HealthePeople® - Achieving Healthy People, Communities, Countries and World

Ideal Health Systems - Person-Centered,
Affordable, Accessible, Quality, Outcomes-Driven
Health Systems

by

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ISBN-13: 978-1548276386
ISBN-10: 1548276383

DEDICATION

People who help build, achieve
and sustain a healthy and thriving
future for all forever.

About the Author

Gary (Chris) Christopherson continues to work countrywide and locally on improving health, reducing vulnerability and building a surviving and thriving future. Currently, he develops strategy, management and policy for creating, managing and sustaining large positive change and building a better, thriving future for all forever

Thrive!® and **HealthePeople**® draw on his 30+ years' experience creating, managing and sustaining large positive change at country and local levels in public and private sectors. He founded ***Thrive!*** (building a thriving future) and **HealthePeople** (building a healthy future. ThrivingFuture.org; HealthePeople.com). He served as a senior leader, manager and policymaker responsible for multi-billion-dollar policy, programs and budgets and thousands of employees. His public service includes: Principal Deputy Assistant Secretary and Acting Assistant Secretary of Defense for Health Affairs and Senior Advisor, Department of Defense; Associate Director, Presidential Personnel, Executive Office of the President, White House; Senior Fellow, National Academy of Public Administration; Senior Advisor to Chief Operating Officer and Deputy Director for the Quality Improvement Group, Centers for Medicare and Medicaid Services, DHHS; Senior Advisor to Under Secretary, Veterans Health Administration, VA; Senior Fellow, Institute of Medicine, National Academy of Sciences; Chief Information Officer, Veterans Health Administration, VA; Director of Health Legislation, House Select Committee on Aging, U.S. House of Representatives.

He wrote several nonfiction books, including **HealthePeople® - Achieving Healthy People, Communities, Countries and World**, **Thrive! - Building a Thriving Future, Thrive! - People's Guide to a Thriving Future, The Thrive! Philosophy** and **Thrive! Endeavor.** Available Amazon.com and ThrivingFuture.org.

He is a sculptor of abstract art, focusing on Thrive! sculptures and creating over 150 sculptures. GChris Sculpture at GChris.com. He wrote several books. Four are science-fiction books entitled **Thrive! - Escape from Extinction**, **Extinction – Failure to Thrive**, **black box** and **The Thrive! Endeavor**. Three are children's fiction books entitled **Thrive or Not to Thrive? – Tale of Two Tomorrows, Angel – Thriving Creator of Artful Things** and **T!rrific [terrific] -What will you do to thrive?** Available Amazon.com and GChris.com.

He received his bachelor's in political science and his master's in urban and regional planning from the University of Wisconsin – Madison, and did doctoral work in health policy and management at John Hopkins University School of Public Health.

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Summary

HealthePeople® - Achieving Healthy People, Communities, Countries and World

Rationale. Throughout the world, including America, we face major challenges and disappointments in achieving healthy people, communities, countries and world. Health status, causes of good and poor health, and health systems for improving health vary widely within communities and countries and across the world. Without a large change in health vision, strategy and execution, our future will be as disappointing as our past.

Vision and Strategy. ***Thrive!*** ® is the overall vision, mission and strategy for achieving and sustaining a thriving future for all. Within that future, **HealthePeople** ® is the vision, mission and strategy for achieving and sustaining a healthy future for all. HealthePeople is a strategy whose near-term vision is to achieve substantially healthier people and substantially healthier communities, countries and world. The long-term vision is to achieve healthy, thriving people globally and healthy, thriving communities, countries and world. This HealthePeople strategy was created with the belief that we can reach this vision via a strategy of high performance, health systems for all people that are self-perpetuating, affordable, accessible, "e" enabled, person-centered, prevention-oriented, and producing high health quality, outcomes and status. Such systems, partly physical and partly virtual, matched to community, country and global needs and conditions, and put into place by collaborative private and public partnerships, will greatly improve accessibility, quality, affordability and health status for all people. Such systems can help achieve a healthy, thriving people, community, country and world.

Guidance. This strategy is guided by and aligned with the U.S. Institute of Medicine (IOM) recommendations. What people want from a high performing health and long-term care system is "staying healthy", "getting better", "living with illness or disability" or "coping with the end of life." IOM has six aims for a high performing health system - safe, effective, person/patient-centered, timely, efficient, and equitable.

Supportive Strategies. Using HealthePeople strategies and models, we can positively transform health systems and achieve healthier people and a healthier world by successfully applying 15 key strategies and two core elements:

- Achieve affordable, accessible, and high quality/performance health systems.
- Focus on people, in partnership with their health partners, as the center of the health universe.

Building and Achieving a Healthy Future and Healthy People. This book - HealthePeople® - focuses on why and how to build, achieve and sustain a successful health system, healthy people and a and a healthy future. To achieve this, the book describes, speaks to the importance of, and walks through how to use ideal health systems, healthy behavior and person-centered health. With these and using HealthePeople as a vision, mission and strategy, the book describes how to build, achieve and sustain healthy communities, countries and world.

Building and Achieving a Healthy and Thriving Future. We should proceed under the belief that we can reach this vision of a healthy and thriving future. Utilizing HealthePeople and ***Thrive!*** as strategies, we can build a substantially healthier world and move toward healthy people and a truly healthy and thriving future. People, whoever they are, wherever they live and whatever their status, deserve and should expect nothing less.

Chapter 1. HealthePeople® - Building, Achieving and Sustaining a Successful Health System and Healthy Future

Ideal Health Systems – How to Build, Achieve and Sustain Successful Health System and a Healthy Future [1]

Why we (people, community, country, world) can and must have a successful health system and a healthy future.

We (people, community, country, world) can have a successful health system and a healthy future. To build a better future, the HealthePeople strategy and tools have been used successfully at the personal level and on larger scales (community, country). As they have in the past, this strategy and these tools can help us build, achieve and sustain a healthy future.[2]

We must have a healthy future. We must do better whether that future appears bad or good. Why? Even if somewhat healthy today, we are not fully healthy, are not likely to be fully healthy in the future, and are still facing uncertainties about the long-term future. We want and need a healthy future.

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[1] This HealthePeople approach can be applied at any level – community (geographic and/or group), country and/or world. The primary difference is scale.

[2] This HealthePeople approach to building, achieving and sustaining a healthy future parallels the broader ***Thrive***! approach to building a surviving and thriving future. ***Thrive!* - People's Guide to a Thriving Future** available via Amazon.com or ThriveEndeavor.org.

Why we must and can do it together.

To build this healthy future, we as people and leaders should be partners in this endeavor from the beginning and through each step. Success is dependent on positive and effective leadership from us as leaders and people. How that leadership comes about is the subject of some debate. Some people argue for a leader driven approach where the leader creates the vision and motivation and the people join and/or follow. Some argue for bottom-up or self-organizing approaches where the people lead and the traditional leaders may or may not join and/or follow. Some argue for a collaborative approach where the traditional leaders and the people (also serving as leaders) jointly provide leadership, vision, motivation, strategy and successful execution. In general, the latter approach probably has the greater potential to create and sustain large, positive change and a healthy community, country and world.

Key to success is the strong desire by us to move our current poor health to a healthy future.

How to build, achieve, and sustain a successful health system and a healthy community, country and world.

To build a healthy future, HealthePeople can be helpful as laid out in the following "how-to", a relatively basic "how-to". The underlying principles and the strategy, models and tools apply to communities from small size and low complexity to very large size and very high complexity (large communities, countries, world).

Step 1. Assess our current state.

The first major step is to understand our current health.

Who is "us"? First go through who we are today. We can be defined by geography (for example, a neighborhood, a region), by political boundaries (for example, a village, town, city, county, state), or by common population characteristics (e.g. racial/ethnic, gender, economics, political view, similar mission, religion, labor, profession, business). It can be a combination of these.

What are our characteristics? Our gender, age, racial, ethnic make-up. Lifestyle. Type of work. Financial situation. Food and drink. Housing. Protection (crime, environmental hazards). Education. Physical and mental health. Personal growth and development. Habitat (living environment,

neighboring communities, part of what state, country, continent). Producing what. Climate. Sustainability.

How healthy are we? How well are we? In terms of performing well? Being well-off (financially)? Being well nourished (food and drink)? Being well housed? Being well protected (exposures, crime)? Being well educated? Being physically and mentally well? Personally growing/developing well? Living within good habitat? Not being vulnerable? Producing personal and public goods? Living within a stable, positive climate? Being sustained?

Answering "yes" to all indicates being currently healthy. Though all "yes" answers would be very good, it is also unlikely. Even with all "yes", there would still be future work to make sure this continues. "No" answers are bad and mean there is current and future work to be done.

What positively or negatively impacts our health? What positively or negatively impacts or is likely to impact our health? What impacts our performing well? Being well-off (financially)? Being well nourished (food and drink)? Being well housed? Being well protected (exposures, crime)? Being well educated? Being physically and mentally well? Personally growing/developing well? Living within good habitat? Not being vulnerable? Producing personal and public goods? Living within a stable, positive climate? Being sustained?

Positive impacts improve and/or sustain health. If they will continue, we probably can focus on other things. If they may or may not continue, action is needed to make them continue and/or to develop other things to compensate. Bad impacts prevent or limit health. If they will not continue, we probably can focus on other things. If they may or may not continue, action is needed to stop them or to avoid or minimize their impact.

This includes the health system we currently have. We need to assess to what extent the current health system contributes to our being healthy and to our having a healthy community, country and world.

What is our near and long-term future behavior? How are we likely to behave in the near and long-term future? For example, will we behave (individual behavior; group behavior, overall community, country and world behavior) so as to protect and improve health support, help each other be healthy, maintain/improve our environment, and sustain our health near and long term. [3]

[3] Health Support – May include physicians, nurses, dentists, optometrists, pharmacists, clinics, urgicare, emergency departments, hospitals, rehabilitation

How will we behave with respect to performing well? Being well-off (financially). Being well nourished (food and drink)? Being well housed? Being well protected (exposures, crime)? Being well educated? Being physically and mentally well? Personally growing/developing well? Living within good habitat? Not being vulnerable? Producing personal and public goods? Living within a stable, positive climate? Being sustained?

Step 2. Strategy to achieve a healthy future.

The next major step is to develop the strategy that will help us build and achieve a successful health system and a healthy future.

How healthy should we be in the near and long-term future? How healthy should we as a whole be in the future? We should be healthy. With this as a guide, we choose the healthy future we want to build and achieve. HealthePeople will help us accomplish that.

Describe how healthy we should be. From our view and to be healthy, indicate to what extent we should be performing well. Be well-off (financially). Be well nourished (food and drink). Be well housed. Be well protected (exposures, crime). Be well educated. Be physically and mentally well. Be personally growing/developing well. Be living within good habitat. Not be vulnerable. Be producing personal and public goods. Be living within a stable, positive climate. Be sustained. Again, we should be healthy.

What must change externally and internally to achieve our healthy future? What must change externally (outside us) and internally (within us) to progress from our current status to achieve the desired future healthy status? Describe all that must change externally and internally for the following. To achieve performing well? Being well-off (financially)? Being well nourished (food and drink)? Being well housed? Being well protected (exposures, crime)? Being well educated? Being physically and mentally well? Personally growing/developing well? Living within good habitat? Not being vulnerable? Producing personal and public goods? Living within a stable, positive climate? Being sustained?

Good changes improve and/or sustain health. Bad changes prevent and/or limit health.

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facilities, home care, nursing homes, assisted living, alternative health/medicine, and others.

This is where we assess our current health system and what must change to achieve healthy people and a healthy community, country and world.

What actions by us are needed to achieve a healthy future? What internal actions (by us) and external actions (by others) are needed to bring about the needed external and internal changes that improve the community, country and world's current status enough to achieve the desired health status? [See "Achieving a Healthy and Thriving Future".] [4]

External actions by others. There are very important external actions that are needed to support the HealthePeople strategy. What external actions by others will bring about the needed changes?

Identify external actions by others that support good changes that will help improve and/or sustain health. If good changes are likely to occur, together with others support them. If good changes are not likely to occur, together with others support them and develop other good changes to compensate.

Identify external actions by others that stop bad changes that prevent or limit health. If bad changes are not likely to occur, together with others ensure they do not. If bad changes are likely to occur, together with others change them, stop them or avoid/reduce their impact.

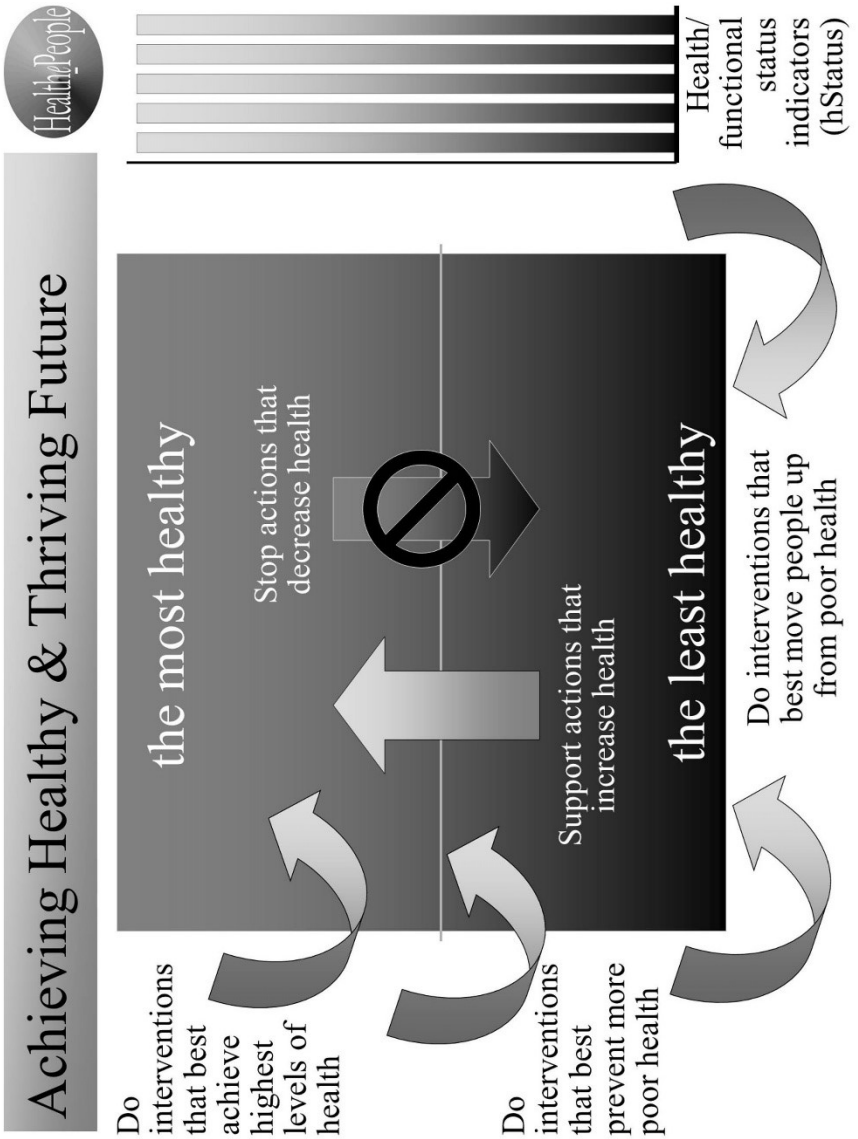
Internal actions by us. There are very important internal actions by us that support the HealthePeople strategy. Individual people and the community, country and world should support the strategy to ensure each person and the community, country and world are healthy.

This is where we decide what actions we must take to ensure our health system will result in healthy people and a healthy community, country and world.

Identify internal actions by us that support good changes that will help improve and/or sustain health. If good changes are likely to occur, support them. If good changes are not likely to occur, support them and develop other good changes to compensate.

Identify internal actions by us that stop bad changes that prevent or limit surviving and thriving. If bad changes are not likely to occur, ensure they do not. If bad changes are likely to occur, change them, stop them or avoid/reduce their impact.

[4] An action is defined as "who will do what to/with whom, where, when, and with what result."



"Achieving a Healthy and Thriving Future".

Overall HealthePeople strategy and actions. The overall HealthePeople strategy and actions need to be documented and agreed to by all of us. This includes what is the successful health system we want to build, achieve and

sustain. This will be the **HealthePeople Strategy and Action Plan**. Different people and public and private organizations will take on different responsibilities. For each action, designate who will do what to/with whom, where, when, and with what result. Make sure all the actions are assigned that are needed to build, achieve and sustain a healthy future

As the strategy is executed, strategy, actions and results should be updated in the **Strategy and Action Plan**.

Periodically, an evaluation - assessing strategies/actions near and long-term impact on near and long-term health – should be done. When a) strategies and actions are not building and sustaining a healthy future and/or b) there are changes externally and in the community, country and world, adjust the overall ***S*trategy and Action Plan**.

The key is to successfully execute the **Strategy and Action Plan** and to build a successful health system and a near and long term healthy future. Each and all must successfully carry out the assigned action. That is, each/all must successfully do what is required to/with whoever is required, where required, when required, and with what needed/desired result. A **HealthePeople Strategy and Action Plan** is only as good as its successful execution and successful achievement of the desired outcome - a successful health system and a healthy future for our people and for our community, country and world.

Chapter 2. HealthePeople® - Achieving Healthy People Via Ideal Health Systems

Ideal Health Systems - Person-Centered, Affordable, Accessible, Quality, Outcomes-Driven Health Systems

An ideal health system is a **"health"** system, not a "health care" or "medical care" system. But health and medical care are key parts of a health system. An ideal health system is **person-centered, affordable, accessible, quality, virtual, integrated and community-focused**. It is **"virtual"** in that not all the elements are owned or managed by any one single organization, not all the elements are in one location, and not all the health support is physically or organizationally connected. It is a virtual, integrated health system in that all the elements are connected functionally, to the person and to support a person's and community, country and world's health. It is a health system in that it supports the health of the person as an individual and the health of the community (whether local, regional, state, countrywide and/or global) of which the person is a part.

An ideal system should achieve healthy people via a strategy of high performance, health systems for all people that are self-perpetuating, affordable, accessible, "e" enabled, person-centered, prevention-oriented, and producing high health quality, outcomes and status. An ideal health system(s) should succeed anywhere in world and result in healthy people, communities, countries and world. An ideal health system(s) should minimize time between illness/injury and their best resolution; maximize prevention; minimize inconvenience (time, travel, paperwork); maximize affordability to person, health support, payer and maximize health status.

An ideal health system has the key characteristics in terms of the system, the person whose health is the focus, and health support for the person. In the following table, the ideal health systems' characteristics are addressed as follows:

- a community/country with most limited resources (usually rural/remote; may have only informal health support and may rely on mostly outside health support),
- a community/country with moderate resources (often a mix of rural/remote & urban), and
- a community/country with high resources (such as larger urban).

With limited exceptions, all characteristics apply to every community and country regardless of size, remoteness, and local health resources. They also apply to the world overall. Mix of resources from within and resources from outside varies widely. Rural and/or remote communities/countries are the most dependent on outside resources. [Note: In the appendix, these tables are split out by type of community to make it easier to understand and apply an ideal community health system for a specific community.]

Ideal Health Systems Characteristics

System Element	Community/ Country Most limited resources (rural/remote)	Community/ Country Moderate resources (mix rural/remote & urban)	Community/ Country Most resources (larger urban)
System - person success measure *	I'm healthy and I stay healthy or become very healthy. I'm functioning well and I continue to function well or function even better. I'm ill and/or not functioning well and I get better. I risk getting worse and I don't get worse. I'm chronically ill and	I'm healthy and I stay healthy or become very healthy. I'm functioning well and I continue to function well or function even better. I'm ill and/or not functioning well and I get better. I risk getting worse and I don't get worse. I'm chronically ill and	I'm healthy and I stay healthy or become very healthy. I'm functioning well and I continue to function well or function even better. I'm ill and/or not functioning well and I get better. I risk getting worse and I don't get worse. I'm chronically ill and

	I successfully manage. I have a disability and I successfully cope. I'm near end of life and I successfully cope.	I successfully manage. I have a disability and I successfully cope. I'm near end of life and I successfully cope.	I successfully manage. I have a disability and I successfully cope. I'm near end of life and I successfully cope.
System - success measure	Healthy people, community, country and world	Healthy people, community, country and world	Healthy people, community, country and world
System - drivers for health	Maximize health status, maximize outcomes, maximize abilities, maximize satisfaction, maximize quality, maximize accessibility/ portability, maximize affordability, maximize patient safety (drive defects/errors to zero), minimize time between disability/illness and maximized function/health (drive time to zero), minimize inconvenience (drive inconvenience to zero), maximize security & privacy	Maximize health status, maximize outcomes, maximize abilities, maximize satisfaction, maximize quality, maximize accessibility/ portability, maximize affordability, maximize patient safety (drive defects/errors to zero), minimize time between disability/illness and maximized function/health (drive time to zero), minimize inconvenience (drive inconvenience to zero), maximize security & privacy	Maximize health status, maximize outcomes, maximize abilities, maximize satisfaction, maximize quality, maximize accessibility/ portability, maximize affordability, maximize patient safety (drive defects/errors to zero), minimize time between disability/illness and maximized function/health (drive time to zero), minimize inconvenience (drive inconvenience to zero), maximize security & privacy
System - support for person	Supports "staying healthy", "getting better", "living with illness or disability" or "coping with the end of life."	Supports "staying healthy", "getting better", "living with illness or disability" or "coping with the end of life."	Supports "staying healthy", "getting better", "living with illness or disability" or "coping with the end of life."

