Institute for Healthcare Improvement

# A Guide for Health Systems to Save Lives from "Deaths of Despair" and Improve Community Well-Being

*This work is funded by*

WELL BEING TRUST

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# Foreword by Well Being Trust

Now is a propitious moment for purposeful action to heal our nation.

In a year when COVID-19 has further unmasked pervasive inequity, widespread system failure, and chronic under-investment in the vital conditions for well-being, it has also shined a light on the generosity, resourcefulness, and resilience of the American people. In this, the vital role of health care systems as community leaders has never been clearer. Concurrently, the essential service of health systems as values-led community anchor institutions, as well as quality care delivery systems, has never been more needed.

This guide is a call to action and a resource for health system leaders to move beyond narratives of doing good things — to being accountable for community outcomes. From delivering care in silos of excellence, to assuring communities of solution. From engaging in community benefit activities, to implementing dose-sufficient investments that apply all assets and levers of our organizations to deliver results. Bottom line, this is an opportunity to deliver with integrity and fidelity to the second half of our mission statements "…and to improve the health of the communities we serve."

Since its birth in early 2017, Well Being Trust (WBT) has been catalyzing, partnering, and investing to build essential capacity for the mental health and well-being movement in the US. In the times of COVID-19 and other compounding threats, this mission is proving to be more vital than ever.

Rooted in WBT's sacred mission to "advance the mental, social, and spiritual health of the nation," our approach to saving lives is reflected in the Framework for Excellence in Mental Health and Well-Being and in *Healing the Nation*, which increasingly serve as a consensus platform for shaping organizational practices, driving public policy changes, and guiding private sector investments that can save lives and produce community-level outcomes. We encourage you to adapt and apply these resources.

Well Being Trust's impact strategy is reflected in the portfolio of more than 100 investments and partnerships focused on community, coverage, and care. This includes the seven elements of movement infrastructure WBT has been carefully curating over the past three years, including: 1) new narratives and voices that normalize conversations on mental health; 2) shared measures and systems of accountability; 3) policy and advocacy mobilization; 4) bringing more resources to the field; 5) aligning leadership and ensuring enabling structures; 6) demonstrating quality, and setting standards for whole person, community-clinical integrated care; and 7) increasing civic muscle by creating opportunities for meaningful individual, family, and community engagement.

WBT's portfolio of investments, alliances, tools, and solution sets — and the organizations and initiatives we helped conceive, design, fund, and sustain (e.g., Inseparable, Mindful Philanthropy, WIN Network, The Springboard, and more) — are designed to help health systems and their local partners lead systemic change on the ground in communities, where lives can be saved and human beings and families can flourish.

Wherever you are in your journey of addressing deaths of despair and increasing health and well-being for all — early stage or deep in comprehensive systems change work — this guide is for you. Here's to living in the promise that is your mission, your call.

Tyler Norris, MDiv
Chief Executive
Well Being Trust

# Executive Summary

In support of Well Being Trust's (WBT) strategic goal to save 100,000 lives from "deaths of despair" (i.e., deaths due to drugs, alcohol, and suicide) and dramatically increase healthy life years over 10 years, the Institute for Healthcare Improvement (IHI) partnered with WBT to evolve a set of recommendations and guidance to help health care systems impact the health and well-being of the populations they serve and their communities. While the guide was written in a particular moment in time, we believe that the strategies both speak to the needs of this moment and that they remain relevant beyond this specific historical moment.

Saving lives from deaths of despair is a complex problem that requires adaptive changes and new solutions to transform systems. IHI has spent years learning alongside health systems and community-based coalitions. We understand that whole system transformation in communities must be co-produced with people with lived experience in order to co-design for equitable systems and outcomes.

This guide is a resource for health care systems to improve mental health and well-being in the communities they serve, focusing specifically on saving lives from deaths of despair. The guide applies a population-based approach, centered on equity, that describes:

- **Who:** Identify the population of focus (whose lives will get better because of this work?)
- **How:** Methods to implement the approach that blend improvement methods with tactics for achieving the Triple Aim
- **What:** Interventions for health systems to focus on, to affect deep change in communities that will save lives, improve well-being, and advance equity

The guide endeavors to provide a comprehensive framework in which multiple stakeholders (e.g., people from marginalized populations and communities and leaders in sectors such as health care, education, justice system, local government, employers) can identify themselves and their contributions. A specific emphasis is placed on the role of health care systems in impacting the care they deliver and leveraging all of their assets to improve the health of populations and communities.

The guide includes:

- A proposed population-based improvement approach with detailed guidance;
- Key drivers to save lives from deaths of despair and example interventions;
- "Start here" guidance and incremental improvements that can be implemented; and
- Additional considerations for health care system leaders as they partner with people with lived experience and communities to save lives from deaths of despair.

# Introduction

In support of Well Being Trust's (WBT) strategic goal to save 100,000 lives from deaths of despair and dramatically increase healthy life years in the next 10 years, the Institute for Healthcare Improvement (IHI) partnered with WBT to evolve a set of recommendations and guidance to help propel the field to action by leveraging the role of health care systems to impact the health and well-being of the populations they serve within their walls and across their communities.

The recommendations presented in this guide are informed by themes identified to date from a literature scan, the existing work of Well Being Trust, key informant interviews conducted by IHI, an expert stakeholder engagement meeting held via videoconference on March 31–April 1, 2020, and the experience and expertise of IHI.

Throughout this process, it has been clear that Well Being Trust and partners in the field are fostering a movement that can transform mental health and well-being in the US. Partners spoke of fundamental shifts in narratives, systems design, and use of aligned metrics as well as changes to public policy, organizational practices, and private sector investments. Indeed, such a movement is required to transform systems that can produce flourishing, thriving, equity, and associated vital community conditions rather than producing despair, suffering, and inequity.

The 1967 Folsom Report initially shared the theory that populations and communities can improve their health outcomes by leveraging explicit partnerships of "the boundaries within which a problem can be defined, dealt with, and solved."[1] This concept of "communities of solution" has evolved over decades to cement several principles that demonstrate how engaging a community wherever they may be on their transformation journey can lead to improved systems and processes and sustain outcomes in health, well-being, and equity.[2]

It is essential to acknowledge that transformational, system-level improvement requires a socio-ecological approach that introduces changes to relationships, networks, culture, and mindsets operating within complex dynamic systems.[3] This transformational, asset-based improvement begins with the community articulating what matters to them, listening and partnering with people with lived experience (PWLE), forming effective stakeholder partnerships, building core improvement skills to ensure sustainability, and constructing core functions to support facilitation of the work.

Built on the learnings from the literature, expert interviews, and stakeholder engagement, this guide describes a recommended population-based approach, based on the Pathways to Population Health Framework, that outlines "who" (potential partners and communities to engage as we consider, "Whose lives will get better because of this work?"), "how" (methods to employ), and "what" (interventions to focus on) for health systems to affect deep change in communities that will save lives, improve well-being, and advance equity.[4]

- **Who:** In the population-based approach, key stakeholders start by identifying the "who" — whose lives will be improved? This section of the guide offers three suggested populations or population segments who bear a disproportionate burden of despair and with whom health systems might work to drive change. Once a population is identified, this becomes the focus around which to build partnerships and organize efforts to save lives from deaths of despair.
- **How:** The methods used to affect change matter. Not all change is improvement and not all improvement is improvement for all. Without intention, inequities persist or worsen. IHI recommends equity-centering methods that are relevant across the specific "who" and "what."

These methods are anchored in the science of improvement and demonstrated techniques to center equity.[5,6,7] Not only does IHI expect the approaches to lead to measurable improvements in outcomes toward preventing deaths of despair, we have also witnessed that organizations and communities utilizing these approaches build longstanding, sustainable, and renewable capacity and capability to impact change over time and to continue creating the vital community conditions for well-being.

- **What:** Regardless of the population identified, the primary drivers of change are similar and can be thought of in these four general categories:
    - Contribute to an environment that promotes flourishing
    - Prevention and recovery
    - Early identification
    - Treatment

As health care systems and their partners engage in work to save lives from deaths of despair by organizing their efforts around the "who," they will also need to prioritize the activities, solutions, innovations, and improvements that matter most within their contexts.

Central to the overarching goal of saving 100,000 lives from deaths of despair is moving toward a system where *all people and places thrive*. Making this shift requires building on existing assets, incorporating new models into traditional structures, and creating space for new thinking related to equity, flourishing, and the associated vital conditions.

