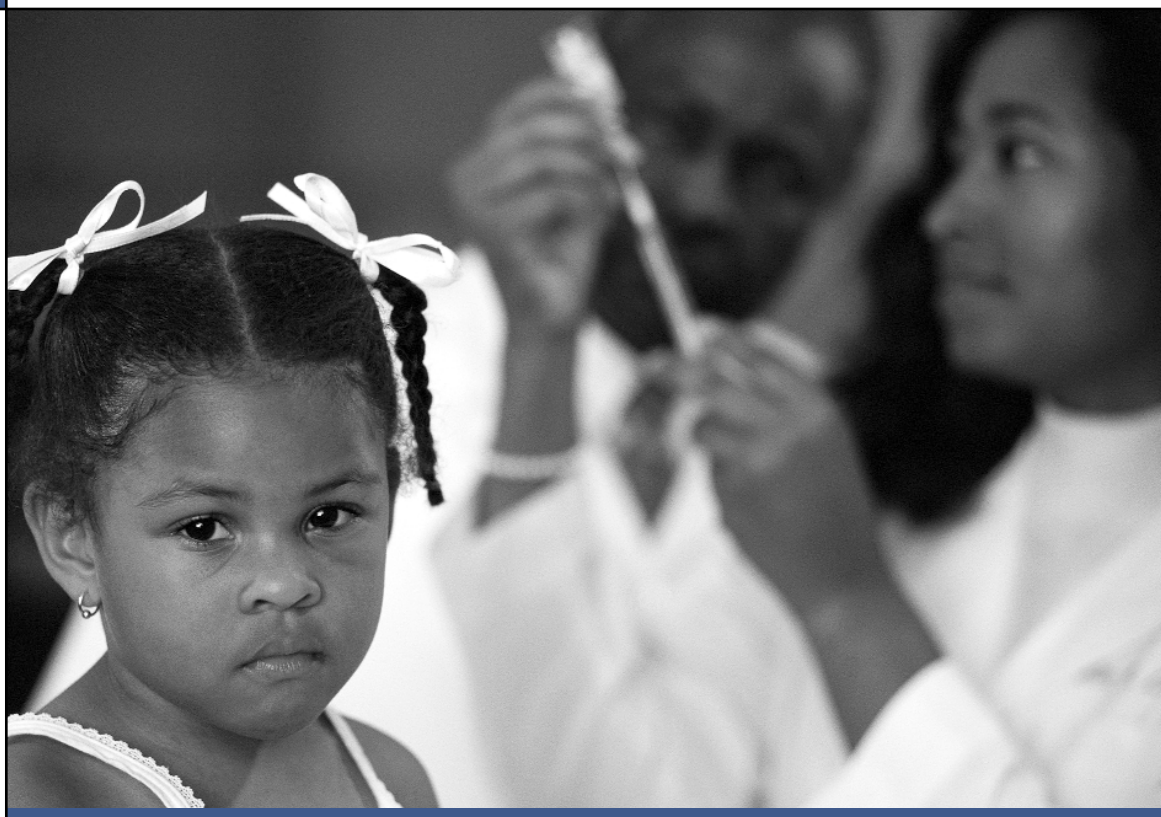
MARCH 2003

Extraordinary Results on National Goals: Networks and Partnerships in the Bureau of Primary Health Care's 100%/0 Campaign

New Ways to Manage Series



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IBM Endowment for
The Business of Government

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FOREWORD

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On behalf of the IBM Endowment for The Business of Government, we are pleased to present this report, "Extraordinary Results on National Goals: Networks and Partnerships in the Bureau of Primary Health Care's 100%/0 Campaign," by John Scanlon.

This report describes how the Bureau of Primary Health Care (BPHC) in the Department of Health and Human Services created a national campaign to achieve a national goal: delivering quality health care to all American citizens and eliminating health-status disparities between vulnerable, uninsured Americans and affluent, insured populations. While the case study presented is about health care, the leadership model described by Scanlon is applicable to all government organizations faced with achieving national goals beyond their immediate reach. Success will require the creation of partnerships and networks working collectively to achieve national goals.

There has been much written in recent years about the need for government to increase its use of partnerships and networks to solve national problems. This report shows how they can be created and fostered. There is little doubt that government budgets will continue to be tight in the years ahead. Thus, government must begin to marshal, coordinate, and inspire other organizations to collectively work on national problems. The report describes how BPHC started and initially led a national movement on a national goal and eventually "handed off" its leadership role to partners in the nonprofit sector.

The report also demonstrates how committed and dedicated civil servants can be creative in developing new approaches to national problems. The civil servants profiled in this report all went "beyond" their job descriptions to provide leadership on a national goal in which BPHC had been legislated a relatively small, defined role. These civil servants can clearly serve as role models for other civil servants who aspire to make a real difference.

We trust that this report will be both informative and useful to executives throughout government as they move to assuming responsibility for national goals.

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Part I:
Achieving National Goals—The Emergence of a New Kind of Leadership

Leadership Lessons from the Bureau of Primary Health Care

Overview

From 1998 to 2001, a small group of managers in a federal agency went beyond their job responsibilities to create an important national movement. They produced results not only much different from what agencies usually achieve, but results that far exceeded the reach of their agency programs alone. If expected results can be called reasonable and ordinary, what this agency accomplished—by assuming a unique leadership role—was extraordinary.

This is a story about a new form of leadership in which agency managers move beyond program and agency goals to pursue a "national goal." A national goal is bigger than those of individual programs or any one agency.

Part I of this report presents the 10 lessons learned about this new form of leadership. It addresses four questions:

- What does leadership on a national goal look like?
- What does it take for this kind of leadership to surface in an organization?
- What does it take to nurture this kind of leadership in an organization?
- What activities are undertaken to achieve national goals?

Part II is a case study of how the campaign was carried out during a four-year campaign time line. It covers the conditions in place that allowed it to start and to move from a federally led movement to a movement now led by organizations outside the federal government.

Background: The Intent and the Setting

In 1998, a group of managers in the Bureau of Primary Health Care (the Bureau), Department of Health and Human Services, launched what they called the 100% Access/0 Health Disparities Campaign. The vision was to have every community in America provide 100 percent of its residents access to quality health care. In addition, every community would be eliminating health-status disparities, the severe and pervasive gaps in health status that show up in a community when vulnerable, uninsured populations are compared with affluent, insured populations.

The Bureau is responsible for categorical programs that contribute health service assets to needy communities, including the community health center grant program and the National Health Service Corps. The agency's mission is "assuring access to preventive and primary care for vulnerable populations." Its programs provide health care to the neediest but reach only about 10 to 20 percent of the 45 million uninsured and vulnerable. From this perspective, the 100%/0 leadership team saw the potential of a community-based solution to the uninsured problem. Their experiences told them that communities could provide access to 100 percent of their residents by restructuring the assets already in the community. The key was to create an integrated delivery system that placed the

uninsured and vulnerable in "medical homes," shifting them from using wildly expensive emergency rooms to a cost-effective primary care system.

The team's vision was to have all 3,000 communities in America with integrated health systems in place delivering 100% access and 0 health disparities. Its goal was 500 communities enrolled in the campaign within three years. The progress of these 500 communities toward the 100%/0 goal was to be tracked and assistance was to be provided to accelerate progress.

Federal staff with other full-time management responsibilities were able, in a three-year period, to launch a self-organizing, self-sustaining movement. That movement now has multiple networks of leadership at the national, state, and local levels aligned in pursuit of a common vision with measurable goals.

The Face of Leadership on a National Goal

What does leadership on a national goal look like? It looks like a self-organized group with a common vision and an impossible goal. The participants appear extroverted in their actions, always networking outside the agency, always making deals. They will strike others in their own organization as either entrepreneurial or crazy.

Access to Health Care: A Catastrophic National Problem in Search of a Solution

The 100%/0 campaign is a bottom-up solution to a serious national problem. The nation's health care system is acknowledged to be a financial, organizational, and performance mess. It's a $1.4 trillion system that provides great care for some, some care for many, and little or no care for about 20 to 25 percent of the population. At any given point, 40 to 50 million people seem to be uninsured. National and state efforts to reform this system have foundered.

The magnitude, severity, and longevity of this situation were recently summarized by six former cabinet secretaries of the Department of Health and Human Services, as reported in the *Atlanta Journal-Constitution*, November 19, 2002:

> The nation's health care system is too costly, inefficient, unfair and in need of an overhaul, six former secretaries of Health and Human Services agreed Monday in Atlanta. In a rare display of unanimity among both Democrats and Republicans who headed the federal health establishment during five administrations, the former Cabinet members also agreed that, despite its flaws, the system won't be reformed any time soon.
>
> Donna Shalala, who served as secretary of the department during the Clinton administration, bluntly characterized the system as "a mess." "The health care system can't survive in its present state, because we can't afford the way it is organized," she said. "But there is no agreement about what the solution should be…"
>
> The former secretaries…warned that the real inequities in the U.S. system—which ranks first in the world in cost, and 35th in overall efficiency, according to World Health Organization surveys—aren't much closer to resolution than they were during the quarter of a century that they presided over it. The secretaries'…views on the nature of the health care problem were remarkably similar…
>
> "We need to shift the mix of physicians from the specialties to primary care," said Louis Sullivan, who served as HHS secretary in the first Bush administration… "The big barrier to health care is cost," said F. David Mathews, who headed the department under President Gerald Ford. The group said drug companies, doctors, hospitals, insurers and Congress share responsibility for the system's problems. But the group said the American people and their priorities also contribute to the nation's health care woes. "We have to persuade people that they have control over their own health future," said former Surgeon General David Satcher. "Sixty-five percent of Americans are obese or overweight," he said, noting that much of the problem is a result of poor dietary habits and sedentary lifestyles.

Table 1: Ten Leadership Lessons from the Bureau's Campaign for 100% Access & 0 Health Disparities

1. Collaborate and network.	Pursuing a national goal is all collaboration and network development.
2. Reveal hidden assets.	The leadership team discovers and gains access to hidden assets that they and others own by articulating a bold campaign goal.
3. Operate in campaign mode.	The team takes shape around the development of a campaign goal and game plan.
4. Search for national goals.	Around government programs are higher national goals, ones beyond the reach of the program, that can be achieved by leadership campaigns using the programs as "platforms."
5. Find the leadership below the surface.	The leadership for national goal campaigns is already there, ready to surface and focus.
6. Accept the natural resistance.	The leadership team sees organizational resistance as natural and legitimate and does not hear it as a veto.
7. Distinguish the ready and the not ready.	The leadership team spends most of its time with people who are ready to play and is respectful of those who are not ready.
8. Make and secure commitments.	The work of the campaign is making and securing commitments, and the tendency to create internal bureaucracy and special projects is seen as unnecessary, distracting work.
9. Tell leadership stories.	Leaders generate commitments and action by conveying their leadership story and the leadership stories of others when they speak.
10. Practice the discipline of leadership.	Leadership on national goals is both a calling and a teachable discipline that is available to all federal executives.

The core leadership group that created the 100%/0 campaign consisted of 10 people who were seasoned and relatively senior in position:

- Dr. Marilyn Gaston, director, Bureau of Primary Health Care
- Mary Lou Andersen, deputy director, Bureau of Primary Health Care
- Jim Macrae, director, Office of State and National Programs
- Chuck Van Anden, branch chief, National Health Service Corps
- Dennis Wagner, special assistant to the Office of the Director
- Donald Coleman, director, Media Center
- Rick Wilk, regional field staff, Chicago Office
- Regan Crump, director, Division of Special Populations

- Dr. Eric Baumgartner, director, Community Access Program
- John Scanlon, JSEA, Inc., consultant to the Office of the Director

With only two exceptions, Dennis Wagner and John Scanlon, these leaders had full-time job responsibilities in managing ongoing Bureau programs and activities and continued to carry out their full-time jobs throughout the campaign. Wagner was brought to the Bureau on detail from the Environmental Protection Agency as an expert in social marketing. He came to develop the national partnerships that would ultimately take over the campaign and was the full-time coordinator of the campaign. Scanlon served as a consultant to Marilyn Gaston on her strategic agenda and helped her translate her strategic intent into a project robust enough to achieve it. He also served as a coach to and member of the team that created the 100%/0 program.

This leadership team functioned as a group of peers, all of whom saw the world from the perspective of a grand mission they were committed to carrying out. They met weekly and interacted frequently. In the meetings, everyone at the table was proactive and ready to make commitments—there was no single person in charge.