System - characteristics	System is safe, effective, person/patient-centered, timely, efficient, and equitable providing, to extent feasible, comprehensive health support.	System is safe, effective, person/patient-centered, timely, efficient, and equitable providing comprehensive health support.	System is safe, effective, person/patient-centered, timely, efficient, and equitable providing comprehensive health support.
System - affordability	Affordable for person and any other payer. People with limited resource receive needed support from community and/or country.	Affordable for person and any other payer. People with limited resource receive needed support from community and/or country.	Affordable for person and any other payer. People with limited resource receive needed support from community and/or country.
System - accessibility	Accessible (time, distance, availability) for every person.	Accessible (time, distance, availability) for every person.	Accessible (time, distance, availability) for every person.
System - quality	High quality processes produce positive outcomes and high health status. “Right care for every person every time.”	High quality processes produce positive outcomes and high health status. “Right care for every person every time.”	High quality processes produce positive outcomes and high health status. “Right care for every person every time.”
System - safety	Safe an environment as possible in which to receive health support.	Safe an environment as possible in which to receive health support.	Safe an environment as possible in which to receive health support.
System - design and operations	Best systems design and operational thinking is applied to and across the full range of health support.	Best systems design and operational thinking is applied to and across the full range of health support.	Best systems design and operational thinking is applied to and across the full range of health support.
System - dynamic and interactive	System is dynamic as locations for health interventions	System is dynamic as locations for health interventions	System is dynamic as locations for health interventions

	change, as person changes, as people providing health support change, and as events unfold for person and, her/his "health system" and "health environment". Is interactive where influences are interacting with each other to change how they impact the person and health.	change, as person changes, as people providing health support change, and as events unfold for person and, her/his "health system" and "health environment". Is interactive where influences are interacting with each other to change how they impact the person and health.	change, as person changes, as people providing health support change, and as events unfold for person and, her/his "health system" and "health environment". Is interactive where influences are interacting with each other to change how they impact the person and health.
System - collaborative partnership	Collaborative partnership of people, public and private payers, and health care organizations substantially improves access, affordability, quality and health status for all people.	Collaborative partnership of people, public and private payers, and health care organizations substantially improves access, affordability, quality and health status for all people.	Collaborative partnership of people, public and private payers, and health care organizations substantially improves access, affordability, quality and health status for all people.
System - public health	Public health approach to community health linking with personal health support.	Public health approach to community health linking with personal health support.	Public health approach to community health linking with personal health support.
System – community and country support	Health system earns and has strong support from community and country.	Health system earns and has strong support from community and country.	Health system earns and has strong support from community and country.
System – health support **	Best mix of resources within and outside of community. The fewer the	Best mix of resources within and outside of community. The fewer the	Use best mix of resources within and outside of community. The fewer the

	resources within the more outside resources should be used. Connect with outside resources using full range of virtual means – phone, internet, etc. Share health records as appropriate. Refer to outside resources when outside expertise within community. Many resources will be needed from outside community.	resources within the more outside resources should be used. Connect with outside resources using full range of virtual means – phone, internet, etc. Share health records as appropriate. Refer to outside resources when outside expertise within community. Many but not all resources likely within community.	resources within the more outside resources should be used. Connect with outside resources using full range of virtual means – phone, internet, etc. Share health records as appropriate. Refer to outside resources when outside expertise within community. Most resources likely within community.
System - health records	Sharable, comprehensive health records to extent feasible. Paper if necessary; electronic health records if feasible; standardized data; information share encrypted via internet. Use "virtual health system(s)" of electronic health records (EHR), personal health systems/records (PHS/R), information exchange (IE) and information standards to extent feasible.	Sharable, comprehensive health records to extent feasible. Paper if necessary; electronic health records if feasible; standardized data; information share encrypted via internet. Use "virtual health system(s)" of electronic health records (EHR), personal health systems/records (PHS/R), information exchange (IE) and information standards.	Sharable, comprehensive health records to extent feasible. Paper if necessary; electronic health records if feasible; standardized data; information share encrypted via internet. Use "virtual health system(s)" of electronic health records (EHR), personal health systems/records (PHS/R), information exchange (IE) and information standards.
Person - person-	Person-centered health support for	Person-centered health support for	Person-centered health support for

centered health	whole person and maximizing choice and self-care. Special attention to most vulnerable persons.	whole person and maximizing choice and self-care. Special attention to most vulnerable persons.	whole person and maximizing choice and self-care. Special attention to most vulnerable persons.
Person - healthy partners	Healthy Partners as strong partnership between person and their health support to improve resource use and health outcomes.	Healthy Partners as strong partnership between person and their health support to improve resource use and health outcomes.	Healthy Partners as strong partnership between person and their health support to improve resource use and health outcomes.
Person - family and community support	Family and community support of person helps avoid things that harm health and provides support that improves health.	Family and community support of person helps avoid things that harm health and provides support that improves health.	Family and community support of person helps avoid things that harm health and provides support that improves health.
Person - human behavior	Successfully address human behavior as key to achieving health. Partner with person on motivation and ability that positively affect key behaviors that improve health and avoid harming health.	Successfully address human behavior as key to achieving health. Partner with person on motivation and ability that positively affect key behaviors that improve health and avoid harming health.	Successfully address human behavior as key to achieving health. Partner with person on motivation and ability that positively affect key behaviors that improve health and avoid harming health.
Person - history, genetics and environment	Partner with person to incorporate history, environment and genetic factors into any strategy that improves health and avoids further harming health.	Partner with person to incorporate history, environment and genetic factors into any strategy that improves health and avoids further harming health.	Partner with person to incorporate history, environment and genetic factors into any strategy that improves health and avoids further harming health.

Health Support - health home	Partnership between person and primary health support creates mutually agreeable "health home providing trustworthy, comfortable provider and place, provides or facilitates a person-accessible repository (actual or virtual) for all of the person's health information (including the complete health record), and works to monitor and improve the whole health of the whole person across all settings and across all preventive, primary and specialty care.	Partnership between person and primary health support creates mutually agreeable "health home providing trustworthy, comfortable provider and place, provides or facilitates a person-accessible repository (actual or virtual) for all of the person's health information (including the complete health record), and works to monitor and improve the whole health of the whole person across all settings and across all preventive, primary and specialty care.	Partnership between person and primary health support creates mutually agreeable "health home providing trustworthy, comfortable provider and place, provides or facilitates a person-accessible repository (actual or virtual) for all of the person's health information (including the complete health record), and works to monitor and improve the whole health of the whole person across all settings and across all preventive, primary and specialty care.
Health Support - use best support	Best health support (prevention, diagnosis, treatment, rehabilitation) for person. Should be safe, efficacious and effective. Should not be limited to "modern medicine".	Best health support (prevention, diagnosis, treatment, rehabilitation) for person. Should be safe, efficacious and effective. Should not be limited to "modern medicine".	Best health support (prevention, diagnosis, treatment, rehabilitation) for person. Should be safe, efficacious and effective. Should not be limited to "modern medicine".
Health support - care in community	Much of health's interventions occur outside health care facilities and in the	Much of health's interventions occur outside health care facilities and in the	Much of health's interventions occur outside health care facilities and in the

	community. Much is self-care.	community. Much is self-care.	community. Much is self-care.
Health support - care coordination	Care coordination helps people with multiple conditions and multiple sources of health support.	Care coordination helps people with multiple conditions and multiple sources of health support.	Care coordination helps people with multiple conditions and multiple sources of health support.
Health Support - prevention	Prevention of illness and injury should be primary strategy at the person and community level.	Prevention of illness and injury should be primary strategy at the person and community level.	Prevention of illness and injury should be primary strategy at the person and community level.
Health Support - evidence-based	Obtain/use evidence-based health support. Obtain via internet and/or as integrated into electronic health record. Use trusted sources. Address co-morbidity. Avoid conflicting therapies.	Obtain/use evidence-based health support. Obtain via internet and/or as integrated into electronic health record. Use trusted sources. Address co-morbidity. Avoid conflicting therapies.	Obtain/use evidence-based health support. Obtain via internet and/or as integrated into electronic health record. Use trusted sources. Address co-morbidity. Avoid conflicting therapies.
Health support - payment	Payment to health support based on effective care and resource use. Payment affordable, fair, and value-based.	Payment to health support based on effective care and resource use. Payment affordable, fair, and value-based.	Payment to health support based on effective care and resource use. Payment affordable, fair, and value-based.
Health support - privacy	Protects privacy of health care and information, especially particularly sensitive information such as sexually transmitted diseases, drug and alcohol	Protects privacy of health care and information, especially particularly sensitive information such as sexually transmitted diseases, drug and alcohol	Protects privacy of health care and information, especially particularly sensitive information such as sexually transmitted diseases, drug and alcohol

	abuse/misuse, and mental illness.	abuse/misuse, and mental illness.	abuse/misuse, and mental illness.

* Person – person whose health should be optimized and for whom health system and support is being provided

** Health Support – May include physicians, nurses, dentists, optometrists, pharmacists, clinics, urgicare, emergency departments, hospitals, rehabilitation facilities, home care, nursing homes, assisted living, alternative health/medicine, and others.

Person

Person health and function - The ideal system understands a person's health and function from the person's perspective and understands and does what it takes to maintain and improve health and function. Ideally, a person spends her/his whole life where "I am healthy and function well." But almost every person will need a high-performance health system during her/his life as it includes many different health situations. The ideal health system successfully supports a person across the full range:

- I'm healthy and I stay healthy or become very healthy.
- I'm functioning well and I continue to function well or function even better.
- I'm ill and/or not functioning well and I get better.
- I risk getting worse and I don't get worse.
- I'm chronically ill and I successfully manage.
- I have a disability and I successfully cope.
- I'm near end of life and I successfully cope.

Person-centered - The ideal health system is **"person-centered",** meaning that all efforts of the system are centered on the individual person (of which there are over seven billion worldwide) and their staying healthy, getting better, living with illness or disability, and coping with the end of life.[5] Each person is different to some greater or lesser degree. She/he can differ in genetics, environment, occupation, family and community support, attitude toward and knowledge of health and health care, ability (including physical ability and knowledge/skills), and motivation (though each person has the need to survive and desire to thrive). Centering the

[5] Institute of Medicine, "Crossing the Quality Chasm: A New Health System for the 21st Century, 2001 and the Foundation for Accountability (FACCT), 2001

health system on the person and making any health intervention match the individual person helps the system help the person achieve better health and functioning.

Partnership among person and providers - Within the "health support" part of the health system, the "partnership" between the person and her/his health support and payers is key. Ideally, a person spends her/his whole life where "I am healthy and function well." But for most every person, life includes many different health situations where a partner is important:

- I'm healthy and, together with you, I stay healthy or become very healthy.
- I'm functioning well and, together with you, I continue to function well or function even better.
- I'm ill and/or not functioning well and, together with you, I get better.
- I risk getting worse and, together with you, I don't get worse.
- I'm chronically ill and, together with you, I successfully manage.
- I have a disability and, together with you, I successfully cope.
- I'm near end of life and, together with you, I successfully cope.

Motivation and Ability - The ideal system and its health support people understand how a person's motivation and ability affects her/his behavior as it relates to health. But it is more than just the person's motivation and ability; it is also her/his health support's motivation and ability. One of the substantial weaknesses in today's health support is the lack of skills and knowledge with respect to human motivation and ability and how it relates to improving health related behavior. This lack exists even though most of the knowledge exists and it continues to improve. Health support must partner with a person on motivation and ability that positively affect key behaviors that improve health and avoid harming health.

Behavior - As with motivation and ability, the ideal system and its people understand how a person's behavior affects health and works successfully with the person and her/his family and health support to improve health. The person's behavior affecting health includes general lifestyle, efforts to reduce risk factors (including obesity, tobacco use, alcohol and drug misuse), rehabilitation, and adhering to care requirements (including taking needed medications and doing rehabilitation, following post-surgical follow-through). But it is more than just the person's behavior; it is also her/his health support's behavior. One of the substantial weaknesses in today's health support is the lack of skills and knowledge with respect to

human behavior and how behavior relates to improving health. This lack exists even though most of the knowledge exists and it continues to improve. Health support must partner with a person on the key behaviors that improve health and avoid harming health.

History, genetics and environment - To positively affect health, the system's health support understands the person's genetics and health-related history and environment and how to work with them. Health support must partner with a person to incorporate history, environment and genetic factors into any strategy that improves health and avoids further harming health.

Family and community support -The system and its people understand the key role that family and community support can play in avoiding things that harm health and providing support that improves health. Support can be psychological when a person is sick or has a disability or when a person is trying to improve on a health-related behavior. Support can be physical when a person needs reminding on taking a medication, needs to get to health support, or needs care for a condition which limits the ability to think, move or do basic functions like food preparation or personal hygiene. Support can be provided by family members, friends, neighbors, community volunteers, and private and public sector community organizations.

Financial resources - The ideal system recognizes that a critical aspect of ability is each person's different ability to afford health support based on their financial resources and public and/or private health insurance coverage. It ensures that a lower ability to pay does not prevent a person from receiving needed health support.

"Virtual" integrated health system

Health home - Within the health system, a partnership between the person and her/his health support creates a mutually agreeable "health home" that provides a trustworthy, comfortable health support team and place, provides or facilitates a person-accessible repository (actual or virtual) for all of the person's health information (including the complete health record), and works to monitor and improve the whole health of the whole person across all settings and across all preventive, primary and specialty care.

Care coordination across settings and across primary care, prevention and specialty care – Care coordination for people with multiple conditions

and multiple health support sources is lead by the person and her/his Care Coordinator in close partnership with her/his primary health support. Care across all settings and across prevention, primary care, specialty care and non-traditional care is fully coordinated to help achieve the best use of resources and achieve the best outcomes and health and functional status.

Comprehensive services - The health system includes the full range of services needed for prevention, for rehabilitation, and for diagnosis and treatment by primary health support and all needed specialties and in all needed settings. In the case of rural or small communities, this may require partnering with other communities to make comprehensive services available and to help ensure reasonable accessibility, including travel.

Care in the community - Recognizing the value of care in health support organizations and their facilities (hospitals, physician offices, nursing homes), much of health's future interventions occurs outside health support facilities and in the community. Health support organizations provide some of that care, for example via telehealth. Other organizations provide some health support (for example, promoting positive health behaviors and/or reducing risk factors like obesity, tobacco use and alcohol and drug misuses). Family and the community provide some support like what has been done since before there was formal health care. The person does self-care from prevention to treating minor illnesses and injuries to rehabilitation.

Population and public health - The health system fully integrates with public health agency support at all appropriate levels (including local, state, country, world). The public health agency provides leadership and core services and resources for overall population health for the community, country or world. Working collaboratively with the private sector and other public health agencies, the public health agency also serves as the lead and coordinator for the community, country and world's population health. Other private and public organizations which have responsibility for a segment of the community, country and world and their health effectively carry out that responsibility.

Affordability, including insurance - The system ensures that achieving good health for the person and the community is affordable for all payers - self, employer, private insurance, and public insurance (funded by taxpayers). To help ensure affordability for the person and to avoid health-related financial catastrophes, affordable health insurance (public and/or private) is needed that full addresses a person's ability to pay premiums, coinsurance and non-covered health care costs.

All payer, affordable, fair, value-based payment - Payment is the same for all payers (private insurance, public programs, employer self-funded plans, and individual persons) for the same service. Payment rates should be fair in that they pay what it appropriately costs to provide high quality health support. Payment is based on value provided whether for an episode of care or per capita for a month or year of health support.

e-enabled - Each person and her/his health support are fully enabled with electronic systems to the extent feasible. Such systems include electronic health records (with decision support) and personal health systems (access to EHRs, personal health data, education, support, communication with health support). They follow standards for content, decision support and exchange. They facilitate accurate, complete, secure and private exchange of personal health information among each person and any health support at any time in any place.

Partnership among private and public sector - The ideal system is dependent on both the private and public sectors partnering to create, operate and sustain a system that is used effectively by every person, uses valuable resources effectively and efficiently, and achieves the highest health and functional status possible for every person. Private and public sector health support organizations partnering with public health agencies is essential to providing the full range of health support (prevention, primary care, specialty care, inpatient care, nursing home and home care, rehabilitative care, non-traditional care) in the full range of settings, including in the community.

Performance

Good person health - As indicated earlier, the ideal system understands a person's health and function from the person's perspective and understands and does what it takes to help maintain and improve health and function. Ideally, the person and the supportive system together increase the chances that a person spends most of her/his life where "I am healthy and function well." The system's performance is measured by each person's and all persons' health and functional status throughout life.

Good community/country health - The ideal system understands a community, country and world's overall health and functional status, understands the people's perspective, and understands and does what it takes to help maintain and improve health and function for all people. Ideally, the person and the supportive system together increase the chances that the whole community, country and world spends most of their lives

where everyone can say “I am healthy and function well.” The system’s performance is measured by each and every person’s health and functional status throughout their lives. Further, the people and their lifestyles, their work, and their environment (home, neighborhood, work, education, recreation) do minimal harm to health and help improve health and function.

Affordable - The ideal system is affordable for every person and every payer - self, employer, private insurance, and public insurance funded by taxpayers. It ensures that every person gets needed health support without negatively affecting essential food, shelter, transportation, education and other basic necessities of living. The person is responsible for using the health system prudently so as to not waste valuable health resources and is responsible for taking all reasonable steps to live a healthy lifestyle and to partner with her/his health support so as to increase the likelihood that a health problem is successfully diagnosed and treated (including rehabilitation from injury or illness and treatment of injuries and acute and chronic illness).

Accessible - The ideal system is accessible, not just in terms of affordability, but in terms of all aspects of accessibility. This includes physical proximity, physical access into a health care facility (including accessibility and usability for people with disabilities), reasonable hours for non-urgent care, transportation for regular and urgent care, transportation for emergency care, non-discriminatory for any reason, and reasonable accommodation for special needs (including language, cognitive limitations, cultural needs).

High quality - The ideal system provides high quality health support and produces good outcomes reflecting the best knowledge available on how best to prevent and treat health problems and maintain and improve function.

Safe - The ideal system provides as safe an environment as possible in which to receive health support. This includes successfully minimizing misdiagnosis, inadequate or wrong care, negative drug-drug interaction, and illnesses acquired while at a health care facility.

Minimized inconvenience - The ideal system minimizes inconvenience for the person needing health support. Having to spend too much time in waiting rooms or having trouble getting into care (for example, getting an appointment) can be a major inconvenience, especially for a sick or injured person. When a person is sick or worried, time between visits and tests can be especially inconvenient, even more when the time span is days or

weeks. In rural and some urban areas, travel time and distance can be inconvenient. The ideal system minimizes inconvenience to as close to zero as is possible.

Privacy protected - The ideal system protects the privacy of personal health information, especially particularly sensitive information such as sexually transmitted diseases, drug and alcohol abuse/misuse, and mental illness. Personal health information becoming public can be embarrassing, compromise trust, increase insurance rates or prevent insurability, threaten or prevent employment.

Private and public sector supportive actions and interventions

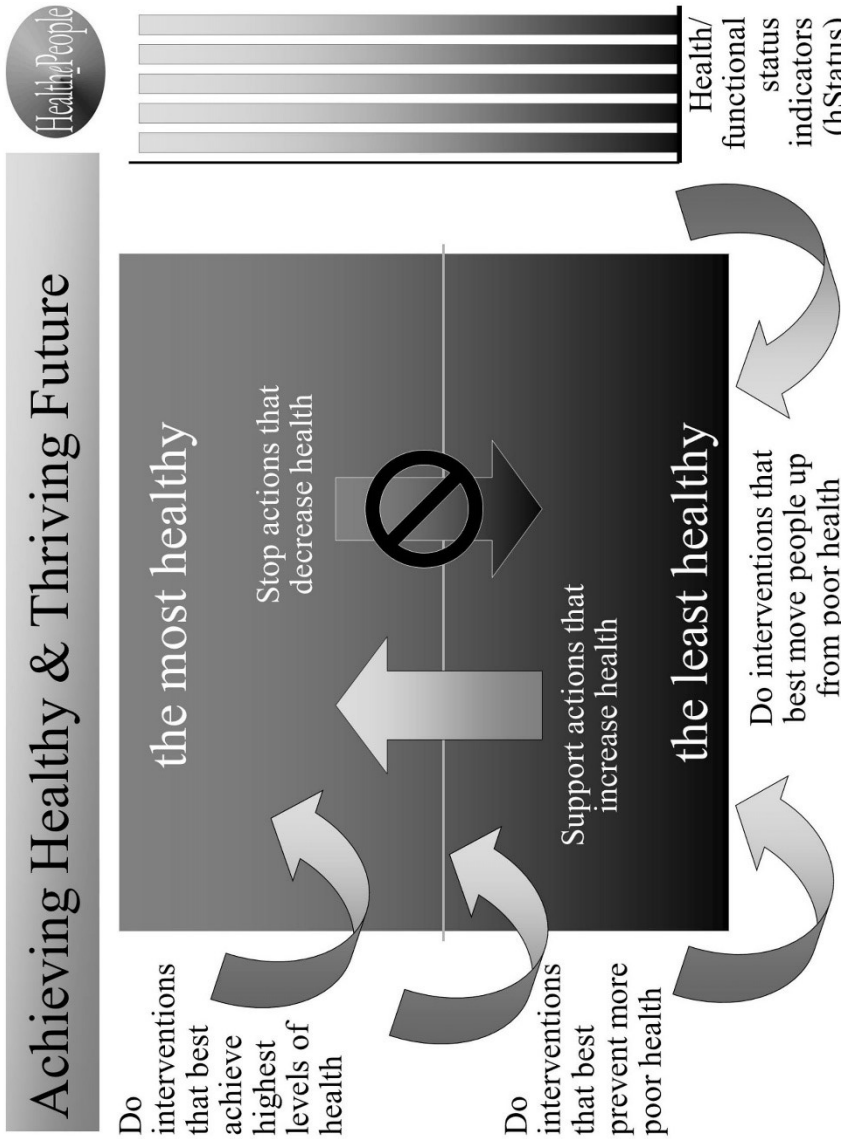
For a person and the community, country and world, there are actions that improve health or make it worse. In a systematic and coordinated manner, the ideal health system improves health status by helping support actions that increase health and helping stop actions that decrease health. People (including the person and her/his health support and other parts of the private and public sectors) who are part of the system do interventions that best:

a) achieve the highest levels of health,

b) prevent more poor health, and

c) move people up from poor health.

To improve health most, we need to execute a "systematic strategy" – a “system” of actions that continuously stops actions that push people down to less healthy states and supports actions that lift people out of poor health and toward being healthy. This “system” of actions, when well designed and executed, can perpetually prevent much poor health and support people moving up from poor health to being healthy. [See “Achieving a Healthy and Thriving Future”]



"Achieving a Healthy and Thriving Future."

The overall strategy is built upon a strategic improvement and behavior model for health. We need to set the target health and functional status we are trying to achieve under the vision "healthier/healthy people". Given the

target status, we can decide on the target outcomes needed and on the target health system needed to achieve those outcomes. Comparing the optimized outcomes and health system with the current health system and its performance, we can determine the "delta", i.e., the needed improvements in the current health system and its outcomes to achieve the ideal health system and its much better outcomes.

Knowing what needs to be improved, we can then determine what personal and health support behaviors should change. Human behavior, both by a person and her/his health providers, is key to making and sustaining the improvements. Existing behavioral models helps us think through how we bring about the behavior change necessary to make the improvements.[6] Together, the system and behavior changes are intended to produce improved health and functional status for all.

Outcomes-Based Health System

An ideal outcomes-based health system successfully supports a person is ill, injured or has a disability and/or is just trying to maintain or improve health. The person has health support partners in this effort. For this person and her/his health support partners, they know, specifically for this person, what diagnostic procedures and treatments are most likely to work or not work and what is safe and what is not safe. For treatments that are riskier (the evidence is less definitive), they know the risks and benefits. They have this information in real time and at the point of care. For treatments that are most likely to work and are sufficiently safe, they know how best to apply the treatment. The person has a personal health record/system that uses this information together with the person's specific factors and treatment plan. They have an electronic health record system with automated decision support that uses this information together with the person's specific factors and health support expertise. They share their successes and failures back with the rest of the community, country and world for the greater good.

To fully achieve this system, we need to successfully execute the following strategies. A free and publicly available database of outcomes-based evidence is created and maintained in perpetuity. This database includes the worldwide knowledge on prevention, diagnostic procedures and treatment safety, efficacy and effectiveness. To access the database, a core set of user-friendly tools are free and publicly available for use by

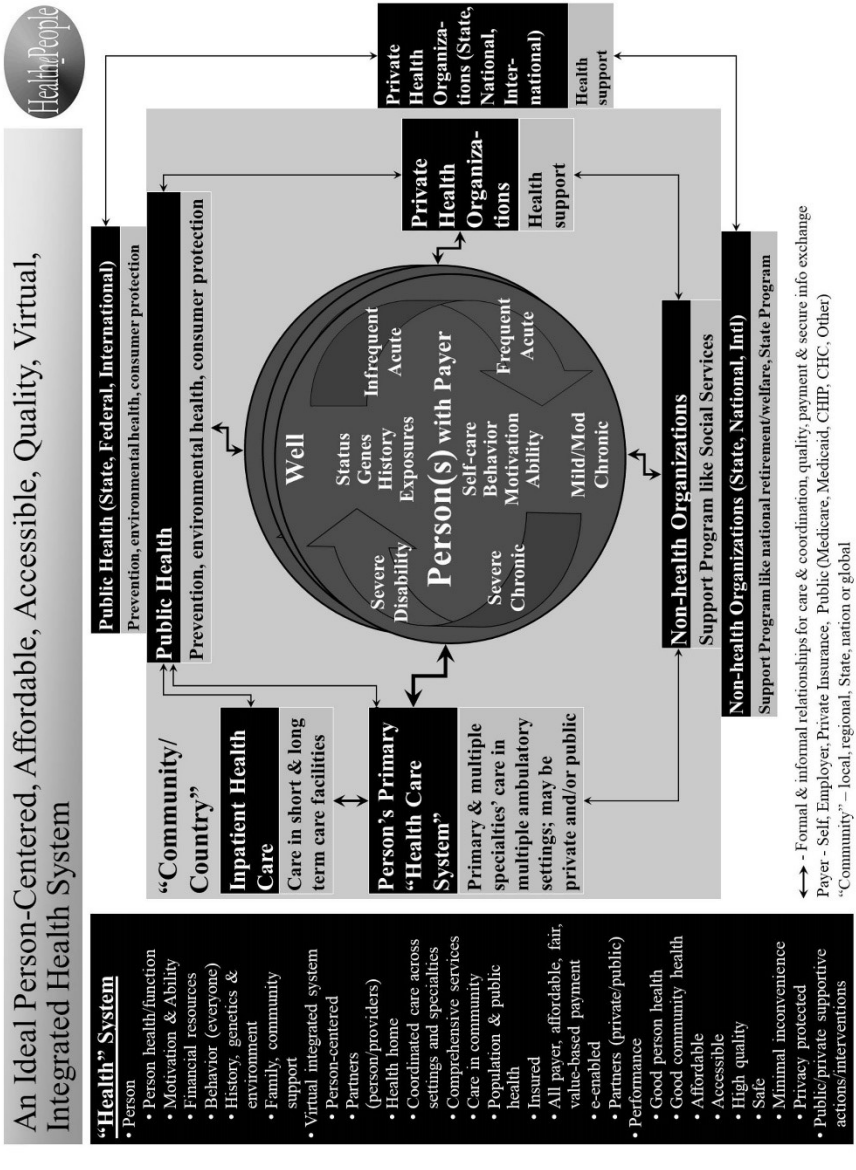
[6] Such a behavioral model is the "Behavior Effectiveness Model (BEM)", Gary A. Christopherson, 1974, 2012 and 2015

individual persons (e.g., patients, consumers, family, friends) and their health support. A larger pool of outcomes-based evidence is created that goes beyond controlled clinical trials. This larger pool addresses a broader number and range of people (gender, race, age, family history, environmental exposure, socio-economic factors) and enables more person-specific diagnostic procedures and treatment. To the extent feasible, electronic health record systems (EHRs) are in place that bring together the person's individual factors, prevention information, diagnostic information, treatment information for this and historical care (prevention, acute, chronic, long-term). These EHRs incorporate automated decision support including clinical guidelines and the available outcomes-based evidence. The EHR and associated systems are able to exchange information with other health support EHRs in ways that are real time, secure, safe and effective.

