AGENDA

King County ACH Regional Health Improvement Plan Workgroup (RHIP)

November 19, 2015, 12:00-2:00 pm
401 Fifth Avenue, Seattle – Chinook Building, 1311/1312
Conference Bridge Line 206-263-0100

Objectives

- Provide updates from the ACH ILC, Performance Measurement work group, and Consumer/Community Voice Ad-hoc Committee
- Discuss revised outline for a future regional health improvement plan
- Identify and agree on what to take to ACH Interim Leadership Council

10 minutes	**Welcome & Introductions (Wendy Watanabe)** **Objectives and agenda review**
45 minutes	**Relevant updates & discussion:** • **ACH ILC (Janna Wilson)** • **Performance Measurement WG (Lee Thornhill)** • **Consumer/Community Voice Ad-hoc Committee (Wendy)**
60 minutes	**RHIP Outline and Framework Discussion**
5 minutes	**Next Steps**

NEXT MEETING: December 17, 2015

FOR DISCUSSION ONLY - DRAFT MATERIAL FOR 11/19/15 RHIP work group meeting

Outline of a King County Regional Heath Improvement Plan (think of it as "version 1.0" . . .)*[Initial material – Title, Contents, Contact Information; Who/how developed, etc.]*

Section 1: PURPOSE OF THE PLAN

This section would explain that this document is meant to serve as action and accountability framework for the King ACH.

Communicates at high level actions underway to make the transformation vision a reality. It's a framing that addresses and helps us collectively see the interdependence of the many social, economic, physical, environmental, and spiritual factors that affect health, well-being, and equity in our region.

Within that larger frame, it articulates a small set of current priorities / common agenda that the King County Accountable Community of Health (ACH) structure is actively focused on advancing and why. Shows alignment to Healthier Washington. A tool to help people coordinate with others in areas of interest; prevent duplicative efforts; etc. Captures/builds upon work already being done in KC. Make clear it's a living plan. Not meant to supersede other plans or their priorities. A frame for knitting silos/sectors.

Section 2: HEALTH & WELL-BEING ASSESSMENT LANDSCAPE

This section could describe: **The current state of what regional/local assessments are produced now? How, by whom, what cycle, and for what purpose (what actions, resources does each govern**?)

Explain we have looked across sectors that influence health. Found many types of assessments and priorities articulated. AAA Aging plan, United Way, community action agencies, Public Health plan, city-specific; neighborhood-specific, regional homeless plan, housing and community development plan, hospital joint Community Health Needs Assessment, King County ESJ plan, comprehensive plans, FQHCs, behavioral health plans, etc. Include Gloria's grid of common themes among the current plans in an appendix. Reinforces the value of working across sectors – common themes bubbled up.

What types of assessment might be missing, that need to be considered in future ? xxxx xx

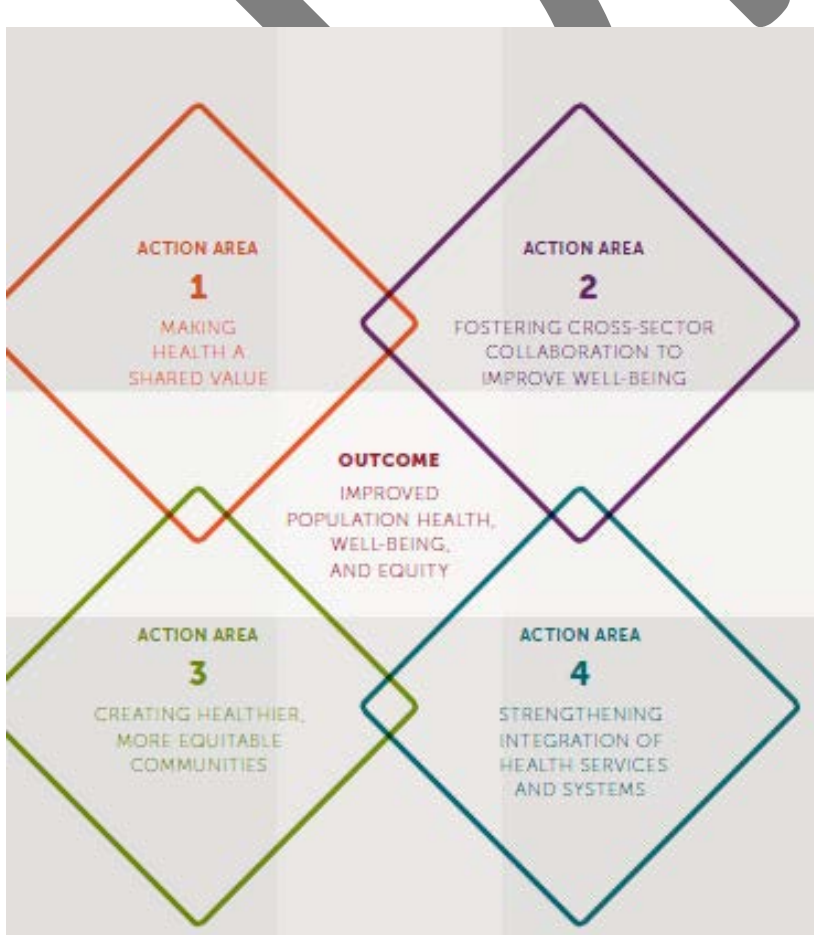
Recommendations for future changes in how our ACH region approaches assessment work
Example – could certain assessments be coordinated or even merged in the future?
Are there improvements in approaches to community engagement and inclusion?

Section 3: WHAT WE KNOW / WHAT THE DATA SAYS

Brief demographic description of region. Point/link to existing data dashboards that speak to health needs/assets of the region; disparities – CHNA, community health / Social Determinants of Health indicators, Maps, dashboards from places like WA Health Alliance, etc. Not a long section – Lift in data from community members - testimonials, stories – this is what people want King County to look like/be like (versus what it is now). Use data to support and illustrate.

Section 4: REGIONAL HEALTH FRAMEWORK FOR ACTION [borrow from Robert Wood Johnson Fnd. Culture of Health action areas?]

A framework for talking about HOW we work on health and well-being improvement in the region . Key is that it's an equity framework (versus disease/deficit /need focused). [*Question – how would Triple Aim get layered in*?] Four interlocking action areas that advance transformation vision:



Group reaction from 10/15/15 meeting:
Like framework for KC ACH – syncs with national framework, includes actions for care delivery and community focus

Group suggestions from 10/15/15 meeting:

- Add equity, add public will e.g., "Making health and health equity a shared value and create public will"
- Depict interconnectedness among all areas and non-linear/organic aspects
- Make framework as concrete as possible
- Address finance and sustainability as key in outline, or if not, where?
- Defining terms – means different things to different sectors
- Measure integration of services and improved access
- Include a commitment to close the equity gaps

DRAFT

Section 5: WHAT'S HAPPENING IN THE ACTION AREAS ?

Action Areas and ACH priorities (* bold = current ACH priority) . This section could feature work occurring in each action area in King County. Use hyperlinks so people can connect – not lengthy descriptions. Tone could be lots of people/entities working, in many ways, on health and equity in King County. There's a place for everyone in this work.

Examples for Action Area 1 – Making health [*or equity*?] a shared value

??? what kinds of efforts would we spotlight here?
*** Accountable Community of Health development**?
Regional equity network development?
King County Equity and Social Justice plan?

Examples for Action Area 2 – Fostering Cross Sector Collaboration

* **Housing-health partnerships**
Climate change and health; Preparedness/community resilience work
Business support for workplace health & well-being
Roadmap Project
Early childhood/ACES related/VROOM
African Americans Reach and Teach Health (faith/health collaborations)
King County Hospitals for a Healthier Community
School-based health centers
Health in all policies
Washington Medical-Legal Partnership (Children's, Harborview, Odessa Brown, Sea Mar, Valley Cities)

Examples for Action Area 3 – Creating healthier, more equitable communities

***Communities of Opportunity**
Other place-focused partnerships: eg : Yesler; Kent4Health; Auburn; BUILD Health (Chinatown-ID), etc.
Partnerships to Improve Community Health (PICH)
Healthy King County Coalition
Health Coalition for Children and Youth
Law Atlas PolicyTracker
Etc

Examples for Action Area 4 – Strengthening integration of health services and systems

***Physical/Behavioral Health Integration**
*** Familiar Faces (**health/justice/housing/employment) - or could be action area 2?
Coverage is Here King County
Reducing Readmissions Safe Tables Partnership
Accountable Care Organization/Network development activity in the region
Aging and Disability Resource Network
Pediatric Partners in Care (CMMI grant)
Racial/ethnic health boards/coalitions (Somali Health Board; Asian/PI Health Board)
Community Alternatives to Boarding Task Force
Vulnerable Populations Strategic Initiatives (EMS-led)
Neighborhood Health Link (Group Health clinical-social needs connector)
Electronic Health Record/Health Information Exchange
Etc.

Section 6: THE ACH PRIORITY FOCUS AREAS AND ALIGNMENT WITH HEALTHIER WASHINGTON

A bit more in this section on the **bolded initiatives** and their outcomes/measures frameworks (more about regional initiatives designed to move beyond siloed approach to health…..)

Criteria for priority (bolded) initiatives:

- Addresses an intractable or emerging regional challenge/opportunity
- Suited to a multi-sector, collaborative approach
- Strong potential for high impact
- Broad leadership energy; enthusiasm to pursue
- Includes elements that overlap/align with Healthier Washington's priorities (i.e, can move the needle on regional health outcome measures that state is asking ACHs to work on with them)
- Addresses Triple Aim and return on investment (ROI)

This section describes the alignment with state level priorities

- How do the priority (bolded) initiatives align with and contribute to Healthier Washington Common Measure Set?

DRAFT

- How do the priority (bolded) initiatives align with and contribute to the State's Prevention Framework priorities?
- Short discussion of coordination/alignment with fellow ACH regions

Section 7: Financing the Future, Financing Success

RHIP work group identified this section as key to the plan's success. This section could perhaps spotlight ways in which creative partnerships are driving $$ upstream and driving toward outcomes. Pay for Success projects. Hospital CHNA joint investments. Medicaid Waiver's role. Value-based purchasing, etc.

Section 8: Evaluation – a commitment of systems/sectors to come together to take stock – What difference did it make?

The collective impact change process involves three stages of development, each of which requires a different approach to performance measurement and evaluation. In the later years, community partners should expect to achieve meaningful, measurable change in outcomes. Lay out here a commitment of some kind e.g. Partners come together every few years to look at various report cards from different sectors to determine *if, where, and for whom* efforts are making progress. On Triple Aim. On health equity, etc. Local data consistently show that lower income communities bear a higher burden of poor health outcomes

Section 9: PLACEHOLDER – Section on articulation of Medicaid Waiver priorities for KC Region?

If appropriate -Sounds like could entail processes/actions/parameters not yet known.

FOR REFERENCE – How Robert Wood Johnson Foundation characterizes the four action areas

1. Positive movement in this Action Area will fuel a greater sense of community, an increased demand for healthy places and practices, and a stronger belief that individual actions can make a difference in the well-being of others.

#2 This Action Area places new focus on collaborations that include sectors typically viewed as "outside" of health care, and demonstrates how these cross-sector collaborations can play an essential role in building a Culture of Health.

#3. The goal of this Action Area is to encourage communities to fulfill their greatest health potential by improving the environment in which residents live, learn, work, and play

#4. This Action Area aims to strengthen a system of coordinated care that integrates and better balances treatment, public health, and social services

The Framework is not a call for new, large-scale government programs. It is intended to leverage current resources, encourage innovative partnerships, and ultimately reduce national health care costs over time. It is meant to empower individuals, parents, and caregivers in making healthy choices, while fostering more equitable environments that help make those choices possible

Why use the term Action *Framework*?

Unlike a *model*—which implies something formulaic, fixed, and final—a *framework* speaks to a built-in fluidity. The Action Framework invites individuals, communities, and organizations to utilize the structure and find entry points relevant to their unique needs and goals. The Framework is not a *blueprint*, but rather suggests multiple pathways for action.

Link to Framework:
http://www.rwjf.org/en/email/from-vision-to-action--measures-to-mobilize-a-culture-of-health0.html

DRAFT

Evaluating the Accountable Communities of Health

Center for Community Health and Evaluation

An Accountable Community of Health (ACH) is a group of people in a given geographic area representing entities from a variety of different sectors with a common interest in improving health. With support from the state, nine ACHs are formally organizing across Washington for the purpose of coordinating activities, jointly implementing new health related projects, and advising state agencies on how to best address health needs within their geographic area.

Evaluating the progress of ACHs

The Health Care Authority (HCA) has contracted with the Center for Community Health and Evaluation (CCHE) to evaluate the ACHs. CCHE aims to understand how ACHs come together, agree on community health priorities, engage in health improvement activities, contribute to the Healthier Washington initiative, and work towards becoming sustainable coalitions. As an evaluation partner, CCHE provides timely feedback from multiple data sources to Healthier Washington and HCA staff about success factors, challenges, and lessons learned to inform program improvement. CCHE will also assess the ACHs' impact at the end of the project.

Measuring outcomes. A measurement framework has been designed to guide the assessment of the ACHs' progress (see visual on the next page). The framework balances the need to compare across the ACHs and the need for individual ACHs to tailor some outcome measures to their regional priorities. The framework divides ACH outcomes into:

- Short-term operational measures about the strength and functioning of the ACH as a coalition
- Intermediate activity measures about ACH project work and Healthier Washington activities
- Long-term regional health measures about project impact on regional health indicators and statewide health improvement priorities

Collecting data. Data is being collected from multiple sources to understand ACH capacity and progress.

- Site visits to all nine ACH regions to see ACH's in action
- Interviews with backbone staff and ACH members to understand ACH development, regional ACH activities, and their participation in state-level Healthier Washington activities
- Surveys of ACH members to gather members' perceptions of their ACH
- Observation of meetings where ACH members are convened to discuss the statewide initiative
- Review of grant applications, designation proposals, and reports submitted by ACHs to HCA

CCHE's evaluation approach

When your goal is to improve community health, you have questions about what works. At the Center for Community Health and Evaluation (CCHE) we take a collaborative approach to help find the answers. We partner with coalitions, health departments, and many other organizations, on evaluation planning, data collection, analysis, and reporting. Our approach emphasizes sharing data and evaluation findings with our clients when it is most helpful for their activities and decision-making.

Measuring the Chain of Impact

Balancing local variation with a coordinated statewide measurement strategy

Short-term Operational & Collaboration Measures

Measure ACH function, strength and collaboration as a coalition:

- Collective Action
- Collaboration
- Governance/ Leadership
- Representation
- Sustainability
- Data Capacity
- Community Engagement

Evaluate progress with operational & collaboration measures

Intermediate Activity Measures

Measure ACH project-specific progress

Community-driven projects based on local health needs and in consideration of existing initiatives

Evaluate progress with tailored evaluation metrics

Measure ACH participation in Healthier WA more broadly:

- Coordinated statewide activities
- Practice Transformation, Behavioral Health Integration, Payment Reform, etc.

Evaluate with metrics tailored to the nature/type of each ACHs participation - TBD

Long-term Regional Health Outcome Measures

Regional variation: Each ACH selects measures from a subset of the Common Measure Set (TBD) to match project goals.

Measures categories:

- Child/Adolescent health
- Adult primary/preventive care, including Adult Diabetes control, testing and screening
- Adult Behavioral Health
- Adult ED visits & readmissions
- Health care costs

Statewide alignment: Healthier WA team identifies the subset of measures that span the various Healthier WA activities. This set is then used to measure impact across all initiatives in all regions, including the participation of ACHs.

10.28.15

Healthier Washington: Accountable Communities of Health

***DRAFT** Theory of Change Model*

Inputs

Healthier Washington Funding | **Local Resources** | **Existing Regional Initiatives**

Key Condition

ACH Designation: Readiness to Implement Strategies

Strategies

Build Operational Elements
- Governance
- Structure
- Staffing
- Convening
- Data capacity
- Financial plan
- Sustainability
- Relationships

Develop & Strengthen Regional Partnerships (clinical and broader community partners)

Community Health Planning
- Develop Regional Health Needs Inventory, including health inequities
- Development of Regional Health Improvement Plan, including social determinants of health priorities

(To Be Clarified)

State-level Partnerships
- Advise & consult with Healthier WA
- Bring regional perspective to state policy and practice decisions
- Follow HCA guidelines for ACH role

Outcomes

Increased Organizational Capacity
- Management, stability, transparency regarding decision making, etc. meet criteria for optimal operations
- Local partners have committed resources

ACHs are Sustainable

Cycle of collaboration and improvement

Strengthened Regional Collaboration
- Greater range of actors engaged / sharing understanding / aligned on a set of key health improvement priorities that are informed by regional data
- Partners pursuing complementary activities, with alignment facilitated by the ACH
- Partners pursuing collective ACH projects funded by local & other partner investment

Increased Implementation of Regional Complementary and Collective Health Improvement Activities

Project-related Change in Policy, Practice and Systems

To be determined by Healthier WA

Key questions about ACH role & partnership, including level of resources for ACH health improvement work

Reach a level of project magnitude, spread and sustainability needed to achieve regional change

Regional Changes in Policy, Practice, and Systems

Impact

- **Regional population-level changes in health and well-being (regional and State) and improvements in health equity**
- **Regional changes to the Triple Aim: Improve access and quality, decrease cost**

Center for Community Health and Evaluation www.cche.org

Robert Wood Johnson Foundation

FROM VISION **TO ACTION**

A FRAMEWORK AND MEASURES TO MOBILIZE A CULTURE OF HEALTH

FALL 2015

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Photos clockwise from top left: Tyrone Turner, Mike Belleme, Pablo Durana, Tyrone Turner, Lynsey Addario, Tyrone Turner

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Cover Photos:
Top row, from left:
Tyrone Turner
Jay Ferchaud
Jordan Gantz
Roger Tully

Second row, from left:
Tyrone Turner
Pablo Durana
Flynn Larsen
Tyrone Turner

Third row, from left:
Mike Belleme
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Fourth row, from left:
Tyrone Turner
Roger Tully
Tyrone Turner
Josh Kohanek

WELCOME

IMPROVING AMERICA'S HEALTH BY WORKING TOGETHER AND MEASURING PROGRESS

When it comes to improving health, well-being, and equity in America, we often say that we are all in it together. But we as a nation have largely addressed health issues in parallel tracks, with limited cross-sector collaboration.

How can we start working *differently* to accelerate the pace of progress? How can we join forces across sectors to build a comprehensive Culture of Health that enables all in our diverse society to lead healthier lives, now and for generations to come?

This report presents an Action Framework, and a corresponding set of national Measures, designed to mobilize an integrated course of action by many individuals, communities, and organizations. Developed over the past 18 months, the Framework is the product of rigorous research and analysis, dynamic discussions, and valuable feedback from leaders across the public and private sectors.

Grounded in the legacy of those who have worked to advance health for years, the Framework also invites new participants to join the movement—many of whom may not have considered themselves to be influencers of health before now. It illustrates the transformative role that everyone can play, or may already be playing, in this national effort.

By expanding upon existing national metrics, this initial set of Measures aims to spark a dialogue about the many factors that influence health and provide entry points for action that resonate with people of every walk of life. These evidence-based Measures highlight the importance of families, educators, industry, the media, and other key players in shaping our physical, mental, economic, and social well-being.

The Framework is not a call for new, large-scale government programs. It is intended to leverage current resources, encourage innovative partnerships, and ultimately reduce national health care costs over time. It is meant to empower individuals, parents, and caregivers in making healthy choices, while fostering more equitable environments that help make those choices possible.

At the Robert Wood Johnson Foundation, building a national Culture of Health has become our central focus. But we are well aware that no individual, community, organization, or initiative can change the trajectory of America's health alone, and lasting change will not happen overnight. It will take collective engagement and unprecedented coordination between the public and private sectors. It will take talent, teamwork, and tenacity.

