Unfortunately, once external funding runs out, many local programs fade away and die, even if they had been successful at fulfilling their original mission, simply because no other source of funding support appears viable. Instead, the attention of the same community entrepreneurs that built earlier programs shifts towards the task of identifying new programs, and filling out applications for a new round of funding competition, directed (at the funders' behest) on some other set of goals. What is missing is any sustained effort on the part of local leaders to institutionalize these initiatives, to exert the effort needed to make those programs sustainable.

In our analysis of the reasons behind the long-term success of Grand Junction, Colorado, we identified a contrasting focus on making sure that certain high-priority programs are funded, by local provider organizations if necessary, once external funds dry up. McGinnis (2014) concludes that this sense of collective ownership of a few critical programs lies at the heart of the Grand Junction model of top-down collaboration on health care, driven from the top-down. It was our intention to help catalyze a similar

sense of a long-term community resource stewardship perspective in Bloomington, but, as will be detailed below, that effort has not yet proven to be very successful.

In Grand Junction and Cedar Rapids, graduate student members of the MHC research team (Ryan Conway and Claudia Brink) conducted interviews with health care professionals and community leaders in their respective regions. In Bloomington, graduate student Carrie Lawrence and Workshop affiliate Joan Linton conducted interviews with health and social care professionals and community leaders as well as IU faculty and staff. The activities reported in this paper went well beyond these initial interviews. In effect, we used the connections we established through the interviewing process to identify and bring together particularly energetic and committed thought leaders in what we hoped would be an effective team to lead a sustained community-based effort to transform the nature of the local health and health care system.

This story went through four phases, thus far, and we will detail each of these below. Briefly, in Phase I, we identified some of our MHC Bloomington interviewees for later follow-up discussions. For Phase II we formed nine focus groups from those who proved most interested in participating in additional efforts, and asked one representative from each of these focus groups to join us in a plenary session to set priorities for sustained effort at community action. Phase III began with the formation of a steering committee that further honed one of the high-priority items identified in the earlier phases, specifically the establishment and maintenance of a Health Information Commons directed at general public use. By this time the funding for the MHC project had been exhausted, and for Phase IV one of us (Linton) took the lead of securing additional funding from university sources. A day-long conference was held and an initial website is still being developed. At this point our research team effectively lost control over this health information commons (for reasons to be detailed below), which could be interpreted as either good or bad (or, more likely, a little bit of both. For the near future we envision moving to a Phase V focused on working with the service-learning office of IU to encourage undergraduate students to get involved in community projects related to health and health care. In this way we hope to institutionalize a connection between town and gown, and to sustain these efforts with a steady stream of new energy from new cohorts of students.

The next section provides a brief overview of relevant research literatures, but the bulk of this paper is devoted to exploring each phase in turn. We conclude with some general observations, and share the lessons, both negative and positive, that we have drawn from this experience.

A Brief Review of the Literature

In this action research project we facilitated community level conversations around priority health concerns and provided opportunities to share information, pool resources within and outside traditional health care services, and collectively act to improve the health of local community members. This process created a synergistic movement to strengthen human and social capital needed for public-decision-making and problem-solving. Lastly, this model may help to combine the efforts of upstream, midstream, and downstream approaches to develop policy, best practices, and improve health of community members while reducing health inequalities and reduce health related costs. Encouraging community level collaboration and collective action with this type of model is important for encouraging inclusive local partnerships to work together while addressing health determinants at local levels. However, these efforts need to be given the necessary level of resources and the enabling guidance that this type of model may provide.

In response to the continuing rise in health care costs and the current mandates in health care service delivery, communities around the nation continue to explore innovative methods of improving

community health and health care information gathering and sharing through community level coordination. Patients, health care providers and local community leaders can establish partnerships in health rather than the individual episodic medical intervention based health care environment which currently is the norm in this country. Community led initiatives have demonstrated their ability to develop and sustain practice of collaboration that enables them to manage resources, which is critical to their long-term survival (Krishnaswami, Simmons & Joseph, 2012; Wallerstein & Duran, 2008; Freeman, 2001). The primary objective of this project was to develop and enact a comprehensive model of community level health improvement by identifying and connecting a diverse group of community members interested in improving health outcomes within one specific community.

A variety of collaborative community partnerships in relation to improving local health outcomes have been examined in the research literature. Within the public health field, the ability of engaged and active community members to encourage transformation in costly community wide health issues related to individual behaviors (diet, exercise, and preventative health screenings) illustrate that informed decisions can influence improved population-level health outcomes (Roussos and Fawcett, 2000; Butterfoss, Goodman, & Wandersman 1996; Lasker, Weiss & Miller, 2001). Additionally, the importance of such partnerships is emphasized to ensure the success of community-level health interventions (Curtis & Jones, 1998). As communities identify health priorities and develop local interventions, such partnerships are essential in the examination of individual community's abilities to leverage existing resources needed to address health concerns. These types of community partnerships are seen as an important component for building local capacity and engagement to address community health issues (Francisco, Paine, & Fawcett, 1993). Encouraging local collaborations to frame their identification of health issues within the local context and develop a focused-response sustainability plan may lead to viable and quality health interventions (Bushy, 2000; Ricketts, 1999; Eberhardt, et al., 2001, Fryer, et al., 1999; Lovett, Haynes, Sunnenberg, & Gale, 2002; Lin, Allen, & Penning, 2002).