Gaston and Andersen—the Bureau's director and deputy director—participated as team members, not acting in their roles as executives. As the Bureau's top leaders, though, they did play the special role of brokering the alignment of the campaign mission and campaign work to the agency mission and legislative charter. They kept the campaign work within the discretion allowed by law and regulation.

The team did essentially three things. First, they articulated an "impossible" national goal and crafted a plan to achieve it. Second, they continually brainstormed how events and processes that were going to happen anyway could be used to carry out the plan. The bold goals enabled them to see possibilities and opportunities already there but up to that point hidden. Third, they created partnerships to form and access networks. There were partnerships with successful communities that would serve as benchmarks for 100%/0. Partnerships

Dr. Marilyn Gaston

with national organizations whose membership networks reached into communities. Partnerships with communities in action on 100%/0. In effect, the team built a network of networks.

Three initial lessons emerged from watching this unique group in action:

Lesson 1: Collaborate and network. Pursuing a national goal is an exercise in collaboration and network development. Those seeking to pursue national goals need to somehow create a "space" where hierarchy can be set aside and collaboration can happen. In this case, agency executives became part of the team rather than traditional line managers, and the "price of admission" to participate on the team was the willingness to make commitments to act. Action often means developing partnerships with networks that give the group reach.

Lesson 2: Reveal hidden assets. The leadership team discovers and gains access to hidden assets that they own and others own by articulating a bold campaign goal. The routine work of running federal programs creates assets for federal managers that are often not seen or acknowledged. These hidden assets involve access to people and networks, influence, credibility, knowledge. The assets are revealed by the articulation of a grand mission that one is truly committed to achieving. The campaign team referred to this phenomenon as the "abundance principle."

Lesson 3: Operate in campaign mode. The team takes shape around the development of a campaign goal and game plan. Bringing in Wagner, an expert in social marketing campaigns, emboldened and energized the team, brought a campaign philosophy and attitude the team lacked, and rounded out the skill set of the team. His full-time role gave the team a center to turn to.

What Does It Take for This Kind of Leadership to Surface in an Organization?

In retrospect, it seemed like the campaign was already there, ready to happen. The organization only had to relax and let it happen.

The sequence of events that created this effort began with a conversation. An assistant challenged Andersen on the strategic goals of the Bureau: "Our goal should be 100 percent access." This was way beyond the10 to 20 percent access to primary care the programs achieved and the expected gain from incremental funding increases. A seemingly impossible goal would be rejected, and even ridiculed, in most organizations. But Andersen shared it with others and it came alive. Three factors converged to give it life:

- People were present with career-long interest in improving access to health care.
- Professionals were seeking additional meaning in their work.
- A larger mission context existed, providing legitimacy.

No one person showed up with the leadership vision for the campaign. Instead, all team members came with a clear direction to their careers. Those who joined the team had a deep, career-long commitment to the nation having an effective safety net. Gaston, for example, came to the Bureau with more than a management agenda. She was an advocate for measuring and eliminating health status disparities. She talked about the "safety net we need vs. the safety net we have." She wanted to describe that gap and put it into the policy development processes. Others on the team had similar, unrealized missions or intentions. These ambitions were held in check somewhat because they called for engaging processes, organizations, and leaders outside the Bureau and outside the federal government. But Andersen and Gaston cultivated these ambitions. A latent leadership drive among many in the Bureau was cultivated through conversations and evolved into a common leadership vision. There were many professionals in the Bureau eager to give meaning to the roles and jobs in which they found themselves. They constantly asked, "Why am I doing this?" and "What does it mean?" Already seeking, many were drawn to the campaign. The campaign helped them find a higher meaning in their jobs and gave greater purpose to what they were doing. Regan Crump described it as the opportunity to be part of a movement:

Healthy People 2010: A Public Source of National Goals for the Campaign

The vision of 100% Access and 0 Disparities flows from the goals of *Healthy People 2010*, the prevention agenda for the nation.

Developed by the Office of Disease Prevention and Health Promotion of the Department of Health and Human Services, *Healthy People 2010* states national health objectives. It identifies the most significant preventable threats to health and establishes national goals to reduce those threats. *Healthy People 2010* builds on initiatives pursued over the past two decades.

There is no funded program behind *Healthy People 2010*. The intent is for it to be used by many people, states, communities, professional organizations, and others to help them develop new ways of improving health. They all are encouraged to integrate their program's content into other programs, special events, publications, and meetings. *Healthy People 2010* offers a simple but powerful idea: Provide health objectives in a format that enables diverse groups to combine their efforts and work as a team.

This national agenda has two overarching goals: (1) increase quality and years of healthy life and (2) eliminate health disparities. It states more specific goals for 28 focus areas, one example being: Improve access to comprehensive, high-quality health care services.

The 100%/0 team was in an organizational culture that was deeply committed to the Healthy People 2010 agenda and the goals it established.

> "I never had to be convinced. 100% is such a moral imperative that we don't have to agree that 'it can be done,' it was about 'it must be done.'… I was excited about the idea of the campaign. First it was huge. It had the big, bodacious goals that Dr. Gaston was always asking for. Second, it called for us to bring in many other organizations because we can't do it alone. Third, it required people to work across sectors—government, private sector, charity—and to go beyond health. And fourth, 100% access for everyone is so moral, so ethical, so right. It's like the civil rights movement. It's proactive, creative."

Mary Lou Andersen

As personal interest and meaningfulness brought people together, the group needed to find a larger mission context than the categorical programs and agency mission could provide. This larger context would serve to legitimize a campaign on national goals. For the Bureau, that context has existed for decades—Healthy People 2010, the official prevention agenda for the nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats. Healthy People 2010 set forth a number of goals, including (1) improve access to comprehensive, high-quality health care services and (2) eliminate health disparities.

There is, however, no federally funded program to achieve those goals. Healthy People 2010 is to be used by many key actors—states, communities, professional organizations, and others—to help them develop programs to improve health. 100%/0 was one way that BPHC managers and staff could articulate and pursue official national health goals. They had a kind of permission to go for it.

Two lessons emerged from watching this team form:

Lesson 4: Search for national goals. Associated with government programs are higher national goals that, although beyond the reach of the program, can be achieved by leadership campaigns using the programs as platforms. The mission and policy context of a categorical program and an agency can be used to legitimize and empower a leadership campaign on national goals. The program platform provides the networks, access, and events through which others can be enrolled in the campaign as partners.

Lesson 5: Find the leadership below the surface. The leadership of national goals is already there, ready to emerge and focus. Listen for leaders already within the organization but frequently out of sight. Create or find a "safe space" in which they can surface. As leadership spirit surfaces, put it into action—don't let it wilt under criticism, advice, gossip, wishing, or planning.

What Does It Take to Nurture This Kind of Leadership in an Organization?

It turned out that the team was responsible for its own morale and performance. As the leadership team began this work, it found that the morale of the team depended on how it reacted to engagement with others. The team learned to draw energy from the positive engagements and to accept and not judge the negative encounters.

When the 100%/0 team brought the campaign to those outside the Bureau and outside the federal government, the members generally were greeted with enthusiasm and support. An external meeting was almost always energizing, creative, and productive. This validation and affirmation served as a market test of the campaign and as the primary source of energy and high morale for the team.

Inside the Bureau, the response was not always positive. It was a major challenge to launch a campaign

like this within an organization that lacked clearly assigned responsibility for the national goal. Legitimate and natural forces resisted. Team members' reactions to negative responses had to be managed or the team would become discouraged and defensive.

Resistance showed up in two forms: criticism from peers within the Bureau and anxiety from volunteers who wanted to help. The first was overt. The team scheduled briefings with each member of Gaston's executive team to explore how the work of the entire Bureau could be used as a platform for enrolling communities and finding models that worked. The response ranged from the support of a few to harsh rejection by most. They heard statements that sounded critical:

- "As stewards of the federal dollars, we shouldn't be putting money or staff attention into anything but direct service delivery grants. Everything should be directed to serving patients."
- "This campaign is not in my job description. It looks like and feels like more work. There is no reason for me to take it on."
- "That is not our mission or role or responsibility."
- "Hogwash! I do not believe it is doable. Communities can't do it. We don't know how to show communities to do it."
- "This campaign work is a criticism of the effectiveness of our programs and it is inappropriate."
- "We are about health centers and corps placement. Period."

Team members recalled this as an unpleasant exercise:

- "At that time many of the other managers saw us as quacks, as out-of-control entrepreneurs." (Chuck Van Anden)
- "I was frustrated at their reaction. Not that they didn't get it, but that they resisted trying to get it. It was the unwillingness to even entertain it. They had great security in the status quo. I could see where the investment would have a big payoff, but they didn't see the possibility. It took the wind out of our sail…but we regrouped and repackaged the message." (Regan Crump)

From the experience grew important leadership values for the team and principles for the campaign. The team heard the criticism but did not take it personally or as a veto. They heard no in response to their request for help and support, but they avoided getting defensive and remained open to working with those who made critical comments.

The second form of resistance was subtler in that it first appeared to be support. Many staff stepped forward to help. They were bright, highly educated, serious people ready to lend a hand. In return, they wanted to be assigned tasks and given the necessary resources. A task agenda began to grow:

- "We need forms to fill out whenever any staff person engages a community."
- "We need someone to collect the data and produce reports."
- "We need to set up a committee to define what a community is."
- "We need to define what 100% access is so we can tell the communities."
- "We need a list of resources we can offer communities."
- "We need a technical assistance tool kit."

As the list grew, anxiety grew among the volunteer staff: "How does this relate to my performance plan? What is the budget?" The leadership team found itself under great pressure to organize all kinds of special projects that gave this work legitimacy and resources. The staff challenged them: "If you are serious, then let's build a very well-defined system and put the resources we need into it."

When the guidance and project resources failed to arrive, volunteer staff began to withdraw. One team member commented: "The staff retreated. They wanted to be helpful. They were initially interested, but these were not their primary jobs or their 'real' work. They were not committed to 100% access. And it was not their style."

At first, the requests and offers from the volunteer staff seemed reasonable and logical. But soon the team saw that creating more task and project work would sink the campaign. And it wasn't the right

kind of work for a campaign. Several team members commented:

> "This campaign could not be accomplished in formal structure and rules. And we know government has structure and rules. This was a proactive, fluid movement. We went way beyond what we were legally required to do. It is part of our higher mission, but it could not be done within the structure in place to run programs."

> "The campaign was the most exciting and interesting kind of work. It's all about an idea, a vision, and getting people excited about it. It's not related to a program. It's not a program. It's not contingent on having dollars to spend. If it's approached as a program, it crashes. It's getting people to just do something. It's about commitments. That is the beauty of it."

Three lessons emerged from watching the team interact with individuals and groups inside and outside the Bureau:

Lesson 6: Accept the natural resistance. The leadership team sees organizational resistance as natural and legitimate, and does not hear it as a veto. Leadership teams manage the resistance they run into. Expressions of indifference, rejection, hostility, and cynicism will be voiced and will trigger anger and defensiveness in the team. This leadership team had to develop a mind-set that heard rejection as an expression of a different set of interests, not as an attack on the team.

Lesson 7: Distinguish the ready and the not ready. The leadership team spends most of its time with people who are ready to play and is respectful of those who are not ready. In this case, energy and morale came from positive conversations, mostly outside the organization, with people who were excited about something. By definition, the resources needed to achieve the goals of the campaign are outside.

Lesson 8: Make and secure commitments. The work of the campaign is to generate commitments. The leadership team sees the tendency to create internal bureaucracy and special projects as generating more work rather than commitments. Without legislative and budget authority, more formal structures and special projects are not appropriate or sustainable.

What Activities Are Undertaken to Achieve National Goals?

A member of the original team described the work of the campaign as simple and easy:

> "This was easy. All we did was uncover what was already going on and put a spotlight on it! We didn't create it or do it. We found people doing it, said 'great job,' showed it to others, and saw others start doing it. Shining a spotlight, encouraging those doing it, and giving courage to others to try it. People said, 'Wow, it can be done.'" (Jim Macrae)

As the team developed its confidence and approach, it came to see its work as different from traditional policy development, program management, or administrative work. Most work in organizations is planned, with a certain level of resources committed to activities designed to produce a known result. Managers know how to get the results they want from these traditional activities. They know what they don't know and can secure the expertise that will cover those areas. Traditional work requires managers to be in control of sequential work processes. It's linear, convergent, and predictable.