We do not presume to present all the answers in this report. Rather, it is our hope that it will broaden the discussion about what influences health, welcome new allies, spotlight stories of success, and inspire new collaborations so, in a generation's time, America can achieve the level of health that a great nation deserves.

RISA LAVIZZO-MOUREY, MD, MBA
PRESIDENT AND CHIEF EXECUTIVE OFFICER

ALONZO PLOUGH, PHD, MPH
VICE PRESIDENT, RESEARCH-EVALUATION-LEARNING, AND CHIEF SCIENCE OFFICER

INTRODUCTION

Photo: Tyrone Turner

America is at a pivotal moment of change regarding the health of her people: a moment of great urgency and unprecedented opportunity. Over the past few decades we, as a nation, have worked to improve health by focusing primarily on the health care system. But this has not achieved better health for all. More recently, we have started to recognize that health and well-being can be greatly influenced by complex social factors: where we live, how we work, the soundness and safety of our surroundings, and the strength and resilience of our families and communities. But knowing this has still not led to widespread progress, collaboration, or equity in health.

HEALTH IN AMERICA: A HIGH PRICE FOR SHORTER, SICKER LIVES

Despite some recent slowdown in spending, our nation's overall health care expenditures are unparalleled at nearly $3 trillion annually.[1] Though close to 18 percent of our GDP is spent on health care, the highest percentage in the world,[2] we continue to lose nearly $226 billion in productivity per year because of personal and family health issues.[3] Compared to people in similar high-income countries, Americans have poorer health and shorter life expectancy, and U.S. adults age 50 and older have a higher prevalence of cardiovascular and other chronic diseases.[4]

Over one-third of children ages 5 to 17 (35.9% of girls and 35% of boys) are overweight or obese in the United States, the highest rate among 17 peer countries.[5] These young Americans have a real chance of becoming the first to live sicker and die younger than their parents' generation.

Nearly one-fifth of all Americans live in low-income neighborhoods offering few opportunities for healthy living: little access to nutritious food, inadequate housing, pollution, high rates of crime, and scarce job opportunities.[6] These factors have a tremendous impact on health, and one sector alone cannot address them all.

NEARLY
$3 TRILLION
Annual health care expenditures in the United States

CLOSE TO
18% of U.S. GDP
Highest percentage spent on health care in the world

NEARLY
$226 BILLION
Productivity lost per year because of personal and family health issues

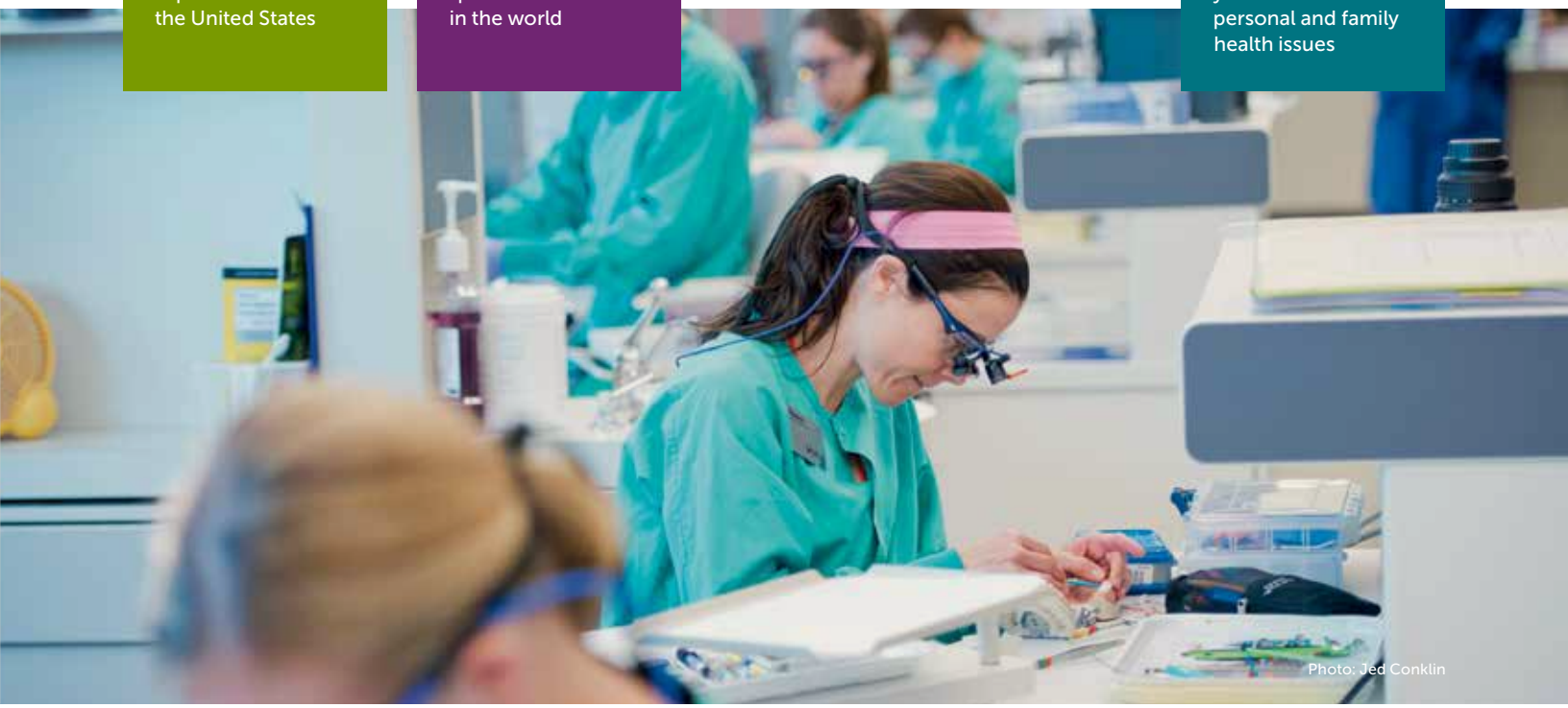


Photo: Jed Conklin

What is holding our nation back from better health for all?

For too long, our nation has defined being healthy as simply not being sick. Health is often presented as a goal that is separate from other aspects of life, rather than the bedrock of personal fulfillment, the anchor of community well-being, and the fuel of national prosperity. Good health is still seen as a luxury that is out of reach for many, and despite ongoing efforts positive change is not occurring at a promising pace.

Building a national Culture of Health means creating a society that gives all individuals an equal opportunity to live the healthiest lives possible, whatever their ethnic, geographic, racial, socioeconomic, or physical circumstances happen to be.

INTRODUCTION

OVER 1/3

Children ages 5 to 17 overweight or obese in the United States

Photo: Pablo Durana

To achieve lasting change, our nation cannot continue doing more of the same. We must embrace a more integrated, comprehensive approach to health—one that places well-being at the center of every aspect of American life. This approach must focus largely on what happens outside the health and health care systems, recognizing the importance of the decisions that individuals and families make, as well as the factors found in communities, business and corporate practices, schools, and the many other spheres of everyday life.

Building a Culture of Health calls for broad collaborative actions, not simply government mandates. It requires a clear public covenant among individuals, families, and communities to spearhead sustainable change with partners across sectors. Mobilizing progress will require new ways of engaging the private sector, solutions that bridge public and private sector collaboration, and structures that support innovation and entrepreneurship.

Using what we have learned from the successes and shortcomings of past initiatives, we must increase the opportunities for all individuals and communities to make healthier choices. And instead of starting from square one, we can and should creatively integrate valuable community resources and existing efforts into the Culture of Health movement.

This new perspective on health must become an essential part of our nation's cultural fabric, achieved by weaving together the threads of physical, mental, economic, social, and spiritual well-being. Creating a national movement toward better health is not a short-term initiative; it is a cultural shift that will take time, determination, and, above all, the input of many.

54%

Voting-age Americans voted in the 2012 general election

268,500

More tweets per month sent by Americans about illness care than about wellness, on average

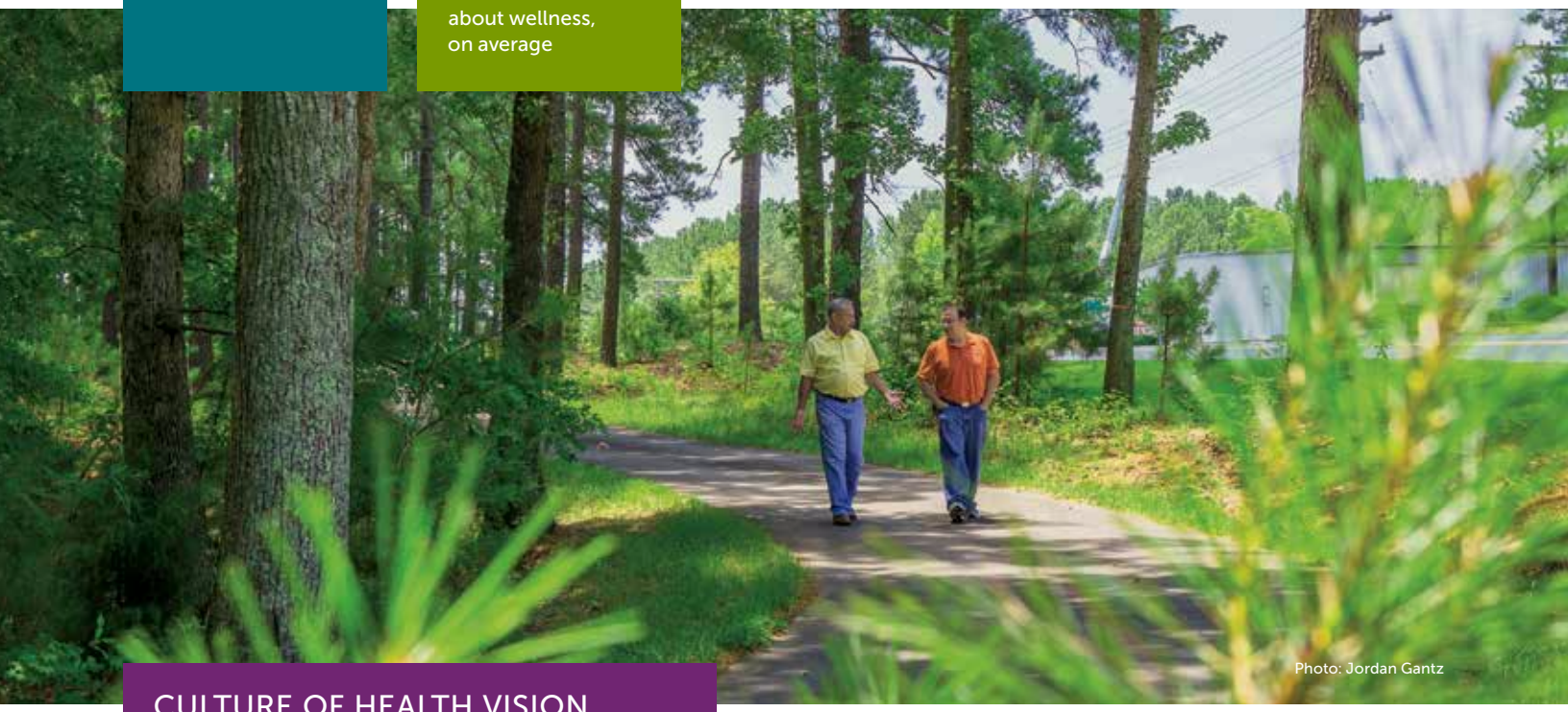


Photo: Jordan Gantz

CULTURE OF HEALTH VISION

WE, AS A NATION, WILL STRIVE TOGETHER TO BUILD A CULTURE OF HEALTH ENABLING ALL IN OUR DIVERSE SOCIETY TO LEAD HEALTHIER LIVES, NOW AND FOR GENERATIONS TO COME.

The Culture of Health Action Framework: Catalyzing Collaboration, Charting Progress

Building a Culture of Health requires action within and across sectors, because progress in one area will advance progress in another. But what areas of action should Americans work toward? How should our actions connect to one another? How can we find starting points that speak to the many different actors within communities? And what specific measures will gauge improvement?

In collaboration with the RAND Corporation—and with valuable input from partners, experts, colleagues, and communities across the country—the Robert Wood Johnson Foundation (RWJF) has developed an **Action Framework** to help our nation broaden the discussion about health and accelerate an integrated course of action by many individuals, communities, and organizations. The Framework is drawn from rigorous research and analysis of the systemic problems holding our country back from a level of health that a great nation deserves.

INTRODUCTION

Photo: Tyrone Turner

The Action Framework reflects a vision of health and well-being as the sum of many parts, addressing the interdependence of social, economic, physical, environmental, and spiritual factors. It is intended to generate unprecedented collaboration and chart our nation's progress toward building a Culture of Health. Equity and opportunity are overarching themes of the entire Action Framework—not merely to highlight our nation's health disparities, but to move toward achieving health equity.

The Action Framework groups the many actors, and the many facets, of a Culture of Health into four **Action Areas**—each connected to and influenced by the others. These Action Areas are intended to focus efforts and mobilize an integrated course of action by many individuals, communities, and organizations.

Each Action Area contains a set of **Drivers** that indicate where our nation needs to accelerate change. The Drivers are the engine of the Action Framework, providing a set of long-term priorities both nationally and at the community level. The Action Areas and the Drivers are the essential, enduring structure of the Action Framework and will remain constant over time.

Each Action Area is also accompanied by a set of national, evidence-based **Measures**, rigorously selected as points of assessment and engagement. By design, the Measures are not limited to traditional health indicators; instead, they encourage us to think of health in broader ways, incorporating all aspects of well-being. They are intended to serve as entry points for dialogue and action about health among a diverse group of stakeholders and across sectors. The Measures will illustrate progress and will evolve over time to keep pace with changing conditions.

The Measures highlight upstream factors that may not typically be associated with health care, and reflect actions that involve many more sectors and institutions than traditional health and health care services. Ambitious in scope, many of the Measures draw from existing sources, while others are based on new data gathered for this report.

OVER 80%

Food and beverage ads that young children (ages 2 to 5) see that do not meet standards for healthy nutrition

17th

United States life satisfaction ranking among similar industrialized countries

9%

Full-time police officers who have responsibilities for community-oriented policing

Photo: Mike Belleme

It is our hope that the unique interconnectivity of the Action Framework will lead to more intentional collaboration between and across sectors, and will foster a more holistic view of how health and well-being are shaped. Creative collaborations that transcend traditional boundaries must become the new normal if we are to successfully tackle our nation's urgent and disparate health challenges.

As we make progress in the four integrated Action Areas, we believe the nation will approach an **Outcome** of improved population health, well-being, and equity. This will change how our nation invests in health, how we build systems to promote well-being, and how we evaluate success. Individuals and families will affirm stronger commitment to their responsibilities in making healthier choices, and the public and private sectors will place a higher value on health as the essential building block of a productive, thriving society. Motivated by this shared value, we as a nation will prioritize and promote well-being so that all people can have access to healthier, more equitable neighborhoods and high-quality, efficient, and affordable health care services. And as we shift our spending from a disproportionate orientation toward intensive medical care to a better distribution across prevention programs that promote health, we should see an overall decrease in health care spending and improvements in how we prevent illness and manage chronic disease.

We recognize that building a Culture of Health is a long-term initiative that may span a generation or more. It will require unique implementation and assessment strategies that will develop over time.

CULTURE OF HEALTH ACTION FRAMEWORK

See Appendix for corresponding Drivers and Measures.

WHY THIS? WHY NOW? FUNDAMENTALS OF THE ACTION FRAMEWORK

What is the purpose of the *From Vision to Action* report?

This report is meant to describe the urgent need to catalyze change in health, well-being, and equity. The Culture of Health Action Framework is intended to spur dialogue and collaborative action between individuals, communities, and organizations across the public and private sectors. Additional research and other supporting materials will be developed to further outline RWJF's strategy and specific activities, and also to show how communities are embracing the Framework. The Culture of Health website will provide an additional platform for sharing new information and promising practices.

CULTURE OF HEALTH VISION: UNDERLYING PRINCIPLES

1. Good health flourishes across geographic, demographic, and social sectors.
2. Attaining the best health possible is valued by our entire society.
3. Individuals and families have the means and the opportunity to make choices that lead to the healthiest lives possible.
4. Business, government, individuals, and organizations work together to build healthy communities and lifestyles.
5. Everyone has access to affordable, quality health care because it is essential to maintain, or reclaim, health.
6. No one is excluded.
7. Health care is efficient and equitable.
8. The economy is less burdened by excessive and unwarranted health care spending.
9. Keeping everyone as healthy as possible guides public and private decision-making.
10. Americans understand that we are all in this together.

What is the origin of the Action Framework?

In 2014, RWJF proposed a vision of America where we all strive together to build a national **Culture of Health** *that enables all in our diverse society to lead healthier lives, now and for generations to come*. Ten underlying principles (at left) provided the foundation for this vision and the inspiration for the Action Framework, developed to mobilize a national Culture of Health and achieve an Outcome of improved population health, well-being, and equity.

How was the Action Framework developed?

The Action Framework and its components—the Action Areas, Drivers, and Measures—are drawn from rigorous research and analysis of the systemic problems holding our country back from a level of health that a great nation deserves. RWJF developed the Action Framework in collaboration with the RAND Corporation and with valuable input from more than 1,000 experts, partners, colleagues, community members, focus group participants, and global leaders during an 18-month period.

Why is the Action Framework needed?

Despite ongoing efforts to improve the health of our nation, positive change is not occurring at a promising pace. The Culture of Health Action Framework is intended to be broad and strategic, setting a national agenda and mobilizing a movement to improve health, well-being, and equity. The Framework offers an integrated, evidence-based, and comprehensive approach to addressing the societal influences of health and well-being. In doing so, it calls for unprecedented collaboration between individuals; organizations in the private and public sectors; and communities representing a range of social, demographic, and geographic characteristics.

Why use the term Action *Framework*?

Unlike a *model*—which implies something formulaic, fixed, and final—a *framework* speaks to a built-in fluidity. The Action Framework invites individuals, communities, and organizations to utilize the structure and find entry points relevant to their unique needs and goals. The Framework is not a *blueprint*, but rather suggests multiple pathways for action.

Why is equity an overarching theme?

In order to truly build a Culture of Health, we cannot leave anyone behind. Everyone should have the opportunity to pursue the healthiest life possible, no matter where they live or work, the color of their skin, or the amount of money they have. That is why achieving health equity is a goal that permeates the entire Action Framework.

What is the key difference between the Action Areas, Drivers, and Measures?

The Action Areas and Drivers constitute the essential and enduring structure of the Action Framework. They establish the priorities we should focus on as nation, and they will remain constant over time. The Measures are adaptable and will evolve to keep pace with changing conditions.

How were the Culture of Health Measures selected?

The Measures are intended to be illustrative indicators of where our nation needs to improve in order to advance a Culture of Health. The Measures have been rigorously identified as having the evidence base necessary to lead to improved health and well-being.

Through an intensive process of screening and winnowing, an initial list of hundreds was honed down to the set included in this report. Individual Measures were reviewed using criteria such as relevance, validity, and potential for collaborative action. Then, the full set was reviewed for its cohesiveness in broadly increasing health equity, while also addressing major national health challenges such as obesity.

The Measures include protective factors that if increased would improve health; they also include risk factors that if reduced would improve health and well-being. They are intended to be clear and understandable—empowering various audiences to make positive changes in health behaviors and policies.

Additionally, the Measures are intended to:

- Inspire dialogue and action
- Highlight priority areas that have eluded our focus as a nation, but which are crucial to building a Culture of Health
- Encourage a broader view of health, incorporating all aspects of well-being
- Welcome sectors not traditionally associated with health or health care services, encouraging cross-sector collaboration
- Provide entry points for individuals, families, and communities across diverse populations
- Support healthy choices
- Focus on both drivers and outcomes of health and well-being
- Include data that are accessible and represent powerful signals of change

How is this set of Measures different from existing national metrics, such as *Healthy People 2020*, *America's Health Rankings*, and the Institute of Medicine's *Vital Signs*?