The current research in traditional health policy supports community collaborations that collectively develop and implement creative, effective, and sustainable solutions which improve individual health and health care system challenges (Silow-Carroll, Waldman, & Meyer, 2001; Alexander et al, 2001; Shortell et al, 2002; Clark et al, 2010). Such partnerships share and use information which can inform policy development based on issues of concern to the communities involved. Promoting community partners' ability to engage in advocacy efforts utilizing their knowledge of local context, these partnerships generate opportunities to mobilize community members and organizations to advocate for health related policy change (Freudenberg, Rogers, Ritas, Nerney, 2005; Minkler et al, 2008). Additionally, these types of community partnerships may increase the integrity and emphasis of community policy initiatives with policymakers and the larger community (Themba-Nixon, Minkler, Freudenberg, 2008; Israel et al, 2008).

Elinor Ostrom's work on "managing the commons" and coproduction has proven applicability across diverse fields of research and practice. Its applicability to health and healthcare is explored in the present study. Our focus on the development of a Health Information Commons provides a relatively simple entry into the complex economy of healthcare, which defies easy categorization into purely private or public goods, club good or common pool resource. While the internet is not so much a common pool resource as it is a combination of private and public goods (Axelrod 2010), a digital health information commons comes closest to providing a public good. The information it produces is not subtractable and is potentially open to all users, although access can be a limiting factor. Insofar as building this web-based commons requires leveraging of human and financial resources among community partners and across community organizations, collective action studies have generated diverse models to analyze structural variables that affect individual behaviors and the likelihood of cooperation. These studies reaffirm "the core variables of reputation, trust, and reciprocity," and indicate that "at any one time multiple variables affect [these] core variables" (Ostrom 2010).

We also draw on the influential work of Marshall Ganz (2007, 2010), a community activist of considerable renown. Ganz was instrumental in helping organize the migrant farm labor movement led by Caesar Chavez a few decades ago, and more recently in the innovative fund-raising candidate that supported both of Barack Obama's Presidential election campaigns. For our purposes, we are especially drawn to Ganz's emphasis on a movement's need to build a compelling and shared narrative, by beginning with participants sharing their "story of self" as a basis for building towards a shared "story of us" and then a transformation of this goal into a practical campaign plan as a "story of now." In our project, this step was especially critical in the transition from Phase II to III, as will be clarified below.

In implementing our web-based project, there is no lack of health information exchanges to draw from in organizing a Health Information Commons, and studies also point to the uses of social software as a means of coproducing web-based information (Pellegrini 2007). Coproduction on the web serves as a crucial basis for the coproduction of health and social care, an area of growing interest among care practitioners who see this as a means of value creation where traditional economic thinking has run aground (Stephens, Ryan-Collins, Boyle, 2008; Loeffler, Taylor, Gooby, Bovaird, Hine-Hughes, and Wilks, eds., 2012). Finally, studies in health communication and health education attest to the value of developing community-based interventions attuned to the needs and circumstances of local cultures. Such holistic, culture-centered model is more likely (than the bio-medical model) to be effective in affecting individual behavior and promoting culture change, that is, from a culture organized around treating sickness to one organized around promoting health and wellbeing (Dutta, 2004. 2009).

An Overview of the Action Research Process:

The community has established many community-wide initiatives which have demonstrated diverse yet independent approaches to improve the health of the individuals who live within and around the community. The current case study utilized methodologies from community based participatory and action research approaches, and concepts from deliberative democracy (Israel et al, 2008; Ryfe, 2005). These qualitative methods included in-depth interviews and focus groups. Thus far four distinct phases have been manifested:

Phase I

1. Identification and engagement of key community members involved in the health care system or community level health promotion programs. Then, 60 semi-structured interviews through a snowball sampling (Bernard, 2002).
2. Analysis of interviews using thematic analysis (Daly, Kellehear, & Gliksman, 1997) and participants divided into focus groups to represent a cross section of the community and through like-minded themes identified in the individual interview. Analysis of findings and recommendations were presented to focus groups prior to group meetings.

Phase II

3. Focus groups were conducted through deliberative dialogue: participants shared their experiences and had the chance to modify researcher findings (some did). In addition, using a deliberative democratic approach (Blee and Taylor, 2002), each focus group developed priorities areas with possible solutions and decided on an action item. Each group then elected a member to represent the group's health priorities and action item in a meeting of group representatives.
4. A plenary session with focus groups representatives was held to review priority areas and action items, to come up with a potential project that most fully encompasses the goals of the action items over the short and longer term, and to develop an action plan to promote collective action in the community towards implementing the project.

