



FROM VISION  
**TO ACTION**

MEASURES TO MOBILIZE  
A CULTURE OF HEALTH

## CONTENTS

---



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

1	WELCOME
2	INTRODUCTION: WHY THIS? WHY NOW?
8	CULTURE OF HEALTH ACTION FRAMEWORK
10	<b>ACTION AREA 1</b> MAKING HEALTH A SHARED VALUE
16	RIVERSIDE COUNTY, CALIFORNIA: CULTIVATING A BROADER VIEW OF HEALTH
24	<b>ACTION AREA 2</b> FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING
30	CAMDEN, NEW JERSEY: AT CAMPBELL SOUP, THE SPECIAL INGREDIENT IS COLLABORATION
38	<b>ACTION AREA 3</b> CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES
44	TULSA, OKLAHOMA: WHERE HEALTH STARTS EARLY AND EMBRACES THE WHOLE FAMILY
52	<b>ACTION AREA 4</b> STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS
58	JACKSON, MISSISSIPPI: IT ALL COMES TOGETHER AT THE (MEDICAL) MALL
66	<b>OUTCOME</b> IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY
73	NEXT STEPS
74	WILLIAMSON, WEST VIRGINIA: HARNESSING HEALTH'S ECONOMIC RIPPLE EFFECT
82	APPENDIX

Cover Photos:  
Top row, from left:  
Tyrone Turner  
Jay Ferchaud  
Ed Kashi  
Roger Tully

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

Third row, from left:  
Mike Belleme  
Jordan Gantz  
Getty Images  
Roger Tully

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

# FOR DISCUSSION

WELCOME

# IMPROVING AMERICA'S HEALTH BY TAKING ACTION AND MEASURING PROGRESS

We believe that America is at a pivotal moment of change regarding the health of its residents, a moment of both 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. More recently, we have recognized 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 not led to widespread progress or equity in health.

At the Robert Wood Johnson Foundation (RWJF), we have asked why. What can be done to accelerate change? How can we help sectors work across and between traditional boundaries to build a comprehensive Culture of Health, enabling 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 critical areas where action is needed to improve health and well-being. The Framework is aimed at improving population health *and* motivating cultural change that builds a shared value of health and an integrated, cross-sector approach. It builds on the energy and legacy of those who have worked to advance collaboration and innovation in the health arena for years. It also invites new participants—many of whom may not have considered themselves to be influencers of health before now—to join the movement, and provides them with ways to see the transformative roles they can play, or may already be playing, in this national effort. When it comes to improving America's vitality, we are all in it together.

As Bill Gates has noted, "You can achieve incredible progress if you set a clear goal and find a measure that will drive progress toward that goal." Expanding upon national metrics such as Healthy People 2020, the Measures outlined here are meant to spark dialogue about the many factors that influence health and also

provide preliminary entry points for action. We expect these Measures, set on paper but not in stone, to evolve from the input and innovation of many.

At the Robert Wood Johnson Foundation, building a comprehensive Culture of Health has become the central aim of our research and our investments. But we are well aware that no individual, community, organization, or initiative can change the trajectory of our nation's health alone, and lasting change will not happen overnight. It will take collective engagement and cohesive action. It will take time, and it will take determination. 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, spotlight stories of success, welcome new allies, 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

## FOR DISCUSSION



## INTRODUCTION

## WHY THIS? WHY NOW?



Photo: Tyrone Turner

For decades, leaders in health and health care have focused on improving the quality, cost, and value of health care in America. They also have worked to amplify the role of social, physical, and policy determinants of health. But this work has largely been performed in parallel tracks with limited cross-sector collaboration.

As a result, change is not occurring evenly or quickly enough across all segments of our population. Good health is still viewed as a luxury and accepted as out of reach for many. Health is often presented as a goal that is separate from other aspects of life, and not the bedrock of personal fulfillment, community well-being, and national prosperity. Despite ongoing efforts to improve the health of our nation, positive change is not occurring at a promising pace.

## FOR DISCUSSION

## 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

## 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.<sup>1</sup> Though close to 18 percent of our GDP is spent on health care, the highest percentage in the world,<sup>2</sup> we continue to lose nearly \$226 billion in productivity per year because of personal and family health issues.<sup>3</sup> 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.<sup>4</sup>

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.<sup>5</sup> 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.<sup>6</sup> These factors have a tremendous impact on health, and one sector alone cannot address them all.

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 key influences of factors found in communities, business and corporate practices, schools, and the many other spheres of everyday life.

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. We know that 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.

# FOR DISCUSSION

## INTRODUCTION

**OVER  $\frac{1}{3}$** 

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

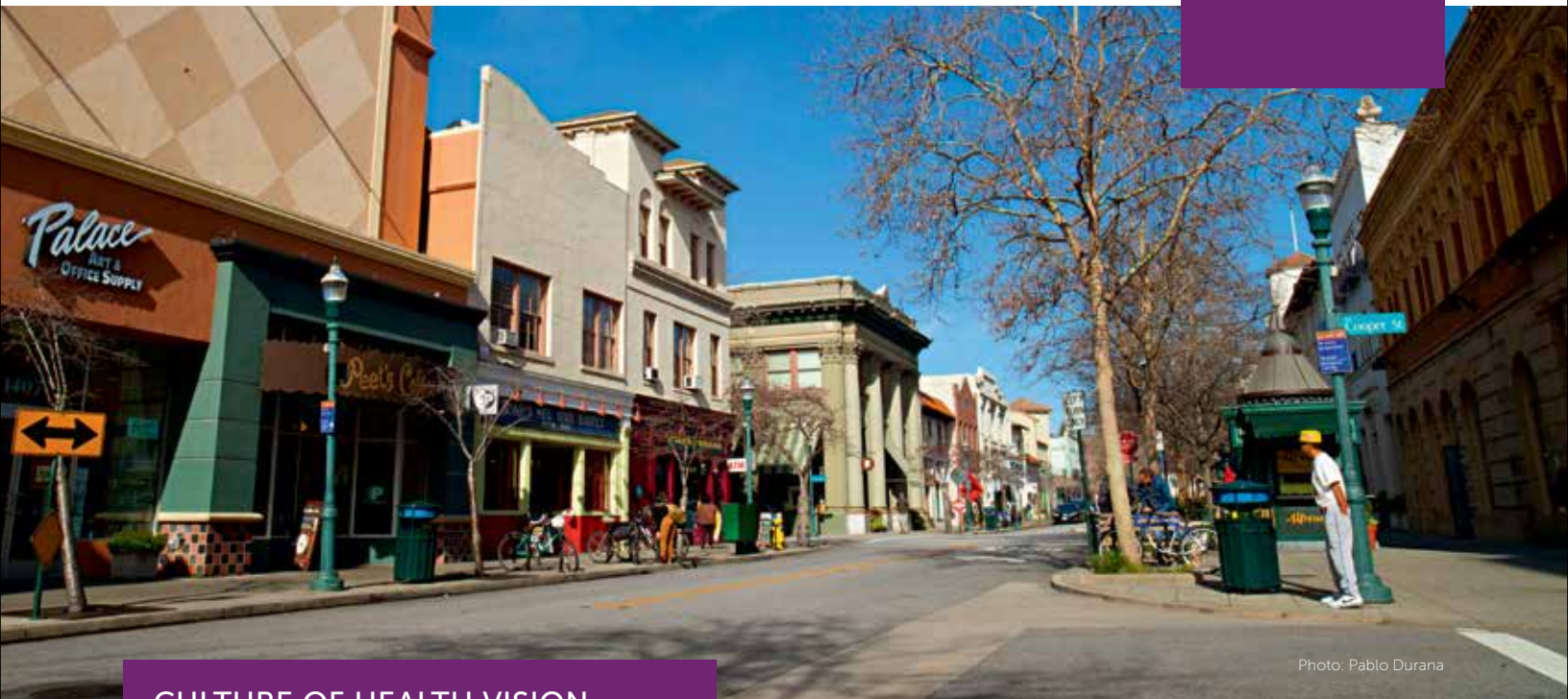


Photo: Pablo Durana

**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:

**Charting Progress, Catalyzing Change**

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 and colleagues across the country—RWJF has developed a framework to chart and catalyze our nation's progress toward building a Culture of Health. This **Action Framework** reflects a vision of health and well-being as the sum of many parts, combining components essential to improving population health *and* motivating cultural change. Its four **Action Areas**—each connected to and influenced by the others—are intended to focus efforts and mobilize an integrated course of action by many individuals, communities, and organizations.

**FOR DISCUSSION**



**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

The Action Framework and Action Areas 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. This Framework demonstrates the interdependence of the many social, economic, physical, environmental, and spiritual factors of health and well-being.

Each Action Area includes a set of corresponding **Drivers** and **Measures**, to help catalyze and track progress. The Drivers are the engine of the Action Framework, providing a set of priorities for national investment that will remain constant over time. The Measures, however, are expected to change. Rather than being definitive, the Measures are intended as starting points for conversation and action. They will illustrate progress and evolve to keep pace with changing needs.

Ambitious in scope, some of the Measures draw from existing sources, while others are based on new data gathered for this report. The Measures encourage us to think of health in broad ways, incorporating all aspects of well-being. They include 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.

