Culture of Health
Sentinel Community Insights

How Community Systems Are Changing to Advance Health, Well-Being, and Equity
About This Report

The Sentinel Communities Surveillance project began in 2016 and has been monitoring activities related to how a Culture of Health has been developing in each of 29 diverse communities around the country. The purpose of the project is to learn more about how each community is working within its own historical context and current landscape to communicate about health and well-being, develop systems that promote health, and address health equity. Information on each Sentinel Community’s work is summarized in community reports, as well as cross-community insights reports on emerging themes, including this report on systems change to advance health, well-being, and equity.

This report includes themes from across all communities and specific examples from: Butte, Mont.; Milwaukee, Wis.; Tacoma, Wash.; Tennessee; Toledo, Ohio; and San Diego County, Calif.

The information in this report was obtained using several data collection methods, including key informant telephone interviews; an environmental scan of online and published community-specific materials; a review of existing population surveillance and monitoring data; and collection of local data or resources provided by community contacts or interview respondents. Interviews were conducted with individuals in the community representing several organization types (for example, grassroots, government, for-profit) working in a variety of sectors (for example, health, business, education, faith-based, and environment). Information collected through environmental scans includes program and organizational information available on internet websites; publicly available documents; and media reports. Population surveillance and monitoring data were compiled from publicly available data sets, including the American Community Survey (ACS); Behavioral Risk Factor Surveillance System (BRFSS); County Health Rankings (CHR); and other similar federal, state, and local data sources.
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Introduction

Systems change is a critical part of building a Culture of Health and advancing health equity because systems evolutions can fundamentally reform the policies and processes that have posed structural barriers and driven persistent inequities. Over the past five years, communities have been grappling with the best ways to foster positive, sustainable action to improve the health of their residents—whether it means having consistent access to quality healthcare, mitigating the negative impacts of social factors on health, or addressing the inequities and role of systemic racism exposed by disproportionately rising rates of chronic disease and the COVID-19 pandemic. However, changes that reposition how a community promotes health and well-being are not simple and are often plagued by a lack of long-term commitment among community leaders and residents faced with competing priorities and limited resources for sustainability. True systems change helps to address these challenges by institutionalizing changes in how “work gets done,” whether though new ways of working together, financing, or sharing of data or information. This report provides an initial look at systemic changes to advance health, well-being, and health equity through the environmental scan and stakeholder interviews conducted for the Sentinel Communities Surveillance project.

As such, the report provides a foundational analysis of what changes are happening in the systems that support health in a community and not simply change at the level of individual organization or within a particular sector. While the initial Sentinel Communities Surveillance project posed questions about systems change, it was not geared to be a systems change analysis. As such, this report should be viewed in the context of that limitation—these are early insights to be further examined in subsequent phases of this work.

WHAT IS A SYSTEM OF HEALTH AND WHAT IS SYSTEMS CHANGE WITHIN THAT?

For this report, we define a System of Health as those systems or parts of systems that interact to produce or impede health. We include upstream drivers of health (e.g., economic conditions) that mitigate health problems and system features that produce health gains, such as improved mental health.

Several models and frameworks articulate the process or stages of systems change. In broader equity and social change, a framework offered by Catalyst 2030 is particularly useful to consider. While this framework was developed in the context of the United Nations Sustainable Development Goals, it reflects many of the cultural and systemic shifts that undergird a Culture of Health. In this framework, systems change is defined as “the adjustments or transformations in the policies, practices, power dynamics, social norms, or mindsets that underlie the societal issues at stake.” The Catalyst approach describes change in three levels: incremental (e.g., new practices), structural (e.g., new structures or organizing models), and transformative (e.g., fully shifted mindsets and mission). Other frameworks are useful when considering systems change in health, specifically. Carey and Crammond (2015) examined a systems approach to addressing social determinants of health and identified systems components to change, such as the paradigm (i.e., the “systems’ deeply held beliefs”), the goals, the structures (i.e., the interconnection of system elements), and feedback loops (i.e., how the system responds to new information). Lukas and co-authors (2007) described a transformational model for change in healthcare systems. In this framework, components such as the impetus to transform, leadership commitment, improvement initiatives in the form of active problem-solving, alignment of activities, and integration of efforts are core parts of changing the system that guides the delivery of healthcare and are relevant to systems change in health more broadly.