## Context for this Work

Since beginning this work, the COVID-19 pandemic has swept the world, touching every community. And in the wake of the murders of George Floyd, Breonna Taylor, Ahmaud Arbery, Rayshard Brooks, Tony McDade, Daniel Prude, Walter Wallace, Jr., and many other people of color, there have been widespread calls and protests to end systemic racism and police violence that have long plagued the US and the world. IHI recognizes and anticipates that a "second curve" of diseases of despair and threats to well-being will follow closely on the heels of the still rising curve of coronavirus infections (and indeed, has already begun).[8]

As we reflect on what these crises mean for this work, a few things become clear. The need to support well-being, taking an approach that is both broad (driving narrative and policy-level change in terms of a social movement) and deep (focusing improvement at a local level, particularly where the largest equity gaps exist) has never been more imperative. Indeed, levels of despair in the US are rising and may continue to do so for some time due to chronic trauma, the economic downturn, social dislocation, and uncertainty about prevention and treatment plans relative to COVID-19 and other cascading crises.[9]

These crises create urgency, which may also create a unique opportunity for innovation and transformation, the need for which has been hiding in plain sight and is hidden no longer. IHI's recommendations aim to capitalize on this unique moment to address systemic inequities and harms, laid bare by both the COVID-19 pandemic and the violent loss of Black lives, and leverage the opportunity for health systems to lead change.

## Fueling a Movement

Based on IHI's experience and WBT's extensive work to understand and build an infrastructure to support a movement, we recognize that movements require a set of complimentary activities that are both broad and deep and require time and persistence.[10,11] The broad activities help build the will, create the conditions for, and remove the barriers to change. The deep activities drive change locally on the ground. WBT, in its short history, is well underway with broad efforts, convening and partnering with organizations in otherwise siloed efforts to influence policy, framing a national narrative about well-being and vital community conditions, and building the will to create the conditions for change.

Within the last two years, WBT has provided targeted investments in movement infrastructure, having reverse-engineered social movement praxis and then make targeted investments to support system transformation efforts. Thanks to specific publications — *Pain in the Nation*, *Healing the Nation*, and *Projected Deaths of Despair During COVID-19* — and the collaborative efforts of the WIN Network and the Centers for Disease Control and Prevention to develop a national resiliency springboard, the rhythm of messaging and policy advocacy is gaining strong momentum.[12,13,14,15]

The recommendations in this guide are intended to compliment and leverage these broad strategies with the deep work required within local systems and communities that can be galvanized by health care systems through their assets, services, and partnerships to transform local practices and systems. The approach and recommendations align closely with WBT's Framework for Excellence in Mental Health and Well-Being (see Appendix A), with a focus on advancing partnerships within the community to transform mental health and well-being best practices while continuing to innovate, learn, and spread proof-points in support of community-wide whole system transformation. The recommendations focus on the aspect of movements that support local change and fuel the continued hope for, belief in, and commitment to broad-scale transformation and change in systems and communities.

# Improving Health and Well-Being: The Role of Health Care Systems

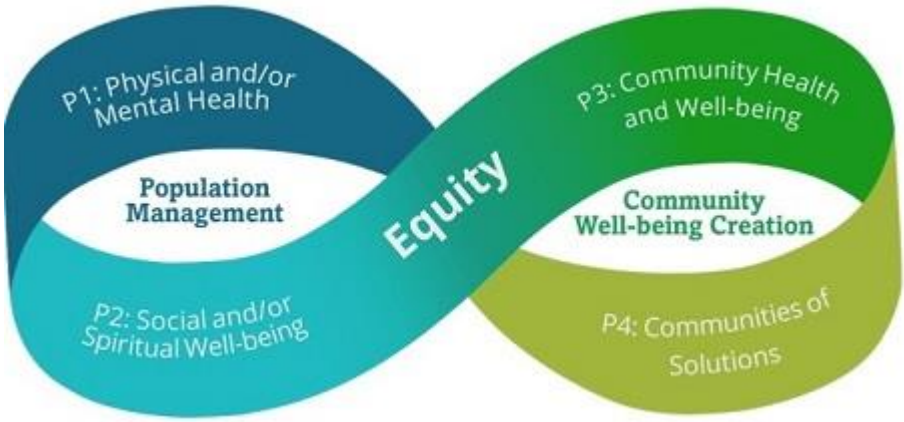
Since the passing of the Affordable Care Act, nonprofit hospitals were given the opportunity to address the health needs of those outside of their health care walls. Serving as anchor institutions, these organizations are tethered to the communities in which they are located by their mission, invested capital, and customer relationships to benefit the long-term health and well-being of the communities they serve.[16] Health care systems have the opportunity to leverage their many assets and hold their policies and practices (including hiring, purchasing, and investing) to the highest standards of social responsibility in order to improve population health and well-being.

The Pathways to Population Health (P2PH) initiative, designed through the convening of 100 Million Healthier Lives in partnership with the Institute for Healthcare Improvement, supports health care systems in making practical, meaningful, and sustainable advances in population health.[17,18] The Pathways to Population Health Framework (see Figure 1) — developed in partnership with the American Hospital Association/Health Research & Educational Trust, Network for Regional Healthcare Improvement, Stakeholder Health, and Public Health Institute — has been implemented by several organizations that participated in the P2PH initiative. Health care systems can also apply the P2PH Framework to improve the mental health and well-being of

the populations and communities they serve. The P2PH Framework serves as the foundation of the population-based approach described in this guide.

While health care organizations are committed to improving health outcomes for the populations they serve, there is often an opportunity to deepen awareness of the factors beyond medical care that affect health and well-being and perpetuate health inequity. The P2PH Framework depicts four portfolios of activity spanning from within the walls of the health care system to partnerships in the community. The framework focuses on addressing the whole person — physical, mental, social, spiritual — in framing well-being, while putting equity at the center. The P2PH Framework and tools can help health care delivery systems view their role both as service provider and community partner.

**Figure 1. Pathways to Population Health Framework**




# Proposed Approach: Who, How, What

## Who: Identify the Population of Focus

Initiatives that drive local improvement to reduce deaths of despair must start by identifying whose lives will get better as a result of this work. IHI uses the following definition of population health, articulated by Drs. David Kindig and Greg Stoddardt:[19]

*Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as nations or communities, but can also be other groups such as employees, ethnic groups, disabled persons, prisoners, or any other defined group.*

### Three Suggested Populations of Focus

This section of the guide offers three suggested populations or population segments who bear a disproportionate burden of despair and with whom health systems might work to drive change: patients served by the health care system, health care providers and staff, and high-risk populations in a community or geographic location. Once a population is identified, this becomes the focus around which to build partnerships and organize efforts to save lives from deaths of despair.

### 1. Patients Served by the Health Care System

Another approach to identifying the population of focus is to think about a group of people who are served by a particular service within the health care system. A health care system may choose to start, for example, with patients with multiple comorbid mental health diagnoses who utilize their psychiatric services. People with mental health and substance use challenges frequently present to primary care, the emergency department, and other services. A health care organization may choose to start with one or more of these groups to identify opportunities to redesign for better health outcomes. When aiming to save lives for a specific patient population a health care system serves, it is critical to consider ways to both improve the health system's services and to partner with others in the community to strengthen supports and vital conditions that contribute to well-being and flourishing.[20]

### 2. Health Care Providers and Staff

Magnified during the COVID-19 pandemic, the health care workforce has experienced significant trauma.[21] The workforce includes providers, food service staff, environmental services staff, community health workers, and all who contribute their skills to ensure a functioning health system. Physicians, nurses, and other health care workers face extremely high rates of burnout — emotional exhaustion, depersonalization, and feelings of inefficacy resulting from chronic work-related stress — though rarely seek treatment, which may result in worsening illness or even death by suicide.[22,23]

Many health system leaders have made caring for their workforce their highest priority and there is continued need to increase emphasis on supporting these individuals that will require cultural shifts, healing spaces, and system-level changes. Many challenges that the workforce is facing are not unique to the pandemic. Ongoing efforts must include addressing meaning and purpose, choice and autonomy, wellness and resilience, and other factors as described in the IHI Improving Joy in Work Framework.[24]

### 3. Populations in a Community or Geographic Location Most Affected by Deaths of Despair

Deaths of despair are not distributed uniformly and affect certain groups of people at disproportionately high rates. One approach is to focus on a population segment in the community that is at high risk of deaths of despair. *Healing the Nation* identifies the following focus populations: Native Americans, LBGTQ+ people, pregnant and postpartum women, immigrants, veterans, people with co-occurring mental health disorders and intelligence and developmental disabilities, and unhoused individuals.[25] Another approach is to use a geographic location (e.g., neighborhood, city, county, state, reservation) to identify a population of focus. For example, some of the highest numbers of people who die from suicide, alcohol, opioids, and other drugs live in New Mexico, West Virginia, Alaska, and Wyoming.[26] Sometimes a geographic approach galvanizes a broad group of stakeholders around an overarching aim, such as making "Scotland… the best place in the world to grow up."[27]

There is a growing understanding of the importance of redesigning the system to support those who are most marginalized by the current system — such as designing curb-cuts for people with mobility impairments — which has ripple effects that benefit everyone.[28,29] Focusing on those with the highest risk and/or the highest costs for the organization provides an opportunity to design with those in greatest need and subsequently adapt the processes and systems for other subpopulations.[30] By partnering with marginalized populations and communities to redesign care and supports to drive toward better and more just mental health and well-being

outcomes, these system improvements can serve as a model for all organizations and communities.