Phase III

5. A steering committee of our participant pool was then convened to explore the necessary resources and refine the proposed project, building and maintaining a community *Health Information Commons*. Multiple meetings were held to address challenges of the proposed project as well as exploring the types of capital needed to implementation and ensure success of the project.
6. All of the participants were invited to a culmination event to disseminate findings and share the details of the plan. Participants to come up with a list of "needs" and advice on where and how to leverage community resources to implement the project.

Phase IV

7. We convened a day-long conference with broad participation from the community, including Indiana University's Bloomington campus. The goal is to secure campus-community partnerships to create the website, fill information needs, and define what success means and how it is measured.
8. Initiate and track progress of community action plan over time to provide a descriptive analysis of process.

We now discuss each of these phases in more detail.

Phase I Findings: Interview Themes

COLLABORATION ACROSS ORGANIZATIONS

In our interviews with some 60 community leaders, participants reported a broad range of collaborations, from promoting health awareness and healthy behaviors to sharing information and resources in serving clients, to shared investments in new health care delivery and/or coverage for employees, etc. Many of these are successful and still ongoing, and they seem to far outnumber the failures. Respondents pointed to a number of factors that account for both successes and failures:

1. *A shared goal:* where there is a goal that everyone agrees to, it grounds a plan of action and brings partners together across differing institutional missions. This also means that there should not be any hidden agendas. Where there are hidden agendas and a lack of transparency, trust is violated, and as a result people are unable to work together; plans fall apart and "nothing gets done."
2. *Buy-in from the top:* throughout the interviews participants reported that those who are around the table must have either direct power or influence that directs decision making and allocation of resources. Many participants cited ACHIEVE as the model.
3. *Communication:* in successful collaborations communication must be constant and transparent. All partners have a voice and their opinions are heard and respected. The coordinator keeps everyone informed on developments, especially when some people can't make a meeting. Conversely, as one participant puts it, "when stuff fails, it's always communication."
4. *Networking and continuity:* relationships are formed or are in existence prior to the collaboration. It was reported that some of the best ideas were developed over a casual lunch. In some cases, this social dimension to networking allows for collaborations across networks. By the same token, it may also mean that some groups are less open than they appear. The continuity of relationships builds largely from consistent and regular meetings, whether they consists of all of the members of the collaboration or subsets. Several participants noted continuity of relationships as a success factor for an existing health initiative. Others identified the high staff turnover in community organizations as a key factor in less than positive partnerships.

While reports on collaborations were predominantly enthusiastic and positive, participants also mentioned factors that limited collaborations.

1. Many participants mentioned governmental policies as a limiting factor among governmental agencies, between these agencies and other entities in the community, and among non-governmental organizations. For example, gaps in sidewalk construction often come down to boundary issues and resource disparities between the city and the county. On a national scale, one participant felt that “the pendulum has swung too much toward one model fits all,” and would like “too see government support local decision-making.”
2. Another limiting factor has to do with economics. One participant raised a point about collaborations that should happen but don’t because community organizations are competing for funding. This also happens on the level of large healthcare providers within the community; some participants cited the competition between physician groups.

ISSUES AND PRIORITIES

Participants talked about both issues that are directly related to health and healthcare, and issues that indirectly impact people’s health in the community. Their comments reflected a shared awareness of health and healthcare as part of a broader community ecology—a community that, for most of the participants, extends beyond the city of Bloomington to surrounding counties.

Most of the health issues identified in the Bloomington community were right in line with CDC and the WHO priorities (U.S. Department of Health and Human Services, 2011). Health issues included mental health, prevention or wellness, maternal/child health, our aging population, access to health, and uncertainty regarding the sustainability of the nation’s health care system and the impact of national health policies may have on local communities. In confronting these issues, some participants turned to models that emphasized holistic health and preventive care, others would like to have a public conversation on needs and costs. While perspectives may differ, there seems to be an emerging focus on the need to affect policy relating to health and health care.

Summary of Phase I

As a result of the emergent themes described above the research team developed the next phase of work which further explored the main issue raised of improving communication and coordination of programs and services. The team also explored social networks and uncovered possible leverage points by providing a larger conversation that may develop integrated care pathways to improve health in the Monroe County/Bloomington community.

Phase II Focus Groups: Facilitating a Conversation around Health

In spring 2012, Carrie and Joan organized a round of nine focus groups, drawn from our interview pool, asked each group to select a representative to a second round of focus group discussion, in hopes the end result will be a package of concrete proposals that might address many different aspects of the local situation. We have begun looking at this in terms of a variation on the basic themes of deliberative democracy.

As summarized below, each of the nine focus groups came up with different priorities, although they clustered around some kind of health information commons (to gather and disseminate data for providers

and citizens), wellness co-op, and miscellaneous public health campaigns (children and maternal health, elder care, better coordination of funding sources).

ACTION ITEMS FROM THE FOCUS GROUPS

1. Create a co-op that extends health/wellness services to community, especially the uninsured and underinsured. Begin with a “champion,” get business buy-in then apply for funding. Assessment and medical information exchange will be key components.

2. Create outcome–management databases that employers, policy makers, and health care professionals can mine: what types of services are needed and who needs them? How is service provided? What is appropriate care?