The work of national goal campaigns is not like that. The goals are way beyond the resources at hand, so the work has to be about developing relationships to deploy other organizations' resources. The team, generating new possibilities and opportunities, does not know what it does not know. The work is not linear. The work is about seeking multiple outcomes from activity and geometric leveraging. It's about divergent activity and paths. Finally, it is about having a bold goal, bold enough to contain all the divergent activities and paths and bring them back together. If traditional management work is "plan, allocate, do," then the work of the campaign is the work of leadership: "declare, discover, enroll."

The work of leadership on national goals turns out to be playful, improvisational, and fun. But until

one gets used to it, it can be very unsettling. It calls for the leadership team to step into an empty space where possibilities exist but at first cannot be sensed or seen. As the 100%/0 team took that step, they began to develop a style and method.

The team evolved a campaign method that had five important elements:

- **Develop networks.** Build partnerships to access networks that can reach into communities and deliver assistance.
- **Generate and manage commitments.** Use requests and offers to create action and movement with every encounter.
- **Seek and deploy models that work.** Use benchmark communities and leaders as role models and blueprints for action that inspire and guide.
- **Organize call-to-action events.** Run events that cause breakthroughs in community enrollment and progress while strengthening the networks working on the campaign.
- **Adopt a signature style.** Convene and engage people in a way that generates commitments and makes things happen.

These five elements describe the nature and structure of the campaign work. They are parts of a whole. The strength and success of the campaign stem from the networks that extend the effort. The vision is conveyed by the successful communities that are showcased. The call-to-action events broadcast the campaign. The signature style is a way to be effective while doing the work of generating commitments through requests and offers. (Part II, the case study of the campaign, will describe these elements in action.)

The campaign's experience was that this work is easier and more fun than one might have expected. Two lessons emerged from watching the team produce extraordinary results.

Lesson 9: Tell leadership stories. Leaders generate commitments to action on national goals by telling their leadership story when they speak. Leadership campaigns to achieve national goals work when team members tell their personal stories and share the leadership stories of others. These stories are, first, a compelling call to action and, second, a celebration of models that work. With these stories, leaders stand for the national goal as a possibility and thus cause opportunities to appear. These opportunities are seized in the moment by making requests and offers to generate commitments.

Lesson 10: Practice the discipline of leadership. Leadership on national goals is both a calling and a learned discipline available to all federal executives. The discipline consists of the methods and the style that become part of a leader's everyday activity. These methods can be learned, taught, and adapted to other situations. Without them, without the discipline, the calling never comes to life. The 100%/0 team found the discipline necessary to carry out a campaign and made it their style. This leadership discipline can be seen in action in the Part II case study.

From National Goal to National Movement

From 1998 to 2001, a small group of managers in one federal agency created a national movement. They produced results on national goals generally felt to be impossible. Their goal seemed beyond reach because it required both intergovernmental and public-private collaborations. The Bureau's experience shows how federal programs can become the platforms on which to create a critical mass of collaboration necessary for realizing national goals.

Leadership on national goals is a kind of leadership that career and appointed executives throughout government can demonstrate. The potential leadership team is already just below the surface in many organizations, and existing programs have already generated the hidden assets that can be mobilized and deployed. The methods to use, while somewhat counterintuitive to an administrative or management culture, are available and teachable. National goal campaigns can deliver a high return on investment, and, for the most part, the investments have already been made.

Part II:

How to Achieve National Goals—A Case Study of Leaders Leveraging Partnerships

Introduction

Leadership on national goals, as defined here, has the feel of creating something out of nothing. To be more exact, it takes the assets and energy that are available, but often hidden, and brings them together to produce big results that would not happen in the business-as-usual course of events. How does something like this happen?

In the 100%/0 campaign, six kinds of work were carried out as the campaign evolved from the intention of a group of leaders into a national movement.

It all began with individuals seeking leadership relationships with others. That seeking resulted in a self-directed leadership team forming itself through two *formative activities:*

- **Creating open space for leadership (1997–1998).** The career calling of several managers and staff created interest in and energy for working together. A space was created for leaders to surface and for a collaboration to form.
- **Creating a campaign (1998–1999).** A core group (called "Just Do It") formed itself and recruited others. The 100%/0 team evolved. It created the "game" to be played, a national campaign with bold, measurable goals.

The team then created the content and infrastructure of a campaign. The content is the stories of successful communities that demonstrate what a 100%/0 health care system can look like, and the leadership stories of how to bring that about. The infrastructure is the networks that enable communication among communities in action. The two *building activities* were:

- **Partnering with national networks to extend reach (1999–2000).** The team, guided by the social marketing experience of Dennis Wagner, entered into partnerships with national membership organizations. They gave the campaign team access to membership networks and thus to thousands of communities. Alliances were also created with organizations that were acting with communities on similar goals.
- **Partnering with benchmarks of the vision (1999–2001).** Communities that had successfully created 100%/0 systems were identified, and their leaders enrolled in the campaign as role models, teachers, and advocates.

The intended result of all these activities was for communities to commit to transform their health care safety net into a 100%/0 delivery system. The goal was to reach a critical mass of partnership and community enrollment that would result in a self-sustaining movement. The *outcome activities* were:

- **Enrolling communities in action (1999–2001).** Over three years, more than 500 community leadership groups were engaged in various ways to commit to 100%/0. National and local pacing events were used to enroll communities and accelerate community progress.
- **Forming a national movement (2001–2002).** By 2002, at least four organizations had formed to continue enrolling and working with communities on 100%/0. The locus of leadership had moved from the Bureau team to organizations outside the federal government. The team had successfully launched a national movement.

Figure 1: Time Line of the 100%/0 Campaign: From Leadership Intent to National Movement

Six Types of Campaign Work Carried Out	1997	1998	1999	2000	2001	2002
		Bureau's Leadership Team in Action				
1. Create Open Space for Leadership	Latent, hidden leadership called forth.	"Just Do It" group forms and recruits.	The 100%/0 leadership team in place.			
2. Create a Campaign		Game plan developed for a campaign.	Bold goal set: Enroll 500 communities.			
3. Partner with Benchmarks of the Vision			Leaders of Buncombe and Hillsborough join campaign as benchmarks.		New community benchmarks emerge around campaign events.	
4. Partner with National Networks to Extend Reach			Performance partnerships and alliances formed.	Performance partnership concept wins federal business award.		
5. Enroll Communities in Action			First two pacing events: PCAs* and GHPC.**	National and local pacing events used to enroll 500 communities and accelerate progress to 100%/0.		
6. Form a National Movement					Four new national enterprises form to assume leadership and carry 100%/0 campaign forward.	

* PCAs = State Primary Care Associations
** GHPC = Georgia Health Policy Center

The time line for the six levels of work is shown in Figure 1. The Bureau's campaign activities extended over a four-year period. The Bureau leadership team was in action from 1998 to 2001. In 1997, the leadership forces came together to launch that work. By 2002, the campaign was effectively a national movement led by organizations outside the federal government.

How the work was invented and executed demonstrates the creative and generative nature of a leadership campaign. Jim Macrae was right when he said "the work is easy." But it's unusual work that takes getting used to. It uses a method of "declare, discover, enroll" rather than the traditional "plan, allocate, do."

Creating Open Space for Leadership (1997–1998)

The Bureau's director and deputy director did not mandate the 100%/0 campaign—a leadership campaign cannot be ordered or regulated into existence. Instead, they created an open space where the natural leadership within the Bureau could surface and self-organize. They formed that space by declaring intent, setting up forums for leadership development, and acknowledging leadership when they heard it.

Leadership begins with intent that has passion and commitment behind it. Both Marilyn Gaston and Mary Lou Andersen brought that with them to the Bureau.

Gaston, a pediatrician, came to the Bureau as its director in 1991 from the National Institutes of Health. She found a centrally controlled set of programs being managed aggressively, like a business with a bottom line. She quickly saw that she was bringing a new approach to management (an open, participatory model) and a new strategic focus (the result we deliver is better health).

> "I found the Bureau being managed as a business, to the bottom line. The mission was to increase access to care. Performance was the number of community health centers funded, dollars spent, number of patients served. I appreciated this discipline and structure. It worked. I wanted to continue that. Yet, I felt I brought something different and wanted to see something added. I was about people's health. I brought a clinical perspective. I added 'and improve health outcomes' to the mission. I called the centers 'healing centers.' I put primary care in the name of the Bureau to have a broader view than programs and centers. I added the motto, 'The people we serve, the people we are.'"

In the mid-'90s, Gaston began talking about the "safety net we needed vs. the safety net we had." She wanted to describe the total need and the gap in order to introduce the issue into the policy-making process and the program management system.

> "In speeches to the National Association of Community Health Centers, in meetings with my executive team, I began to ask about our 'penetration' into the need out there. I asked my managers to tell me not only how many we see, but also how many we need to be seeing. I asked them to give me a system for monitoring the unmet need. I wanted to be able to explain our penetration into the universe of need and show what it would take to serve everyone in need."

Her executive team did not leap into the open space she was trying to create for leadership.

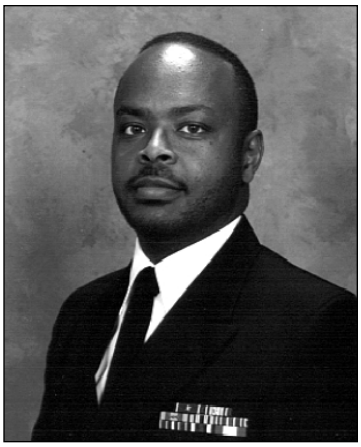
> "Whenever we would set program goals, the staff would avoid the gap and penetration issue. Instead I got, 'last year we served x, next year we will serve x plus a few more.' They would not say how many they wanted to serve. When I asked for bold goals, I got the number they thought they would have funding to serve in five years."

Gaston also wanted to go "beyond access to success." She called for action to eliminate health status disparities.

> "In 1994, part of the Clinton administration's mission was stated as: 'reduce health status disparities.' That is not good enough. There is no urgency or call to action in 'reduce.' I had the Bureau push 'eliminate.' We want the nation to eliminate disparities. We sold it, first to Dr. Claude Earl Fox, the HRSA administrator, and then to Dr. David Satcher, the surgeon general. When people would complain that 'eliminate' is too bold, too unrealistic, I would ask 'what is the level of disparity you are willing to live with?' ...
>
> "In 1997 and 1998, 'eliminate disparities' took on new meaning for me. Eliminating disparities was viewed by many in Washington as impossible. But I visited communities that were taking specific disparities and eliminating them! Low birth weight of African American babies vs. white babies, teen pregnancy in low-income schools vs. upper-income neighborhoods. We could show it can be done, people are doing it. That gave me inspiration and courage."

In 1997, Andersen had arrived at the Bureau to be the deputy director. Then 67 years old, Andersen had been in the federal government since the mid-'70s. Early in her career, she was responsible for taking federal health programs into Appalachia and West Virginia. She found she had a knack for pulling all the pieces together on the ground: "In three years we opened 27 health clinics in West Virginia. In those days we integrated services and did it at the community level." A natural community organizer, she believed in community-based organizations and health care as the keys to social justice. She believed the way to get things done was to get things done. "Just do it" was her favorite expression.

Gaston and Andersen both were at points where they could see the time when their federal careers would end. (Andersen would retire in 1999 but continue to work as a consultant to HRSA through 2001. Gaston would retire in January 2002.) Throughout 1997, they discussed what their legacy would be. They asked who would be the future stewards of the program tradition and the future leaders of the more ambitious interpretation of the mission? They wanted to leave with the right mission and the right people in place.



Regan Crump

Encouraged by the experiences of the Food and Drug Administration, they put in place a leadership development opportunity for the staff, a 12-month program run by the Council for Excellence in Government (CEG). A group of 20 to 30 mid-level managers spent one to three days a month in work sessions and visiting public and private organizations that are benchmarks of excellence. Experienced coaches guide participants in developing leadership behavior, and each participant takes on a leadership project.

Andersen saw the program as a strategic step. It gave her and Gaston access to staff that they couldn't easily reach by going through the line. Andersen saw Gaston's executive team as being in the old command and control school of management and resistant to her vision and requests. CEG was an opportunity to engage another level of potential leadership. "We hand selected the participants. These were the future stars, usually deputies to the executive team. We wanted them to break free, and they did." The first class of 20 middle-level managers started late in 1997.

Much of leadership practice is sensing and encouraging the leadership of others. Andersen was very good at seeing and cultivating leadership.