A FRAMEWORK FOR SYSTEMS CHANGE WITHIN THE SENTINEL COMMUNITIES

We use systems change theory to examine how the Sentinel Communities are fundamentally changing approaches and structures to prioritize health and well-being and to address health inequities. Sentinel Communities that are more effectively producing positive health for all residents tend to have pursued some form of systems change.

Building from systems change research, like that briefly summarized above, we articulate a framework for understanding how Sentinel Communities are approaching the organizational and structural changes required to cultivate a sustainable foundation for health action and to create that System of Health.

We start first with the levels of systems change (Figure 1a), primarily adapting the Catalyst 2030 framework but with modifications to fit the Sentinel Communities effort. In the first phase of systems change, we describe the transitional level of systems change, which is primarily readying the community context or ecosystem for broader change actions. In this level, we are primarily focused on change that includes these categories:

• Initial shifting of health views and approaches.

• Changing health service patterns.

• Adding new measures or data to capture well-being and/or health equity.

• Convening differently about health issues.
In the **structural** level of systems change, we step beyond those first transitional moves, with a focus on concrete, operational changes, to include these categories:

- Changing structures (i.e., restructuring health data structures, new cross-sector, organization collaborations, and so forth).
- Shifting actions (i.e., health or related policies that change how health initiatives are resourced, defining policies on what is acceptable health practice in a community).

In the **transformative** level of systems change, there is a significant restructuring, realignment, or overhaul of a system’s design, to include these categories:

- Fundamentally changing the mission of the health system, or at least the objectives for the mission.
- Changing how the full health system (i.e., the system that includes health care and other programs that address health outcomes) is designed and/or organized.

**FIGURE 1A. LEVELS OF SYSTEMS CHANGE**

**TRANSITIONAL**

**STRUCTURAL**

**TRANSFORMATIVE**

It should be noted that transformative change is not a quick process, nor was it frequently observed in the Sentinel Communities, as we will describe in later sections. Further, communities can still realize positive health action with transitional and structural changes. But transformative is likely the only level of systems change that shifts orientation and mindset in ways that are sustainable and results in change flowing through all the sub-components of a system.

**WHAT COMMUNITY ACTIONS AND STRATEGIES SIGNAL EACH LEVEL OF SYSTEMS CHANGE?**

Figure 1b adds example **signals** of change within those three levels—transitional, structural, and transformative. These signals are indicative that a move is happening systemically in the System of Health in a community. At the **transitional** level, we may observe the mayor describing the importance of health in a state of the city address. At the **structural** level, we may see efforts to codify cross-sector collaborations and move them to more stable coalitions. Key policies introduced, such as the pursuit of Health in All Policies, also fall within the structural level. Although important steppingstones toward transformative change, such policies often lack clarity about how that policy will be operationalized, the term length (if any), accountability of community leaders and stakeholders to that policy change, and how it is intended to shape the governance of a community. **Transformative** changes are observed when there is a fundamental and more permanent shift in how health investments are prioritized, or how sectors in the system work together as core practice. One example is when a community selects a positive health outcome (e.g., emotional well-being) as a primary metric of community health, and all organizations and sectors work collectively and are held accountable in some way for achieving that shared vision. To be sure, communities may have signals occurring at multiple levels of systems change at once. We argue, however, that transitional and structural changes are necessary but not sufficient actions for transformative change in the System of Health. As such, communities can make structural changes and never move to adopting any transformative approaches to systemic reform.