3. Target children (especially from vulnerable populations), and engage them to learn about health, possibly using games to motivate them. The schools have done a lot, but we should not take time out of classes or add burden to teachers. Perhaps use IU students in service-learning classes.

4. Address poverty as major issue in changing behavior. Have one-on-one conversation with clients at service agencies in order to learn about barriers they face to accessing health and other services. Instead of top-down studies, start by asking people we serve what their needs are.

5. Addressing maternal and child health: develop some type of assessment of people who are not utilizing health care services or other health-related programs in the community. Focus on culture and health disparities.

6. To expand communication among providers: organize forum of healthcare providers in related services (not just physicians). To improve patient-provider communications, bring funding and training together; ensure interpreters are trained with cultural and medical knowledge.

7. Explore feasibility of extending “Personal Pathways” course to the community, especially to people from poverty. Program can be tailored to the needs of specific groups, and uses trained people to can relate on many levels.

8. Have community health workers to represent people, work around barriers. Focus on older adults and end-of-life – primary care and palliative care. This addresses delivery of care beyond what hospitals can do.

9. (a) Create mechanisms to streamline funding from sources to relevant agencies, and create a more coordinated approach to funding applications; (b) figuring out ways to do effective messaging (in “selling the invisible”) and to incentivize participation.

In May, 2012, we sponsored an initial meeting of a group of representatives selected by each of these focus groups, to try to come to some kind of specific direction for future collective action. To facilitate these discussions, we distributed a full summary of where the focus groups agreed; how they defined “culture”; significant culture changes already taking place that they had observed in the Bloomington community; what they saw were requirements for culture change; and what needed to happen to incentivize individual behavior change towards making the healthy choices (see Table 2).

In our discussion leadership efforts we were inspired by the pioneering work of Marshall Ganz, a well-known community activist leader. This table is organized in terms of a sequence from a *"story of self"* → *"story of us"* → *"story of now"* in order to emphasize the shift we were making from the interviews (and even the focus groups) to a collective story that has some element of urgency to it (the story of NOW)

During this and subsequent discussions, representatives from the 9 focus groups met and came up with a smaller set of priorities that seemed especially promising for immediate action:

- to shift culture from sickness removal to health and wellness co-production
- by coordinating collective action across organizations and community groups
- in order to improve the quality of health and wellness in our community

Further discussions resulted in a consensus on a single priority, namely, the idea for an online Health Information Commons and how the interrelated action items from the focus groups contribute to such a commons. The logic that lay behind this proposal is outlined below, and illustrated graphically in Fig. 1.

The proposed community Health Information Commons was intended to

- Collect and disseminate health and wellness information across different levels (basic support for all of the action items)
- Provide data on kinds of services needed, who needs them (Action items 2, 6)
- Address delivery system: where services are available, and what is appropriate care (Action items 2, 6)
- Facilitate collaborations in community-based research on health and wellness issues (support for all of the action items)
- Enhance communication and collaboration among health and wellness professionals (Action item 6)
- Help consumers access information about health and wellness issues and services (Action item 3, 4, 5, and 9b)
- Bridge health education and behavior change through culturally appropriate messages (Action items 9b especially, and other action items generally)
- Improve collaboration across organizations on grant applications and other funding issues (Action item 9a)

This Health Information Commons could provide the basis for

- Assessments of ongoing initiatives, with attention to social determinants of health (Action items 2 and 6)
- Planning of new initiatives, e.g. extending Personal Pathways to vulnerable populations (Action item 7)
- Planning for new personnel, e.g. Community Health Workers (Action item 8)
- Creating new models of care, e.g. a health and wellness co-op (Action item 1)
- Connecting models and practices to policy (support for all of the action items)

Phase III: Transition Towards Coordinating Action to Promote Better Health and Wellness Outcomes

In June, the research team met with two members from the ACHIEVE leadership who were also members of the more broadly based Active Living Coalition to plan the transition. We helped form a steering committee representing strategic positions within the community:

- The steering committee will steward community collaborations over the long term in moving the community from a sickness to a wellness culture
- members are from the local YMCA, the city (both ACHIEVE leaders); the Active Living Coalition, business (with connection to employees benefits, insurance, legislative compliance); IU Health; IU School of Public Health; and Bloomington's Healthlinc (local health information exchange).
- The research team will continue to support, monitor, and help document the process

In July, the steering committee met to plan. Below are our findings:

- As a group we are still too elite to effect broad-based community action that would produce positive health and wellness outcomes
- We need to engage the community at large by
    - beginning with a forum of the participants from Phase 1 (the interviews)
    - focusing on first steps toward building the Health Information Commons
- To ensure a productive forum, the committee will need to:
    - Work with a network analysis of the participants from Phase 1
    - Draw from a soft-systems approach to managing change
    - Provide a conceptual framework for Health Information Commons
    - Identify others needed in the planning and creation of web-based site that provides the sharing of health related information

Only a few of these potential leads were followed up on, perhaps because the notion of using a systems model, no matter how "soft" that model might be, sounded too academic and impractical. Community leaders on the steering committee started to exert more ownership over the project, and the contributions of members of our research team began, in accordance with the core principles of community-based participatory research, to be less central to the direction of discussions. So far, the committee had managed to tackle a dynamic process of change within a community that is itself a dynamic ecosystem. For this reason feelings of uncertainty along the way were understandable.