She listened to staff. Early in 1997, she and Ronda Hughes, her special assistant, were planning the retreat where the Bureau executive team would set goals with performance measures and targets. Andersen asked, "What should be our target for an increase in the number of people served?" Hughes made a provocative response: "Our target goal should be 100 percent access." She then explained, "Our mission means we are responsible for all 45 million in need, not just the 9 million our programs reach. The strategic plan should also be about how we serve the 35 to 40 million our programs are not reaching!"

Andersen's immediate reaction was, "Are you crazy? Where are we going to get the extra billions of dollars to do that?" But her community organizer instincts told her that Hughes had taken Gaston's vision and quantified it as a motto she could work with: 100% access! "I knew this would not get far with the executive team. I needed to find some people to play with it and get excited about it first. I needed to know what the heck I was talking about." Andersen talked with mid-level managers in the Bureau she thought might find the idea interesting. Not only was there excitement about the idea, but many asserted that achieving 100% access was plausible, if attempted at the community level. Their experiences had given them confidence that communities could organize and create great safety nets around and beyond the federal and state programs available to them.

In addition to listening, Andersen challenged staff. Early in 1998, several CEG fellows asked her to help them collaborate on their CEG projects. "A number of the CEG fellows came to me. They were antsy to do something. I offered to convene them in my office if they were ready to have a serious conversation. They sure were ready." Andersen invited eight to 10 fellows and mid-level managers to her office for weekly meetings. Participation was voluntary. Several dropped out and others were invited. A core group quickly formed its own unique identity as the Just Do It group.

Rick Wilk

"Mary Lou asked us to discuss what we thought about the direction of the Bureau. We decided we stood for 100%/0. We wanted to use our programs as platforms from which to realize that vision. How do you do that? How can we work together? 'Just Do It' enabled us to refine our message and to figure out how to use our programs, our every day work, as platforms to create 100%/0." (Chuck Van Anden)

"Mary Lou convened us and urged us to go into action. Her charge was 'just do it.' Chuck Van Anden brought Nike 'Just Do It' hats to the next meeting. We became the 'Just Do It' group and agreed to take off our program hats and wear our 'Just Do It' hats when we were together. We wouldn't relate to our division, office, or branch." (Regan Crump)

"We left our program agendas at the door. We took off our program hats and became the 'Just Do It' group. We figured out how to take a big concept into action. For me the ideas were: communities can do it, communities can take control, communities can make a difference. I always believed it. Just give them courage. I came into government believing in community action, the power of people." (Jim Macrae)

It turned out that 100% access and 0 disparities were visions of the future they all felt they were called to make happen.

By expressing intent, Gaston and Andersen were finding others ready to collaborate. They were also uncovering assets they didn't know existed. An interesting example is Rick Wilk, who was in the Chicago regional office and, in a sense, out of sight, below the surface. He soon emerged as one of the campaign leaders. He brought to the team experiences and a method that the team could use.

> "The CEG fellow program put me with and in front of people who were doing the mission work. This was important to me because I was out in the regional office and had no contact with headquarters.
>
> "Early on I was one of two people selected by the class to present projects to Dr. Gaston. My CEG project was 'creating affiliations between hospitals and health centers to generate more center capacity and more access to care.' I have created these affiliations in the past, and each one generated 5,000 new people getting care with no additional federal grants! That's equivalent to putting 3 FTE physicians in the poverty community. The hospitals find it in their best interest to put in money and physicians, and to donate space, equipment, and services. Their charity care costs go down. It's a win/win deal.
>
> "The way the Bureau usually gets more access is to hand out more grants. My message to Dr. Gaston was, 'I can get a large number of people in a community access without having to give a grant.' I know I can do it because I have done it in several communities. Right now my current workload in grant administration prevents me from putting time into forming these affiliations. Mary Lou said, 'We have to do something about this.' Soon I was reassigned to Jim Macrae and told to work on the hospital/health center affiliations as one approach to achieving 100% access.

Jim Macrae

> "CEG was an incredible personal development experience for me. It was an opportunity for me, after doing the same administrative work for seven years, to grow. I learned you can do bigger work than just the tasks you are assigned. If you work bigger, it leads to greater satisfaction and more opportunity for advancement, and you see greater things happen. And the best part is that it's a lot of fun."

Wilk's advocacy and experience had a big impact on the people playing with 100% access. His personal experience with a very simple type of restructuring generated more access, more primary care access, and more resources for health centers. Here were a set of relevant experiences as well as interest buried deep in the Bureau/HRSA organization, and Gaston and Andersen created the open space for them to surface.

At the beginning of 1998, there were a few individuals with ideas and vision. During the year they became the Just Do It group, recruiting and attracting a core team of 10. By early 1999, they were a united force, a broader 100%/0 leadership team with a game plan ready to launch a national campaign.

Creating a Campaign (1998–1999)

The "Just Do It" group saw itself taking on something big and important. With members meeting weekly and interacting daily, the purpose to be pursued was quickly articulated. It had three important attributes:

- **It's 100% access and it's 0 health status disparities.** In the beginning it was just 100% access. Generally, team members could see how to increase access: more doctors, more clinics, more outreach, more cultural competence, all done through financial restructuring. Eliminating disparities, though, always brought people up short. That seemed harder to achieve because of issues of lifestyle, race, cultural differences, and poverty. Gaston asked that the campaign and the team work with communities to tackle disparities. The team was ready for that and agreed.
- **100%/0 can be achieved by communities today.** Gaston asserted that achieving 100%/0 was a matter of political will in communities, not one of resources or new federal programs. "I know communities can do this because I have been out there and I have seen some of them doing it. If a few can do it, the others can. This is an issue of political will." This sounded right to everyone in the Just Do It group—to some, because it just had to be done; to others, because they had experiences with communities similar to Gaston's.
- **It relies on evidence and data.** Gaston was constantly calling for examples backed up with data. Over time, as she became the leading public figure and spokesperson for 100%/0, she became more and more insistent on being able to present evidence. Often she would draw a line in the sand, preventing a desired event from happening or refusing to make a requested speech unless someone came up with examples she could use. The ability to track community progress and describe the results achieved by communities in action became a major priority of the campaign.

The game plan was simple: *Ask communities to do it and then inspire and guide them by showing them other communities that had done it*. The game plan had three important elements: a bold goal with a performance measure, replication of what works, and network partnerships for reach.

It took a lot of conversation to formulate a goal that was bold and audacious for the team's circumstances. The goal they came up with at first looked impossible: *Enroll 500 communities and accelerate their progress to100%/0 by 2001*. The group constantly asked itself: How do we measure success on that goal? How do we track progress?

Chuck Van Anden of the NHSC had been assessing community experiences with Corps placements and believed he had seen communities transform health care. He accepted the challenge of translating the campaign vision and goal into a measurement system. He came up with a 10-step scale that became an important tool for articulating goals, managing the campaign, and, later, creating performance agreements with national partners.

The 10 steps defined a generic community development process. Each step was a milestone that a

Bold, Audacious Goals: The Engine of Leadership

Bold national goals startle and draw resistance in organizations. Introducing them takes courage and the willingness to deal productively with the resistance. The resistance is natural. Bold national goals always define a kind of performance that managers do not want to be accountable for, and often defy conventional wisdom.

In the Bureau, conventional wisdom was against 100%/0. The prevailing view was that 100% access called for more federal funding. Congress would have to give an additional $4 to $5 billion to the health center program to cover all the uninsured. That was not going to happen. Most felt the real solution was universal insurance coverage. The Clinton administration had failed to get health care reform in its first term and that was a dead topic. How the nation closes the gap in access to health care was considered a policy issue beyond the domain of the Bureau. The conventional wisdom said there was nothing to be done by the Bureau.

The campaign goals also went far beyond the program goals the Bureau managers and staff traditionally set, ones they could deliver with the program resources for which they were given responsibility. For example, developing so many new center grantees and National Health Service Corps (NHSC) placement sites. The 100%/0 team was making itself accountable on goals for which it did not have the required resources and was committing to find and secure those resources. That was a different kind of work than the traditional grant and program administration of the Bureau.

In May 1999, the100%/0 team presented its goals to the Bureau executives and managers in the strategic planning process. The group was startled by these goals and resisted them. “Some felt that it was imprudent to set such ambitious goals, others felt it was not appropriate work for the Bureau. They were being honest and protective of Dr. Gaston and the Bureau.” (Regan Crump)

Reasonable counter proposals were made by staff. The first was to move to a pilot approach, which involved selecting two cities and focusing on them, then doing a demonstration and evaluating it to show it can be done. Another proposal was to focus on the 10 neediest communities. The team saw these reasonable goals taking them down a different path into project management. They acknowledged the advice but stayed committed to enrolling 500 communities.

The campaign goal eventually became part of the Bureau’s strategic plan. The team gained support within the executive team by promising to increase access to primary care by making relatively small investments in community development. They were promising to deliver more communities ready to apply for CHC grants and NHSC placements. The team was learning how to run the campaign to produce results that Bureau divisions and offices valued *and* perform on campaign goals at the same time.

community was expected to achieve in building its 100%/0 delivery system.

The campaign team estimated that the country consisted of 3,000 communities. (There are about 3,000 counties in the country and 2,000 federally designated health profession shortage areas, many of them counties.) The vision of the 100%/0 campaign was now articulated as 3,000 communities across the country moving through the 10 steps. The goal was to have 500 communities being tracked on the scale in three years. Figure 2 identifies the 10 steps and illustrates how the scale was used to report campaign progress.

The second element of the game plan was an approach to replication of what works. Experience shows that it takes about four years for a community to move from step 1 to step 10. The campaign aimed to accelerate that rate in each community. The team believed it could help communities move through each stage fast by linking them to a network of successful communities for inspiration and guidance.

The breakthrough idea of the team is that it would first replicate the leadership behind models that work and expect the models themselves to be greatly adapted to local circumstances.

Replication was a concept that the team had experience with. The Bureau had created an annual innovation award program, called Models That Work, to identify and spread successful community health projects. The team understood that social innovations and best practices were rarely replicated on a large scale. Innovations did not transfer successfully because the passion and commitment that generated them were not present in the adopting community. The Just Do It group believed that while a model of success was a useful blueprint, it was the leadership that had to be replicated. They concluded they had to identify and work with leaders in each community. They would use models that work to stimulate interest, to inspire, and to guide. They would use the leaders from successful communities as role models and teachers.

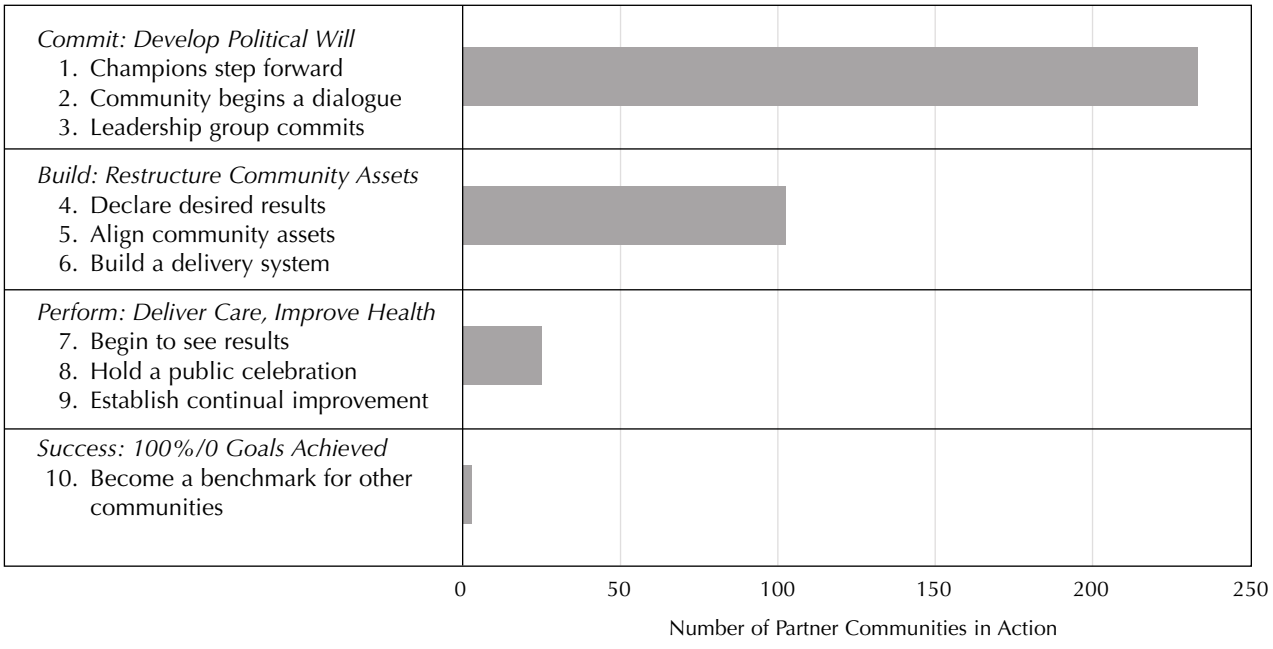
The third element, network partnerships, came from outside the Bureau. The Just Do It group had to figure out how to reach and engage 500 communities quickly and 3,000 communities in the long run. They had no staff or budget for this work. The answer was to leverage themselves through networks. Ask organizations with networks reaching into many communities to use these channels and relationships to enroll communities in the campaign. That answer came to them from another federal agency.