**FIGURE 1B. SIGNALS OF SYSTEMS LEVEL CHANGE**

**TRANSITIONAL**

**SIGNALS OF TRANSITIONAL CHANGE**

- New health conversations, acknowledgement of need to work differently
- New collaborations (e.g., on specific issue, effort, need)
- Changes in service delivery (e.g., increases in referrals to community partners)

**STRUCTURAL**

**SIGNALS OF STRUCTURAL CHANGE**

- Codifying collaborations, transition to established coalitions, new partners, voices, shared goals and objectives
- Establishment of new government offices, divisions, budgets, to focus on aspects of health, equity, etc.
- Sharing of data, information, resources across a limited number of sectors, for specific purpose, DUAs, MOUs
- Policy change (e.g., HiAP, required equity reviews), task forces, action plans

**TRANSFORMATIVE**

**SIGNALS OF TRANSFORMATIVE CHANGE**

- Full system alignment around shared mission and objectives (a shared focus or new “north star”)
- Fundamental changes in how stakeholders work together (efficiencies), decisions are made, investments prioritized
- Integrated data available to all stakeholders—access to same information for decision-making
While we focus principally on the levels of systems change and signals of that change in this report, further analysis of systems change in Sentinel Communities requires a consideration of the attributes of systems change (i.e., the characteristics and features of the system that need to be in place to help transition a system through levels of change). Systems change attributes may include the following:

- The ability of the system to address conflict and embrace complexity.
- The features of the system that support evidence-based action.
- The entry points in the system that allow actors in the system to have agency and power in decision-making.

In short, not having attributes like these in position can stall progress between levels of systems change and impede the full realization that any transitional and structural changes could have on the health and well-being of the community.

**Systems Change in the Sentinel Communities**

Below, we provide examples of systems change in the Sentinel Communities, organized by the type of change. Not surprisingly, examples of transitional change were more common than examples of structural change. None of the Sentinel Communities illustrate all elements of a transformative approach to systems change, but a few are on their way to fundamentally rethinking the orientation of systems toward shared goals, operational strategies, resources, and data.

**EXAMPLES SIGNALING TRANSITIONAL CHANGE**

Sentinel Communities experiencing transitional systems change are early in the process of transforming their approach to health, well-being, and equity. These communities may have previously worked in silos to address community health priorities, reacting independently to emerging trends and concerns. As they have begun thinking about systems change, stakeholders in these communities have initiated new conversations about health. For example, acknowledging the need to work differently through cross-sector collaborations or strengthening referrals between health and social service providers. While communities in the transitional phase are developing the building blocks for systems change, many collaborations are new, narrowly focused on a specific health issue, or have only recently expanded to other health outcomes. As a result, sustainability and impact remains unclear. Butte, Mont., and Toledo, Ohio, provide two examples of communities with activities representative of transitional systems change.

**Butte, Montana**

Community stakeholders in Butte were becoming increasingly concerned with the prevalence of substance abuse, poor mental health, and homelessness in the small community. Local homeless shelters were at capacity at the same time that state budgets for health and human services and suicide prevention were being cut. It was clear that prior efforts to address these issues were insufficient and that an approach that considered the root causes of behavioral health challenges and their connection to homelessness was needed. The community health narrative evolved from one focused on putting “band-aids” over larger systemic issues to a narrative rethinking the way the system was working. In an effort to identify service gaps and make community-wide recommendations to fill those gaps, the Behavioral Health Local Advisory Council was established in 2021. The council includes representatives of various agencies providing behavioral health services and residents with behavioral health needs.

**Toledo, Ohio**

The Northwest Ohio Pathways HUB regional care coordination system launched in 2007 to combat infant mortality in Lucas County (home to Toledo). Rates of infant mortality and other poor birth outcomes (pre-term births, babies born at low birthweight) in the county were higher than in peer communities, particularly for Black families and families with low incomes. Through the care coordination system, community health workers connect pregnant women and girls and those of child-bearing age to medical insurance, healthcare, food, housing, transportation, and workforce development services. Since its inception, the Pathways HUB has expanded the number of service providers in its network, increased the number of families served; and led to improvements in birth outcomes for participants relative to the community at-large. New funding in 2015 led to the expansion of the model to address diabetes, heart disease, and other chronic conditions; and in 2020 it was expanded to youth experiencing homelessness.