Health care is personalized, incorporates the best outcomes-based evidence, and learns every time care is provided or a new study is completed. Putting outcomes-based evidence into practice helps achieve healthier people, and healthier communities, countries and world.

Design and Operation an Ideal Health System

What is an ideal health system design? An ideal health system is designed to be person-centered, affordable, accessible, quality, virtual, integrated and community-focused. It is a "virtual health system" for the purpose of achieving the highest level of personal and community, country and world health and function by integrating the health support of many supportive organizations and services working together under both formal and informal relationships. [See "An Ideal Person-Centered, Affordable, Accessible, Quality, Virtual, Integrated Health System"]



"An Ideal Person-Centered, Affordable, Accessible, Quality, Virtual, Integrated Health System."

For communities, country and world, the health system should consist of the following elements engaged in the related behaviors:

- Person partnering with her/his payer (self, employer, private insurance, public insurance)
    - Behavior, self-care, "community" support
- Person's primary "Health System"
    - Primary & multiple specialties' support in multiple settings; may be private and/or public
- Inpatient health care
    - Care in short & long-term care facilities
- Public health at the local level partnering with public health at the state and country levels.
    - Prevention, environmental health, consumer protection
- Private health organizations at the local level which may also be partnering with private health organizations at the state and country levels.
    - Health support
- Non-health organization at the local level which may also be partnering with non-health organizations at the state and country levels.
    - Support program like social service, public and private retirement and income support, national/state/local programs

The ideal health system has the person and the community, country and world as its center. Everything it does and achieves is centered on them.

The health system understands and accepts that the person and the community, country and world are focused on their (and the people they care about) need and desire to be healthy. Most people and most communities/countries do not have health support as their primary interest. Most people just want to live and enjoy their lives. Health support is something the person needs as a means to remove or minimize any health or function problems that get in the way of living and enjoying her/his life.

The health system understands and accepts that, in general, a person, a community and a country are better off (health, best use of resources) to the extent to which each and every person stays as healthy and highly functional as possible and only uses the health system when there is an

unavoidable injury, illness or disability or when it is possible to prevent injury, illness or disability. [7]

The health system understands and successfully addresses the full range of a person's health - being well and/or having infrequent acute illness, frequent acute illness, mild/moderate chronic illness, severe chronic illness, and severe disability. At any given time, a person may be well. Or a person may be somewhat well but may be dealing with a disability or managing a non-severe chronic disease. Or a person may not be well and experiencing multiple health problems - a disability, a chronic disease, an injury and/or an acute illness.

The health system understands and successfully addresses that, over time from before birth until death, a person's personal status and health and functional status may change many times. The needs of the mother and infant are different than that of an older child than that of a young adult than that of a middle-aged adult than that of an older adult. Over time, the health and functional issues are often different but not necessarily so. Severe disability can occur at any age and can span a little or much of a person's life.

In a community, all combinations of personal status and health and functional status may exist at any time and over time and at any phase of life. They need to be successfully addressed by the health system.

As detailed earlier, the ideal health system understands and helps achieve affordability, quality, accessibility and high levels of health and functional status for the person. It understands and helps achieve affordability for the person's payer. This is essential whether the payer is the person her or himself, an employer, private insurance, and/or public insurance. Cost and cost increases are kept as low as possible without compromising quality and access. Only needed health support is provided. Health support is consistent with generally accepted practice and best available evidence. Health support is provided in the most effective and efficient manner consistent with producing the best outcomes and health and functional status.

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[7] The system recognizes and accepts that, for most communities and countries, health care is a desirable necessity to help keep its people healthy but not a major economic force. For a small number of communities and countries, health care is a major economic force. Health care can be an economic plus if the net benefit from health care payers outside the community/country exceeds what the community/country and its people pays itself for health care.

How does the ideal health system operate? In many ways, it is the mostly informal health system that we have today but it performs at a much higher level. The relationships among health support continue but are more person-centered, are more integrated, are more effective and efficient, and better share a person's care-related information.

Starting at the beginning of a person's life, a formal partnership begins with primary health support (e.g. a pediatrician, family practice physician). There are already formal partnerships with the other family members. These partnerships not only address the individual family member but do so in the context of the whole family. The family may have a "family" partnership with a family practice. As a person progresses through life, the person's health support partner changes, including from a pediatrician for children to a different physician for adults. That change is done seamlessly as the person chooses different health support, health records are transferred, and the two sources of health support collaboratively transition the person's care. The same may happen later in life if a person chooses to partner with a geriatrician. During a person's life, a person may change health support and the same seamless transition occurs.

The health system starts with a partnership between a person and her/his primary health support (for example, a primary care physician). Almost every person benefits from a successful partnership with primary health support in the primary health system who understands and helps address a person's health from being well through acute illness through chronic illness through a disabling condition. The focus of the partnership is to understand and address the whole person's health and to keep the person as healthy as possible.

Since a person may experience any health problem over her/his lifetime, the partnership must have available and, as needed, successfully use a wide range of health resources. These resources include primary care, preventive and wellness care, specialty care, inpatient care, rehabilitative care, nursing home care, palliative care, home and community care and support, alternative care and non-traditional care. These resources may be provided by the private sector (non-profit and for-profit organizations and individuals) and/or public sector. Most services and support are provided within the community but some services and support will come from outside the community. For example, the internet provides access to a wide range of services and support from anywhere at any time. Through a good partnership between a person and her/his primary health support, these resources can be used most effectively and efficient to the benefit of the person and her/his payer.

But the community/country changes and so must the ideal health system if it is to stay "ideal". People change. Health support changes. Health care and its delivery change. The science changes. Further, the ideal health system itself needs to be proactive and help bring about positive change through actions and interventions available to it and that are consistent with its mission.

In a systematic and coordinated manner, the ideal health system improves health status by helping support actions that increase health and helping stop actions that decrease health. People (including the person and his/her health support and other parts of the private and public sectors) who are part of the system do interventions that best a) achieve the highest levels of health, b) prevent more poor health, and c) move people up from poor health.

The ideal health system recognizes the following as key health drivers and uses them as guidance and as measures of our progress toward a healthy community.

- Maximize health status
- Maximize outcomes
- Maximize abilities
- Maximize satisfaction
- Maximize quality
- Maximize accessibility/ portability
- Maximize affordability
- Maximize patient safety (drive defects/errors to zero)
- Minimize time between disability/illness and maximized function/health (drive time to zero)
- Minimize inconvenience (drive inconvenience to zero)
- Maximize security & privacy

Achieving a healthy and thriving future for people and their communities, countries and world is what we need and want. Achieving healthy communities, countries and world is what we need and want. Achieving healthy people is what we want. Achieving ideal health systems - person-centered, affordable, accessible, quality - is what will achieve healthy communities, countries and world and healthy people.

Chapter 3. HealthePeople® - Achieving Healthy People Via Person-Centered Health

Ideal Person-Centered Health Systems - Person-Centered, Affordable, Accessible, Quality, Outcomes-Driven Health Systems

"Person-centered health", in its entirety, is very different than almost any care provided today by any health support or health system. But if "health" and "healthy people" is what we want to achieve, then "person-centered health" is how we need to operate.

It is different in attitude, culture, design and operation. It is different in that is it a "health system" rather than a health care or medical care system. It is different in using the term "person" rather than terms like patient, consumer, or enrollee. It is different in that it views the person and her/his "self-care" as necessary to the successful achievement of health. It is different in using the term "health" rather than the term medicine. It is different in its focus on "health" rather than illness, injury and disability. It is different in its focus on health status rather than illness or disease burden. It is different in focusing on "health outcomes" rather than treatment outcomes. It is different in using the term "electronic health record" versus electronic medical record. A "health" system integrates care inside and outside of medical/health care facilities while a medical care system focuses more on the care provided within medical/health care facilities. It is not just about "care" but is about all of the factors that determine a person being healthy or not. The focus is on what is trying to be accomplished (outcome) rather than on what is being done (process) or what is being corrected or prevented. All these other terms have value but

should not be the primary drivers or define the end goal or how we get to that end goal. Healthy people is the end goal.

Health Support – When Is It Not Person-Centered and When Is It?

While many providing health support today believe they are providing "person-centered health," many of them and many others, in the true sense of the term, are not. What are indications that health support is not truly person-centered?

1. Not putting the person at the center of health care plan development and delivery.
2. Not an optimized involvement of the person in self-care.
3. Not a partnership between the person and his/her health support.
4. Not making a person's satisfaction with care a critical success factor.
5. Not addressing the critical role that a person's behavior plays (especially for chronic care and prevention) nor how to achieve target behaviors (e.g. medication adherence, smoking cessation, weight reduction, post-surgery follow-up).
6. Not optimizing health outcomes and status for the person.
7. Not providing health support between episodes of illness.
8. Not providing health support in a way in which the person is better willing and able to succeed.
9. Not sharing the right information at the right time in a way usable by the person.
10. Not having an electronic health record (EHR) covering all of a person's care by that health support and by other health support.
11. Not having an electronic personal health system (PHS/R) that a person can use to get information, make transactions, self-enter information, access the health record, message with health support, access eHealth support services (e.g. risk reduction programs, moderated group sessions) or help coordinate care.
12. Not sharing/exchanging (when appropriate and authorized) a person's electronic health record information with another health support involved in the person's health support.
13. Not checking for and avoiding conflicting therapies (e.g. drug-drug interaction).
14. Not doing prevention or early intervention well.

15. Not truly personalizing (not doing "mass personalization") population-based health programs.
16. Not addressing co-morbidity (e.g. multiple illnesses requiring multiple medications) well.
17. Not taking a good personal and family history nor fully incorporating it into the care plan.
18. Not taking into account the family, friends, coworkers and other parts of a person's community that impact health or involving them when appropriate.
19. Not coordinating across all settings (self-care, clinic, hospital, nursing home, community care).
20. Not coordinating across all health support (primary care, specialty and subspecialty care).
21. Not taking into account the person's environment (home, work, school, community)
22. Not incorporating genetics into prevention and health care.
23. Not operating at the convenience of the person but instead primarily operating at the convenience of the health support.
24. Not paying sufficient attention to persons without financial access and putting all the care and attention on those with financial access.
25. Not worrying about the affordability of health support to the person or her/his payer(s).
26. Not helping with the "portability" of health support and the information necessary to make care portable.
27. Not taking the extra steps to ensure the provided health support is safe.
28. Not appreciating a person's privacy concerns.

What is person-centered health? We would suggest that person-centered health is "The person a) is supported as a unique and whole person who changes over time, b) is at the center of self-care, formal health support and informal health support, b) has, receives and provides necessary health-related information, c) has health support coordinated via an effective person and health support partnership, and d) achieves good health outcomes and high health status.

To be truly person-centered, all of the above indicators need to be turned around into a "positive" direction (e.g. the person is put at the center of the development and delivery of a person's health support plan) as follows:

1. Puts the person at the center of health support plan development and delivery.
2. Optimizes involvement of the person in self-care.
3. Has a partnership between the person and her/his health support.
4. Make a person's satisfaction with health support a critical success factor.
5. Addresses critical role that a person's behavior plays (especially for chronic care and prevention) and how to achieve target behaviors (e.g. medication adherence, smoking cessation, weight reduction, post-surgery follow-up).
6. Optimizes health outcomes and status for the person.
7. Provides health support between episodes of illness.
8. Provides health support in a way in which the person is better willing and able to succeed.
9. Shares the right information at the right time in a way usable by the person.
10. Has and uses an electronic health record (EHR) covering all of a person's health support by that health support and by other health support.
11. Has (makes available) and uses an electronic personal health system (PHS/R) that a person can use to get information, make transactions, self-enter information, access the health record, message with health support, access eHealth support services (e.g. risk reduction programs, moderated group sessions) or help coordinate care.
12. Shares/exchanges (when appropriate and authorized) a person's electronic health record information with another health support involved in the person's health support.
13. Checks for and avoids conflicting therapies (e.g. drug-drug and drug-allergy interaction).
14. Does prevention or early intervention well.
15. Truly personalizes (does "mass personalization") population-based health programs.
16. Addresses co-morbidity (e.g. multiple illnesses requiring multiple medications) well.

17. Takes a good personal and family history and fully incorporates it into the health support plan.
18. Takes into account the family, friends, coworkers and other parts of a person's community that impact health and involves them when appropriate.
19. Coordinates across all settings (self-care, clinic, hospital, nursing home, community care).
20. Coordinates across all health support (primary care, specialty and subspecialty care).
21. Takes into account the person's environment (home, work, school, community)
22. Incorporates genetics into prevention and health support.
23. Operates at the convenience of the person instead of primarily operating at the convenience of the health support.
24. Provides attention and "care" to persons with and without financial access.
25. Makes health support affordable to the person and his/her payer(s).
26. Helps with the "portability" of health support and the information necessary to make care portable.
27. Takes the extra steps to ensure the provided health support is safe.
28. Appreciates a person's privacy concerns and protecting privacy, including the security of health records and messages.

Model for Person-Centered Health System.

What is the design for a person-centered health system (e.g. one that includes care in the community) and how does it function? How does it ensure that it has the characteristics described above? A model for a person-centered health system. (See "Model for a Person-Centered Health System.")

"Model for a Person-Centered Health System."

Person at the Center. The person-centered health system starts with the person at the center. Key information on the person is collected, accessed and incorporated into the person's health plan (what will be done by the person and their health support together to optimize health outcomes and maximize health status). The system and its health support know the

person's current health status, person's and the family's health-related history, genetic information and relevant exposures (home, workplace, community). Also, the person's health related behavior, motivation and ability is known and incorporated. The person's ability and willingness to do appropriate self-care and partner with her/his health support is built into the person's health plan.

The health system recognizes how history, current status and potential future health status will play a role in the person's health plan. It recognizes that at any time, the person may be in one or more states (well, infrequent or frequent acute episodes, mild or moderate chronic illness, severe chronic illness, have a temporary or permanent disability). For example, the person might be well but have a disability with which they have learned to cope well. The person might have a severe chronic illness and be hit with frequent acute illnesses as well. The mix of these states is likely to change over time.

Health Support. The health system accesses the full range of facility-provided health support, including clinics, hospitals and nursing homes. But what is the "character" of that health support? Such health support, in a person-centered system, creates a partnership between the person and her/his health support, using the best of both and creating a synergy by bringing them together. It makes quality and safety high priorities to avoid doing harm to the person and to optimize health outcomes and status for the person. It understands "accessibility" from the person's perspective and successfully tackles the full range of access issues (physical, social) to ensure the person gets what health support is needed whenever and wherever needed. It recognizes the importance of affordability and takes the necessary steps to ensure affordability for the person and for whoever is the person's payer.

But a person-centered health system goes beyond facility-based health support and accesses and integrates in the full range of community-based health support, including home care and assisted living environments. It reaches further and accesses workplace, schools and other community settings as is appropriate. Linking to home, school, workplace and other community health capabilities provides a total health system of health support that recognizes that the person spends most of his/her life outside of health care facilities. This linking also brings to bear key people who can provide health support, including formal health providers and community programs. More will be said later about the role for and value of the person's family, friends, co-workers and neighbors.

Within a particular system, the eHealth system provides and integrates an electronic health record (EHR), a personal health system (PHS/R), electronic health record exchange with other health support, standardized data, self-entered information from the person, electronic messaging and phone contact between the person and her/his health support, trusted health information on issues relevant to the person's health, eHealth transactions (e.g. prescription drug refills, scheduling) and eHealth program support.

The health system provides or accesses eHealth program support that includes the full range of supportive services that a health system can provide using electronic devices, a computer, the Internet and a phone. They include risk reduction programs, pre-work or follow-up to acute care, and chronic disease management. They provide the opportunity for "mass personalization" whereby eHealth programming can be targeted to those who will benefit most and the programming can be individualized to the person's specific target behaviors, motivation, ability, and community support system, and to changes over time.

Healthy Partners.

In all our efforts to do health reform and build a healthy community, country and world, we seem to be getting lost in the complexities of health care organizations and payment mechanisms. In America, the alphabet soup includes acronyms like ACO, PPO, HMO, MCO, etc. Instead, we should go back to the future by combining the strengths of a simpler time with the strengths of current and future time. Think of the best (not the shortcomings) of television's Dr. Welby with the best of what we know about high performance health (high accessibility, quality, affordability, outcomes). I'll put a simple label on it - **"Healthy Partners"**. Put another way, it is more of "person-centered health".

Why **Healthy Partners**? Let me respectfully suggest that it may be the only approach that offers hope to billions of people desperately looking to improve and sustain their health without breaking everybody's bank.[8] It may be the only approach that we already know how to do, is relatively simple and easy to execute in every community, country and worldwide, is acceptable and desirable to people, is acceptable (maybe desirable) to the vast majority of health providers, greatly improves health and health

[8] Note: This is not at all to diminish the need for payment support and mechanism like health insurance. However, even if everyone has sufficient health insurance or other financial support, an approach like **Healthy Partners** is needed.

support quality, and is affordable to the person, the payer, the community, and the country.

The available evidence supports the view that high quality and highly accessible health support saves money while improving health. If this is true and we believe it, then this is the quickest, easiest, and best way to get to high performance (high accessibility, quality and affordability) health for all people. If we believe this, then now is the time to act accordingly.

What is **Healthy Partners**? Very simply, it is the long lost partnership of the person (and family and friends), the health support (matched to the needs of the person) and the payer (involving the person as self-payer, taxpayer, employee).[9] In many ways, the fictional Dr. Welby had it right. He had a partnership with the person for whom he cared (not only did he provide health support but he actually cared about the person). He included family and friends when appropriate and available. He provided preventative and therapeutic care. He knew about the person's environment (for example, home, work, school, and neighborhood). He knew the person's behavior. He knew about the person's history. He was the person's partner in health.

But he didn't know everything. He didn't know the person's genetics, except for what he knew about the person's parents and grandparents. He wasn't able to fully keep up with the latest medical breakthroughs and best evidence-based care. He didn't have as effective or broad a range of therapeutic interventions. He didn't have as timely, effective or broad a range of diagnostic information. He didn't have electronic health records. He didn't have an easy way to track and manage care across time or across persons. He didn't have an easy way to share information with other health support caring for the person. He didn't have as strong a network of other health support to team with as can and should exist today and for the future. He didn't have an appropriately incentivized payment system.

So how do we combine the best of Dr. Welby with the best of current and future time? **Healthy Partners** is a three-part partnership between the person, his/her primary health support and her/his payer. The primary and voluntary partnership is between the person and her/his primary health partner. The primary health partner is not a "gatekeeper" but is a facilitator and coordinator of care. When there are multiple conditions and providers, the health partner may partner with another health partner, a Care Coordinator. The person and the primary health partner recognize and

[9] In some cases, there may be multiple payers. As is done today, there will need to be coordination of payment.

respect this partnership. All health support is organized around the person and this essential partnership. Again, this is “person-centered health”. The payer supports this primary partnership and is part of a larger partnership. All the other health partners (for example, specialists, hospitals, nursing home, home and community care, pharmacists, labs, imaging, public health, mental health providers and rehabilitation) involved in a person’s health support this primary partnership and are part of a larger partnership. They recognize and respect this primary relationship. The person and his/her primary health partner recognize and respect the value of all these other health partner and involve them appropriately. (See “Healthy Partners”)

So, how do this partnership and a person’s health improvement and sustainment get paid? It is relatively simple. The person, his/her primary health partner and the payer create the voluntary partnership. It starts with the person choosing a primary health partner who agrees to be a health partner, provide primary health support and, preferably, to coordinate the overall care for the person. Again, in certain cases, a Care Coordinator will be important. The payer recognizes and respects that partnership and pays the primary health partner appropriately. For example, the payer provides a monthly payment for coordinating care and pays higher for primary care. The payer recognizes and values the partnership and the high value of primary health partner by raising current payment levels by a substantial percentage. The primary health partner recognizes and values the higher payment, the payment for coordination of care, and the new partnership with the person and the payer. Key is that the primary health partner and the payer move from an adversarial relationship to a partnership. Key is that the person now has partners in ensuring accessibility, quality and affordability and improving and sustaining health.

"Healthy Partners"

What are the action steps to make this happen successfully?

1. Every person is strongly encouraged to improve and sustain his/her own health and to help ensure health care quality, affordability,

and accessibility consistent with the best ways to improve and sustain health. Every person is strongly encouraged to enter into a partnership with a primary health partner to improve and sustain health, jointly do primary care, and jointly coordinate care. When there are multiple conditions and providers, a Care Coordinator is important. Payers may want to provide incentives for a person's behavior that increases affordability, reduces health risks and increases successful treatment.

2. Every primary health partner who a) has a current agreement with a person to be the primary health partner, and b) acts as the primary health partner receives a substantial percentage increase in payment from the respective third party payer.
3. Every primary health partner who a) agrees to coordinate care across all of a person's providers and b) coordinates that care receives a monthly payment from the respective third party, public or private payer.
4. Every primary health partner who receives any of the above payments agrees to a) partner with a self-pay person who wants to have a primary health partner and b) provide primary care and coordinated care to the person at no additional charge beyond normal charges.
5. Every primary health partner who receives any of the above payments agrees, to make all reasonable effort to use the best available, evidence-based health support consistent with the needs of the person receiving health support. Every other health support is strongly encouraged to make all reasonable effort to use the best available, evidence-based health support consistent with the needs of the person receiving it.
6. Every primary health partner who agrees to be a primary health support partner and effectively use a fully functional electronic health record system (EHR) receives a fully functional EHR, including hardware, software, training and installation. Operating, updating and replacement costs are the responsibility of the primary health partner. A fully functional EHR must be certified and meet functional, data and exchange standards, provide clinical decision support, be able to exchange information with other providers, and include full information and tools important to effective and efficient primary and coordinated care. The cost is either funded by the country's national and/or state government or is proportionately funded by the respective third party, public and

private payers. Every other provider is encouraged to use a fully functional EHR (as above) that includes full information and tools important to effective, efficient and coordinated care. Payers are encouraged to help with the EHR funding for these providers as well.