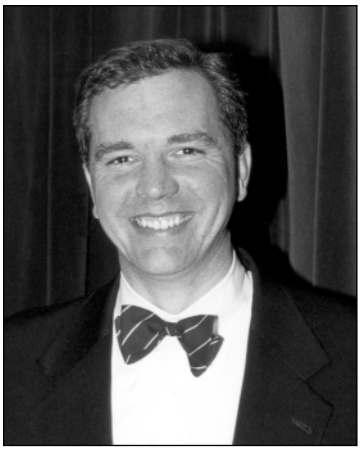
In the fall of 1998, the group met Dennis Wagner. An expert in social marketing from the Environmental Protection Agency, Wagner had experience with national campaigns to achieve national goals that were not backed by legislated mandates or funded programs.

Gaston and Andersen recruited Wagner to lead a social marketing campaign for 100%/0. He joined the Bureau and the campaign team in December 1998 as the Just Do It group was becoming the 100%/0 team. Wagner introduced a set of methods and principles that would become an important part of the 100%/0 game plan. The four most dramatic were:

- Extraordinary results flow from public commitment to bold goals.
- Partnership networks dramatically extend reach and influence.

Figure 2: 100%/0 Campaign Performance on 10-Step Scale
(As reported to the administrator of the Health Resources and Services Administration, September 2001)





Dennis Wagner

- Results are achieved by being tight about the what and loose about the how.
- Work is generating commitments through "requests" and "offers."

Using a simple communication model, Wagner showed how one person could reach millions by enrolling partners that controlled access to networks. The campaign could use the communication channels of national membership organizations to reach leaders in every community. For example, a national organization such as the United Way had chapters in 50 states and every community. This approach addressed the Just Do It group's issue of reach. Here was a method for reaching 3,000 communities. And the partnership approach seemed more feasible than the program and project activity orientation that kept surfacing within the Bureau.

Partnering with trusted sources was a key to campaign success. Moving target audiences requires collaboration with multiple respected sources. Target audiences usually need to hear information or requests for action a number of times from a number of trusted sources before they act. Repetition and reinforcement by multiple sources increase the likelihood of action.

Going into 1999, the team was starting to make the campaign fully operational. That involved two additional stages of intensive work: creating the partnership networks of national organizations and communities, and finding the benchmark communities that show it can be done.

Partnering with Benchmarks of the Vision (1999–2001)

A good route to success is to find out what works and do more of it. One of the most important quests of the 100%/0 team was to find examples of communities that have put in place 100% access delivery systems. The team saw that it was looking to set benchmarks for three dimensions of success:

- The service delivery system and its performance
- The process and time line the community used to build the system
- The leadership that caused it to happen

The intent was to develop a relationship with the benchmark leaders and showcase them to other communities.

The first two benchmark models came to the attention of the 100%/0 team through the Harvard Innovations in Government Award program: Hillsborough County and Buncombe County. They were as different as night and day in their origins and delivery models, yet similar and powerful in the results they produced. Both could show "better health for more people for less money" (Hillsborough's motto).

Hillsborough responded to a county financial crisis and involved a political campaign to get a sales tax passed. With elected officials and county government leading the effort, Hillsborough used a new sales tax to put in place a major delivery system reform that was organized as a health care enrollment plan and managed by county government.

The Buncombe County program emerged from a long-term concern for citizens who were underserved. Its guiding force was leadership from the physician sector. Planning and implementation grants from the Robert Wood Johnson Foundation helped launch the effort. Buncombe County saw its health care sectors self-organize into an integrated delivery system with a physician-led, "better organized charity care" program as the catalyst and the glue. Both Buncombe and Hillsborough established collaborative planning processes that involved all key players and sectors.

These two models and their differences were exciting to the 100%/0 team. They demonstrated that the work could be done, validated the process described in the 10-step scale, and proved there was more than one way for communities to do this work. The nature of these cases and the work with the leadership behind them profoundly affected the team and helped shape the method and direction of the campaign.

Alan McKenzie and the Buncombe County Medical Society

February 1999 was an important moment for the team. Four people from the 100%/0 team visited Buncombe County and had the team's first encounter with a full-scale, well-documented community 100%/0 delivery system. Having read a brief description of Buncombe County's Project Access in a description of the 1999 Harvard Innovations in Government Award winners, the team called to arrange a site visit because it

sounded too good to be true. Project Access was a charity care program run by Buncombe County Medical Society as well as an organizing force for, and a component of, a comprehensive, integrated delivery system.

The Medical Society had created a physician-financed health care plan for specialty service for the uninsured. This initiative provided easy access to between $3 and $4 million in donated services each year. It took the charity care of individual physicians and organized it into a health care system program. The leadership of Project Access then used the charity care program to organize with other players a comprehensive set of primary care, secondary care, pharmaceutical, and hospital services. That collaboration enabled Buncombe County to serve the 18,000 residents who were uninsured and whose income was under 200 percent of the federal poverty level.

Later, the team learned that a year earlier the Innovations Award site evaluator had expressed the same excitement:

> "In the Innovations application, Project Access is presented as an attempt to provide health care for uninsured patients in Buncombe County, North Carolina, through uncompensated care volunteered by the physician members of the Buncombe County Medical Society. While that presentation is entirely accurate, the site visit uncovered a much more ambitious goal—to build an integrated system of care for all the citizens of Buncombe County. Project Access has achieved much of this aim.... With a combination of positive incentives, subtle sanctions, keen political savvy, and meticulous management, the Buncombe County Program has achieved an admirable local version of health reform while avoiding the fatal pitfalls that have swamped more prominent public and private attempts to change health systems….I know of no other community where so much has been achieved." (Miles Shore, MD, Harvard University, Site Evaluator's Report to Selection Committee, July 1998)

The site visit boosted the work of the 100%/0 team. It revealed to the team how leadership was a

Alan McKenzie

constant force in developing an integrated delivery system and showed how these systems could be made sustainable. It gave the team a vivid picture of what the system looks like. Finally, the site visit led to a major partnership for replication.

The team went to Buncombe looking for a successful model to replicate. With that in mind, the team was excited by the widespread ownership it found on-site. Physicians, pharmacists, county executives, county health department, community health center director—all expressed compelling stories about their participation in Project Access. The team could see what a powerful experience it would be for a group from another community to visit Buncombe.

While on-site, the team explored with McKenzie his interest in having Buncombe County and Project Access play a prominent national role in the 100%/0 campaign. Given his responsibilities as executive director of the Medical Society and manager of Project Access, this was not a casual decision to make, but he agreed.

The Bureau's team was nervous about how to follow through. They had no budget with which to get McKenzie involved and no program to plug him into. One member summed up the team's conclusion: "If we are for 100%/0 and we can't figure out a way to partner with this guy and this community, we might as well quit." The team did figure out a way, though. In the fall of 1999, the Buncombe County Medical Society signed a cooperative agreement to be a performance partner with the

Bureau. McKenzie agreed to enroll 45 communities over three years and to move them along the 10-step scale as they implemented their own adaptation of Project Access. McKenzie went on to play three roles in the campaign. He presented the Project Access story at state and national meetings as a 100%/0 model that works, he signed up communities to implement Project Access and coached them through the 10 steps, and he became a leader of the national100%/0 campaign team.

The first community to replicate Buncombe County's Project Access was Wichita, Kansas. Led by Dr. Paul Uhlig, a local surgeon, this replication happened quickly. Nine months after contacting McKenzie and visiting Buncombe County, Wichita Project Access was seeing patients. In 2001, McKenzie had hired staff to handle all the requests for technical assistance. By the end of the year, the Buncombe County Medical Society was working with 50 communities and approximately 21 had begun to see patients. In 2002, the replication effort was transferred to the new, not-for-profit American Project Access Network.

Phyllis Busansky, Cretta Johnson, Pat Bean, and Hillsborough County, Florida

The second model that came to the team's attention was Hillsborough County's health care plan. In addition to the Harvard Innovations in Government Award, it had received the Bureau's annual Models That Work competitive award.

An impressive plan, it replaced a fragmented, short-term, emergency-driven delivery system in financial crisis with a comprehensive, coordinated, managed care network. Hillsborough HealthCare is a comprehensive plan for indigent county residents who do not qualify for other coverage. The program is administered by the county's Department of Health and Social Services. Several networks—made up of primary care physicians, specialist, and hospitals—deliver the services. The program began in 1992, financed by property tax and a special sales tax. Of the estimated 39,000 potential enrollees, the program was seeing 34,000 by 1998.

Phyllis Busansky

Being a formal county government program, its performance and costs are well documented. Performance measures are tracked and audited. Operating since 1992, the managed care network had a track record of remarkable results in both reducing costs and improving health.

In May 1999, the team invited Cretta Johnson, director of the program, to one of its first 100%/0 enrollment events. Over the next 18 months, Johnson presented the Hillsborough model at several events. In April 2000, Patricia Bean, deputy county administrator and one of the leaders in developing Hillsborough HealthCare, hosted a meeting of county commissioners from around the country to showcase the plan.

With Hillsborough, the 100%/0 team had a powerful example of a model that works. The template of system operations and performance was established. Hillsborough proved a community could do it on its own, could produce big system changes without the federal government. It had eloquent spokespersons in Johnson and Bean to describe how the process works.

But something was missing. Lacking was a good picture of the leadership force or the steps the community went through. With a "how to do it" that sounded like "first pass a sales tax, then build a health care plan," the campaign team found most audiences dismissive. One community developer put it this way: "If I had all that money, I could

Better Health for More People for Less Money: The Hillsborough County Example

Integrated community health care systems can demonstrate better health for more people for less money. Hillsborough HealthCare of Hillsborough County, Florida, reported the following remarkable results in its 1998 annual report.

The System

- Supported by a sustainable source of funding: a local option local sales tax of up to one-half of one cent, authorized by the state legislature and enacted by the county in 1991, along with $26.8 million per year in property taxes as mandated by the State of Florida for indigent care.
- Increased the number of health clinics (access points) from four to 12, and the number of people served from 15,000 to 28,000.
- Replaced a fragmented, short-term, emergency-driven delivery system with a comprehensive, coordinated, and managed continuum of care networks.
- Increased the number of participating hospitals from three to five, and established a panel of referral specialists where none had existed.

The Results

- Reduced costs, per member per month, from $600 to $202 by 1997.
- Reduced the average length of hospital stay from 10.2 days before the plan to 5.1 days.
- Reduced the average number of admissions per thousand patients from 133.6 during the first year to12.4 for the year 1997.
- Saved $10 million in emergency room diversions since inception.
- Served twice as many people and spent $47 million doing so in 1997, even though in 1990 costs had been projected to rise from $35 million to $105 million by then.
- Changed the predominant reason for hospital admissions, in just four years, from “avoidable admissions” to those that are typical for the general population.
- Changed the health status of the served population, as evidenced by fewer hospital admissions for preventable conditions, for example:

	Percent of all Admissions	
	1992/93	1996/97
Diabetes	26%	3%
Gall Bladder	10%	2%
Asthma	9%	1%

- Lowered the sales tax from one-half of one cent to one-quarter of one cent, reflecting the cost controls in place with a full access system.

build a great health care system, too!" People saw the remarkable system but then dismissed any possibility that they could build one like it. They considered the sales tax initiative that made restructuring possible to be something that just happened. The idea of creating their own tax or alternative financing was beyond most people's imagination. The team felt it had to find the people who got the local sales tax in place and showcase them.

In June 2000, the 100%/0 team met the person who led the sales tax campaign, Phyllis Busansky, a former elected county commissioner. One of the champions and leaders of the two-year campaign, she was retired from politics and consulting.