Though adaptable, the Measures have been rigorously identified to have the evidence base necessary to lead to improved health and well-being. They represent a marriage of different data sources, not just to engage different sectors, but to reflect the complexity of decision-making and the multipronged ways communities get things done. They are intended to inspire a national movement and also provide a menu of possible actions at the local level.

It is important to note the relationship of these Culture of Health Measures to already existing metrics developed to track health status and outcomes, including Healthy People 2020 and America's Health Rankings. The Culture of Health Measures have been purposely selected to build upon such efforts by highlighting underlying factors of health that are not represented in other national reports. The Measures are uniquely focused on upstream social, economic, and policy indicators that, if improved, should significantly enhance population health and well-being on a national level.

**FOR DISCUSSION**

## INTRODUCTION

---



Photo: Tyrone Turner

Our development of the Culture of Health Measures was closely aligned with the framework used for this report's "sister set" of data, the RWJF/University of Wisconsin *County Health Rankings & Roadmaps*. Like the county health data, the Culture of Health 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 key health outcomes to facilitate local dialogue and action. Rather, the Culture of Health Measures intend to address specific, systemic factors that drive health, shape health perspectives, and inform the evolution of local and national change. The two complementary sets of measures will be linked in future discussions about improving America's health. (See Appendix for more information about the *County Health Rankings*.)

The Culture of Health Action Framework is designed to establish priorities while also offering a number of entry points that resonate with our nation's many diverse communities. It is our hope that the unique interconnectivity of the Action Areas will lead to more intentional collaboration between and across sectors and 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. *Equity and opportunity are overarching themes of the entire Action Framework—not to merely highlight health disparities, but to move toward eliminating them.*

## FOR DISCUSSION



**OVER 80%**

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

**17<sup>th</sup>**

United States life satisfaction ranking among similar industrialized countries

**9%**

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

Photo: Mike Bellemere

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. Individuals, communities, and organizations across sectors will place a higher value on health as the essential building block of a productive, thriving society. Motivated by this shared value, they will collaborate to prioritize and promote well-being so that all people—regardless of income, ethnicity, or ZIP code—will have access to health and health care services, including the prevention or management of chronic disease. We will see an overall reduction in health care spending and the financial and emotional burden placed on caregivers. Policymakers will integrate health and well-being into public policy, giving special focus to increasing equity.

We recognize that building a Culture of Health is a shift that may span a generation or more. It will require unprecedented collaboration and also will require unique implementation and assessment strategies that will develop over time. In many communities the journey has already begun, and we have included some stories of progress to help others set their own course. As the stories throughout this report suggest, a Culture of Health can take many forms depending on a community's distinct needs, resources, and goals. We know it will take many hands to weave the diverse threads of health into the richly textured fabric we call American life, and it is our hope that this Action Framework will help join them together to create a healthier nation for all.

**FOR DISCUSSION**

# CULTURE OF HEALTH ACTION FRAMEWORK



See Appendix for corresponding Drivers and Measures.

## FOR DISCUSSION

## FROM VISION

In 2014, the Robert Wood Johnson Foundation proposed a vision of America where we all strive together to build a national Culture of Health—a *culture that enables all in our diverse society to lead healthier lives now and for generations to come.*

Ten underlying principles provided both the foundation and goal for this vision. By clustering the 10 principles into four Action Areas, we established a framework to chart and catalyze progress toward the Outcome of improved population health, well-being, and equity.

### 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.

## TO ACTION

### CULTURE OF HEALTH ACTION FRAMEWORK ACTION AREAS

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

### DRIVERS

Each Action Area contains a set of Drivers indicating where we as a nation need to accelerate change. These Drivers are the engine of the Action Framework and provide a set of priorities for investment that will remain constant over time. RWJF expects that many actors will work to develop approaches to advancing the Drivers both nationally and at the community level.

### MEASURES

Each Action Area is also accompanied by a set of national Measures, selected to illustrate progress and spark dialogue about the many factors that influence and improve health. The Measures are not meant to delineate every indicator of population health, but rather to represent key elements of possible change. As we make progress toward a Culture of Health, the Measures may evolve but the Drivers will stay the same.

Three key considerations informed the selection of this first set of evidence-based Measures:

**Expansion:** Broaden the concept of “health,” with well-being as a central focus—inviting us to consider the conditions beyond the clinic walls where health flourishes or falters

**Inclusion:** Welcome sectors not traditionally associated with health or health care services, to encourage collaborative action

**Action:** Provide a menu of entry points for engagement that resonate with our nation’s many diverse communities

### INTENDED OUTCOME

Improved population health, well-being, and equity



ACTION AREA



## 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 turnout  
Volunteer engagement

**FOR DISCUSSION**



Photo: Ed Kashir

FOR DISCUSSION





## 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 community 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.

## FOR DISCUSSION



**DRIVERS:****MINDSET AND EXPECTATIONS**

The views and expectations we have about health ultimately inform the decisions we make as individuals, 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?

**MEASURES:****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<sup>7</sup>

**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<sup>8</sup>

**Public discussion on health promotion and well-being**

Proportion of tweets discussing health promotion and well-being to tweets discussing acute medical care<sup>9</sup>

**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)<sup>10</sup>

**Social support**

Percentage of adults, 18 years and older, noting they have adequate social support from partner, family, and friends<sup>11</sup>

**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. Volunteering demonstrates that residents care about the outcomes of their community and want to cultivate positive change. Moreover, communities that can access volunteers as part of local capacity 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 turnout**

Percentage of eligible voters who reported voting in general election (national and by state)<sup>12</sup>

**Volunteer engagement**

Percentage of adults and young people who reported volunteering (national and by state)<sup>13</sup>

## ACTION AREA 1:

## MAKING HEALTH A SHARED VALUE

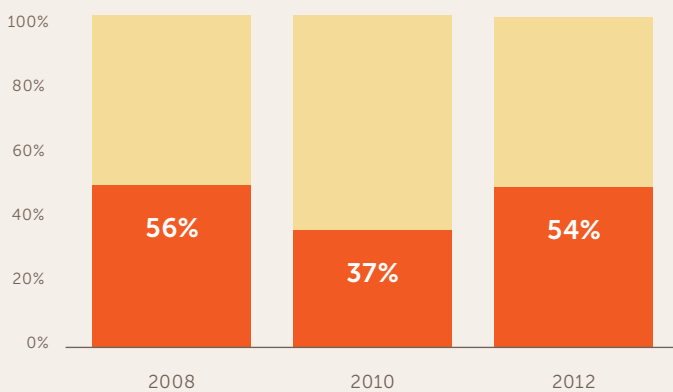
## DATA SNAPSHOT

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 TURNOUT

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

## VOTER TURNOUT IN GENERAL ELECTION



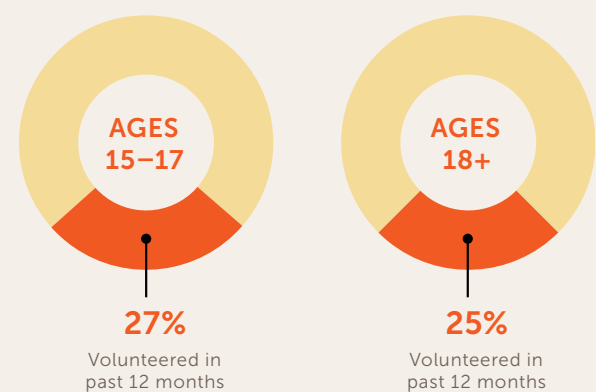
Calculated as total ballots in general election over the total eligible voting-age population (2008, 2010, 2012).

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

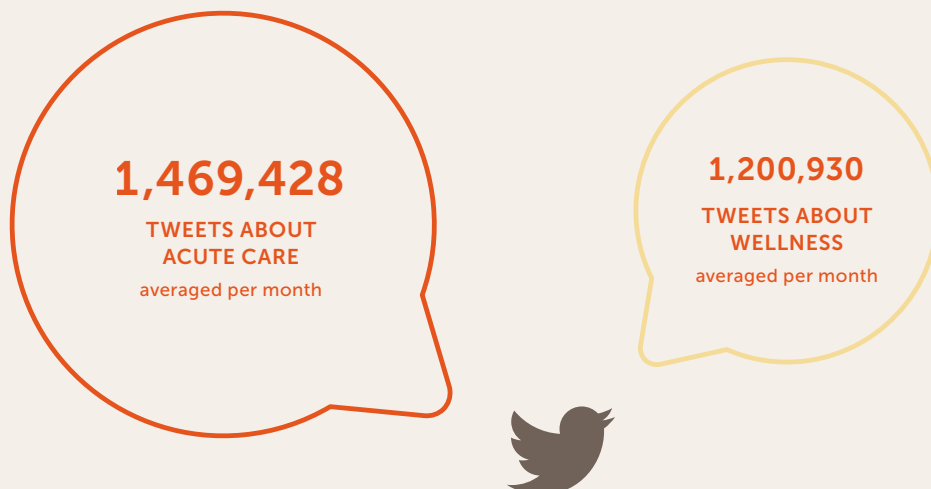


Data source: U.S. Census Bureau Current Population Survey September Volunteer Supplement 2013 (as reported by the Corporation for National & Community Service).

