

County Health Rankings & Roadmaps


Irene M. Wielawski

Editors' Introduction

It is no exaggeration to describe the Robert Wood Johnson Foundation as a data-driven organization. There is an inherent belief in the value of good data. The importance of data is illustrated by the many surveys the Foundation has funded to measure such things as access to and quality of care and the percentages of people who smoke, are uninsured, or are overweight. The Foundation has developed quantitative indicators of program results, and it conducts a statistical analysis that measures its own performance as presented in a “scorecard.”

But it would be a mistake to conclude that the Foundation cares about data only for its own sake. Rather, the Foundation tends to collect and disseminate data as a way of informing policy and improving programs—thus the great importance given to communicating the results of surveys and studies and of putting them in easily understandable language. The series of Cover the Uninsured Week campaigns is perhaps the most telling example of using data to inform public policy and raise the public’s consciousness.

In this chapter, Irene Wielawski, a veteran health care journalist and frequent contributor to the *Anthology* series, explores a new and important source of data, the County Health Rankings, and examines the way in which they are used, especially through the County Health Roadmaps, to encourage local policies that can improve the community's health. In a sense, the County Health Rankings & Roadmaps merge the Foundation's long-standing interest in good data with its newer interest in activities to improve the health of entire populations and communities. And, as Wielawski observes, the County Health Rankings have, in fact, spurred action to improve population health at the local level—either directly through interventions that encourage better health or indirectly through job creation and economic development.

 **T**he Rosedale section of Kansas City, Kansas, in Wyandotte County, shows many signs of a neighborhood that has seen better days—broken sidewalks, houses needing paint, boarded-up storefronts, and empty lots. But there are also bright spots—evidence of a community pulling together to turn things around. Vegetable gardens sprout in some of the vacant lots. Bike paths are being built. And newly poured concrete sidewalks near some elementary schools make it possible for children to walk safely to and from school.

Wendy Wilson, executive director of the Rosedale Development Association since 1993 and a self-described “old hippie,” is the driving force behind many of these revitalizing efforts in her ethnically diverse neighborhood of fourteen thousand people. A petite woman with short steel-gray hair and a no-nonsense demeanor, Wilson sees each project as part of the “interconnected” mosaic of community life: If families don’t have nourishing food, their health will suffer along with their ability to work and learn. If schools are substandard, children will be handicapped in qualifying for higher education. If a community looks rundown, it will have a harder time attracting new business. And if there are no new businesses, residents will be deprived of services and potential employment.

This holistic view of community life is reflected in the mission of the Rosedale Development Association, described on its website as “policy influencing and advocacy, land use planning, housing construction, crime reduction, public space improvement, youth programming, supporting neighborhood associations and providing assistance to residents and businesses for a host of issues and concerns.”¹

Unfortunately, few of the government programs and philanthropies that Wilson and the Association have turned to for support over the years shared that vision. “Most of them seemed to look at things piecemeal,” Wilson said. “They’d see dilapidated

buildings and want to fund a housing program, thinking that would fix the community. But, of course, it can't—not by itself."

In the Rosedale Development Association's cramped storefront office on Southwest Boulevard, Wilson and her staff of four young community workers began to doubt that their way of seeing things would ever be embraced by the national agenda setters. And then, in 2010, they were swept up into a countywide planning process stimulated by a program of the Robert Wood Johnson Foundation.

Called "County Health Rankings & Roadmaps," the program uses health and demographic data analyzed by the University of Wisconsin Population Health Institute to score the healthiness of every county in each of the fifty states. The process essentially turns out a report card for each county that identifies strengths in the population, such as low rates of smoking or obesity, and weaknesses, such as high rates of unemployment or births to teenagers. The most striking message of these report cards is the relatively small role played by medical services. Timely access to affordable and high-quality health care—the factors emphasized in the long-running U.S. debate on health reform—account for only about 20 percent of a community's health. Of far greater influence are social, environmental, and behavioral factors such as poverty, violent crime, poor nutrition, inadequate education, and physical inactivity. "I read their report on my county," says Wilson, "and thought, 'Wow, the Robert Wood Johnson Foundation gets it!'"