Below are some examples of populations with high rates of deaths of despair, including those further impacted by COVID-19, who might be prioritized by health care systems in their improvement efforts. These subpopulations may include providers, staff, patients, and/or community members. The populations listed below are a starting point — a health care organization, with its key stakeholders, may choose to focus their efforts on one or more of these groups based on local needs. Additionally, health systems should pay attention to intersectionality when prioritizing a population (e.g., those who fall into multiple populations most affected by deaths of despair, for example pregnant women experiencing unemployment).

- **Indigenous people:** American Indians and Alaska Native (AI/AN) populations have some of the highest rates of deaths of despair. AI/AN have the highest rates of death by suicide among all other population segments and are 2.6 times more likely to die of alcohol misuse than the general population.[31]
- **LGBTQ+ populations:** According to the Centers for Disease Control and Prevention, suicide is the second leading cause of death among youth ages 15 to 24.[32] Among youth who identify as lesbian, gay, bi-, trans, queer, or questioning, the likelihood of death by suicide has been estimated to be two to seven times greater than the likelihood of death by suicide among heterosexual youth.[33]
- **People experiencing unemployment:** More than 40 million Americans have filed for unemployment since March 2020 due to the COVID-19 pandemic. Those most disproportionately impacted by the virus are women between the ages of 18 and 24 with lower educational attainment, and occupational segregation is leading to more people of color being economically impacted by the pandemic. Metropolitan areas from Chicago, IL, to Florence, SC, are seeing devastating numbers of Black and Hispanic residents without jobs.[34]
- **Pregnant and postpartum women:** In the US, roughly 1 in 8 women report experiencing symptoms of maternal depression, and these rates vary widely including by geography. Rates of symptoms of maternal depression were closer to 20 percent in subgroups of women who reported being ages 19 years or younger, of American Indian/Alaska Native ethnicity, smoking cigarettes during pregnancy or postpartum, having experienced intimate partner violence before or during pregnancy, or self-reporting depression before or during pregnancy.[35] There are racial/ethnic inequities in both prevalence rates and depression-related mental health care.[36] The COVID-19 pandemic, while its effects remain emerging, may further exacerbate levels of anxiety and depression among pregnant and postpartum women.[37,38,39]
- **Essential workers beyond health care:** Also magnified by the pandemic, certain aspects of the workforce considered "essential" have experienced disproportionate burden of exposure to the virus, fear, and stresses that threaten well-being. Unfortunately, much of this burden falls on people in low-paying jobs who are already struggling with economic and other challenges. This, too, has played out as a disproportionate burden on people of color.

Each population-based effort to improve mental health and well-being needs a defined population of focus with whom health care systems can partner around a shared aim to drive better outcomes for those people most impacted by their efforts to save lives from deaths of despair.

### Identify and Prioritize Your Specific Population of Focus

- **Use data:** What are your data telling you? Who's not thriving? Whose well-being and health can be improved? Are there equity gaps to be closed?
- **Engage with stakeholders:** Convening and listening to community stakeholders, people with lived experience,[40] or others with whom trusting relationships exist can provide insight into whose lives can be improved.
- **Geographic location:** Consider whose poor health is closely linked to the community's broader economic vitality.

### Identify Partners

A movement to reduce deaths of despair needs to be anchored in real change driven by and with people at the community level. Once the population segment is identified, health care organizations need to identify who to partner with to drive change. The key to building partnerships is leveraging all assets and shifting power closest to the solutions — closest to those whose lives are most affected.

The most central group of partners to engage is often referred to as people with lived experience (PWLE) such as patients, providers, staff, and community members — those who exhibit the characteristics of the population whose well-being will be improved. This is not easy. People who have experienced or are experiencing thoughts about suicide or alcohol or substance misuse can be difficult to reach. And yet, they are the individuals who have the most to gain through these efforts and who have the closet view to what works, what doesn't work, and what might work relative to the design and redesign of current systems and supports.

One starting point is for health care systems to identify an organization that has established trusted relationships with PWLE. That organization can serve as an important convener, providing ongoing support and engagement with PWLE.

Next, consider what other departments, organizations, and partners need to be engaged. Success often requires engagement throughout the organization, within the community, and even across sectors because the health and well-being of individuals are multifactorial and inherently complex. Trusting relationships are critical and are built over time; when seeking to identify potential partners, consider leveraging existing assets such as Patient and Family Advisory Councils, physician peer networks, and community benefit departments. As a health care organization broadens its partnerships, some trusted local partners may include the local chapters of national organizations such as National Alliance on Mental Illness or other sectors such as education, justice, and housing.

The considerations described below can assist in identifying partners.

- **Aligned values:** Seek those who share core values, particularly a commitment to address inequities and injustices.
- **Assets directed toward marginalized populations:** When possible, identify partners that pull power and resources toward organizations led by people of color or others who have been historically disadvantaged.
- **Trusted relationships:** Seek partners who have established trusted relationships with PWLE and other key stakeholders.

- **Willingness to engage in the method:** Seek partners who are committed to learning and action (refer to the section on "How" below).
- **Infrastructure to organize and convene:** It can be helpful to include one or more partners that have assets to support convening and managing the work.
- **Readiness for transformation:** There are several assessment tools available to determine an organization's or a community's current state of readiness for tackling complex issues.

For health care organizations, IHI recommends using The Compass, developed in conjunction with the Pathways to Population Health Framework, to support organizations in identifying their current activities and how to best leverage the components within each portfolio of the framework.[41]

For communities, IHI recommends using the Community Transformation Map, developed through the 100 Million Healthier Lives SCALE initiative.[42] The tool contains three sections for each member of the coalition or stakeholder group to complete and then talk through before charting a path forward together: How the Community Approaches the Change Process; How Members of the Community Relate to One Another and Create Abundance; and How the Community Leads for Social Change and Equity.

## How: Methods to Implement the Approach

If we commit to using this moment to transform our health care organizations, communities, and systems, then aligning on *how* we approach that process matters. IHI recommends a community-wide whole system redesign that encompasses strategies in the following areas:

- Population-based improvement approach;
- Design principles;
- Approach to spread and scale-up; and
- Measuring to understand impact.

Together, these methods for the "how" can guide how to improve – across topics, across systems and communities — toward transformation in a way that accelerates learning, resilience, and equity.

### Population-Based Improvement Approach to Save Lives from Deaths of Despair

The path to recovery, resilience, and transformed systems requires working in ways that put continuous learning and improvement at the center; help us see and transform systems rather than blame individuals; use data to inform action; make visible vulnerabilities and inequities and provide tools that enable us to meaningfully work to eliminate inequities; and facilitate co-design with others, unleashing everyone's agency and power (i.e., ability to achieve shared purpose).[43]

IHI's recommended approach to improve well-being and save lives from deaths of despair blends improvement methods (specifically, the Model for Improvement, see Appendix C)[44] with tactics for achieving the Triple Aim (improved health for populations, improved experience of care, at lower per capita costs).[45] Achieving these outcomes will require the cross-sector partnership of key stakeholders such as health care systems, public health, and social services, in collaboration with people with lived experience.

The population-based improvement approach has four overarching components, each with a set of guiding questions (which always include advancing equity) that build on one another. Table 1 outlines the approach which embeds learning and improvement skills within and across systems and communities, and at both the individual and group levels, as a means to support sustainability.

**Table 1. Population-Based Improvement Approach to Improve Well-Being and Save Lives from Deaths of Despair[46]**

| Population Health Improvement Components | Guiding Questions (Each with Connected Equity Question) | Key Elements of the Approach |
|---|---|---|
| 1. Understand the population, align leadership and governance, and co-develop aims | • What are we aiming to accomplish — for and with whom?<br>• Who is not thriving, and what would it take for that to change?<br>• In what ways are those most affected by inequity partnering in governance, leadership, and initiatives we undertake? | • Identify the population of focus (in partnership with those in the population most affected by deaths of despair)<br>• Understand the population's assets and needs through quantitative data review as well as client and provider interviews<br>• Establish and/or align leadership and governance structures based on assets and the needs of the population of focus<br>• Co-design leadership structures with people most affected by deaths of despair<br>• Co-design clear and concrete aims |
| 2. Identify a cogent set of population-level measures that matter for the population of focus | • How will we know if the changes we make are creating the improvements and system transformation we seek?<br>• How will we know if equity is improving? | • Identify and use measures that matter — both subjective and objective, inclusive of topic-specific and overall well-being of people, communities, and the system in which the transformation is occurring |
| 3. Identify and assemble a portfolio of projects and investments that together will achieve outcomes | • What changes can we make that will result in lasting improvements and elimination of inequities of those experiencing despair at multiple levels (individual, interpersonal, organizational, cultural)?<br>• Who is missing from our shared tables, in leadership and in participation? | • Working with people most affected by deaths of despair, establish and implement a portfolio of strategic improvement initiatives<br>• Prioritize a mixture of existing and new initiatives to redesign the system (including care/service delivery and coordination, data integration, etc.)<br>• Rebalance the portfolio of initiatives over time as you learn |
| 4. Create and continuously improve a learning system that will facilitate spread and scale-up of improvements | • What are we learning that we can share, scale up, and spread to others?<br>• What do we still need to learn or improve? | • Engage in overall testing and learning in iterative cycles that align with the aims and advance scale-up and spread<br>• Have a bias toward sharing — learning from both successes and "failing forward" |

## Design Principles

IHI recommends adopting and applying the design principles described below to facilitate transformational and lasting improvements.