The research team served as facilitators of the meetings and, following the lead of the community members, we later proceeded at a pace that the committee felt more comfortable with. Having materialized from these meeting a few prioritized collaborations and resources, the research team has phased out its facilitation of meetings, with the understanding that key community champions would continue the planning process. The culmination event was planned for January 2013, at which the research team would disseminate the research findings and ownership of the project would transition to the champions. In addition, we projected multiple community forums that would be held later in the spring to build campus-community partnerships that would address other priority areas and provide further resources in the creation of the community Health Information Commons website.

As it happened, only one community forum has yet been held, which is the focus of the fourth and current phase.

Phase IV: Planning Community Action with University and Community Support

To secure funding for implementation of the recommended action, in January, 2013 Joan Pong Linton submitted a proposal to the College of Arts and Science's Ostrom Grant Program. The proposal received $6,000 in funding from the Program, along with an additional $1,650 in matching funds from several academic units on campus.[1]

As described in the proposal, the purpose of the project was to engage the Bloomington campus and community in a broad range of course-based and research-based partnerships to begin the work of coproducing a sustainable healthy Bloomington. The first step to achieving this long-term goal was to create a web-based Health Information Commons (HIC) as a means for community-wide information sharing and a basis for coordinating efforts and fund-raising towards improving health and wellness in Bloomington. The proposal further defined a holistic approach to health, one that takes into account diverse factors affecting the health and wellbeing of individuals, and that goes beyond a bio-medical model to address mental, behavioral, social, environmental, financial, intellectual, and spiritual aspects of health. Through culture-centered practices, holistic health aims to engage individuals in coproducing their own health with support as needed from health /wellness and social care providers.

The project would involve:

1. a day-long conference to bring together key participants from the Bloomington campus and community to learn about the HIC project and identify potential partners
2. following the conference, a half-day symposium to promote campus awareness, with workshops led by IU's Service–Learning Program to help new partners devise plans for successful collaboration
3. two speakers, depending on availability, to keynote at the conference and at the follow-up symposium:
    a. Cynthia Barnes-Boyd, PhD, FAAN, director of University of Illinois in Chicago's Neighborhood Initiative and Healthy City Collaborative http://www.ihrp.uic.edu/researcher/cynthia-barnes-boyd-phd-faan
    b. Mohan J. Dutta, Courtesy Professor of Communication at Purdue University, and Professor and Head of the Department of Communications and New Media at the National University of Singapore, and author of *Communicating Health* (2008) and *Communicating Social Action* (2011) http://web.ics.purdue.edu/~mdutta/

The proposal envisioned that the campus and community could partner on this web-based project in ways that were mutually beneficial. While community organizations have a number of needs that they could not readily fill, many of these needs could be filled by faculty undertaking research in partnership with community organizations and by students in course-based service–learning projects. At present, only a small part of these needs is being met by a number of courses in Public Health and Service–Learning. But the potential is there for broader partnership involving all schools, given the diverse areas of needs, and the HIC's emphasis on the full spectrum of holistic health. Furthermore, this project would facilitate new

[1] In applying for this grant, we were also to secure matching funds from several academic units: English ($200); Political Science ($150); African American and African Diaspora Studies ($300); Asian American Studies Program ($500); Latino Studies Program ($300); the School of Social Work ($200). We also received in-kind support Vincent and Elinor Ostrom Workshop in Political Theory and Policy Analysis; the Indiana Memorial Union (in-house advertising, coffee for one program from its Food Service); and Residential Programs and Services (advertising at the dorms, resources for the fairs).

connections between researchers and community organizations to pursue and implement future research projects and grant proposals.

Community organizations would be able to build the Health Information Commons by filling these needs:

- learn from client groups (including especially vulnerable populations) how best to address them and incentivize them to coproduce their own health and wellness
- develop mechanisms for information sharing across organizations and levels
- develop strategies for effective messaging across the spectrum of holistic health
- develop culture-centered communication strategies to publicize health and care services to the public, including especially individuals from vulnerable populations
- devise ways to reach clients on a personal level in order to affect individual behavior and promote personal accountability
- develop mechanisms for coordinated efforts in fund-raising, grant applications, and resource sharing
- recognize community assets and community contributions to teaching, research and promote the development of new and existing knowledge

These partnerships would, in turn, benefit the campus, its students and faculty:

- help to secure further research funding for monitoring, measuring, and documenting the progress and assessing outcomes relating to the HIC and to the long-term shift to a culture of health and wellness for the Bloomington campus and community
- increase opportunities for faculty to undertake community-based research on health and policy issues, as well as Scholarship of Teaching and Learning (SOTL) research projects
- increase opportunities for students to practice the skills of community-based research and networking and, through experiential learning, prepare them as future professionals and citizens
- provide new avenues of meaningful engagement with the Bloomington community as a basis for faculty development and retention
- provide new opportunities for interdisciplinary and multidisciplinary research and service projects among faculty and students
- promote diversity on the Bloomington campus through an issue—health and wellness—that cuts across cultural and institutional differences
- heighten the visibility of IU Bloomington as a 21st century university-citizen