Busansky described how the Hillsborough plan grew out of the financial crisis the county government faced. Florida county governments are responsible for indigent care. In the late 1980s, Hillsborough's bill was about $30 million a year and was growing at about 20 percent a year. The cost would soon exceed its property tax cap. Busansky organized a coalition to develop a solution and then launched a political campaign to put it in place. The sales tax solution required state legislature action, and they were turned down once before they finally got it. She was one of the seven county commissioners who voted for the sales tax; the one who did not vote for it was the only commissioner not to be reelected.

Busansky immediately saw Hillsborough as a model for 100%/0. She argued that, for most communities, creating 100%/0 was a matter of creating political will, and they could do that by organizing a local campaign. She believed that moving to 100%/0 required the 3 *p*'s: "It's people, politicians, and press. You need everyone to see that this works for them. You have to realize that the politicians care and will respond. They need to hear simple things they can do and see that the voters are behind it. If you have the people, the politicians will act. You can't make this happen without local government behind it. And finally you need to involve the media. This has to be out in everyone's face. To get change you have to keep it in the public eye. Tell the press what you are trying to make happen and create events they can report on."

Busansky felt that regardless of what model a community adopted, the development of political will had to happen. Elected officials can be a leadership force and a receptive audience in a campaign to create a 100%/0 delivery system. The Bureau awarded Busansky a small contract to provide technical assistance to the political leadership in up to eight communities. She became a performance partner with the campaign and soon became a national leader in the100%/0 campaign.

Models That Work: The Currency of the Campaign

As the campaign carried out events in 2000 and 2001, benchmark models began to proliferate. Benchmarks were continually being added to the campaign portfolio. They included financing methods such as the triple payer insurance plan of Muskegon County, Michigan, that provided coverage for employees of small businesses. They included examples of strategic elements of an integrated system such as the Jessie Tree in Galveston, Texas, a central safety net referral and assistance system.

The campaign comes alive whenever people experience successful models and the leadership behind them. Therefore, the primary campaign communication tactic is a call-to-action event where communities, success models, and coaches all come together to generate commitments and make deals. The next two sections describe how the models that work were brought to communities.

Partnering with National Networks to Extend Reach (1999–2000)

In January 1999, the 100%/0 team began to approach national organizations that had the potential to be partners. The strategy was to create a network of special purpose networks willing, for whatever reason, to also support the 100%/0 campaign. The 100%/0 team found three sources of networks to advance the campaign: those associated with federal programs, national membership organizations, and organizations with similar access missions.

Using Programs as Campaign Platforms

Managers on the team found that their own operations contained networks that could be engaged in this work. Grant activity and contractor initiatives that reached into many communities could be leveraged. It took a special effort to create the partnership relationship. In principle the campaign activity piggybacks on resources being spent anyway for other purposes. The managers found they had some discretion to follow this strategy.

The Bureau's Office of State and National Programs (OSNP), managed by Jim Macrae, was responsible for, among other things, support grants to state primary care associations (PCAs). Their members were primary care centers in communities throughout the state. This network of state advocates of primary care for the poor was a natural group to be enrolling communities in 100%/0. Moreover, in 1999 OSNP was about to fund approximately half the PCAs to hire community developers. The objective was to help communities meet the conditions necessary to apply for health center grants and NHSC placements. Macrae had the insight that this site development work would put them in underserved communities with community leaders who could also lead a 100%/0 transformation. It might be possible to ask the community developers to enroll the communities they work with in 100%/0 if it helped them accomplish their site development agenda.

This work could not be mandated by OSNP because it was not part of the original intent of the grant funding. But it might be possible to enroll the community developers by asking. This turned out to be the case. An enrolling meeting was held in May 1999 to secure PCA and community developer commitments to bring the communities they worked with into the campaign.

In the spring of 1999, Macrae declared to the team that the goal of 500 communities enrolled was achievable. If the 26 states with community developers each were to get 10, that would bring progress toward the goal to the halfway mark. It was becoming clear to the team that large numbers of communities could be engaged by networks natural to their agency. This same approach was used by Van Anden with the NHSC site development and later by Dr. Eric Baumgartner with the Community Access Program.

Developing Performance Partnerships

The more networks the team could engage, the more points of influence could be turned on in any one community. With so many stakeholders in any

community's health care system, hundreds of possible local champions could be engaged. The list included physicians' organizations, hospitals, pharmacists, unions, local elected officials, local government managers, and the faith community. Most local organizations and professionals belong to several national membership organizations. One of Wagner's responsibilities was to find national organizations that had members or affiliates in hundreds or thousands of communities and sign them up as partners.

The task was to find one or more people in the national membership organization who were willing to be a champion for enrolling communities. Once a champion was found, Wagner would develop a "performance contract" and enter into what he called a "performance partnership." The Bureau would provide $50,000 to $100,000 per year under a cooperative agreement to cover staff costs in working through its channels to enroll and assist communities. The organization would enter into a three-year agreement to enroll, for example, 25 communities and have them move through the 10-step scale at a specified rate. The partner would commit to performance targets and to report progress quarterly using the 10-step scale. As the communities reached step 7, the partner would report on the number of people given new access to comprehensive services and the number of dollars committed to providing access.

A community reaching step 7 was expected to generate $1 million to $100 million worth of new access depending on its size. The return on investment was extraordinary. Rather than relying on direct federal appropriation, communities were restructuring existing assets to increase access to primary care for the underserved. Very small investments in social marketing by the Bureau triggered large community reinvestments in access to care.

In 1999, Wagner put in place eight formal performance partnerships. Four of the partnerships were with national membership organizations whose members were in local communities and who had a professional interest in health care systems. They represented philanthropy, local elected officials, local government executives, and a health care specialty:

Eric Baumgartner

- United Way of America
- International City and County Managers Association
- National Association of Counties
- American Academy of Pediatrics

Two of the performance partnerships were with organizations that had been funded by foundations to help communities develop their health care systems. Each had its own mission and set of relationships with many communities. The leaders of these efforts were very comfortable with the mission of 100%/0 and were excited about entering into a performance partnership:

- Coalition for Healthy Communities and Cities, Health Research & Educational Trust, American Hospital Association
- The Access Project, Brandeis University

And two other partnerships were with individuals who represented the first two benchmarks of 100%/0 community leadership:

- Alan McKenzie, president, Buncombe County Medical Society
- Phyllis Busansky, retired county commissioner, Hillsborough County

With McKenzie, the intent was to replicate the Buncombe County Medical Society's Project Access through the leadership of medical societies and physicians in partner communities. McKenzie

had a template for an integrated delivery system and a process for creating it that other communities could follow. He committed to helping 45 communities. With Busansky, a prime mover in the creation of the Hillsborough model, the focus was on creating political will in local government for 100% access. She entered into a performance agreement to take eight communities through steps 1, 2, and 3 on the scale.

In September 2000, the Bureau's performance partnerships concept was one of six winners of the annual Business Solutions in the Public Interest Award given by the Council for Excellence in Government, *Government Executive* magazine, and the Office of Federal Procurement Policy (of the Office of Management and Budget). It honors agencies with innovative acquisition strategies that advance government management and performance. The Bureau was singled out because of the unique way it created partnerships to achieve its mission through social marketing. *Government Executive* described the program in its federal procurement review issue:

> "The Bureau of Primary Health Care's 100% Access and Zero Disparities campaign showcases how agencies are…taking advantage of partnerships with nonfederal entities. Upon discovering it was reaching just a quarter of the 43 million Americans who are underserved and underinsured for health care, the bureau had to find a way to reach nearly 33 million people without

The Bureau: A Platform for Reaching National Goals

The Bureau of Primary Health Care is one of four bureaus in the Health Resources and Services Administration (of the Department of Health and Human Services).

The health access safety net program. For the period covered by this report (1998–2001), the two cornerstone programs of the Bureau were the community health centers (CHC) program and the National Health Services Corps (NHSC). Both bring medical professionals into poor and underserved communities. They deliver comprehensive preventative and primary care services to the neediest, poorest, and sickest patients in rural and inner city areas. Both have become successful and effective programs. They are important elements of the nation's health care safety net for the poor.

Program scale. The Bureau manages a $1 billion grant program supporting approximately 650 community health and migrant health centers that serve 9 million people each year (40 percent are uninsured and 70 percent are below the poverty level). Grants go to community-based organizations governed by community boards. The centers provide primary and preventive health care services in designated "medically underserved" areas where income, geography, and culture limit access for vulnerable populations. About 4,500 physicians work in health centers in our neediest communities.

NHSC places medical professionals in underserved communities through scholarship and loan repayment agreements. About 2,500 professionals serve in these communities each year, and they commit to serve three years. Each year about 700 clinicians graduate and 600 to 700 are added. An estimated 21,000 alumni practice today.

Infrastructure. A sophisticated infrastructure supports this service network. The National Association of Community Health Centers is the national trade association serving and representing the interests of America's community health centers. It is an effective developer and advocate of the federal program. Each state has a Primary Care Association (PCA), which is a membership association of all the federally funded health centers in the state. The PCAs receive federal grants to develop new sites and to improve the operations of centers. Grants are also made to state health organizations (primary care organizations) to assist in the development of need data and the designation of "medically underserved areas." The Bureau enters into cooperative agreements—with such national organizations as the National Governors Association and the National Conference of State Legislators—to transfer information and keep stakeholders informed. In addition, the Bureau manages center financing, pharmacy, technical assistance, and other support programs that assure a high-quality, sustainable primary care network.

adding staff or budget. It is accomplishing the goal by identifying communities that have eliminated health disparities and guaranteed care to the underserved and matching them with communities in need of help. The Bureau funds efforts to replicate communities' successes, pairing civic leaders from a mentor community with those of a locality in need of assistance. The Bureau doesn't fully fund each effort. Rather, it has come to see itself as part of a 'social marketing' effort, sharing the success of certain communities." (Anne Laurent, Government Executive, August 2000)

Karen Minyard

Forming Alliances

The campaign team continually encountered organizations whose own mission and work made them natural allies for 100%/0. Some were willing to co-lead on the campaign and to use their programs and projects as campaign platforms. The alliances formed with no cost to the Bureau—a win/win relationship that extended the networks of the campaign and the alliance partners.

The most powerful alliance was formed with the Georgia Health Policy Center (GHPC) at Georgia State University. In 1997 GHPC was funded by the state at a million dollars per year to design and run Networks for Rural Health (NFRH). The program guides rural communities in Georgia through a comprehensive coalition-building effort in which they craft a health care system that works for community residents. NFRH's rural health "developers" coach community leaders through a disciplined process (seven well-defined steps) that systematically enables leadership and vision to surface, creates political will, develops knowledge, and builds infrastructure. As communities develop the social capital needed to make these changes, NFRH encourages them to "collaborate with neighboring communities" to make improvements that individual communities would be unable to accomplish. These multiple-community collaboratives are then able to acquire facilities and management information services that they could not otherwise afford. The result is integrated regional and local health care systems that provide greater access and deliver health status.

In the summer of 1999, the NFRH director, Karen Minyard, approached the 100%/0 campaign team to help her facilitate a two-day conference in which community teams from across Georgia would plan the transformation of their health care systems. This turned out to be an extraordinary event and a defining moment for the 100%/0 team. (See a description of this event on page 38.) Here was someone running what was, in effect, a statewide campaign for 100%/0, and she had been doing it on the ground with dozens of rural Georgia communities since 1997. Karen Minyard became a co-leader in the national campaign. GHPC used its own resources to participate in 100%/0 events throughout the 1999–2001 period. GHPC also agreed to be the 100%/0 champion for communities in Georgia and to track their progress on the 100%/0 scale.

The Bureau's team went on to develop working relationships with other organizations deeply committed to increasing access. They included health care systems, such as Ascension Health Care and The Sisters of Mercy Hospital System, and large multi-community foundation demonstrations, such as The Community Care Network and Communities in Charge.

Enrolling Communities in Action (1999–2001)

Dennis Wagner would say, "The work of the campaign is three things: making commitments ourselves, securing commitments from others, delivering on commitments. If you are not doing one of these three things, you are not doing the work." The route to success in the campaign is all about securing commitments. It is having a leadership group in the community commit to 100%/0 and then working with them as they generate the local commitments that take the community through each of the 10 developmental steps. Over three years, more than 500 community leadership groups were engaged in various ways to commit to 100%/0.

The 100%/0 leadership team used big, public events to generate commitments. Each event was designed to make deals up to and during the meeting. The team referred to them as "pacing events" and gave them names like A Call to Action. These events set the pace needed to achieve the goal of 500 communities in action by 2001. The events themselves were carefully paced to generate commitments and action.