7. Every health support is expected to effectively and efficiently share the information that supports a person's health and health support and is consistent with the person's preferences and consents.
8. Organizations and individuals working to improve health and health support quality, and the country's government and other third-party payers partner to provide all providers with the latest information on how to ensure accessibility and affordability, provide effective and efficient health support, and improve and sustain health.
9. Using the best available means, providers and other public and private organizations and individuals should support persons by adopting "person-centered health" that organizes health support around the person and helps a person stay healthy, get better, live reasonably well with illness or disability, and cope with the end of life.
10. Public health agencies, other public organizations, and private sector health organizations should partner to build healthy communities as necessary to building healthy countries and world. All levels of government and the private sector, should partner to appropriately resource, design and implement these efforts to ensure accessibility, affordability and quality and to improve and sustain health for all people.

For all the reasons noted, **Healthy Partners** may well be the best primary health model. It may well be the model on which we should focus our support. It may well be the model on which we should bet our payers' support and money. It may well be the model on which we should bet our health support's support. It may well be the model on which we should bet our, our families, our friends, and our community's health. It may well be the model on which we should bet our achieving healthy people and a health and thriving future.

Care Coordination.

Care Coordination is best used to optimize (improve and sustain) health of a person or persons who have multiple health-related issues and multiple sources of health support that affect health status. The more health-related issues and the more complex the person's health-related situation, the more valuable is the Care Coordinator. It is helpful for persons receiving care from more than one health support (e.g. primary care provider(s), specialty care provider(s)), in more than one setting (e.g. clinic, hospital, nursing home, assisted living, home care), and/or involving more than one health related factor[10] (e.g. performance, finances, nourishment, housing, security, education, illness or injury, development, habitat, other vulnerability). It is not intended to help manage what is primarily a single health condition by a single health provider in a single setting with only one health-related issue. The only exclusionary criteria are that and that the person does not want care coordination. It is best done by a high-quality professional (e.g. physician, nurse, health social worker, physician assistant) who can effectively partner with a person and a person's health support and has a high commitment to optimizing person-centered health.

An effective Care Coordinator partners with the person and the person's health support to optimize a person's health. To accomplish this, the Care Coordinator listens to, observes and learns about the person and what needs to be done to optimize health. This involves connecting with the person's relevant health support and gathering the necessary information from them and the person's health record(s). With the necessary information and collaboratively, the Care Coordinator develops the appropriate strategy and actions that will best optimize the person's health. Actions are then taken in partnership with the person and the person's health support. The Care Coordinator periodically reviews progress, strategy and actions and make the necessary adjustments in concert with the person and the person's health support. Together, the Care Coordinator, the person, and the person's health support can and should best optimize the person's health.

Care Coordination is not a new concept. In some ways, it dates back to the early days of health care when a health provider in small communities

[10] Health-related factors: performing poorly or badly, being poor (financially), being poorly nourished, being poorly housed, being poorly protected (exposures, crime), being poorly educated, being physically or mentally ill (people), growing and developing poorly or badly, living within poor or bad habitat, being excessively vulnerable, not being sustained.

knew and acted upon a person's total health-related situation. It was understood that the chances of a person being healthy decreases when multiple health-related issues interfere with a person's health. One later example was an inner-city health system in Milwaukee (WI) in the late 1970s that created care coordinators (primarily nurses and social workers) to partner with and coordinate the care of higher risk persons who needed and received health support from multiple health-related providers (including preventive health, primary care, specialty care, hospital care, public health, dental, mental health, social services and financial assistance).

In today's complex health world, Care Coordinators have an especially valuable role to play and have more information and better tools to help them and the person and the health support they support. Today, person and health support behavior are playing a more critical role and require Care Coordinators and health support who understand and support a person's behavior that will best optimize health. Care Coordinators are essential to optimizing personal health for persons with multiple health related issues. To best optimize personal health, it is essential that effective Care Coordinators are in place and are strongly supported by the health organizations for whom they work.

Care in the Community.

In America today, much of what impacts health occurs outside the direct health support system. This includes the impact of self-care, personal behavior, and the environment. Further, four forces are changing how we support health for Americans. First, more and more care is being provided in non-hospital settings for a number of reasons. Second, eHealth is developing quickly as a means to extend health support outside of and with health support facilities. Third, personal involvement in and control over health is increasing as people understand a) the impact of personal health behavior and health environment on health status and b) the tools and information available to help improve health status. Fourth, given that sustaining and improving health is increasingly about chronic illnesses and behavior change, the need for a continuing "partnership" between people and their health support is growing. With this developing future, what we are choosing to call "care in the community" offers a model for improving the use of scarce health resources and for improving personal health.

The purpose and desired outcome of this effort is to help improve health status via the enhanced system of care that makes use of effective "care in

the community" and "personal health systems/records", such as the concept of a "My Health<u>e</u>People."[11]

Potential "Care in the Community" Model. What is the model? How might it function to improve health? Care in the Community is built on the principle that the person is the center of the "health universe." All health support should be person-centered and be coordinated to improve their personal health and the health of those in their own "personal community." It recognizes and addresses that a person's health status and needs change over time as people move through periods of wellness, acute episodes and chronic illness and disability. A person may be experiencing both acute and chronic illnesses at the same time. A person may be relatively well and, at the same time, have a well-managed chronic illness. A person may have a disability and still be functioning well due to prosthetics use or other care. Care in the community seeks to support the whole person and their own "personal network" and the full scope of needs over time. Care in the community builds upon clinic and hospital resources, enhances them with care outside those care settings, helps bring all health resources together and coordinates care in a person-centered way and with an effective partnership between the person and their health support.

In terms of a model for such a "care in the community" system, one model for building a system is person centered incorporating a) direct interactions with one or more health support and b) utilization of a personal health system (e.g., like the concept of a My Health***e***People) for self-care and shared care management with one or more health support. (See "Person Centered View of "Care in the Community" including "My Health***e***People")

[11] "My Health***e***People" is a concept for an electronic personal health system that a) is owned and controlled by the person, b) serves as a web portal, and c) enables coordination of care, trusted health information access, electronic health record access and sharing, transactions, messaging among persons and health support, and eHealth program health support (e.g., moderated discussions, chronic disease management and monitoring, risk reduction)

"Person Centered View of "Care in the Community" including "My Health*e*People"

Potential "Care in the Community" Supportive Services. This model can help improve self and shared care and brings to bear, via a My Health*e*People type personal health system, a wide range of supportive services, including health record access, self-entered health information, messaging between health support and person, trusted eHealth information, automated eHealth program transactions, and eHealth program support (electronic health services targeted at managing and improving health). A personal health system could potentially support the person and coordinate care in the following ways:

- Health Record
    - Access part of or whole electronic health record
    - Self-enter personal health information
    - Share person's electronic health record among health providers
    - Share persons' electronic health record w/ family or "delegate"
- Messaging (with health provider)
    - [See Health Support" services for additional "messaging" opportunities]
- eHealth Program Information
    - Receive trusted information via access to website
    - Receive trusted information via health provider programs and facilities
    - Access links to health-related sites
- Automated eHealth transactions
    - Check and/or fill prescriptions
    - Check, confirm and /or make appointments
    - Check co-payments; make co-payments
    - Register for benefits and/or care; communicate change in registration status
- eHealth Program Support
    - Coordination of care
    - Self-assess health (e.g. self-monitoring; identify health problems)
    - Access basic "diagnostic/therapeutic" tools appropriate for self-management

- Monitor health (e.g. report blood pressure, glucose, pain, weight, wounds)
- Participate in sponsored support or discussion groups
- Receive health behavior reinforcement (e.g. reduce smoking and alcohol use)
- Have telehealth consult with health provider
- Access safety services (e.g. drug-drug interaction checks)
- Receive electronic reminders (e.g. taking pills on time; upcoming appointments)
- Use "check in", for those living alone and at risk, to report they are "okay"
- Bi-directional question/answer between providers and persons
- Receive notification of non-sensitive test results
- Track progress on treatment

Potential "Care in the Community" Impact on Health and Health Care. In envisioning the results of this effort, the "care in the community" strategy substantially changes how we support health. Under this strategy, we move to a person and population centered health system. We create a partnership between people and their health support. We enhance self and shared care already being done. We strengthen and expand care provided in the community. We tightly coordinate and integrate care in health care facilities with care outside health care facilities. And, we use eHealth personal health systems (e.g., like My Health***e***People) that includes records, messaging, transactions, information, and services to support and tie together the full range of care.

Care in the community lends support to optimizing health, abilities and satisfaction of the people targeted by the strategy. It moves from a reactive "safety net" mode into a proactive "intervene early" and "keeping people healthy" mode. It supports targeted interventions to specific populations (an "enrolled" population, people who are relatively well, people with acute episodes, people with chronic illnesses and people with severe chronic illness and/or disability). Through mass personalization of eHealth, it supports targeted interventions to specific individuals based on their individual needs and preferences. For organizations that see themselves as taking responsibility for the health of their population (a "public health" perspective), "care in the community" helps. For organizations that are trying to get more benefit for the same dollars, it can help stretch those

dollars further. For those trying to use all the available care settings to their best advantage, care in the community adds settings. Care in the community also can help health support organizations better use best practices and more ideal systems. It also brings to bear a more optimal use of health and information technologies to improve people's health.

Health Environment.

Moving outside the health care system and the formal community programs, there are many influential factors and much potential health support outside the traditional health care system. The "health environment" plays a major role in health outcomes and health status and in how the traditional health support system impacts outcomes and status. It plays key roles in a person-centered health system.

As alluded to earlier, it starts with the people who surround the person, the human factors. These are the people with whom the person spends the greatest proportion of her/his time. The family, at many points in the person's life, impacts health positively and negatively. It can be a source of positive health influences (e.g. positive reinforcement of positive health behaviors) and it can be a source of negative influences (e.g. poor food choices, stress). The same is true for friends, co-workers and neighbors. A person-centered health system recognizes the importance of all these people to the person's health, takes these influences into account, and works to reduce the impact of negative influences and engage the positive influences.

With respect to the family, there are historical influences. Family history - the influences being behavioral, environmental and genetic - plays a major role in the person's health. These influences are critical to understanding the person's health, why it is what it is, and how to positively change it. Research continues on the influence of genetic factors and on what interventions can harness the positive factors and reduce the negative factors.

Beyond the family, there are many other environmental factors – home exposures, work exposures, school exposures and community exposures. Some are historical. Some are current or future. To improve health requires understanding these exposures, their impact on the person's health, and their potential for positively or negatively impacting health.

Outside self-care and outside the formal health support system are non-health-care community resources. These have many forms and differing

value. Some resources are not-for-profit and some are for-profit. Some are relatively informal and some are formal. Some do evidence-based interventions; some do not. Some are trustworthy and some are not. Some are tied to specific illnesses or injuries (e.g. cancer, Alzheimer's); some are non-health related affinity groups (e.g. senior citizens, religious groups, co-workers). Many of these have health impacts, some negative and some positive. A person-centered health system trying to improve health takes them into account and helps to minimize the negative impacts and maximize the positive impacts.

These environmental factors (outside the person and outside of the formal health support system) are built into a person-centered health system and its efforts to improve health outcomes and status. Failing to address these factors reduces the probability of improving the person's health.

Dynamic, Interactive System.

If all of this was static and independent, it would be challenging enough. But it is not. The system is dynamic because the locations for health interventions change. It is dynamic because the person changes in many, many respects. It is dynamic because the people providing health support change. It is dynamic because time comes into play as events unfold for the person and, her/his "health system" and "health environment". Beyond being dynamic, it is interactive where influences are interacting with each other to change how they impact the person and her/his health. Understanding that this is the reality gives the person and his/her health support a better understanding of why some interventions work better than others and why interventions need to be dynamic and interactive.

Virtual Health System.

Wrapping around this health system and the other health and non-health systems is the eHealth capability to make it a "virtual health system", bringing together all parts of the formal and informal health system. Part the responsibility for the virtual health system lies with each particular health system and part of this responsibility lies with other parties outside the particular health system. A strong virtual health system "connects the dots" and provides a wide range of support to the person, his/her clinicians and community health support both within a particular health system and across health systems. A person-centered, virtual health system "breaks down the walls" and enables the person and his/her health suppordt to

better bring to bear the full health resources appropriately, affordably, anytime, anyplace and in real time.

Today, four forces are changing how we support health. First, more and more care is being provided in non-clinic and non-hospital settings for a number of reasons. Much of this care focuses more on the person and his/her community. Second, eHealth is developing quickly as a means to extend health support within and outside of health support facilities. Third, personal involvement in and control over health is increasing as people understand a) the impact of personal health behavior and health environment on health status and b) the tools and information available to help improve health status. Fourth, given that sustaining and improving health is increasingly about chronic illnesses and behavioral change, the need for a continuing, effective "partnership" between the person and her/his health support is growing. With this developing future, what we are choosing to call "person-centered health" offers a model for improving the use of scarce health resources and for improving health outcomes and status.

Chapter 4. HealthePeople® - Achieving Healthy People and Communities Via Healthy Behavior

Ideal Health Systems for Healthy Behavior - Person-Centered, Affordable, Accessible, Quality, Outcomes-Driven Health Systems

If we want to achieve healthy people, we have a very big problem receiving very little attention. It is the one thing that could best improve health, health support and health reform. It is the one thing that the health world knows and does the least about. What is it? People's behavior. This can change. This must change.

Why must we make this change? Our inability and unwillingness to deal with people's behavior means we waste more money, keep health support more inaccessible and unaffordable, deliver less high-quality care, and fail to adequately improve health.

Healthy Behavior

When we smoke or eat unhealthy foods, go to an emergency room when a physician's office is more appropriate, or don't manage a chronic condition well, we hurt ourselves and we hurt everyone else. When a physician orders the wrong or too many tests, makes the wrong diagnosis, prescribes a treatment less effective than other treatments, or fails to follow-up on a treatment's outcome, the treated person is hurt and so is everyone else. When a major health reform effort fails to understand the problem and the role of people's behavior, designs and legislates less effective programs that do not address behavior, and fails to manage a program effectively

because of how people actually behave in the real world, everyone is harmed.

How can we make this change? We address the behaviors of each person, hundreds and thousands of people, and billions of people, such as how healthy they live their lives, when and where they use health support, how well they "partner" with their health support, and how well they follow treatments.

We address health support behaviors, such as how they train and continue to learn, how well they "partner" with people needing care, how well they collect information, diagnose, treat and follow-through, and how well they "partner" with other health support caring for a person.

We address health policymaker, program manager and health care manager behaviors, such as learning about the population and people's behavior in that population, building people's health support behavior into those systems, designing programs and policies that take into account behavior, helping people and health support achieve more successful behavior, and learning about and designing more effective systems for improving health.

Today we have the necessary behavioral and systems knowledge, models, tools and strategies. They will get even better over time. We know how to apply them to individual people and sources of health support, to their partnerships and to community, state and country policymakers and managers. We just need to start using them. We need to use them across the full spectrum of health and health support. We need to apply them at the individual level and at the community, country and world level.

Consider just one current issue –health reform anywhere in the world. By applying behavioral and systems models, strategies and tools, we can greatly improve our understanding of our current health systems and the need for their transformation. We can better understand people's behavior in that system and how to improve that behavior in a transformed health system. We can better design, legislate and manage a transformed and healthy system. We can create and sustain effective health systems that are affordable, are accessible, are high quality and, most importantly, substantially improve the health of all people.

Behavior Effectiveness Model (BEM) for Healthy Behavior [12]

Much of the ineffectiveness of achieving healthy behaviors and building a better and preferably a healthy future can be traced to the inability and often lack of motivation to deal positively with human behavior. Traditionally, people trying to effect positive change (e.g., building a better and healthy future) are not sufficiently capable of or motivated toward dealing with human behavior. Effective dealing with human behavior is a critical skill that can be acquired and is enhanced through experience. People can achieve healthy behavior by learning to use behavioral skills and by using experience to increase effectiveness.

Building a healthy future, in part, can be measured in terms of human behavior. For example, we refer to the person's lack of ability or lack of motivation to do some behavior. When a community wants to achieve some positive change and outcome, people must be able (e.g., have sufficient funding, have no legal restrictions, have requisite knowledge and skills) and motivated (e.g., see it as desirable, see it filling a need). For a community, country and world, implementers of change must be able and motivated to accept and execute the change. Implementers must see the change as effective in achieving personal and/or community, country and world outcomes. We need to better assist and/or affect decisions and actions and better design and evaluate change strategies in terms of behavior requirements.

When we wish to understand, assist and/or affect the person's or persons' behavior in a specific decision or action or over a series of decisions or actions, we need a "handle" which identifies discrete determinants of behavior and provides a model which indicates how these determinants affect near and long-term behavior.

One such model, the Behavior Effectiveness Model (BEM), assumes that behavior determinants can be identified for behavior objectives and provides more effective models and tools for achieving behavior objectives.

BEM's value lies in 1) being relatively parsimonious, 2) incorporating key aspects of other behavioral models, 3) being "computable" (i.e., it can use databases (personal and environmental characteristics, desired behaviors and tailored interventions)), 4) tailoring applicability to more than one

[12] For more on the BEM, see **Behavior Effectiveness Model** book available via Amazon.com or ThriveEndeavor.org In other publications, this is referred to as the Behavioral Effectiveness Model.

person simultaneously by using individual characteristics and desired behavior(s) and 5) using evidence-based interventions that can be tailored to those characteristics and the desired healthy behavior.

How does it work? As shown in the following table ("Behavior Effectiveness Model (BEM) – Improving Healthy Behavior"), BEM is designed to 1) apply interventions that help achieve the desired target healthy behavior, 2) learn more about the person or population involved, 3) learn more about interventions and 4) learn more about the "system" in which intervention are used. It can also be used for prediction, analysis and program development and evaluation. The model can be applied to 1) an individual person, 2) populations whose characteristics are sufficiently the same, and/or 3) populations of individuals for which each individual gets a personalized and tailored intervention. The model can be linked to a database so that it can use and produce information and support personalized and tailored interventions:

- For any number of individuals and over any period of time
- For one-time behaviors and behavior over time
- For change in a single behavior and multiple behaviors.

Table. "Behavior Effectiveness Model (BEM)" – Improving Healthy Behavior

BEM use for achieving desired behavior is as follows:

1. Identify the person or population whose behavior is targeted.
2. Decide what is the desired behavior or behaviors. Note that some behavior is one-time and some is recurring.
3. Assess motivation in terms of its current and future characteristics.
4. Assess ability in terms of its current and future characteristics.
5. Assess environmental variables, both controllable and uncontrollable and both perceived and real.
6. Assess how motivation, ability and environmental variables are likely to affect future behavior without further intervention.
7. Assess what are likely to be the intrinsic (internal to the person or population) and extrinsic (external to the person or population) consequences of projected behavior and what is likely to be the person or population's satisfaction.

8. Assess how consequences and satisfaction are likely to affect future behavior
9. Assess how projected behavior, without further intervention, matches to desired behavior.
10. Assess what interventions will best move projected behavior to desired behavior for the near and long term.
11. Apply the interventions and assess their effect.
12. Adjust the interventions as needed over time and based on result.
13. Feed the interventions into overall strategy and supporting strategies.

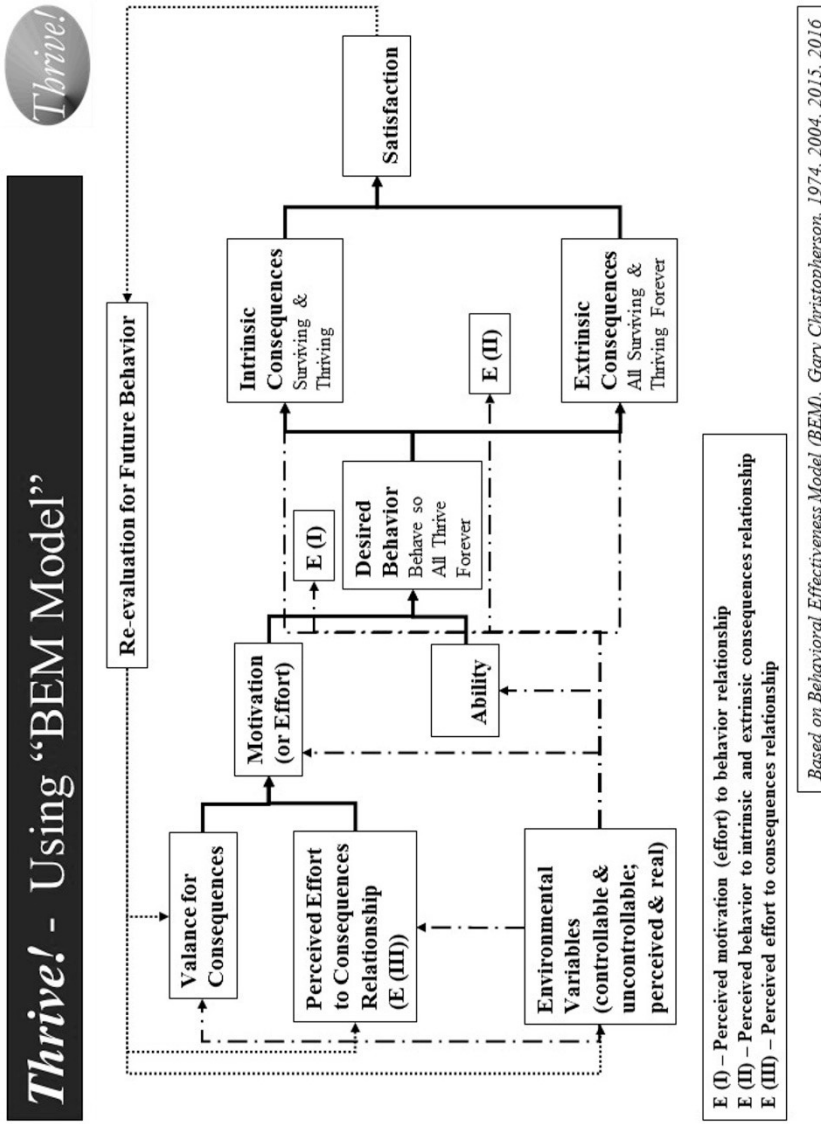
BEM has several elements that operate as inputs to or outputs from the intervention models used and can help change behavior. (See Behavior Effectiveness Model (BEM) (Christopherson, 2015).” The elements include the following:

1) Valence (value) of consequences is how the person(s) values the consequences that the person may or will face. They may be intrinsic (internal to person(s)) or extrinsic (external to person(s)).
2) Expectancy III (E (III)) is the person’s or persons’ perception (or the actual projected) probability that the person’s or persons’ effort will result in each consequence.
3) Motivation (effort) is what the person(s) is expected to try to do (that is, try to do the behavior) and is calculated using the “valence of consequences” and E (III) above.
4) Ability is the person’s or persons’ capability to do the behavior. Any ability that is essential to the behavior and is at low levels means that the person(s) is unlikely to be able to do the behavior even if other less essential ability factors are high.
5) Behavior is the desired behavior to achieve the desired vulnerability/thriving outcome. Behavior probability is calculated using motivation and ability probabilities.
6) Consequences are the expected results of effort to do the behavior or the behavior itself. Valence is modified to reflect the actual valence when the consequence occurred.

7) Expectancy I (E (I)) is the person's or persons' perception (or the actual projected) probability that the person's or persons' effort will result in desired behavior.
8) Expectancy II (E (II)) is the person's or persons' perception (or the actual projected) probability that the person's or persons' behavior will result in intrinsic and/or extrinsic consequences.
9) Satisfaction is the person's or persons' level and direction (positive/negative) of satisfaction with what happens, especially as compared to expectations. It is especially key when the behavior is recurring or when a future behavior is related.
10) Environmental factors (EF) are those outside influences affecting motivation and ability and may be current or projected. They include program interventions to improve probability of desired behavior initially and over time. They may be controllable or uncontrollable and may be real and/or perceived. They are factors outside the factors in the model. Environmental factors can impact the model at several points as noted by the "EF" arrows depicted in the model figure above.