The Culture of Health Measures have been purposely selected to build upon such efforts by highlighting underlying factors that influence health not represented in other national reports. The Measures are uniquely focused on tracking upstream social, economic, and policy indicators that, if improved, should significantly enhance population health and well-being on a national level. The Institute of Medicine and federal health officials recognize how these Measures align with their work to improve national health metrics, and how these Measures advance the way our nation gauges actions aimed at addressing the social determinants of health.

The Measures use a variety of data sources and methodologies by design—not just to engage different sectors, but also to reflect the complexity of decision-making and the multipronged ways communities get things done. For example, this is the only set of measures that uniquely combines broad influences, from business investment to early childhood development to urban design. While some Measures directly address health care services and the patient experience, many reflect underlying societal issues that influence health and well-being. The Measures speak to the importance of social support and community; public discussions around health promotion; and policies that facilitate collaboration across sectors.

How do the Culture of Health Measures complement the *County Health Rankings & Roadmaps*?

The development of the national Measures was closely aligned with the framework used for the Foundation's "sister set" of data, the *County Health Rankings & Roadmaps*. Like the county health data, the Measures presented in this report highlight many factors that influence health. However, we did not duplicate any of the *County Health Rankings* measures, which serve the specific purpose of ranking counties along standard

health outcomes to facilitate local dialogue and action. The Culture of Health Measures address specific, systemic factors that drive health at a national level; broaden the dialogue about what cross-sector actions improve health; and inform the evolution of local and national improvement efforts.

How can individuals and families use the Action Framework?

In a Culture of Health, individuals and families play an important part in spearheading sustainable local change. The Action Framework is intended to inspire, strengthen, and support individuals, families, caregivers, and communities in making healthier choices and engaging in healthier behavior.

Personal responsibility plays a key role in achieving better health and well-being. Individuals and families can engage with their communities and promote the kind of collective action that is needed. However, the evidence is clear that not all community environments and economic conditions give people the opportunity to make healthy choices. The Action Framework is intended to mobilize progress in building healthier, more equitable communities. In this approach, government is a partner, but does not always take the lead.

How can public- and private-sector organizations use the Action Framework?

Since every sector has a role in building a Culture of Health, we anticipate that a wide variety of stakeholders and sectors will use the Action Framework. As such, it is our hope that leaders across communities and sectors will review the Action Framework, see their work reflected in it, and contribute to it through their own efforts and ingenuity.

The Framework builds upon the energy and legacy of those who have worked to improve health, well-being, and equity for years. It also opens the door to new allies and provides entry points showing the transformative roles they can play—or may already be playing—in this national effort.

As a whole, the Measures can be used to guide city, state, or regional planning efforts. For instance, a mayor and his or her team can use the Action Framework to inform investment strategy and local evaluation of health and well-being. A consortium of public- and private-sector leaders could come together to plan for health actions using the Framework. Given the way the Framework uniquely links social, economic, and environmental factors, it can be used in many different planning contexts.

The Measures speak to a wide swath of sectors including ***housing*** and ***community development***; ***environmental*** and ***civic engagement*** organizations; ***law enforcement***; the ***media***; ***education***; and those organizations dedicated to expanding ***opportunity and equity***. A few ways that other important sectors are represented in this work include the following:

- ***Health care professionals*** are critical to the Culture of Health by strengthening the quality and value of health care services and ensuring those services are well integrated into a full system that consistently supports consumers and providers.
- For those who work with ***children and families***, the Action Framework includes specific measures to improve health across the lifespan.
- The Action Framework also addresses the important role of ***businesses***, which help create incentives and other policies to enhance health, and build consumer and employee demand for healthier practices and products.

How will RWJF use the Action Framework?

We intend for this Framework to guide the Foundation's work over the next 20 years, with annual updates. Our commitment is reflected in three ways:

- Investing in building the evidence base on the Drivers and Outcomes of a Culture of Health
- Examining ways to improve the systems of prevention and care that promote well-being, including how we train the next generation of health leaders and how we elevate promising strategies for innovation, rapid learning, and implementation through our programmatic funding
- Providing evidence-based information to decision-makers that informs the development of strategies and policies advancing broad collaboration for health improvement

RWJF does not intend to be the exclusive agent of change. We are one of many organizations working toward the common cause of improving health, well-being, and equity in America, and we hope to motivate others to join us in this national effort.

What is the timeframe of the Action Framework?

Creating a national movement toward better health is not a short-term initiative. It's going to require a cultural shift that may take a generation or more to achieve. It will take time, determination, and, above all, the input of many. The Framework's Outcome Areas and Measures will help gauge the progress of long-term improvement efforts.

ACTION AREA

1

MAKING HEALTH A SHARED VALUE

DRIVERS

MINDSET AND EXPECTATIONS

Value on health interdependence

Value on well-being

Public discussion on health promotion and well-being

SENSE OF COMMUNITY

Sense of community

Social support

CIVIC ENGAGEMENT

Voter participation

Volunteer engagement

Photo: Ed Kashi

1

MAKING HEALTH A SHARED VALUE

Photo: Roger Tully

For a comprehensive cultural shift to happen, health must be valued by all. Americans need to understand that we are all in this together, and keeping everyone as healthy as possible should guide public and private decision-making.

The Action Framework places our nation's values and expectations about health front and center. It establishes health as a core building block of personal fulfillment, thriving communities, and a strong, competitive nation. It does not, however, prescribe that a single definition of health should be held by all; rather, that achieving, maintaining, and reclaiming health is a shared priority, defined in different ways by different entities.

This Action Area emphasizes the importance of individuals, families, and communities in shaping and prioritizing a Culture of Health. Everyone should feel engaged with their community's decisions, evidenced by a sense of trust and voice in the process, and reflected by actions such as voting and volunteering. In addition to gauging our sense of community, the Measures are intended to encourage discussion about how relationships with friends, neighbors, and fellow community members motivate the decisions we make about health and well-being.

Positive movement in this Action Area will fuel a greater sense of community, an increased demand for healthy places and practices, and a stronger belief that individual actions can make a difference in the well-being of others. This will also be reflected in local leaders and decision-makers prioritizing health in all areas of community life.

DRIVERS:

MEASURES:

MINDSET AND EXPECTATIONS

The views and expectations we have about health ultimately inform the decisions we make as individuals, families, businesses, communities, and as a nation. Do we understand that our health affects the health of others and vice versa? Do we expect health to be prioritized in our policies and consumer choices?

Value on health interdependence
Percentage of adults, 18 years and older, in strong agreement that their health is influenced by peers, neighborhood, and the broader community[7]

Value on well-being
Percentage of adults, 18 years and older, interested in how their community invests in well-being, signaling a broader expectation for well-being[8]

Public discussion on health promotion and well-being
Proportion of tweets discussing health promotion and well-being to tweets discussing acute medical care[9]

SENSE OF COMMUNITY

Research suggests that individuals who live in socially connected communities—with a sense of security, belonging, and trust—have better psychological, physical, and behavioral health, and are more likely to thrive. If people do not see their health as interdependent with others in their community, they are less inclined to engage in health-promoting behaviors or work together for positive health change.

Sense of community
Aggregate score on two subscales of the Sense of Community Index: emotional connection to community and sense of belonging to community (membership) among adults, 18 years and older[10]

Social support
Percentage of adults, 18 years and older, noting they have adequate social support from partner, family, and friends[11]

CIVIC ENGAGEMENT

Civic engagement creates healthier communities by developing the knowledge and skills to improve the quality of life for all. Voting is a key component of a healthy society, yet many Americans do not vote regularly. Activities such as volunteering, community organizing, and participating in community groups demonstrate that residents care about the outcomes of their community and want to cultivate positive change. Moreover, communities with strong civic engagement are better able to respond and recover during an emergency. These Measures reflect whether Americans feel motivated and able to participate and make a difference.

Voter participation
Percentage of eligible voters who reported voting in general election[12]

Volunteer engagement
Percentage of adults and young people who reported volunteering[13]

ACTION AREA 1:

MAKING HEALTH A SHARED VALUE

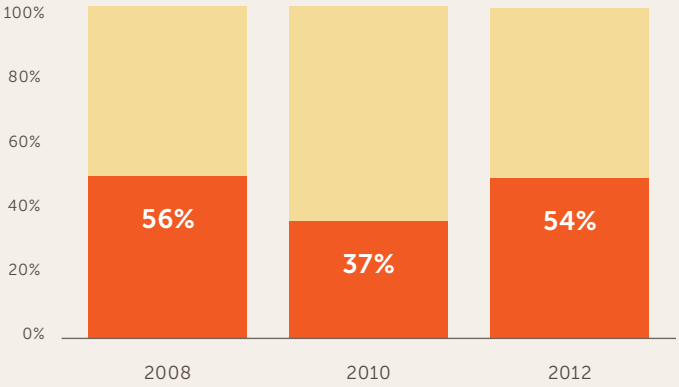
DATA SNAPSHOT

In a Culture of Health, we have a strong sense of community guided by health as a core value and driven by active civic participation. People engage by voting and volunteering in the community, and join in conversations that emphasize the promotion of health and well-being.

VOTER PARTICIPATION

54% of voting-age Americans voted in the 2012 general election

VOTER PARTICIPATION IN GENERAL ELECTION



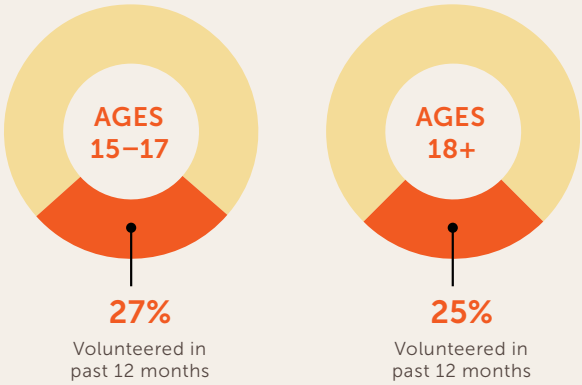
Calculated as total ballots in general election over the total eligible voting-age population (2008, 2010, 2012).

Data source: 2012 U.S. Atlas on general election turnout (aggregate from state election boards).

VOLUNTEER ENGAGEMENT

One-quarter of adults (18 years and older) reported volunteering in past 12 months

VOLUNTEERING BY AGE GROUP IN THE UNITED STATES

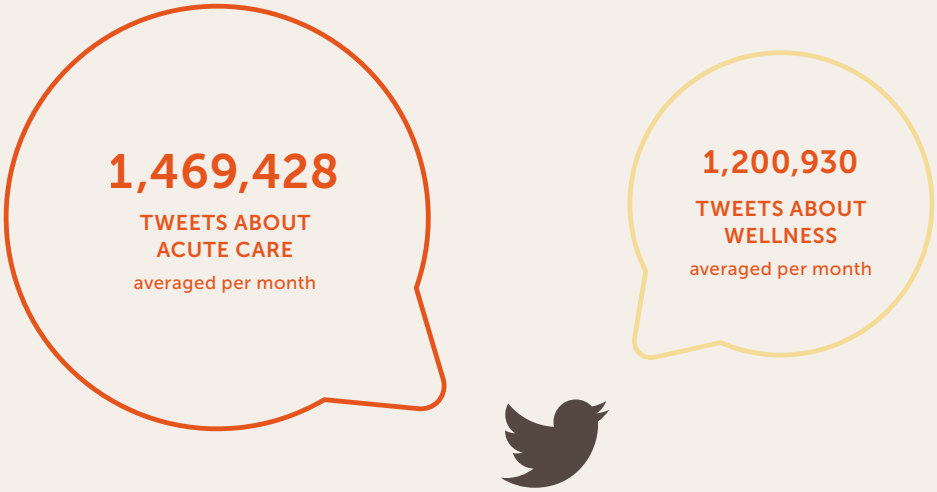


Data source: U.S. Census Bureau Current Population Survey September Volunteer Supplement 2013 (as reported by the Corporation for National & Community Service).

PUBLIC DISCUSSION ON HEALTH PROMOTION AND WELL-BEING

On average, Americans sent about 268,500 more tweets* per month about acute health care (illness care) than they did about wellness

AVERAGE MONTHLY FREQUENCY OF TWEETS BY TOPIC



Data source: These data from 2014 will be used as a baseline for future trend analyses to track changes in usage of these terms over time.

*Includes geotagged tweets and tweets by users with U.S. locations in their Twitter profiles.

CHANGE IN ACTION

Photo: Mike Belleme

THE HEALTHY MONADNOCK 2020 INITIATIVE

The Healthy Monadnock 2020 initiative has united the region of Monadnock, N.H., in its goal of becoming one of the healthiest communities in the nation. Founded by the Cheshire Medical Center/Dartmouth-Hitchcock Keene in 2007, Healthy Monadnock 2020 has been embraced by local government, schools, coalitions, businesses, and community members. More than 500 Monadnock region residents joined together to develop strategies to improve health and well-being in their community.[14] Recognizing the importance of social connections, the community set a goal to increase volunteerism from 67 percent in 2012 to 75 percent by 2020.[15]

LIVE WELL SAN DIEGO

Live Well San Diego began in 2010 as a health strategy adopted by the San Diego County Board of Supervisors. It has evolved from a government health initiative into a comprehensive, long-term, regional vision to advance the overall health, safety, and well-being of all San Diego County residents. Emphasizing the importance of a collective effort, Live Well San Diego is driven by a wide range of partners including health care providers, businesses, schools, faith-based organizations, and veterans groups. There are three components to the vision: *Building Better Health* calls for improving health and supporting healthy choices; *Living Safely* calls for ensuring residents are protected from crime and abuse, and communities are safe and resilient to disasters and emergencies; and *Thriving* calls for cultivating opportunities for people to grow, connect, and enjoy the highest quality of life. Transparent measures track and spur progress.[16]

RIVERSIDE COUNTY, CALIFORNIA

Photo: Eric Lowenbach/Getty Images

CULTIVATING A BROADER VIEW OF HEALTH

Photos: Tyrone Turner

Jay Orr took a circuitous path to become the man in charge of America's 10th largest county, one with 2.2 million people and nearly as big in size as New Jersey. He never considered himself an advocate for health, or had even been all that interested in health. He was a prosecutor. He loved putting bad guys in jail. But now, as the executive officer of Riverside County in Southern California, Orr has made health a top priority.

"Building prisons and fighting drugs, that's what gets you re-elected in local government," he says. "Talk about health, and people think, 'Oh, okay, you're a liberal, you're a Democrat.'" But, in fact, Orr is a Republican. Which, he adds, has nothing to do with how he's come to see improving health as an economic engine and necessity. "This is about survival," he says. "How do you attract new employers, quality employers, when your residents have some of the highest rates of obesity, diabetes, and heart disease in the state?"

Riverside County is among the least healthy in California, ranking in the bottom third in several key measures. When Orr became county executive officer in early 2012, 64 percent of his own 20,000 county work force was obese or overweight. It was clear to him that the county's health care costs could become crippling unless the work force got healthier.

WE'RE ALL IN THIS TOGETHER

In June of 2012, Orr declared his county would become the healthiest in the state, as well as "the safest, most business-friendly, and best place to live in America." He knew the economy and health went hand-in-hand, so he decided to support reforms that broadened the definition of health. He brought together strange bedfellows—competing hospitals, an insurer, universities, and a raft of community organizations—to discuss how better health could serve as an economic engine that would benefit everyone.

Then, he went to work on his own employees who were enormously receptive. He extended their union breaks from 15 to 20 minutes, and encouraged them to put on walking shoes. "Get out on the street," he told them, "and go walk a mile." He didn't mandate anything. He was never preachy. "I'm unhealthy. So are you," he said. "I'm not pointing fingers. I'm not telling you to diet. I'm telling you that we all need to fight to improve our health together. I have the same weight issues you have. I have the same stresses you have. I need to get healthy because I have children. You have children. We need to do this."

As part of this effort Orr also began visiting different county departments, going on walks with workers and posting videos on YouTube. "Some are kind of goofy," he admits. "They put a mic on me. I go out to the transportation yard, walk around, see big trucks, and I get in a big truck. We laugh it up and I leave. Then we push the video out to all 20,000 employees. Everybody can see we're all in this together."

Recently, Orr asked county workers to focus on what he calls the Four Ws: "Walking, water, watch what you eat, and watch your weight."

"If you can do these four things," he told them, "you're addressing chronic illness."

"THE FOUR Ws: WALKING, WATER, WATCH WHAT YOU EAT, WATCH YOUR WEIGHT.

IF YOU CAN DO THESE FOUR THINGS, YOU'RE ADDRESSING CHRONIC ILLNESS."

JAY ORR

Photo: Tyrone Turner

Photo: Tyrone Turner

HEALTH HAS NO BOUNDARIES

A while back, to save money, the county removed water coolers from its office buildings, Orr said. "The unintended consequence is nobody drinks water anymore. Everybody goes to the soda machine or coffee machine. We were penny-wise and pound foolish." So, Orr brought water back, installing "hydration stations" that provide filtered water from the tap. "People like it," he says. Employees are filling their bottles. The county is promoting water drinking. It's a win-win.

In 2011, the county passed the Healthy Riverside County Initiative and Orr has led the charge to turn that initiative into an integrated countywide effort. He has raised visibility and effectiveness of many existing programs, and zeroed in on four main goals: physical activity, healthy eating habits, tobacco control, and improving built environments—sidewalks, bike trails, gardens—in existing and new developments. Additionally, the county has established a coalition to help municipalities share ideas about improving health, and how they might launch their own initiatives.

Orr is the most visible in trying to build a Culture of Health, but truly is just one of many. Laura Roughton, the former mayor of Jurupa Valley, one of the poorest cities in Riverside County, with some of the greatest health disparities, says she experienced a new understanding of health when she listened to a speaker discuss factors like sidewalks, clean air, bike paths, strong schools, jobs, and access to healthy food. "Oh, my gosh: It's all connected," she remembers thinking. "Health has no boundaries." This revelation motivated her to help establish the Healthy Jurupa Valley initiative, and she has become a devoted crusader for community health.

As part of a demonstration that Roughton likes to give to local groups, she dresses up like a doctor—with a white lab coat, a black bag, and a play stethoscope around her neck. "When you think of health, I bet you think of the white coat," Roughton, still a city council member, says to audiences. And then she pulls out of her black bag a series of props—a soccer ball, a toy fire truck, a piece of fruit, a book, a welcome home sign—all to convey the broader definition of health. Residents of her city are beginning to understand, and beginning to get involved. Volunteers are building gardens with raised beds at elementary schools, painting intersections, organizing mural projects for old buildings, setting up farmers' markets. "I can see walls coming down between agencies, nonprofits, counties, and cities as we all work toward this goal," Roughton says. "I am grateful to Jay Orr for his big-picture vision of health."

ONE STEP AT A TIME

Orr says he is most excited about what is still to come. Last year—at his instigation—the county, local universities, and an insurer teamed up in a novel partnership to start an evidence-based diabetes intervention with 100 residents in Jurupa Valley. Orr and others hope in the next few years it will improve the health of tens of thousands in that city and will be replicated throughout the county.

His most recent plan, which is still in the works, is to establish a clinically integrated network for the county. The network will include three hospitals that have been competitors in the past: Riverside's county hospital, San Bernardino's county hospital, and the Loma Linda University Medical Center. A fourth partner in the integrated network will be the Inland Empire Health Plan, which covers 1.2 million Medicaid patients. All will share a common medical records system and other information. The goal is to give people quality care in the most appropriate and convenient settings.

"Jay was a big part of this," says Bradley P. Gilbert, MD, chief executive officer of Inland Empire Health Plan. "Jay as a CEO of a county having this level of interest in health; that is really unusual."