Participants at an event were as few as 50, but typically around 200, with the most being 800 and 6,000. Events generally included four overlapping groups:

- people from communities in action or getting ready to take action
- leaders from benchmark communities
- people from organizations that could provide assistance to the communities at each stage of development
- the national leadership team in a facilitative, coaching role

The team developed a method for making these events successful, called the campaign's "signature style." That style made these events unusual and exciting by almost everyone's experience. It was common for participants to comment: "I have never been to a meeting like this;" "I cannot believe you all are from the federal government;" "This meeting is the standard by which I want to run and judge the meetings I hold;" "This conference [June 2001, Washington, D.C.] is the gold standard for conferences;" or "This is how I want my organization to run events."

Pacing Events Make Things Happen

The first two formative pacing events were held in 1999: the May event with the State Primary Care Association community developers and a September event with Georgia Health Policy Center's rural communities.

Over the next two years, 2000–2001, the team used more than two dozen events, an average of one a month. The more intense efforts are listed in Table 2. (These are distinct from the hundreds of events the partners participated in as they spread the message and provided technical assistance.) They are organized into five types, showing the 100%/0 team's flexibility in seizing opportunity.

Table 2: Major 100%/0 Campaign Pacing Events

Type of Event	Date	Description
Formative Pacing Events	May 1999	Community Development Conference with state primary care associations, 4H Center; Bethesda, Maryland
	September 1999	Georgia Health Policy Center; Macon, Georgia
National 100%/0 Campaign Events	June 2000	National conference of 300 people; Cambridge, Massachusetts
	June 2001	Communities in Action, national conference of 800 people from several hundred partner communities; Washington, D.C.
	October 2001	National videoconference on health status disparities with 6,000 participants at 190 sites across the country
Community Calls to Action	Fall 1999	Community of Emanuel County, Georgia
	November 2000	Community of Galveston, Texas
	Winter 2000–2001	Community of Cleveland, Ohio
	January 2001	Community of Northern New Mexico; Santa Fe, New Mexico
	March 2001	Texas Community in Action Summit; Austin, Texas
	September 2001	Community of St. Louis, Missouri
	October 2001	Louisiana State Event; Baton Rouge, Louisiana
	December 2001	Community of Akron, Ohio
Partner Events	April 2000	National Association of Counties, annual event conducted as visit to the Hillsborough Health Plan; Tampa, Florida
	May 2000	Community Access Program, Annual Grantee Conference, convening teams from grantee communities; Baltimore, Maryland
	April 2001	Project Access PACE Conference; Asheville, North Carolina
	November 2001	National Community Care Network Demonstration Program, annual conference; New Orleans, Louisiana
	November 2001	4th Annual New England Rural Health Roundtable Symposium; Merrimack, New Hampshire
Campaign Presentations to Strategic Audiences	September 1999	Virginia Primary Care Association, annual meeting with keynote speaker Dennis Wagner
	November 1999	Kansas Primary Care Association, with keynote speaker Dr. Donald Weaver
	July 2000	Health Resources and Services Administration, Quality Conference with a session by Dennis Wagner; Vail, Colorado
	August 2000	National Association of Community Health Centers, annual conference with keynote speaker Dr. Marilyn Gaston; Chicago, Illinois
	January 2001	South Carolina Primary Care Association, annual meeting with keynote speaker Dr. Donald Weaver
	May 2001	Society of Teachers of Family Medicine, annual conference with keynote speaker Dr. Marilyn Gaston

Three major national events gave the campaign nationwide attention and energy. Significant effort went into planning them. Each was well funded by the national partners, foundations, and the Bureau. The intent was to bring all partners together in person and in spirit. With dozens of national partners and hundreds of community partners, that means a lot of people. These three events engaged 300 people, then 800, and then 6,000, the last being a national teleconference with 190 participating sites.

Community call-to-action events were organized on both the community level and statewide. A community event was sponsored by the community itself with the intent to take all the stakeholders to a higher level of collaboration and progress on the 10-step scale. State organizations sponsored the state events and drew in large numbers of community teams. These were very effective in bringing communities into the campaign.

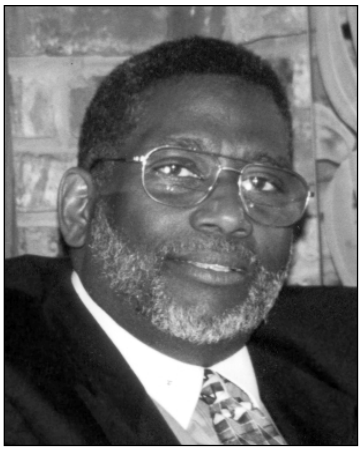
As the team gained experience with its approach, it realized that its partners traditionally held events each year that could be made into pacing events for the campaign. Usually they were annual learning and social networking conferences. It was easy to add the signature style of the campaign with its focus on action. The partner conferences in Table 2 were organized as pacing events with the campaign team facilitating the whole or major parts of the conference.

Finally, as the messaging and requests and offers became sharper, the team began to seek speaking engagements in forums that would provide access to potential community champions. Campaign presentations incorporating the signature style were made at conferences with strategic audiences.

Creating the Signature Style of a Pacing Event

Pacing event participants secured commitments they needed for the next steps in their communities. "Signature style" became a way for the team to describe how to behave in meetings to get those results. They formed this style as they went from event to event.

The style they developed called for a highly interactive meeting designed to produce commitments.



Donald Coleman

Usually the day before an event the team members on-site would meet with the organizers, the facilitators, and the benchmark leaders to review the signature style guide. A version of the guide is shown in Table 3.

Many of the critical elements of the style emerged from the two formative pacing events in 1999. The first was the meeting of the PCA community developers and directors on May 17–18. About 60 people met at the 4H Center in Bethesda, Maryland, at an event that began the process of developing the signature style.

A technique called "effective questions" was used to frame that meeting. (See Doug Krug and Ed Oakley, *"Enlightened Leadership: Getting to the Heart of Change."*) The question the meeting ran on was "What can a PCA community developer do to enroll the communities they are working with into the 100%/0 campaign?" All the interactions in the meeting were then viewed as conversations in which participants generated answers to that question.

The team introduced a generic model of an integrated delivery system, with primary care at the center rather than the hospital, and the 10-step development scale. With that as context, they introduced three of the early benchmark 100% leaders: McKenzie of Buncombe County, Johnson of Hillsborough County, and Uhlig of Wichita, Kansas, the first community to replicate Project Access. These 100%/0 community spokespersons proved to

Table 3: Signature Style for Community Call-to-Action Events (June 2001)

The meeting is interactive, with everyone in the room in a conversation for action.	• Elicit the natural leader each person is by asking each person to assume that role for this event. • Keep presentations short and crisp and ask speakers to speak in seven- to ten-minute blocks, followed by the audience working with what was heard. • With everything needed for 100%/0 in the room, ask everyone in the room to be both faculty and student. • Guide the conversations in the room with "effective questions." • Create space for audience to engage in every presentation (What was said? What was heard? What was exciting? What insights did it provoke?…) • Organize exercises in which participants share insights and intent, where affinity groups form to work, where people can make deals.
All conversations are framed and paced to move the audience toward action on 100%/0.	• Employ "framing," i.e., request from the audience the kind of listening that leads to action. • Prepare "effective questions" and ask the audience to respond to them after each speaker. Avoid question and answer formats. • Use "future newspaper headline" exercises to help groups define and express intent. • Incorporate exercises to generate bold goals and commitments. Use pacing-event planning exercises to help groups move to action. • Model effective expressions of commitment (action, result, date). • Introduce "requests and offers" as a way to generate commitments and make deals in the room. Point to examples already happening in and around the event. • Have people stand and express their commitments—and have others in positions of authority acknowledge them. • Have resource organizations in the room ready to offer assistance.
Participants self-organize into the conversations they are ready to have.	• Use "open space" for participants to form around topics they define and want to work on (*Open Space Technology; A User's Guide* Harrison Ownen, 1997). Enable people to interact with each other. • Plan traditional breakout sessions to give participants work time with the speakers.
Conversations are stimulated by examples of successful 100%/0 communities.	• Invite representatives of successful communities to be visiting coaches. • Include successful leaders who can (1) inspire, (2) attest that transformation is possible, (3) show how to do it, and (4) form technical assistance relationships with communities in action. • Use compelling video cases to showcase successful 100%/0 communities. (Contact Donald Coleman, Health Resources and Services Administration, Media Center.)
Success is noticed and celebrated.	• Showcase leaders from other communities who have been successful. • Bring in national and state leaders to hear and acknowledge community commitments, offer support, and declare success. • Stimulate press coverage to bring the story of action to the community. • Highlight the unique leadership nature of this work. Hold sessions for the audience on the nature of the leadership work involved using motivational speakers (such as Doug Krug, *Enlightened Leadership*). • Secure commitments from visiting communities to organize future pacing events.

be powerful advocates simply by telling their leadership stories and describing the impact of the systems they created.

A national partner with resources to help communities move forward was in the room. The Access Project (different than Buncombe County's Project Access), based at Brandeis University, was funded by the Robert Wood Johnson Foundation at $10 million for four years to help communities protect and improve access to care for uninsured and underserved populations. Community champions left with a link to a helping resource.

A technique called "open space" was used to have meeting participants self-organize into work groups. (See *Open Space Technology; A User's Guide,* by Harrison Owen, Berrett-Koehler Publishers, 1997.) The open space technique introduced the idea that at a 100%/0 event, everyone is a speaker and a listener, a teacher and a student. The traditional professional meeting has the audience in a passive, listening role. A new dynamic was created with this technique, and the event was one large conversation.

In a session at the end of the event, participants were given an opportunity to make offers, requests, and commitments. As a voice of the campaign, Gaston joined this session and for 30 minutes received and acknowledged the commitments people made. This was an exciting, playful session with serious results. Several state groups challenged each other to a competition in enrolling communities. Community developers formed relationships with each other and with the resource people in the room.

While the 4H Center event enrolled people who would in turn enroll communities, the GHPC event later that year brought the community leadership groups themselves into the room. The program director, Minyard, brought from six to nine key stakeholders from each of over a dozen communities to Macon for two days to work on how they could transform their health care systems. Each community group included county executives, hospital administrators, providers, and citizens. She had several top state government health officials attending to hear from these communities how the state could help. A number of models-that-work speakers showed the community groups how their efforts could work.

John Kotter on the Skill of Communicating Emotionally

"People change what they do less because they are given *analysis* that shifts their *thinking* than because they are shown a *truth* that influences their *feelings*. This is especially so in large-scale organizational change….

Change leaders make their points in ways that are emotionally engaging and compelling as possible... They provide a means for the show to live on with physical objects that people see each day … or with vivid stories that are told and retold. But whatever the method, they supply valid ideas that go deeper than the conscious and analytic part of our brains—ideas with emotional impact."

From John P. Kotter and Dan S. Cohen, *The Heart of Change: Real-Life Stories of How People Change Their Organization* (Harvard Business School Press, 2002)

The interactive style of the campaign was applied to this audience of 200. At one point the community groups, assisted by coaches and facilitators, spent significant blocks of time creating their own community vision and collaboration. They came back into the full session and shared their commitments with each other and state officials.

Minyard's event was able to accelerate the progress of a large number of rural communities. It created a conversation that began to align state government in support of these communities. Her convening of communities became a core part of the template for future 100% campaign pacing events.

Understanding the Demand and Need for Pacing Events

Communities get stuck. Today, everyone agrees the health care system does not work and all the players want it to change. In every community, stakeholders are convening to fix whatever they can. But fixing calls for collaboration among parties that often have no history of collaboration. They lack the

common vision that fosters it and the common language that enables it. Not surprisingly, these conversations become fragmented, settle on small projects, and eventually break down. Players have neither the time nor the patience for a process that takes time and patience. The campaign team found that many communities are willing and able to organize pacing events to get unstuck. The experience in Galveston, Texas, illustrates the situation that can create demand and the breakthrough that can result.

In 2000, Galveston's health care safety net was running out of money. They had to lower eligibility for specialty services from 100 percent of poverty to 17 percent. Leaders in the county government and the medical establishment sought advice from Phyllis Busansky. They were excited about moving forward to create a plan and a financing strategy organized around a sales tax, yet they had no plan. She suggested a community event, a call to action where they would unveil a plan. A three-day community event was scheduled for November of that year.