There are several outputs provided by the model that predict what will happen initially and over time, including:

- Ability -- Given the person's or persons' own abilities and the impacting environmental factors (factors that negatively and/or positively impact the person's or persons' ability), how able is the person(s) to do the desired healthy behavior?
- Motivation -- Given how the potential consequences are valued and how effort is expected to result in consequences, what is motivation direction at what intensity?
- Behavior -- Given motivation, ability, consequences and expectations, what is the expected health behavior, its likelihood, its intensity, and its direction?
- "Pre" Satisfaction -- Given expectations, motivation, ability, health behavior and consequences, what is the expected satisfaction?
- "Post" Satisfaction -- Given what health behavior and consequences actually happened, what is the actual satisfaction and what is its implication for subsequent behavior?



"Behavior Effectiveness Model (BEM) (Christopherson, 2015)."

BEM, as noted below, is designed and used here to 1) apply interventions that help achieve the desired target healthy behavior, 2) learn more about the person(s) involved, 3) learn more about the intervention itself and 4)

learn more about the "system" in which the intervention is used. Examples of the potential uses include:

- Impact behavior
  - Analyze current behavior and the factors that impact that behavior
  - Predict future behavior and the factors that impact that behavior
  - Support interventions that impact behavior and incorporate the factors that impact behavior
- Learn more about the person(s).
  - Information on ability and motivation.
  - Information that was initially incomplete or inaccurate.
  - Information that changes over time due to changes from the intervention, from the environment independently, and/or from the person independently.
- Learn more about the intervention.
  - On what individual person(s) does the intervention work and not work and what degrees in between (works X% of the time; produces Y% of the desired result)?
  - How can the intervention best be targeted for use by/with different individual persons?
  - How does the intervention need to be changed to match changes in individual persons?
  - How can the intervention be improved generally and for individual persons based on lessons learned?
- Learn more about the system in which the model is being used and the environment in which it and its persons operate.

BEM can be and is used here used for prediction, analysis and program development, including:

- It can be used as a predictive model for motivation/effort, health behavior and satisfaction.
  - The person's or persons' characteristics (valence or value of potential consequences; expectations that effort will lead to specific consequences; cognitive and physical ability) are entered into the model and predicted results (expected level of motivation/ effort, expected behavior

and expected level of satisfaction) are processed through the model.
    - The model also can utilize environmental factors that influence any the person's or persons' characteristics. The model also can then use the predicted results and environmental factors to predict subsequent effort, behavior and satisfaction.
- It can be used and is used here as an analytic model to better understand what is working and not working, why, and what changes are needed.
    - If there is a lack of motivation, the model can help work through the perceived consequences, the perceived linkages of effort to those consequences and provide options for what needs to be changed.
    - If the desired health behavior is not occurring, the model helps work through what factors (e.g., persons' or persons' ability, their expectations about consequences, their general motivation, their satisfaction with previous efforts with an intervention, the effects of environmental factors) need to be changed.
    - If the desired satisfaction is not achieved, the model can help work through why not and provide options for what needs to be changed.
- It can be used and is used here for program development to develop or modify a program intervention for particular individuals and/or generally.
    - Based on the person's or persons' characteristics and the desired health behavior, the program intervention can be designed or modified to improve likelihood of successfully achieving the desired health behavior. For some persons, the focus might be on ability, motivation or both.

The model can be applied and is applied here to 1) an individual, 2) persons or populations whose characteristics are sufficiently the same, and/or 3) persons or populations of individuals for which each individual gets a personalized/customized/tailored intervention.

The model can be linked to a database so that it can produce information and support personalized/customized/tailored interventions:

- For any number of persons and over any period of time
- For one-time behaviors and behavior over time
- For change in a single behavior and multiple behaviors.

How has it been used and helped? BEM's primary use to date has been for improving health. Its earliest use was in the middle 1970's, helping develop a high blood pressure control program in Milwaukee, Wisconsin. The desired behavior was adherence to methods for controlling high blood pressure. These methods could be medication use and/or life style change (e.g., diet, exercise, stress reduction). Through the use of BEM, the program was better able to get people to get their blood pressures checked and controlled and to determine the likely success of particular methods with a specific person and with persons with similar characteristics. The blood pressure control program was seen as a national model for community blood pressure control.

Person Model. The Person Model helps us to understand that each person goes through several life stages depending on how long they live and how that impacts behavior. If status (e.g. health) is to be improved, it is seldom a one-time intervention and generally should be done across the life span. As a result, the Person Model works by applying BEM over an individual person's time and life stages. (See "Person Model" – Applying BEM Over Each Person's Time and Life Stages.)

The Person Model, with BEM as the underlying model, recognizes that each person is different at the beginning, throughout the life stages, and near the end. For health status to be improved, the strategy needs to be both specific to each person across the life span and effective for all persons across the life span. (See following table "Person Model – Applying BEM Over Each Person's Time and Life Stages")

The model has been used to design the **HealthePeople** strategy to improve health and health care across America. The same design has applicability in a person, communities, countries and world.

"Person Model – Applying BEM Over Each Person's Time and Life Stages."

Table. "Person Model – Applying BEM Over Each Person's Time and Life Stages"

The Person Model use for achieving desired behavior is as follows:

1. Identify the person, persons or population whose behavior is targeted.
2. Decide what is the time frame or life stage(s) to be addressed. The preferred time frame is the whole life.
3. Decide what is the desired behavior or behaviors over time and through life stages.
4. Apply BEM as a recurring model (running the model as many times as necessary) adjusting to changes in motivation, ability and environmental variables.
5. Assess what interventions will best move projected behavior to desired behavior for the covered time and life stage(s).
6. Apply the interventions and assess their effect on an ongoing basis.
7. Adjust the interventions as needed over time and based on result.
8. Feed the interventions into the overall strategy and supporting strategies.

At the Centers for Medicare and Medicaid Services (CMS), the model was used in 2005 to enhance the overall strategy for national quality improvement for health care. The desired behavior was of effective health support over time. The model helped identify what target health support personnel behaviors, on an ongoing basis, could produce the best health outcomes. Based on that, an approach was laid out using current and new interventions to improve health support behavior in a way that would produce improved outcomes and health status for the foreseeable future and over the health care providers' careers (life stages). These interventions were used to improve the overall quality improvement program for CMS. It was also used at the Centers for Medicare and Medicaid Services to help with the draft strategic and operational plan.

The model was used in the early 2000s to create a new model called "person-centered health". The Person-Centered Health Model has been

used to refine the programs of the Veterans Health Administration, including overall care, care in the community and the VHA health information system (electronic health record and personal health record systems).

Population Model. The Population Model addresses health status from the perspective of what is happening at any point in time and the effect on a diverse or non-diverse population. BEM is the underlying model for adjusting strategy to address points in time across persons and their life stages. This model also applies to other differences (e.g., racial, ethnic, income, vulnerability) in the target population (See "Population Model" – Applying BEM at a Point in Time across Persons and Their Life Stages)

The Population Model, with BEM as the underlying model, recognizes that strategy, at any point in time, must be both specific to each applicable person across the life span and effective across all persons across the life span. (See Table. "Population Model – Applying BEM at a Point in Time across Persons and Their Life Stages") Taking a time slice, the model recognizes that at any specific time, the target population likely includes persons from all different stages of life (pre-birth, birth, child, adolescent, early adult, middle adult and senior adult). At that time, each person has different status levels, different factors affecting status, and different responses to efforts at improving status. This can be seen in how major disasters (e.g., tsunamis, earthquakes, disease outbreaks, crop failures, and drought) affect people differently. This can be seen in how program interventions (e.g., health) affect people differently.

At the Centers for Medicare and Medicaid Services (CMS), the model was used in 2006 to design the draft CMS Strategic and Operational Plan for 2007-12. It was used to address CMS's disparate beneficiary population and the timing and design of program interventions. The plan was designed to address the needs of both younger and older Medicaid beneficiaries, beneficiaries with disabilities, and healthier and severely ill Medicare beneficiaries. It also addressed the populations that are pre-Medicaid and pre-Medicare. The plan recognized that over time, these populations change as new age cohorts moved into the program. These Population Model interventions were then used to develop the draft overall Strategic and Operational Plan for CMS.

"Population Model – Applying BEM at a Point in Time across Persons and Their Life Stages"

Table. Population Model – Applying BEM at a Point in Time across Persons and Their Life Stages

The Population Model use for achieving desired behavior is as follows:

1. Identify the population whose behavior is targeted.
2. Decide what are the point(s) in time and life stage(s) to be addressed.
3. Decide what is the desired behavior or behaviors at different points in time across persons and their life stages.
4. Apply the BEM model across time and across populations and their life stages taking into account their differing motivation, ability and environmental variables.
5. Assess what interventions will best move projected behavior to desired behavior across time and across populations and their life stages.
6. Apply the interventions and assess their effect on a population on an ongoing basis.
7. Adjust the interventions as needed over time and based on result.
8. Feed the interventions into the overall strategy and supporting strategies.

For the DoD Military Health System (MHS), the model was used in the 1990s to work with pre-military, active service, Guard and Reserve, veterans, retirees and their families. All are the responsibility of the MHS. Key points in time greatly affect how the health programs work and their effect. Earlier wars (and their effects) such as the two World Wars and the Korean War are very different than the Vietnam War than the first Iraq War, as well as the second Iraq War and then the Afghanistan operations. They are all likely to be different than future wars and other military actions. All of these factors were built into the overall strategy for the future Military Health System that was re-engineered to improve performance, enhanced with a force health protection program, and was made more flexible to adjust to different futures.

The model has also been used to design a **Health*e*People** strategy to improve health and health care across America. The same design has applicability in communities, countries and world.

When we successfully build people's behavior into our health support and health reform models, we will more successfully deliver high quality health support producing better health outcomes, design and implement health reform and transformation, and improve people's health status. Further, we will greatly reduce waste, improve access and produce better outcomes. Importantly, we will have a healthier, more effective and sustainable health systems. More importantly, we will have healthier people. Most importantly, we have the means to have healthy people in our communities, our countries and our world.

Chapter 5. HealthePeople® - Achieving Healthy People and Communities [13]

Ideal Community Health Systems - Person-Centered, Affordable, Accessible, Quality, Outcomes-Driven Community Health Systems

In every community, we face major challenges and disappointments in achieving healthy people and healthy communities. Without a large change in health vision, strategy and execution, our future will be as disappointing as our past. To positively change that future, HealthePeople is a strategy whose near-term vision is to achieve substantially healthier people and substantially healthier communities. The long-term vision is to achieve healthy, thriving people and healthy, thriving communities. This HealthePeople strategy was created with the belief that we can reach this vision via an endgame strategy of high performance, health systems for every community that is self-perpetuating, affordable, accessible, "e" enabled, person-centered, prevention-oriented, and producing high health quality, outcomes and status. Such systems, partly physical and partly virtual and put into place by collaborative private and public partnerships, will greatly improve accessibility, quality, affordability and health status for every community. Such systems can help achieve healthy people and healthy, thriving communities.

[13] Note the chapters on the world, countries and communities have some redundancy. Each chapter stands on its own when combined with the chapter on person-centered health.

Rationale.

Today in almost every community worldwide, we are spending a substantial portion of the community's economy on health without producing healthy people or a healthy community. Without a large change in health vision, strategy and execution, every person and every community's future will be as disappointing as in the past.

We still do not have and are not on the track to achieve the community health systems we need. While much good work has been done on the issue of a high-performance health system by organizations like the Commonwealth Fund, there is still not a clear idea of what should be the ideal community health system that will achieve healthy people and health communities.[14]

HealthePeople is an attempt to describe such a health system. The characteristics of ideal community health systems are suggested. The design of an ideal health system is suggested as it might apply to a "community". Key is to have a system that is desirable to people, ensures affordability, quality and accessibility, and achieves healthy people and a healthy community.

When achieving healthy people and communities, every community today has much to offer on both how to do it and how not to do it. Communities in America are important examples of both and provide useful lessons for every community wanting to achieve healthy people and a healthy community.

Some American communities are well thought of when it comes to specialty and super-specialty diagnostics and treatment for a single condition. Beyond that, their reputation for best health support is mixed.

There is and should be little disagreement over the need for every community to have a substantially better health system. None of the key indicators – health status, accessibility, quality, affordability – are at acceptable levels for communities spending substantial amounts of their economy on health.

- **Accessibility –** Every community has accessibility issues, especially in inner city and rural areas. A collaborative partnership of people, public and private payers, and health organizations can substantially improve access for all people.

[14] Commission on a High Performance Health System, The Commonwealth Fund, 2006-2012

- **Quality –** Health status and outcomes produced by every community's health "system" are inadequate given the needs of the people and the proportion of the economy expended. Too little of our medical and health knowledge is being effectively applied to prevent and treat health problems and to ensure health support is safe. A collaborative partnership of health organizations and the people they serve can substantially improve health support quality and health outcomes for all people.
- **Affordability –** The unaffordability of health support is challenging every community and their people as individuals and families (inhibiting needed access and causing bankruptcies). These problems continue to grow. A collaborative partnership (health organizations, the people they serve, and the people and organizations who pay) can much more effectively use a community's valuable health resources and ensure affordability.

Some communities are spending enough money. Some are spending too little because of choice or lack of community financial resources. In every community, we are not getting the requisite payoff in terms of health outcomes/status or satisfaction.

Guidance

HealthePeople is a community strategy guided by and aligned with the Institute of Medicine (IOM) recommendations. IOM provides a way of viewing the health system's performance through the eyes of people themselves. What people want from a high performing health and long-term care system is that they are "staying healthy", "getting better", "living with illness or disability" or "coping with the end of life." Some people may experience more than one of these at the same time. IOM's quality reports have six aims for a high performing health system. They stress it should be safe, effective, person/patient-centered, timely, efficient, and equitable.

Utilizing their guidance, a very high performing health and long-term care system would perform well from the person's perspective and achieve the IOM aims. As depicted in the attached table, that very highly performing health system would "check all the boxes." (See "U.S. Institute of Medicine Six Aims & Person's Perspective on Health")

We need to recognize the following as key health drivers and use them to guide our work and measure our progress toward a healthy community:

- Maximize health status
- Maximize outcomes
- Maximize abilities
- Maximize satisfaction
- Maximize quality
- Maximize accessibility/ portability
- Maximize affordability
- Maximize patient safety (drive defects/errors to zero)
- Minimize time between disability/illness and maximized function/health (drive time to zero)
- Minimize inconvenience (drive inconvenience to zero)
- Maximize security & privacy

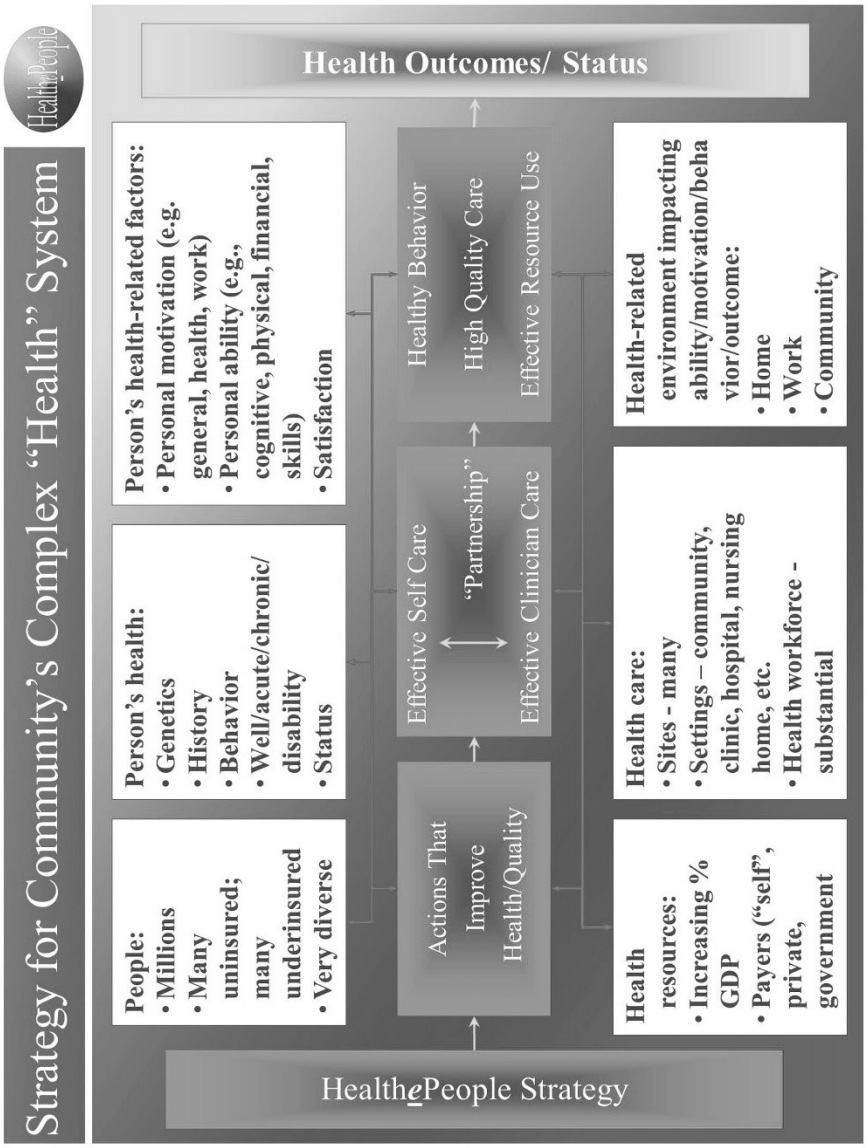
Third, we need to understand and successfully deal with a community's health system complexity if we want to substantially improve health outcomes and health status for all people. The Figure below lays out the complexity gauntlet which must be successfully run. (See "Strategy for a Complex Community's "Health" System") To be fully successful, we must address the people factors (population, diversity, insurance status, health factors, health-related factors) and the non-people factors (health resources, health support, health-related environmental factors). We must focus on a) affecting the actions that improve/reduce health quality to b) create a strong partnership between the person and their health support to c) improve health support quality and effective resource use those results to d) substantially improve health outcomes and status.

Institute of Medicine Six Aims & Person's Perspective on Health

Supportive of IOM principles and aims, Health*e*People supports health professionals/providers, persons/patients, and the rest of the health care system in continuing to innovate and find better ways to achieve key goals more effectively.

Person's Perspective on Health & LT Care Needs	Aims for Health & LT Care Performance/Quality					
	Safe	Effec-tive	Person/ Patient-centered	Timely	Efficient	Equi-table
Staying healthy	+	+	+	+	+	+
Getting better	+	+	+	+	+	+
Living with illness or disability	+	+	+	+	+	+
Coping with the end of life	+	+	+	+	+	+

"U.S. Institute of Medicine Six Aims & Person's Perspective on Health"



"Strategy for a Community's Complex "Health" System"

Vision, Endgame Strategy and Mission

The HealthePeople **near-term vision** – achieve substantially healthier people and a substantially healthier community - is far different than the one we can expect from our current glidepath. Much more so is the **long-term vision** - achieve healthy people and a healthy community. All current indicators and trends point to a future where access, quality and affordability continue to be unacceptable. Under a better vision and strategy with the same resource commitment, communities can achieve substantially healthier people and a substantially healthier community.

To reach this vision, the **endgame strategy** is to achieve a high performance, communitywide health and long-term care system for all people that is self-perpetuating, affordable, accessible, "e" enabled, and producing high health quality, outcomes and status. A community's health system should bring together and to bear the full force of people and their health support, their payers, their communities and their governments.

To reach this vision and endgame strategy, the **mission** is to create and support collaborative partnerships that help build a high performance, communitywide health and long-term care system for all people that is self-perpetuating, affordable, accessible, "e" enabled, and producing high health quality, outcomes and status. This unprecedented collaboration can achieve great progress as we have seen communities achieve historically on other national issues. HealthePeople achieves full success when a community's health system achieves and sustains healthy people and a healthy community.

Strategy for a Healthy Community

HealthePeople is a collaborative strategy to transform to affordable, person-centered, outcomes-driven, and "***e***" enabled health systems that help achieve better health. Succeeding with this strategy across all health support will positively transform health support. We can use a community's valuable health resources much more effectively, reduce vulnerability, and achieve much healthier people and a much healthier community. Within this strategy are two core elements:

- First, achieve affordable, accessible, and high quality/performance health systems. This involves more than medical interventions or traditional healthcare services. It requires a full range of health-related resources from across the community and beyond.

- Second, focus on people—consumers, patients, enrollees, and members. They are the center of the health universe and must be treated as such, forming strong partnerships between individual persons/patients and their health support.

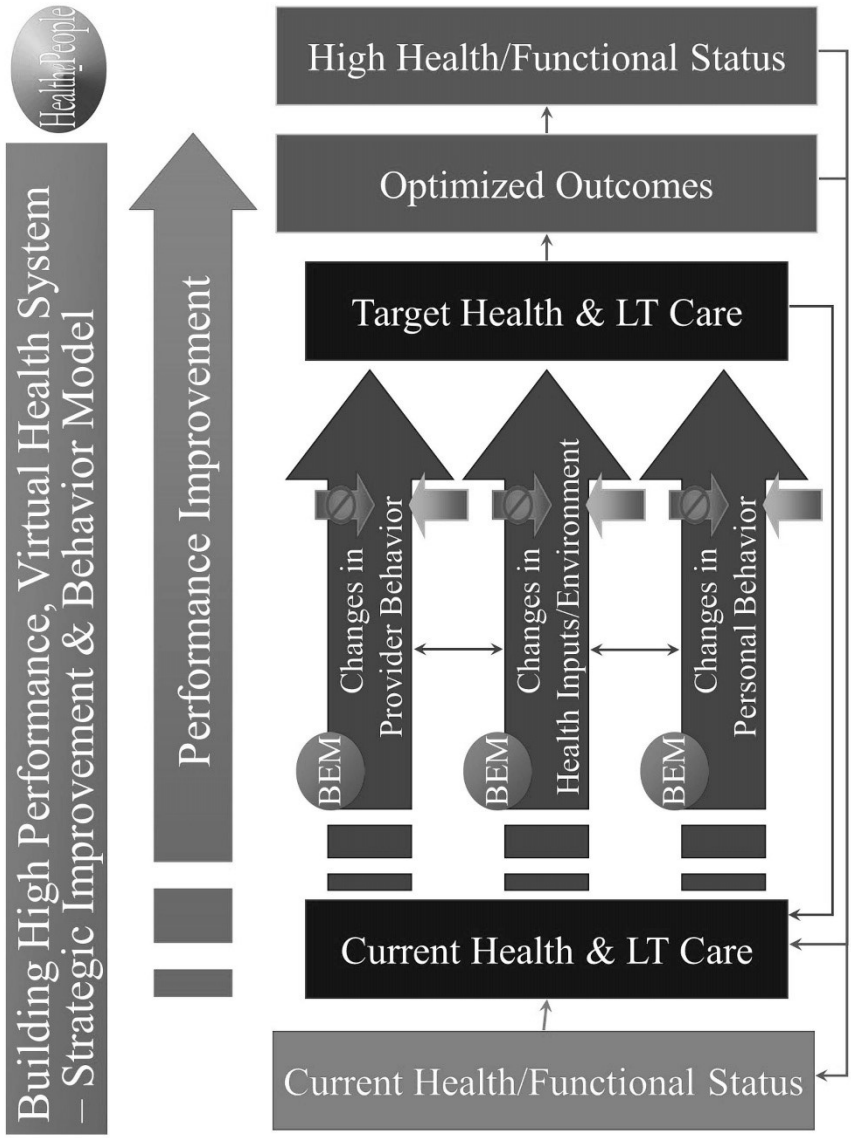
To build out the strategy and supportive strategies, this strategy utilizes a public health intervention model designed to help increase the number of healthy people and reduce the number of vulnerable and/or unhealthy people. (See "Achieving High Level of Health/Function & Effective Resource Use – Public Health Model) It targets interventions that best achieve the highest level of health and function, best prevent more poor health, and best move our most vulnerable people up from poor health. The success of the interventions is measured by the degree to which we stop actions that decrease health and support actions that improve health. Success is also measured by how well the private and public sectors, including health professional leadership, "move the numbers", i.e., substantially improve the key status indicators of health and function.