- **Emphasize culturally humble co-design and co-production processes that put people most affected at the center:** Develop a shared purpose of "what matters" to those affected by deaths of despair. Build and sustain partnerships to co-design and implement solutions with those in the system most affected by inequity (e.g., clients, patients, families, community members) to reflect improvements needed, drive co-production, and support sustainability efforts.

  One collaborative improvement model that IHI uses is the Action Lab, a highly adaptable structure and strategy for bringing together a diverse team to make meaningful progress on a complex goal in a short amount of time (generally 100 days).[47] Action Labs use human-centered design principles, which put the people most affected by the topic area to be addressed at the center of designing new solutions. Participants then use systems thinking and continuous improvement methods to better understand the system(s) involved and work in a structured way to improve outcomes and achieve a concrete goal. The model has been used successfully in more than 100 different communities to address hundreds of complex issues such as food insecurity, homelessness, senior care, maternal outcomes, activating neighborhood assets, youth development, and improving emergency services. Because of the heavy focus on engaging those most affected by the topic area, this model has been used successfully for improvement efforts focused on health equity.

- **Prioritize equity as foundational and drive action at multiple levels:** Transforming systems in ways that support those who are most marginalized by the current system ultimately builds stronger systems for everyone.[48] By working with vulnerable populations and communities to redesign care and support to drive toward better and more just mental health, well-being, and outcomes, these system improvements can *both* address existing inequities and serve as a model that ultimately benefits all communities through spread and scale-up.

  We can center our work around equity by continually asking, "Who isn't thriving?" and "What would it take to change that together?" Learn, understand, and seek to shift historical and current inequities — what they are, why they are in place, how they are sustained at multiple levels (institutional, cultural, interpersonal, individual) — so the new systems will be designed for equity.

  Understand embedded power structures within the community, including discussing and assessing the constraints to building equity and engaging traditionally marginalized voices in the community (e.g., racial, ethnic, income inequities).

- **Call out and then address systemic racism and racial inequity specifically:** This work includes recognizing that our systems have been designed to achieve worse outcomes for communities of color; shifting language from "persons of color do worse…" to "our system(s) produce poorer outcomes for people of color;" and combining continuous improvement and an equity lens to systematically identify and improve until racial inequities no longer exist.

- **Let data, both quantitative and qualitative, drive decision making:** This work includes the following:

  - Create and use data systems and measures that support learning and inform action;
  - Use data for improvement instead of judgment or accountability;

  - Use measures that matter to people most affected by inequity at multiple levels (individual, group, community);
  - Integrate data into existing workflows and learning systems; and
  - Include both qualitative and quantitative data as a part of a learning system, as stories are a good way to help illuminate both the problems and potential solutions.

  These data design recommendations integrate with the approaches described in the "Measuring and Understanding Impact" section.

- **Build and rely on trusting relationships to create sustainable systems:** Relationships, trust, collaboration, and transparency are essential for sustainable solutions, so actively work to develop and nurture trusting relationships.
- **Even within sector-led work, eliminate silos and advance cross-sector collaboration:** Saving lives from deaths of despair will require that a full-range of sectors and community residents work together, based on all the assets they hold, to advance common goals.
- **Cultivate mindsets and approaches for adaptive, complex challenges:** Achieving the aims is an adaptive challenge, rather than a technical one. To succeed, all stakeholders will need to adopt adaptive mindsets and approaches (e.g., fail forward, growth mindsets as well as assets-based approaches that uncover and use the strengths within communities as a means for sustainable change).[49,50,51,52]
- **Build capacity and capability for transformation at the community level:** This is critical so that the community as a whole, each sector, and community residents are better equipped to address deaths of despair and equity and become better overall problem solvers. Building capacity and capability includes both quality improvement and change management methods, as well as individual and group work to understand systems of oppression and structural racism. Identify and tap into existing agency and community governance structures to drive efforts and venues for meeting and collaboration which draw on existing strengths within agencies, organizations, and associations.

  The Community Transformation Map[53] (which aligns to the Community of Solutions framework and associated skills[54]) provides a framework for understanding, building, and self-assessing key areas required for community transformation.

- **All teach, all learn, all lead:** For the system to be meaningfully different, we will not solve problems alone. We commit to learning together and sharing widely what we learn and discover, including learning from "failing forward" along the way.

### Spread and Scale-up

Bringing successful approaches to scale is part of the science of improvement.[55] This method can be agnostic to content, and we need to understand complex adaptive change and adapt to relevant environmental drivers. Key aspects of the spread and scale-up approach are described below.

- **Identify the scalable unit:** The scalable unit is the *community of learning and improvement*. As described above, this community is formed around a population of interest and a shared aim to drive change with people in that population to reduce deaths of despair and promote flourishing.

- **Demonstrate change is possible:** Each initiative driven by a community of learning and improvement represents a set of learnings to be replicated or scaled. Though change needs to be driven locally and adapted to the local context, many of the key learnings will be relevant to others and, when shared, will speed adoption.
- **Build the will for change:** The data, stories, and learning that emerge from each community of learning and improvement, when shared broadly, can help build the will for change.
- **Create the conditions for adoption:** As each new community or sector adopts changes to drive improvement, broad policy changes can serve to reduce or eliminate existing barriers to improvement.
- **Build skills to drive change locally:** Even if the will for change is strong and evidence of possibility exists, in order to center PWLE in the work and leverage community assets, change must be driven locally. Strengthening local leadership and improvement skills are key facilitators to success.
- **Create mechanisms for shared learning:** As other communities and representatives within and across sectors begin to adopt changes and/or drive new innovations, improvement accelerates through shared learning. Creating opportunities for teams to learn together as they drive improvement is a critical accelerator.

### Measuring and Understanding Impact

The measurement framework we propose for understanding impact, at scale, to save lives from deaths of despair aligns with measurement for improvement (rather than measuring for research or accountability purposes).[56] IHI's recommended approaches are relevant both for specific interventions and to learn about impact at scale over time.

- **Measure what matters most to those most affected** — both nationally and at the level of any specific intervention.
    - **Measure for equity:** To know whether equity gaps related to deaths of despair and thriving are changing, they must be measured and tracked over time. Including items that assess sociodemographic characteristics (e.g., race, ethnicity, socioeconomic status) and stratifying measures by these sociodemographic characteristics is one way to assess equity. It can also be helpful to measure the upstream structural, programmatic, or policy factors that create, sustain, and influence equity gaps.
    - **Measure objective and subjective outcomes, including well-being:** A person-centered measurement strategy will include not only objective measures (e.g., number of deaths or rates of substance use stratified by race/ethnicity), but also subjective measures (e.g., self-reported mental health). At the center of this measurement strategy is asking people what matters to them, so that measures are meaningful to those most affected by inequities in the system. Moreover, a holistic measurement strategy that supports "whole person, whole system, whole community" improvement will include measures of overall well-being (e.g., current life satisfaction) in addition to measures specific to a particular outcome or process (e.g., use of mental health services and supports). Continue to align with existing and emerging (e.g., recommended leading indicators for Healthy People 2030) national standards.[57,58] Well-being tools are available for both adults and youth and include collaborations among leading researchers and initiatives.[59,60,61]
- **Measure at multiple levels and align measurement approaches:** Align with other national, state, and local approaches wherever possible, including Well Being in the Nation

(WIN) Measures.[62] Individual and community-level thriving are fostered or undermined by factors that exist at multiple levels, from the community and institutional levels to the interpersonal and individual levels. To understand the system of factors that influence despair and thriving, and how improvement activities are changing those systems, it is essential to measure at multiple levels. For example, to optimize use of telehealth services in a way that responds to the needs, assets, and cultures of community residents, it could be important to measure factors at the institutional level (e.g., financial investment in telehealth in the health care system and in broadband Internet in the community), interpersonal level (e.g., percentage of Black, indigenous, and people of color [BIPOC] community residents who report that they have a health care provider they trust), and individual level (e.g., percentage of BIPOC residents who report a high level of self-efficacy related to their health and well-being).