## 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.

## FOR DISCUSSION



## CHANGE IN ACTION

Photo: Mike Bellemo

### 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.<sup>14</sup> Recognizing the importance of social connections, the community set a goal to increase volunteerism from 67 percent in 2012 to 75 percent by 2020.<sup>15</sup>

### LIVE WELL SAN DIEGO

Live Well San Diego began in 2010 as a health strategy, but has evolved into a comprehensive, long-term effort to advance the overall health 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 initiative: *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 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.<sup>16</sup>



---

# RIVERSIDE COUNTY, CALIFORNIA

Photo: Eric Lowenbach/Getty Images

## FOR DISCUSSION

---

# CULTIVATING A BROADER VIEW OF HEALTH

---

Photos: Tyrone Turner



Jay Orr took a circuitous path to become the man in charge of America's 10<sup>th</sup> 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.

FOR DISCUSSION







## RIVERSIDE CO CALIFORNIA

### 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."

Photo: Eric Lowenbach/Getty Images

## FOR DISCUSSION





Photo: Tyrone Turner

**FOR DISCUSSION**



## RIVERSIDE CO CALIFORNIA



### 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.”

### FOR DISCUSSION



## 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



## FOR DISCUSSION





## RIVERSIDE CO CALIFORNIA

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

Photo: Eric Lowenbach/Getty Images

## FOR DISCUSSION



FOR DISCUSSION



ACTION AREA



## FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING

### DRIVERS

ENUMERATION  
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 resilience

Health in all policies

# FOR DISCUSSION





Photo: Roger Tully



## 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.

## FOR DISCUSSION

**DRIVERS:****ENUMERATION 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.<sup>17</sup> 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.

**MEASURES:****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<sup>18</sup>

**Opportunities to improve health for youth at schools**

Annual number of school-based health centers that provide primary care<sup>19</sup>

**Business support for workplace health promotion and Culture of Health**

Index of employer health promotion and practices (by size of business)<sup>20</sup>

**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<sup>21</sup>

**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<sup>22</sup>

**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<sup>23</sup>

**Climate resilience**

Annual percentage of states with climate action plans (or number)<sup>24</sup>

**Health in all policies**

Annual percentage of families with parents eligible for Family Medical Leave Act (FMLA) coverage who can also afford it, nationally and by state<sup>25</sup>

**FOR DISCUSSION**



## ACTION AREA 2:

FOSTERING CROSS-SECTOR COLLABORATION  
TO IMPROVE WELL-BEING

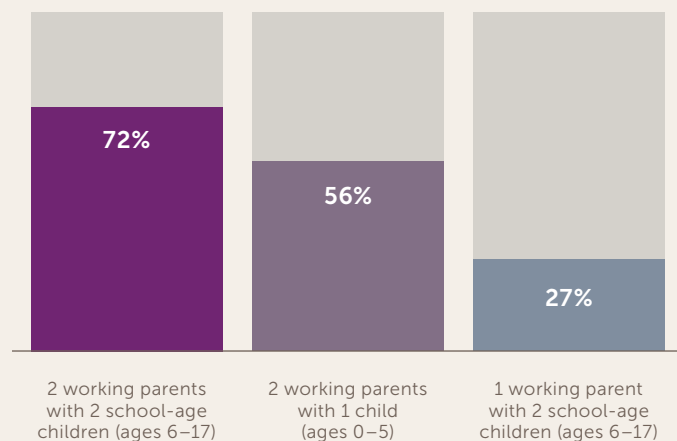
## DATA SNAPSHOT

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

Many American families cannot 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.

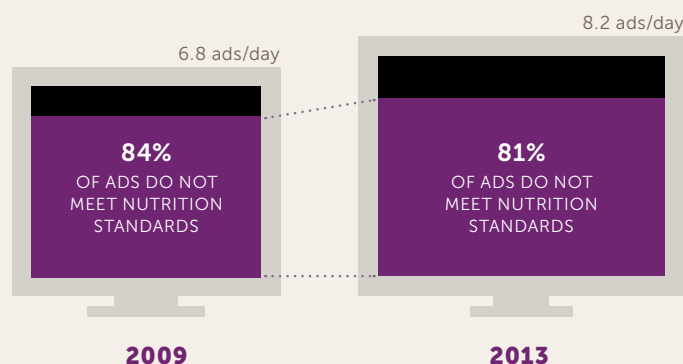


Data source: Bureau of Justice Statistics Census of State and Local Law Enforcement Agencies (CSLEA is fielding 2014 now; the last survey was fielded in 2008).

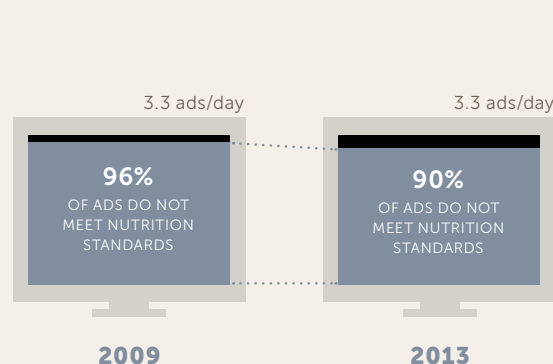
## YOUTH EXPOSURE TO FOOD AND BEVERAGE ADVERTISING

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

## ALL PROGRAMMING



## CHILDREN'S PROGRAMMING



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

## FOR DISCUSSION



## CHANGE IN ACTION

Photo: Tyrone Turner

### NATIONAL CENTER FOR MEDICAL-LEGAL PARTNERSHIP

The National Center for Medical-Legal Partnership bridges two famously antagonistic professions to address legal needs that have an impact on health; for example, people who are wrongfully denied 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 250 health care institutions in 36 states<sup>26</sup> 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.<sup>27</sup>

### 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.<sup>28</sup>



CAMDEN,  
NEW JERSEY



Photo: Lynsey Addario

FOR DISCUSSION



# AT CAMPBELL SOUP, 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's 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 Soup 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.

FOR DISCUSSION



## CAMDEN, NEW JERSEY

### A COLLECTIVE EFFORT

"My hat is off to Campbell's," 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 5<sup>th</sup> 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."

### FOR DISCUSSION





Photo: Samantha Appleton

FOR DISCUSSION





## CAMDEN, NEW JERSEY



Photo: Samantha Appleton

### COOKING UP HEALTHY PRACTICES

As part of the health focus at ECO Charter—and other participating schools—5<sup>th</sup>-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."

### FOR DISCUSSION

Photo: Lynsey Addario

Last year, the ECO 5<sup>th</sup>-graders didn't just cook at Campbell's. 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's 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



FOR DISCUSSION





## CAMDEN, NEW JERSEY

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

Photo: Lynsey Addario

## FOR DISCUSSION





FOR DISCUSSION





ACTION AREA



## 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

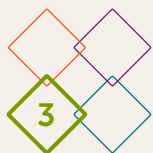
FOR DISCUSSION





Photo: Tyrone Turner





### 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 a key role in well-being. However, we will not achieve a Culture of Health unless business, government, individuals, and organizations work together to build healthier, more equitable communities.

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.<sup>29</sup>

***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.*** This set of Measures brings together the physical, social, emotional, and economic factors that make the healthy choice the easy choice for all. 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.

## FOR DISCUSSION

**DRIVERS:****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.

**MEASURES:****Housing affordability**

National percentage of families spending 50 percent or more of monthly income on housing costs for either rent or mortgage<sup>30</sup>

**Access to healthy foods**

Percentage of counties with limited access to healthy foods<sup>31</sup>

**Youth safety**

Percentage of middle and high school students who reported feeling safe in their communities and schools<sup>32</sup>

**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.<sup>33</sup> 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 (also known as index of dissimilarity)<sup>34</sup>

**Early childhood education**

Number of states where 60 percent or more 3- and 4-year-olds are enrolled in preschool<sup>35</sup>

**Public libraries**

Number of library outlets per 100,000 people, nationally and by state<sup>36</sup>

**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<sup>37</sup>

*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.<sup>38</sup>*

**Air quality**

Percentage of population covered by comprehensive smoke-free indoor air laws, by state<sup>39</sup>

### ACTION AREA 3:

# CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES

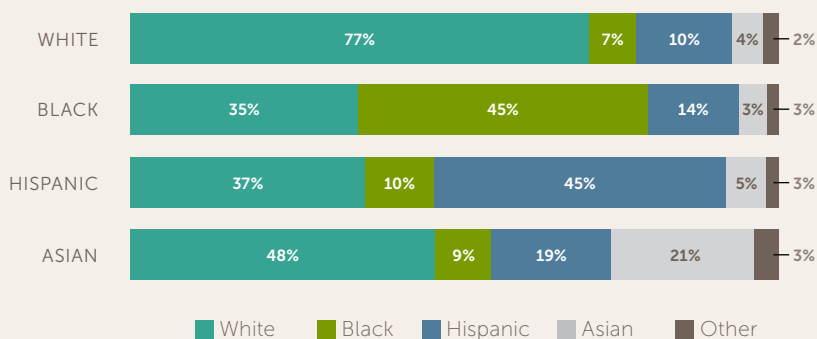
## DATA SNAPSHOT

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

Most white Americans live in communities that are not diverse

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



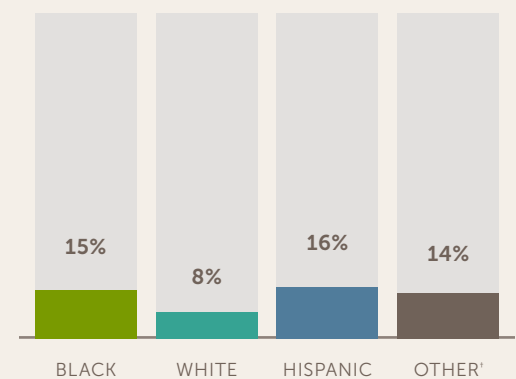
Major contrasts exist between the typical residential experience of whites versus that of other racial/ethnic groups in the United States. Differences between affluent and poor racial/ethnic minorities (but especially blacks and Hispanics) result in neighborhoods where income segregation exacerbates 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 significantly 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