— — — **Resetting the Conversation about Health**

In fact, the link between health and how we live was not a new discovery for the Robert Wood Johnson Foundation when it set out to expand the work of the University of Wisconsin Population Health Institute into a comprehensive fifty-state ranking system. The Foundation has long been aware of the importance of so-called social determinants of health. As far back as 1972, in his first

annual report as the Foundation's president, David Rogers wrote that even though the Foundation was going to focus on improving medical care, he recognized that "while there are serious inequities in available health care, the same is true in other major aspects of our national life, such as housing, nutrition, education, and employment. All of these contribute in important ways to health, or lack of it . . . many of our most lethal illnesses stem from the ways in which we use automobiles, alcohol, and drugs, or neglect our bodies; these illnesses are not susceptible to medical intervention working in isolation from other sectors of society."²

Nor is the relationship of environment and lifestyle to health a novel concept for public health experts who for centuries have documented these connections—contaminated water supplies, unsanitary hospital conditions, spitting on the sidewalk, lack of mosquito netting, crowded tenements—and, when remedies became available, have pushed for government and civic action. An example is the swift adoption by most countries of lifesaving vaccines once they proved safe for young children. Not only health professionals led the charge for mass vaccination; government and education officials also helped by making vaccines available at low or no cost and mandating them for school enrollment. This collaborative approach greatly accelerated public acceptance of a scientific breakthrough and resulted in millions of people being saved from disability and premature death.

Less obvious—but no less critical to population health—are the myriad collaborations between government and the private sector on issues that many people would consider outside the medical realm. Take road safety, for example. From decisions by municipal highway departments on where to locate traffic lights, crosswalks, and speed bumps to choices made by automobile manufacturers on such things as chassis materials, airbag release points, crumple zone design, and seatbelt locks, each rests on a foundation of concern for public safety.

This collaborative commitment frayed somewhat during the 1980s, 1990s, and early 2000s as the national conversation

about health became focused on affordability. Patrick Remington, professor and associate dean at the University of Wisconsin School of Medicine and Public Health, recalls how even physicians lost sight of their historic role as civic leaders on health matters. “As health care became more of a business enterprise,” he says, “and as health care leaders saw businessmen taking over, there was a tremendous push for physicians to get MBAs in order to qualify as administrative leaders.” Suddenly, it seemed smart for physicians to view their practices as business enterprises oriented solely to the needs of paying “customers.” Traditional but often unpaid community service roles such as being the team doctor at school athletic events or volunteering in a free clinic for the poor took a back seat. Among employers, the conversation turned to strategies on ways to discourage the use of health benefits or increase workers’ share of the insurance premium. In policy and political circles, the focus was on how to cover the growing number of Americans without health insurance and not break the bank.

The trend dismayed Remington and others in the public health field who knew the limits of medical science to fix most people’s health problems. Clinicians—even those scrambling to add MBA to the MD or RN after their names—knew this as well through their daily interactions with patients. The reason for the visit might be fatigue or insomnia, but the larger context—a patient’s fifty extra pounds, the six-pack-a-night habit, hounding creditors—often mattered more from a health standpoint and influenced treatment decisions. “The fact that we have high rates of unemployment, children in poverty, smoking, and obesity that affect health is not a surprise to physicians,” says Remington. “But during this period physicians stopped feeling they had community responsibility or accountability for these social conditions.”

—∞— **From Global Snapshots to Local Action**

Most people don’t think or talk about their health in the crisp terms of a business school case study. They use emotional and

unscientific phrases like “I’m not myself” and “I’m stressed out” even when seeking help for overtly clinical symptoms like back spasms or digestive problems. The failures of their bodies are inseparable from the larger tableau of their lives, including social and environmental conditions. Global health studies support this view of health as more than personal biology, documenting, for example, significantly shorter lifespans in countries with inadequate health care systems, unchecked infectious disease, contaminated water, and ongoing warfare.

Although they illuminate the larger context of health, these global snapshots give little guidance on what people living in these places actually can do about unhealthful conditions. The scale is too large. Breaking down the data by country helps somewhat, but the focus is still too diffuse to stimulate citizen action. In the United States, for example, a project of the United Health Foundation, in collaboration with the American Public Health Association and the Partnership for Prevention, called *America’s Health Rankings*, has compiled health-related data for each of the fifty states every year since 1990. It’s a popular story with the media, but only a handful of states have significantly improved their standings—notably Vermont which climbed from seventeenth place in 1998 to first place in 2010.³

By contrast, Mississippi and other poor southern states such as Louisiana, Arkansas, and Alabama remain glued to the bottom, with Mississippi coming in last for ten years straight. That track record has bred a sort of gallows humor among health officials in the persistently low-scoring states. “Thank God for Mississippi,” they say every time their own state ekes out a ranking just shy of worst in the nation. The quip barely masks the frustration of trying to make headway against myriad local health-undermining conditions within the bare-bones budgets of chronically poor states. What’s needed is local buy-in. But to get that requires greater public understanding about health and its disparate influences, and a better tool to identify and remedy unhealthy conditions than existing big-picture snapshots

like *America's Health Rankings* or the massive state and federal government data sets utilized primarily by researchers.

