

Place-Based Practices Shape the Healthy Communities Movement

BY MONTE ROULIER

In 1995, a group of Scranton, Pennsylvania, civic leaders concluded it was time for a new way to approach the region's future. Inspired by several other communities using a Healthy Communities process, they launched Forging the Future. At the time, this long-term, vision-driven, holistic, participative, asset-oriented, and upstream model was a radical departure from the status quo.

Over a period of about fourteen months, nearly four hundred stakeholders came together regularly to develop a plan that would bend negative trends and realize untapped potential. The planning process birthed an ambitious fifteen-year vision, and seven key performance work teams focused on areas such as economy and jobs and art and culture. Even though Scranton was experiencing one of the highest downtown business vacancy rates in the country, the group implemented a number of strategies to revitalize the downtown through a coordinated approach to arts, culture, and tourism. The plan took advantage of local talent and of aging, although once wonderful, music and theater venues. The initiators saw the overall process as a means to foster a greater sense of community, a prime motivation of other healthy community efforts at the time.

Technological and social changes of the last twenty to twenty-five years have profoundly influenced the ways communities approach the work of health and quality-of-life improvements. Few communities today would be willing or able to pull off a fourteen-month planning process with over three hundred stakeholders on a broad range of focus areas. Forging the Future leaders used snail mail and the telephone as the primary mode of communication. Having never experienced meetings where stakeholders possessed smart phones (and the competing interests of real-time texts/e-mail/Facebook), they could not imagine the level and depth of access to information and data made possible through a Google search or Web-based apps. Nor could they imag-

ine that an obesity epidemic and lifestyle-induced chronic diseases would eventually dominate the focus of the vast majority of Healthy Communities efforts across the country. A new landscape of challenges and opportunities has forced new ways of addressing community change. These new approaches are commonly referred to as place-based strategies, an emergent transformative force within the larger Healthy Communities movement.

Place-based approaches recognize that where we spend most of our time—neighborhoods, workplaces, schools, and places of worship—has enormous influence on the choices we make each day. An overarching theme is making the healthy choice the easy choice. The many community change efforts that comprise this place-based movement often place a strong emphasis on healthy eating and active living (HEAL); policy making and environmental changes to shift behavior and norms and health equity; or acting to address the growing health disparities, particularly with low-income and minority community members, that are largely rooted in factors related to place.

Although there are no exact formulas for place-based approaches, there are clear essential practices that lead to its enhanced benefits and results. Five emerging essential practices are discussed next.

Weave Mutual Interests into a Common Vision

Working with a shared vision as starting point has been a staple practice for most healthy community efforts and entails much more than simply crafting a nice vision statement. It requires a critical mass of community members and partners sharing a vision or common understanding of both the benefits to be derived and the nature of underlying challenges.

Individuals and organizations alike need to see how fundamental needs and interests will be met through

this common vision. LiveWell Greenville (LWG) in South Carolina was able to do just that when it envisioned a more walkable/bikeable community and made the case for investing substantial resources in trailheads (one being central to downtown trail networks). The local Chamber of Commerce recognized how this strategy could contribute to quality of life and to recruitment of new business. The school district viewed trails and related street enhancements as creating safer and more healthful ways for children to get to school (and potentially to save money on busing). Greenville's two primary hospitals found walking trails to be an asset in chronic disease prevention and management. As LWG coordinator Eleanor Dunlap said, "Our partners may use slightly different words to make the case for active transportation—bikeable, walkable, and connected to public transportation—in Greenville, but we all recognize we are describing the same desired future."

The shared vision for active transportation allowed the LWG partners to build a broad constituency and to persevere through legal challenges and also through early but vocal citizen opposition, regulatory roadblocks, and financial setbacks. The partners knew they had a good chance of shifting the way community members got around by providing the choice of easily accessible trails connecting to practical and compelling destinations. The Swamp Rabbit, a 17.5-mile multi-use trail system running along the Reedy River connecting Greenville County with schools, parks, and local businesses, opened in 2010 and has seen extraordinary increases in usage each year since—more than meeting the mutual interest of the partners. It has become a prized asset and has led to a chain of additional actions.

LWG is using this same formula for four other goal areas:

1. To help different sectors and community partnerships discover mutual interests
2. To act in concert on big policy or environmental changes (e.g., the trail system and funding mechanisms)
3. To support coordination among various initiatives (e.g., outreach or installation of bike racks)
4. To tether vision to measurable strategies and outcomes

Make Wise Use of Data and Technology

The need to save time and resources has prompted collaboratives to rethink strategies for data collection, analysis, and management. New technologies for securing, visualizing, and managing data are improving assessment, case making, and performance.

A place-based collaborative in the Quad Cities region on the border of Illinois and Iowa is finding new ways to use data and technology. Access to healthy foods is a growing concern for regional leaders and community members, prompting the Quad Cities collaborative to move toward creating a regional food system with a sustainable food access plan. As a starting point, an accurate map was developed of the region's food deserts, a term used to describe places where it would be difficult, if not impossible, to find fresh, affordable fruits and vegetables. A Web-based mapping utility secured by the United Way allowed coalition members to combine and correlate locally collected data (from grocery stores and food pantries) with other relevant publicly available data on a broad range of focal areas, such as schools, poverty, and the retail food environment. The result is a Web-based map that allows the entire community to identify neighborhoods and areas in greatest need of healthy and affordable food outlets. Maps enable the coalition to engage the tacit wisdom of a broader set of community stakeholders—adding insight into the specific challenges and generating solutions. The maps are easily updated to show new assets and progress toward shrinking the food deserts.

The Quad Cities coalition recognized the need to be utilization focused in its data and assessment for the place-based efforts. Although former community health needs assessments offered some context, subcounty-level data are needed to pinpoint challenges and opportunities. Securing data at zip code level (e.g., for schools and fast food locations) and/or at block level has become essential for place-based strategies. More communities like Quad Cities are also utilizing tools geared to HEAL assessments—such as the YMCA's Community Healthy Living Index or doing walkability and/or food access audits—to collect meaningful observational data in and around settings where people live, work, attend school, or play.

Many communities are drowning in a sea of data and often have duplicate assessment and data collection efforts. The LiveWell Omaha partnership in Douglas County, Nebraska, is evolving a Web-based system and processes to ensure that its community improvement efforts share reliable health and quality-of-life indicators. The business, nonprofit, and government leaders who share governance for LiveWell Omaha have come to realize that a shared measurement system with common measures serves an important role in community discussion, community education, and collective action.

Artfully Blend Policies, Programs, and Promotion

Policy and environmental strategies are essential for deep and sustained change, but the greatest impact generally comes when these are combined with programs and creative promotion.

For example, the PedNet Coalition in Columbia, Missouri, found that policies and environmental improvements—street improvements involving sidewalks, crosswalks, bike lanes, and crossing guards—alone would not lead to long-term behavior changes. It would take a combination of these improvements plus programs—in particular, Columbia’s nationally recognized “walking school bus” and bicycle safety courses—to tip behavior change so that children and families would begin walking or bicycling to school.

Each year PedNet and scores of partners sponsor “Bike, Walk & Wheel Week,” a highly visible and popular week of music in the parks, bike giveaways (recycling bikes for lower-income families), breakfast stations at schools and workplaces promoting biking/walking, and a local celebrity car versus bike challenge. This event is strategically aimed at recruiting families to participate in walking school bus programs (a walking school bus is a group of children walking to school with one or more adults) and at growing support for future infrastructure investments—building a constituency for change.

Place-based coalitions across the country are turning to full-blown branding strategies and campaigns to help cement and grow communitywide support for place-based changes. For example, a Nashville, Tennessee-based coalition called Nashvitality has been very intentional about branding, coordinating

social media, recognition efforts, and creative advertising. According to David Campbell of the Metro Nashville Health Department, “Nashvitality is now a brand that means something to the residents of Nashville; it means we are striving to live out values of a healthier and greener city. We make sure to connect our many place-based projects—our new bike share program, our workplace wellness initiatives, and our greenway and food access initiatives—to a brand that represents a new way of working and living together.” Plans are under way to encourage and ensure that whenever businesses, schools, and workplaces use the brand, they also adhere to a high level of healthy eating/active living policies and practices.

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Adopt an Opportunistic and Experimental Mind-set

Long-range action plans become static and are prone to irrelevance when operating in a dynamic political, social, and fiscal environment. Given today’s rapidity of change, the nature of place-based strategies requires a highly adaptable approach. No cookbook exists for executing place-based strategies; rather, effective place-based change leaders increasingly think and behave like social entrepreneurs, testing small changes and scaling what works. When anchored with a strong vision, place-based coalitions can afford to be highly adaptable, even opportunistic, while maintaining fidelity to their long-term goals.

Investing in complete street policies and strategies (e.g., making it easy to cross the streets, walk to shops, and bicycle to work) was an aspiration, though not initially a top priority, for Birmingham Alabama’s Health Action Partnership (HAP), primarily because of the perceived political and fiscal climate. Things changed when the mayor and City of Birmingham decided to move forward with a sizable repaving project to be completed prior to Birmingham’s hosting the international Davis Cup Tennis Tournament. HAP members seized the opportunity to educate city leaders about the benefits of complete streets. They convinced leaders to

make slight adjustments to the paving project, such as striping bike lanes and adding signage (which would have been much more costly to do later). HAP was able to capitalize on the opportunity because the members were flexible.

Effective coalitions constantly scan for assets and opportunities. Such opportunities often arise unexpectedly. HAP was also working to link healthy eating and physical activity with smoke-free environments. After a poll showed stronger-than-anticipated community support for tobacco-free environments, HAP learned of an interest in smoke-free ordinances on the part of two influential bar owners and seized on another opportunity. Its approach of combining a pilot program of smoke-free nights at the most popular bars along with a coordinated media effort presenting data from polls to justify public support became instrumental in advancing smoke-free policies. Highlighting a pressing problem that needs a solution and building on existing assets are great ways to generate momentum. Assets may include willing volunteers or school or civic leaders who like to be early adopters.