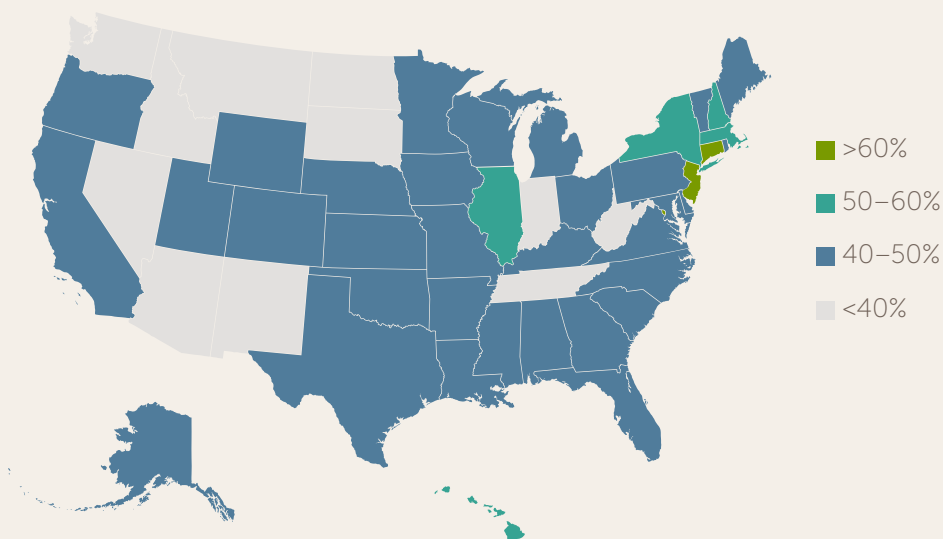
Data source: Annual NIDA Monitoring the Future Survey (baseline goes back more than 10 years; most recent data are December 2014).

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

<sup>†</sup>Asian American, Pacific Islander/Native Hawaiian, American Indian/Alaska Native

## EARLY CHILDHOOD EDUCATION

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



Data source: American Community Survey, 2013.





## CHANGE IN ACTION

Photo: Pablo Durana

### **FEDERAL RESERVE PARTNERS WITH MINNEAPOLIS-ST. PAUL**

In the Twin Cities of Minneapolis-St. Paul, the Federal Reserve came together with local housing, community development, and health sectors to address low-income residents' needs for affordable housing, access to health care, safe streets, and more. The crux of the effort focused on a low-income housing complex in St. Paul and a senior center in Minneapolis, both designed with a holistic approach to the built environment. These communities meet residents' needs and support health through convenient access to a YMCA fitness center, medical clinic, rehabilitation services and more. Co-locating services like this saves money on transportation, lowers health care costs, and allows residents greater independence. In addition, as part of the region's "big picture" vision of equity and integration, the development plan called for a mix of affordable and market rate housing to preserve existing communities while also attracting a diverse group of new residents.<sup>40</sup>

### **PURPOSE BUILT COMMUNITIES**

Purpose Built Communities is modeled on the 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 were 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 occurred. The employment rate of low-income adults increased from 13 percent to 70 percent; the neighborhood's Drew Charter School moved from last to first place among 69 Atlanta public schools; and violent crime dropped by 90 percent. The model is being replicated in communities across the nation.<sup>41</sup>

# FOR DISCUSSION



---

TULSA,  
OKLAHOMA



Photo: Anne Rippe/Getty

FOR DISCUSSION



# 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.”

## FOR DISCUSSION





## TULSA, OKLAHOMA

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: Anne Rippe/Getty

## FOR DISCUSSION



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 \$3 million annually to operate each of Tulsa's three Educare sites. The Kaiser Foundation contributes only three percent of the funding. "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.

## FOR DISCUSSION





## TULSA, OKLAHOMA



### 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 \$20 a month to all Educare family members and staff. Educare will pay the \$20, as long as somebody in the family goes at least once a week.

When Kathleen 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."

Photo: Anne Rippey/Getty

### FOR DISCUSSION



## HEALTH CARE COVERAGE

Between October of 2013 and June 2014, Berrett and her small team interviewed all 1,158 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 two 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



## FOR DISCUSSION



## TULSA, OKLAHOMA

### 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 9<sup>th</sup> 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, only 8 percent relapse.