Against this backdrop, the University of Wisconsin's Public Health and Health Policy Institute (the name was changed in 2005 to Population Health Institute) decided in the early 2000s to devise a more locally relevant statistical snapshot. The idea was to present selected data in the larger context of socioeconomic and behavioral health influences so that people could see not only the level of health in their communities but also the contributing environmental and socioeconomic conditions. The goal was to help community leaders see their inherent role in safeguarding public health.

"We specifically picked health access and affordability," says Remington, who at the time was director of the institute, located within the University of Wisconsin-Madison School of Medicine and Public Health. "But we also picked behaviors and employment rates and children staying in school and so on." Remington's research team decided to work off the *America's Health Rankings* model and adapt it to Wisconsin's counties. To show the interrelationships between people's health and their lifestyles and living conditions, the researchers merged traditional health "outcomes" information such as life span and rates of disease with so-called health "determinant" information such as rates of tobacco and alcohol use and physical inactivity. The "determinants" factors were categorized this way:

- Access to medical care, including whether people had health insurance, regular dental care, and blood pressure checks
- Health behaviors, including tobacco use, physical activity, consumption of fruits and vegetables, incidence of sexually transmitted diseases, and so on
- Socioeconomic factors, including the high school graduation rate and household income

- The physical environment, such as air and water quality and lead levels*

The County Health Rankings that emerged gave equal weight to the factors contributing to the quality of people's health, including the consequences of living with chronic illnesses such as diabetes, as they did to premature death (statistically measured as "years of potential life lost"). "Health outcomes are often reported in terms of mortality, since years of life is very important and mortality data are available and reliable," Remington and colleagues explained in their debut report, *Wisconsin County Health Rankings, 2003*. "However, most of us believe that health is measured not only in years of life but also in the quality of those years. Thus, we have created a health outcome ranking that incorporates how people in Wisconsin communities rate the state of their health while alive."⁴

Wisconsin's experiment wasn't an overnight success. Some critics questioned the statistical legitimacy of comparing sparsely populated rural counties against densely populated metropolitan counties with plentiful resources but also greater infrastructure costs and socioeconomic diversity. The feedback stimulated refinement of the model. "We got complaints, we made changes," Remington says. And the researchers frankly acknowledged in the report cards that some of the data upon which the rankings were based was several years old, albeit the best available. This disclosure was characteristic of the pull-no-punches style of the report cards,

* The original Wisconsin Health Rankings in 2003 attributed 10 percent of health status to access to medical care; 40 percent to behavioral factors; 40 percent to socioeconomic factors; and 10 percent to the physical environment. Upon a further review of the literature after the scope of the program became national, the Institute revised the formula to accord with the latest findings. It attributed 20 percent of health status to medical care; 30 percent to behavioral factors; 40 percent to socioeconomic factors; and 10 percent to the physical environment.

which were aimed at forging a respectful dialogue and partnership with community leaders who were engaged in a difficult task.

From Wisconsin's counties came glimmers of response. One county, with grant support from the American Academy of Pediatrics, started a program in which at every doctor's visit young children receive a book to take home and read with their parents—an activity considered by child health experts to be important for emotional development and school readiness. Another county, in a rural part of the state, responded to damning statistics on dental health and inappropriate emergency room use by partnering with the local hospital to open a sliding fee-scale medical and dental clinic for people without health insurance.

“The rankings aren't the be-all and end-all, but they're a conversation starter and they get people working on things,” says Remington.

—∞— **Taking the Conversation National**

In 2008, Remington and his team approached the Robert Wood Johnson Foundation for a modest grant that would enable the University of Wisconsin Population Health Institute to expand the Wisconsin model to five additional states. Instead, the Foundation offered nearly \$5 million so the Institute could produce report cards for every county in every state—a total of three thousand counties.⁵

James Marks, a leading expert on disease prevention who joined the Foundation in 2004 as senior vice president in charge of health, championed the fifty-state push. The evidence from Wisconsin suggested that giving communities the tools to identify their own health disparities might yield more comprehensive and sustained attention than grant-funded, single-issue initiatives. A fifty-state archive of county report cards also had a better chance of creating national awareness of the so-called social determinants of health than experiments in a few scattered states. Furthermore, Marks believed the report cards had the potential to spur broad-based action to reduce health disparities among

Americans—a problem the Foundation had long considered a funding priority.

