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Commentary

Who Says Population Health is a Long-Term Game? 100-day Projects Can Generate Short-Term Results for At-Risk Groups

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MOST EXPERTS AGREE that 2 of the keys for increasing the quality and efficiency of our health care system are to improve the coordination of care, and to focus on prevention and wellness, particularly for at-risk populations.[1] Unfortunately these are often approached as massive, long-term undertakings with little chance of success. No matter how much institutional consolidation has occurred, there are still dozens of care providers coming at problems from different professional perspectives with conflicting incentives and limited capacity for collaboration. Of course, many of these providers do not focus on prevention and wellness at all, and those that do address these issues struggle with conflicting data sets and measurement tools, lack of funding, and disagreements about behavioral determinants. The net result is that population health often is perceived as a complex, long-term set of constructs rather than an opportunity for immediate impact.[2]

But it doesn't have to be just a long-term game. In fact, our experiences working on corporate, social, and international development efforts suggest that although the long-term approach described may be necessary, it is far from sufficient. In addition, communities can pursue a parallel path while these long-term structural adjustments take shape. This path can lead to dramatic and near-term impact on key indicators, such as reducing unnecessary emergency room visits, while at the same time nudging the culture of the various local organizations toward collaboration, innovation, and transparency.

Let's look at how this has been unfolding with communities that are tackling chronic homelessness, a long-standing, complex population health issue with all the characteristics described above.

Reducing Homelessness in 100 Days

According to the US Department of Housing and Urban Development (HUD), there were approximately 650,000 homeless adults in the United States in 2010, with more than 100,000 considered to be "chronically homeless." Of the chronic group, three quarters were male, with an average age approaching 50, and one third were veterans. Mortality rates for this group were 4 to 9 times higher than the general population, and their health care costs also were proportionally higher because of high usage of emergency rooms, sobering centers, clinics, and other service facilities.[3]

Given the size, scope, and cost of this problem, the Obama administration launched Opening Doors: Federal Strategic Plan to Prevent and End Homelessness in 2010, a major policy and legislative initiative to tackle homelessness. The goal was to end chronic and veteran homelessness by 2015, and end homelessness for families, youths, and children by 2020. The plan called for coordination across federal agencies and set useful policy standards. But much of the work still needed to occur at local levels in collaboration with the many social service agencies and care providers that deal with people experiencing homelessness daily. Although good progress was made in the first 2 years, the pace of housing placements remained too slow to reach the national goals. The federal agencies involved were doing a terrific job working together at the national level. What seemed lacking was the belief in each community that the goals could be achieved, and coordination between all parties involved at the local level.

Fast-forward to June 2014, a mere 4 years later. The 100,000 Homes Campaign that was launched in 2010 with the aim of housing 100,000 of the most vulnerable homeless individuals in the country announced that it had achieved its goal—ahead of target. As of June 11, a total of 101,628 chronically homeless individuals had been housed by communities participating in the Campaign, including 31,000 veterans. The announcement was made by the head of the US Interagency Council on Homelessness (USICH), which coordinates the federal response to homelessness, who emphasized how significant this was for the overall momentum toward reaching the national goals.

Equally impressive was that some of the fundamental dynamics that previously had made it difficult to tackle homelessness at the community level had started to shift: Service providers were working together, sharing information, and learning from each other; private and public sector organizations were collaborating; and best practice policies and solutions were being tailored to meet unique local requirements.

This acceleration over the past 2 years was fueled by a collaboration between the 100,000 Homes Campaign and

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the Rapid Results Institute (a nonprofit organization founded by the authors of this paper) to change the reality on the ground.[4] Supported by the Veterans Administration (VA), HUD, USICH, and several private foundations, the 2 organizations designed 100-day journeys for communities that helped them break through to new and sustained levels of performance in their housing placement rates.

Participants in these journeys—launched through Rapid Results Housing Boot Camps—were community teams that included case managers and homeless program managers from the local VA, HUD field officers, and representatives from the Public Housing Authority, the local nongovernmental organizations (NGOs) working on ending homelessness, and the mayor's office. At the Boot Camps, each team committed to a seemingly impossible 100-day goal, often involving doubling its average placement rate. The teams then spent the rest of the 2-day event figuring out how they would achieve that goal, using proven strategies and practices, such as Housing First (an approach that centers on providing homeless people with housing quickly and then providing services as needed), as well as their own homegrown solutions. And because there were teams from multiple cities present at each Boot Camp, there also was an opportunity to cross-fertilize ideas—and engage in friendly competition.