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



Photo: Samantha Appleton

Photo: Anne Rippe/Getty

## FOR DISCUSSION





FOR DISCUSSION



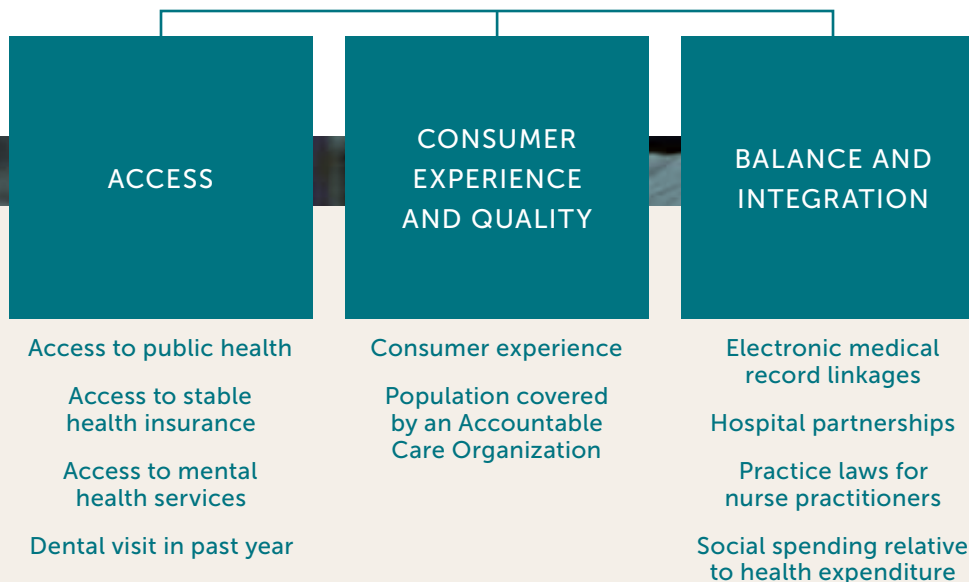


ACTION AREA



## STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

### DRIVERS



FOR DISCUSSION



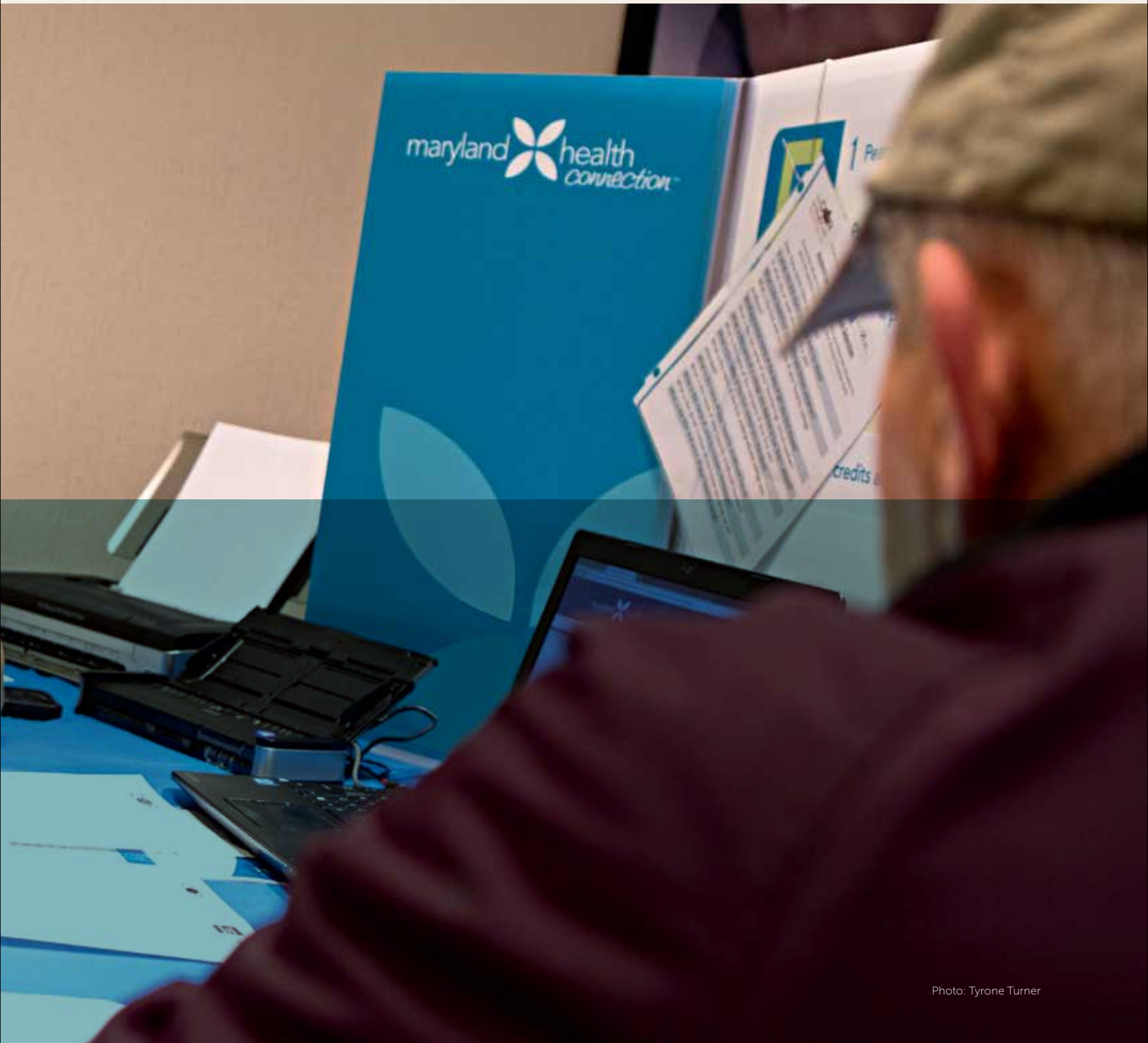


Photo: Tyrone Turner



## 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 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 last year's report from the *RWJF Commission to Build a Healthier America*, "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.<sup>42</sup> 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.

## FOR DISCUSSION



**DRIVERS:****ACCESS**

Several factors influence access to health care, 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 care when it is needed and having the opportunity and tools to make healthier choices.

**MEASURES:****Access to public health**

Percentage of population served by a comprehensive public health system<sup>43</sup>

**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<sup>44</sup>

**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<sup>45</sup>

**Dental visit in past year**

Percentage of adult population, ages 18 years and older, who report a dental visit in the past year<sup>46</sup>

**CONSUMER EXPERIENCE AND QUALITY**

Frustration with the health care system has become far too common. Appointments can be hard to get, forms and paperwork may be confusing, and family members and other caregivers are often excluded from the process. 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.

**Consumer experience**

Consumer Assessment of Healthcare Providers and Systems (CAHPS) summary measure of consumer experience across ambulatory, hospital, and home health care settings at the state level<sup>47</sup>

**Population covered by an Accountable Care Organization (ACO)**

Percentage of population whose health care provider is part of an ACO<sup>48</sup>

**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.<sup>49</sup> 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<sup>50</sup>

**Hospital partnerships**

Percentage of hospitals partnering with 10 or more different types of community organizations; these could include local health departments, substance abuse and mental health organizations, and faith-based organizations<sup>51</sup>

**Practice laws for nurse practitioners**

Number of states that have laws and regulations that support full scope of practice for nurse practitioners<sup>52</sup>

**Social spending relative to health expenditure**

A ratio of annual social spending to annual health expenditures in the United States<sup>53</sup>

- *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:

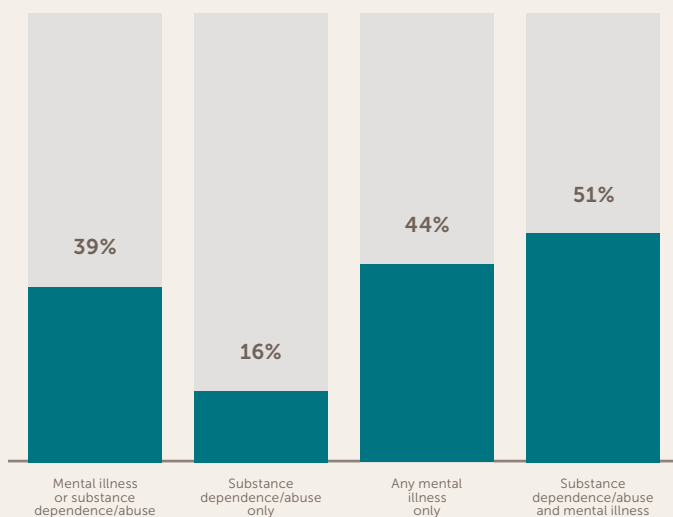
## STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

## 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

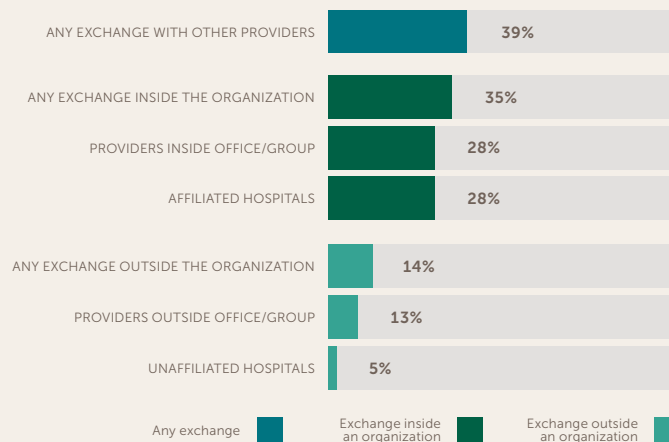


Data source: National Survey on Drug Use and Health, 2013. Substance dependence or abuse is based on DSM-IV. Mental illness is based on WHODAS and K6. Sample size: 67,838.

## ELECTRONIC MEDICAL RECORD LINKAGES

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

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

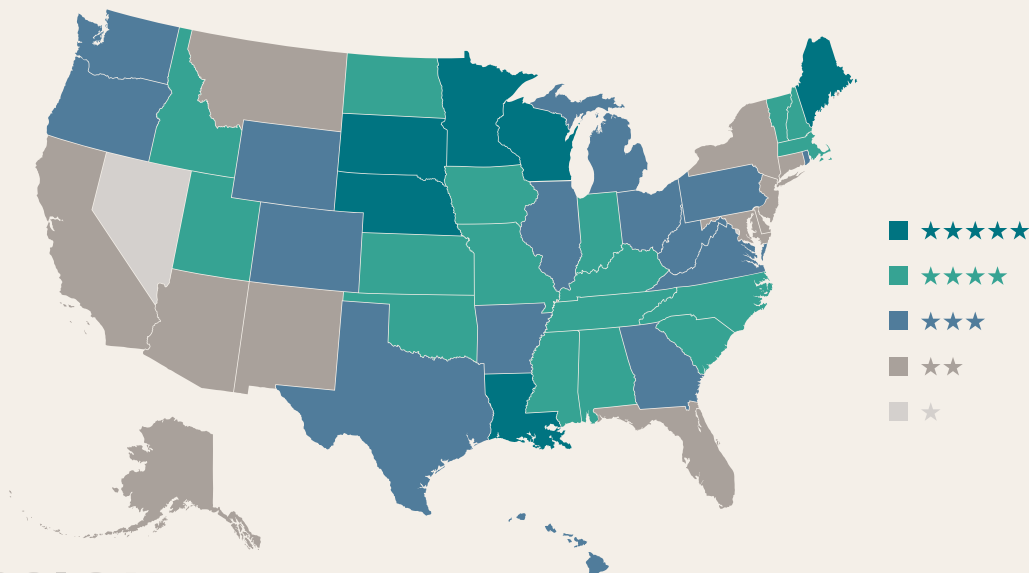


Data source: National Electronic Health Records Survey, 2013.

## 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.

FOR DISCUSSION





## 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.<sup>54</sup>

### HEALTH LEADS

*Health Leads*, a national health care organization, enables physicians and other health care providers to systematically screen patients for food, heat, and other essential health needs—and then “prescribe” those resources. At the Health Leads’ desk in the clinic, well-trained and well-supervised college student advocates “fill” the prescriptions, working closely with patients to access community resources. Health Leads advocates also update the clinical team on whether a patient received a needed resource, which helps inform decisions about care. In 2012, Health Leads’ corps of 900 advocates served 11,500 patients in 23 clinics across six geographic areas, all with significant Medicaid patient populations.<sup>55</sup>

### 11<sup>TH</sup> STREET FAMILY HEALTH SERVICES CENTER

11<sup>th</sup> Street Family Health Services Center is meeting the needs of a low-income Philadelphia community while reducing disparities. Health services are integrated through a cross-disciplinary core care team: nurse practitioners serve as primary care providers; behavioral health consultants address emotional and quality-of-life factors; and social workers connect patients to services outside the clinic. A nutritionist, physical therapist, and dentist may also serve on the core care team. Visits to the center grew from 2,200 in 2003 to 30,000 in 2011, with sharp increases in behavioral health and dental services. According to the center’s Director Patricia Gerrity, “I think we’ve helped our patients become activated patients, to take initiative in managing chronic illness or maintaining their health. And we’ve seen progress in lowering blood pressure, managing diabetes, and more.”<sup>56</sup>

# FOR DISCUSSION

---

JACKSON,  
MISSISSIPPI

Jackson  
Medical  
Mall



Thad Cochran  
Center

Photo: Tyrone Turner

**FOR DISCUSSION**

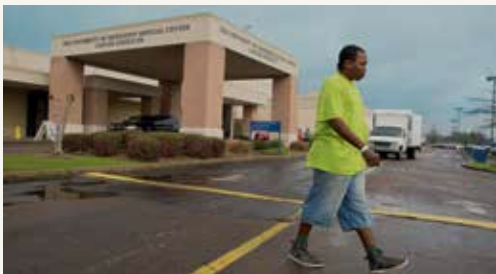


---

# 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® 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.

## FOR DISCUSSION



## JACKSON, MISSISSIPPI

### 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 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

## FOR DISCUSSION





Photo: Tyrone Turner

FOR DISCUSSION



## JACKSON, MISSISSIPPI



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.