A network of youth-serving organizations banded together in Nashville to test organizational policies and practices that lead to healthful eating and more active environments for youth. They came together over a six-month period to experiment with evidence-based strategies. They looked at what worked, what did not work, and effective ways to scale strategies in an effort to create healthier “youth zones” across the metro area. A group of participating organizations that included the YMCA, United Way, and Boys & Girls Club entered the collaborative experiment with the attitude that failures are to be expected and provide good opportunities for learning and adapting, a powerful approach that is bearing results and often snowballs into other viable opportunities and even greater results.

Distribute Leadership and Spread the Movement

Most of these initiatives have ambitious aims, limited staffing, and strong reliance on volunteers. Place-based initiatives are often complex—involving many organizations and partners—and do not rely on hierarchy or individual organizations to mandate performance. This coordinated work effort looks

more like movement mobilization than program management.

No single model exists for leading and organizing a place-based collaborative. Some communities house them within existing organizations, such as health departments or YMCAs, and some incorporate them as separate nonprofit organizations, while others rely on a variety of collaborative partners to fulfill these core leadership and support functions. Whatever model is used, the effective ones usually have these characteristics:

- *Engage the right mix of individuals.* At the core they have a strong leadership team with a mix of individuals representing different sectors and perspectives and willing to contribute their influence, skills, and/or networks for the greater good of the community. They also have action teams/work groups that include an appropriate mix of partners, content experts, and stakeholders (including those who shoulder the greatest burden of health disparities) who can implement targeted strategies effectively.
- *Build team and team skills.* A group working together needs solid relationships and a sense of being part of a team to perform well. Annmarie Medina of Activate Tucson said, “Making time for our respective team relationships outside of a traditional meeting format—doing site visits, watching movies, and eating together—as well as attending relevant learning events, has helped us build trust and stick together when things get tough.” Endeavoring to implement policy and environmental strategies is new territory for many team members; providing them with education and capacity building allows them to contribute fully. Building team skills and capacity often includes helping people find their voices as effective advocates and understand effective ways to influence policy-making processes.
- *Provide collaborative infrastructure.* Collaboration within and across coalition teams requires substantial support: facilitation; communication through meetings, notes, notices, and updated action plans; research to determine proven strategies; evaluation to establish the baseline and identify gaps; and convening meetings. The HAP of Jefferson County, Alabama, leaned on its United

Way partner to help cultivate action team facilitators and to support communication between action teams. This support has been crucial to HAP's successful implementation of place-based solutions.

One key to spreading the movement is to help local organizations adopt their own policies and practices. Because so many of the policy/environmental improvements are also specific to settings, numerous opportunities exist for local organizations to adopt and implement place-unique improvements, for example, helping local nonprofit organizations, small and large workplaces, and places of worship to customize and implement their own healthy-eating, active-living policies and practices. Another improvement might be helping government agencies adopt procurement policies that support healthy eating for employees and contribute to the local food system. These are powerful and sometimes easy ways to reach and engage a broad number of community members and to contribute to core strategies.

Of course, helping community members take basic meaningful daily actions, such as biking to work and supporting the local farmers' market, is also at the heart of changing community norms and spreading the movement.

Conclusion

Today hundreds of community collaboratives are employing place-based strategies. Many of these have received funding and technical assistance from

sources like the Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation, the W.K. Kellogg Foundation, and/or Kaiser Permanente, along with several larger statewide foundations. Clearly, the increased public focus on the obesity epidemic and issues of physical inactivity and unhealthful nutrition has garnered an unprecedented level of collaboration among funders and researchers as well as state and local networks of place-based coalitions.

As place-based approaches mature, there is a growing recognition that the potential impact of these strategies to combat obesity extends well beyond benefits of community members' physical health. These same strategies have the added benefit of creating physical spaces that are conducive to a greater sense of belonging and social cohesion—a powerful antidote to suburban sprawl and the car-centric landscape of strip malls and fast food joints. They are proving to be a powerful way to reestablish, or create for the first time, places worth caring about. This returns us to the vision and promise of early health community efforts like Forging the Future: To create and sustain health, people need, and are naturally wired to thrive in, places where there is an authentic sense of community and connection to place.

Monte Roulier is the cofounder and president of Community Initiatives, an organization dedicated to building healthy and whole communities.

Community Commons A Unifying Public Good Web Site for Healthy, Sustainable, and Livable Communities

BY CHRISTOPHER L. FULCHER

In the spring of 2010, a distributed network of leaders who were collaborating on policy, systems, and environmental change approaches for improving population health and community vitality initiated a national conversation in Indianapolis, Indiana. The purpose of this conversation was to increase and sustain the impact of local, state, and regional initiatives working for the vision of healthy people in healthy places, toward a more equitable and prosperous United States of America.

From this conversation emerged Community Commons, an online interactive mapping, networking, and learning utility for the broad-based healthy, sustainable, livable communities' movement (www.communitycommons.org). This national public good Web site provides easy-to-use, free-to-end-user, democratized access to collaboration tools, data, maps, reports, and stories that supports collective impact for the health of people and places. The primary audiences include communities (civic leaders, municipalities/agencies, and multisector collaborations), funders (public and private), and intermediary organizations (policy, technical assistance, and evaluation organizations).

Why Is Community Commons Important?

Community Commons serves as a network of networks to help communities learn who is doing what and where around the country that might be related to their work, focus areas, and strategies. To this end, an interactive, searchable "Map of the Movement" of the broad-based Healthy Communities movement features the locations and content of place-based, evidence-informed initiatives. All content contributed or saved by users (maps, stories, videos, images, etc.) can be filtered by type of content and initiative(s). The "Map of the Movement" changes the conversation from a funder-centric view

of their initiative cohort to a community-centric view of funded activities *across* funders. A broad landscape perspective of people, places, partnerships, and impacts is needed to accelerate learning and advance the field.

What Are the Essential Features of Community Commons?

Community Commons adopts a user-centric design approach that provides users with individual profiles and a coherent navigation structure to access social media, stories, tools and functionality. Specifically, Community Commons offers free access to:

- *Individual customizable profiles.* Each user has an individual profile that can be customized with an image and description. The user profile can hold saved maps, reports, documents, files, and inspiring articles read on the Commons. Users can also access a list of all groups they belong to in their individual profile.
- *Interactive mapping and data engine.* The Commons' mapping tools include thousands of interactive mapping layers covering a variety of topics that include health, education, poverty, food systems, socioeconomic, demographic, and other community context data layers that may be visualized at the state, county, zip code, tract, block group, or point levels for all communities in the United States. Users can create unlimited maps to share via e-mail and hyperlinks as well as create maps to print and save as images. Users can take advantage of the variety of selection and query tools in the interactive mapping environment and customize maps to their own community.
- *Reporting tools.* The Commons' reporting tool allows users to create a variety of reports for their county or region. Users can compare their county or region to the state and the nation. The reports

include charts, graphs, data descriptions, and interactive maps. The reports can be saved, shared, or downloaded as PDF or Word files. One reporting tool, the Community Health Needs Assessment (CHNA), is designed to assist hospitals (with particular attention to critical access and other smaller facilities), nonprofit organizations, state and local health departments, financial institutions, and other organizations seeking to better understand the needs and assets of their communities and to collaborate to make measurable improvements in community health and well-being.

- *Public group spaces and request-to-join private group spaces.* The Commons includes a number of topic-based public groups that provide an opportunity for collaboration and dialogue among the Commons community. Users can visit these groups and then join a group of interest. There are also private group spaces on the Commons that users can visit and request to join. Within the groups, users can discuss maps, reports, shared files and documents; collaborate around a co-editable document; and discuss topics via forums and discussion threads.
- *Contextualized resources.* Resources include starter maps, social media tools, widgets, data apps, case stories, news feeds, compelling videos, hot-off-the-press features of communities and leaders having an impact, tutorials, and other useful resources that are added on an ongoing basis.

How Is Community Commons Different from Comparable Efforts?

To further accelerate this network of networks, major investments once made toward disconnected custom Web sites are now being aligned in the Commons as “group” spaces to provide coherency across place-based funded activities. A Commons group space is a customized Web site, linked to the Commons, that provides a home page for an organization or network that includes collaboration spaces, content, logo, customized tools, and subgroup spaces if needed. The level and complexity of customization varies across each group space based on funder needs and level of funding. Organizations are able to amplify their respective online activities to the larger Community Commons audience that would other-

wise be marginalized in their former disconnected Web sites that have smaller audiences and/or numbers of Web site visitors.

All Commons group spaces have private-public areas where the private space is reserved for an organization or network to upload and check local data, pull content together, and generate stories; the public space is reserved for the organization’s or network’s dissemination of content to the broader public. The funder or community collaborative for that group space decides what content is made publicly available. User roles allow only those with the necessary credentials to see and access additional tools and functionality.

There are several distinguishing features of the Commons model. First, when funding ends for grantees or organizations no longer have funding to maintain their subscription for advanced access, they will continue to have access to all existing content generated as part of their funded group engagement; however, they will not have access to the full suite of custom tools. For example, a national network of grantees that sunsets when funding ends will continue to have access to their individual profile and group space without interruption in service (e.g., they do not need to migrate to Community Commons from a disconnected custom Web site with a different navigation structure) because they are already embedded in the Commons. Although funding ends for grantees, a community may elect to subscribe for continued access at a nominal cost to the full suite of custom tools uninterrupted. All communities, including those that never receive national funding, have public access to the Commons. In addition, any community has the opportunity to create a customized group space by subscribing to additional tools and functionality at a nominal cost.