Photos: Tyrone Turner

Still, Orr knows that success will literally come one step at a time, with the spread of more and more programs like Fit Fridays, a weekly effort to get children to walk to school. Principal Gerardo Aguilar at S. Christa McAuliffe Elementary in Riverside admits that at first he was reluctant to participate. He saw the program as just another responsibility in his already too-busy day. But it has really caught on. Now "Grandpa Frank" Allen, 72, who has two grandchildren at the school, leads the weekly trek. Some 200 students meet at a park about half a mile from school and together they walk to class. Victor Ly, 33, a car salesman, says he usually doesn't have time to walk with his daughters, Vikki, 10, and Vivian, 5. He drops them at school and then drives to work. Except now on Fridays they all walk together, because the girls love it.

"Tallyho, let's go!" Grandpa Frank shouts as the children, wearing sunglasses and blowing whistles, process on a gorgeous Southern California morning.

Photo: Tyrone Turner

ACTION AREA

FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING

DRIVERS

NUMBER AND QUALITY OF PARTNERSHIPS

Local health department collaboration

Opportunities to improve health for youth at schools

Business support for workplace health promotion and Culture of Health

INVESTMENT IN CROSS-SECTOR COLLABORATION

U.S. corporate giving

Federal allocations for health investments related to nutrition and indoor and outdoor physical activity

POLICIES THAT SUPPORT COLLABORATION

Community relations and policing

Youth exposure to advertising for healthy and unhealthy food and beverage products

Climate adaptation and mitigation

Health in all policies (support for working families)

Photo: Roger Tully

2

FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING

Photo: Tyrone Turner

Health means much more than simply not being sick. And for well-being to flourish, we must consider the community settings that routinely influence our health such as neighborhoods, schools, and workplaces. ***This Action Area places new focus on collaborations that include sectors typically viewed as "outside" of health care, and demonstrates how these cross-sector collaborations can play an essential role in building a Culture of Health.***

Across the nation, hospitals, health systems, and medical professionals continue to make important strides in mobilizing the collaborative Culture of Health vision. But the health care sector cannot bear sole responsibility for improving the country's health. While progress in cross-sector collaboration has been made in recent years, we need to ensure that more partnerships can reach their full potential. We must break down silos that separate improving health from the work of education, business, transportation, community development, and other historically "nonhealth" sectors that form an integral piece of the health puzzle. We also must ensure that organizations representing traditionally vulnerable communities are actively included in dialogue and decision-making.

The Measures highlight the extent and effectiveness of cross-sector collaborations and investments, and suggest an even broader range of partnerships. When we succeed in this Action Area, health and public health professionals join with schools, faith-based organizations, businesses, environmental groups, and other community partners to make the healthy choice the easy choice. Corporations invest in healthy community development to cultivate a more productive workforce. Different sectors recognize their unique contributions to well-being and align their resources accordingly—working as a cohesive whole. We spread and scale successful collaborations, spurring improved health and well-being locally and nationally.

DRIVERS:

MEASURES:

NUMBER AND QUALITY OF PARTNERSHIPS

Research indicates that building relationships among partners is the most challenging aspect of creating change, and that leadership is particularly important for cross-sector synergy.[17] Other key factors include establishing a history of collaboration between organizations, ensuring participants have the resources they need, and building a sense of shared accountability. A Culture of Health calls for assessing the effectiveness of our partnerships and the integration of healthy practices in schools and workplaces—settings where well-being can flourish or falter.

Local health department collaboration
Percentage of local health departments that collaborated with community organizations in at least four public health program areas in the past year[18]

Opportunities to improve health for youth at schools
Annual number of school-based health centers that provide primary care[19]

Business support for workplace health promotion and Culture of Health
Index of employer health promotion and practices (by size of business)[20]

INVESTMENT IN CROSS-SECTOR COLLABORATION

In addition to measuring the quality and quantity of cross-sector collaborations, it is important to track investments that support these partnerships. Corporate and federal contributions have the power to impact our nation's health and well-being, both directly and indirectly.

U.S. corporate giving
Annual dollar amount of U.S. corporate contributions to education (K–12 and higher education) and to community/economic development sectors[21]

Federal allocations for health investments related to nutrition and indoor and outdoor physical activity
Annual dollar amount of federal appropriation to select health initiatives

POLICIES THAT SUPPORT COLLABORATION

Policies can play a key role in encouraging and maintaining collaboration across sectors, as well as creating incentives for different sectors to contribute what they can to the cause of improving our nation's health. These Measures highlight policies that have the potential to catalyze widespread improvement in health and overall well-being.

Community relations and policing
Percentage of full-time sworn personnel who have served as community policing or community relations officers, or were designated to engage regularly in community policing activities[22]

Youth exposure to advertising for healthy and unhealthy food and beverage products
Annual measure of children's exposure to TV ads for unhealthy foods/beverages[23]

Climate adaptation and mitigation
Annual percentage of states with climate adaptation and mitigation action plans[24]

Health in all policies (support for working families)
Annual percentage of families with parents eligible for Family Medical Leave Act (FMLA) coverage who can also afford it[25]

ACTION AREA 2:

FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING

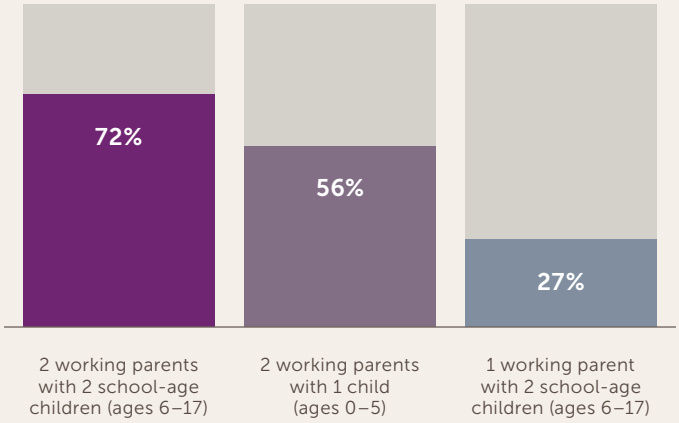
DATA SNAPSHOT

In a Culture of Health, we break down silos that separate improving health from the day-to-day work of businesses, schools, and other community institutions. These and other historically "nonhealth" sectors recognize their important contributions to well-being, aligning resources and policies accordingly. Public and private sectors work together to support population health and well-being.

HEALTH IN ALL POLICIES (SUPPORT FOR WORKING FAMILIES)

Many American families cannot afford to take the time to care for relatives, which can put strain on the family and affect the health of loved ones

PERCENTAGE OF FAMILIES THAT MAKE ENOUGH ANNUALLY TO MEET BASIC NEEDS AND AFFORD FAMILY MEDICAL LEAVE ACT BENEFITS, BY FAMILY TYPE



Data source: Current Population Survey Social and Economic Supplement (baseline data are 2012, 2013) and the Basic Economic Security Tables (2010).

COMMUNITY RELATIONS AND POLICING

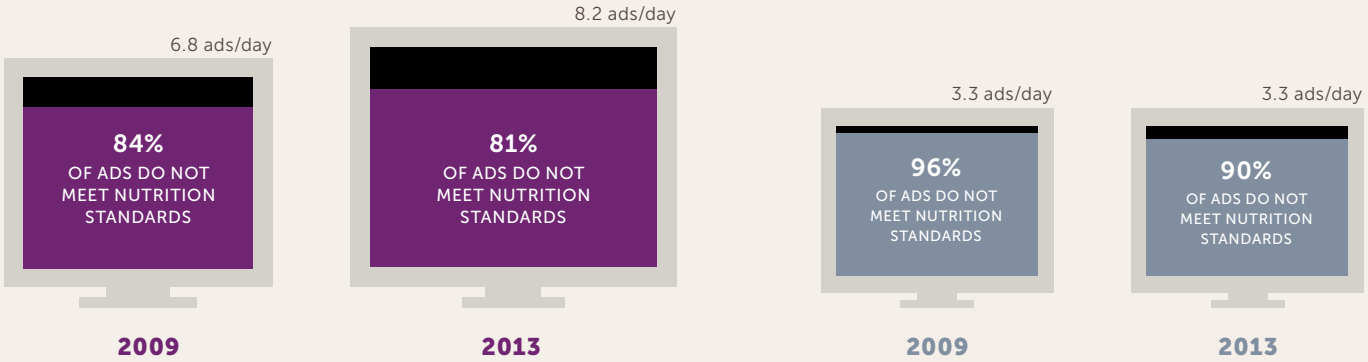
Community policing, and community-oriented policing specifically, reflects a transition from traditional policing, which can be reactive to crimes, to a model that fosters a positive relationship between the public and police. Police programs designed to improve law enforcement relationships with the public, including community policing, have been shown to reduce crime, and specifically violence.

FULL-TIME POLICE OFFICERS WHO HAVE RESPONSIBILITIES FOR COMMUNITY-ORIENTED POLICING (69,592)

Data source: Bureau of Justice Statistics Census of State and Local Law Enforcement Agencies (CSLLEA is fielding 2014 now; the last survey was fielded in 2008).

YOUTH EXPOSURE TO FOOD AND BEVERAGE ADVERTISING

Over 80% of the food and beverage ads that young children (ages 2 to 5) see do not meet standards for healthy nutrition



Data source: Data licensed from Nielsen Media Research (fielded in 2013 with trend data available back to 2009).

CHANGE IN ACTION

Photo: Tyrone Turner

NATIONAL CENTER FOR MEDICAL-LEGAL PARTNERSHIP

The National Center for Medical-Legal Partnership bridges two often antagonistic professions to address legal needs that have an impact on health; for example, people who are wrongfully denied insurance or food assistance benefits, or those who live in housing in clear violation of sanitary codes. Nationwide, Medical-Legal Partnerships (MLPs) have become integrated with the fabric of health care delivery. MLPs are now found in over 270 health care institutions in 36 states[26] and counting, with nearly 60,000 patients assisted in 2014. Published studies have shown that patients better comply with health care treatments after their legal needs have been addressed by an MLP, and legal assistance targeted at housing conditions improved the health of asthma patients.[27]

CROZER-KEYSTONE HEALTH SYSTEM

Crozer-Keystone Health System (CKHS) is situated in Delaware County, Pa., an area with oil refineries and other heavy industries that impact air and water quality. CKHS addressed the prevalence of pediatric asthma in its community through a comprehensive, cross-sector approach. The first step was contacting the state Environmental Protection Agency, which fined companies for releasing pollutants above permissible levels. The health system also collaborated with a community organization, Chester Environmental Partnership, to run an indoor/outdoor home intervention and environmental remediation and education program. CKHS joined with local schools to launch the Kids Asthma Management Program, providing screenings and asthma awareness days, and partnered with children's soccer leagues to encourage exercise. As a result of these collaborative, multipronged efforts, the 9-11 calls for asthma-related symptoms in children have decreased to less than 1 percent of what they once were. The program implemented with Chester Environmental Partnership showed a reduction in frequency of children's asthma flare-ups, improvement in asthma control, and a decrease in emergency room visits.[28]

CAMDEN, NEW JERSEY

Photo: Lynsey Addario

AT THE CAMPBELL SOUP COMPANY, THE SPECIAL INGREDIENT IS COLLABORATION

Photos: Samantha Appleton

In 2007, the Campbell Soup Company® made a historic decision. It would keep its corporate headquarters in Camden, N.J., where it has been for 146 years, despite the city's significant economic and social challenges. But that wasn't all. Campbell also announced that it would pump $1 million a year, for 10 years, into a bold challenge—to reduce childhood obesity and hunger in Camden by 50 percent.

Campbell executives conceived this effort on the White House Lawn, inspired by Michelle Obama and her *Let's Move!* campaign. Data showed that 42 percent of the city's 23,000 children were obese at the time, and there wasn't any way to measure how many were hungry. Campbell hired Kim Fortunato—who came from Operation Warm, a nonprofit that distributes new winter coats to children—to lead the initiative, the first of its kind in the food industry.

From the beginning, in autumn of 2011, Fortunato knew the issues Campbell intended to address were complex. She needed to recruit the broadest spectrum of partners and get them to check their egos at the door. They needed to join forces—across sectors—if they were going to truly build a Culture of Health in one of the nation's poorest cities.

A COLLECTIVE EFFORT

"My hat is off to Campbell," says Dr. Jeffrey Brenner, executive director of the Camden Coalition of Healthcare Providers (CCHP), and a MacArthur "genius" grant recipient. "You should start projects like this with an audacious goal, and this is an audacious goal. Camden is only 79,000 people, eight square miles. And if it works in Camden—we're like the poster child for dysfunction—it will work anywhere."

Fortunato rounded up great partners, 10 in all, including The Food Trust to focus on nutrition education and access to fresh, healthy foods; The Food Bank of South Jersey to stress cooking instruction; Brenner's group for data collection and evaluation; the YMCA to promote exercise; Food Corps to help build community gardens; and a regional planning commission. And the first thing Fortunato had to admit was that she didn't know—none of them knew—the answers. Campbell Healthy Communities, as the campaign is known, would be a collective effort.

The partners agreed on four areas of focus: access to healthy food, nutrition education, access to physical activity, and creating public will. They would concentrate on changing systems, like getting the school district of Camden and local Head Start programs to create nutritional guidelines and policies, and initiate after-school soccer programs at 19 locations citywide. They also would work toward changing the culture at specific sites, including a local Head Start center, a public school, and a charter school run by Antoinette Dendtler.

Dendtler grew up on a farm in rural Virginia, surrounded by farm animals. "I was connected to the environment in a meaningful and significant way," she recalls. "I didn't understand why people had to go to the grocery store to buy vegetables for a very long time because we grew our own."

In her teens, Dendtler spent summers in the Bronx and Brooklyn with relatives, seeing an entirely different side of the world. After getting a master's degree in education from Harvard, she decided her life's mission was to help disadvantaged students get an education. In 2005, she founded the Environment Community Opportunity (ECO) Charter School in Camden.

From the start, Dendtler tried to create a Culture of Health at ECO Charter. There are no vending machines, no junk food at school parties. But Dendtler will be the first to admit that health didn't become a truly fundamental part of the school culture until the Campbell Healthy Communities partnership got involved.

Every month, The Food Trust helps teachers create lesson plans, worksheets, and activities. The Food Bank of South Jersey brought stoves into the school and leads cooking classes in the evenings with students and parents, giving them the ingredients to cook the same meals at home. The Food Corps built a vegetable garden with raised beds and helps the students tend them. The YMCA runs recess, keeping the students moving and engaged. When kids get tagged playing dodge ball, they can't get back into the game until they name four vegetables.

Kindergarten children now count with carrot sticks and celery, do groupings with grapes and cherry tomatoes, then taste the produce and talk about how it makes them feel. In the 5th grade, students go to a grocery store, write about it, and answer questions based on food labels, nutrition, and ingredients, requiring them to do math problems.

Recently, an ECO staffer calculated how many teaspoons of sugar were in the most popular sugary drinks and snacks, filled plastic bags with the appropriate amount of sugar and stapled the lumpy pouches below pictures of the drinks and snacks on the school bulletin board. Many parents have told Dendtler they had no idea that the food they were buying was so bad for their children. It makes her happy, she says, when parents tell her: "I can't go to the grocery store anymore without my child telling me don't eat this or that, or don't buy this or that." "We've now made these connections, and institutionalized these practices," says Dendtler. "Now it lives in the school. It's now part of our every day."

Photo: Samantha Appleton

Photo: Samantha Appleton

COOKING UP HEALTHY PRACTICES

As part of the health focus at ECO Charter—and other participating schools—5th-graders get to take four cooking classes at Campbell's headquarters with the company's chefs and nutritionists, in the beautiful consumer test kitchens.

During one class, students sampled whole grains—quinoa, bulgur, and barley.

"How many of you have heard of quinoa?" asked Jane Freiman, director of the consumer test kitchens.

No hands went up.

"This is your lucky day!" she said, passing around paper cups filled with the uncooked grains.

"What does that look like?" Freiman asked.

"Birdseed," one student replied.

They sampled all the cooked grains and then prepared salads with carrots, apples, almonds, peppers, and many other ingredients, rinsing and slicing and dicing. They learned about the emulsive properties of mustard, mixing it with oil and vinegar to make salad dressing. Then they all sat down to eat. Dendtler asked the students, "Have you changed anything in your life in terms of eating or healthy practices?" And one by one they answered.

Jeremiah Crespo: "My mom used to make me white rice, and now she's making me brown rice because I told her that white rice, some stuff is taken out of it, and brown rice, has all that good stuff in it."

Terri Bell: "My mom buys Kool-Aid® but I told her the sugar is bad and now we drink more water and less Kool-Aid."

Angelo Rodriguez: "I don't eat regular fried chicken. I eat baked chicken."

"Why?" asked Dendtler, following up.

"Fried chicken has oil and sodium, and baked chicken doesn't," he explained.

"Well, it has less," Dendtler said.

Julianna Santiago: "I tried tofu and I like it. My mom buys it and I eat it now in salads."

Last year, the ECO 5th-graders didn't just cook at Campbell. They also shadowed eight different managers to learn what they do. Dendtler says this is just one of the many unexpected benefits of the Campbell initiative. The collaboration's reach across the community is another.

Today, The Food Trust is working with 36 bodegas, about one in four in Camden, encouraging owners to carry at least four fresh fruits and vegetables. Those that stock even more can qualify for free refrigerators, baskets, and shelving. As a result, some bodegas are now offering customers up to 16 new fruits and vegetables.

Additionally, a program called Soccer for Success®, a co-investment with the U.S. Soccer Foundation®—operated by the YMCA of Burlington and Camden Counties—offers after-school programming to nearly 700 students. To measure the program's impact on kids' weight, organizers are recording the body mass index of children in the program every year. In 2014, 44 percent fell into the healthy-weight category before the soccer program began. After two 12-week sessions, that number rose to 48 percent. By the same token, 56 percent of the participants were classified as overweight or obese before the soccer practices, 51 percent after.

Photos: Samantha Appleton

The other side of the Healthy Communities effort deals with hunger and food insecurity. As part of a pilot program at Our Lady of Lourdes Hospital in Camden, 900 patients were asked questions about food insecurity. More than half said within the last 12 months they had either run out of food and had no money to buy more, or they were worried that they'd run out of food before they could get money to buy more. By posing the same questions to families at schools, after-school programs, Head Start programs, medical practices, and other places around the city, Camden Coalition of Healthcare Providers intends to build a database about hunger in Camden. "The fact that we're building a system to track hunger in Camden is a huge milestone," said Natasha Dravid, a senior program manager with CCHP.

All the partners in the Campbell initiative say they see signs of hope emerging in many places, like the Head Start program where Mary Mitsdarffer of The Food Trust was recently reading a story to a group of youngsters seated in a semicircle around her. The tale was about a fish that wished it could eat fruits and vegetables. In a burst of enthusiasm, 4-year-old Xzayvion Ruiz interrupted her, raising both arms, flexing his biceps, singing out: "Every time I eat my vegetables I get strong!"

Photo: Samantha Appleton

27th St
NO LEFT TURN
ROBINSON
931-3133

ACTION AREA

3

CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES

DRIVERS

BUILT ENVIRONMENT/ PHYSICAL CONDITIONS

- Housing affordability
- Access to healthy foods
- Youth safety

SOCIAL AND ECONOMIC ENVIRONMENT

- Residential segregation
- Early childhood education
- Public libraries

POLICY AND GOVERNANCE

- Complete Streets policies
- Air quality

Photo: Tyrone Turner

3

CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES

Photo: Tyrone Turner

Everyone in America deserves a fair and equal chance to pursue health. To improve the vitality and prosperity of our entire nation, we must eliminate health disparities that are often tied to geographic, demographic, and social factors. Personal choice and responsibility play key roles in well-being. Individuals, families, and organizations must join together to make the healthy choice the easy choice for all.