Within the model, there are interventions that improve health or make it worse. To improve health, there are the overall key strategic areas – stop those interventions/actions that make health worse support those interventions/actions that improve health. To improve health most, we need to execute a "systematic strategy" – a "system" of actions that continuously stops actions that push people down to less healthy states and supports actions that lift people out of poor health and toward being healthy. This "system" of actions, when well designed and executed, can perpetually prevent much poor health and support people moving up from poor health to being healthy.

The overall strategy is built upon a strategic improvement and behavior model for health. Using the model depicted below, we need to set the target health and functional status we are trying to achieve under the vision "healthier/healthy people". (See "Building High Performance, Virtual Health System – Strategic Improvement and Behavior Model") Given the target status, we can decide on the target outcomes needed and on the target health system needed to achieve those outcomes. Comparing the optimized outcomes and health system with the current health system and its performance, we can determine the "delta", i.e., the needed improvements in the current health system and its outcomes.

"Achieving High Level of Health/Function & Effective Resource Use – Public Health Model"

Knowing what needs to be improved, we can then determine what personal and health support behaviors should change. Human behavior, both by persons (beneficiaries, enrollees, consumers, patients) and health support, is key to making and sustaining the improvements. The behavioral model BEM helps us think through how we bring about the behavior change necessary to make the improvements. Together, the system and behavior changes are intended to produce improved health and functional status for all of a community's people.

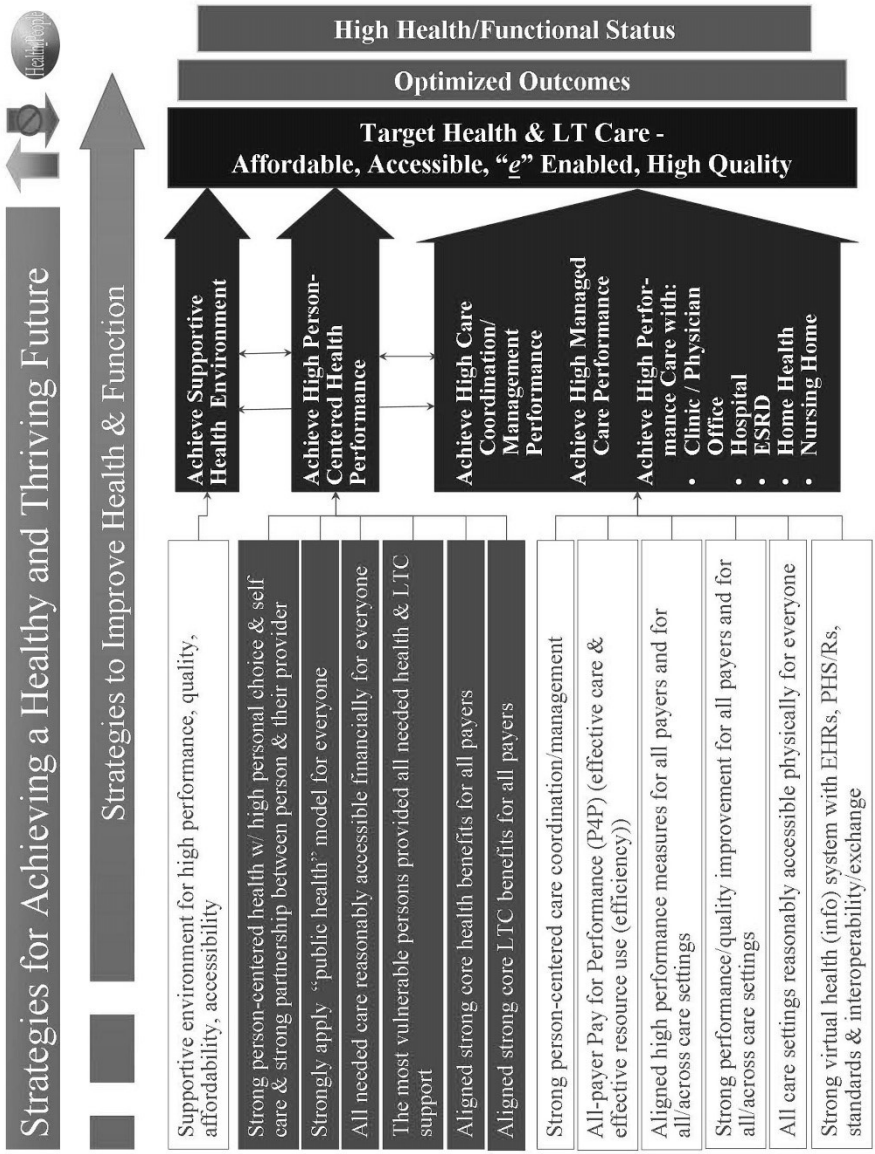


"Building High Performance, Virtual Health System – Strategic Improvement and Behavior Model"

Under the HealthePeople vision and overall strategy and using supportive strategies and models, we can positively transform a community's overall health system and achieve a healthier community by successfully applying the following 15 supportive strategies:

1. Create a supportive environment for high performance, quality, affordability, accessibility
2. Support strong person-centered health with high personal choice, self-care and a strong partnership between the person and their health support to improve resource use and health outcomes
3. Support strongly and collaboratively applying "public health" model
4. Support all needed care reasonably accessible financially
5. Support the most vulnerable persons being provided all needed health and long-term care (LTC) support
6. Support strong core health benefits
7. Support strong core LTC benefits
8. Support strong person-centered care coordination/management
9. Support effectively using prevention to avoid illness and disability and associated cost
10. Help ensure long term affordability
11. Support pay for effective care & effective resource use
12. Support aligned high performance measures for all/across care settings
13. Support strong quality/performance improvement for all/across care settings
14. Support all care settings being reasonably accessible physically
15. Support strong virtual health (info) system with EHRs, PHS/Rs, standards & interoperability/exchange

The following Figure lays out from right to left how a) high health and functional status is produced by b) optimizing health outcomes which are produced by c) an affordable, accessible, "e" enabled and high-quality health system which is produced and enhanced by d) a supportive health environment and high person-centered and health care performance which is produced by e) the successful application of 15 strategies. (See "Strategies for Achieving a Healthy and Thriving Future")



"Strategies for Achieving a Healthy and Thriving Future"

While all 15 supportive strategies are essential, there are several strategies that have unique potential and deserve elaboration and greater attention:

- Person-Centered Health - where the person a) is at the center of self-care, formal health support and informal health support and b) has that health support coordinated via an effective person and health support partnership.
- High Performance Health Systems - where the best systems design and operational thinking is applied to and across the full range of health support settings from individual clinics to hospitals to integrated health systems.
- Care in the Community – where care coordination and ***e***Health are utilized as means to better support people's health outside ("in the community") and with health support facilities in real time at anytime and anywhere.
- Quality/Health Improvement - where we build upon IOM work on quality, better use evidence-based care, and develop and use behavioral models for person and health support behavior to improve health support quality and health outcomes and status. One key focus is "right care for every person every time." Another key focus to more effectively use prevention and early intervention to avoid illness and disability.
- Un- and Underinsured - where we build upon IOM work on uninsured and develop and execute strategies that ensure affordability and solve the un- and under-insured problem in way supportable by key leaders and public.
- Virtual Health Systems - where we develop and use "virtual health system(s)" of electronic health records (EHR), personal health systems/records (PHS/R), information exchange (IE) and standards. Though "virtual health systems" are only part of the answer, creating communitywide health system requires the enabling "***e***".

Building Healthy Communities Vision and Strategy

As communities, we should proceed under the belief that communities can reach this vision via an endgame strategy of a high performance, communitywide health and long-term care system for all people that is self-perpetuating, affordable, accessible, "e" enabled, and producing high health quality, outcomes and status. Such a communitywide system, partly physical and partly virtual and put into place by collaborative private and

public partnerships, will greatly improve accessibility, quality and affordability for all people. Utilizing HealthePeople as an organizing strategy, we can build substantially healthier communities and move toward truly healthy communities. People deserve and should expect nothing less.

Chapter 6. HealthePeople® - Achieving Healthy People and Countries [15]

Ideal Country Health Systems - Person-Centered, Affordable, Accessible, Quality, Outcomes-Driven Country Health Systems

When achieving healthy people and countries, every country today has much to offer on both how to do it and how not to do it. America is an important example of both and provides useful lessons for every country wanting to achieve healthy people and a healthy country.

America is well thought of when it comes to specialty and super-specialty diagnostics and treatment for a single condition. Beyond that, America's reputation for the best health support is mixed. Today America spends 1/6th (about $2.5 trillion) of its national economy on health without producing healthy Americans or a healthy America. The 2010 Health Reform law is very helpful but is not enough. Without a quantum change in health vision, strategy and execution, America's future will be as disappointing as its past.

To achieve healthy people and healthy countries anywhere in the world, HealthePeople is a proposed national strategy whose near-term vision is to achieve substantially healthier people and a substantially healthier country. The long-term vision is to achieve healthy people and a healthy country. This HealthePeople strategy was created with the belief that a country can reach this vision via an endgame strategy of a high performance,

[15] Note the chapters on the world, countries and communities have some redundancy. Each chapter stands on its own when combined with the chapters on person-centered health and ideal health systems.

countrywide health and long-term care system for all people that is self-perpetuating, affordable, accessible, "e" enabled, and producing high health quality, outcomes and status. Such a country health system, partly physical and partly virtual and put into place by collaborative private and public partnerships, will greatly improve accessibility, quality and affordability for all of a country's people. Such a countrywide system can greatly improve health and help achieve healthy people and a healthy country.

Rationale

There is and should be little disagreement over the need for every country to have a substantially better health system. None of the key indicators – health status, accessibility, quality, affordability – are at acceptable levels for countries spending substantial amounts of their economy on health.

- **Accessibility –** Every country has accessibility issues, especially in inner city and rural areas. A collaborative partnership of people, public and private payers, and health organizations can substantially improve access for all people.
- **Quality –** Health status and outcomes produced by every country's health "system" are inadequate given the needs of the people and the proportion of the national economy expended. Too little of our medical and health knowledge is being effectively applied to prevent and treat health problems and to ensure health support is safe. A collaborative partnership of health organizations and the people they serve can substantially improve health support quality and health outcomes for all people.
- **Affordability –** The unaffordability of health support is challenging every country and their people as individuals and families (inhibiting needed access and causing bankruptcies). These problems continue to grow. A collaborative partnership (health organizations, the people they serve, and the people and organizations who pay) can much more effectively use a country's valuable health resources.

Some countries are spending enough money. Some are spending too little because of choice or lack of country financial resources. In every country, we are not getting the requisite payoff in terms of health outcomes/status or satisfaction.

Guidance

HealthePeople is a country strategy guided by and aligned with the Institute of Medicine (IOM) recommendations. IOM provides a way of viewing the health system's performance through the eyes of people themselves. What people want from a high performing health and long-term care system is that they are "staying healthy", "getting better", "living with illness or disability" or "coping with the end of life." Some people may experience more than one of these at the same time. IOM's quality reports have six aims for a high performing health system. They stress it should be safe, effective, person/patient-centered, timely, efficient, and equitable.

Utilizing their guidance, a very high performing health and long-term care system would perform well from the person's perspective and achieve the IOM aims. As depicted in the attached table, that very highly performing health system would "check all the boxes." (See "U.S. Institute of Medicine Six Aims & Person's Perspective on Health")

We need to recognize the following as key health drivers and use them to guide our work and measure our progress toward a healthy country:

- Maximize health status
- Maximize outcomes
- Maximize abilities
- Maximize satisfaction
- Maximize quality
- Maximize accessibility/ portability
- Maximize affordability
- Maximize patient safety (drive defects/errors to zero)
- Minimize time between disability/illness and maximized function/health (drive time to zero)
- Minimize inconvenience (drive inconvenience to zero)
- Maximize security & privacy

Institute of Medicine Six Aims & Person's Perspective on Health

Supportive of IOM principles and aims, Health**e**People supports health professionals/providers, persons/patients, and the rest of the health care system in continuing to innovate and find better ways to achieve key goals more effectively.

Person's Perspective on Health & LT Care Needs	Aims for Health & LT Care Performance/Quality					
	Safe	Effec-tive	Person/ Patient-centered	Timely	Efficient	Equi-table
Staying healthy	+	+	+	+	+	+
Getting better	+	+	+	+	+	+
Living with illness or disability	+	+	+	+	+	+
Coping with the end of life	+	+	+	+	+	+

"U.S. Institute of Medicine Six Aims & Person's Perspective on Health"

We need to understand and successfully deal with a country's health system complexity if we want to substantially improve health outcomes and health status for all people. The Figure below lays out the complexity

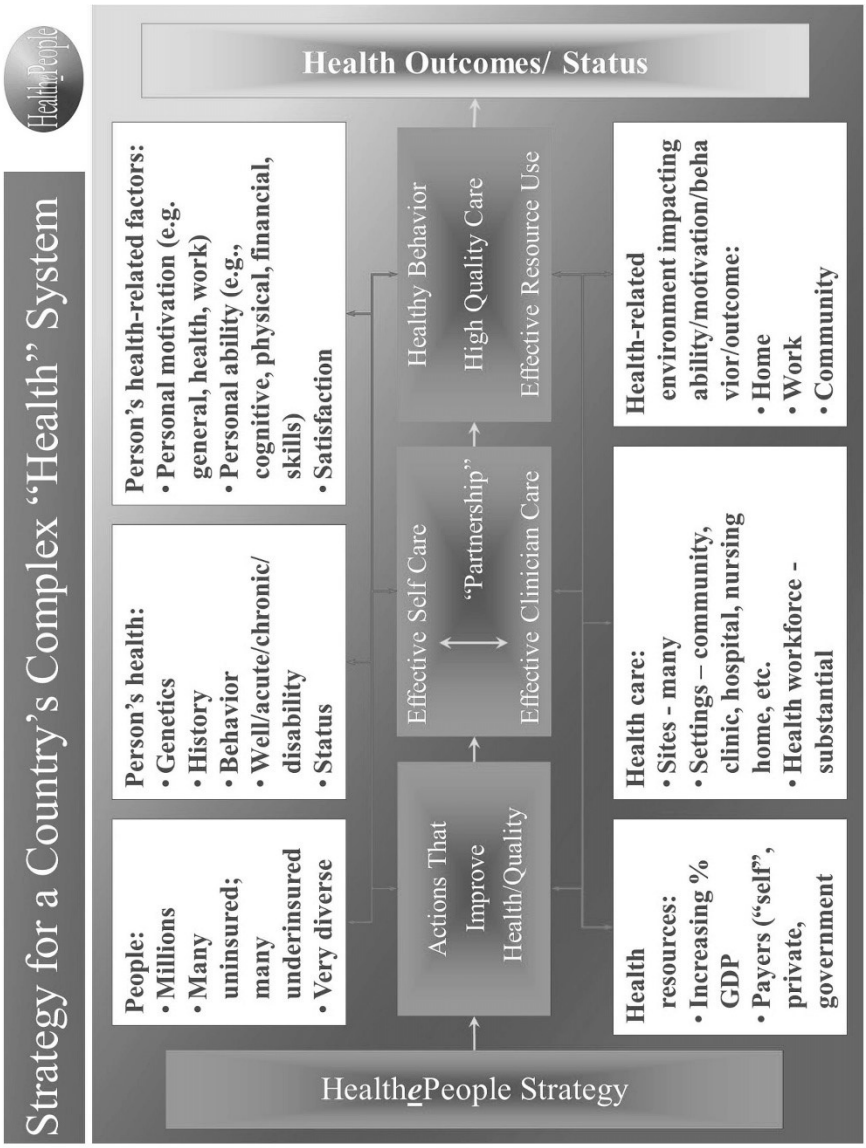
gauntlet which must be successfully run. (See "Strategy for a Complex Country's "Health" System") To be fully successful, we must address the people factors (population, diversity, insurance status, health factors, health-related factors) and the non-people factors (health resources, health support, health-related environmental factors). We must focus on a) affecting the actions that improve/reduce health quality to b) create a strong partnership between the person and their health support to c) improve health support quality and effective resource use those results to d) substantially improve health outcomes and status.

Vision, Endgame Strategy and Mission

The HealthePeople **near-term vision** – achieve substantially healthier people and a substantially healthier country - is far different than the one we can expect from our current glidepath. Much more so is the **long-term vision** - achieve healthy people and a healthy country. All current indicators and trends point to a future where access, quality and affordability continue to be unacceptable. Under a better vision and strategy with the same resource commitment, countries can achieve substantially healthier people and a substantially healthier country.

To reach this vision, the **endgame strategy** is to achieve a high performance, countrywide health and long-term care system for all people that is self-perpetuating, affordable, accessible, "e" enabled, and producing high health quality, outcomes and status. A country's health system should bring together and to bear the full force of people and their health support, their healthcare payers, their communities and their governments.

To reach this vision and endgame strategy, the **mission** is to create and support collaborative partnerships that help build a high performance, countrywide health and long-term care system for all people that is self-perpetuating, affordable, accessible, "e" enabled, and producing high health quality, outcomes and status. This unprecedented collaboration can achieve great progress as we have seen countries achieve historically on other national issues. HealthePeople achieves full success when a country's health system achieves and sustains healthy people and a healthy country.



"Strategy for a Country's Complex "Health" System"

Strategy for a Healthy Country

HealthePeople is a collaborative strategy to transform to affordable, person-centered, outcomes-driven, and "***e***" enabled health systems that help achieve better health. Succeeding with this strategy across all healthcare will positively transform health care. We can use a country's valuable health resources much more effectively, reduce vulnerability, and achieve much healthier people and a much healthier country. Within this strategy are two core elements:

- First, achieve affordable, accessible, and high quality/performance health systems. This involves more than medical interventions or traditional healthcare services. It requires a full range of health-related resources from across the community and beyond.
- Second, focus on people—consumers, patients, enrollees, and members. They are the center of the health universe and must be treated as such, forming strong partnerships between individual persons/patients and their health support.

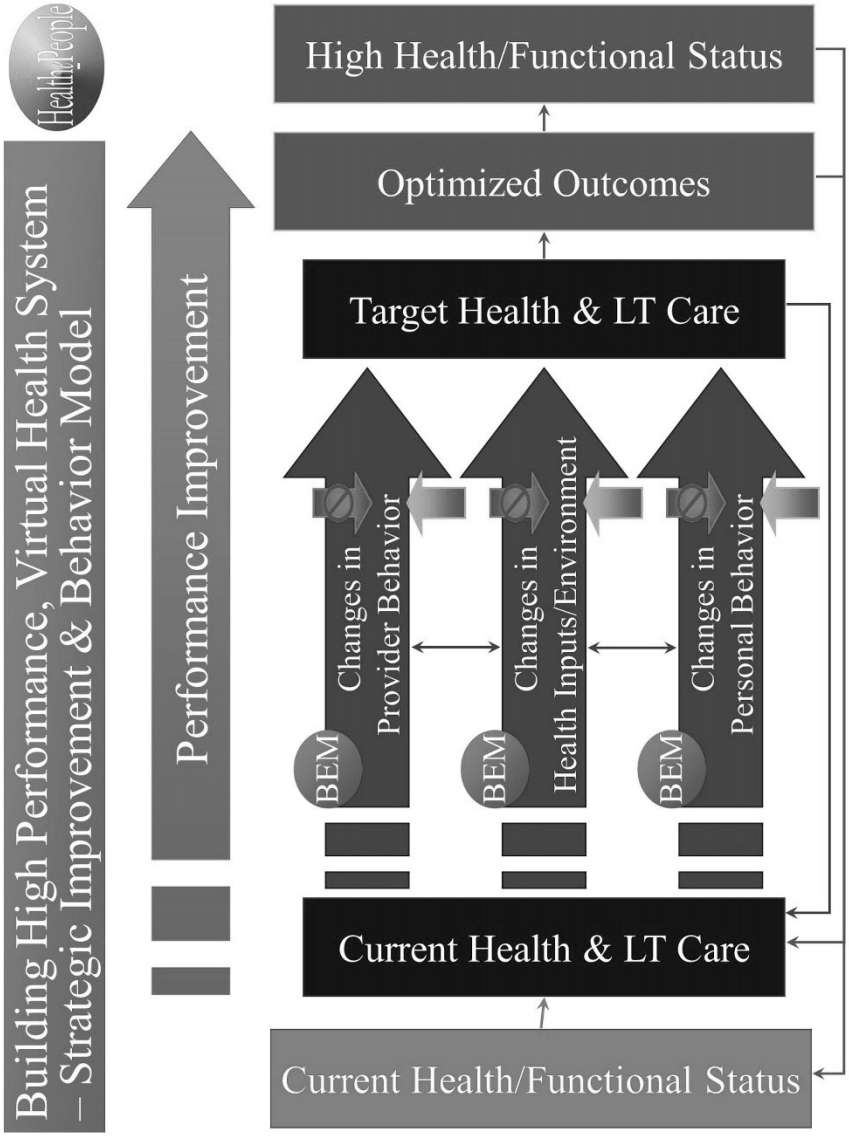
To build out the strategy and supportive strategies, this strategy utilizes a public health intervention model designed to help increase the number of healthy people and reduce the number of vulnerable and/or unhealthy people. (See "Achieving High Level of Health/Function & Effective Resource Use – Public Health Model) It targets interventions that best achieve the highest level of health and function, best prevent more poor health, and best move our most vulnerable people up from poor health. The success of the interventions is measured by the degree to which we stop actions that decrease health and support actions that improve health. Success is also measured by how well the private and public sectors, including health professional leadership, "move the numbers", i.e., substantially improving the key status indicators of health and function.

Within the model, there are interventions that improve health or make it worse. To improve health, there are the overall key strategic areas – stop those interventions/actions that make health worse support those interventions/actions that improve health. To improve health most, we need to execute a "systematic strategy" – a "system" of actions that continuously stops actions that push people down to less healthy states and supports actions that lift people out of poor health and toward being healthy. This "system" of actions, when well designed and executed, can perpetually prevent much poor health and support people moving up from poor health to being healthy.

"Achieving High Level of Health/Function & Effective Resource Use – Public Health Model"

The overall strategy is built upon a strategic improvement and behavior model for health. Using the model depicted below, we need to set the target health and functional status we are trying to achieve under the vision "healthier/healthy people". (See "Building High Performance, Virtual Health System – Strategic Improvement and Behavior Model") Given the target status, we can decide on the target outcomes needed and on the target health system needed to achieve those outcomes. Comparing the optimized outcomes and health system with the current health system and its performance, we can determine the "delta", i.e., the needed improvements in the current health system and its outcomes.

Knowing what needs to be improved, we can then determine what personal and health provider behaviors should change. Human behavior, both by persons (beneficiaries, enrollees, consumers, patients) and health providers, is key to making and sustaining the improvements. The behavioral model BEM helps us think through how we bring about the behavior change necessary to make the improvements. Together, the system and behavior changes are intended to produce improved health and functional status for all of a country's people.