Marks also shared Remington's view that the national conversation about health had become overly focused on cost and affordability, creating a false public message that health could be bought with an insurance card. That, in turn, allowed people like doctors and hospital executives, mayors, school superintendents, and business and religious leaders to withdraw from their previously embraced obligations to address unhealthy conditions in their communities. "Too many Americans are dying young and too many people say they don't feel well," says Marks. "This is not the fault of health departments or the health care system nor is it solely their job to fix these problems. It's an obligation for all of us to contribute to health."

The Foundation saw the Wisconsin model as more than just an educational tool for those seeking to understand the roots of ill health in their communities. It also had the potential to be a powerful social-messaging vehicle to, in Marks' words, "galvanize action" by elected officials and other community leaders. Hence the importance of ranking counties from best to worst in their respective states, and breaking out specific data to show civic leaders where they were beating state averages and where they were falling down on the job. The Foundation hoped to stimulate people's competitive instincts while also helping them identify health problems that could reasonably be tackled and, over time, reduced. The theory was that success in achieving a higher rank or ameliorating a specific problem would provide the psychic boost needed to keep going on problems as entrenched as obesity, substance abuse, and crime. In this way, the annual report card might play a role similar to that of the giant United Way thermometer displayed during community fundraising campaigns. Each uptick toward the top helps stimulate a collective sense of accomplishment and recharges enthusiasm for reaching the goal.

In October 2008, the Foundation authorized County Health Rankings: Mobilizing Action Toward Community Health (MATCH), providing roughly \$5 million through August 2012

to pay for three successive annual rankings. The Population Health Institute issued the County Health Rankings in 2010, 2011, and 2012, and the Foundation assisted with a sophisticated media campaign, including creation of an easy-to-use public website showcasing the report cards and supporting research; instructional webinars on social change strategies; press conferences; and promotional videos on communities working to improve local health conditions.

Two years later, in October 2010, the Foundation made a \$15 million commitment to follow up on its initial investment in County Health Rankings by adding a program called County Health Roadmaps. Headed by Bridget Booske Catlin, a colleague of Remington at the University of Wisconsin, County Health Roadmaps enabled the Population Health Institute to build on the momentum created by the County Health Rankings by supporting, with two-year grants totaling up to \$200,000 (with a required match of cash and in-kind services), up to thirty-two counties and communities taking action to improve the social, behavioral, and environmental conditions that undermine health. (The Foundation added \$1.3 million in 2012 for the grants program.) In addition, the Roadmaps program provides support for a new center providing technical assistance to communities around the country (not just those funded by the Roadmaps program), for new partnerships with national organizations such as United Way, and for an annual prize that recognizes communities for their outstanding work to improve health.

“It’s not good enough to tell people to take walks outside when they live in a dangerous neighborhood, or to eat fresh fruits and vegetables if there is no supermarket nearby,” says Brenda Henry, a senior research and evaluation officer at the Foundation. “The Roadmaps initiative is intended to put our money where our mouth is and help communities devise strategies to move the needle on community improvement.”

To assist communities as they plan and implement their strategies, the Foundation commissioned Community Catalyst, a

Boston-based national advocacy organization, to provide technical assistance to the communities selected. The projects range widely, from efforts to help ex-convicts reenter their communities, to improved transit systems, to preschool programs, to business coalitions working toward local job creation. The thread that binds them to County Health Rankings is that they in some way target what researchers consider to be the social determinants of poor health.

Abbey Cofsky, the Foundation program officer in charge of County Health Rankings & Roadmaps, acknowledges the long and difficult road to turning around health-eroding personal behaviors and socioeconomic conditions. “We don’t expect to transform health outcomes with two-year grants,” Cofsky says. “But we do see County Health Rankings & Roadmaps projects as a way to change how community leaders invest time and resources. And they are critically important steps towards gaining better public understanding of health—notably that how well we feel and how long we live are influenced by factors outside the health care system.”

So where has it led? The most measurable result has been in media coverage. The Foundation’s Marks says the first fifty-state County Health Rankings report generated thousands of print, radio, and television reports. And for a brief moment, the report actually made it to the top of the hit parade on the search engine Google. It’s harder to measure the response—and the quality of response—from the counties themselves. Some haven’t done anything to speak of. Others leaped to examine their problems and strategize about solutions. Still others saw activity by smaller units within the county—a city, perhaps, or a school system—to address a single factor with implications for people’s long-term health.