Second, with a user-centric design in place, all users, regardless of their level of access, have a consistent, coherent navigation structure in place and will be able to directly benefit from new tools and functionality generated from other public good grants and contracts. A most recent example of this direct benefit is the launching of the Community Health Needs Assessment (CHNA) tool that is now embedded in Community Commons.

Third, the Commons provides a larger and growing audience base to share stories, policies, maps, and related content that would not otherwise be available via disconnected systems with smaller, content-specific audiences. The traffic generated through the Commons can be directed to external organization Web sites through the stories and related content generated via their individual profile or group space. This growing audience base, supported in part by aligned investments, advances the Healthy Communities movement.

A Vision for Community Commons

Although the Community Commons Web site currently is more health focused with stories, data, reports, and group spaces, the longer-term vision of the Commons will transcend health to include other sectors, such as environment, natural resources, agriculture, education, and public policy. For many years, the organizers of Community Commons have focused our discrete project activities in these multiple sectors from a geographic information system (GIS) and data perspective. Our holistic or “ecological” systems perspective and related project work for engaging communities has not yet manifested itself in the Commons; however, given the broader definition of health as it relates to the Healthy Communities movement, these sectors also will align in the Commons.

Prosumer Data

Web sites are increasingly being built to accommodate two types of people: consumers and prosumers. Consumers go to Web sites to browse and consume information (Web page content, images, audio, videos, documents, articles, etc.) that currently reside there. Prosumers, in contrast, go to Web sites to produce or contribute information (data, content, images, audio, videos, documents, articles, etc.). The ability of companies to mine large databases (think big data) rests on the thousands, if not millions, of prosumers who willingly provide data as part of the terms and conditions for accessing Web sites. One prosumer activity—crowdsourcing—offers a wealth of data for companies to further understand preferences and behaviors. Public sector organizations also collect basic prosumer data; however, given the disconnected nature of data collection efforts and lack of protocols around types of primary data to collect, there are not a sufficient number of data

points to perform big data analytics. We have many data sparks but no networked intelligence fire.

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An example of a prosumer activity might be community sourcing playground conditions in communities across the country. Community sourcing coordinated by trusted anchor organizations—rather than crowdsourcing by individuals—may improve data quality and ensure protocols are adhered to, which in turn provides the basis for comparative analyses that may inform public policy. Place-based nonprofits, grantees, and volunteer organizations can visit local playgrounds and use their smartphones to take photos and answer a very simple survey related to playground conditions and the surrounding environment. This survey should be simple, short, and fun rather than overwhelmingly detailed. Submitted surveys and associated photos are automatically geotagged with their locations and added to servers along with thousands of other responses, which will provide the broadest reach to capture the level of prosumer data necessary for analyses. These data can be mined based on the attributes collected and overlaid with other GIS data layers to better understand spatial, socioeconomic, and built environment characteristics that may inform playground use (or underuse) and steps that might be taken to improve conditions.

This example is technically quite doable, and several efforts currently are under way; however, the sparks generated from these innovative activities may not be generating the needed fire. The challenge is aligning organizations with a commitment to a coherent communications channel for messaging that may lead to coherent data collection and analyses and meaningful change. For example, national organizations might commit to coordinated dissemination of a monthly community source survey where the month of March might be “Community Source Your

Playgrounds!” Now, imagine the volume of prosumer data generated by a VSS topic *each month*, containing three to five questions only (plus capturing images or videos).

What are we doing in the public sector (nonprofits, foundations, institutions of higher education, and government agencies) around big data to better understand community or aggregated population-level characteristics? Where is a transparent, collaborative, networked-intelligence capacity to help us make more informed decisions on improving the health of our communities across the country? The answer is, in part, organizational alignment and commitment and, in part, technology-based platforms such as Community Commons that leverage public good big data.

Conclusion

We believe that a nation full of healthy, thriving communities is closer than you think. To get there, we will need to work and learn together. This effort is about creating a collective impact. It is about building communities where everyone can thrive. It is for this reason that Community Commons was created—to bring change makers together to connect with thought leaders and peers, share stories and strategies, and use the latest technology and tools to make lasting change.

Christopher L. Fulcher is codirector of the Center for Applied Research and Environmental Systems, located at the University of Missouri, Columbia.

Promising Strategies for Building Healthy Communities for All

BY MARY M. LEE

Where you live shapes your health. If you live in a community with access to good jobs, quality schools, health care, and social services, you are likely to thrive. But if your neighborhood lacks these essential elements, you are more likely to suffer from obesity, asthma, diabetes, heart disease, or other chronic conditions. Failing schools, low wages, and the absence of jobs severely restrict opportunities, raising the likelihood that you will be the victim of a crime.

Place and Race Matter

Place and race are intimately connected in America, where neighborhoods remain highly segregated due to both historic and recent discriminatory public policies in housing, zoning, land use, and urban planning. Racialized policy and practice have shaped every system within our communities, from education to employment, from transportation to commerce. This legacy of institutional racism has resulted in communities that have been disadvantaged by design. People of color disproportionately live in neighborhoods that lack access to health care, quality education, employment opportunities, healthy food, transportation, quality housing, clean air and water, services, and amenities; these same neighborhoods have the most entrenched obstacles to social and economic opportunity.

Race alone is a powerful determinative of health, even after controlling for factors such as income or education. Although higher levels of education typically correlate with higher life expectancies, race still trumps education for people of color. For example, according to Murphy and to Braverman and coauthors, African American college graduates have shorter life expectancies than whites with only a high school education. As reported in 2008 in *Life and Death from Unnatural Causes: Health and Social Inequity in Alameda County*, another troubling example is that babies born to college-educated black women in that California county have a higher risk of dying before their first birthday than do

the infants of white high school dropouts. People of color also suffer disproportionately from many health conditions that shorten or compromise the quality of their lives: Infant mortality, asthma, diabetes, and heart disease top the list of chronic, preventable diseases that are all too common among people of color.

Public policies and the discriminatory practices and customs that followed caused and perpetuated the deplorable conditions that have excluded and weakened communities of color. Although there are success stories as well, the obstacles to prosperity remain deep, ingrained, and difficult to overcome in a sustainable and equitable manner. Policies are statements of the values—such as equity—that we want to see fostered widely and deeply; therefore, concerted action in crafting and implementing policy is a critical strategy. Policy makers in both the private and the public sectors must adopt strategies to eliminate barriers to success and advance healthy, equitable outcomes. The time is now, especially because the country is undergoing a profound demographic transformation as the population of Americans of color grows very rapidly.

America's Tomorrow

Given demographic trends, reducing racial and class inequity is not only the right thing to do, it is fundamental to the economic future of the nation as a whole. In 2012, for the first time, more than half of all babies born in this country were of color, a trend that is expected to continue. America will soon pass many more demographic milestones. By 2018, the majority of American youth will be youth of color. By 2030, the majority of the young workforce will be of color. Our country is projected to become majority people of color by the year 2042; California passed this milestone more than a decade ago.

Consequently, there is a growing racial generation gap between America's oldest and youngest. Eighty percent of seniors are white, compared with

54 percent of those under age 18. Too many elders and decision makers do not see themselves reflected in the faces of the next generation, and they are not investing in the educational systems and community infrastructure of the future in ways that enabled their own success. This racial generation gap not only puts youth of color at risk, it threatens the well-being of the entire nation.

As the country rapidly transitions to a majority people-of-color nation, it is even more imperative that communities of color have opportunities to contribute to our economy. We need a new economic growth model that is driven by *equity*.

Equity is the opposite of one size fits all; it is right-sizing approaches to overcome the challenges of today to reach a better tomorrow for all. An equitable society is one in which all have the opportunity to reach their full potential. An equity-driven economic growth model assesses every community's situation and develops the specific policies and strategies necessary for everyone to thrive, including the creation of real pathways for low-income people and people of color to contribute to growth and democracy. The Conversation on Regional Equity, an effort that brought together early leaders and thinkers in what has become an emerging field of research and community practice (2006) considers equity in a community to be achieved when "all neighborhoods are supported to be vibrant places with choices for affordable housing, good schools, access to open space, decent transit that connects people to good jobs, and healthy and sustainable environments" (p. 5).

Neglecting communities of color for so long has resulted in gross inequity and an unsustainable future where America cannot compete on a global level. An equity-driven growth model, resulting in policy actions that consider both race and place, is integral to the elimination of health disparities and the creation of robust, safe, and opportunity-rich communities.

Promising Strategies

Understanding the connections among race, place, and health is necessary to build healthy communities. To create effective solutions that build on the assets of a community, we must employ equity-driven

strategies and policies that consider both race and place.

An equitable society is one in which all have the opportunity to reach their full potential.

This is not a zero-sum game—an equity agenda would not eliminate or transfer existing opportunities from some communities to others. The goal is to end practices that are harmful to people of color and replace them with approaches that enhance both their opportunities and their life outcomes, thereby expanding prosperity for all.

Target Strategic Places

The challenges facing people of color often can be addressed by targeting specific places. The work of the Harlem Children's Zone in New York City is a prime example. The initiative identified a clearly marked geographic area with significant needs to provide comprehensive services to the predominantly black population that resides within the zone. The initiative was the inspiration for the federal Promise Neighborhoods program, which takes a similar place-based approach to address the needs of communities of color.

Place-Based Strategies

Place-based strategies can transform distressed neighborhoods into opportunity-rich areas with high-quality housing and schools, public transportation, thriving businesses and retail stores, walkable and safe streets, and essential services. Federal place-based initiatives such as the Promise Neighborhoods (and the soon-to-be-launched Promise Zones), the Sustainable Communities Initiative, the Healthy Food Financing Initiative, and Choice Neighborhoods are helping hundreds of communities across the country implement place-based strategies to improve neighborhoods and connect people to opportunity.