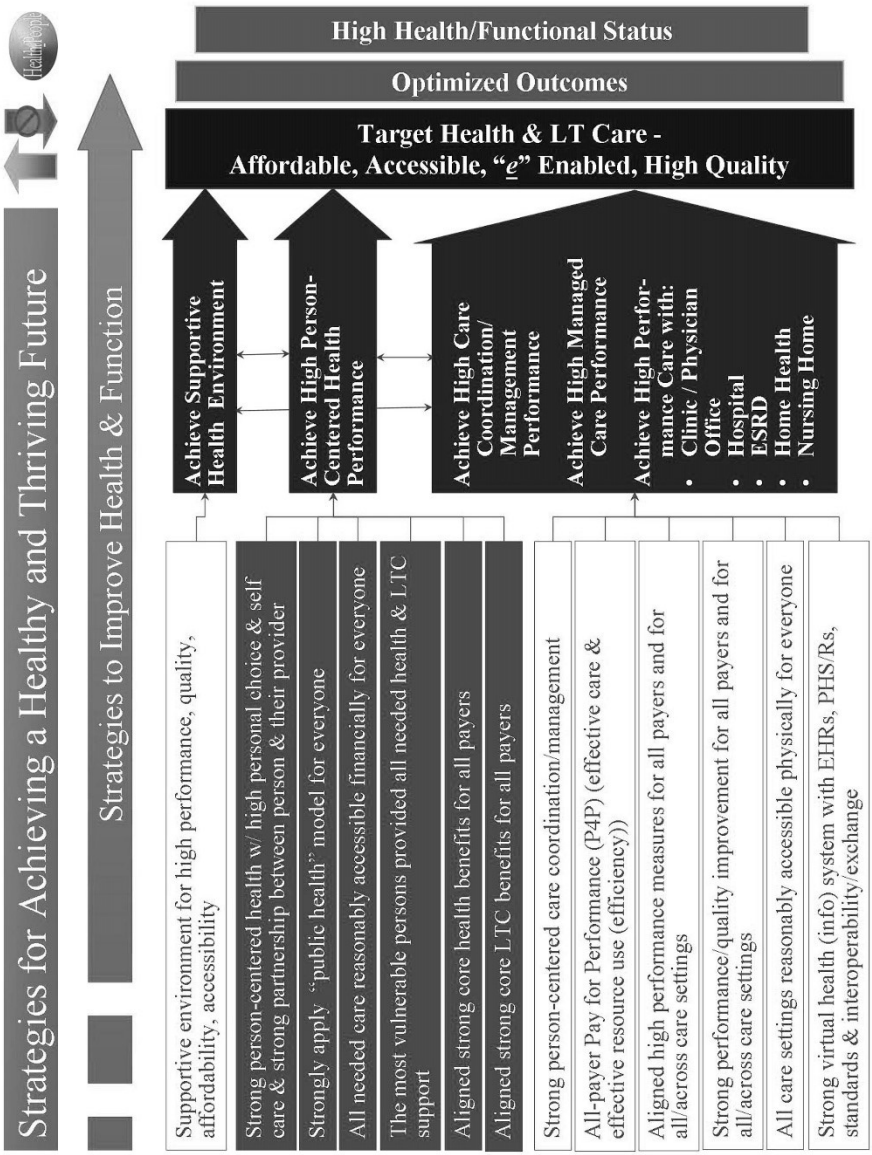


"Building High Performance, Virtual Health System – Strategic Improvement and Behavior Model"

Under the HealthePeople vision and overall strategy and using supportive strategies and models, we can positively transform a country's overall health system and achieve a healthier country by successfully applying the following 15 supportive strategies:

1. Create a supportive environment for high performance, quality, affordability, accessibility
2. Support strong person-centered health with high personal choice, self-care and a strong partnership between the person and their health support to improve resource use and health outcomes
3. Support strongly and collaboratively applying "public health" model
4. Support all needed care reasonably accessible financially
5. Support the most vulnerable persons being provided all needed health and long-term care (LTC) support
6. Support strong core health benefits
7. Support strong core LTC benefits
8. Support strong person-centered care coordination/management
9. Support effectively using prevention to avoid illness and disability and associated cost
10. Help ensure long term affordability
11. Support pay for effective care & effective resource use
12. Support aligned high performance measures for all/across care settings
13. Support strong quality/performance improvement for all/across care settings
14. Support all care settings being reasonably accessible physically
15. Support strong virtual health (info) system with EHRs, PHS/Rs, standards & interoperability/exchange

The following Figure lays out from right to left how a) high health and functional status is produced by b) optimizing health outcomes which are produced by c) an affordable, accessible, "e" enabled and high-quality health system which is produced and enhanced by d) a supportive health environment and high person-centered and health support performance which is produced by e) the successful application of 15 strategies. (See "Strategies for Achieving a Healthy and Thriving Future")



"Strategies for Achieving a Healthy and Thriving Future"

While all 15 supportive strategies are essential, there are several strategies that have unique potential and deserve elaboration and greater attention:

- Person-Centered Health - where the person a) is at the center of self-care, formal health support and informal health support and b) has that health care/support coordinated via an effective person and health support partnership.
- High Performance Health Systems - where the best systems design and operational thinking is applied to and across the full range of health support settings from individual clinics to hospitals to integrated health systems.
- Care in the Community – where care coordination and ***e***Health are utilized as means to better support people's health outside ("in the community") and with health care facilities in real time at anytime and anywhere.
- Quality/Health Improvement - where we build upon IOM work on quality, better use evidence-based care, and develop and use behavioral models for person and health support behavior to improve health care quality and health outcomes and status. One key focus is "right care for every person every time." Another key focus to more effectively use prevention and early intervention to avoid illness and disability.
- Un- and Underinsured - where we build upon IOM work on uninsured and develop and execute strategies that ensure affordability and solve the un- and under-insured problem in way supportable by key leaders and public.
- Virtual Health Systems - where we develop and use "virtual health system(s)" of electronic health records (EHR), personal health systems/records (PHS/R), information exchange (IE) and standards. Though "virtual health systems" are only part of the answer, creating countrywide health system requires the enabling "***e***".

Building Healthy Countries Vision and Strategy

As countries, we should proceed under the belief that countries can reach this vision via an endgame strategy of a high performance, countrywide health and long-term care system for all people that is self-perpetuating, affordable, accessible, "e" enabled, and producing high health quality, outcomes and status. Such a countrywide system, partly physical and partly virtual and put into place by collaborative private and public partnerships,

will greatly improve accessibility, quality and affordability for all people. Utilizing HealthePeople as an organizing strategy, we can build substantially healthier countries and move toward truly healthy countries. People deserve and should expect nothing less.

Chapter 7. HealthePeople® - Achieving Healthy People and World [16]

Ideal Global Health System - Person-Centered, Affordable, Accessible, Quality, Outcomes-Driven Global Health System

Throughout the world, we face major challenges and disappointments in achieving healthy people, communities, countries and world. Without a large change in health vision, strategy and execution, our future will be as disappointing as our past. To positively change that future, HealthePeople is a strategy whose near-term vision is to achieve substantially healthier people, communities, countries and world. The long-term vision is to achieve healthy, thriving people globally and a healthy, thriving world. This HealthePeople strategy was created with the belief that we can reach this vision via an endgame strategy of high performance, health systems for all people that are self-perpetuating, affordable, accessible, "e" enabled, person-centered, prevention-oriented, and producing high health quality, outcomes and status. Such systems, partly physical and partly virtual and put into place by collaborative private and public partnerships, will greatly improve accessibility, quality, affordability and health status for all people. Such global systems can help achieve healthy people and a healthy, thriving world.

Rationale

[16] Note the chapters on the world, countries and communities have some redundancy. Each chapter stands on its own when combined with the chapter on person-centered health.

There is and should be little disagreement over the need for the world to have substantially better health and supportive health systems and to better integrate them. Every country has its own set of issues that fail to produce a sufficient level of health. Health issues do not just affect a particular country and can easily spill across country borders.

- **Accessibility** – Globally, needed health (including long term care) services are insufficiently available and/or accessible to many people, communities and countries, especially rural and inner-city communities. A collaborative partnership of people, public and private payers, and health support organizations can substantially improve access for all people.
- **Quality** – Globally, health status and outcomes produced by current health systems are inadequate given the needs of people. Too little of our medical and health knowledge is being effectively applied to effectively prevent and treat health problems, to ensure health support is safe and to achieve high health status.[17] A collaborative partnership of health support organizations and the people they serve can substantially improve health support quality, health outcomes and health status for all people.
- **Affordability** – The unaffordability of health support is particularly challenging throughout the world. Without further action, these problems will continue to grow. Some countries (like America) are spending enough money. Other countries vary widely on the relationship between spending and need. We are not getting the requisite payoff in terms of health outcomes/status or satisfaction. A collaborative partnership (health support organizations, the people they serve, and the people and organizations who pay) can much more effectively use valuable health resources and ensure affordability.
- **Global Health Support** – Many illnesses, especially infectious diseases, do not respect country borders. The ease and amount of international travel, the movement of food and other goods, and the movement of infectious disease carriers increase the risk of infectious disease spread. Further, people do not always experience illness or injury in their home country and must depend on another country's health system for health support. Across the world, a

[17] Health Support – May include physicians, nurses, dentists, optometrists, pharmacists, clinics, urgicare, emergency departments, hospitals, rehabilitation facilities, home care, nursing homes, assisted living, alternative health/medicine, and others.

collaborative partnership of health support organizations and the people they serve can substantially improve health support to improve health support quality, health outcomes and health status for all people.

Guidance

HealthePeople is a strategy guided by and aligned with the U.S. Institute of Medicine (IOM) recommendations. IOM provides a way of viewing a global health system's performance through the eyes of people themselves. What people want from a high performing health and long-term care system is that they are "staying healthy", "getting better", "living with illness or disability" or "coping with the end of life." Some people may experience more than one of these at the same time. IOM's quality reports have six aims for a high performing health system. They stress it should be safe, effective, person/patient-centered, timely, efficient, and equitable.

Utilizing their guidance, a very high performing global health and long-term care system would perform well from the person's perspective and achieve the IOM aims. As depicted in the attached table, that very highly performing health system would "check all the boxes." (See "U.S. Institute of Medicine Six Aims & Person's Perspective on Health")

We need to recognize the following as key health drivers and use them to guide our work and measure our progress toward healthy people and a healthy world:

- Maximize health status
- Maximize outcomes
- Maximize abilities
- Maximize satisfaction
- Maximize quality
- Maximize accessibility/ portability
- Maximize affordability
- Maximize patient safety (drive defects/errors to zero)
- Minimize time between disability/illness and maximized function/health (drive time to zero)
- Minimize inconvenience (drive inconvenience to zero)
- Maximize security & privacy

Institute of Medicine Six Aims & Person's Perspective on Health

Supportive of IOM principles and aims, HealthePeople supports health professionals/providers, persons/patients, and the rest of the health care system in continuing to innovate and find better ways to achieve key goals more effectively.

Person's Perspective on Health & LT Care Needs	Aims for Health & LT Care Performance/Quality					
	Safe	Effec-tive	Person/ Patient-centered	Timely	Efficient	Equi-table
Staying healthy	+	+	+	+	+	+
Getting better	+	+	+	+	+	+
Living with illness or disability	+	+	+	+	+	+
Coping with the end of life	+	+	+	+	+	+

"U.S. Institute of Medicine Six Aims & Person's Perspective on Health"

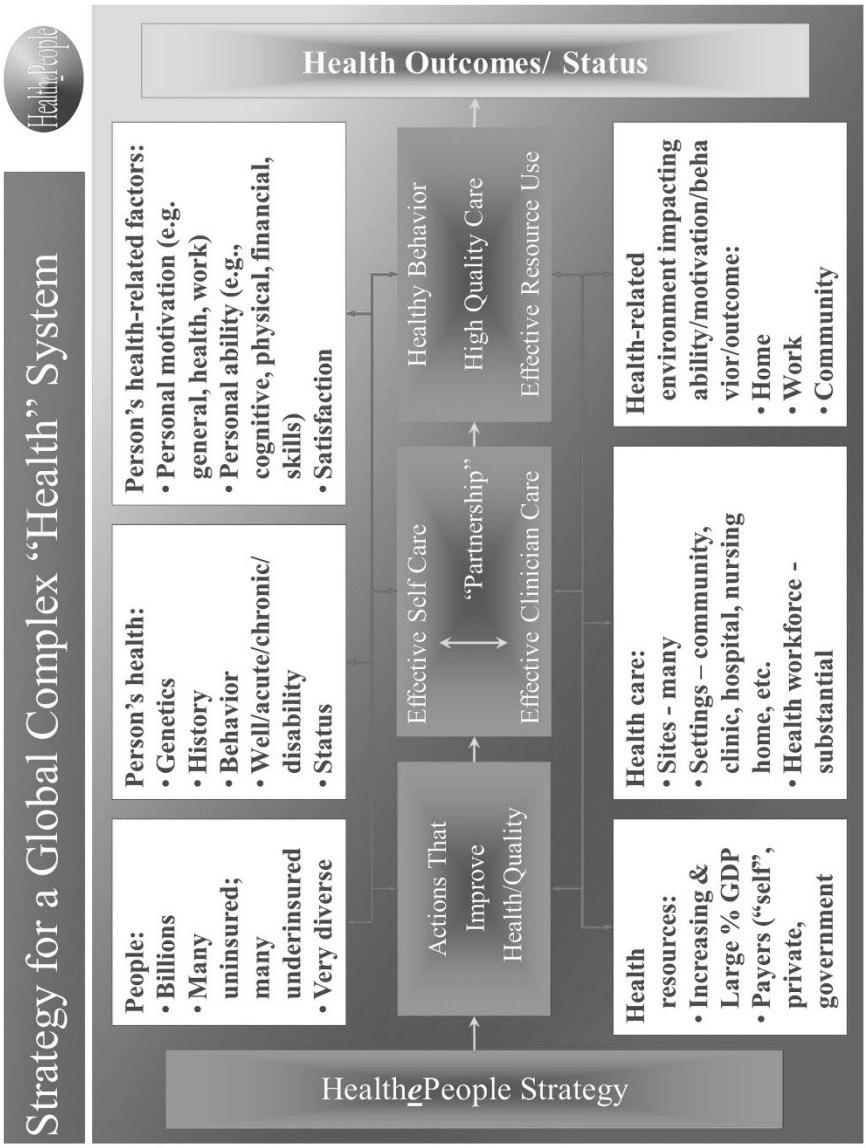
We need to understand and successfully deal with every community and country's health system complexity from a global perspective if we want to substantially improve health outcomes and health status for all people worldwide. The Figure below lays out the complexity gauntlet which must be successfully run for a country. (See "Strategy for a Global Complex Health" System") To be fully successful, we have to address the people factors (population, diversity, insurance status, health factors, health-related factors) and the non-people factors (health resources, health support, health-related environmental factors). We should focus on a) affecting the actions that improve health quality to b) create a strong partnership between the person and their health support to c) achieve healthy behavior, high health support quality and effective resource and to use these to d) substantially improve health outcomes and status.

Vision, Strategy and Mission

Thrive!® is the overall vision, mission and strategy for achieving and sustaining a thriving future across the world. Within that future, **HealthePeople**® is the vision, mission and strategy for achieving and sustaining health and well-being across the world.

The HealthePeople **near-term vision** – achieve substantially healthier people and a substantially healthier world - is far different than the one we can expect from our current glidepath. Much more so is the **long-term vision** - achieve healthy and thriving people and a healthy and thriving world. All current indicators and trends point to a future where access, quality, affordability, and health status continue to be unacceptable. Under a better vision and strategy with the same resource commitment, we can achieve healthy people and a healthy world.

To reach this vision, the **strategy** is to achieve high performance, health systems for all people that are self-perpetuating, affordable, accessible, "e" enabled, person-centered, prevention-oriented, and producing high health quality, outcomes and status. Effective health systems should bring together and bring to bear the full force of people with their health support, their healthcare payers, their communities and their governments.



"Strategy for a Global Complex "Health" System"

To reach this vision and strategy, the **mission** is to create and support collaborative partnerships that help build and sustain high performance, health systems for all people that are self-perpetuating, affordable, accessible, "e" enabled, person-centered, prevention-oriented, and producing high health quality, outcomes and status. This unprecedented collaboration can achieve great progress as we have seen countries achieve historically on other countrywide issues. HealthePeople achieves full success when health systems achieve and sustain healthy and thriving people and a healthy and thriving world.

Strategy for a Healthy and Thriving Future

HealthePeople is a collaborative strategy to transform to affordable, person-centered, prevention-oriented, outcomes-driven, and "***e***" enabled health systems that help achieve better health. Succeeding with this strategy across all of health will positively transform health support. We can use our world's valuable health resources much more effectively, reduce vulnerability, and achieve much healthier people and a much healthier world. Within this strategy are two core elements:

- First, achieve affordable, accessible, and high quality/performance health systems. This involves more than medical interventions or traditional healthcare services. It requires a full range of health-related resources and support from across a community, across a country, and globally.
- Second, focus on people—consumers, patients, enrollees, and members. They are the center of the health universe and must be treated as such, forming strong partnerships between individual persons and their health support.

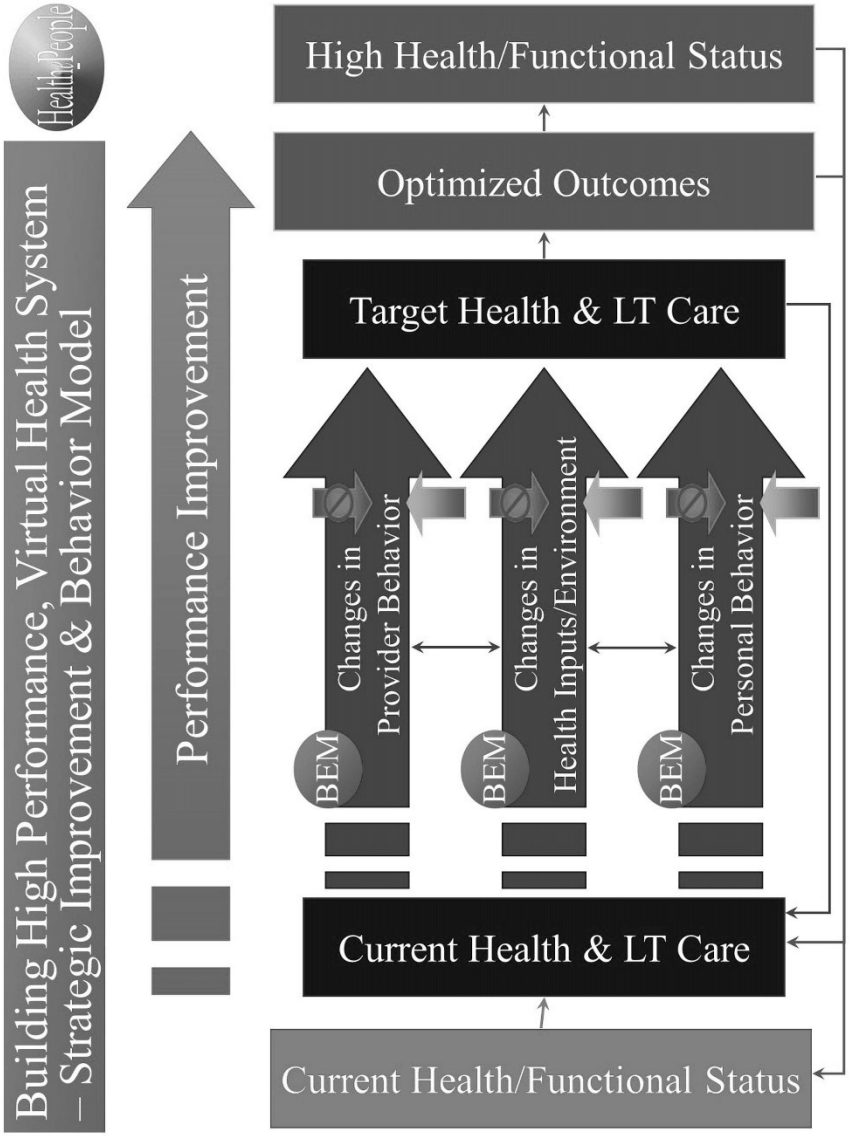
To build out the strategy and supportive strategies, this strategy utilizes a public health intervention model designed to help increase the number of healthy people and reduce the number of vulnerable and/or unhealthy people. (See "Achieving A Healthy and Thriving Future") This model applies to people worldwide. It targets interventions that best achieve the highest level of health and function, best prevent more poor health, and best move our most vulnerable people up from poor health. The success of the interventions is measured by the degree to which we stop actions that decrease health and support actions that improve health. Success is also measured by how well the private and public sectors, including health professional leadership, "move the numbers", i.e., substantially improving the key status indicators of health and function.

"Achieving A Healthy & Thriving Future"

Within the model, there are interventions that improve health or make it worse. To improve health, there are the overall key strategic areas – stop those interventions/actions that make health worse and support those interventions/actions that improve health. To improve health most, we need to execute a "systematic strategy" – a “system” of actions that continuously stops actions that push people down to less healthy states and supports actions that lift people out of poor health and toward being healthy. This “system” of actions, when well designed and executed, can perpetually prevent much poor health and support people moving up from poor health to being healthy.

The overall strategy is built upon a strategic improvement and behavior model for health. Using the model depicted below, we need to set the target health and functional status we are trying to achieve under the vision “healthier/healthy people globally”. (See “Building High Performance, Virtual Health System – Strategic Improvement and Behavior Model”) This model applies as well to health systems throughout the world. Given the target status, we can decide on the target outcomes needed and on the target health system needed to achieve those outcomes. Comparing the optimized outcomes and health system with the current health system and its performance, we can determine the “delta”, i.e., the needed improvements in the current health system and its outcomes.

Knowing what needs to be improved, we can then determine what personal and health support behaviors should change. Human behavior, both by persons (beneficiaries, enrollees, consumers, patients) and health support, is key to making and sustaining the improvements. The behavioral model BEM helps us think through how we bring about the behavior change necessary to make the improvements. Together, the system and behavior changes are intended to produce improved health and functional status for all people globally.