Following are two examples of action spurred, in part, by the County Health Rankings & Roadmaps initiative. The problems spotlighted in the data categories were, for the most part, already known. But in one case, Wyandotte County, Kansas, the mayor

swung the report card like a billy club to get people around the table who had never worked together on a common task. In the other, Hampden County, Massachusetts, an existing community health coalition in the depressed city of Springfield got a boost toward a long-cherished jobs project to alleviate urban unemployment.

—w— Wyandotte County, Kansas

Remember Wendy Wilson? She's the community activist stubbornly applying "old hippie" thinking to improve life in down-at-the-heels Rosedale. Rosedale, in turn, is part of Kansas City, Kansas, which is the dominant city in Wyandotte County, located just across the Missouri River from the better-known Kansas City, Missouri. There are only two other municipalities in Wyandotte County, Bonner Springs and Edwardsville, both small towns. Because of this, Kansas City, Kansas, and the county operate in a unified government structure. The city's mayor, Joe Reardon, is also Wyandotte County CEO, which means that everything—good and bad—that happens in the county's 156 square miles lands on his desk.

The first health rankings, released in August 2009, were actually a precursor to the national version, which was rolled out a year later. Kansas was one of a handful of states that used the Wisconsin model to independently rank their own counties. When the results were in, Wyandotte sat at the bottom of Kansas's 105 counties. The health rankings arrived in Wyandotte County amid a hailstorm of bad news. Already economically depressed from a steady decline in meatpacking jobs, Wyandotte was reeling from the ripple effects of a national recession that showed no signs of abating. Bankruptcies and foreclosures were at record levels and property values had plummeted—triggering a vicious cycle of reduced tax revenue and corresponding reductions in government services just when people needed them most. For Wyandotte County to be publicly spotlighted as the least healthy county in

the entire state of Kansas was, to say the least, a stunning new challenge to Reardon's four-year-old administration. He decided to meet it head on.

"There's a moment in time for a political official and this was mine," says Reardon. "I simply had to own the rankings even though the problems that were identified had been with us for a long time and I knew it was going to be very difficult to change our ranking in short order."

Caitlin McMurtry, a policy analyst at the Kansas Health Institute that did the 2009 ranking analysis, recalls the phone call she got from an exercised Joe Reardon, summoning her to Kansas City. McMurtry's sit-down with Reardon was the beginning of an ambitious, two-year research and planning process called Healthy Communities Wyandotte. County health director Joe Connor remembers how widely—and how passionately—opinions ranged during the early meetings at City Hall. Everyone seemed to have an opinion on how to solve Wyandotte's health problems. There certainly were a lot to choose from. Wyandotte County exceeds both Kansas and national norms for smoking, obesity, and sexually transmitted infections. Its teen birth rate is twice that of the Kansas rate and more than three times the national rate. Joblessness and the percentage of uninsured residents are higher than the U.S. rates, and preventable hospital stays exceed both Kansas and national benchmarks.

But mostly, Connor remembers the mayor's parting words at the kickoff meeting: "Oh, by the way, Joe Connor's going to lead this."

Connor was the logical choice, of course. As director of the Wyandotte County/Kansas City Public Health Department, he already supervised public and environmental health, air quality, and emergency preparedness. He was also known for his organizational acumen, which played out in Healthy Communities Wyandotte through the formation of five actions teams: communications, education, environmental infrastructure, nutrition, and health services.

Political observers identify another factor in his selection: Connor's stature as a true "son of the Dotte." Like Mayor Reardon, Connor grew up in Kansas City, Kansas, had family connections throughout the county, and regularly stepped up as a volunteer in schools, community organizations, and at church. As for the charismatic Reardon, not only is he one of the youngest mayors in the city's history, he's also the son of the late Jack Reardon, a popular civic leader, mayor from 1975 to 1987, and namesake of Kansas City's Jack Reardon Convention Center. Between them, Connor and Reardon were able to corral just about every community leader necessary to bring credibility, practical know-how, and political clout to the undertaking.

The capstone was their recruitment of Barbara Atkinson, who was then the executive vice chancellor of the University of Kansas Medical Center, one of the largest employers in Wyandotte County and seat of the state medical school. "The fact that Barbara Atkinson, Joe Connor, and Mayor Reardon teamed up and came to every meeting, that's what sold me," says Martha Staker, director of Project EAGLE, a program for infants and preschool children considered at risk for health and learning problems. Staker ended up chairing the Education for a Healthy Community action team.