Photo: Tyrone Turner

## FOR DISCUSSION



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



FOR DISCUSSION

## JACKSON, MISSISSIPPI

### 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 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

Photo: Tyrone Turner

## FOR DISCUSSION





FOR DISCUSSION



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

FOR DISCUSSION





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

FOR DISCUSSION

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."*<sup>57</sup> 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 social justice—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.

## FOR DISCUSSION



**OUTCOME AREAS:****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 care-givers, we gain a window into whether health has been woven into the fabric of our culture.

**MEASURES:****Well-being rating**

Well-being rating in three areas: Health, Life Satisfaction, Work/Life Balance<sup>58</sup>

- *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<sup>59</sup>

**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.<sup>60</sup> 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<sup>61</sup>

**Disability associated with chronic conditions**

Number of disability-adjusted life years (DALYs) for the top 10 U.S. chronic diseases, by age and sex<sup>62</sup>

**OUTCOME AREAS:****REDUCED HEALTH CARE COSTS**

It is well understood that rising 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 (and growing) 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<sup>63</sup>

**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<sup>64</sup>

**Annual end-of-life care expenditures**

Annual average Medicare payment per decedent in the last year of life<sup>65</sup>



Photo: Tyrone Turner

**FOR DISCUSSION**



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

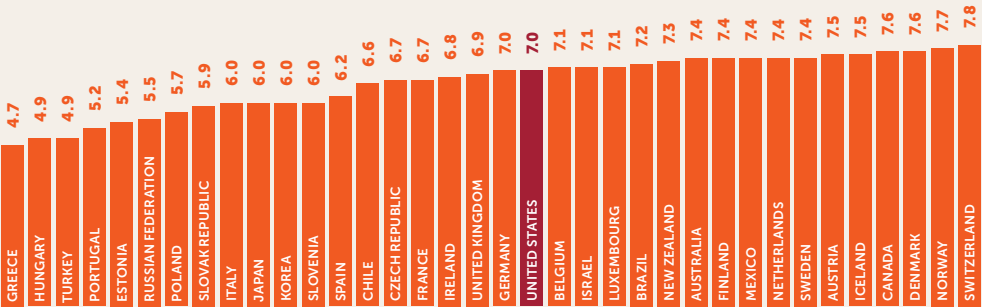
Of all OECD countries, the United States ranks 17<sup>th</sup> in life satisfaction

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").

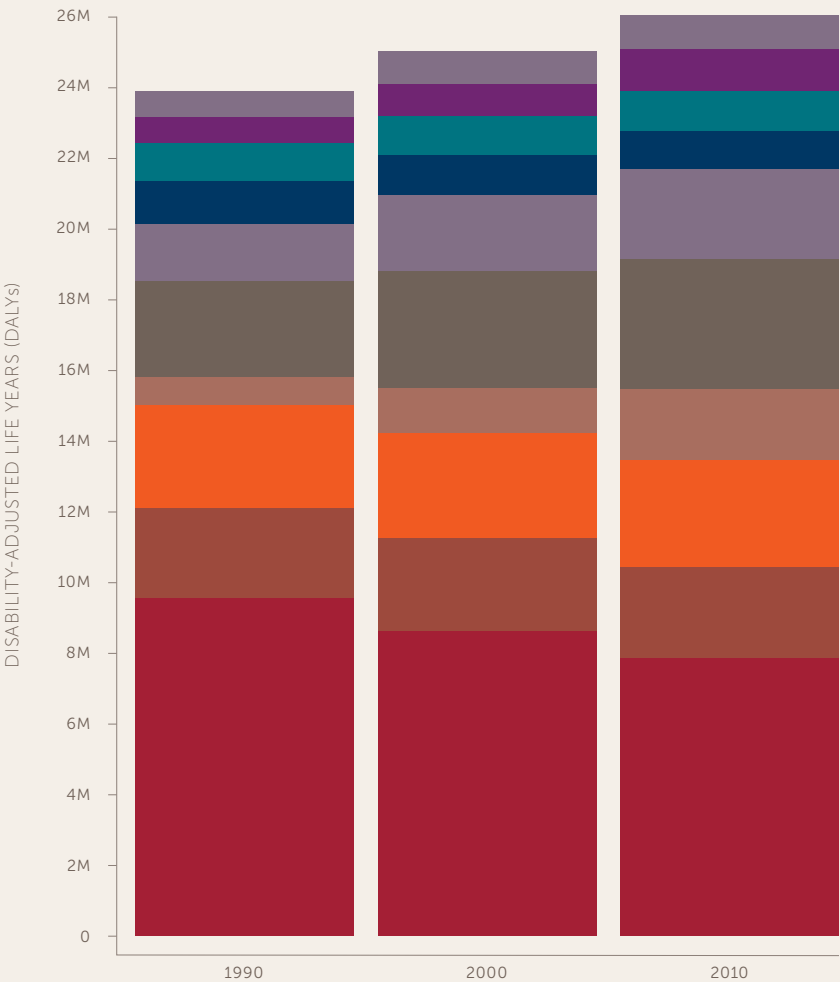
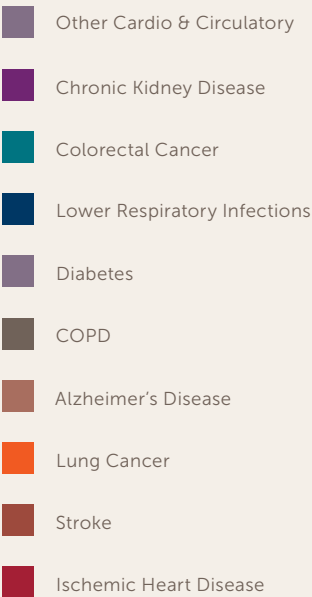
The Better Life Index (BLI) compares 36 countries across 11 topics of well-being. The BLI is important to monitor because it gives us a bird's eye view of how Americans are faring overall. Results of this Measure can help policymakers think strategically about how to assign resources.



DISABILITY ASSOCIATED WITH  
CHRONIC CONDITIONS

Despite some improvements in overall chronic disease management, the disability associated with disease continues to reduce quality of life 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<sup>66</sup>

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.



## NEXT STEPS

---

### ONGOING CONVERSATION

RWJF is developing a user-friendly website that will be unveiled 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 of the Measures, detailing significant factors such as race, ethnicity, and income levels when possible. 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.

We will gather feedback on the utility of the Action Framework in a number of ways:

- We will form a national advisory group consisting of researchers and both community and sector leaders.
- Three new RWJF research programs will focus on building the evidence base on the most significant factors in building a Culture of Health.
- Annual updates will report on the progress of collaborative actions, the evolution of the Measures, and how our investments are aligning with the Action Framework.

## FOR DISCUSSION

---

WILLIAMSON,  
WEST VIRGINIA



Photo: Tyler Evert

**FOR DISCUSSION**



---

# 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."

FOR DISCUSSION





## WILLIAMSON, WEST VIRGINIA

### 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: Tyler Evert

## FOR DISCUSSION





Photo: Tyrone Turner

FOR DISCUSSION





## WILLIAMSON, WEST VIRGINIA



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, Hurley 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.