Finally, there would also be benefits overall to both campus and community:

- a healthier community, which translates into higher productivity, lower absenteeism, and better economic health for employers like IU and the community as a whole
- increased trust and reciprocity between campus and community
- strengthened relationships with community organizations to share and pool resources to seed and explore new funding opportunities that are mutually beneficial

Day-Long Conference:

Planning of the community forum/conference took place over the summer and fall of 2013. The Steering Committee secured Cynthia Barnes-Boyd as the keynote speaker, and scheduled the conference for late October. When the speaker went into emergency surgery, the conference was postponed to February 28, 2014, with workshops on planning possible partnerships to follow in late April, 2014, to be facilitated by the IU Service–Learning Program. At one point, some members of the Steering Committee considered working with a small number of health care providers and campus participants from the School of Public

Health. They reconsidered when it was pointed out that funding for the conference had come from the College, and that several units outside of the School of Public Health had provided matching funds, and would look forward to participating.

The conference program ran from 9:00 a.m. to 3:00 p.m., with an hour for lunch. Both the Dean and the Associate Dean of the School of Public Health spoke, the latter highlighting the school's collaboration with community leaders. Keynote speaker Barnes-Boyd delivered a power-point presentation on attitudes and best practices for successful community–campus partnerships. A short networking session followed in which participants were invited to talk about their interests and needs, and the community or campus units they represented.

During the afternoon session, Joan Linton and Nicole Schonemann (director of IU's Service – Learning Program) announced follow-up workshops for conference participants who had ideas for partnerships with a campus or community partner, and might have potential partners in mind.
Linton passed out forms on which participants would specify their goals in form partnerships and, where possible, identify a potential partner. The session then shifted to three breakout discussions relating to: (1) Grant Writing/Fundraising; (2) Marketing/Effective Messaging, and (3)Sharing Information Across Organizations.

About 50 participants, including the steering committee, attended the morning session; however, only about half the number stayed after lunch to network on partnerships. Of that number, 18 returned evaluations and 6 community members returned forms in which they specified their needs and interests in partnerships; none had identified a potential campus partner. The tables from the breakout discussions each turned in a bullet-point report that represented the beginnings of "action plans."

Of the participants, 12 were from the School of Public Health; 8 were from other campus units; 6 from various IU Health offices (3 on the steering committee); 2 from the IU Health Center; 3 were from the business sector; 3 were from the for-profit medical community; 4 were educational personnel outside IU, 4 from community organizations, and 6 from the local government.

Next Steps

Since 6 conference participants have indicated their interest in partnerships (without identifying potential partners), over the summer the director and staff from IU's Service Learning Program will contact these participants to help them in preparing for productive partnerships and locating potential partners. This summer work will lay the groundwork for one or more fall workshops to advise new partners in planning co-productive community-based research and/or service–learning projects.

In addition to the fall workshops, we plan to organize a symposium to promote campus-wide awareness and interest in the original project of creating a web-based community health commons. This event would include a keynote address by Prof. Mohan Dutta, and significant participation from all the schools that includes faculty, students, staff, and community members.
To help cover expenses of the fall campus event and the workshop(s), Linton has requested and received an extension on the Ostrom grant detailed above.

Part of the funding ($500) would also be used as matching funds for the Service-Learning Program to apply for a "Listening to Communities grant" ($2,000). If awarded, the additional funding would go towards supporting the Service–Learning Program's work with the new partnerships. Perhaps our efforts along these lines will soon eventuate into a new Phase V of this project.

Challenges and Responses

In this process we experienced several challenges and responded to them as they arose. Among the most noteworthy are the following.

We found it very difficult to maintain momentum on this project. All participants are very busy with their own responsibilities, and we did not manage to convince them that this particular project should become one of their top priorities. A few participants attended regularly, but the total number of participants varied widely across meetings, and, frankly, a critical mass of highly-committed leaders never emerged.

The health/care system is so complex that it was very difficult to sustain focus on specific projects. Discussions at some meetings were a bit too expansive and unfocused. Some participants in meetings had specific agenda items that they insisted were especially important, and they were often quite eager to get started on those plans as quickly as possible. As a consequence, they became impatient with the longer and more deliberate pace at which we hoped to proceed. Over time, some of these participants peeled off and went their own way.

To be brutally honest, our research team did not devote the level of concentrated effort that would have been required to fully accomplish our goals. For each of the faculty and students on our core research team, this project competed for our time and effort with the pressing needs of other projects. Unfortunately, we were not able to structure this project in a way that directly contributed to the dissertation research projects being undertaken by the student participants on our research team, and thus much of their attention was naturally directed at their primary goal of completing their degree. One of the faculty members (McGinnis) went on sabbatical leave in the midst of this process, and became deeply engaged in his work at this destination institution. Another member of the research team (Lawrence) accepted a teaching position elsewhere, and both the long commute and the responsibilities at her new institution made her continued participation all but impossible. The remaining member (Linton) was also effectively sidelined when the steering committee decided to meet at a time when she had a standing weekly College committee meeting. In sum, our research team did not have sufficient time or resources to give this project the attention it needed to succeed.