Collectively, team members committed hundreds of hours of personal time to hone ideas for health-enhancing community projects and related policy revisions. Staker's team, for example, worked on a system of incentives to reduce Wyandotte County's 40 percent high school dropout rate. The County Health Rankings report hadn't told educators anything they didn't already know about school dropouts, but viewing the dropout problem in the context of other Kansas counties and statewide trends helped spur the community to take action.

"We're a blue-collar town, meaning a lot of our kids come from families that did not necessarily finish high school but still had good-paying jobs in the meatpacking plants," says Reardon. "Well, the world's changed. We have a meat slicing plant that

Sara Lee opened here recently with two hundred jobs. But the entire plant is computerized—no human hands touch the meat! Our kids need different skills from their parents and it's our job to prepare them.”

Action team leaders recruited people they thought had the professional expertise and practical wisdom to shape ideas into recommendations for action or policy change. Wendy Wilson was tapped for the Healthy Food action team, which eventually got behind a recommendation for zoning restrictions so that fast-food restaurants couldn't have drive-through service in residential areas. This was primarily to eliminate danger to pedestrians from cars zipping in and out, but the recommendation also dovetailed with the sidewalk construction projects under way to encourage walking to school and elsewhere. Wilson was thrilled to see her ideal of holistic neighborhood planning being embraced by others, but she also came to realize that teammates had been thinking similarly all along. “Working on the team introduced me to people who could be allies for our work in Rosedale,” says Wilson.

Bob Van Maren, superintendent of the Bonner Springs-Edwardsville school district, likewise met potential collaborators through his work on the Education for a Healthy Community team. “I've become more aware of what other people are doing in the community and how we can help each other,” he says.

Among the goals endorsed by the action teams are dental care clinics; school policies to foster nutritious eating habits in children; a nurse home-visiting program; training and deployment of community health workers; after-school mentoring projects; mental health outreach; a countywide communication initiative to educate people about healthy living; tax credits for farm produce vendors; and training programs to promote cultural competence.

This last goal came about through the influence of Mary Lou Jaramillo, president and CEO of El Centro, a social service agency relied upon by the county's growing Spanish-speaking population. Jaramillo insisted that an El Centro representative sit on every action team to make sure the needs of Latino residents

were incorporated into the new initiatives. She recalled the chaos that erupted in the Latino community when Kansas state school authorities adopted a “no exceptions” policy to its school immunization requirement. “We had some new immigrant families who simply weren’t familiar with immunization,” she says. “They don’t take their children to the doctor unless they are sick. Their children were barred on the first day of school, and suddenly we had all those parents coming to El Centro, very upset.”

In response, El Centro launched programs to train neighborhood women to be *promotoras de salud*—community health educators—to explain things like immunization requirements and the reasons for preventive care such as prenatal and well-baby checkups. Through the action teams, Jaramillo hoped to integrate her agency’s specialized programs with those of the health department and other agencies so Latino families could benefit from municipal offerings such as blood-pressure screenings, flu shots, and other health and wellness programs.

The work of the action teams officially ended in December 2011, when Healthy Communities Wyandotte delivered its report on goals and priorities to Mayor Reardon and shared it with county residents on the health department’s webpage. There was a brief euphoric feeling of accomplishment—followed by a huge letdown.

The precipitating event was the Foundation’s rejection of Wyandotte County’s application for a Roadmaps grant. County officials had been confident of getting a grant because of the Foundation’s demonstrated enthusiasm for the planning process undertaken by Healthy Communities Wyandotte—including sending a camera crew to film action team meetings and featuring the video on websites promoting the County Health Rankings project.

The failure to get a Roadmaps grant came as a shock that undercut momentum and spawned second-guessing. “What did we do wrong?” people wondered. The grant was seen as crucial to launching projects that could sustain popular interest in

tackling health threats. The fact remains that many of these threats correlate with poverty, and Wyandotte is one of the poorest counties in Kansas, a state whose own coffers are depleted by national recession. Where, people asked, was the capital for health coaches and new mental health services and after-school mentoring and more sidewalks to come from?

Ever practical, as civic leaders in hard-up communities tend to be, Wyandotte's political leaders are now eyeing "community contribution" revenue from a new casino in the western part of the county. An estimated \$2 million will become available to the Wyandotte/Kansas City Unified Government in January 2014. If Mayor Reardon is still in office (the reelection contest is in 2013), he says he plans to push hard for Healthy Communities projects. But he needs a majority vote by county commissioners and notes that some of them have already suggested alternative investments.