Public Infrastructure Investments

Public infrastructure investments can connect workers to jobs and educational opportunities, increase business productivity, and foster growth and competitiveness. Infrastructure renewal is a promising strategy that creates opportunities to transition to

the clean energy economy of the future, starting first by increasing energy efficiency and improving environments in low-income communities of color. We support equity-driven policies that target areas where the need is greatest and employ local residents, particularly those from communities of color and other historically underrepresented groups. Examples of such programs include Portland's Clean Energy Works project, the national Emerald Cities Collaborative working in ten cities across the country, Hire Houston First, and community workforce agreements being utilized by the Los Angeles Department of Public Works, Los Angeles Unified School District, and Los Angeles Community College District.

Cradle-to-Career Pipelines

Cradle-to-career pipelines expand education and employment opportunities for vulnerable youth. Early childhood education is one of the most cost-effective investments in existence, particularly for low-income children of color. Researchers from prominent institutions such as Harvard and the University of Chicago have documented the positive impacts resulting from expanding early childhood education, including an increased likelihood of academic success, college graduation, or career training and acquiring quality jobs. Another example is the federal Promise Neighborhoods program, described earlier.

Innovative Financing Mechanisms

Innovative financing mechanisms can attract and sustain small business development in underserved communities. Public/private initiatives that assist entrepreneurs in developing grocery stores, farmers' markets, and other food retail options in low-income neighborhoods without access to healthy food are prime examples of the effectiveness of this strategy. The pioneering Pennsylvania Fresh Food Financing Initiative, launched in 2004, was the model for programs that have now been launched in California, Illinois, New Jersey, Colorado, New York, and New Orleans, Louisiana. In 2010, the federal government launched the Healthy Food Financing Initiative, taking the program to a national scale. As a result, more than a hundred new and upgraded stores are making healthy food available to hundreds of thousands of low-income consumers, and thousands of jobs have been created. This ap-

proach could be adapted to any number of business sectors.

Adopt Comprehensive Strategies

To achieve an improved health outlook for all in the places where people live, the next more comprehensive strategies are also needed.

Enhance Political Power

Civic engagement among people who are traditionally underserved, especially people of color and immigrants, is critical to enacting policies that advance equity. In California, for example, the electorate is disproportionately older and whiter than the general population. As a result, the state's politics often ignore the needs of underrepresented, nonvoting communities within the larger population. Increasing the civic engagement of diverse communities can lead to dramatic results. For example, with critical support from low-income communities of color, California passed an increase in upper income and sales taxes last year to reverse painful cutbacks and enhance funding for education, health, and other critical state services.

Organize and Engage Residents of Vulnerable Communities

People of color and immigrants must also have the power to help set and implement an action agenda. Community residents have crucial insight into their most pressing needs, their community strengths, and the solutions that will be likely to succeed and endure. Struggling communities must be supported and provided with access to detailed information and analysis about root causes of barriers to opportunity and the possibilities to remove them in formats that are relevant, accessible, and in appropriate languages. In Oakland, California, Urban Habitat—a grassroots organization that focuses on environmental, economic, and social justice—has undertaken this strategy by launching the Boards and Commission Leadership Institute. Since 2009, the institute has recruited and trained low-income residents and people of color to serve on public boards of agencies that make decisions about the issues that affect their lives, particularly agencies that address core equity issues of transportation, public planning, land use, housing, health, and jobs.

Enforce Existing Laws That Prohibit Discrimination

Practitioners and advocates must pursue rigorous enforcement of existing antidiscrimination laws. Successful enforcement can reduce disparities while increasing awareness of available legal protections and the consequences of violating these laws. People who know their rights are less likely to be victimized, and potential violators are put on notice that they cannot act with impunity. The nation's network of fair housing laws provides a powerful example. The Federal Fair Housing Act is a comprehensive statute that prohibits discrimination in housing transactions based on an array of factors, including race, national origin, sex, and religion. Combined with fair housing protections adopted by several states, these laws have expanded protections to those renting or buying homes or applying for mortgages or insurance. Yet evidence of discrimination persists. Vigorous enforcement plus education is essential to make the goal of fair housing a reality.

Eliminate Discriminatory Policies

Not only must we enforce existing laws; it also is necessary to ensure that current policies do not inadvertently deepen racial inequities. At times, policies may seem to be crafted to benefit everyone or to help vulnerable populations, yet they often accomplish the opposite. For example, zero-tolerance policies in schools may not appear to be biased; presumably they were implemented to curb disruptive behavior in schools. But data show these policies do not make schools safer or support learning; furthermore, because of the biased way they have been applied, such policies disproportionately punish students of color, pushing them out of school, increasing their risk of incarceration, and diminishing their life chances.

Policy goals can and must be accomplished without disproportionately burdening vulnerable groups—there are better ways to make schools safer than to summarily expel students. Student court, community service, counseling at-risk students, and other demonstrated alternative measures are much fairer than summary expulsion and vastly more effective at creating an atmosphere that supports learning. According to the Fix School Discipline organization at <http://www.fixschooldiscipline.org/solutions>, “Over 13,300 schools across the country are implementing

. . . positive behavior supports [and] report reductions in problem behavior, a more positive school climate, greater safety, and improvements in academic achievement. Studies have also shown reductions in office discipline referrals of up to 50 percent per year. Secondary benefits include improved academic achievement, reduced dropout rates, higher teacher retention, and a more positive school culture.”

Shift Public Perceptions

Powerful imagery hardwires our brains with biases. All too often, television, newspapers, magazines, and social media primarily present negative images of people of color. The mainstream must be held accountable for coverage that reflects the diversity and the strengths of our increasingly multiracial and multiethnic communities. Advocates and community stakeholders must also maximize opportunities to utilize new technology and media tools to tell their own stories and disseminate authentic images. A compelling example of shifting perceptions was the 2012 effort to gain support for the DREAM Act, a federal proposal to grant conditional permanent residency to the children of undocumented immigrants. This multifaceted, broad campaign incorporated video and social media to create a movement that transformed attitudes toward immigrants on a national scale.

Winning support for and implementing a comprehensive national policy agenda is difficult under the best of circumstances. Given the current climate of divisiveness and gridlock, as well as mean-spirited cuts to basic programs for access to food and health care under the banner of austerity, the undertaking is daunting. The only viable option is determined, sustained, collective action to advance equity: action that will achieve just and fair outcomes in education, employment, wealth, and by extension, health.

Together, we can create a productive nation that honors and supports the extraordinary diversity and energy of its residents by making sure that every community is a healthy, vibrant, opportunity-rich place to work, study, and play: the kind of place where we all want to live.

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Mary M. Lee is a deputy director at PolicyLink, a national advocacy organization working to advance equity and social justice, where she helps guide the PolicyLink Center for Health Equity and Place.

Building Healthy Communities over the Long Run

Lessons from the Colorado Healthy Communities Initiative

BY DOUG EASTERLING

The World Health Organization in 1986 formulated the concept of healthy cities around two key principles: (1) health planning and health promotion should incorporate a broad definition of “health,” and (2) community members need to participate fully in determining which health issues are addressed and how they will be addressed. Communities around the world have experimented with various approaches to carrying out these principles. Some of these efforts are incremental augmentations to conventional health planning while others are radical overhauls of community decision-making structures and processes.

In the United States, foundations such as Kellogg, Robert Wood Johnson, California Wellness, California Endowment, the Colorado Trust, and Sierra Health have funded Healthy Communities initiatives in which multiple communities pursue a prescribed model of planning and implementation. Evaluations of these initiatives demonstrate mixed success, with some models being more effective than others and the same model working better in some communities than in others. It turns out to be exceedingly challenging to bring diverse stakeholders together around a common agenda and to generate meaningful action that actually improves health, especially at a communitywide level.

Colorado Healthy Communities Initiative

One of the more successful of these multi-site initiatives was the Colorado Healthy Communities Initiative (CHCI), which was jointly launched by the Colorado Trust and the National Civic League (NCL) in 1992. Originally conceived as a five-year, \$4.5 million initiative, CHCI eventually spanned an eight-year period with a total investment of \$8.8 million on the part of the trust. A total of twenty-nine urban, rural, and suburban communi-

ties throughout Colorado participated in various aspects of the initiative. These communities varied tremendously in terms of geographic size (from 2 square miles to 9,247 square miles) and population (from 2,700 residents to 249,000 residents).

Like most other foundation-sponsored approaches to healthy communities, CHCI required each participating community to convene a broad set of stakeholders to engage in a comprehensive strategic planning process. The CHCI approach to planning was mapped out initially by John Parr, who was then NCL president. Parr hired Tyler Norris to flesh out a more specific process. Norris’s model spelled out a step-by-step process of visioning, data collection, deliberation, goal setting, and action planning, all carried out in an inclusive, consensus-oriented manner. Each CHCI community was expected to complete the prescribed planning process over twelve to fifteen months.

Of the twenty-nine stakeholder groups that began the planning process, all but one completed all the specified steps, ending with the creation of an action plan. Most of these planning efforts had high levels of participation from a broad cross section of stakeholders. In the average community, forty-nine stakeholders participated in at least three meetings. The largest stakeholder group had 130 active participants while the smallest group had fourteen.

Each of the twenty-eight stakeholder groups that successfully completed the planning phase received an implementation grant of \$100,000 to be expended over two years (although most were extended). These grants were intended to cover key elements of each community’s action plan. The Colorado Trust initially restricted the implementation grants to projects that specifically advanced Healthy People 2000 objectives but eased these

restrictions based on concerns raised by the first round of communities.