Photo: Tyler Evert

## FOR DISCUSSION



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

**FOR DISCUSSION**



## WILLIAMSON, WEST VIRGINIA

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

Photo: Tyler Evert

## FOR DISCUSSION





**FOR DISCUSSION**

## APPENDIX

## CULTURE OF HEALTH ACTION FRAMEWORK

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

FOR DISCUSSION



## APPENDIX

# COUNTY HEALTH RANKINGS & ROADMAPS

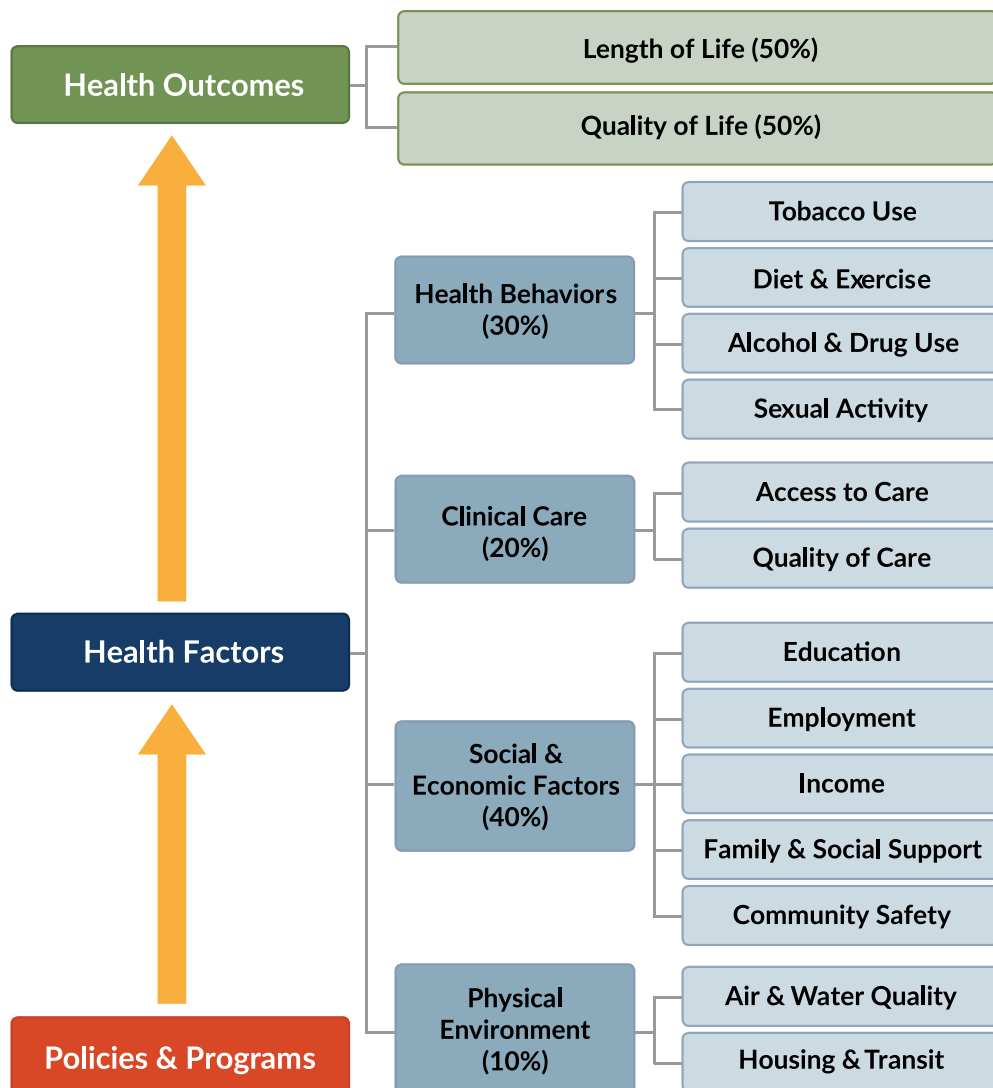
## BUILDING A CULTURE OF HEALTH COUNTY BY COUNTY

The *County Health Rankings & Roadmaps* program helps communities identify and implement solutions that make it easier for people to be healthy in their homes, schools, workplaces, and neighborhoods. Ranking the health of nearly every county in the nation, the *County Health Rankings* illustrate what we know when it comes to what is keeping people healthy or making people sick. The *Roadmaps* show what we can do to create healthier places to live, learn, work, and play. The Robert Wood Johnson Foundation collaborates with the University of Wisconsin Population Health Institute to bring this program to towns, cities, counties, and states across the nation.

Based on the *County Health Rankings Model*, the *Rankings* are unique in their ability to measure the overall health of each county in all 50 states on the many factors that influence health. They have been used to bring together government agencies, health care providers, community organizations, business leaders, policymakers, and the public to advance local health improvement solutions.

Visit [countyhealthrankings.org](http://countyhealthrankings.org) to view the *Rankings*, the underlying measures, and tools to help communities use their data to identify opportunities for improvement and action toward building a Culture of Health.

## COUNTY HEALTH RANKINGS MODEL



## ENDNOTES

- 1 *National Health Expenditures 2013 Highlights*. Centers for Medicare & Medicaid Services, [www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf). Accessed March 6, 2015.
- 2 *The World Bank Group. Health Expenditure, Total (% of GDP)*. Washington: World Health Organization National Health Account database, <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>. Accessed Feb. 26, 2015.
- 3 *National Health Expenditures 2013 Highlights*.  
Stewart WF, Ricci JA, Chee E, Morganstein D. Lost productive work time costs from health conditions in the United States: Results from the American productivity audit. *J Occup Environ Med*. 2003;45(12):1234–1246. [www.cdc.gov/workplacehealthpromotion/businesscase/reasons/productivity.html](http://www.cdc.gov/workplacehealthpromotion/businesscase/reasons/productivity.html).  
Arkin E, Braveman P, Egerter S, Williams D (eds.) *Time to Act: Investing in the Health of Our Children and Communities*. Princeton, N.J.: Robert Wood Johnson Foundation Commission to Build a Healthier America; 2014. p. 90.
- 4 Woolf SH and Laudan A, eds. *U.S. Health in International Perspective: Shorter Lives, Poorer Health*. Washington: National Academies Press; 2013. [www.ncbi.nlm.nih.gov/books/NBK154476/](http://www.ncbi.nlm.nih.gov/books/NBK154476/). Accessed March 6, 2015.
- 5 Woolf and Laudan, [www.ncbi.nlm.nih.gov/books/NBK154476/figure/ch2.f5/?report=objectonly](http://www.ncbi.nlm.nih.gov/books/NBK154476/figure/ch2.f5/?report=objectonly). Figure 2–5. Accessed March 6, 2015.
- 6 Arkin, et al., p. 22.
- 7 Data source: *RWJF National Survey of Health Attitudes* (also known as *Culture of Health*) (using two survey panels, fielding Spring 2015).  
The two panels are probability-based and designed to be nationally representative of American adults, spanning geography, age, gender, and race/ethnicity, and using appropriate statistical weights. The RAND American Life Panel is made up of over 4,500 individuals who agree to participate in occasional online surveys. Respondents are recruited using address-based sampling and random digit dialing. To ensure representativeness of the panel, computers and internet access are provided when needed. Surveys are conducted in English and Spanish. The panel contains an oversample of vulnerable populations. Panel members are drawn from all 50 states, and the District of Columbia. We also use the GfK Knowledge Networks panel. The survey was conducted using the Web-enabled KnowledgePanel®. Initially, participants are chosen scientifically by a random selection of telephone numbers and residential addresses. Persons in selected households are then invited by telephone or by mail to participate in the Web-enabled KnowledgePanel®. For those who agree to participate, but do not already have Internet access, GfK provides at no cost a laptop and ISP connection.
- 8 Ibid.
- 9 Data source: Sample of tweets sent within the United States over a recent period that use keywords/hashtags related to two health-related domains: wellness/well-being and acute health care. The indicator is calculated using the volume of wellness/well-being-related tweets divided by the volume of acute health care-related tweets in that time period.
- 10 Ibid.
- 11 Data source: Using Behavioral Risk Factor Surveillance System (BRFSS) item included in *RWJF National Survey of Health Attitudes* (also known as *Culture of Health*) (last BRFSS national data are 2010).
- 12 Data source: *2012 U.S. Atlas* on general election turnout (aggregate from state election boards).
- 13 Data source: *U.S. Current Population Survey* (compiled by Corporation for National & Community Service) (fielded in 2013 and opportunity to trend over the past decade). Washington; 2013.
- 14 Health Research & Educational Trust. *Hospital-Based Strategies for Creating a Culture of Health*. Chicago: Health Research & Educational Trust, p. 28.
- 15 Healthy Monadnock 2020, [www.healthymonadnock.org](http://www.healthymonadnock.org). Accessed Feb. 26, 2015.
- 16 Live Well San Diego, [www.livewellsd.org](http://www.livewellsd.org). Accessed Feb. 26, 2015.  
Live Well San Diego *Top 10 Live Well San Diego Indicators*, [www.livewellsd.org/content/livewell/home/make-an-impact/top-10-live-well-indicators.html](http://www.livewellsd.org/content/livewell/home/make-an-impact/top-10-live-well-indicators.html). Both accessed Feb. 26, 2015.
- 17 Lasker R, Weiss ES, Miller R. Partnership synergy: A practical framework for studying and strengthening the collaborative advantage. *Milbank Quarterly*. 2001;79(2):179–205.  
Lasker R and Weiss ES. Creating partnership synergy: The critical role of community stakeholders. *J of Health Human Svcs Admin*. 2003; 119–139.  
Lasker R and Weiss ES. Broadening participation in community problem solving: A multidisciplinary model to support collaborative practice and research. *J of Urban Health: Bulletin of the New York Academy of Medicine*. 2003; 80(1):14–47.
- 18 Data source: *NACCHO Profile Survey*; fielded every three years. 2013 data are used for baseline and then a different set of questions that is focused on partnerships across sectors will be asked in 2016. This same set of questions was last fielded in 2008, so trend is available. The 2016 (and 2008) measure will then be “Percentage of local health departments that collaborate with community organizations from at least four sectors.”