Unfortunately, well-being in America can be unduly and unequally influenced by income, education, and ethnicity. Our ZIP code may be as important as our genetic code in determining health. In New Orleans, a person born in the Lakeview area can expect to live 25 years longer than one born near Iberville just a few miles away. In Washington, D.C., a few Metro stops can mean a difference of up to seven years in life expectancy.[29]

The goal of this Action Area is to encourage communities to fulfill their greatest health potential by improving the environment in which residents live, learn, work, and play. While we have made strides in creating healthier environments, we must ensure that community settings support overall well-being and extend to upstream influences of health including early childhood education.

Successes in this Action Area result in Americans living in neighborhoods that offer access to nutritious and affordable food, recreational facilities, lifelong learning environments, and active transportation methods such as bike trails and sidewalks. These environments continuously provide for the healthy development of children and the ability to age in place for older adults.

DRIVERS: | **MEASURES:**

BUILT ENVIRONMENT/ PHYSICAL CONDITIONS

The built environment—or the physical space in which we live, learn, work, and play—is key to a community's well-being. For example, sidewalks in good condition and active transport routes, such as bicycle lanes, are features of the physical environment that may provide greater access to exercise and healthy food options. However, to take advantage of these opportunities, it's essential that we feel safe in our neighborhoods, parks, and schools.

Housing affordability
Percentage of families spending 50 percent or more of monthly income on housing costs for either rent or mortgage[30]

Access to healthy foods
Percentage of U.S. population with limited access to healthy foods[31]

Youth safety
Percentage of middle and high school students who reported feeling safe in their communities and schools[32]

SOCIAL AND ECONOMIC ENVIRONMENT

Our social environment, such as enduring racial and socioeconomic segregation, can also influence health and impact a community's sense of trust and cohesion. In addition, research points to strong connections between our environment, economic vitality, and health. We know that children who attend preschool are more likely to stay in school, go on to hold jobs and earn more money—all of which are linked to better health.[33] Public libraries continue to serve as important hubs of enrichment and well-being—providing community connections and computer access, and links to civic engagement, health literacy, and resilience.

Residential segregation
Evenness with which racial/ethnic groups are distributed across communities (index of dissimilarity, exposure to diversity)[34]

Early childhood education
Number of states where 60 percent or more 3- and 4-year-olds are enrolled in preschool[35]

Public libraries
Number of library outlets per 100,000 people[36]

POLICY AND GOVERNANCE

This area spotlights policy aimed at creating healthy environments, with an emphasis on collaboration between residents and large institutions, both governmental and corporate. Too often, we see health-promoting initiatives fall short without the policy structures in place to sustain them.

Complete Streets policies
Number of jurisdictions with Complete Streets policies in place[37]

Adopting a Complete Streets policy means that every transportation project will make the street network better and safer for drivers, transit users, pedestrians, and bicyclists. These policies allow communities to direct their transportation planners and engineers to routinely design the entire right of way to enable safe access for all users, regardless of age, ability, or mode of transportation.[38]

Air quality
Percentage of population covered by comprehensive smoke-free indoor air laws[39]

ACTION AREA 3:

CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES

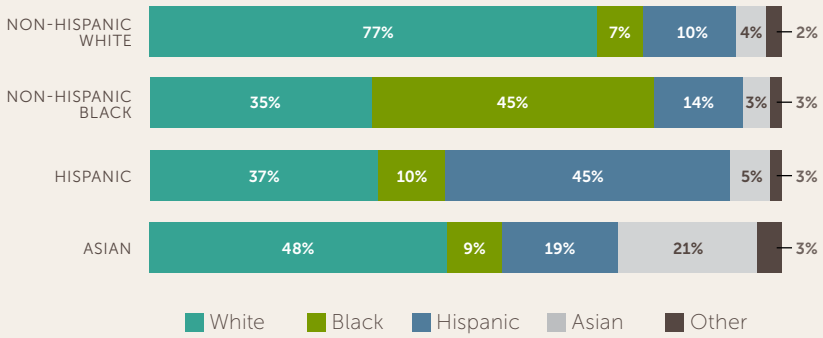
DATA SNAPSHOT

In a Culture of Health, our community settings and policies support well-being by affording equitable access to health opportunities and resources. These include upstream influences on health such as enrollment in early childhood education, access to economic resources, and feeling safe in the community.

RESIDENTIAL SEGREGATION

On average, far more white Americans live in communities that are not as diverse as the communities in which black Americans or other groups live

DIVERSITY EXPERIENCED BY EACH RACIAL/ETHNIC GROUP, WITHIN CENSUS TRACT



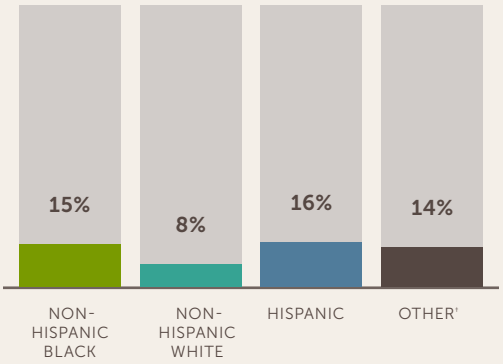
Major contrasts exist between the typical residential experience of whites versus that of other racial/ethnic groups in the United States. Differences between affluent and poor racial/ethnic minorities (but especially blacks and Hispanics) result in neighborhoods where income segregation exacerbates racial residential segregation. Such "concentrated disadvantage" limits access to social, economic, and political opportunity.

Data source: American Community Survey, 2013.

YOUTH SAFETY

Youth feelings of safety vary by race/ethnicity

PERCENTAGE OF U.S. SECONDARY STUDENTS* WHO FEEL UNSAFE SOME, MOST, OR EVERY DAY WHILE GOING TO AND FROM SCHOOL, BY RACE/ETHNICITY



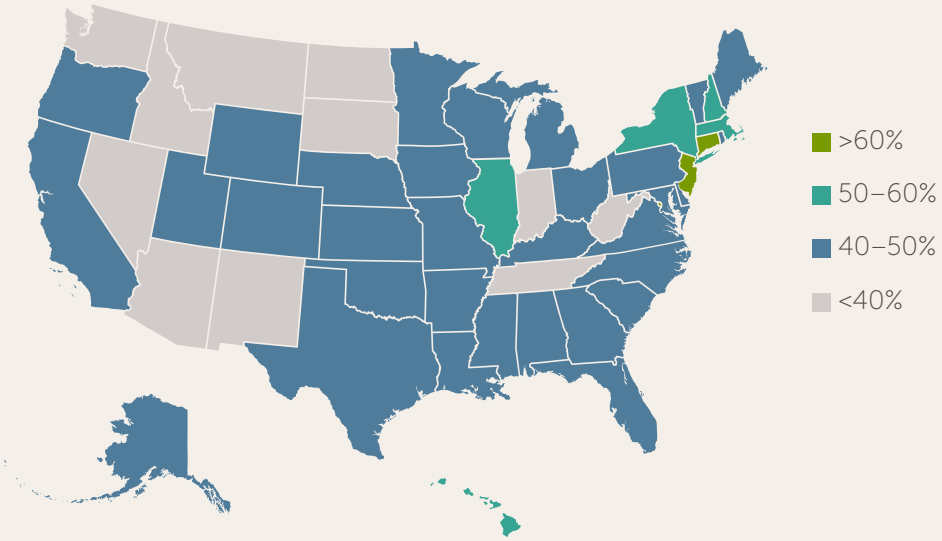
Data source: Annual NIDA Monitoring the Future Survey (baseline goes back more than 10 years; most recent data are December 2014).

*Secondary students include 8th-, 10th-, and 12th-grade students within the coterminous United States. Differences between racial/ethnic groups significant at p<.001.

†Asian American, Pacific Islander/Native Hawaiian, American Indian/Alaska Native

EARLY CHILDHOOD EDUCATION

Few states report high enrollment of 3- and 4-year-olds in preschool



Data source: American Community Survey, 2013.

Our nation's low-income children start school at a disadvantage with respect to early skills, behaviors, and health. Fewer than half (48%) of these children are ready for school at age 5, compared to 75% of children from families with moderate and high income—a 27 percentage point gap.

http://fcd-us.org/sites/default/files/Evidence%20Base%20on%20Preschool%20Education%20FINAL.pdf

CHANGE IN ACTION

Photo: Pablo Durana

ROLLING HILLS DEVELOPMENT

On the East Side of Saint Paul, Minnesota, residents of Rolling Hills Apartments now have a healthier place to call home. Research by the East Side Family Clinic revealed that diabetes, obesity, and hypertension were common in the racially and ethnically diverse neighborhood. So, in addition to renovating 108 affordable housing units, the improvement plan called for on-site medical services to increase access to health care, vegetable gardens to support healthy eating, and a new community space with activities to promote social connectedness. Project partners and funders—spanning the fields of health care, human services, community development finance, and culture—introduced environmental changes that helped address the health needs of more than 400 Asian and African refugees who reside in the housing development. "The traditional community development conversation was one about siting, density, and affordability requirements. Framing our work as 'building healthy communities' has helped us to broaden the conversation and bring more people to the table," said Andriana Abariotes, executive director of Twin Cities LISC (Local Initiatives Support Corporation), a key project funder. The Federal Reserve Bank of Minneapolis has helped to spotlight projects such as these, which illustrate the important role that community developers have in building a Culture of Health.[40]

PURPOSE BUILT COMMUNITIES

Purpose Built Communities is modeled on the East Lake Foundation's redevelopment of Atlanta's East Lake neighborhood, which was once known for poverty and crime, but today is widely recognized for community revitalization. In 1995, instead of tackling poverty, urban blight, and failing schools piecemeal, a group of community activists and philanthropists addressed all of these issues at once. Distressed public housing units were demolished and replaced with new apartments, half of which are market rate. The neighborhood, which once had 1,400 extremely low-income residents, is now home to 1,400 mixed-income residents. In addition, shared facilities and services bring neighbors together and foster a sense of community. Remarkable changes have occurred. The employment rate of low-income adults increased from 13 percent to 75 percent; the neighborhood's Drew Charter School moved from the lowest performing public school in Atlanta to among the highest performing in both the city and the state of Georgia; and violent crime dropped by 90 percent. The model is being replicated in 12 communities across the nation.[41]

TULSA, OKLAHOMA

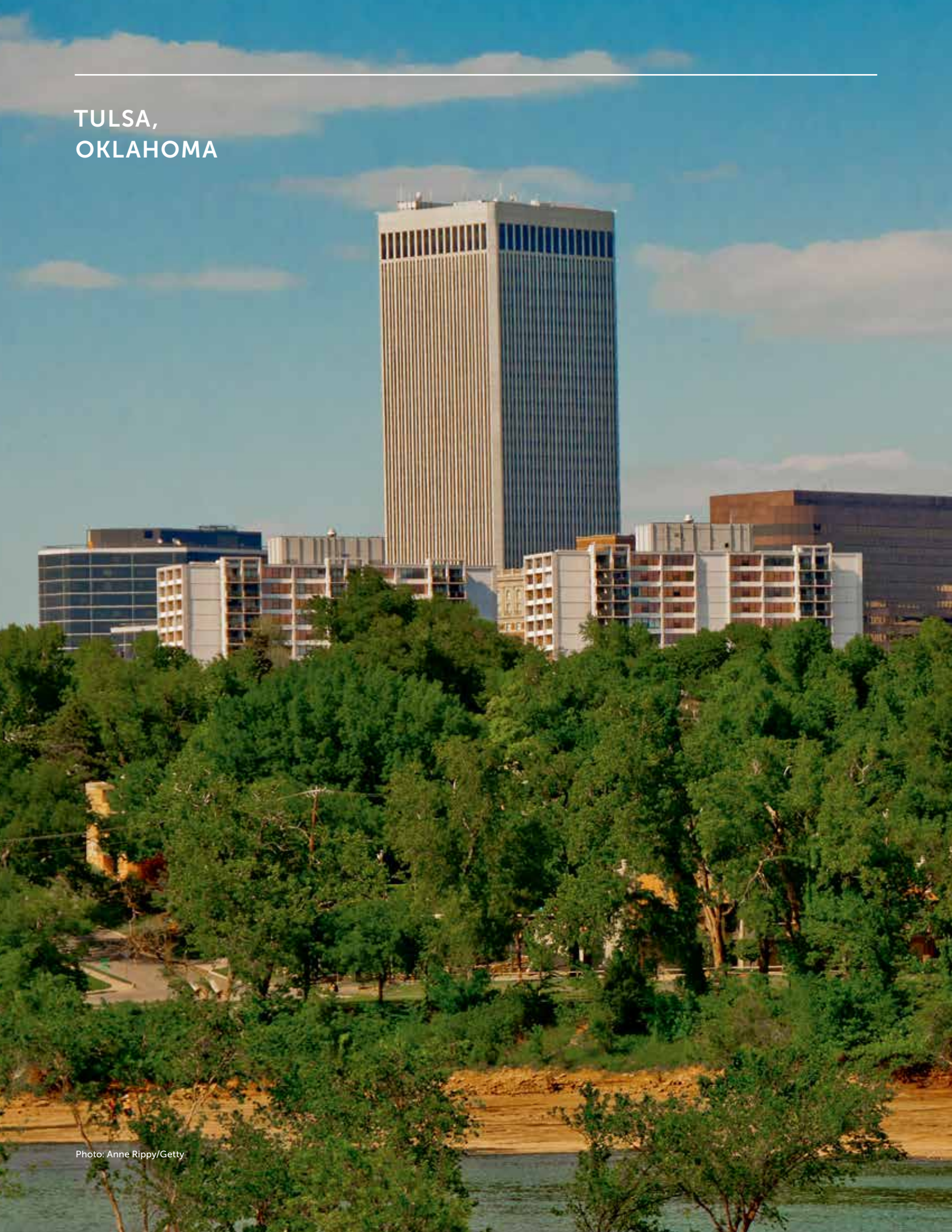


Photo: Anne Rippy/Getty

WHERE HEALTH STARTS EARLY AND EMBRACES THE WHOLE FAMILY

Photos: Samantha Appleton

Amy Emerson, a pediatrician, burst into the quiet waiting room of the Indian Health Care clinic in Tulsa, Okla., like a force of nature and plopped herself right down on the floor. "Hey everybody," she sang out, "we're going to read some books! Who likes books? Do you like books?" She began reading a picture book with so much animation and enthusiasm in the lifeless room that she quickly drew in toddlers and parents.

"Where's the bunny? Do you see the bunny?" she asked an infant. But her real target was the parents. The toxic stress on low-income parents trying to juggle everything can sap the joy from life. "Did you know Day One is a perfect time to begin singing and talking to your baby?" Emerson asked the parents listening at the Indian clinic.

Head of community engagement for an organization called Tulsa Educare, Emerson is training volunteers to visit waiting rooms like this in clinics and doctors' offices citywide. She's met with over 200 pediatricians and primary care doctors to encourage them to write prescriptions for parents to read to their children. She's also working with churches to host "family reading nights."

Sitting on the floor reading *Pete the Cat*, she interrupted herself to tell parents, "Tulsa is the best city in America to be born in right now."

If not the best, it is certainly among the most innovative. Through a combination of robust public and private partnerships involving schools, libraries, universities, doctors, churches, and foundations, it seems the entire city is committed to building a Culture of Health for its residents. And the emphasis begins at birth.

Under a program that began in the spring of 2015, each baby born in Tulsa is visited by a nurse who gives new parents books to read and explains how important singing, talking, and reading is to the infant brain. Billboards and TV commercials promote the Talking is Teaching campaign—just one of many efforts to target health as early in life as possible.

This focus on Tulsa's youngest citizens began with business leader and philanthropist George Kaiser. In the early 2000s, looking to give back to his community, Kaiser was captivated by research that found most of the social, emotional, and cognitive development of a child occurs in the years right after birth. Policymakers in Oklahoma already understood the value of early childhood education. Since 1998, the state has offered universal pre-K to all 4-year-olds. But Kaiser felt that wasn't early enough. "The focus is on birth to age 3," he says. "Eighty-five percent of the brain is developed in the first three years."

Over the last decade, the George Kaiser Family Foundation has spent hundreds of millions of dollars enhancing early childhood development; always partnering with other organizations, coming up with new ways to reach out to the greater community. It's part of a larger effort to integrate improved health and well-being into every aspect of life for residents of Tulsa. Kaiser says Tulsa is the perfect city for building a Culture of Health—it has organizations eager to work together, evaluate, adjust, and even admit failure and start over. Creating real and lasting change will take time, determination, and persistence, and Tulsa is committed to making it work.

The Kaiser Foundation's first move was to bring Educare to Tulsa. Educare is an immersive preschool program that offers children in disadvantaged communities all-day, year-round preschool from as early as 6-weeks-old to age 5. Students have the same teacher for the first three years; they learn in small classes; and they and their families receive personalized support in the classroom and at home.

Photo: Samantha Appleton

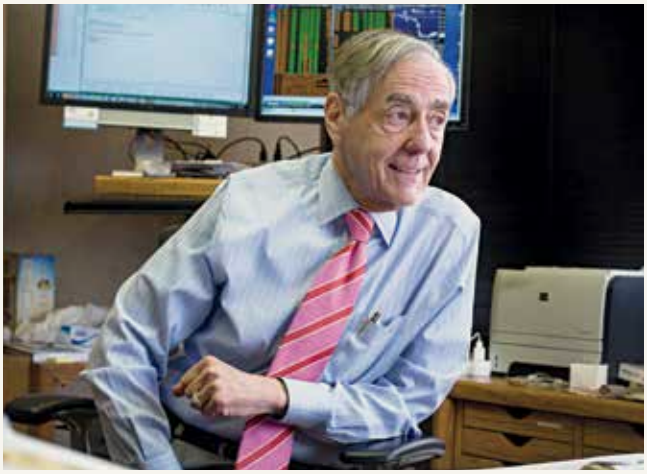


Photo: Samantha Appleton

The entrance to every Educare building is a large piazza, bathed in sunlight from skylights. Each class is led by one teacher with a bachelor's degree in early childhood education, and there are always two teachers in a room. One recent morning in a Tulsa classroom of 3- and 4-year-olds, the children were paired off in stations. At one, a child lay on a carpet and the other, with the help of a teacher, measured his body length with paper clips, teacher and child counting the number of clips out loud. At another station, children matched geometric shapes on the computer, dragging a triangle over a pizza slice or a cone over a party hat. Another two painted with watercolors. At still another station, the kids moved letters around in a sandbox to build words and sentences. "We can't bake the cake until we find the 'B'," the teacher explained.

Each teacher is videotaped, and then watches herself in action, first alone, and then with a master teacher assigned to every school. Every family has access to mental health counseling, and a family advocate works with families to help resolve other problems.

Educare simply would not be possible without public-private partnerships. It costs $10.7 million annually to operate Tulsa's three Educare sites. The Kaiser Foundation contributes $3 million of that. "Our money is really blended and braided," said Caren Calhoun, executive director. Thirty-seven percent comes from federal Head Start and Early Head Start; 34 percent from the Oklahoma early childhood education program (the state's universal pre-K program); four percent from the state Department of Education; four percent from the state's child and adult food program; and the rest from several smaller public and private sources.

Evaluation of Tulsa's three schools by Dr. Diane Horm, founding director of the Early Childhood Education Institute at the University of Oklahoma at Tulsa, shows Educare children enter kindergarten as ready socially, emotionally, and academically as children who do not live in poverty.

Photo: Samantha Appleton

BEYOND THE CLASSROOM

The impact of Educare in Tulsa reaches well beyond the classroom. Annie H. Berrett, with the OU School of Community Medicine, directs the Educare Family Health Project. She has partnered with the Tulsa YMCA to offer memberships for just $25 a month to all Educare family members and staff. Educare will pay the $25, as long as somebody in the family goes at least once a week.

When Katherine Redd, a kitchen manager at Educare, started going to the Y, she was taking medication for high blood pressure and anxiety. But after attending dance classes six evenings a week, her doctor allowed her to stop both. "I've lost three hitches in my belt," she says proudly.