The action plans consisted of anywhere between two and ten projects aimed at a broad range of quality-of-life issues, including health, recreation, environmental quality, education, housing, economic development, youth, families, older adults, civic engagement, communication, and leadership. Roughly one-third of the action plans also called for the creation of a new organization that would institutionalize the “healthy communities” process beyond the planning process.

Beyond developing their own projects and programs, the local CHCI organizations facilitated planning and problem-solving processes that set the stage for system-level strategies to improve community health and well-being.

Outcomes and Impacts

Over the years following the planning process, CHCI communities launched a host of important projects, programs, and initiatives, including health clinics, family resource centers, recreation facilities, a mobile van, leadership training programs, community indicators projects, master plans, civic forums, and even a new community foundation. For instance:

- The High-Five Plains project created the Strasburg Clinic (for urgent care) and established a satellite campus of Morgan Community College in Bennett. Kit Carson County created Frontier Health Network to oversee the development of a countywide health insurance program.
- Piñon Project (Cortez County) opened three Family Resource Centers that provide parent education, literacy training, and life skills and also developed a training program for civic leaders (Montezuma Leadership) that attracted twenty participants per year.
- Pueblo County established within a local school the Eastside Health Center (La Familia Puerta), which provides parenting classes, immunizations, and health resource education.

It is important to note that many of the most impactful projects resulting from CHCI were not included in the original action plans. Instead, they were developed by the local CHCI organizations that emerged following the planning phase. By 1999, a total of twenty-one communities had set up a new organization to implement the CHCI action plan and/or to facilitate ongoing community problem solving. These organizations became vehicles for growing the work and for learning how to do healthy communities over the long run. A statewide organization, the Colorado Healthy Communities Council, was created in 1995 to facilitate networking and peer learning among these local groups. The Colorado Trust supported the operations of CHCC and also provided it with a pool of challenge grant funds that CHCC awarded on a competitive basis to local CHCI organizations.

Beyond developing their own projects and programs, the local CHCI organizations facilitated planning and problem-solving processes that set the stage for system-level strategies to improve community health and well-being. Some of these big-ticket payoffs are listed next.

- Healthy Mountain Communities convened an economic sustainability task force that developed a community-supported agriculture project and also facilitated regional transportation partnerships that set the stage for the Roaring Fork Transportation Authority, which now operates the second largest bus system in Colorado.
- Mesa County Civic Forum engaged in planning efforts that led to the creation of Grand Valley Transit System, which provides bus service to eight hundred low-income, disabled, and elderly citizens.
- Kit Carson County established Healthy Living Systems through the CHCI implementation grant and built twenty units of low-income housing in four sites across the county (Country Roads Housing) as well as two assisted-living facilities (the Beehive and the Legacy).
- Prowers County created High Plains Health Center (HPHC), which opened in Lamar in 1995 through the efforts of Health Resources, Inc., a group of county volunteers who were actively engaged in the CHCI planning process. Over the

next sixteen years, HPHC grew to be one of the dominant health care providers in southeastern Colorado, with eighty-one staff members and an annual budget of \$5 million.

In addition to generating high-impact projects and programs, CHCI also benefited the civic infrastructure of the participating communities. For example, Ross Conner's evaluation in 1999 found that over three-fourths of the stakeholders participating in the planning process increased their ability to analyze community problems and to work collaboratively. A majority developed at least some new leadership skills. Beyond building the capacity of stakeholders, the planning process set in motion a shift in how communities go about making decisions and solving problems. Stakeholders came to realize the value of civic engagement, visionary planning, and collaboration, which led to the creation of new organizations to continue the CHCI process. Although many of these organizations were unable to sustain themselves over the long run, their work continues to show a lasting impact on community capacity and civic culture across Colorado.

Implications for Community-Based Health Initiatives

CHCI generated broader and deeper levels of community impact than can be claimed by nearly any other multisite HCC initiative. In many respects, it is a best practice. But it is crucial to qualify that assessment with a recognition of how CHCI actually achieved its impacts. CHCI was initially viewed—at least by the board and staff of the Colorado Trust—as a planning-based approach that would allow local stakeholders to identify and implement high-leverage strategies to improve health. A community would presumably complete its CHCI process in three and a half years. However, the path to impact was not nearly so linear and ordered. Many of the most impressive projects that took shape as a result of CHCI (e.g., the High Plains Health Center, the Strasburg Clinic, the Frontier Health Network, the Roaring Fork Transportation Authority) were not even mentioned in the action plans. Instead, they were formulated through planning processes facilitated by the new organizations that formed in various CHCI communities during the implementation phase.

Looking back at CHCI from a 2013 vantage point, it becomes clear that the planning process was not a mechanism for getting to definitive solutions but rather an initial step in an ongoing journey. Stakeholder groups generated ambitious action plans as part of their planning work, but these turned out to be first approximations of the work that actually occurred over subsequent years. The action plans were valuable not because they were strategic and comprehensive but because they specified an initial round of work that set the stage for more interesting, creative, and powerful projects.

Over time, the actors involved in the work got smarter about the health of their communities, the underlying factors that influence public health, and how to intervene effectively on those factors. They also strengthened their networks and deepened their ability to work together toward shared goals. In other words, they built their collaborative intelligence.

This shift in how communities identify and solve problems is arguably CHCI's most profound and lasting impact. Over the past twenty years, the culture of problem solving in Colorado has come to emphasize civic engagement, collaboration, systems thinking, and inclusive decision making. CHCI was not the only impetus for Coloradans to begin thinking and acting this way, but it was one of the first initiatives to clearly spell out and promote the defining principles. The planning process played an essential role in exposing residents from across the state to a new way of working together and a new way of thinking about the health of their communities. That intelligence ripened and matured over subsequent years as local residents practiced the principles of CHCI and experimented with new processes for collaborative problem solving. Any attempt to replicate CHCI should support participants during all phases of the work.

Doug Easterling is chair of the Department of Social Sciences and Health Policy at Wake Forest School of Medicine.

Healthy Polk 2000 to Healthy Polk 2020 What a Long, Strange Trip It Has Been

BY BECKY MILES-POLKA,
CHRIS FRANTSVOG,
AND RICK KOZIN

In March 1993, the Polk County, Iowa, Board of Supervisors created the Polk County Health Planning Committee, charged with “developing a Polk County community health plan.” With leadership provided by the director of the Polk County Health Department (PCHD) and the county manager, the initial planning committee developed a mission statement:

Healthy Polk is a movement of individual citizens and community organizations with a mission to *improve health status, longevity and quality of life* for persons of all age groups, socioeconomic levels and ethnic backgrounds living in Polk County, Iowa.

With minor modifications, this remains the mission twenty years later. As the italic words indicate, the intent of the mission was to have a direct impact on health conditions in our community. Although much progress has been made on health outcomes, the movement has impacted our community in other ways as well.

Investments

The Polk County Board of Supervisors made a considerable investment of county resources in getting the initiative off the ground. Significant staff support was provided by both the health department and the county manager’s office. This in-kind investment was complemented by annual direct cash investments in projects advancing the work to impact community-identified priorities. All told this investment probably exceeded \$500,000 to date.

Financial commitments by the county helped to leverage additional dollars. Based on the early success and energy generated by the work around the original Healthy Polk 2000 plan, the Annie E. Casey Foundation committed resources for local leaders to engage Tyler Norris, national Healthy Communities

expert, for assistance in developing the Healthy Polk 2010 plan.

More important, local funders (Polk County Empowerment and the Mid Iowa Health Foundation) began to align their own investments with the priorities identified by the community through the Healthy Polk planning processes.

Community Engagement

From the project’s inception, Healthy Polk leaders intended to create more than a plan or a new coalition. It was to be a movement with a strong emphasis on community input, community engagement, and community ownership.

The PCHD provided early leadership for the movement. This was critical in recruiting the necessary senior-level decision makers from key partner institutions (e.g., United Way and the hospitals) to establish Healthy Polk’s credibility. In turn, these leaders successfully recruited, from within their own organizations, the next tier of leaders who were necessary, and willing, to get actual work done.

These people became the work group leaders and recruited their work group participants. In general, these people were high-middle level management. They had the necessary flexibility and autonomy within their job descriptions to play this additional convener role. They were also able to play a liaison role between their own organization’s senior leaders and the movement leaders. However, these high-middle level, highly committed change agents were caught between community priorities and organizational priorities. Over time, we learned how difficult it was to replace these leaders when they moved on to other things.

With the adoption of the healthy community model for the development of Healthy Polk 2010,

movement leaders recognized the importance of more participation and involvement from residents. In developing the plan, five town hall meetings were convened throughout the community for public input. Using a community dialogue process, over 650 county residents shared what they thought were the most pressing concerns. From this input Healthy Polk leaders identified the six community “trend benders” to guide the work between 2001 and 2010.

Community health plan writers often fail to listen to what is really important to people’s vision of success, with the result that initiatives to change the health of a community sometimes put forward goals using language that residents find difficult to relate to in their day-to-day lives.

This level of engagement was deepened even further for the Healthy Polk 2020 plan. Through participation in an online survey, responding to a telephone interview, or attending a community conversation, over 2,300 people identified potential community priorities. After this list was narrowed to “measurable” priorities, 150 Polk County residents convened on a midwinter Saturday morning for a traditional Iowa-style community caucus to choose the final ten priorities that serve as our current agenda.

It is important to note that as the level of community engagement increased, the scope of the Healthy Polk agenda broadened. Compared to the more traditional chapters on alcohol, mental health, cancer, and diabetes in the 2000 plan, the new plans included “community engagement” and “spirituality” (2010 plan); and affordable housing, affordable transportation, and access to healthy food (2020 agenda). These new inclusions were a direct product of community dialogues.