Our rationale for investigating this case was primarily local convenience, since the Bloomington area does not stand out as an especially successful one with respect to its performance on health care measures. There are many examples of community collaboration on projects related to public health in one form or another, and these programs are, to some degree, coordinated by a local team of community leaders. This team was built through the ACHIEVE program (which organizes public health proposals in Bloomington), and we hoped to use them as our community advisory board. In the end, the local ACHIEVE team came to see our efforts as undermining their position as community coordinators, and expressed concern that our research team may be infringing on their territory. It took some effort, especially on the part of Carrie and Joan, to ameliorate their concerns. But by the time we smoothed that out the grant period was coming to an end. We found it a bit surprising that even non-profit groups could express such a strong sense of territorial protection of their own turf, but are now convinced that similar problems are likely to be experienced in other communities as well.

Meanwhile, broader economic forces did not support this kind of action. Our project overlapped with the key implementation phases of the 2010 Affordable Care Act, with all the attendant uncertainty and partisanship associated with its informal name ObamaCare. Locally, the dominant hospital in the Bloomington area, IU-Health Bloomington, continued its efforts to secure its financial base. IU-Health Hospital hired more physicians to work on its staff, and worked with Southern Indiana Physician's Group to consolidate independent primary care providers in the multi-county area around Bloomington. Indiana

University, the largest employer in the region, shifted many of its maintenance workers to outside contractors, in order to avoid having to provide them with improved health insurance coverage. Other workers (at both IU and the hospital) found their weekly hours reduced below the 30 hour threshold set by the ACA to qualify as full-time workers for whom the corporation would be required to provide health benefits. IU-Health Hospital also laid off professional staff throughout its operations.

In addition, major local news stories in the summers during the period covered by this project concerning breakdowns in negotiations between local stakeholders: Anthem insurance, IU-Health hospital, and IMA/Premier Healthcare (an independent multispecialty physician's group). It's hard to shake the sense that IU Health Bloomington is embarked on a sustained effort to build an integrated health care delivery system the old-fashioned way, through a combination of horizontal and vertical integration of health care services. None of this is conducive to the kinds of community-based innovation that our project was intended to inspire.

Despite these continuing challenges and our incomplete responses to them, we remain convinced that continued efforts along these lines remain worthwhile. Our hope is that the service–learning connection will turn out to be a long-term and sustainable one. Once we get a few students and faculty engaged in community issues related to health and social care, including development and analysis of data, messaging on health and wellness, ethical promotion of services to the community (including its most vulnerable populations), we hope they will encourage other students and faculty to do the same. Ideally, we might see a steady stream of new students with these kinds of interests, and IUB will come to be known as a great place to attend if you want to learn about a multi-disciplinary approach to health and wellness that brings systems thinking and community-based governance to bear on these issues in their specific contexts. We encourage readers to stay tuned for further developments.

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Table 1-A. Themes from Interviews (Phase I)

Shortages and Related Needs	Prevention	Public Education	Health-related Behaviors
Primary care physicians and providers, especially those who accept Medicare and Medicaid. Need to foster primary care (esp. recruitment and retention of providers) Needs in the area of long-term care, preparation for the increase aging population A comprehensive healthcare system that includes naturopaths etc. STD testing facilities • Question of who will pick up tab? • Overall lack of physicians who talk with patients about sexual health A comprehensive healthcare system that includes naturopaths etc. Mental health services • Need better community awareness • Not enough psychologists and psychiatrists • Overall access to mental health services, including services for veterans, age-related conditions such as dementia, substance abuse treatment, bi-polar, etc. • Specialty center for dementia and Alzheimer's, postpartum depression issues • Mental health coalition was started but did not sustain Transportation, housing shortage and affordability • These are barriers to access as well as contribute to stress of a patient which may contribute to health issue	Obesity repeatedly raised as issue for community and state Make healthy choices easy, affordable, and safe (e.g., provide sidewalk access to healthy activities site) Education is a must for people to make the choices Better preparedness for disaster recovery Mental wellbeing and stress management Employee wellness	When it's appropriate to use the ER Patients need to be invested in living healthily (how to incentivize?) Language barriers to education Education must addresses audiences in their everyday contexts The consumer is key to driving healthcare reform Understanding medication Chronic disease prevention and treatment	Need to seed healthy habits early in life • Birth to age 5 education (Early Head Start) • Parent Education (Healthy Families) Address negative life styles (e.g., GOAL, IHAP) Get families to buy-in to their own health (family to drive culture shift) Need to figure out how to build a culture of wellness in the work place that inspires rather than impose on people to make healthy choices