Berrett has also partnered with Marleta Giles, at Oklahoma State University's extension in Tulsa, to teach nutrition classes at the Educare centers. Giles not only cooks healthy meals like chicken tarragon over a bed of spinach, but also gives parents groceries so they can go home and prepare the meals themselves. She teaches about healthy ingredients, the importance of fresh fruits and vegetables, and how to read labels. Zenobia Mayo, 65, who helps daughter Kaicee Mayo, 27, raise grandson, Jackson, 3, went to two 16-week class sessions. Jackson used to chant, "Chicken nuggets, chicken nuggets, burger, burger, burger," every time his grandmother passed the McDonald's® on the way home from Educare. "When we found out how much fat and salt and oil and grease were in a Happy Meal®, well, I drive a different way so we don't go by those golden arches," Zenobia says.

"We are better people because of it," Kaicee says of the nutrition classes. "I am a better parent for Jackson."

HEALTH CARE COVERAGE

Between October of 2013 and June 2014, Berrett and her small team interviewed all 1,145 adults affiliated with Educare in Tulsa—parents, cousins, grandparents, whoever was part of the child's household. Their screenings found that 246 family members had no health coverage, and many were undocumented. Berrett's team worked hard to get as many as possible insured under available public and private plans. For the others, the Kaiser Foundation subsidized their care at three local clinics. In the end, all but 22 people were covered. The total annual cost of the Educare Family Health Project, funded by Kaiser, is $559,000.

ACCESS TO CARE

In the early 2000s, Tulsa was in a very dark place regarding equal access to health care. Data showed a 14-year difference in life expectancy between those living in the predominantly minority neighborhoods of North Tulsa and largely white South Tulsa. Nearly all the doctors were located in South Tulsa, with "just a handful" serving residents in North Tulsa, according to Gerard Clancy, MD, vice president for health affairs at the University of Tulsa.

But, over the past decade things have improved. A $20 million new clinic was built in North Tulsa, and 27 new doctors have started providing care to the community. Many are graduates of the University of Oklahoma School of Community Medicine, one of the few medical schools in America with a primary mission of turning out doctors who understand poverty and are committed to helping the underserved.

"What we're pleased by is health statistics are starting to turn," Clancy said. "We've improved access, and in cardiovascular health for adults, we've dropped the number of deaths from heart attacks and strokes. And infant mortality has improved. We don't have final numbers yet, but it looks like that 14-year difference in life expectancy is starting to improve."

Photo: Samantha Appleton

RECOVERY AND COUNSELING

Amanda Spicer, 27, says she was saved by yet another Kaiser-funded program, Women in Recovery. Amanda's mother was an alcoholic. Amanda was drinking by age 11 and dropped out of school by 9th grade. By age 20, she was convicted of forging prescriptions and spent five months in jail. When she got out, her mother was strung out and had lost the house, and soon Amanda was back shooting methamphetamines, sleeping in cars and cheap hotels. She got arrested again for drug possession and found out she was pregnant.

Tulsa's Women in Recovery gave Amanda safe, comfortable housing, and helped her get mental health and addiction counseling. The center provided her with medical care and classes in nutrition and parenting. She now has a job. "Before I got in the program my life was so dark, so empty," Amanda says. "Women in Recovery allowed me to taste something great, and once I tasted that, I didn't want to go back."

Women in Recovery can serve up to 100 recovering addicts at one time. The program, run by the nonprofit Family & Children's Services, usually lasts 12 to 18 months. Seventy percent who enter the program complete it, says Kaiser Foundation program officer Amy Santee. Of those who complete it, the recidivism rate is only 8 percent.

Amanda gave birth to a baby girl and named her Payton. By three months of age, Payton was enrolled at Educare.

Photo: Samantha Appleton

ACTION AREA

4

STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

DRIVERS

ACCESS

Access to public health

Access to stable health insurance

Access to mental health services

Routine dental care

CONSUMER EXPERIENCE AND QUALITY

Consumer experience

Population covered by an Accountable Care Organization

BALANCE AND INTEGRATION

Electronic medical record linkages

Hospital partnerships

Practice laws for nurse practitioners

Social spending relative to health expenditure

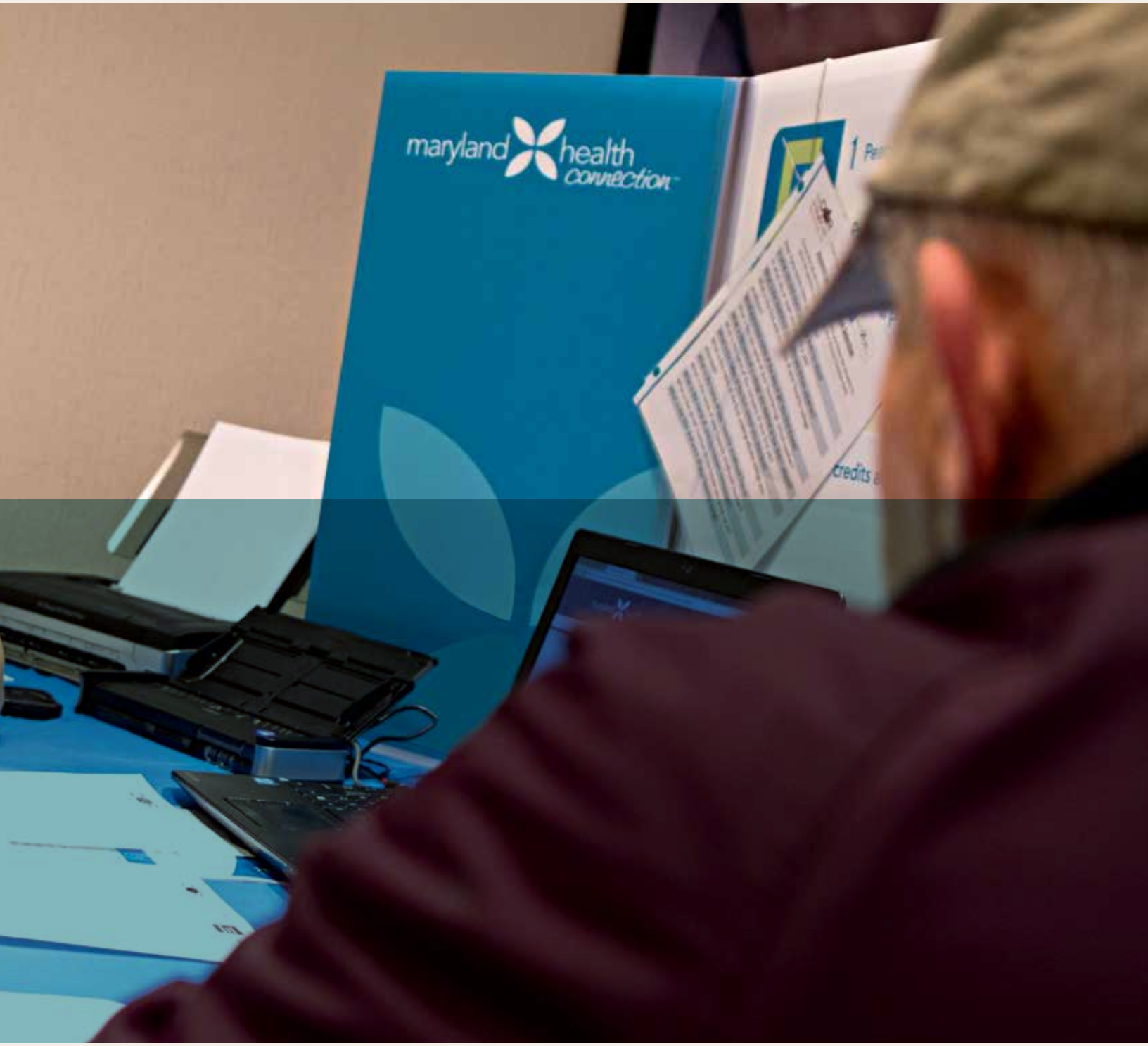


Photo: Tyrone Turner

4

STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

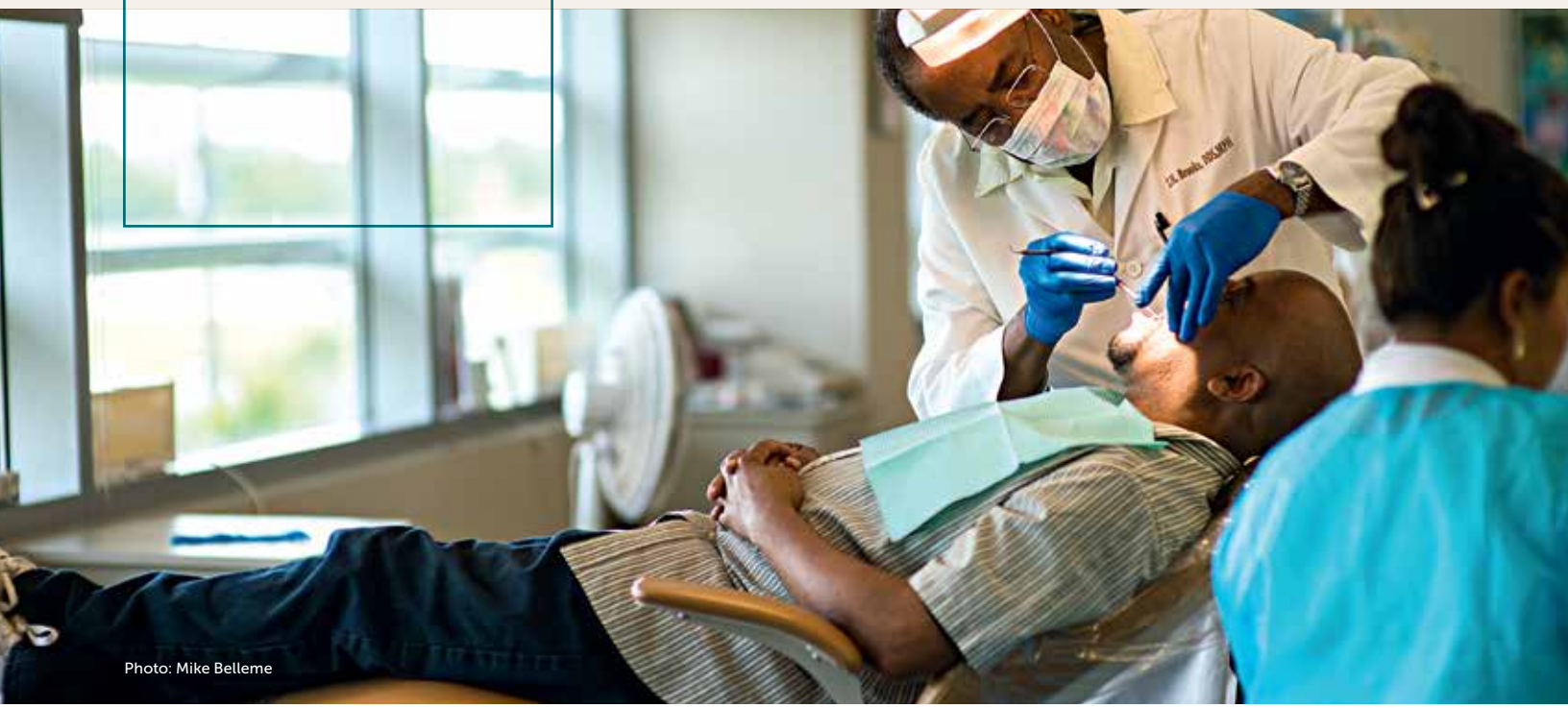


Photo: Mike Belleme

Imagine high-quality, efficient, and affordable health care available to everyone living in the United States—where, when, and how they need it. The transformation of our nation's health care system provides an extraordinary opportunity to re-imagine the future of health and health care delivery in America. ***This Action Area aims to strengthen a system of coordinated, quality care that integrates and better balances medical treatment, public health, and social services.*** It calls for a care delivery system that rewards value rather than volume and increases consumer engagement, shared decision-making, and transparency of data showing cost and quality of care.

As recommended in the *RWJF Commission to Build a Healthier America* report, "The health care system must acknowledge and systematically address those realities of patients' lives that directly impact health outcomes and costs." Specifically, the goals of value-based care—improving quality while reducing costs—cannot be achieved without meeting patients' *social* needs.[42] This means examining the role of health care as part of a larger network and deepening connections with a broader set of partners. It also means reframing our assessments of patient access and experience.

When we succeed in this Action Area, people will be provided with the information and tools to become *active participants* in their own high-value care. Likewise, health care providers will be empowered with the community connections needed to help patients lead healthier lives, and care will be as much about *actively promoting* health as treating illness. By enhancing the patient experience, and more deeply integrating medical care with preventive and social services, we should see an improvement in the overall quality of health care and a reduction in excessive health care spending. In this 360-degree view, health professionals work together with individuals, families, caregivers, and community partners to build a culture of care coupled with compassion.

DRIVERS: | **MEASURES:**

ACCESS

Several factors influence access to health services, including the expansion of health insurance coverage. But access must be seen as more than having insurance. It must be more broadly defined as being able to get comprehensive, continuous health services when needed and having the opportunity and tools to make healthier choices.

Access to public health
Percentage of population served by a comprehensive public health system[43]

Access to stable health insurance
Percentage of population, ages 18 to 64, with stable health insurance, or no change in the source of health insurance[44]

Access to mental health services
Percentage of adults 18 years and older, who report having mental health or substance abuse problems, and who received treatment[45]

Routine dental care
Percentage of adult population, ages 18 years and older, who report a dental visit in the calendar year[46]

CONSUMER EXPERIENCE AND QUALITY

When people don't feel connected to, or in control of, the full complement of medical and social services, they are more likely to delay or avoid care. In a Culture of Health, health care providers help patients thrive by planning for the care that's needed inside and outside the clinic. This means that all individuals are treated with dignity, and that cultural differences are honored and respected. Additionally, provider networks such as Accountable Care Organizations (ACOs) can improve the consumer experience by creating a coordinated health care system, with a network of doctors and hospitals sharing financial and medical responsibility for patients' health.

Consumer experience
Consumer Assessment of Healthcare Providers and Systems (CAHPS) summary measure of consumer experience across ambulatory, hospital, and home health care settings[47]

Population covered by an Accountable Care Organization (ACO)
Percentage of population whose health care provider is part of an ACO[48]

BALANCE AND INTEGRATION

A Culture of Health calls for better balance between prevention and acute/chronic care services, as well as the intentional integration of public health, social service, and health care systems. When these systems work in sync, we will see an improvement in the efficiency and quality of care delivered, leading to reduced hospital re-admissions, decreased health costs, and a more seamless health care experience.[49] In short, more people will get the preventive and social services they need early and avoid unnecessary medical care.

Electronic medical record linkages
Percentage of physicians who share data with other providers and hospitals, with the goal of encouraging integration, collaboration, and communication[50]

Hospital partnerships
Percentage of hospitals that have a collaboration or alliance with one or more organizations in each of these categories: local government, state agencies, and other community-based agencies[51]

Practice laws for nurse practitioners
Number of states that have laws and regulations that support full scope of practice for nurse practitioners[52]

Social spending relative to health expenditure
A ratio of annual social spending to annual health expenditures in the United States[53]

- *Social spending* is defined as cash benefits, direct in-kind provision of goods and services, and tax breaks with social purpose (e.g., job training, housing assistance), in U.S. dollars
- *Health expenditures* is defined as spending on hospital care, physician and clinical services; other professional services; dental services; other health, residential and personal care services; home health care; nursing care facilities and continuing care retirement communities; prescription drugs; durable medical equipment; other nondurable medical products

ACTION AREA 4:

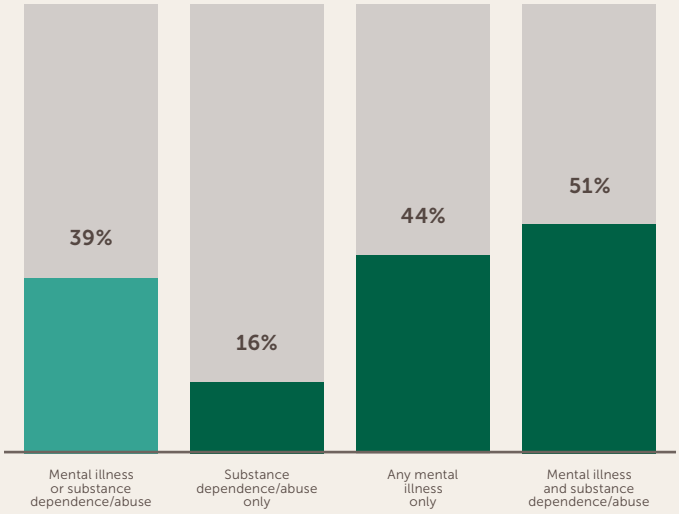
STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

DATA SNAPSHOT

A Culture of Health calls for a care delivery system that integrates and better balances medical treatment with public health and social services—increasing patient access, engagement, and satisfaction. Coordination and shared information among providers helps to ensure quality, safety, and continuity of care.

ACCESS TO MENTAL HEALTH SERVICES

39% of adults who report mental illness or substance abuse receive treatment

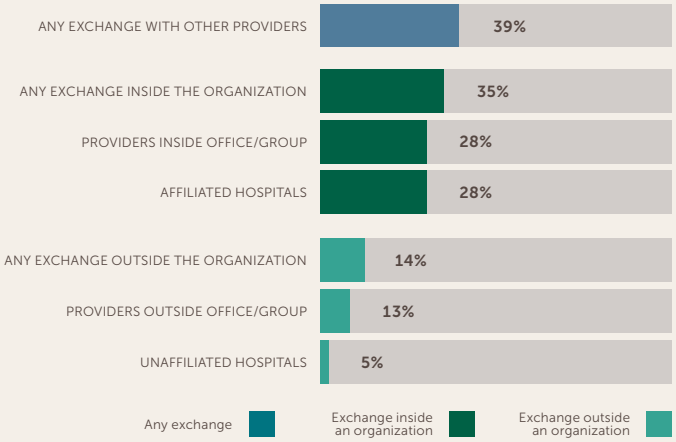


Data source: National Survey on Drug Use and Health, 2013. Substance dependence or abuse is based on DSM-IV. Mental illness is based on WHODAS and K6. Sample size: 67,838.

ELECTRONIC MEDICAL RECORD LINKAGES

39% of office-based physicians engage in any health information sharing with other providers

OFFICE-BASED PHYSICIANS' ELECTRONIC HEALTH INFORMATION EXCHANGE WITH OTHER PROVIDERS, BY ORGANIZATIONAL AFFILIATION

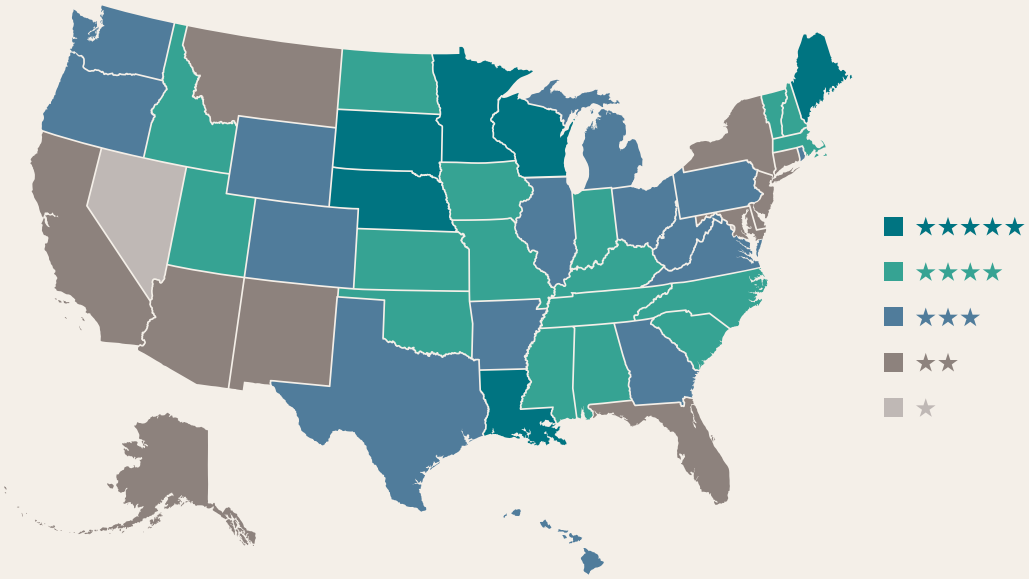


Data source: National Electronic Health Records Survey, 2013.