Impact on Conditions

Shortly after the release of the Healthy Polk 2010 plan, many community leaders were introduced to results-based accountability (RBA). This framework has been instrumental in how we think about our impact on the health conditions in our community. We now have a clearer understanding about

the distinction between community-level *results* and program-level *performance measures*.

And there is now a clearer recognition of the distinction between measuring how much we did compared to how well did we do it and is anyone better off?

In retrospect, many of the outcomes from the work of Healthy Polk 2000 would be considered “how much we did.” However, the work accomplished by Healthy Polk 2010 did make people better off.

- More children enrolled in the State Children’s Health Insurance Program—from 19 percent in 2001 to over 95 percent 2010
- Oral Health/Des Moines Smile squad. Reduction in preschool children with untreated caries from 24 percent in 2008 to 18 percent in 2012
- Reduction in children with elevated lead levels from 4.7 percent in 2000 to 2.3 percent in 2008 (a 51.1 percent reduction)
- Reduction in teen smoking and drinking by 38 percent/27 percent respectively from 2000 to 2008
- Infant mortality down from 7.4 per thousand to 5.7 per thousand from 2000 to 2011
- Mothers initiating breastfeeding at birth increased from 67.15 percent to 76.6 percent from 2000 to 2010

Measuring success *is* important. But consider for a moment whether community residents will resonate more with an outcome they can actually see as opposed to numerical success measurements. Community health plan writers often fail to listen to what is really important to people’s vision of success, with the result that initiatives to change the health of a community sometimes put forward goals using language that residents find difficult to relate to in their day-to-day lives. Here is an actual example of one indicator from a community health plan: “Limit the upward prevalence trend of diabetes to 0.2 percent per year.” Question: Are residents likely to hop on board a community campaign to impact “prevalence”?

There is absolutely nothing wrong with the numerical measurement just given. Our experience has

been that some community partners may require the proof of hard data before they will get involved. As Paul Mattessich and Ela Rausch conclude in *Collaboration to Build Healthier Communities* (2013), creating healthy communities will require metrics that appeal both to community members and to experts from multiple sectors in the community.

But if you intend to maximize the number of individuals, groups, and institutions hopping on board (or perhaps joining together to push is a better metaphor) to change health outcomes, then you will need to speak their language. You need to give voice to their visions of what a healthy community could be.

The Healthy Polk movement, especially in its 2010 and 2020 versions, has tried to encapsulate the community's vision by asking questions like this one: "If everyone in Polk County were healthy, what would it look like?" The replies that came back were ones like these: affordable, healthy food; accessible, affordable transportation; equal access to health care for all and youth who are more physically active every day.

The decision to capture a vision-based community agenda was intentional. We think that people who live, work, and play in Polk County will be energized by a goal they can understand, one they can see. The Healthy Polk movement is working to identify and promote opportunities for community members to turn their visions into action that can change the health of our community.

Role of PCHD

As stated, the PCHD director played a critical leadership role in conveying visibility and credibility for Healthy Polk in the beginning. Although that senior leadership commitment was crucial, the Health Department lacked the capacity to provide the necessary support services that are now associated with being a backbone organization.

This deficit was addressed when the department hired a full-time public health planner with strong community organizing skills at the time of the release of the 2010 plan.

After the director retired, his next two successors did not assume a movement leadership role. Additional planners were hired in the community organizer model, which strengthened the PCHD's support role.

What about the Data?

Both the 2000 and 2010 plans included clear, measurable goals. Yet it has not been a high priority of either the Healthy Polk movement in general or the PCHD specifically to collect the necessary data and report on progress to the community.

The Healthy Polk movement is working to identify and promote opportunities for community members to turn their visions into action that can change the health of our community.

As mentioned, this is not due to the lack of data indicating progress. Part of the reason for this way of prioritizing can be explained by certain ambivalence with statistics as the best indicator of success (compared to stories and experiences). But it also can be explained by a lack of capacity at the PCHD to do the necessary collection, reporting, and analysis.

Taking It to the Next Level

The product emerging from our evolving definitions of the terms "investment," "leadership," "engagement," and "impact" is a new model for community initiatives. It stands in marked contrast to earlier models that emphasized:

- Decentralized investments in a broad blanket of programs
- Distributed leadership around programmatic elements
- Recruitment of individuals to fill the programs
- Impact measured through program results

The new model, instead, focuses on:

- Concentrating community investments of dollars and efforts in order to double-down on one or

two narrowly focused initiatives with high impact potential

- PCHD asked by Healthy Polk leaders to be a decisive leader in identifying and guiding community initiatives
- Mobilization of community residents to advance key initiatives
- Impact measured by a combination of statistics and observable experiences

How does the new model work? First, Healthy Polk leaders facilitate a dialogue among community partners with unique knowledge of the priority area (e.g., food, health access) and others who are familiar with community change. PCHD provides a list of initiative outcomes drawn from existing strategic plans that have been created by Healthy Polk stakeholders over the past one to two years. The goal is to identify one or two narrowly focused initiatives, each with a high likelihood of resident engagement and success in moving the needle within the priority area.

Second, PCHD selects one initiative (if more than one has been specified) from the list that has the highest potential for impact based on these characteristics:

- It will involve/engage thousands of individuals.
- The concepts, actions, and desired behaviors are broadly understandable to individuals and organizations.
- The effort has a clearly defined beginning, end, and outcomes.
- Sufficient support and investment can be garnered among key stakeholders and partners.

Third, PCHD will write a scope of work for the initiative that will include a budget, themes for promotional efforts, and measures of success. It will also include key deliverables, such as:

- Overall outcomes for the initiative

- Numbers of individuals to be engaged and target populations (if any)
- Purpose and frequency of mobilizing events
- Targeted institutions and organizations to be organized

Several key Healthy Polk leading partners will raise the necessary funds for the initiative. Proposals will be accepted from individuals and firms with demonstrated expertise in achieving successful campaign outcomes. One firm will be awarded a contract to conduct the project (subcontracts will be allowed).

The first two phases of the kickoff of this new model were under way as this article was being written. In early June 2013, a group of thirteen community partners met to consider four different outcomes to increase access to affordable, healthy food. After rich discussion, they selected an outcome titled “Closer Food,” which focuses on every neighborhood having “fresh fruits and vegetables available, or options for food delivery for sale at least weekly.” A Healthy Polk leadership team has set a funding level of \$200,000, and ideas are being considered for the initiative, which could begin as soon as January 2014.

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Becky Miles-Polka is owner of Within Reach Consulting Services LLC.

Chris Frantsvog is public health planner for the Polk County Health Department.

Rick Kozin is director of the Polk County Health Department.

Memphis

Faith in Healthy Communities

BY GARY GUNDERSON

The Healthy Communities movement of the 1990s was imported from Europe but adapted well to the social ecology of the United States. It had no natural enemies (who could be against a healthier community?) and was blessed with many enthusiasts working in a striking array of professional settings. Perhaps the movement was *too* easy to accept, too *easy* to agree with. Now, twenty years on, there are signs that its basic ideas are becoming part of the operational mind system of some institutions that would seem to be its greatest beneficiaries: health care organizations and networks of religious congregations.

The first, hospitals, are still barely breaking a sweat when it comes to community health, the primary testament to which is the remarkable attention they are paying to the recent and very minor requirements of current “community benefit” legislation (the essence of which merely requires them to do some kind of assessment of community needs and report how they are going to align their community activities with at least some of those needs). This feels more like a first step twenty years late than a mature grasp of the promise of healthy communities. Healthy Communities was and is still a movement, not a plan. People who measure success at the scale of populations and organizational culture learn to value increments and surprises but also go deeper. One surprise involves the second obvious partner—religious networks—which finally seem to be embracing community as mission.

Memphis is among the last places one would look to find a population with which to scale healthy hope. The city is at the wrong end of every list, which is predictable given its economic logic. Memphis is to cotton as Johannesburg is to gold, spinning a similar tapestry of inevitable, if not intentional, pathologies visible in patterns of race and gender and every way of measuring health. These are twisty, wickedly complex, self-replicating patterns that every next generation quickly accepts as normal. Even the religious dynamic, as in South Africa, tends toward complicity and accommoda-

tion to suffering and privilege rather than toward transformation.

Although Dr. Martin Luther King Jr. was killed in Memphis, his dream did not die with him. Today in Memphis 529 congregations, mostly, but not entirely, African American, work in a relationship called covenants that makes possible the practical movement toward what Dr. King called the “Beloved Community.” This is more radical than “healthy community,” more resonant in Memphis’s mud and blood than European ideals. Today these congregations, one faith-based health system, and a plethora of community partners are the heart of what is now widely known as the Memphis model. Hospitals and public health leaders from around the country are interested because the large-scale partnerships have shown evidence of moving patient data in directions that matter to them: lower costs and higher participation in trust-sensitive secondary services, such as hospice, rehabilitation, and home care. Even more striking is evidence of 39 percent longer time out of the hospital after treatment and a decline in gross charity care cost in the zip code where the covenant partners are concentrated.

The ideas underlying the work in Memphis, which are now spreading to many other communities, trace back to the Interfaith Health Program at the Carter Center (IHP), which was a small but visible part of the Healthy Communities movement at its inception. The IHP was created after the Closing the Gaps collaboration in 1986 by the Centers for Disease Control and the Carter Center that exhaustively documented that roughly two-thirds of deaths before age sixty-five are due to preventable causes. President Jimmy Carter, Dr. Bill Foege, and the Park Ridge Center for the Study of Health, Faith, and Ethics called a meeting in 1989 of religious leaders to see if they could grasp the moral opportunity to address these issues (which they could, of course). This stream of moral energy converged with the Healthy Communities movement. Both rested on the obvious, but radical, notion that “community” is not the

name of a *patient* but the critical *partner*. Community *people* are not “boots on the ground” to be used by medical experts but brains on the ground with intelligence to be blended.