As *The New York Times* reported, the initial wave of Rapid Results Boot Camps delivered powerful early results, all within 100 days.[5] In New Orleans, for example, a team simplified paperwork needed to process a veteran's application for subsidized housing, and unified the process across several agencies. In Detroit and Houston, teams set up a 1-stop shop for people experiencing homelessness, so that their requirements for receiving support could be completed in 1 day. In Atlanta, a team set up a competition to incentivize VA case managers to focus more sharply on the most vulnerable veterans. Nine of the 13 participating cities made dramatic gains, and 4 of them set a new benchmark for housing chronically homeless people—averaging more than 1 person housed each day during the 100-day period.

Encouraged by the initial success, HUD commissioned more of this work in 2013. The Campaign and the Institute organized 6 more Rapid Results Boot Camps, engaging more than 40 cities. Teams focused on placement rate acceleration, with the aim of increasing monthly placement rates to a point that would end veteran and chronic homelessness in each city by December 2015. This wave of Boot Camps was supported by data that showed each community what its placement patterns were in the past and the performance rate that was needed to end homelessness.

This spurred participating communities to collaborate and compete in even more intense ways. Communities began to challenge each other about who would cross the finish line first—with senior leaders from HUD, the VA, and USICH fueling the competition through carefully choreographed participation throughout the 100-day journeys. As a result, participating communities were able to lift their 2013 average monthly placement rates by an average of 128% in their first 100 days, while focusing the housing support on the hardest cases. Some communities tripled and a few even quadrupled their placement rates. This lifted the bar for everyone: The placement numbers that were reported by communities participating in the 100,000 Homes Campaign ramped up to 50,000 by May 2013, and then shot up past 100,000 in early June of 2014.

Implications for Population Health

It might be easy to dismiss this experience by saying that homelessness is not really a medical condition like diabetes, obesity, or heart disease. However, we have seen this approach work for other seemingly intractable medical problems in settings outside of the United States. For example, in Eritrea, we worked with the Ministry of Health, the UNAIDS program, NGOs, and community-based organizations to reduce the incidence of HIV among commercial sex workers, and found that 100-days goals to get these women into early testing, prevention, and treatment clinics in local cities made a huge difference in the national infection rate.[6] In Nepal, we collaborated with a World Bank team and others to improve infant mortality by increasing the food intake of pregnant women by 1 egg per day in villages across the country.

Based on these experiences and the progress on homelessness, we believe that there are a few lessons worth exploring when tackling the challenges of population health.

First, population health success requires the *mobilization of a new ecosystem* to bring together the right people and reconfigure the existing resources and assets in service of common interests. In our work with homelessness, plans invariably involved close collaboration and coordination between federal agency leaders, their field staff, local housing authorities, city officials, local NGOs, and other stakeholders. In several communities, for example, the teams colocated agency reps to improve communications and make it easier for veterans and other chronic cases to access the system more easily. The ecosystem also included private sector foundations, such as Chase, Starr Companies, and The Home Depot, which joined forces to enable the teams to come together.

However, bringing together people who haven't collaborated previously is tricky territory. That's why it is critical to have a *common goal that different parties can own and rally around*. The 100-day time frame created a sense of urgency—and it also made it easy for team members to temporarily suspend some of the assumptions and mental models that held them back in the past. This spurred a flurry of rapid experimentation with new solutions and new ways of working. For example, at the Boot Camps, each local team mapped out the maze of procedures that a chronically homeless person has to navigate to get housed, and decided how they would simplify these steps to achieve their goal. They also actively coordinated outreach and targeting efforts to better locate chronically homeless people and, more importantly, win their trust. Most of these decisions were put to the test in the first 30 days of the implementation period, and then were adjusted several times during the 100 days. These goals were set—and progress was reviewed—in workshop-style meetings, so that the various agencies were accountable to one another and to the public for achieving the breakthrough results to which they'd committed.

The teams also had to sustain a momentum of results, creative energy, and collaboration during the 100-day implementation period, in spite of the difficulties they encountered. They did this by *harnessing the power of peer pressure and peer support* through cross-learning, emulation, and competition across all teams. Various mechanisms were used

to deliberately build this into the process, including organizing team leaders into small learning cohorts that shared experiences with each other every 2 weeks.

Population health management is a systemic challenge requiring the coordination and collaboration of multiple organizations in the community, health care, government, and elsewhere. Although innovation in any setting isn't easy, there are many useful ideas from the corporate sector and other parts of the nonprofit sector that can be applied. If the experience with veteran and chronic homelessness is any guide, then mobilizing the ecosystem, rallying around challenging and exciting 100-day goals, and harnessing the power of peer groups can help making population health improvement a reality, and not just a long-term hope.

Author Disclosure Statement

Drs. Ashkenas and Siegal, and Mr. Matta are founders of the nonprofit Rapid Results Institute, which is discussed in this commentary. Mr. Matta serves as President of the Rapid Results Institute. The authors declared no other potential conflicts of interest and received no funding for the research, authorship, and/or publication of this commentary.

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