CONSUMER EXPERIENCE

Six states have the highest possible rating (five stars) on the patient experience index

CAHPS SUMMARY MEASURE OF CONSUMER EXPERIENCE ACROSS AMBULATORY, HOSPITAL, AND HOME HEALTH CARE SETTINGS AT THE STATE LEVEL



Note: The patient experience index is a measure of the overall patient experience in a state. The information that goes into the index comes from nationally representative surveys of the experience of adult patients in outpatient, inpatient, and home health care. Multiple domains contribute to the assessment of experience in each setting, including but not limited to the timeliness of care, provider communication, and access to services.

Data sources: Home Health Consumer Assessment of Healthcare Providers and Systems (CAHPS), Medicare CAHPS from individual plan reports, and Adult Hospital CAHPS.

CHANGE IN ACTION

Photo: Matthew Moyer

SPARTANBURG REGIONAL HEALTHCARE SYSTEM

Spartanburg Regional Healthcare System (SRHS) in South Carolina formed a partnership with 10 community organizations to create AccessHealth Spartanburg, designed to connect low-income, uninsured people to health care and address barriers to health services. By better coordinating primary care and focusing on the social issues that affect health—such as transportation, access to medications, housing, and employment—the program reduced hospital costs for the targeted population by 42 percent and hospital admissions by 31 percent. In 2013, SRHS's charity care was reduced to $81 million—a $35 million reduction in five years. It's a win-win for the hospital and the patient population, with both significant health improvement and cost savings.[54]

HEALTH LEADS

Health Leads increases access to health and health care services by addressing the social and economic factors that contribute to illness. As a service provider, Health Leads is helping health systems to create models for integrating patient social needs into care, using a full spectrum of tools including the Health Leads' Desk, where providers "prescribe" basic resources like food and heat. Well-trained student Advocates stationed in the clinics work side-by-side with patients to "fill" those prescriptions by accessing community resources and public benefits. In addition to its work as a service provider, Health Leads works with health systems at the leadership level to build momentum in the sector for addressing patient social needs. In this role, Health Leads shines a light on best practices and participates in critical efforts around evaluation and value measurement.[55]

SHELLER 11TH STREET

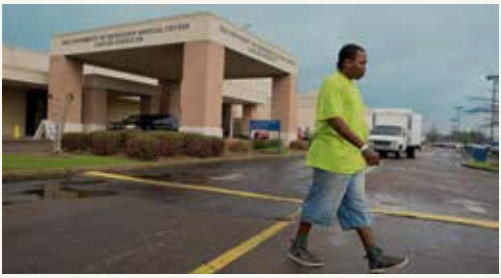
The Stephen and Sandra Sheller 11th Street Family Health Services of Drexel University meets the needs of an underserved community of residents of four public housing developments in North Philadelphia. It operates on a patient-centered, integrated, and trauma-informed care approach. Visits to the center grew from 2,200 in 2003 to 36,000 in 2015. According to Dr. Patricia Gerrity, the center's director and Drexel University College of Nursing and Health Professions' associate dean, "Sheller 11th Street is becoming certified in The Sanctuary® Model to work toward greater personal, intrapersonal, and communal health." The center also collaborates with the community, schools, and churches to promote health through a farmers' market, walking club, urban farm, public art projects, cooking classes, and after-school programs.[56]

JACKSON, MISSISSIPPI

Photo: Tyrone Turner

IT ALL COMES TOGETHER AT THE (MEDICAL) MALL

Photos: Tyrone Turner



The Jackson Shopping Mall opened in 1968, the first in the state and the pride of Mississippi, with anchor stores JCPenney®, Gayfers, and Woolco. The mall was the heart of a thriving community, in the geographic center of the city, and throngs of people streamed in to shop.

And then, suddenly, they didn't.

There was racial unrest. Economic decline. Surrounding neighborhoods fell into decades of crime and decay, and the mall became an abandoned eyesore. Meanwhile, the rates of obesity, heart disease, and other chronic illnesses in Mississippi soared to become among the worst in the nation. And the cavernous Jackson Mall became a symbol of despair. That was then.

Today, the mall has been reborn as the Jackson Medical Mall, and it's a place for healing. The once fractured community can now come together and not only shop, but also find what they need to improve their health—a flu shot, affordable chemotherapy treatment, a path to opportunity in the form of GED classes, or maybe just a good meal shared among friends. The mall is now bustling with health and social services, providing easy access and superior care to the underserved. The Jackson Medical Mall is evidence of what is possible when inspired citizens, institutions, and governments work together.

A NEW HEALTH HUB

The mall's comeback story begins with the late Dr. Aaron Shirley, a civil rights leader and a pediatrician, who grew up in rural Mississippi, attended medical school out of state because of segregation, and became the first African American medical resident at the University of Mississippi Medical Center in 1965. In 1970, Shirley pioneered the opening of the Jackson-Hinds Comprehensive Health Center, which became a national model for community health clinics providing comprehensive care. In 1993, he was awarded a MacArthur "genius" grant for his unique insight into rural and urban health care and the significant influence that community factors have on health.

Shirley showed his brilliance again in 1995 when he thought of turning the abandoned shopping mall into a health hub. Instead of seeing it as a center of blight, Shirley saw the mall as an easily accessible place that could offer people the many things they need to be healthy, all under one roof. Not just clinical care, but also opportunities to attain safe and stable housing, enhance education, and connect with neighbors.

Shirley approached the head of the University of Mississippi (UM) Medical Center, where low-income residents in and around Jackson went for hospital care. The hospital's own clinic, with only 28,000 square feet of space, was bursting at the seams. Patients experienced long waits to schedule appointments, and could rarely count on continuity of care. The late Wallace Conerly, who was in charge of the medical center and medical school at the time, loved the idea of the "medical mall" and agreed to move his clinic into a former department store with 165,000 square feet of space.

But because of lingering racial distrust, Shirley, who died in 2014 at the age of 81, knew that many African American residents of Jackson might be suspicious of a traditionally white-run institution opening its doors in a low-income neighborhood. So he also recruited Jackson State University and Tougaloo College—two highly respected, historically African American colleges—to join the Medical Mall project as founding partners.

"This was his real genius," says Dr. James "Jimmy" Keeton, the current head of the University of Mississippi Medical Center and medical school, and a vocal supporter of the Medical Mall.

The Jackson Medical Mall opened its doors in late 1996, offering immunizations, family planning, tuberculosis screening, and other services. Over the next few years, services expanded to include HIV and STD clinics, as well as a robust Women, Infants, and Children program run by the state health department and university partners. The UM Medical Center first opened its ambulatory clinic based at the Medical Mall in 1998, and later brought in specialty clinics including dentistry, renal treatment, women's health, pediatrics, and one pharmacy that charges on a sliding scale and offers lower rates to uninsured patients. They also opened a cancer institute in the old Woolco store, where most of the hospital's radiation, chemotherapy, and outpatient care is now performed, for patients of all income levels.

Some things haven't changed, however. You can still get your hair cut at the Mall, get your shoes shined, shop at some retail stores, and eat at the Piccadilly cafeteria. It was meant to be a community gathering spot. And it is. In 2001, the Mall's official name was changed to the Jackson Medical Mall Thad Cochran Center, in honor of the Republican U.S. Senator who has been one of the Mall's greatest champions.

Photo: Tyrone Turner

Photo: Tyrone Turner

WITHOUT IT, I WOULDN'T BE HERE

"Talk about impact, just look at the numbers," says Terrence Shirley, the founder's son and administrator of the Medical Center's cancer institute. "All these clinics have at least 200,000 patient visits a year. Those numbers of people were not accessing health care before the mall opened."

Here are a few stories behind those numbers:

"I love it to death, because without it I wouldn't be here," says Daphney Wright, 50, waiting in a wheelchair for her ride home after a visit to the pain management clinic. Six years ago, Wright was shot in the leg with a 12-gauge shotgun. The leg was amputated at the UM Medical Center, but she's received all of her follow-up care—orthopedic, psychiatric, pain management—at the mall, near her home.

Marion Blount, 63, was also waiting for transportation to take him home from dialysis. Nearly every bus route in the city comes to the Medical Mall. Blount, a Vietnam vet, recently began doing his treatments at the Medical Mall, which has 23 chairs running three shifts a day. "It's great," he says. "You don't have to sit around no hospital, waiting on a chair."

Jackie Hudson, 36, comes monthly to the sickle cell clinic, and has since she was 21. "They have some of the best doctors here," she says. "I get great care."

The idea of going to a mall to improve health is unusual enough—but what makes the Medical Mall even more revolutionary is that it's about much more than medicine. There's a day-care center in the mall. GED classes are offered there, as are classes to train certified nursing assistants. The United Way comes and does tax returns for free. People can sign up for health insurance under the Affordable Care Act there.

Jackson State University has moved its health sciences programs into the old J.C. Penney space, and students take classes there. Jackson State is also trying to open Mississippi's first school of public health and locate it in the Medical Mall. The Jackson Heart Study—following 5,300 African Americans for generations, modeled on the famous Framingham Heart Study—conducts all of its interviews and examinations at the Medical Mall.

The mall offers opportunities for living a healthier, more prosperous life—and not just for patrons, but also for the 1,500 mall employees.

Tim Brown, 31, went to Lanier High School just blocks away, and to Jackson State. While he was working on his master's in public health, he got an internship with the clinic for HIV-AIDS and STDs located at the Medical Mall. Brown would work all day in the third-floor clinic and then go downstairs to attend class. He earned his degree and now works full time at the Medical Mall helping with research on a project called Better Sex with Latex, focused on reducing the rate of HIV infection among African American men.

"It changed my life," Brown says of the Mall.

Erica Reed could easily say the same. She started out in housekeeping for the Jackson Medical Mall Foundation, working nights as she pursued a college degree at Belhaven University. Primus Wheeler, the executive director of the Jackson Medical Mall Foundation, who tries to employ and promote from the community, noticed Reed's work ethic and her abilities, and kept giving her more opportunities and responsibilities at work. Now Reed is his chief of staff.

Her ambition?

"To sit right there," she says, pointing across the desk to Wheeler.

"I'm just keeping the chair warm," he smiles in reply.

Photo: Tyrone Turner

COMMUNITY DEVELOPMENT

Recently, the Jackson Medical Mall Foundation began focusing on community development beyond the Mall. The Foundation helped build an 80-apartment senior citizen housing complex and 44 single family houses in the area, with plans for 100 more, all designed to provide home ownership to individuals and families earning as little as $25,000 a year.

Dorothy K. Murriel, a 61-year-old widow on disability, recently moved onto Prosperity Street, into a new two-bedroom with a small yard and garage. She pays $370 a month in mortgage. "I am very happy," she gushes. "I plan to be here until I die."

Two banks have opened in the area—one minority-owned—and a credit union. The foundation helped build a new grocery store just across the parking lot from the Medical Mall. The only grocery within 3.9 miles, it is now one of the busiest stores in the Save-A-Lot® chain.

Lace Gibbs, 23, was recently picking out fresh produce at the Save-A-Lot, where collard greens were 69 cents a bunch and green grapes were $1.99 a pound. "There was nothing here," she says. "Before this opened, we'd drive miles to another store."

Jennifer Spane, 52, who works in IT for the UM Medical Center located in the Medical Mall, walks five laps around the interior—one lap is half a mile—on her lunch break. And she's not the only one. Walkers come steadily from 5 a.m. to 10 p.m. "People love to walk here because it's safe and convenient," Spane says.

"The medical mall [model] is ideal," said Corey Wiggins, director of the Mississippi Economic Policy Center. "You have this convergence of all these things: services, resources, research, training, education, a community gathering place. This is a living experiment. We're trying to shift and shape the health of a community, and what health care looks like in Jackson."

"We've created a village here, a community," says Dr. James Keeton, head of the University of Mississippi Medical Center and dean of the School of Medicine. "They know that we care, and that we're all in this together."

Photo: Tyrone Turner

CENTER
SPEED LIMIT
5

OUTCOME

IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY

OUTCOME AREAS

ENHANCED INDIVIDUAL AND COMMUNITY WELL-BEING

Well-being rating

Caregiving burden

MANAGED CHRONIC DISEASE AND REDUCED TOXIC STRESS

Adverse child experiences

Disability associated with chronic conditions

REDUCED HEALTH CARE COSTS

Family health care cost

Potentially preventable hospitalization rates

Annual end-of-life care expenditures

Photo: Tyrone Turner

1 MAKING HEALTH A SHARED VALUE

2 FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING

3 CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES

4 STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

OUTCOME: IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY

Photo: Tyrone Turner

When progress is made in the four integrated Action Areas, we believe the nation will substantially improve overall population health, well-being, and equity. ***In a Culture of Health, people flourish physically, mentally, and socially throughout their lifespan.*** Well-being does not necessarily mean attaining perfect health. Instead, it is defined as having the capacity and the opportunities to live as healthy a life as possible.

We recognize that building a Culture of Health requires steadfast commitment, dynamic collaboration, and unique implementation and assessment strategies that will develop and have impact over time. The following Outcome Areas are intended to gauge key long-term improvements as we place a high value on health, align forces across sectors, create healthier and more equitable communities, and strengthen the relationship between medical treatment, public health, and social services. How will mobilizing action in these areas affect the prevalence of childhood trauma and the burden of managing chronic disease? Will we see a shift in expenditures related to health care and caregiving? Will individuals and communities report a greater sense of well-being?

The Outcome Areas encompass improvements in health our nation has long sought to attain. They also reflect the World Health Organization's definition of health as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*[57] We would add to this definition the goals of resilience, adaptation, and attaining the highest level of well-being possible. The entire Culture of Health Action Framework is designed to give special attention to equity and opportunity—not to merely describe the health disparities that exist, but to eliminate them. Research that improves our understanding of how we close these gaps and change the odds for achieving healthier lives is sorely needed.

OUTCOME AREAS:

MEASURES:

ENHANCED INDIVIDUAL AND COMMUNITY WELL-BEING

The Culture of Health Action Framework emphasizes *well-being*, which can be evaluated by both subjective and objective data. *Individual* well-being can be defined as the extent to which people experience happiness and satisfaction, and are realizing their full potential. Key aspects of *community* well-being include community health, economic resilience, educational capacity, and environmental adaptation. By measuring well-being among individuals, communities, and caregivers, we gain a window into whether health has been woven into the fabric of our culture.

Well-being rating
Well-being rating in three areas: Health, Life Satisfaction, Work/Life Balance[58]

- *Health:* Average life expectancy and percentage of population at least 15-years-old who report "good" or better health
- *Life Satisfaction:* Weighted sum of different response categories based on people's rating of their current life relative to the best and worst possible lives for them on a scale from 0 to 10, using the Cantril Ladder
- *Work/Life Balance:* Percentage of dependent employees whose usual hours of work per week are 50 hours or more, and average amount of hours per day that full-time employed people spend on leisure and personal activities

Caregiving burden
Average amount of out-of-pocket financial and emotional investment in caregiving, as reported by adults 18 years and older[59]

MANAGED CHRONIC DISEASE AND REDUCED TOXIC STRESS

A Culture of Health is intended to support a trajectory of well-being throughout the lifespan, addressing any health issues as early as possible. Today, more than half of all Americans suffer from one or more chronic diseases; by 2020, the number of those with chronic conditions is expected to grow to 157 million. There are significant disparities, with the burden of chronic conditions experienced disproportionately by low-income people and ethnic minorities.[60] In addition, a growing area of research has focused on the relationship between childhood trauma (such as domestic violence, substance abuse, and neglect) and the risk for physical and mental illness in adulthood. By measuring the prevalence of chronic disease and adverse child experiences (ACEs), we can gauge whether the health of the population is improving.

Adverse child experiences (ACEs)
Percentage of population, ages 0 to 17 years, with two or more reported ACEs, as reported by parents[61]

Disability associated with chronic conditions
Number of disability-adjusted life years (DALYs) for the top 10 U.S. chronic diseases[62]

OUTCOME AREAS:

REDUCED HEALTH CARE COSTS

It is well understood that health care costs are placing a significant burden on all sectors of American society, and that the United States spends more per capita on health care than other countries. Our nation has also seen the steepest increase in health care spending, despite the fact that our health outcomes have not markedly improved. As we measure overall health costs in relation to outcomes, we must also keep a close eye on *how* and *when* we spend. Progress will entail not only improving efficiency and avoiding unnecessary procedures, but managing issues early and preserving dignity across the lifespan.

MEASURES:

Family health care cost
Average health care expenditure by family[63]

Potentially preventable hospitalization rates
Overall U.S. admission rates for chronic and acute conditions per 100,000 population, including:

- *Chronic:* Diabetes with short-term complications; diabetes with long-term complications; uncontrolled diabetes without complications; diabetes with lower-extremity amputation; chronic obstructive pulmonary disease; asthma; hypertension; heart failure; angina without a cardiac procedure
- *Acute:* Dehydration; bacterial pneumonia; or urinary tract infection[64]

Annual end-of-life care expenditures
Annual average Medicare payment per decedent in the last year of life[65]

Photo: Tyrone Turner

OUTCOME:

IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY

DATA SNAPSHOT

In a Culture of Health, everyone has the opportunity to flourish physically, mentally, and socially throughout their lifespan. We close the gaps that prevent people and communities from reaching their greatest health potential. By reducing the burden and expense of illness for individuals and caregivers, we increase the vitality of our nation.

WELL-BEING RATING: LIFE SATISFACTION

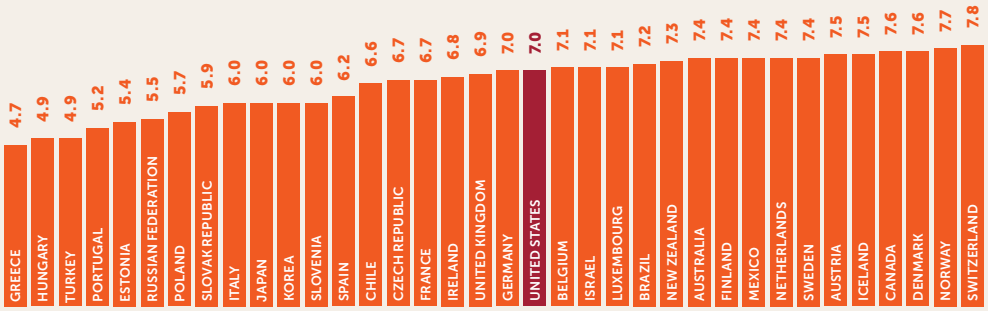
Of all OECD countries, the United States ranks 17th in life satisfaction

The Better Life Index (BLI) compares 36 countries across 11 topics of well-being. The BLI is important to monitor because it gives us a bird's eye view of how Americans are faring overall. Results of this Measure can help policymakers think strategically about how to assign resources.

OECD BETTER LIFE INDEX LIFE SATISFACTION MEASURE*

Data source: Organisation for Economic Cooperation and Development (OECD) Better Life Index Life Satisfaction measure, 2013.