  - **Adopt a core set of measures as well as measures specific to the outcomes and processes in a particular initiative:** Core measures include both outcome and system-level measures that are common across multiple initiatives (e.g., related to well-being, morbidity and mortality, and individual and system-level equity measures). It's also important to identify specific measures related to the outcomes and processes in a particular initiative (e.g., referrals to mental health supports, availability of mental health supports in the community), with data for these measures stratified by key equity factors (e.g., race/ethnicity, rural/urban/tribal).
  - **For intervention-level measurement, choose measures that are proximal to the intervention:** When considering measures at the intervention level (whether that is at the local, state, or national level), clearly define the intended outcomes for that intervention. Consider asking, "Whose lives will get better because of this work? How would we know?" Then align measures to be as close to the intervention as possible.
  - **Consider time lag and life course:** For some interventions, the outcome may be something that is *not* experienced. Indeed, this is the case for the overall measure of lives saved from deaths of despair. For some contributors to deaths of despair, there are closer time lags between morbidity and mortality (e.g., deaths from suicide or opioids use compared to alcohol-induced deaths, which may take longer and are difficult to measure). Analysis approaches may consider actual rates versus expected rates (based on historical trends, though COVID-19 does complicate this), considering intervention versus non-intervention communities if that design is possible (and then comparisons of lives improved across those communities). There also may be key intermediate measures that may track closer to prevention, considering "never needed to treat" for factors such as substance use, mental health admissions, and opioid overdose admissions.

- **Measure for improvement:** A measurement strategy for an improvement initiative involves tracking multiple measures, including outcome, process, and balancing measures, with data collection and tracking occurring frequently (e.g., monthly) to allow learning from rapid changes in support of improvement. The Community Transformation Map is one tool to support process measurement for community change.[63] Selecting a parsimonious set of measures that matter to the population segment is ideal, as is integrating data collection and tracking into usual workflow as best as possible. Measurement for improvement is supported by the use of visual displays of data (e.g., run or control charts) that inform and motivate improvement efforts (e.g., adapting an activity).

## What: Interventions to Affect Deep Change in Communities

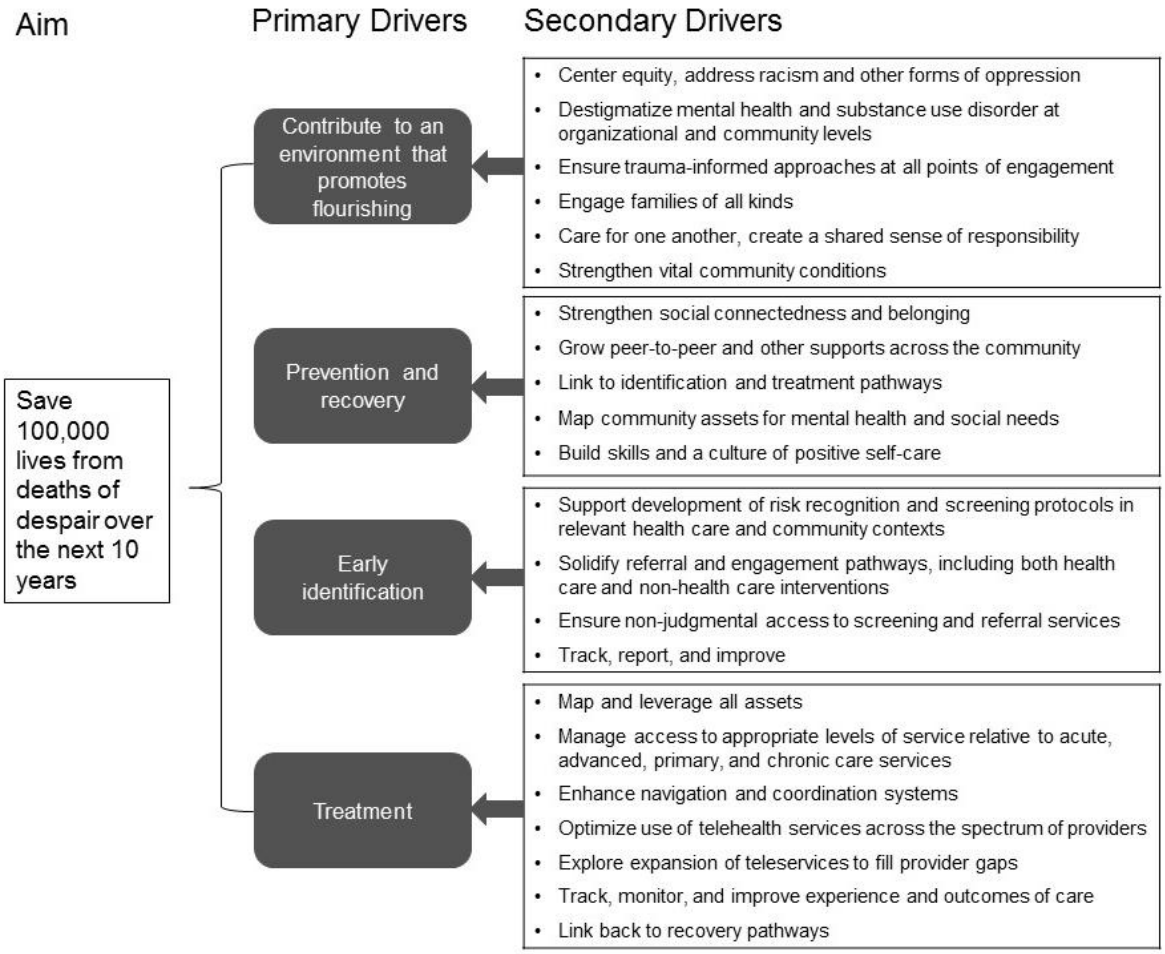
Central to the overarching goal of saving lives from deaths of despair is how the field might move toward a community-wide whole system redesign that creates flourishing. Making this shift requires building on existing assets, incorporating new models into traditional structures, and creating space for new thinking related to equity and flourishing. Once a community or sector commits to reducing deaths of despair for a specific population segment, determining the next steps could be challenging. The driver diagram in Figure 2 provides a starting point and was developed by scanning existing work, reviewing the literature, and conducting interviews with key stakeholders.

Leveraging the guiding principles and approaches described in the "How" section above, a group of stakeholders from the health care organization, partners, and members of the chosen population segment review the driver diagram together and identify areas to explore or strengthen for their organization or community. Each stakeholder group brings strengths and assets and may choose to focus their energy initially on a group of projects within one primary driver; ultimately, success is driven by a balanced portfolio of projects across multiple drivers.

Given that variation exists within and across institutions (e.g., health care, businesses, education) and communities, IHI is not providing a specific set of protocols to save 100,000 lives from deaths of despair. Rather, based on the evidence and intelligence gathered from the field to date, the driver diagram provides a sample set of approaches to be selected and tailored to a specific population, community, or context. We anticipate that each specific setting (e.g., each organization, each community) will need to be sensitive and responsive to its particular context — a one-size-fits-all approach rarely works.

The driver diagram in Figure 2 illustrates a draft theory of change to save 100,000 lives from deaths of despair, outlining four primary drivers and corresponding secondary drivers. Within this section is a brief description of each primary driver along with some examples of interventions to consider. See Appendix B for additional examples of interventions. These drivers relate to the WBT Framework for Excellence (see Appendix A) by providing an initial set of recommendations for how to engage stakeholders (e.g., health system, education system) to connect and coordinate assets and resources to affect outcomes for health and well-being.

**Figure 2. Preliminary Driver Diagram to Save 100,000 Lives from Deaths of Despair**




Health care organizations pursuing a population-based approach to improve well-being and save lives from deaths of despair will first start by identifying partners, with emphasis on PWLE, and select one or more populations of focus. Following the principles and process described in the "How" section above, together they map their assets and identify opportunities for improvement. The interventions they choose to address those opportunities for improvement become the portfolio of initiatives to drive improvement in well-being for the chosen population.

Well Being Trust has bright spot examples to learn from, including BeWell OC, an effort in southern California bringing together a robust, community-based, cross-sector strategy — public, private, academic, faith, and others — to create a community-wide, coordinated ecosystem to support optimal mental health.[64] The hypothetical example of a health care organization described below illustrates the approach.

**Health Care Organization Example: Population-Based Approach to Save Lives from Deaths of Despair**

A local health care organization (HCO), part of a larger national health system, serves a population that crosses both an urban and a rural area near Portland, OR. Within their region and reflected in their community health needs assessment, they have seen an increase in both suicides and drug overdoses in teens and pre-teens. Though kids of all races are affected, the rate appears to be increasing most dramatically in teens of color. Recently there was a highly publicized suicide of a nonbinary teen.

Each loss of life represents an extreme trauma for the local community. This has sparked an increased will for action across many sectors and organizations in the community as well as departments in the HCO. Key leaders from the HCO community benefit department, the young adults psychiatric unit, population health division, and diversity and inclusion council come together to discuss if there is action they can take to improve outcomes for this population.