**EXAMPLES SIGNALING STRUCTURAL CHANGE**

Those Sentinel Communities that have progressed to making structural changes on the path to systems change are those with mature and high-quality coalitions; where infrastructure and data use agreements for ongoing or more real-time data sharing between sectors has been established; or new offices or divisions within government have been created to focus on addressing health, well-being, or equity in a systematic and holistic way. Some communities have also codified an approach to structural change through policies that require health or equity impact assessments, task forces, or established action plans. Communities in the structural phase of systems change are creating structures with staying power and the ability to have impact across a spectrum of health and equity issues in the community. These communities have begun to establish governance and accountability for change on a systems level, and have tackled some initial challenges with integrating data and resources across sectors. Here are two examples from Tennessee and Milwaukee.
**Tennessee**

The Tennessee Livability Collaborative began with four core state departments (health, transportation, education, and economic development) in 2015 and is currently comprised of 23 departments and agencies. The voluntary collaborative—whose mission is “improving the prosperity, quality of life, and health of Tennesseans through state department collaboration in the areas of policy, funding, and programming”—meets bi-monthly and is facilitated by the Office of Primary Prevention in the Tennessee Department of Health. The collaborative has a shared vision focused on livability and high quality of life, creating opportunities for health, healthy foods, education, employment, recreation, and culture. A three-year evaluation of the collaborative showed increased collaboration across agencies, improved understanding of other agencies’ work, alignment of funding opportunities, creation of staff positions to facilitate cross-sector collaboration, new assessments related to livability, and improved data sharing. Recent developments include the creation of the state’s first livability index to align on shared measures, with a future goal of these measures feeding into departmental and agency strategic plans and budgeting decisions.

**Milwaukee, Wisconsin**

Established in early 2021, the city of Milwaukee’s Office of Equity and Inclusion was created to build the capacity of city departments to advance racial equity and update policies and practices that could contribute to inequity. The core functions of the department include racial equity and inclusion, small business development, accessibility, and support for the city’s Equal Rights Commission. Through the strategies laid out in its Racial Equity Action Plan, the office has made progress toward systems change by authorizing a Racial Equity and Inclusion Leadership team, improving internal processes to create a more diverse hiring pipeline for city jobs, and implementing tools to assess and institutionalize equity in city departments. For example, starting in 2021, all city departments were required to use the Governmental Alliance on Racial Equity (GARE) Racial Equity Toolkit to evaluate at least one of their program’s contributions to (in)equity, develop an annual report on the use of the toolkit, and to document associated changes to policy and resource allocation to address any concerns identified during the process.

**San Diego County, California**

In San Diego County, an integrated Health and Human Services Agency (HHSA) provides services that span public health, healthcare, housing, community development, mental and behavioral health, child well-being, and aging. Their unified service-delivery model has allowed HHSA to coordinate a strategy to promote health and its various drivers, including housing, food security, and access to services in a way that is both cost-effective and drives toward shared outcomes. Additionally, HHSA’s Live Well initiative has been operating for 10 years with a “vision for a region that is Building Better Health, Living Safely and Thriving.”

**Tacoma, Washington**

In 2020, Tacoma launched the Transforming Tacoma Initiative—a “systemic transformation” to fundamentally re-imagine city operations to address equity (and redress inequity, becoming an anti-racist institution). To date, Transforming Tacoma efforts have included the city’s Office of Equity and Human Rights leading every city department in developing a Racial Equity Action Plan, implementing strategies to recruit and retain diverse city employees, and transforming utilities provision to be driven by equity. Tacoma police have also implemented new strategies under Transforming Tacoma, integrating mental health into police training and initiating a 21st Century Policing in Anti-Racism review.

**Examples Signaling Transformative Change**

Transformative systems change is aspirational for most Sentinel Communities. A select few communities exemplify some characteristics of transformative change, including system alignment around a shared mission and objectives—a common “north star.” Stakeholders in these communities have begun working together in fundamentally different ways, making decisions collaboratively and prioritizing investments in ways that align with this common vision. And data systems across sectors from public health, healthcare, education, social services, housing, and more are being integrated to facilitate service coordination, efficiency, and improved outcomes. Promising examples come from San Diego County, Calif., and Tacoma, Wash.
Accelerators and Facilitators of Systems Change

Insights from Sentinel Communities suggest that several factors accelerate or facilitate systems change—prompting communities to reexamine their current goals, objectives, and approaches toward health and well-being and develop innovative ways of working together. These include fundamental shifts in health narrative, changes in leadership, less prescriptive and restrictive funding, and emerging priorities or unanticipated events that require immediate action.