Barbara Atkinson, the former University of Kansas Medical School executive who helped lead the planning process, remains foursquare behind the recommendations. As a pathologist and longtime champion of partnerships between the medical school and county health projects, she did not need County Health Rankings to teach her the complexities of population health. But Atkinson is concerned about leaning too hard on a strategy that employs fear of ill health to power efforts to ameliorate what most people see as poverty-related conditions.

"I think it's a hard sell and can make people jaded," Atkinson says, noting that even the term *public health* implies *welfare* to some people. She hopes that early funding goes to projects to help Wyandotte's youngsters avoid early pregnancy and, at minimum, attain a high school diploma. In her judgment, tangible and timely results are more likely to result from such education-related initiatives than from efforts to reduce the rates of smoking, alcohol abuse, and obesity. Corresponding improvement in the employment opportunities for Wyandotte's young people will, Atkinson believes, help to sell longer-term investments in population health.

“The money commitment has to be long term in order to measure results or progress,” says Atkinson. “We can’t be fighting for renewal every year.”

—❧— **Hampden County, Massachusetts**

Based on the analysis by County Health Rankings, Hampden County, Massachusetts, and Wyandotte County, Kansas, could be twins—albeit 1,400 miles apart.

Compared to other counties in their respective states and to some national benchmarks, their scores are terrible. Each has nearly double the U.S. unemployment rate. They have more violent crime in their communities than other places do, more births to teenage mothers, more single-parent homes, and a higher percentage of people who report feeling unwell, physically and mentally. The combination of these factors portends significant long-term health problems and shorter life spans if residents fail to turn things around.

The difference is in how community leaders have responded to the report cards. Where Wyandotte dug into each data category and spent two years developing a multipronged plan to remedy health hazards, Hampden boiled everything down to a single goal: *more jobs*.

Health is explicitly *not* the driver of activities currently being supported by a two-year Roadmaps grant of roughly \$200,000 a year to Hampden County. There are some health care players, notably the two major health systems in the region, Baystate Health and the Sisters of Providence Health System. But their participation has as much to do with their business interests in Hampden County as with their health care mission.

The other difference is the focus of the project. It is centered exclusively on the city of Springfield and, more specifically, on neighborhoods where county-level health statistics don’t even begin to describe the hazards of living there. “The County Health Rankings are really a poverty map,” says Frank Robinson, who

wears two hats in the Hampden County venture. One is as director of community health planning for the region's major hospital, Baystate Medical Center. The other is as executive director of a business coalition called Partners for a Healthier Community, which successfully competed for a Roadmaps grant. "Bad as Hampden County looks, the conditions in some neighborhoods in Springfield are grossly worse," Robinson says. "The rankings kind of wash out the true picture of our population's needs."

This merger of local wisdom with the County Health Rankings report card has prompted an economic development push called the Wellspring Initiative. Modeled on the successful Evergreen Cooperatives in Cleveland, Ohio, Wellspring is seeking to create new businesses to compete for service contracts—and jobs—that Springfield's anchor institutions are currently outsourcing to distant vendors. Among the enterprises under consideration is a commercial laundry that could serve the needs of local hospitals, colleges, nursing homes, and other institutions. Also under discussion is a fresh food distribution hub, through which fruits and vegetables would be purchased from local growers and sold to institutional clients.

In addition to the Baystate and Sisters of Providence health systems, Wellspring's backers include the Center for Public Policy and Administration and the Center for Popular Economics at the University of Massachusetts, Amherst; several local colleges and universities; community partners such as Jobs with Justice, Pioneer Valley AFL-CIO, and the New North Citizens Council, a social service agency in one of Springfield's most distressed neighborhoods; and funding partners such as the MassMutual Foundation and the United Way of Pioneer Valley. The project's technical advisers include the Federal Reserve Bank of Boston, which deploys economic data much in the way the University of Wisconsin Population Health Institute uses health statistics to create the County Health Rankings. A Wellspring report based in part on the bank's 2010 report, titled *Jobs in Springfield*,

Massachusetts: Understanding and Remediating the Causes of Low Resident Employment Rates,⁶ starkly laid out the case for more jobs:

- Annual household income in Springfield's poorest neighborhoods ranged between \$15,000 and \$17,000, compared to a Massachusetts average of \$64,000.
- Of 10,300 jobs in Springfield, only 1,500 are held by Springfield residents due to gaps in education and skills.
- Although anchor institutions in Springfield annually purchase \$1.5 billion in goods and services, 90 percent of the contracts go to businesses outside the region.