The leader of the community benefit department reaches out to a local funder who has supported initiatives to address teen health. Together, they choose to invest initial funding to convene key stakeholders for a community-based Equity Action Lab to scope the problem, set an aim, create a shared initial theory of change, and propose solutions to test and advance. A group of local students, a trusted local LGBTQ+ community-based service organization, some teachers and administrators from a local high school, a couple of parents, and some health care providers and leaders coalesce to share their recommendations from the two-day Action Lab experience.

In service of reducing teen deaths from suicide and substance use and improving well-being, they see opportunities in their community to build on existing assets to strengthen activities related to their theory (or driver diagram). They form working groups or improvement teams to pursue four initial tests of change, as described below.

**1) Train health care providers and educators in trauma-informed approaches**

There is general recognition that many teens in the community have experienced trauma whether based on historical oppression (e.g., race, gender identity, sexual orientation), interpersonal or family trauma, and/or current events. Often, interaction with community institutions (e.g., schools, health care organizations) can result in re-traumatizing youth and aggravating rather than relieving distress. Next step: The improvement team will seek to learn from local and/or national or global experts as they plan to explore, test, and advance trauma-informed approaches in both school and clinical sites.

**2) Expand peer-to-peer support for teens struggling with issues of coping**

In this community, there is already a small but strong peer support group based in the LGBTQ+ community-based organization. The partners choose to invest in and expand these services in partnership with the community-based organization and local students. The expanded services include helping identify students in need and linking them to other available services.

**3) Strengthen linkages between schools and health care**

The local school and HCO agree to strengthen their relationship to support improved screening, early identification, access, treatment, and support for all students in need.

**4) Ensure availability of telehealth services for all in need**

All stakeholders recognize that the use of telehealth services has increased more than 1,000-fold during the COVID-19 pandemic. Early interviews with local teens indicate that many prefer this format due to multiple privacy, anonymity, and convenience issues. The HCO commits to continuing to offer telephone and other virtual visits as key access points (and simultaneously commits to advocating for appropriate insurance coverage). The school will investigate creating a private consultation room for remote mental health visits during the school day after classes resume on campus.

Overall, the local health care organization both commits to advancing specific actions within its organization to drive improvement (e.g., training emergency room, primary care, and mental health service providers on trauma-informed approaches; making all aware of peer support services available in the community; linking with school-based services; continuing access to telehealth services) and supporting collaborative community-based action.

As the working groups pursue these improvements, they may choose to learn, adapt, or adopt from interventions that have been implemented elsewhere.

# If You Do Nothing Else, Start Here

The example above describes a population-based approach that centers equity and co-designs with people with lived experience in service of pursuing system-level transformation to save lives from deaths of despair. Some health care organizations or partners may not be ready to commit to these principles. Below are suggestions for incremental improvements health care systems might implement that will likely result in marginal incremental impact. Ideally, this incremental change approach acts as a steppingstone to engage people most affected by despair as well as cross-sector partners to co-design and co-produce lasting system-level transformation. These examples are organized by the primary drivers (see Figure 2) in reverse order, as that is where, within the health system, there is often the most will and energy for improvement.

- **Treatment:** Expand access and acceptability, particularly virtual access (e.g., phone, video, asynchronous)
- **Early identification:** Increase screening for depression, substance use disorder, and suicide in clinical settings (primary care, ED, other) and community partners (calls to 911, other)
- **Prevention and recovery:** For individuals who have been treated in your health system, strengthen referrals to existing community or peer supports
- **Contribute to an environment that promotes flourishing:** Ensure that all health system employees are being paid a living wage and have access to and coverage for mental health services when needed

Below are some example interventions that align with the four primary drivers, many of which surfaced during interviews and the key stakeholder meeting. See Appendix B for additional example interventions.

## Treatment

Improving treatment may provide a great opportunity for innovation as health systems and communities across sectors consider how and where treatment occurs. There are emerging ways to increase access to services, such as telehealth, and coordinating care and referrals within and outside of health care.

| Example Intervention | Description |
|---|---|
| Telebehavioral Health Program | Through the Indian Health Service Telebehavioral Health Center of Excellence (TBHCE), the program aims to provide, promote, and support the delivery of high-quality, culturally sensitive telebehavioral health services to American Indian/Alaska Native people. |
| Dialectical Behavior Therapy (DBT) | This cognitive-behavioral treatment approach has two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes (refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies). This intervention has demonstrated evidence of effectiveness and is included in the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices. |

**Case Example:** Cabin Creek Health System in West Virginia transitioned to telehealth group therapy for medications for opioid use disorder (MOUD) patients in the midst of the coronavirus pandemic.[65] Staff considered the limitations of virtual appointments (e.g., access to technology, bandwidth, confidentiality of the group) when creating norms to establish productive virtual group treatment and therapy sessions. Patients advocated for virtual group visits to continue peer support and connections with other patients in support of their treatment.

## Early Identification

Creating reliable processes and systems for early identification across health care organizations and sectors can improve the trajectory of those suffering. It will require appropriate screening assessments across population segments and access to resources for both health care and non-health care interventions.

| Example Intervention | Description |
|---|---|
| Pathways Community HUB Model of Care Coordination | This evidence-based HUB model is an accountable community-wide approach that effectively addresses risk factors and improves the health of populations while reducing costs. The model ensures that those at greatest risk within a community are identified and that an individual's medical, behavioral health, educational, and social risk factors are addressed.<br><br>Healthy Bernadillo County demonstrates observed improvements in residents' health as a result of the model. |
| Social Media Use of Artificial Intelligence to Reduce Suicide | The platform uses artificial intelligence to recognize posts that include keywords or phrases indicating thoughts of self-harm, and then displays resources with support options to those persons. |

**Case Example:** ChristianaCare is one example of a primary care program that has integrated behavioral health to support patients who have a positive mental health screening. This integration model permits a behavioral health specialist to see a patient within their primary care visit to avoid

the risk of the patient not following through on a separate appointment with the specialist. The successful model has expanded to cancer, pediatric, cardiac, and intensive care units.[66]

**Case Example:** At Cohen Children's Medical Center (CCMC), the largest provider of pediatric health services in New York State, when a teenage boy with severe depression comes to the ED and doesn't need emergency or inpatient care, but rather to be linked with services immediately, strong cross-sector partnerships can lead to lives saved. CCMC established a behavioral health urgent care center known as the "BH Urgi" that is staffed by a full-time child and adolescent psychiatrist, a full-time licensed mental health counselor, and two full-time patient engagement specialists. They connect patients with the appropriate level of care in the community and through building stronger community partnerships with schools, pediatric practices, and community mental health centers.[67]

## Prevention and Recovery

Prevention strategies build off of improving environments, with an emphasis on the importance of social connectedness and relationships as a mechanism to support those that may be at risk of suffering, including those in recovery who are at risk for relapse.

| Example Intervention | Description |
|---|---|
| **Making Connections** | This initiative is working with 13 urban, rural, and suburban communities to implement community-level prevention strategies to improve mental health and well-being for veterans, young men, and boys of color.<br><br>Making Connections New Orleans (MCNOLA) is working to create better mental health and well-being outcomes for African American men and boys in the city's St. Roch neighborhood, a section of the city drastically impacted by catastrophic natural disasters and high levels of violence and unemployment. MCNOLA has played an important role in the response to trauma in New Orleans, providing a unique perspective by shifting conversations and responses from a focus on deficits and individuals to a focus on community strengths and community-level well-being. The coalition has also helped improve mental health and well-being for men and boys in St. Roch by increasing the use of public spaces to facilitate art, recreation, and cultural expression, and enhancing access to opportunities and services. |
| **Friendship Bench** | This intervention fosters positive mental and emotional health, primarily addressing depression. It can be used in various settings and is usually led by trained lay health workers. |

**Case Example:** Active Minds is a network focused on advancing mental health, education, and support for high school and college students via peer-to-peer dialogue and interaction. The organization, engaged with more than 800 schools, empowers young adults to speak openly about mental health to reduce stigma, encourage help-seeking behavior, and prevent suicides. Now an Active Minds speaker, Abraham Scully shared his story of starting college and becoming overwhelmed with the stress of balancing school and work. Through an Active Minds peer, Abe was connected to resources on campus to identify, diagnose, and begin treating his depression (see Appendix B).