## FOR DISCUSSION



- 19 Data source: *School-Based Health Alliance Census of School-Based Health Centers*; baseline are data from 2010–2011 cycle.
- 20 Data source: From the *Health Enhancement Research Organization (HERO) Employee Health Management Best Practices Scorecard in Collaboration With Mercer* (baseline will be interim data of V4 survey, which was launched in June 2014 and is still in the field).
- 21 Data source: Baseline is CECP's *Giving in Numbers: Trends in Corporate Community Engagement* survey fielded in 2013 (trend data available back to 2001).
- 22 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).
- 23 Data source: Data licensed from Nielsen Media Research (fielded in 2013 with trend data available back to 2009).
- 24 Data source: EPA State Climate and Energy Program (baseline data are 2014).
- 25 Data source: *Current Population Survey Social and Economic Supplement* (baseline data are 2012, 2013) and the Basic Economic Security Tables (2010).
- 26 National Center for Medical-Legal Partnership, Department of Health Policy and Management, Milken Institute School of Public Health, The George Washington University, Washington, <http://medical-legalpartnership.org>. Accessed Feb. 26, 2015.
- 27 National Center for Medical-Legal Partnership. *Impact at a Glance*, <http://medical-legalpartnership.org/mlp-response/impact/>. Accessed Feb. 26, 2015.
- 28 Health Research & Educational Trust. *Hospital-Based Strategies for Creating a Culture of Health*. Chicago: Health Research & Educational Trust, p. 30.
- 29 Arkin, et al., pp. 32–33.
- 30 Data source: U.S. Census Bureau. 2010 *U.S. Census* and 2013 *American Community Survey*.
- 31 Data source: *USDA Food Access Research Atlas*, capturing counties where 50 percent or more of the census tracts have low food access, defined as one or more miles from a supermarket in an urban area, and 10 or more miles from a supermarket in a rural area.
- 32 Data source: Annual NIDA *Monitoring the Future Survey* (baseline goes back more than 10 years; most recent data are December 2014).
- 33 Arkin, et al., p. 41.
- 34 Data source: U.S. Census Bureau. 2010 *U.S. Census*.
- 35 Data source: U.S. Census Bureau. *American Community Survey 2013*.
- 36 Data source: Institute of Museum and Library Services (most recent data FY 12).
- 37 Data source: Smart Growth America, as of 2013.
- 38 Smart Growth America, [www.smartgrowthamerica.org/complete-streets/complete-streets-fundamentals](http://www.smartgrowthamerica.org/complete-streets/complete-streets-fundamentals), accessed Feb. 26, 2015.
- 39 Data source: *Americans for Nonsmokers' Rights Survey*. Berkeley, CA: Americans for Nonsmokers' Rights; 2014.
- 40 *A Holistic Approach to Community Development in Minneapolis-St. Paul*. New York: Local Initiatives Support Corporation, [www.youtube.com/watch?v=A7Byp685uVs](http://www.youtube.com/watch?v=A7Byp685uVs). Accessed March 6, 2015.
- Walljasper J. *Heritage Park: Better Care for Low-Income Seniors*. Local Initiatives Support Corporation, Twin Cities, [www.tclisc.org/news\\_events/PDFs/heritage\\_park.pdf](http://www.tclisc.org/news_events/PDFs/heritage_park.pdf). Accessed March 6, 2015.
- The Big Picture Project: Aligning Housing Plans Along Central Corridor*. Local Initiatives Support Corporation, Twin Cities; 2012, [www.tclisc.org/PDFs/big\\_picture.pdf](http://www.tclisc.org/PDFs/big_picture.pdf). Accessed March 6, 2015.
- Northside Minneapolis: The Power of Collaboration. Local Initiatives Support Corporation, Twin Cities, [www.tclisc.org/neighborhood\\_tours/game\\_plans\\_northside.pdf](http://www.tclisc.org/neighborhood_tours/game_plans_northside.pdf). Accessed March 6, 2015.
- 41 RWJF Commission to Build a Healthier America. *A Time to Act: Investing in the Health of Our Children and Communities*, p. 107.
- 42 Arkin, et al., p. 77.
- 43 Data source: *National Longitudinal Survey of Public Health*. National Coordinating Center, University of Kentucky; 2014.
- 44 Data source: *RAND Health Reform Opinion Study* (using American Life panel, fielding February 2015 and then quarterly).
- 45 Data source: *National Survey on Drug Use and Health*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2013.
- 46 Data source: *National Health Interview Survey*. Atlanta: Centers for Disease Control; 2013.
- 47 Data source: Centers for Medicare & Medicaid Services using data from hospital CAHPS, Medicare CAHPS and home health CAHPS. Baltimore: CMS; 2014.
- 48 Data source: Washington: Leavitt Partners; 2015.
- 49 Institutes of Medicine, 2012; IOM, 2014.

## ENDNOTES

- 50 Data source: *National Electronic Health Records Survey*, which is a separate mail survey as part of the *National Ambulatory Medical Care Survey*; 2013.
- 51 Data source: Washington: American Hospital Association in conjunction with ACHI (2011–2012).
- 52 Data source: American Association of Nurse Practitioners website; 2015, [www.aanp.org/legislation-regulation/state-legislation-regulation/state-legislation-tracking-center](http://www.aanp.org/legislation-regulation/state-legislation-regulation/state-legislation-tracking-center).
- 53 Data sources: OECD *Social Expenditures* (fielded in 2013 with trend data available back to 1980) and *National Health Expenditures 2013 Highlights*, CMS.
- 54 *Hospital-Based Strategies for Creating a Culture of Health*. Chicago: Health Research & Educational Trust; 2014.
- 55 Arkin, et al., 2014.
- 56 *Profile: Edge Runner Patricia Gerrity*. Robert Wood Johnson Foundation, Princeton, N.J.;2009, [www.rwjf.org/en/library/articles-and-news/2009/02/profile-edge-runner-patricia-gerrity.html](http://www.rwjf.org/en/library/articles-and-news/2009/02/profile-edge-runner-patricia-gerrity.html). Accessed March 18, 2015.  
  
*Facts & Figures About 11th Street Family Health Services Center of Drexel University*. 11th Street Family Health Services Center of Drexel University, Philadelphia;2011, [www.drexel.edu/11thstreet/pdf/11th-Street-Facts-and-Figures\\_08.30.11.pdf](http://www.drexel.edu/11thstreet/pdf/11th-Street-Facts-and-Figures_08.30.11.pdf). Accessed March 18, 2015.
- 57 World Health Organization. *WHO Definition of Health*, [www.who.int/about/definition/en/print.html](http://www.who.int/about/definition/en/print.html). Accessed Feb. 26, 2015.
- 58 Data source: Better Life Index (Baseline data are 2012 and there is opportunity to trend previous years). Note: We also include questions on thriving in the *RWJF National Survey of Health Attitudes* (also known as *Culture of Health*) (as supplement); Average score on personal well-being (outlook on life, resilience, thriving).
- 59 Data source: *RWJF National Survey of Health Attitudes* (also known as *Culture of Health*) (using two panels, fielding Spring 2015).
- 60 Bodenheimer, 2009.
- 61 Data source: *National Survey of Children's Health*, 2011–2012.
- 62 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.
- 63 Data source: Combination of data from Census and CMS (Baseline is 2013 Census data, 2012 MEPS, and Congressional Budget Office's *The Budget and Economic Outlook: Fiscal Years 2011 to 2021*.) Will be benched to national health care spending.
- 64 Data source: Baseline data source: SHADAC analysis of 2011 Health Care Cost and Utilization Project (HCUP) data using the Agency for Health Care Research and Quality (AHRQ) Patient Quality Indicator (PQI) and Pediatric Quality Indicators (PDI).
- 65 Data source: CMS Medicare claims, 2013.
- 66 *Donella Meadows. Seattle Citizens Define Their Own Dow-Jones Average*. Norwich, VT: Donella Meadows Institute; 1993, [www.donellameadows.org/archives/seattle-citizens-define-their-own-dow-jones-average](http://www.donellameadows.org/archives/seattle-citizens-define-their-own-dow-jones-average). Accessed April 8 2015.



# FROM VISION TO ACTION: MEASURES TO MOBILIZE A CULTURE OF HEALTH

## LEAD AUTHORS

Alonzo Plough, PhD, MPH  
Robert Wood Johnson Foundation

Anita Chandra, DrPH, MPH  
RAND Corporation

## WRITERS/EDITORS

Karen Gross  
Michael Vitez  
Kate Long  
Loretta Cuccia  
Tanya Barrientos—RWJF  
Joan Barlow—RWJF

## PHOTOGRAPHY

Lynsey Addario  
Samantha Appleton  
Mike Belleme  
Jed Conklin  
Pablo Durana  
Tyler Evert  
Jay Ferchaud  
Jordan Gantz  
Getty Images  
Ed Kashi  
Josh Kohanek  
Flynn Larsen  
Eric Lowenbach  
Matthew Moyer  
Anne Rippy  
Roger Tully  
Tyrone Turner

## DESIGN

Ideas on Purpose, New York

## RWJF, RESEARCH-EVALUATION- LEARNING

Penny Bolla  
Laura Leviton, PhD  
Carolyn Miller, MSHP, MA  
C. Tracy Orleans, PhD  
Tejal Shah  
Margaret Tait  
Matthew Trujillo, PhD

## RWJF, BOARD SUBCOMMITTEE

Julio Frenk, MD, MPH, PhD  
Patricia Gabow, MD  
Jeffrey Koplan, MD, MPH  
Robert Litterman, PhD  
Peter Orszag, PhD

## RAND CORPORATION

Joie Acosta, PhD  
Katherine Carman, PhD  
Tamara Dubowitz, PhD  
Laurie Martin, ScD, MPH  
Christopher Nelson, PhD  
Gery Ryan, PhD  
Blair Smith  
Vivian Towe, PhD  
Malcolm Williams, PhD  
Douglas Yeung, PhD

## EXPERT REVIEWERS

Nancy Adler, PhD  
Sandro Galea, MD, MPH, DrPH  
David Kindig, MD, PhD  
Michael Rodriguez, MD, MPH  
Stephen Shortell, PhD, MPH, MBA

*We are grateful to all those who have contributed to this publication, including all reviewers, members of the RWJF Board of Trustees, and other advisers.*

**FOR DISCUSSION**