Health systems—and their beloved communities—can move toward the health that both science and faith envision.

Well beyond Memphis, the work of healthy communities is visible in the wide instinct among faith-based health systems and governmental partners to adopt the model. When staff from the Department of Health and Human Services and the White House Center for Faith-based and Neighborhood Partnerships visited Memphis in February 2011, they recognized the (then) four hundred covenant congregations working with Methodist Le Bonheur Healthcare not just as a good project but as a whole new class of assets relevant to healthier communities. The early Healthy Communities era had many faith-driven individuals and organizations as members, even some leaders. But it did not have a real model of functional networks with any obvious potential to move data at the community scale. Mara Vanderslice-Kelly (then the acting head of the White House center), then Alexia Kelley, followed by Acacia Salatti, used the Congregational Health Network in Memphis as a foil for the imagination for dozens of health care systems and their regional governmental partners to find in their communities the seeds of covenants of similar scale.

Two White House conferences formed the bookends for a very large amount of learning that is being adapted to San Bernardino County, Brooklyn, Miami, Chicago, and many small left-behind towns of North Carolina. Like the early Healthy Communities movement, it is easy to agree with these new ideas too quickly and overlook the fact that it turns health care systems inside out and upside down. This is why this approach is for the faith at heart, not the faint of heart.

The learning has an edge to it that is close to uncomfortable. It says that health systems—and their beloved communities—can move toward the health that both science and faith envision. To do so de-

mands an ensemble of activities sustained over time that resonates with healthy communities insights of long ago:

1. Move toward the socially complex (the most challenging) patients by engaging them in their neighborhoods, with their families and social networks. Those places are where you find the socially complex assets relevant to the socially complex problems.
2. Move with large-scale, load-bearing partnerships aligned with those other socially mediating community structures relevant to the neighborhoods. Many of those partners will be surprised to find themselves relevant to health outcomes. In fact, they will be surprised to see you in their neighborhoods at all! And they will be surprised to hear you want a partnership, not a deal, project, pilot, symbol, highly targeted measurable data-driven outcome, certain evidence-based *blah blah blah*. Do real work with real partners who have a stake in the future.
3. Move with your own money first. The largest single line item in any hospital’s annual budget is the projection of charity care, which in most decent systems ranges from 5 to 10 percent. While it is very difficult to predict exactly which *individual* will need that kind of care, it is extremely predictable what *neighborhoods*, even streets, they will come from. The trick is to turn what is now seen as an unmanageable liability into a funding stream. It is obvious that proactive mercy should be cheaper than reactive charity—but only if one commits to “a” and “b,” to work in places and partnerships.

A movement is the thing that moves you, not the thing you think you are doing to move others. The spirit that moved in a relative handful of hopeful people twenty years ago turned into the Healthy Communities ideas and structures that morphed and are still morphing, moved and are still moving. The Memphis model spawned the Health Systems Learning Group, which is now moving (sort of like a movement) as Stakeholder Health (stakeholderhealth.org). Like any movement, it blends and jumbles the ideas and experiences, wounds and dreams of those in the movement. It has already spread to the tobacco and furniture towns of North Carolina with different kinds of assets to be

aligned, including thousands of Baptist congregations and an academic medical center. The barbecue has a different sauce here, and people do not want the red stuff from the delta on their pig. The idea of moving toward the broken but potentially healthy complexity in large partnerships resonates deeply with small-town communities. The movement here is called FaithHealthNC (faithhealthnc.org).

What is a movement of faith and health? It is when people sense they do not have to be afraid of each other or afraid of the future. And it is when they begin to move toward each other in trust and toward a

shared future by building the relationships that turn into connections that turn into committees that turn into agreements and policies and practices that over the arc of time channel the energy toward healing, even health. Dr. King was not surprised to be killed by a stupid bullet fired at a dreamer. And he would not be surprised that the bullet that killed him did not kill the dream.

Gary Gunderson is vice president for faith and health, professor of public health science at Wake Forest University Baptist Medical Center, and professor of faith and the health of the public at the Wake Forest University School of Divinity.

The Live Well Omaha Story

BY KERRI PETERSON
AND MARY BALLUFF

It started as a vision in 1995. Omaha had a new mayor who envisioned a new character and image for the city, features that would give it world-class status. The mayor's vision would prove to be contagious as health officials took a similar view and decided that the public and private organizations of Douglas County must set aside agendas, work together, and improve the health status of the county. What was happening locally was also being echoed at the national level. Leland R. Kaiser, Ph.D., a futurist and expert on the changing American health care system, was visiting hospitals and their partners, encouraging them to strive not only to help the patients who walk through their doors but also to improve the health of the community in which their hospitals resided. It became the time for a meaningful conversation.

The Birth of Live Well Omaha: 1995 to 2000

In that year, seventeen partners, including all the major hospitals, insurance companies, the local health department, and public and private agencies, came together to create a vision and a plan for improving the health of the community. Each organization provided funding to initiate the effort. With a budget of just under \$300,000, Live Well Omaha (LWO; known at that time as Our Healthy Community Partnership) was launched. Hundreds of community members helped to determine the four areas of focus by participating in a health assessment process. Task groups of community experts were formed to determine root causes and action plans, and an executive director was hired. Over a period of five years, community health baseline data were collected, task groups were launched to develop action plans, the membership grew from the original seventeen members to thirty-five to form the Collaborating Council, and LWO was on its way to creating health indicators, priorities, and a health agenda.

From Organizational Infancy to Adolescence: 2000 to 2006

Originally, LWO was under the umbrella of the county health department, but as the organiza-

tional infrastructure matured, an independent entity emerged as its own 501(c)(3). A volunteer board, consisting of elected representatives of the member organizations, began the crucial work of creating a strategic vision. The first five years had seen plans develop and key strategies assumed by issue-specific organizations. With so many effective organizations involved, the question arose: Was the task group work making the most of the resources? Answering this question was a tipping point for the direction in which LWO would head after 2001.

To begin with, LWO wanted to recount and truly measure its success. LWO's Annual Report Card on Health for Douglas County combined vital statistics data and key informant interviews to track three to four key indicators in each strategic health area and to show the changes in those indicators over time. The report card featured a section that discussed community assets and action, using the voice of a community expert to describe needed policy, collaborative actions, and successes experienced. In itself, the report card gave the community a marker of progress and a starting point for health dialogues. LWO's board of directors distributed the document to member organizations and local foundations so that the report card would serve as a blueprint both within organizations and across the community's investments to improve the health status in the focus areas. The release of the report card, which has trended data over a decade, has created a communitywide agenda. The partnership between LWO and the Douglas County Health Department enhanced its credibility.

By highlighting key health issues and bringing together interested entities that normally have little, if any, association with, or vested interests in, health care, LWO serves as a catalyst and agenda setter. Every year in October, LWO holds an annual health summit where keynote speakers address a catalytic health topic and time is spent focusing on the community's health priorities. The quarterly Collaborating Council meetings present timely, relevant health topics and significant community actions. Council members also share successes in these meetings.

Each step facilitates a community dialogue that goes beyond the question of “Why?” to ask “How?” and “By when?” this community would make change. Member organizations are challenged to look within their own structures to become a part of a movement.

Although there is no concrete way to point specifically to the work of LWO, Douglas County residents are eating more vegetables and moving more.

As LWO grew, the annual report allowed it to look at its health priorities on a consistent basis. It became clear that reversing the negative health trends would require more than just the hospitals and human service organizations. In a community grounded in businesses, the business community had to be an active participant. Key partners, such as the Chamber of Commerce, Union Pacific, Con Agra, and RDG Planning and Design, were recruited. LWO could help to create a vision of improved health status; a business case was made for why it was imperative to invest in this Healthy Communities initiative. Business demanded that LWO strengthen its infrastructure and identity, which has positioned LWO to act not only as the community catalyst but also now as a trusted convener. LWO’s work became focused on facilitating collaborative efforts and creating a strategic direction. This was the next stage of growth in LWO’s evolution.

Adolescence to Adulthood: 2006 to the Present (from Catalyst to Convener)

Historically, LWO had proven it could be a catalyst and build the social capital needed to take its next growth phase—that is, to be the convener and to lead health interventions. As early as the release of the 2001 Report Card, the impact of obesity on the community became readily apparent. Through a strategic planning process, the Collaborative Council launched an effort to reverse the impact of obesity. An application was submitted in response to the request for proposal issued by Robert Wood Johnson’s Active Living by Design. There were over eight hundred applications, and LWO was one of forty-four communities funded for a four-year period to focus on creating environments that support active

lifestyles. This pinnacle grant laid the foundation for the next phase of work and LWO’s third role of being an umbrella for efforts that targeted any of the report card areas.

Intensive investment and focus went into creating a solid partnership on the issue of obesity. Promotional efforts encouraged Omaha residents to be active at any place, anywhere, and anytime. Physical environments were planned to support active transportation, and policy work laid the groundwork for other grants and initiatives that have changed the community forever. LWO set the strategic vision of a community that was active and had the capacity to encourage healthy eating; this became the backbone for three separately funded initiatives moving toward that one strategic vision. These three separate initiatives, all focusing on healthy eating and active design, used LWO to ensure common branding, complementary fund development, and robust evaluation. Live Well Omaha Kids, Activate Omaha, and Douglas County: Communities Putting Prevention to Work all work collectively toward the same goals.