## Contribute to an Environment That Promotes Flourishing

Transforming the environments where people live, learn, work, play, and pray requires both structural changes in creating vital community conditions as well as behavioral changes in how we address stigma and promote equity within communities and across care delivery.

| Example Intervention | Description |
|---|---|
| Person-First Language | Person-first language doesn't define a person based on any medical disorder. It's nonjudgmental and neutral, and the diagnosis is purely clinical. The Office of National Drug Control Policy recommends, for example, using "person with substance use disorder" rather than "addict." |
| Developing Trauma-Informed Organizations | Driving the transformation of organizations from systems that induce trauma to systems that can sustain healing practices and wellness, which occurs along a continuum from Trauma Organized (i.e., systems so impacted by organizational stress and trauma that they present symptoms similar to those of individuals impacted by trauma) to Healing Organizations and Systems of Care. |

**Case Example:** Foundation for Healthy Communities (FHC) comprises New Hampshire (NH) hospitals that engage in innovative partnerships to improve health and health care across the state, addressing quality of care, access to care, and community health improvement. Since the launch of the Total Population Health Initiative in 2017, FHC has focused on improving the health and well-being of NH residents by fostering connections between health care, public health, and the social determinants of health while advancing health equity.[68] Serving as anchor institutions, these NH hospitals also leverage their community benefit resources to support communities' priorities.

# Considerations for Implementation

Whether you are working on incremental improvement or whole community transformation, we recommend a focus on these implementation considerations. As described throughout this guide, there are robust methods (the "how") to drive and measure change. Interventions (the "what") with various levels of evidence exist across the four drivers. A key decision is to identify the population of focus (the "who") — the persons most affected by deaths of despair and with whom the health system and its partners will work to understand both the challenges and potential solutions, and collaborate to create better systems of care and support.

## Role of Health Care System Leaders

Addressing deaths of despair requires humble, committed health care leadership. Particularly in the current environment, the threats of despair have a direct negative impact on organizational vitality and serve as a call to mission. Health care systems can contribute to the solutions. When tackling complex issues, health care systems have many levers to engage and, within their direct sphere of influence, health care leaders can champion:

- Equitable improvement in the quality and safety of care delivery, strengthening the alignment of existing mental health care quality initiatives to create more value and better outcomes;
- Care for their providers and staff, supporting mental health and well-being, particularly given the challenges of providing care during COVID-19; and
- Intentionally invest to strengthen local workforces and economies.

Health care leaders are called to humbly partner with community members and community organizations, in deference to local expertise, to invest time and resources to co-produce whole system community redesign for improved equitable mental health outcomes. Nonprofit hospitals' community benefit divisions are committed to addressing priority health challenges in their communities, usually identified through the organization's community health needs assessment.

As the threat of poor mental health grows in communities across the US, during and after the COVID-19 pandemic and this challenging time of social unrest, there is great opportunity for hospitals to align their assets and investments with other assets, funders, and partners across their communities in service of common efforts to prevent deaths of despair and improve equity and well-being.

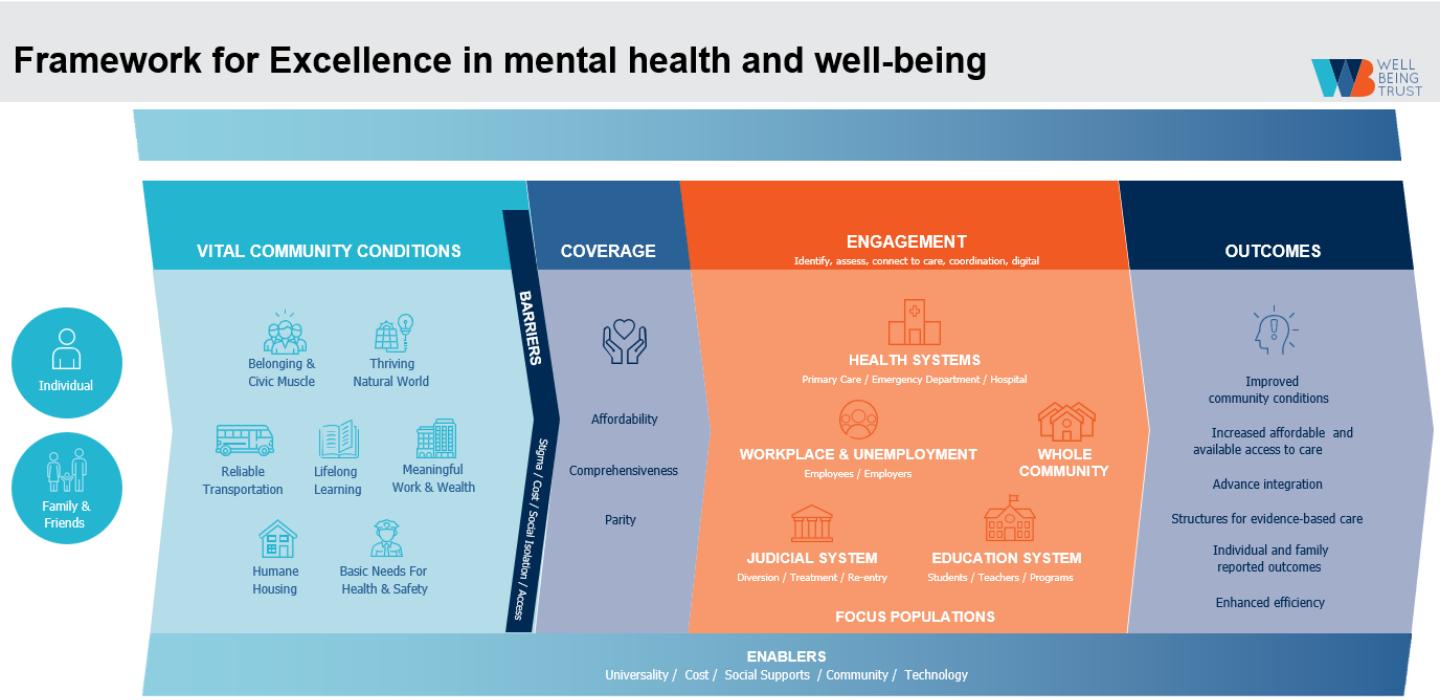
### Leading and Supporting Community Transformation Efforts

Moving from isolated impact within an organization, facility, agency, or subpopulation to impact at the community or national level requires multi-stakeholder collaboration across sectors and groups. This type of co-production requires leadership understanding of the distinctive issues and opportunities presented by collaborative improvement, including governance and decision making across multiple sets of positions and interests; transparent and meaningful measurement; designing and coordinating services at the individual and community level in a way that partners with residents for sustainable adoption; building more equitable systems throughout the change process; and fostering intentional and learning to build the capability to achieve results.

## Conclusion

The recommendations and approach presented in this guide serve as a call to action for health systems and their partners to propel the movement infrastructure that Well Being Trust and national partners have built to strengthen population outcomes to save lives from deaths of despair. Leaders of health care organizations can and must act for clinical-community integration for whole person care and leverage their assets to affect whole system transformation for community-level outcomes.

# Appendix A: Framework for Excellence in Mental Health and Well-Being




Source: *Healing the Nation*. Well Being Trust; 2020. https://healingthenation.wellbeingtrust.org/

# Appendix B: Examples of Interventions to Save Lives from Deaths of Despair

These example interventions, which support saving lives from deaths of despair and build on the driver diagram in Figure 2, were gathered from key informant interviews, a literature scan, and a stakeholder engagement meeting.

The example interventions in this guide have broad variation in evidence, which creates the opportunity for additional innovation, testing, and adaption.

- **Level 1: Well-defined interventions with some documented evidence**
  For example, screening for depression and substance use disorder have strong evidence in particular settings and need to be tested and adapted for other settings.
- **Level 2: Interventions that have not been fully defined or tested**
  For example, peer support interventions have many variations with numerous examples of success leading to a general acceptance of the effectiveness of the approach, though formal studies may be lacking.
- **Level 3: Opportunity for innovative ideas**
  As communities or sectors engage in assets-based, population approaches there will be significant opportunities to develop innovative ideas to meet their particular population's needs through co-design and co-production (discussed in the "How" section above).