"Building High Performance, Virtual Health System – Strategic Improvement and Behavior Model"

Under the HealthePeople vision, overall strategy and models, we can positively transform health systems and achieve a healthier world by successfully applying the following 15 supportive strategies:

1. Create a supportive environment for high performance, quality, affordability, accessibility
2. Support strong person-centered health with high personal choice, self-care and a strong partnership between the person and their health support to improve resource use and health outcomes
3. Support strongly and collaboratively applying "public health" model
4. Support all needed care reasonably accessible financially
5. Support the most vulnerable persons being provided all needed health and long-term care (LTC) support
6. Support strong core health benefits
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8. Support strong person-centered care coordination/management
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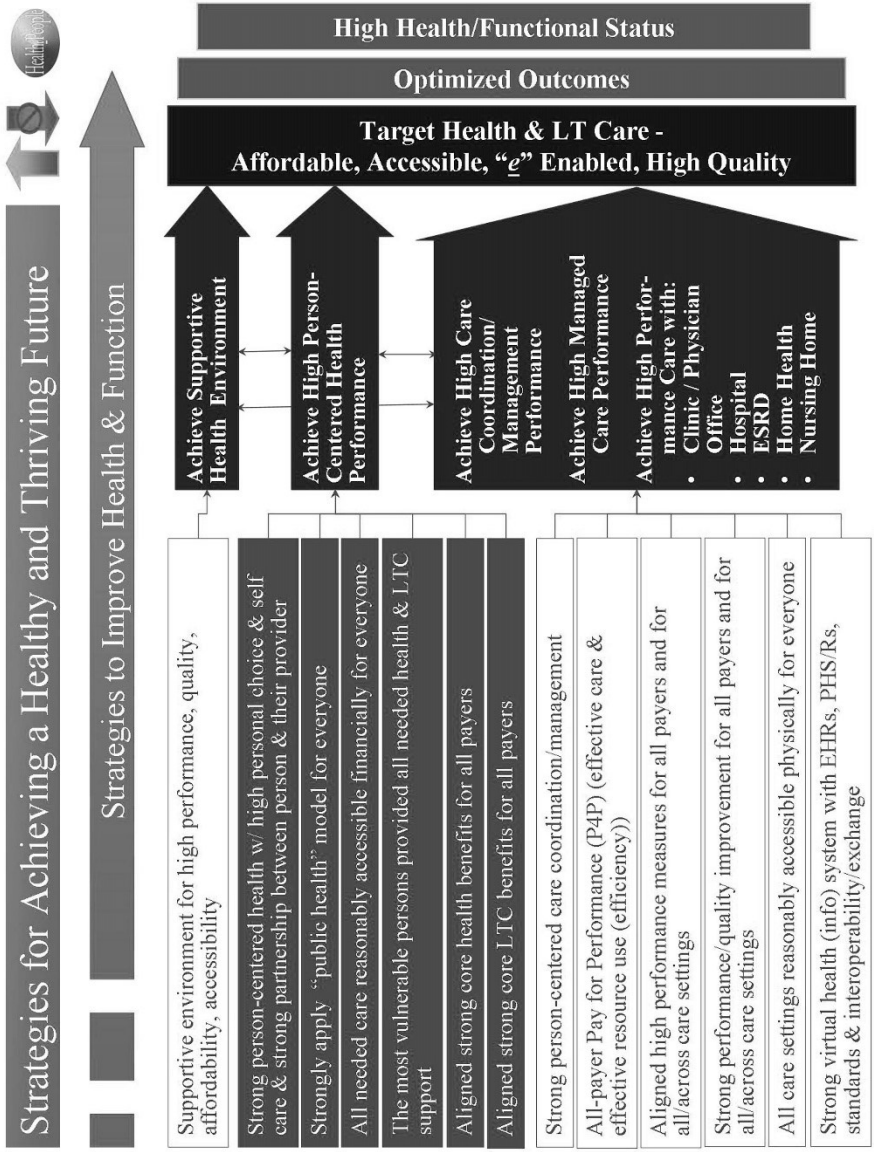
10. Help ensure long term affordability
11. Support pay for effective care & effective resource use
12. Support aligned high performance measures for all/across care settings
13. Support strong quality/performance improvement for all/across care settings
14. Support all care settings being reasonably accessible physically
15. Support strong virtual health information system with EHRs (electronic health records), PHS/Rs (personal health systems/records), information standards & information interoperability and exchange

The following Figure lays out from right to left how a) high health and functional status is produced by b) optimizing health outcomes which are produced by c) an affordable, accessible, "e" enabled and high-quality health system which is produced and enhanced by d) a supportive health environment and high person-centered and health care performance which is produced by e) the successful application of 15 strategies. (See "Strategies for Achieving a Healthy and Thriving Future")



"Strategies for Achieving a Healthy and Thriving Future"

While all 15 supportive strategies are essential, there are several strategies that have unique potential and deserve elaboration and greater attention:

- Person-Centered Health - where the person a) is at the center of self-care, formal health support and informal health support and b) has that health support coordinated via an effective person and health support partnership.
- High Performance Health Systems - where the best systems design and operational thinking is applied to and across the full range of health support settings from individual clinics to hospitals to integrated health systems to public health to non-traditional health support.
- Care in the Community – where care coordination and ***e***Health are utilized as means to better support people's health outside ("in the community") and with health support facilities in real time at anytime and anywhere.
- Quality/Health Improvement - where we build upon IOM work on quality, better use evidence-based care, and develop and use behavioral models for person and health support behavior to improve health support quality and health outcomes and status. One key focus is "right care for every person every time." Another key focus to more effectively use prevention and early intervention to avoid illness and disability.
- Un- and Underinsured - where we build upon IOM work on uninsured and develop and execute strategies that ensure affordability and solve the un- and under-insured problem in way supportable by key leaders and public.
- Virtual Health Systems - where we develop and use "virtual health system(s)" of electronic health records (EHR), personal health systems/records (PHS/R), information exchange (IE) and information standards. Though "virtual health systems" are only part of the answer, creating an effective health system requires the enabling "***e***".

HealthePeople Vision and Strategy for a Healthy and Thriving Future

As communities, countries and world, we should proceed under the belief that we can reach this vision via an endgame strategy of high performance, health systems for all people that are self-perpetuating, affordable, accessible, "e" enabled, person-centered, prevention-oriented, and producing high health quality, outcomes and status. Such health systems,

partly physical and partly virtual and put into place by collaborative private and public partnerships, will greatly improve accessibility, quality and affordability for all people worldwide. Utilizing HealthePeople as an organizing strategy, we can build a substantially healthier world and move toward a truly healthy and thriving world. People across the world deserve and should expect nothing less.

Chapter 8. *Thrive!*® and HealthePeople® - Achieving Healthy and Thriving Future for All

Ideal System for Achieving Healthy and Thriving Future for All

Thriving! Healthy! Vulnerable! These are the keys to a call for creating and sustaining large, positive and timely change and building a healthy and thriving future. We are all vulnerable to a some extent but that can change for the better. ***Thrive!***® is that call to action and a rallying cry for a better and thriving future. **HealthePeople**® is that call to action and a rallying cry for a healthy future. It is a vision and a mission for those wanting to build a better future. To achieve that vision and succeed with the mission, all of us together must strives to energize and empower people to build a healthy and thriving future for ourselves, and our families and friends, communities, countries and world. We must strive to build, achieve and sustain a healthy and thriving future for all forever, to the maximum extent possible.

To truly have a healthy and thriving future, we need to have it for you and everybody's family and friends and every community and every country and every part of and our entire world. When all this comes together, you and all of us will have built, achieved and sustained a healthy and thriving future.

How best to do this? We bring all this together with **Thrive!** and **HealthePeople** where you and all of us together, build, achieve and sustain a healthy and thriving future for all forever.

The endeavor is all of us together. It is vision, mission, strategy and call to action. Its vision is a healthy and thriving future for all forever. Its mission

is to create and sustain large positive and timely change that builds, achieves and sustains a healthy and thriving future for all forever, to the maximum extent possible. Its strategy is to energize and empower all of us together in the vast, sustained human endeavor building and sustaining a healthy and thriving future. Its call for action is to motivate all of us (individual people, groups of people, private sector organizations, governments) to seek a healthy and thriving future, to create and sustain the necessary large positive change, and to work together to build, achieve and sustain a healthy and thriving future.

The endeavor is all of us together building, achieving and sustaining a healthy and thriving future. "All of us together" include individual people, groups of people, private sector organizations and governments. "All of us together" include current and future generations. "All of us together" include you, and everybody's family and friends, and every community, and every country, and every part of and our entire world.

What the endeavor does and how it does it is different than past and current approaches which have major limitations and defects. It is unique and better because it:

- Strives to achieve a healthy, thriving and sustainable future for all forever, to the maximum extent possible.
- Enables the building of a healthy and thriving future for you, your family and friends, your community, your country and our world.
- Joins people of all backgrounds/generations together to achieve a healthy and thriving future.
- Addresses every person, community, country and global issue.
- Uses whole "community" (local, regional, state, country, world/global) strategy for creating and sustaining change and building healthy and thriving futures.
- Uses whole "person" strategy for creating and sustaining change and building healthy and thriving futures.
- Uses whole "system" (community, health, education, economy, housing, etc.) strategy for creating and sustaining change and building healthy and thriving futures.
- Takes an integrated approach to cross-cutting issues.

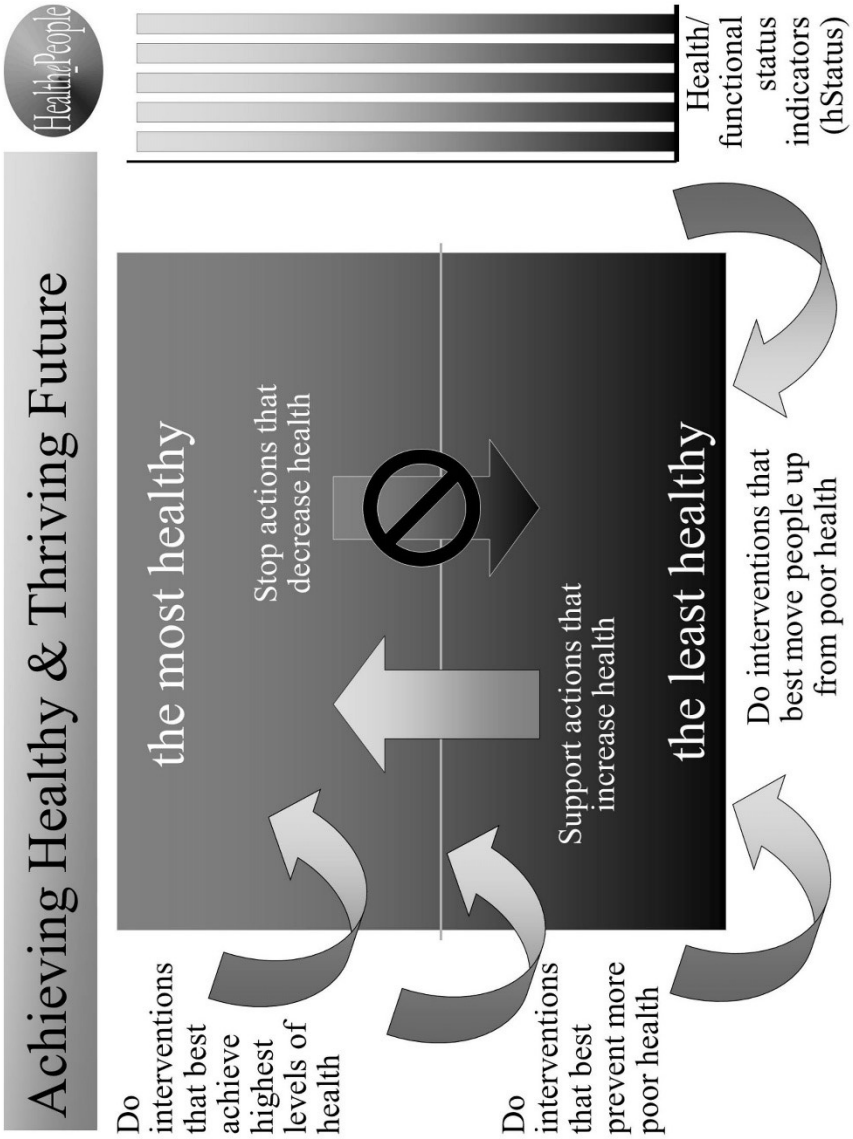
- Uses an integrated approach to people/environment strategy, change and healthy/thriving futures.
- Uses a "person-centered" strategic approach that recognizes people's behaviors are the problem and the solution.
- Uses behavior models (including BEM) and tools to help each and all of us achieve the desired behavior necessary to a healthy and thriving future.
- Uses eMedia and social networking to expand communication and joint action and to activate and coordinate a large endeavor in "real time".
- Uses strategic/operational planning and combines it with strategic/operational management and execution.
- Uses the **HealthePeople** and ***Thrive!*** strategy, models and tools to create and sustain change and build thriving futures.
- Creates a collaborative strategy with the necessary positive actions to build, achieve and sustain a surviving and thriving future.

Each and all of us should develop and take as many positive actions as we can to improve health. The more positive actions taken, the better for all of us. Each and all of us should help build, achieve and sustain a healthy and thriving future for our family and friends. Each and all of us should help build, achieve and sustain a healthy and thriving future for our community. Each and all of us should help build, achieve and sustain a healthy and thriving future for our country. Each and all of us should help build, achieve and sustain a healthy and thriving future for our world, including the Earth on which we depend. Via these actions and the endeavor, each and all of us together should build, achieve and sustain a surviving and thriving future.

What positive actions are needed to bring about the needed changes that improve our current health status enough to achieve the desired healthy and thriving status? [See “Achieving a Healthy and Thriving Future”

Each and all of us identify actions that support good changes that will help reduce vulnerability and/or improve and/or sustain health and thriving. If good changes are likely to occur, together we support them. If good changes are not likely to occur, together we support them and develop other good changes to compensate.

Each and all of us identify actions that stop bad changes that increase vulnerability and/or prevent or limit health and thriving. If bad changes are not likely to occur, together we ensure they do not. If bad changes are likely to occur, together we change them, stop them or avoid/reduce their impact.



"Achieving a Healthy and Thriving Future"

Via the endeavor, all of us together develop our strategy and successfully take the actions to ensure a healthy and thriving future.

When successful, we and all future generations achieve the healthy and thriving future.

When successful, it is more than just people being healthy and thriving. The Earth upon which we depend should be healthy and thriving.

At this time, we should proceed under the belief that we can reach this vision via the above visions and strategies. Utilizing **HealthePeople** and ***Thrive!*** as organizing strategies, we can build a substantially healthier and more thriving world and move toward healthy and thriving people and a truly healthy and thriving future. People, whoever they are, wherever they live and whatever their status, deserve and should expect nothing less.

Appendix - Ideal Community Health Systems

Ideal Community Health System - Most limited resources (rural/remote)

System Element	Community/ Country Most limited resources (rural/remote)
System - person success measure *	I'm healthy and I stay healthy or become very healthy. I'm functioning well and I continue to function well or function even better. I'm ill and/or not functioning well and I get better. I risk getting worse and I don't get worse. I'm chronically ill and I successfully manage. I have a disability and I successfully cope. I'm near end of life and I successfully cope.
System - success measure	Healthy people, community, country and world
System - drivers for health	Maximize health status, maximize outcomes, maximize abilities, maximize satisfaction, maximize quality, maximize accessibility/ portability, maximize affordability, maximize patient safety (drive defects/errors to zero), minimize time between disability/illness and maximized function/health (drive time to zero), minimize inconvenience (drive inconvenience to zero), maximize security & privacy
System - support for person	Supports "staying healthy", "getting better", "living with illness or disability" or "coping with the end of life."
System - characteristics	System is safe, effective, person/patient-centered, timely, efficient, and equitable providing, to extent feasible, comprehensive health support.
System - affordability	Affordable for person and any other payer. People with limited resource receive needed support from community and/or country.
System - accessibility	Accessible (time, distance, availability) for every person.
System - quality	High quality processes produce positive outcomes and high health status. "Right care for every person every time."
System - safety	Safe an environment as possible in which to receive health support.
System - design and operations	Best systems design and operational thinking is applied to and across the full range of health support.
System - dynamic and interactive	System is dynamic as locations for health interventions change, as person changes, as people providing health

	support change, and as events unfold for person and, her/his "health system" and "health environment". Is interactive where influences are interacting with each other to change how they impact the person and health.
System - collaborative partnership	Collaborative partnership of people, public and private payers, and health care organizations substantially improves access, affordability, quality and health status for all people.
System - public health	Public health approach to community health linking with personal health support.
System – community and country support	Health system earns and has strong support from community and country.
System – health support **	Best mix of resources within and outside of community. The fewer the resources within the more outside resources should be used. Connect with outside resources using full range of virtual means – phone, internet, etc. Share health records as appropriate. Refer to outside resources when outside expertise within community. Many resources will be needed from outside community.
System - health records	Sharable, comprehensive health records to extent feasible. Paper if necessary; electronic health records if feasible; standardized data; information share encrypted via internet. Use "virtual health system(s)" of electronic health records (EHR), personal health systems/records (PHS/R), information exchange (IE) and information standards to extent feasible.
Person - person-centered health	Person-centered health support for whole person and maximizing choice and self-care. Special attention to most vulnerable persons.
Person - healthy partners	Healthy Partners as strong partnership between person and their health support to improve resource use and health outcomes.
Person - family and community support	Family and community support of person helps avoid things that harm health and provides support that improves health.
Person - human behavior	Successfully address human behavior as key to achieving health. Partner with person on motivation and ability that positively affect key behaviors that improve health and avoid harming health.
Person - history, genetics and environment	Partner with person to incorporate history, environment and genetic factors into any strategy that improves health and avoids further harming health.
Health Support - health home	Partnership between person and primary health support creates mutually agreeable "health home providing

	trustworthy, comfortable provider and place, provides or facilitates a person-accessible repository (actual or virtual) for all of the person's health information (including the complete health record), and works to monitor and improve the whole health of the whole person across all settings and across all preventive, primary and specialty care.
Health Support - use best support	Best health support (prevention, diagnosis, treatment, rehabilitation) for person. Should be safe, efficacious and effective. Should not be limited to "modern medicine".
Health support - care in community	Much of health's interventions occur outside health care facilities and in the community. Much is self-care.
Health support - care coordination	Care coordination helps people with multiple conditions and multiple sources of health support.
Health Support - prevention	Prevention of illness and injury should be primary strategy at the person and community level.
Health Support - evidence-based	Obtain/use evidence-based health support. Obtain via internet and/or as integrated into electronic health record. Use trusted sources. Address co-morbidity. Avoid conflicting therapies.
Health support - payment	Payment to health support based on effective care and resource use. Payment affordable, fair, and value-based.
Health support - privacy	Protects privacy of health care and information, especially particularly sensitive information such as sexually transmitted diseases, drug and alcohol abuse/misuse, and mental illness.

* Person – person whose health should be optimized and for whom health system and support is being provided

** Health Support – May include physicians, nurses, dentists, optometrists, pharmacists, clinics, urgicare, emergency departments, hospitals, rehabilitation facilities, home care, nursing homes, assisted living, alternative health/medicine, and others.

Ideal Community Health System - Moderate resources (mix rural/remote & urban)

System Element	Community/ Country Moderate resources (mix rural/remote & urban)
System - person success measure *	I'm healthy and I stay healthy or become very healthy. I'm functioning well and I continue to function well or function even better. I'm ill and/or not functioning well and I get better. I risk getting worse and I don't get worse. I'm chronically ill and I successfully manage. I have a disability and I successfully cope. I'm near end of life and I successfully cope.
System - success measure	Healthy people, community, country and world
System - drivers for health	Maximize health status, maximize outcomes, maximize abilities, maximize satisfaction, maximize quality, maximize accessibility/ portability, maximize affordability, maximize patient safety (drive defects/errors to zero), minimize time between disability/illness and maximized function/health (drive time to zero), minimize inconvenience (drive inconvenience to zero), maximize security & privacy
System - support for person	Supports "staying healthy", "getting better", "living with illness or disability" or "coping with the end of life."
System - characteristics	System is safe, effective, person/patient-centered, timely, efficient, and equitable providing comprehensive health support.
System - affordability	Affordable for person and any other payer. People with limited resource receive needed support from community and/or country.
System - accessibility	Accessible (time, distance, availability) for every person.
System - quality	High quality processes produce positive outcomes and high health status. "Right care for every person every time."
System - safety	Safe an environment as possible in which to receive health support.
System - design and operations	Best systems design and operational thinking is applied to and across the full range of health support.
System - dynamic and interactive	System is dynamic as locations for health interventions change, as person changes, as people providing health support change, and as events unfold for person and, her/his "health system" and "health environment". Is interactive

	where influences are interacting with each other to change how they impact the person and health.
System - collaborative partnership	Collaborative partnership of people, public and private payers, and health care organizations substantially improves access, affordability, quality and health status for all people.
System - public health	Public health approach to community health linking with personal health support.
System – community and country support	Health system earns and has strong support from community and country.
System – health support **	Best mix of resources within and outside of community. The fewer the resources within the more outside resources should be used. Connect with outside resources using full range of virtual means – phone, internet, etc. Share health records as appropriate. Refer to outside resources when outside expertise within community. Many but not all resources likely within community.
System - health records	Sharable, comprehensive health records to extent feasible. Paper if necessary; electronic health records if feasible; standardized data; information share encrypted via internet. Use "virtual health system(s)" of electronic health records (EHR), personal health systems/records (PHS/R), information exchange (IE) and information standards.
Person - person-centered health	Person-centered health support for whole person and maximizing choice and self-care. Special attention to most vulnerable persons.
Person - healthy partners	Healthy Partners as strong partnership between person and their health support to improve resource use and health outcomes.
Person - family and community support	Family and community support of person helps avoid things that harm health and provides support that improves health.
Person - human behavior	Successfully address human behavior as key to achieving health. Partner with person on motivation and ability that positively affect key behaviors that improve health and avoid harming health.
Person - history, genetics and environment	Partner with person to incorporate history, environment and genetic factors into any strategy that improves health and avoids further harming health.
Health Support - health home	Partnership between person and primary health support creates mutually agreeable "health home providing trustworthy, comfortable provider and place, provides or facilitates a person-accessible repository (actual or virtual)

	for all of the person's health information (including the complete health record), and works to monitor and improve the whole health of the whole person across all settings and across all preventive, primary and specialty care.
Health Support - use best support	Best health support (prevention, diagnosis, treatment, rehabilitation) for person. Should be safe, efficacious and effective. Should not be limited to "modern medicine".
Health support - care in community	Much of health's interventions occur outside health care facilities and in the community. Much is self-care.
Health support - care coordination	Care coordination helps people with multiple conditions and multiple sources of health support.
Health Support - prevention	Prevention of illness and injury should be primary strategy at the person and community level.
Health Support - evidence-based	Obtain/use evidence-based health support. Obtain via internet and/or as integrated into electronic health record. Use trusted sources. Address co-morbidity. Avoid conflicting therapies.
Health support - payment	Payment to health support based on effective care and resource use. Payment affordable, fair, and value-based.
Health support - privacy	Protects privacy of health care and information, especially particularly sensitive information such as sexually transmitted diseases, drug and alcohol abuse/misuse, and mental illness.

* Person – person whose health should be optimized and for whom health system and support is being provided

** Health Support – May include physicians, nurses, dentists, optometrists, pharmacists, clinics, urgicare, emergency departments, hospitals, rehabilitation facilities, home care, nursing homes, assisted living, alternative health/medicine, and others.

Ideal Community Health System – Most resources (larger urban)

System Element	Community/ Country Most resources (larger urban)
System - person success measure *	I'm healthy and I stay healthy or become very healthy. I'm functioning well and I continue to function well or function even better. I'm ill and/or not functioning well and I get better. I risk getting worse and I don't get worse. I'm chronically ill and I successfully manage. I have a disability and I successfully cope. I'm near end of life and I successfully cope.
System - success measure	Healthy people, community, country and world
System - drivers for health	Maximize health status, maximize outcomes, maximize abilities, maximize satisfaction, maximize quality, maximize accessibility/ portability, maximize affordability, maximize patient safety (drive defects/errors to zero), minimize time between disability/illness and maximized function/health (drive time to zero), minimize inconvenience (drive inconvenience to zero), maximize security & privacy
System - support for person	Supports "staying healthy", "getting better", "living with illness or disability" or "coping with the end of life."
System - characteristics	System is safe, effective, person/patient-centered, timely, efficient, and equitable providing comprehensive health support.
System - affordability	Affordable for person and any other payer. People with limited resource receive needed support from community and/or country.
System - accessibility	Accessible (time, distance, availability) for every person.
System - quality	High quality processes produce positive outcomes and high health status. "Right care for every person every time."
System - safety	Safe an environment as possible in which to receive health support.
System - design and operations	Best systems design and operational thinking is applied to and across the full range of health support.
System - dynamic and interactive	System is dynamic as locations for health interventions change, as person changes, as people providing health support change, and as events unfold for person and, her/his "health system" and "health environment". Is interactive

	where influences are interacting with each other to change how they impact the person and health.
System - collaborative partnership	Collaborative partnership of people, public and private payers, and health care organizations substantially improves access, affordability, quality and health status for all people.
System - public health	Public health approach to community health linking with personal health support.
System – community and country support	Health system earns and has strong support from community and country.
System – health support **	Use best mix of resources within and outside of community. The fewer the resources within the more outside resources should be used. Connect with outside resources using full range of virtual means – phone, internet, etc. Share health records as appropriate. Refer to outside resources when outside expertise within community. Most resources likely within community.
System - health records	Sharable, comprehensive health records to extent feasible. Paper if necessary; electronic health records if feasible; standardized data; information share encrypted via internet. Use "virtual health system(s)" of electronic health records (EHR), personal health systems/records (PHS/R), information exchange (IE) and information standards.
Person - person-centered health	Person-centered health support for whole person and maximizing choice and self-care. Special attention to most vulnerable persons.
Person - healthy partners	Healthy Partners as strong partnership between person and their health support to improve resource use and health outcomes.
Person - family and community support	Family and community support of person helps avoid things that harm health and provides support that improves health.
Person - human behavior	Successfully address human behavior as key to achieving health. Partner with person on motivation and ability that positively affect key behaviors that improve health and avoid harming health.
Person - history, genetics and environment	Partner with person to incorporate history, environment and genetic factors into any strategy that improves health and avoids further harming health.
Health Support - health home	Partnership between person and primary health support creates mutually agreeable "health home providing trustworthy, comfortable provider and place, provides or facilitates a person-accessible repository (actual or virtual) for all of the person's health information (including the

	complete health record), and works to monitor and improve the whole health of the whole person across all settings and across all preventive, primary and specialty care.
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Health support - care coordination	Care coordination helps people with multiple conditions and multiple sources of health support.
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