A FUNDAMENTAL NARRATIVE SHIFT

Shifting the dominant community health narrative from one focused on acute health concerns, healthcare and treatment, or individual responsibility for health, to one that acknowledges “whole person approaches,” the importance of social determinants of health, or other longstanding structural or systemic barriers to health, has been critical to motivating systems change. Such shifts in narrative can be driven by leadership priorities, grassroots efforts to prioritize community needs, or a growing recognition that the community’s current approaches to improving health and well-being are siloed, inefficient, or ineffective (e.g., mental health and homelessness in Butte). This shift in narrative has created a call to action for non-traditional health sectors to become part of the solution, and has oriented community stakeholders around root causes of health and well-being—including historical structures and systems that have contributed to health inequity—providing a starting framework for health systems change.

LEADERSHIP CHANGE THAT REPRESENTS A SHIFT IN PHILOSOPHY

Newly elected or appointed leaders may bring fresh perspectives and shift momentum from the status quo to new ways of working. Newly elected leaders, for example, have worked to elevate community voice, unify the community around a priority cause or issue, and alter power structures by creating new departments (e.g., of health equity), declarations (e.g., racism as a public health concern), or financial commitments (e.g., through budgetary allocations). New leaders also bring diverse perspectives that draw on their prior work, bringing new capabilities, strategic approaches, and networks to bear for systems transformation (e.g., those with city planning expertise working on health issues in Tennessee).

NEW OR DIFFERENT FUNDING OPPORTUNITIES THAT PROVIDE OPPORTUNITY TO RETHINK FINANCING MORE BROADLY

Even if not explicitly intended to catalyze systems change, new funding opportunities can open the door to new ways of working together. For example, funds made available to support recovery from the COVID-19 pandemic were less prescriptive—affording recipients more creativity and flexibility to meet the needs of the community. In some cases, like in Milwaukee, this resulted in new ways of working together to address affordable housing, racial equity, or economic recovery. Additional funds to address health more broadly have come from voter-approved changes to the tax structure or millage rates to direct funding to upstream drivers of health (e.g., through a parks tax) or provide more consistent funding streams to address mental health challenges rooted in systems issues (e.g., Butte).

URGENT COMMUNITY HEALTH ISSUES OR COMMUNITY EVENTS THAT CATALYZE ACTION

In some communities, urgent “all-hands-on-deck” events have brought together partners from different sectors in new ways, which can jump-start efforts to transform systems. For example, manmade (e.g., the Deepwater Horizon oil spill in Mobile, Ala.) and natural (e.g., hurricanes in Tampa, Fla., widespread flooding in Harris County, Texas) disasters required community leaders and stakeholders working in diverse sectors to identify shared goals, data, and create new partnerships, although such efforts were not always sustained. The COVID-19 pandemic also resulted in unprecedented cross-sector collaboration in almost all U.S. communities, with many partnerships (e.g., housing and public health) initiated for the first time. The pandemic also highlighted deficiencies in current systems that promote health and well-being, including insufficient and difficult-to-navigate mental health systems (e.g., San Diego County) or interdependencies between systems that were previously unrecognized (e.g., education and health)—which energized leaders across sectors to reconsider their approaches and allocate funding in different ways. Calls for racial justice across the country have resulted in some communities declaring racism a public health emergency, placing new emphasis on tackling inequitable systems.

Sticking Points and Barriers to Systems Change

Insights from the Sentinel Communities also elevated an understanding of the barriers to systems change. In many cases, these “sticking points” are similar to facilitators but on opposite ends of the continuum. For example, communities that were less likely to undergo health systems change often lacked governance structures to implement sustained change, had misaligned goals among leadership and key stakeholders, competing health narratives, and barriers related to data sharing and interoperability.