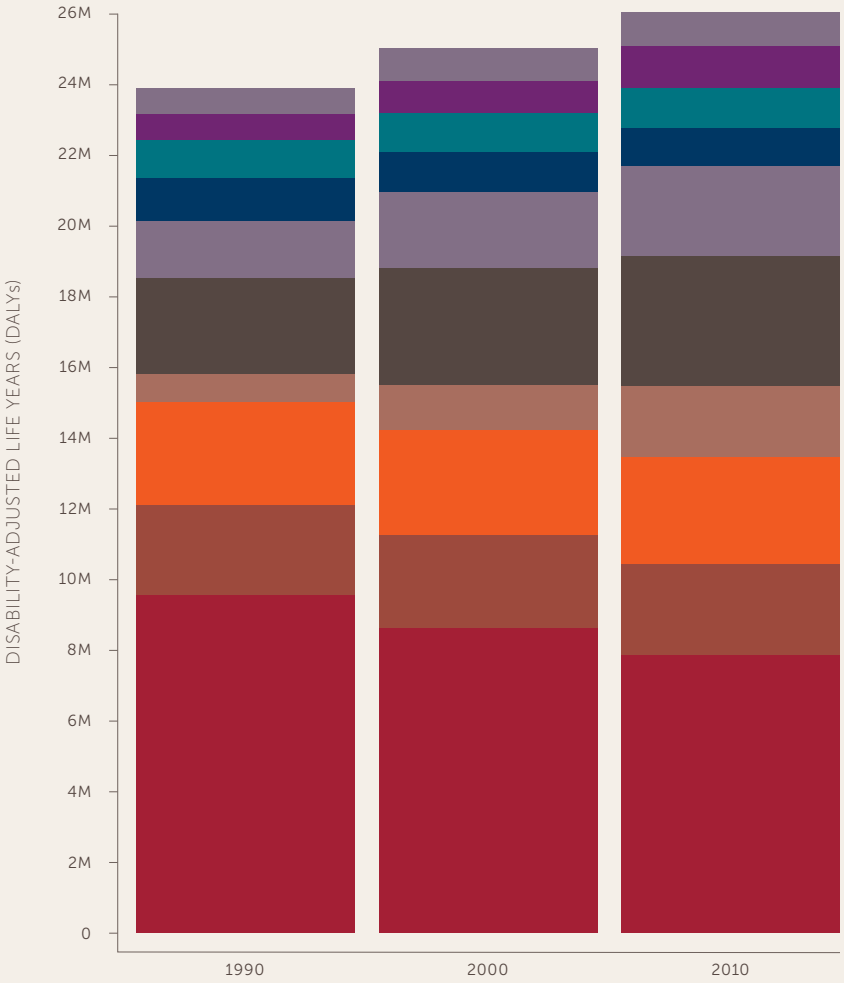
*Weighted-sum of different response categories based on people's rating of their current life relative to the best and worst possible lives for them on a scale from 0 to 10, using the Cantril Ladder (known also as the "Self-Anchoring Striving Scale").



DISABILITY ASSOCIATED WITH CHRONIC CONDITIONS

Despite some improvements in overall chronic disease management, the disability associated with disease continues to reduce quality of life and the number of productive years for many

Data source: Summary statistics from prior DALY work in Global Burden of Disease (Institute for Health Metrics and Evaluation); Baseline data are changes between 1990 and 2010.



> "The indicators a society chooses to report to itself about itself are surprisingly powerful. They reflect collective values and inform collective decisions. A nation that keeps a watchful eye on its salmon runs or the safety of its streets makes different choices than does a nation that is only paying attention to its GNP. The idea of citizens choosing their own indicators is something new under the sun—something intensely democratic."
>
> **DONELLA MEADOWS**
> influential environmental scientist and author [66]

Building a Culture of Health will take time. It's a shift that requires the commitment and persistence of millions of people. It calls for new norms and expectations, expanded knowledge and capacities, innovative practices, and changed behavior. It will require all sectors to work with new partners—spreading and sustaining new approaches. By sharing our successes as well as our struggles, we will help accelerate change together.

The Culture of Health Action Framework is a long-term initiative that will guide RWJF's work and investments over the next 20 years. We look forward to expanding the involvement of diverse stakeholders in conversations and collaborations to refine the Measures in the years to come. The Measures are intended to catalyze engagement and action. Individuals, communities, and sectors might focus on different—but related—indicators that speak most meaningfully to their needs.

ONLINE CONVERSATION

A user-friendly website will be unveiled in late 2015 to encourage dialogue and input regarding the Culture of Health Action Framework and Measures. The website will serve as a go-to source for deeper analysis. In addition, a variety of communications platforms will facilitate an ongoing conversation among researchers, policymakers, and others about building a Culture of Health and refining the Measures going forward.

SENTINEL COMMUNITIES

For a close-up look at how the Culture of Health is taking hold, and to gather detailed information on how the Action Framework is being used to promote and support collective action, we have identified 30 diverse Sentinel Communities across the country that we are following closely at the local level. These communities represent a range of social and demographic characteristics, and include places that have not previously received much national attention in the dialogue about health and well-being.

The Sentinel Communities provide insight into the natural processes of cultural change, cross-sector collaboration, and community engagement, and also identify signals of progress in building a Culture of Health. These communities serve as a national sample group, enabling us to track changes being made in real time. They provide a window into the various ways communities are bringing the Culture of Health Action Framework to life, and allow us to amplify successes and refine the Measures over time.

FROM VISION TO ACTION

Improving the health of everyone in our nation will require a commitment to diversity and respect for multicultural perspectives. It will force us to make hard choices about the use of limited resources. And it will require us to participate in open and honest conversations about what success looks like and where we have not been as effective to date.

Why do we think a cultural shift of this magnitude is possible? Because it's happened before. Only a generation ago, cigarettes were tightly woven into the fabric of American culture; people even used to smoke in hospitals. Back in 1970, the year Earth Day was established, the word "recycling" wasn't part of our common vocabulary, much less a part of our lives. Today, we almost automatically separate paper, plastic, and glass to reduce waste that could be collected and repurposed. One reason is because we've made it easy. It's part of our everyday routines at home, at work, and in our neighborhoods.

Focused on helping everyone in America live healthier lives, and guided by this Action Framework, RWJF is committed to working with others to raise health in the United States to the level that a great nation deserves. In a growing number of communities, people eager to turn ideas into action are already beginning to demonstrate that positive change is possible.

Annual updates will report on the progress of collaborative actions, the evolution of the Measures, and how investments are aligning with the Action Framework.

WILLIAMSON, WEST VIRGINIA

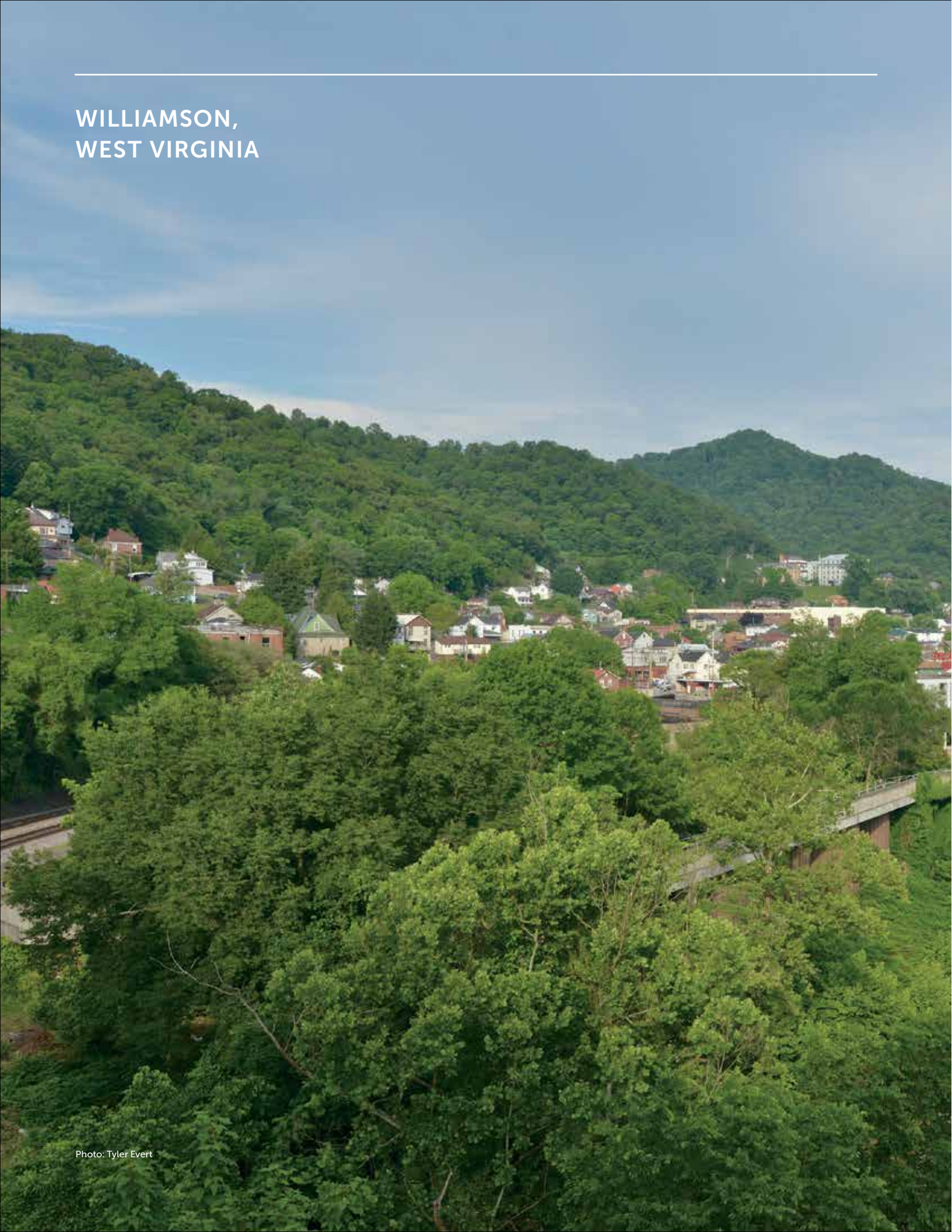


Photo: Tyler Evert

HARNESSING HEALTH'S ECONOMIC RIPPLE EFFECT

Photos from left: Tyrone Turner, Tyler Evert

When she retired from teaching grade school, Debbie Young had a dream for her hometown of Williamson, W.Va. "I had this idea of opening up a little restaurant where people could get fresh, healthy food," she says, "but I didn't think I ever would."

Williamson, population 3,191, is the county seat of Mingo County, best known for the historic feud between the Hatfields and McCoys. In more recent history, however, the county has also become known for having some of the worst health statistics in the nation. In 2012, screenings performed by West Virginia University showed that one in three 11-year-olds had high blood pressure and 35 percent were obese.

"People are trying to change that," Young says, and she wants to be part of the change. She remembers when Williamson was a booming coal town with bustling, crowded streets. Now coal employment has collapsed, and the population has shrunk from a high of 9,400 in 1930 to 3,100 today. "And we've got a generation of kids who've been raised on microwave food," she says.

Fresh food is nothing new to Young. "Growing up, most everything we ate was fresh, because that's what we could afford," she says. "We raised it, canned it, put it up for the winter. My dad was a coal miner. We had a big garden, raised our own meat. There wasn't any such thing as microwave food then."

THE PICTURE IS CHANGING

For four years after she retired, her idea of opening a restaurant was "just talk." Then in 2014, Young's daughter, Natalie Taylor, alerted her to a local "healthy business innovation" contest. "She kept saying, 'Mom, they're giving out seed money for healthy ideas. You ought to go for it. It's your chance.'"

The top prize was $7,000. Young applied. "I didn't win, but I kind of felt like I had, because I got so much good feedback and support," she says. "They gave me business advice, and hooked me up with local food suppliers, and they keep sending customers my way. So I kept going."

"They" are the Sustainable Williamson coalition, a collection of residents determined to turn Williamson into a healthier, more prosperous place. They come from many parts of the community: the Mingo County Diabetes Coalition; local businesses; churches; schools; community college; local government; retired people; college students; stay-at-home moms; farmers; and small business people.

The coalition grew out of a five-year city plan that put public health on the front burner. Five years later, the coalition's projects are visibly changing the town's culture. "We're not trying to take away anyone's right to sit on the couch all day or eat a whole bag of potato chips," says Jenny Hudson, Diabetes Coalition director. "We're just creating other choices for people who want them."

So far, they have created opportunities for people to participate in monthly 5Ks, weekly Tuesday Night Track, and daily runs. Because there is only one grocery store in the entire county, the coalition has built three greenhouses to supply the community's burgeoning farmers' market. They started a running program in the middle schools. They created a community orchard, and built a thriving community garden opposite the Williamson senior citizen apartments. They offer low-cost tai chi and Zumba® classes, and hold diabetes education classes in town, and they drive up and down mountain roads to make house calls, teaching at-risk people how to best manage their health.

"We've got a long way to go, but the picture is changing," Hudson says.

The coalition applied for and got funding to create the Williamson Health and Wellness Center that, in turn, created 20 new jobs. The federally qualified clinic serves about 700 patients a week.

In June of 2014, Williamson received the *RWJF Culture of Health Prize* and decided to use $15,000 of the $25,000 award to encourage the development of healthy businesses. That's where Debbie Young, and her dream of a restaurant, came into the picture.

In September of 2014, she opened 34:ATE, offering the people of Williamson a made-from-scratch lunch menu featuring fresh, locally sourced food, for under $10, when possible. The name refers to Psalm 34:8: "Taste and see that the Lord is good."

"My daughter kept saying, 'Mom, the time's right. Williamson's changing. People are wanting healthy stuff now,'" Young recalls.

Photo: Tyrone Turner

Photo: Tyrone Turner

IMPROVEMENT IS CONTAGIOUS

Walk around Williamson and you'll see the signs of change.

Two blocks from the 34:ATE, a waitress and two cooks work the grill at Hurley Drug Store. Waitress Cashena Hylton usually wears one of the T-shirts she's earned at the monthly 5Ks. "It used to be if you saw somebody running in Williamson, you thought something was wrong," she says, only half joking. "Now you can't drive down the street without passing people running. And people don't look at you strange anymore when you run."

Debra Canterbury, a cook at the drug store, says the pastor's wife at McVeigh Baptist Church talked her into joining a women's healthy eating group. "I told her I didn't see why God would care about what I eat," she says, "but now I'm starting to see it different. I never thought of it this way...but we should be taking care of the bodies God gave us."

"There's a ripple effect," says drug store owner Tim Hurley, who coaches after-school basketball. In the past two years, Hurley says, he's added salads and wraps to his grill's traditional burger-and-fries menu. And they sell well. "We have fresh fruit and vegetables from the farmers' market on the menu now, in season," he says.

The drug store is a good place to track the community's health changes, Hurly says. "Every week, we see customers who have made dramatic improvements, gotten off their insulin, or this or that medicine...It's contagious. When people hear that so-and-so got off their insulin by walking, they think, 'Maybe I could too.' "

Down the hill from Hurley's Drugs, beside the railroad tracks, is the Mingo County Diabetes Association office. Inside, Eva Musik is working on the new mobile farmers' market schedule. Each week, the mobile market drives out of Williamson, loaded with fresh produce that it takes to the "food desert" communities of Mingo County. "Lots of times, when we get to where we're going, people are already waiting for us," Musik says.

Also at the Association office, Vicki Lynn Hatfield might be teaching community members how to use movement and nutrition to bring down their blood sugar, as well as their need for prescriptions. And there's a good chance that Alexis Batausa will be posting photos of the latest community footrace on Facebook.

Williamson used to have only one big race per year, a money-raiser, Batausa says. Few participated. But three years ago, the Diabetes Association teamed up with the area's Tug Valley Road Runners club and started organizing local, low-cost, monthly 5K run/walks, advertised through social media and posters in store windows. About 25 people showed up for the first one. Now, 150 to 200 turn out for the runs, which often have different themes: a zombie run, a run to raise money for the animal shelter. Teenagers volunteer to help.

"Having a 5K every month makes people more likely to do daily runs in-between, so they can beat their best time," Batausa says. "It helps them build a habit."

Tuesday Night Track has also become a social event. "There's not a whole lot to do in Williamson," Batausa says. "But once a week, you can have a great time with 30 or 40 other people, and it costs you just about nothing."

Photo: Tyrone Turner

A block from the Diabetes Association, the City Gym was saved from closure in 2014. One of the Sustainable Williamson partners bought it. Now, half of the building—3,250 square feet—is being converted into Williamson's Health Innovation Hub, where 10 start-up businesses will rent space and share expenses.

"We'll favor businesses with a healthy element," says Dr. Dino Beckett, a primary care physician and one of the principal drivers of the Sustainable Williamson initiative. Five businesses have already reserved spaces, and the construction is providing employment for members of a local vocational-technical program.

"The pieces are coming together," Beckett says. "We've gotten some big grants in the past few years, but when we first started, we only had a few thousand dollars to work with. We built a successful track record with small projects, and that made it possible for us to get bigger grants."

Back at 34:ATE, Debbie Young's daughter, Natalie, says when her mom opened the restaurant, "People told her, 'Nobody in Williamson will eat those salads and stuff!' But they are. We've already proved them wrong on that."

Of course, changing the health of an entire community will take time. Ada Muncy, who has worked at the 7-Eleven® by the town bridge for 13 years, says she still sells "a lot of Big Gulp® and pop." But then, she adds, she sells a lot of water too.

People are used to an unhealthy Williamson, Taylor says, so they may not recognize the signs of change. "But, I see bright spots now. All my friends are posting their workouts on Facebook®. We've got a long way to go, you can see that when you walk down the street. But it's happening."

Photo: Tyrone Turner

APPENDIX

CULTURE OF HEALTH ACTION FRAMEWORK

ACTION AREAS	DRIVERS	MEASURES
1 MAKING HEALTH A SHARED VALUE	MINDSET AND EXPECTATIONS	Value on health interdependence
		Value on well-being
		Public discussion on health promotion and well-being
	SENSE OF COMMUNITY	Sense of community
		Social support
	CIVIC ENGAGEMENT	Voter participation
		Volunteer engagement
2 FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING	NUMBER AND QUALITY OF PARTNERSHIPS	Local health department collaboration
		Opportunities to improve health for youth at schools
		Business support for workplace health promotion and Culture of Health
	INVESTMENT IN CROSS-SECTOR COLLABORATION	U.S. corporate giving
		Federal allocations for health investments related to nutrition and indoor and outdoor physical activity
	POLICIES THAT SUPPORT COLLABORATION	Community relations and policing
		Youth exposure to advertising for healthy and unhealthy food and beverage products
		Climate adaptation and mitigation
		Health in all policies (support for working families)
3 CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES	BUILT ENVIRONMENT/PHYSICAL CONDITIONS	Housing affordability
		Access to healthy foods
		Youth safety
	SOCIAL AND ECONOMIC ENVIRONMENT	Residential segregation
		Early childhood education
		Public libraries
	POLICY AND GOVERNANCE	Complete Streets policies
		Air quality
4 STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS	ACCESS	Access to public health
		Access to stable health insurance
		Access to mental health services
		Routine dental care
	CONSUMER EXPERIENCE AND QUALITY	Consumer experience
		Population covered by an Accountable Care Organization
	BALANCE AND INTEGRATION	Electronic medical record linkages
		Hospital partnerships
		Practice laws for nurse practitioners
		Social spending relative to health expenditure

OUTCOME	OUTCOME AREAS	MEASURES
IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY	ENHANCED INDIVIDUAL AND COMMUNITY WELL-BEING	Well-being rating
		Caregiving burden
	MANAGED CHRONIC DISEASE AND REDUCED TOXIC STRESS	Adverse child experiences
		Disability associated with chronic conditions
	REDUCED HEALTH CARE COSTS	Family health care cost
		Potentially preventable hospitalization rates
		Annual end-of-life care expenditures

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FROM VISION TO ACTION: A FRAMEWORK AND MEASURES TO MOBILIZE A CULTURE OF HEALTH

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