Just calling the event made things happen. Galveston had to come up with a plan and convene a community-wide public event. A task force was formed, scrambled to meet the deadline, and devised a financing solution of a 1 cent sales tax, "a penny for our health." They saw that an intractable problem was not intractable. The 100%/0 team agreed to facilitate the event and ask Gaston, an assistant surgeon general, to come hear the plan. To have Gaston participate, the Galveston leaders had to agree to have a plan ready, convene the community, invite benchmark communities, and make the event a media event. The 100%/0 team arranged for other communities to attend and see a call-to-action event. The team arranged for models-that-work community leaders to attend and speak.

The day before the event, the task force had to present its sales tax plan to the city council. On the opening day of the conference, the Galveston County *Daily News* ran a lead story on the proposed sales tax, a new expense for residents. The next day, a second, more upbeat story appeared with a picture of Gaston and a front-page headline: "Official applauds county health care effort."

Gaston called Galveston a model for the nation. The next week, the paper endorsed the sales tax. The movement of the community from being stuck to being in action was captured in these three articles over a few days.

The pacing event produced a breakthrough for Galveston. On the second day, Gaston invited the leadership to come to a national event in Washington, D.C., in June 2001 to tell their story as a model for the nation. The 100%/0 team followed up. Donald Coleman of the Bureau's Media Center went to Galveston to produce a video about the initiative. The video was shown at the June 2001 event, and the Galveston team's work was celebrated. The national attention and support from November to June created energy and progress in Galveston.

Increasing the Reach of the Campaign through Technology

The Bureau's Media Center, managed by Coleman, turned out to be one of those hidden assets that a campaign will uncover. His work had an increasingly powerful impact on the progress and effectiveness of the campaign.

Coleman stepped forward and made himself part of the 100%/0 team early in 2000:

> "When I first heard 100%/0 I thought it was hogwash. I didn't hear what the team was trying to do. There were no facts or stories for me to hook onto. I was focused on supporting Dr. Gaston as she tried to inspire and rally the staff around the Bureau mission and plan. Then I was in a meeting that turned out to be a face off between the 100%/0 team and some of the Bureau staff. The team was talking about people getting health care and better health in every community. The staff was not responding. That got my attention. I envisioned women like my mother who had no guidance in making decisions about their health. My mother was not served well by the health care system. These women are without the knowledge to defend themselves.

> "I began to ask 'How can we do this campaign?' 'What are the visuals, what are the words we can give Dr. Gaston that will engage people?' As I talked to the team and learned about the communities in action, it got clearer and clearer. This was about a revolution. We crafted Dr. Gaston's speeches and community story videos around the 100%/0 revolution in health care and used the song 'Revolution.' I went to the communities to videotape the community dynamics and the effect on the people. Visiting Sunset Park health system and clinic in Brooklyn was a big event for me. I could see the clinicians, the service, the people, and the difference it was making. We began to capture this story on video for presentations at conferences and call-to-action meetings. The 100%/0 team stuck to its guns, and speaking this revolution became second nature to Dr. Gaston."

Coleman brought visual technology and videoconferencing to the campaign. He produced 3- to 12-minute video stories of the successful communities and called them "visual evaluations." If a success story was valid, he believed, he could capture all four dimensions of success on video: the people served, the leadership, the provider system, and the quantitative results.

> "We let the team tell us they have a model that works. I go there and scout it out. I get a feel for the place and do a site evaluation. Is there a story to tell? As I worked with the 100%/0 team, it became easier to capture the patients' experiences, the people's stories, the leaders' stories about transforming their community. We broke through the data challenge and began to present the heart and soul of the story in the video cases."

Coleman became producer and director of the national campaign events. He organized the June 2001 three-day event with 800 participants, using theater-in-the-round complemented by video and television projection. He created several video cases, including the one for Galveston.

A few months later, in October 2001, he produced a national videoconference with the goal of moving 0 disparities to the forefront of the national campaign. The announcement promised success stories: "Organizations, networks of organizations, and communities across the nation are mobilizing to increase and improve access to health care for all Americans—and they are succeeding. Some are even breaking through to eliminate health disparities!" Communities were asked to commit to developing and reporting on disparity campaigns, the plan being to showcase them in future videoconferences. Coleman envisioned the number of successful community initiatives growing through inspiration and celebration.

The event was a four-hour satellite teleconference broadcast by WETA in Arlington, Virginia. There were 6,000 people at four uplink communities and 187 downlink sites in 49 states, and a facilitator and a moderator at each site. A series of conference calls were used to train the site moderators and facilitators. Sites were donated videoconference facilities in participating communities. Local foundations helped fund the four uplink sites. Communities and sites registered through the Internet, and people were offered guidance in finding free videoconferencing facilities in their communities. (With a cost to the Bureau of approximately $300,000, this effort had greater reach and lower costs than did the traditional convening conference.)

The conference agenda was a series of presentations from the WETA site, followed by group interaction at the downlink sites and then reporting into Washington by video transmission or phone. Commitments made at the sites to launch health status disparity efforts were self-reported to an e-mail location. The conversation was organized around several stories of communities successful in reducing disparities:

- Contra Costa County, California: A community eliminates breast cancer disparities.
- King County, Washington: Network collaboration eliminates diabetes disparities.
- Community health centers: Centers eliminate low-birth-weight disparities.

Leaders of these efforts spoke from the studio, and an evaluative video case was presented on each one.

The October 2001 video conference on eliminating health status disparities marked the end of the Bureau's leadership of the 100% Access/ 0 Disparities Campaign. Following this event, other organizations formed to lead the national campaign.

Forming a National Movement (2001–2002)

During 2000–2001, the 100%/0 campaign was robust and moving fast. By the end of 2001, the team had seen the campaign achieve the following results:

- Dozens of benchmark communities were identified that demonstrate the feasibility of 100% access. Leaders from two of the first benchmark communities—Buncombe County, North Carolina, and Hillsborough County, Florida—became national campaign leaders.
- The art of replication of innovations was mastered. One 100% community model, Project Access in Buncombe County, was replicated in two dozen communities by 2001 with some 60 additional communities in the process of replicating it. A new national organization, American Project Access Network, formed to manage nationwide replication.
- The discipline of reconfiguring a community health care system was captured as a teachable method by the GHPC of Georgia State University. It runs an annual institute to train developers and managers of community 100%/0 systems.
- A collaboration of national partners was created to pursue the goal of 100%/0. These partners include the National Association of Counties, International City and County Managers Association, United Way of America, American Academy of Pediatrics, Health Research & Educational Trust (AMA), The Access Project (Brandeis University), American Project Access Network, GHPC (Georgia State University), and Community Health Partners. These organizations actively enrolled communities through their networks and provided technical assistance to communities in progressing through the 10-step scale.
- In 2000, the Bureau won—for its method of creating performance partnerships tied to mission achievement—an award from the Council for Excellence in Government, *Government Executive* magazine, and the Office of Federal Procurement Policy, the Business Solutions in the Public Interest Award.
- The Community Health Leadership Network, a national intermediary organization, was formed in 2001 with support from the Kellogg Foundation, Ascension Health Care System, and Sisters of Mercy Health Care System. The Bureau encouraged the forming of this organization as a vehicle for expanding the leadership of the campaign.
- National, regional, and community pacing events were being used to accelerate progress and bring life and energy to the campaign. At such events, hundreds of invested people came together to make commitments that created a 100%/0 future. National partners, working with state and community champions, facilitated the events.
- More than 600 communities had enrolled in the campaign. The national partners could track the progress of communities on the 10-step scale and estimate overall impact in terms of the numbers of people gaining coverage through safety net health systems.

In 2001, a change occurred in the Bureau and HRSA that pulled the federal government out of its leadership role. Gaston announced her retirement, and a new administration came to HRSA. HRSA now had a challenging presidential management initiative to implement, the legislated expansion of community health centers. The new HRSA executive team stepped back from a leadership role in the 100%/0 national campaign but continued to use the message and language of 100%/0. (The 100%/0 national partners continue to use their campaign networks to help HRSA achieve its presidential goal of community health center site development.)

The locus of leadership moved from the Bureau's team to organizations outside the federal government. By early 2002, four not-for-profit organizations had formed to continue enrolling and working with communities on 100%/0. Each organization has a different area of expertise:

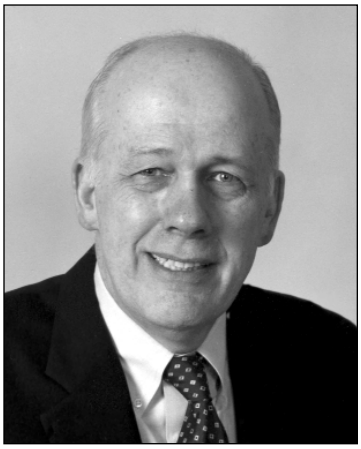
- American Project Access Network (APAN), Asheville, North Carolina—a center for replication of successful social innovations in health care. Alan McKenzie created it to manage the growing replication of Project Access. APAN promotes Project Access, and its involvement of physicians, as a core component of any integrated delivery system and a catalyst for 100%/0. Under the direction of David Werle, it is working with close to 100 communities.
- The Community Health Development Institute of the Georgia Health Policy Institute, Atlanta, Georgia—a center for training community coaches, community health system developers, and the managers of integrated health care systems. Karen Minyard formed the Institute to capture and spread the learning coming out of the campaign at all levels. Over the past two years, under the leadership of Tina Smith, it has held successful training events. It sees the forming and management of collaboratives that are behind 100%/0 systems as a new, unique skill that can be taught and a vocation that can be encouraged.
- Communities Joined in Action (CJA), Olympia, Washington—a center connecting the broad spectrum of leadership on the 100%/0 campaign responsible for creating the bold new goals and game plan. It was formed by Mary Lou Andersen, who currently manages it. CJA's leadership council includes national partners and community benchmark leaders.
- Community Health Leadership Network (CHLN), Washington, D.C.—created to be the infrastructure for the campaign. Phyllis Busansky, who led its formation and served as the first president, promotes the state and community pacing events that give life to the campaign. CHLN is developing resources to continue the community tracking system, put in place a web-based communication system, and organize and support the convening of communities.

These four organizations form a collaborative, each supporting the work of the others. (In fact, board membership and organizational membership overlap greatly.) They are leading the movement.

In 2002, leadership of the 100%/0 campaign shifted from the Bureau's team to the new intermediary organizations. Federal staff managing special purpose programs and support activities were, in a four-year period, able to launch a self-organizing, self-sustaining movement. Today that movement has multiple networks of leadership at all levels, aligned in pursuit of a common vision with measurable goals.

The Bureau's 100%/0 team has successfully launched a national movement in health care reform.

ABOUT THE AUTHOR



John Scanlon is a partner in JSEA Inc., a management services firm. He works with executive teams who are leading their organizations through strategic transitions. He has over 30 years experience installing effective organizational structures and management systems that executives use to produce dramatic results.

Scanlon received a Ph.D. in applied mathematics and chemical engineering from Rensselaer Polytechnic Institute in 1967. Between 1968 and 1980, he worked in the Urban Institute's Program Evaluation Group. As director and project manager, he developed methods for assessing the management of organizations and designed information systems for evaluating large-scale public programs. He specialized in innovative evaluation strategies that were designed to improve program performance and provide timely information for policy making. The Group pioneered such techniques as rapid feedback evaluations, peer review systems, sequential purchase of information, and evaluability assessment. It carried out many evaluations of large federal operational and demonstration programs in education, housing, law enforcement, health care, and legal services. This work led to changes in management policies and practices in the federal government.

Since 1980, Scanlon has specialized in the design of leadership campaigns that enable managers to achieve extraordinary results on their missions and strategic visions. He has worked with several dozen executive teams that were facing challenges that their current management and organizational structure could not resolve. He developed the leadership stories and leadership skills of the team and put in place the campaigns that realized their vision and goals. These campaigns leverage current programs and business lines to extend reach and impact.

He has experience with a broad range of public and private sector organizations. His clients have included a large real estate developer, home health care firms, university-based businesses, a national testing service, banks, the postal service, legal service programs, federal health services program, a federal environmental program, state safety-net organizations, a local school system, local health care businesses, and federal departments and agencies. Each client was going through a major change that called for strategic repositioning and restructuring.

During the time period covered in this report, Scanlon was the advisor to the Office of the Director, Bureau of Primary Health Care, on the national health care reform campaign called 100% Access/0 Disparities. This effort enabled the executive team to realize impacts on access to health care that went beyond the traditional reach of its programs. He is currently a Board Member of the Community Health Leadership Network.

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