Table 1-B. Themes from Interviews (Phase I) -- continued

Consideration of Social Determinants	Cost of healthcare	Institutional clout	Models of local and regional health services
Poverty (unemployed and underemployed) Housing (homelessness and lack of adequate housing for low-income people) Transportation Food (cost, access: food deserts) Environmental quality (safety, sidewalks, complete street projects, affordable Y's, etc.) Geographical barriers (rural needs different from urban) Cultural and language barriers • Resistant to behavior changes Gender barriers • Education (under education, underemployed, poverty)	"Education is the most important piece of change, including changing the way healthcare is paid for (needs to be consumer driven), and need to look at existing models, overseas" Affordable insurance packages for small business/nonprofit employers Interconnectivity for starters: employers wasting a lot of money because they aren't talking with one another Need a clientele who can be responsible for their health choices (education is often trumped by entrenched habits) Need to reduce physician overtreatment Need a way to reduce patient access to unnecessary care • For example, Medical Home model Need targeted health efforts, since counties have different needs Need to provide counties with resources to assess their own health needs Healthcare sustainability is a local problem within national problem: how to make internal and local changes to keep ahead of external, national rates of change	AMA owns the rights to CPT (Current Procedural Terminology) codes; in 2000, bar for diabetes (blood glucose) lowered from 130 to 125. Specialists lobbying for PPO Responsibility of Employer to give back to community or influence on health of community members/employees	School health center (e.g., Indianapolis Community Health Center in High School) Employee health clinic (e.g., Monroe County Public Health Clinic) Medical home model (IHAP: Integrated Health Advocacy Program) Clarion's attraction for Bloomington as the hub of 9 counties

Table 1-C. Themes from Interviews (Phase I) -- continued

Policy	Culture change	A public conversation needed on health and healthcare
Working with policy makers to make legislative changes, for example, that would make it possible for small business owners to afford insurance for their employees • State legislative barriers to health insurance cooperatives (ie. Nonprofit cooperative in the early 90's allowed for the nonprofits to come together on a plan) Educating policy makers (healthy population – healthier economy – more competitive state) Would like government to support local decision-making With health reform policy coming in, problem of staying viable; keeping small business buy-in Need to change the delivery of care from fee for service to paying for care (some see this as "most important piece") A line in the budget for reproductive health and family services; for STD testing facilities; and for free transportation for people in poverty cf. IU student bus pass) Sustainability of community health programs • When programs are started (ACHIEVE) they are grant driven, when grant runs out program stop. • Importance of securing resources or programs/practice through policy development. Local health policy • Bloomington Tobacco Policy/ workplace policies related to health	Media to help get health messages out Technology is helpful but must be coordinated (need to address cost, say, for local pharmacies) Healthcare providers need to become patient-centered Need to address patient-provider perspectives gap, develop better communication and relationships (time a major issue) Patients need to take more active role in working with health care providers on preventive care and management of their chronic conditions People don't see health care as a limited resource Need to address values that pose barriers to open, honest discussion on things that are taboo, e.g., STD, HIV, mental health (for some communities), drug abuse, etc. Need to address drug abuse and alcohol abuse as a kind of culture (especially in a college town like Bloomington)	Topics to be address: • How to organize needs and costs • How to understand the economics of healthcare "How to" suggestions (for successful conversations) • Set priorities for discussion and dig down to values • Do not isolate any one sector; community must come together • Deal with town-gown division • City and county must work together • Units within networks to see larger picture and make small change systemically • "Commons thinking" • A community health plan to begin with the schools • Intensive, well-coordinated, outcome-based discussion

Table 2. Narrating Our Public Narrative – Phase II

Narrating Our Public Narrative: "story of self" → "story of us" → "story of now"

WHERE WE AGREE: Community health is a long-term vision. It requires a shift from an illness culture to a culture of health and wellness.

Culture change observed:

- Shift away from focus on insurance companies to coproducing health
- Employers becoming aware their responsibility extends beyond employees to community
- Emerging emphasis on individual accountability for making healthy choices

Culture defined:

- Personal habits, reinforced through social interactions
- Attitudes to health ("drive-to" approach to medicine; convenience-oriented)
- Culture of poverty at the basis of health disparities
- Language, religious, and other differences in diverse community

Culture change requirements:

- Involve all sectors of the community (including employers who provide consumer blocs, funding, and other resources)
- Address the delivery system and personal choices
- Address communication and dissemination of information across different levels
- Need a common language that can be shared across organizations
- Address gap between health education and behavior change
- Address barriers to basic needs (housing, healthy food, etc.)
- Identify existing structures to build on
- Programs are costly and thus not sustainable—identify what works in a program and scale that piece for the community
- Connect model to policy, beginning with model
- Build assessment into model: if proven to work other groups would want to copy

Behavior change needs:

- Habits are set early in life, must intervene early: target children (especially from poverty); but also attend to mothers, girls before they get pregnant, young and older adults, veterans.
- Transparency of medical information so people can make informed choices and be accountable
- Explore reasons why people aren't accessing resources (stress? Lack of awareness? Lack of motivation? Deeply held values and beliefs? Just too busy?)
- Explore how the culture of poverty poses barriers to behavior change
- Be sure families have the tools to understand and implement health literacy

Figure 1: Community Action Coalition (First Pass) – Phase III