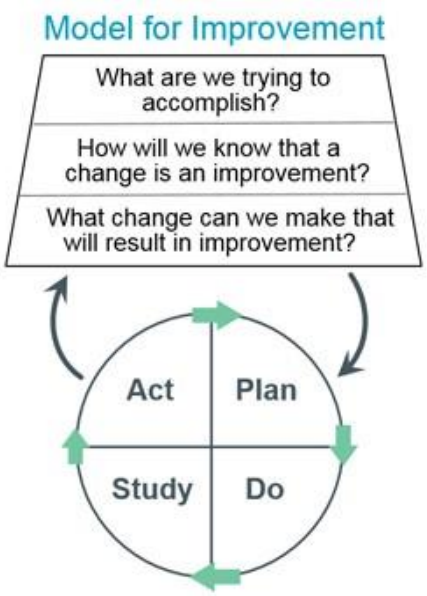
| Change Idea/ Intervention | Description | Driver | | | |
|---|---|---|---|---|---|
| | | Environment | Prevention/ Recovery | Early Identification | Treatment |
| Anchor Collaboratives | Anchor Collaboratives, often led by nonprofits such as health care organizations, strengthen local economic ecosystems by more intentionally aligning and leveraging the significant everyday business activities of local anchor institutions. These include local hiring and purchasing, place-based investing, and community wealth-building practices to create jobs, increase incomes, build community/local/broadly held wealth, and spur community investments to redress systemic inequities. Improving economic ecosystems helps create an environment in which individuals can thrive. | X | | | |
| Office of Civic Well-being | California's city of Santa Monica created an Office of Civic Well-being to launch The Well-being Project, which utilizes measurement and data to understand well-being in the community, including assets, deficits, and direct resources in order to create the conditions in which residents can thrive. | X | | | |
| Person-First Language | Person-first language doesn't define a person based on any medical disorder. It's nonjudgmental and neutral, and the diagnosis is purely clinical. This approach helps reduce the stigma related to a clinical diagnosis. The Office of National Drug Control Policy recommends, for example, using "person with substance use disorder" rather than "addict." | X | X | X | X |

| Change Idea/ Intervention | Description | Driver | | | |
|---|---|---|---|---|---|
| | | Environment | Prevention/ Recovery | Early Identification | Treatment |
| **Project 2025** | The American Foundation for Suicide Prevention aims to reduce the annual rate of deaths by suicide by 20% by 2025 by focusing on firearms, health care systems, emergency departments, and corrections systems. Strategies include educating the firearms owning and selling communities on suicide risk; working with health care organizations to increase the adoption of suicide risk identification and prevention strategies; implementing screening and interventions for at-risk patients seen in emergency departments; and changing the culture of suicide prevention in jails and prisons. | X | X | | |
| **Common Room / A Time to Talk** | In response to the overwhelming pressures felt by health care staff, the UK's National Health Service (NHS) created a series of open spaces for staff to connect and support one another. Hosted by NHS practitioner health clinicians and trained psychologists, these open spaces include a general "common room" open to all staff, as well as role-specific rooms for the specific issues faced by physicians and ambulance staff. | X | X | | |
| **Pathways Community HUB Model of Care Coordination** | This evidence-based HUB model is an accountable community-wide approach that effectively addresses risk factors and improves the health of populations while reducing costs. The model ensures that those at greatest risk within a community are identified and that an individual's medical, behavioral health, educational, and social risk factors are addressed. Healthy Bernadillo County demonstrates observed improvements in residents' health as a result of the model. | X | X | | |
| **Making Connections** | This initiative is working with 13 urban, rural, and suburban communities to implement community-level prevention strategies to improve mental health and well-being for veterans, young men, and boys of color. Making Connections New Orleans (MCNOLA) is working to create better mental health and well-being outcomes for African American men and boys in the city's St. Roch neighborhood, a section of the city drastically impacted by catastrophic natural disasters and high levels of violence and unemployment. MCNOLA has played an important role in the response to trauma in New Orleans by: providing a unique perspective by shifting conversations and responses from a focus on deficits and individuals to a focus on community strengths and community-level well-being; and helping improve mental health and well-being for men and boys in St. Roch by increasing the use of public spaces to facilitate art, recreation, and cultural expression, and enhancing access to opportunities and services. | X | X | | |
| **Active Minds: Peer Support Network** | This network is advancing mental health and support for high school and college students via peer-to-peer dialogue and interaction. Active Minds speaker Abraham Sculley shares his story of starting college and becoming depressed due to the overwhelming stress of balancing school and work, and then getting connected with on-campus resources because of a close friend. | | X | X | X |

| Change Idea/ Intervention | Description | Driver | | | |
|---|---|---|---|---|---|
| | | Environment | Prevention/ Recovery | Early Identification | Treatment |
| Togetherall (formerly Big White Wall) | This an online service providing access to millions with anxiety, depression, and other common mental health issues. | | X | X | X |
| Project Parachute | Project Parachute is a network of licensed therapists who volunteer their time and resources to support other health care workers during the COVID-19 crisis. Volunteer therapists run both individual and group sessions. | | X | X | X |
| Social Media Use of Artificial Intelligence to Reduce Suicide | The social media platform uses artificial intelligence to recognize posts that include keywords or phrases indicating thoughts of self-harm, and then displays resources with support options to those persons. | | X | X | |
| Friendship Bench | This intervention fosters positive mental and emotional health, primarily addressing depression. It can be used in various settings and is usually led by trained lay health workers. | | X | X | X |
| Developing Trauma-Informed Organizations | Driving the transformation of organizations from systems that induce trauma to systems that can sustain healing practices and wellness, which occurs along a continuum from Trauma Organized (systems so impacted by organizational stress and trauma that they present symptoms similar to those of individuals impacted by trauma) to Healing Organizations and Systems of Care. | | X | | X |
| Gatekeeper Training | Gatekeeper training sessions aim to teach specific groups of people to identify individuals at risk for suicide and refer them to appropriate support. Gatekeepers include individuals who have contact with a large number of youths on a regular basis such as teachers, public school staff, peer educators, and physicians. A core component of all programs involves learning the warning signs of suicide and asking people identified as at risk whether they are thinking about killing themselves. Longer training sessions may aim at building skills to provide additional assistance such as collaboration with suicidal youths to develop a safety plan. A heath care system may, for example, partner with relevant community organizations to offer group gatekeeper training sessions.<br><br>Example of use in Garrett Lee Smith Youth Suicide Prevention Program. | | | X | |
| Dialectical Behavior Therapy (DBT) | This cognitive-behavioral treatment approach has two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes (refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies). This intervention has demonstrated evidence of effectiveness and is included in the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices. | | | | X |

# Appendix C: The Model for Improvement

IHI uses the Model for Improvement as the framework to guide improvement work. The Model for Improvement, developed by Associates in Process Improvement, is a simple, yet powerful tool for accelerating improvement. This model is not meant to replace change models that organizations may already be using, but rather to accelerate improvement.




## What are we aiming to accomplish — for and with whom?

To achieve equitable results at scale for populations, we must first identify a population of focus for improving health, well-being, and equity. We recommend focusing on populations or population segments that have been disproportionately affected by inequities, such as deaths from despair, and where health status has considerable room for improvement.

After selecting the population of focus, next steps include deepening understanding of the needs and assets of the population utilizing segmentation; analyzing data stratified by race, ethnicity, gender; and engaging individuals within the population to understand the lived experience of the inequities. This understanding of the population will lead to a decision on concrete aims and goals for improving equitable outcomes. Without shared purpose and concrete aims, efforts to improve deaths of despair and equity may serve narrow purposes and perhaps build trust, but do not move an entire organization, community, region, or nation toward improved outcomes.

The identification of a population of focus will also drive the creation and/or alignment of leadership and governance structures to champion and drive the work over time. Pursuing health equity — which is realized when each individual has a fair opportunity to achieve their full health potential — requires change in a system's culture and infrastructure, as well as specific changes in aspects affecting the community-wide issues that are to be addressed. A number of different individuals and groups are required to effectively adapt and implement these changes, including individuals with lived experience of deaths of despair and the inequities you wish to improve.

IHI also recommends that there is an opportunity — and a responsibility — for health care to set some bold aims to drive toward a transformed system. We have not proposed such aims within this guide because that is work that must be co-designed with those most affected by deaths of despair.

## How will we know if the changes we make are creating the improvements and system transformation we seek?

How will we know if lives are being saved? Identifying a cogent set of system-level measures for population health and equity is necessary to help organizations and coalitions evaluate their progress. These measures must be aligned to the identified population and aims and will help guide priority areas of improvement.

### What changes can we make that will result in lasting improvements and saving lives from deaths of despair at multiple levels?

A guiding purpose, concrete aims, and system-level measures are long-term guideposts, for a period of three to five years or longer. Accomplishing this long-term purpose requires a portfolio of interventions and initiatives in addition to associated projects and investments that can be addressed in the shorter term, which will together achieve population health and equity. Selected projects and investments may center on an entirely new care/service design and/or care coordination model. Another option is to build on an existing project within the organization or region, where appropriate. The portfolio of interventions should tie to an explicit theory or rationale for system-level changes for the population of focus and align with identified population-level measures.

## Guiding Iterative Learning

To drive the outcomes over time toward spread and scale-up, a comprehensive learning system is needed that fosters intentional testing and learning, provides feedback loops to compare performance with specific aims and measures for the designated population, and integrates the assets of leaders and organizations. This includes learning by iterative testing (e.g., Plan-Do-Study-Act [PDSA] cycles, sequential testing of changes, Shewhart time series charts), using informative cases to "act with the individual; learn for the population,"[69] and selecting leaders to manage and oversee the learning system, with particular focus on rebalancing the portfolio of work overtime.

The population-based improvement approach to improve well-being and save lives from deaths of despair that is described in this guide has four overarching components, each with a set of guiding questions (that always include advancing equity) that build on one another. This approach embeds learning and improvement skills within and across systems and communities, and at both the individual and group levels, as a means to support sustainability.

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