UNDEFINED GOVERNANCE OR DECISION-MAKING AUTHORITY

Communities that were unable to transition to more advanced levels of systems change often lacked the governance structures or defined decision-making authority to implement and sustain changes. In some communities, state level policies may preclude local action to change systems and financing (e.g., Butte). Even when enthusiasm and an
underlying narrative support systems change, the most influential leaders in the community may represent community-based or grassroots organizations (as is the case in Stockton, Calif., and New Haven, Conn.), which often lack the capacity, funding, or authority necessary to directly impact systems.

LACK OF LEADERSHIP OR MISALIGNMENT ON SHARED GOALS
While strong leadership can facilitate systems change, a lack of leadership commitment or a misalignment between leaders within a community around the value or process of transforming systems can serve as a barrier to such change. In some communities, key leaders and gatekeepers are not aligned with the goals of improving health, viewing it as the purview of specific sectors like public health, healthcare, or philanthropy. Turnover among leaders has presented a barrier to sustaining change, even in communities with longer-held health narratives that support systems approaches to health or equity (e.g., turnover in city leadership in Baltimore). Finally, those in positions of power have often reached their status through deft navigation of current systems and structures, which provides an incentive to maintain the status quo.

MULTIPLE (AND COMPETING) HEALTH NARRATIVES AND PRIORITIES
Communities often face a constellation of seemingly disparate challenges and priorities, especially among populations historically experiencing vulnerability. Acute events can also detract from the time and dedication needed to tackle holistic, systems thinking (e.g., Toledo). Sometimes even seemingly petty debates over terminology can serve to slow or even derail systems change efforts (e.g., the difference between equity and equality and associated approaches to advance each). In communities that experience challenges moving from a narrative shift to action on health systems change, a primary barrier is often a lack of alignment around a shared goal or narrative for health and well-being that can generate necessary cross-sector buy-in, as is the case in Allegheny County, Pa.

BARRIERS TO DATA SHARING AND INTEROPERABILITY
Data sharing across sectors is an important step in establishing the connections needed to integrate systems and promote health and equity in a more holistic way, but it can present a range of logistical challenges for communities with and without a history of data sharing. Some communities lack basic underlying data infrastructure and capacity to collect, manage, and analyze data—especially small or rural communities like Monona County, Iowa, or Adams County, Miss. Those who do have such capacity may not be able to sustain it long term, given the amount of resources required and the need to keep up with rapidly changing hardware, software, and legal considerations around data protections and sharing. Even those that make data publicly available through open data portals (e.g., Allegheny County) are challenged with making data usable for different audiences and timely enough to inform real-time decision-making.

Conclusions, Implications, and Next Steps
This brief report provides a framework for systems change within the Sentinel Communities, offering conceptualizations of transitional, structural, and transformative health systems change, with concrete examples from Sentinel Communities. Few communities were in the transformative stage of health systems change. While we did find more of examples of communities making transitional and structural systems change, it can be difficult to tell in these earlier stages whether such changes will be sustained, and whether they will have their intended impact. Yet, this work identified several facilitators and barriers related to what is influencing health narrative and decision-making, for instance.

Noted at the outset of this report, the initial Sentinel Communities Surveillance project was not designed to examine systems in detail. As such, this report only presents early insights about systems change in the Sentinel Communities. We will pursue a deeper look at systems change in a sample of Sentinel Communities, with a new phase of work between 2022-2024. This work will specifically explore what “sticks” or “unsticks” communities when endeavoring to make wholesale changes for health, well-being, and health equity.

Given the work we have already conducted in communities, we will be analyzing some of the points mentioned in the prior sections as challenges to health progress, such as financing (what is being funded to get to what outcomes for health, well-being, and equity); data systems (what and how are communities tracking health, well-being, and equity), and intersectoral and intrasectoral policies that align for health, well-being and equity, disrupt prior legacy systems, and so forth. We will explore how communities are advancing through levels of systems change and how they are sustaining progress. We also will spend more time on the systems attributes mentioned earlier in the report, further unpacking how systems are designed to embrace complexity and integrate new insights from diverse stakeholders, particularly in addressing health equity.
References