“Jobs are the key to improving the entire quality of life for our families, including health,” says Michael Denney, executive director of the New North Citizens’ Council, a social service agency in Springfield’s impoverished Memorial Square neighborhood, where the population is largely Latino. “That’s why the job focus of Wellspring is really exciting to me. We used to have factory jobs right here in the neighborhood. People could walk to work, walk home for lunch. But the last one left about seven years ago and now all we’ve got are the McDonald’s and the Dunkin’ Donuts and that wage scale simply doesn’t work when you’re trying to support a family. We need good paying jobs with benefits.”

Phillip González, the project director for the Roadmaps to Health Community Grants, acknowledges Wellspring’s seeming disconnect from the health message of the County Health Rankings. But González, who works for Community Catalyst, which is providing technical assistance under the Roadmaps project, says the Roadmaps portfolio tends toward single-issue projects that relate to health only in the big picture. Besides Wellspring, Roadmaps is funding projects to help children bond with incarcerated parents, prepare young people for school and careers, and improve public transportation.

“Although the Robert Wood Johnson Foundation is a dedicated health funder, that’s not the language or strategy we’re using in Springfield,” says González, adding that civic leaders there pointedly rejected the health message imbedded in the County Health Rankings in order to stay focused on jobs development. “The words to me were just that: ‘Our goal is jobs. Our people need a reason to get up and go to work and pay their bills. Of course, we want them to take care of their health, but first they have to have jobs to be able to pay the co-pays on their medicines and actually take them.’”

Ira Rubenzahl, president of Springfield Technical Community College and a Wellspring Initiative partner, says that he grasps the relationship between life circumstances and health outcomes but believes that a focus on jobs creation is a much more powerful way to galvanize community support for social improvements. “People understand that improving employment opportunities means people can be more self-sufficient, neighborhoods will improve, crime will go down, and the city will have more resources to do what it has to do like fix the roads and plow the snow,” Rubenzahl says.

He notes an additional motivating force: the economics principle of enlightened self-interest among businesses backing—and potentially investing in—Wellspring enterprises. “The college is involved partly because it’s good for our business. More jobs and improvements in the standard of living and local economy mean better health but also less crime and better city services. If the city is so depleted that it can’t plow the roads—and that’s happened in recent winters—our faculty and students can’t get to class. That’s bad for my business.”

— — — Conclusion

Pat Remington of the University of Wisconsin Population Health Institute modestly refers to County Health Rankings as a “conversation starter” that might yield measurable improvements

in population health a generation from now. The modesty is well placed. So much of what the report cards identify as deleterious to health and life span—adult obesity, alcohol abuse, unemployment—are extremely difficult to turn around in the short term. And, as the snapshots of Wyandotte and Hampden counties show, how local communities respond to their report cards and the type of conversation that ensues vary greatly.

Although the improvements in health may not be seen in the near term, County Health Rankings & Roadmaps has nonetheless been valuable as a means to stimulate public discussion of broader influences on health than simply access or lack of access to medical care. This shift in emphasis has been under way for some time among health policy experts grappling with the soaring costs of treating illness. Within the Robert Wood Johnson Foundation, campaigns to reduce smoking and obesity, community-improvement efforts such as the anti-substance abuse programs Free to Grow and Fighting Back, and support for the Commission to Build a Healthier America manifest this broader perspective on population health. Beyond the work of the Robert Wood Johnson Foundation, it can be seen in provisions tucked into the Affordable Care Act to promote healthy behavior and prevent illness, in school policies to teach children about nutrition, and in workplace wellness programs that encourage employees to eat better, exercise more, and stop smoking.

In this larger context, then, the unique contribution of County Health Rankings & Roadmaps is to share this perspective with local communities, give them the tools to set priorities, and provide support to implement homegrown solutions. Wyandotte County, Kansas, and Hampden County, Massachusetts, show how differently the health message of the Rankings may be received and converted to action. But it's the start of an important conversation.

Notes

1. Rosedale Development Association website, <http://rosedale.org>.
2. Rogers, D. "The President's Statement." *Robert Wood Johnson Foundation Annual Report 1972*.
3. United Health Foundation. *America's Health Rankings*, <http://www.americashealthrankings.org/Rankings>.
4. Peppard, P. E. et al. *Wisconsin County Health Rankings, 2003*. Madison: Wisconsin Public Health and Health Policy Institute, 2003, p. 1.
5. RWJF Funding Summary report, funding ID 65017.
6. Kodrzycki, Y. *Jobs in Springfield, Massachusetts: Understanding and Remediating the Causes of Low Resident Employment, Community Affairs Discussion Paper 2009–05*. Boston: Federal Reserve Bank of Boston, 2010.