Although there is no concrete way to point specifically to the work of LWO, Douglas County residents are eating more vegetables and moving more. In 2001, 22.3 percent of adults achieved physical activity requirements, and that percentage rose to 49.6 percent in 2011. In 2002, 12.5 percent of Douglas County adults consumed five servings of fruits and vegetables per day, and that number increased to 35.3 percent in 2011. In addition, the community boasts many examples of corporate wellness and innovative community-based projects designed to make a difference in individual lives. The trends are moving in the right direction. Omaha can boast over thirty miles of new bicycle lanes, a balanced transportation coordinator in the city government, bicycle racks on all city buses, a bicycle commuter map, a Ride Your Bike to Work annual challenge, a B-Cycle bike rental system, Safe Routes to School programs, eight healthy neighborhood stores, farm-to-school efforts, and a visible increase in community gardens and farmers markets.

All of these examples of successes can be attributed to the collective vision and work of LWO and its

partners. Ownership lies within the partnerships. Over \$6 million in funding has been brought in and distributed to the engaged partners to do the work they do best, but that work is guided by the vision LWO holds and stimulates.

Most recently, LWO and the Douglas County Health Department shifted from paper documents to launch a Web-based indicator application. The Web site has helped to move the blueprint beyond the fifty-five-member organization to area citizens. Anyone in the community can access over one hundred various indicators, trends, and best practices regarding Douglas County. Five separate funders have joined together to make this possible.

As new health priorities are identified, LWO and its partners serve as the convener for community dialogue. Interested parties can come under the LWO umbrella; use the 501(c)(3) status, board of directors, and committee structure; and join the momentum of collective impact LWO is providing. This convening role is unique in the community and has created sustainability and flexibility to adjust to issues as needed in the community.

Organizationally, the funding structure has been diversified to incorporate membership dues, grant funds, event income, and sponsorships that will ensure the financial health of the organization. Because of its efforts around communication and the formation of a media bureau, LWO is receiving five to ten media hits a month and has a constant presence through social marketing. This communication effort is targeted at keeping health at the forefront of the citizens.

Into the Future

LWO is making the case for the value of a collective impact organization. Surviving several evolutions, keeping flexible, being responsive to the community's needs, and making the business case all have enabled LWO to survive over time. The foundational blocks have been laid, and LWO is an organization poised to make a difference in the health of the Douglas County community.

Kerri Peterson is director of Urban Initiatives at The Sherwood Foundation and a former director of Live Well Omaha.

Mary Balluff is the chief of community health and nutrition services for the Douglas County Health Department.

Policy and Systems Change to Build Healthy Communities in King County, Washington

BY JAMES KRIEGER

The Epidemic of Chronic Disease and Health Inequity

Communities across the nation are mobilizing to face the intertwined challenges of the epidemic of chronic diseases and persistent health inequities. Dramatic increases in obesity and diabetes may make the current generation of children the first to have a shorter life expectancy than their parents in US history. Growing rates of chronic lung diseases such as asthma and COPD lessen quality of life. The costs of treating chronic diseases are the major driver of escalating health care costs. And chronic diseases are also the greatest contributor to the health inequities that limit quality of life for people with low socioeconomic status and people of color. The gap in life expectancy between those with a college education and those with fewer than twelve years of education is increasing. For example, according to a study published in the journal *Health Affairs*, among white males, the gap in life expectancy at age twenty-five increased from 5.1 years in 1990 to 13.2 years in 2008.

A New Approach to Improving Health—Policy, Systems, and Environment Change

The increases in chronic diseases suggest that old ways of preventing them are not sufficient. Traditionally, prevention has taken place through delivery to individuals of services such as health education and medical care. This approach was based on the recognition that a limited number of health risks (poor nutrition, physical inactivity, and tobacco exposure) is the largest contributor to the development of chronic diseases and that screening and education could modify health-related behaviors. However, health behaviors do not take place in a vacuum—they are shaped by the environments in which people live, work, learn, and play.

The growing realization of the importance of environments—built, social, media, food—as deter-

minants of health has led to a new paradigm of chronic disease prevention. The new paradigm recognizes that policy and systems changes are needed to modify environments so that they promote health by making the healthy choice the easy choice. Policies that affect land use decisions, marketing and advertising, the relative prices of healthy and less healthy products, and food availability in schools and child care (to name a few) shape environments. Systems changes that link organizations in ways that promote health, such as building food systems that distribute locally grown produce to community institutions (e.g., hospitals, schools, child care sites) or connect schools to transportation departments to develop Safe Routes to Schools also create healthier environments.

In King County, Washington, whose largest city is Seattle, our local health department and its partners have adopted this policy, systems, and environment change (PSE) paradigm. With support from the US Centers for Disease Control and Prevention (CDC) and national foundations (Kellogg, Robert Wood Johnson), over the past decade we have led and supported partnerships that have created meaningful changes to prevent chronic diseases in communities most affected by health inequities. (See Table 1 to learn of some of our successes, and find more at <http://www.kingcounty.gov/healthservices/health/partnerships.aspx>.)

As part of our Communities Putting Prevention to Work (CPPW) initiative, funded by CDC with stimulus revenues, we partnered with public housing agencies to ensure that low-income residents could live in smoke-free homes. As a result, 13,546 units at twelve housing agencies are covered by smoke-free policies. To support full policy implementation, grantee agencies engaged administrators, property managers, and residents in the policy development process by educating them about the impact of tobacco on health and increasing

Table 1. Examples of Policy, Systems, and Environment Changes in King County, Washington

Faith-based	Churches remove vending machines, serve healthier food, adopt tobacco-free policies.
Hospitals/Health care	Hospitals implement tobacco-free campuses, reduce sales of sugar drinks. Clinics support access to pools, improve quality of asthma and diabetes care using chronic care model. Mental health sites go tobacco free and offer cessation support. Medicaid health plans begin payment for community health workers.
Schools	Schools implement high-quality nutrition and physical education standards, school wellness policies, Safe Routes to School programs, recess before lunch, Farm to School arrangements.
Child care	Providers implement Farm to Table arrangements and healthy eating, physical activity, and TV screen time reduction policies.
Food system	Farmers' markets increase access for Supplemental Nutrition Assistance Program and Special Supplemental Nutrition Program for Women, Infants, and Children customers; Community Supported Agriculture farm makes deliveries to low-income housing sites.
Food retail	Board of health implements menu labeling regulations for chain restaurants. Neighborhood restaurants increase healthy menu items. Pharmacy chain increases availability of fruits and vegetables.
Local governments	Cities adopt bike and pedestrian master plans, include healthy eating/active living elements in comprehensive plan updates, adopt healthy vending and meeting policies, implement pedestrian safety street improvements to support walking.
Parks	City and county parks implement tobacco-free policies, switch to healthy vending machines, offer women-only swim sessions.
Public housing	Agencies implement smoke-free policies, increase access to physical activity programs, develop housing sites as healthy communities, develop asthma-friendly public housing, install playground and outdoor exercise equipment.

support for people who wanted to quit using tobacco. Housing providers have many fears about the impact of smoke-free policy changes—for example, that vulnerable residents who cannot comply will be evicted. Few actual incidents resulted from the policy change, and eventually people adjusted to it. “The sky has not fallen,” one project staff member pointed out.

CPPW also helped the Reverend Aaron Williams, the senior pastor of the Mount Zion Baptist church in Seattle, improve the health of his congregation. Mount Zion, along with five other churches, introduced more healthy food and beverage options at church events, planted church gardens, encouraged group walking, and introduced limits on time spent in front of computers and televisions at child and teen church programs.

Historically, a culture of ambivalence regarding tobacco has been common at mental health and substance abuse treatment sites, with providers believing that nicotine was less of a health concern than other drugs and had some value for helping clients cope with stress and mental illness. We partnered

with forty-seven mental health and substance treatment agencies to change this culture, implement tobacco-free policies, and offer tobacco cessation programs. Glen, a Vietnam War vet, suffered from schizophrenia and had tried to quit smoking at least seventeen times without success. After his treatment site implemented a client-centered cessation program and became tobacco free, he quit smoking and has remained abstinent for the past year.

The Seattle Housing Authority has redeveloped the High Point public housing site over the past decade, and our health department has provided technical assistance and project development support. The old High Point consisted of 716 older housing units in varying states of deterioration laid out in a suburban-style street plan with cul-de-sacs. It is now a health-promoting, mixed-income, sustainable community with 1,600 new housing units, open spaces and trails, wider sidewalks, traffic-calming structures, a grid street layout, and asthma-friendly homes. A pro-walking campaign secured street crossing and path improvements, created and distributed walking maps, and organized walking groups. A group of Muslim women identified the

need for exercise and swim programs that are women only to respect cultural norms. Their efforts led first to a women's-only swim time at the nearby community pool and then expansion to additional pools across the city.

The PSE approach to making communities healthier is already producing results.

Lessons Learned

The PSE approach to making communities healthier is already producing results. Cities across the country are beginning to see plateaus and even declines in childhood obesity rates. However, rates remain too high, and disparities persist across race/ethnic groups and socioeconomic strata. Some of the lessons we have learned about PSE change work over the past decade are listed next.

- *Engaging with the multiple sectors that influence the health of the community is essential.* Engagement occurs more readily if: there is a foundation of trusting relationships, funding is available to support partners, champions from each sector promote PSE change from within, and the changes both help the partner realize its specific goals and promote community health.
- *Coalitions are sometimes, but not always, the best method of partner engagement.* In some cases, a simple partnership between a public health agency and a sector is sufficient to create change. In other cases, more complex coalitions that include multiple sectors are needed. Coalition development and maintenance are resource intensive—this method of partner engagement should be used judiciously.
- *Government is not always the best change agent.* Public health and other government officials are constrained by the views of elected leaders. They are susceptible to the nanny-state label by proponents of a smaller role for government. Community advocates have more freedom to take on challenging PSE change efforts, and public health can provide technical support in the background.
- *Conservative political advocates will challenge the PSE approach and the role of government in contributing to healthy communities.* They have threatened legal action against local health de-

partments, sought to cut funding for the Prevention and Public Health Fund that is the largest source of federal funding for healthy community work, and lobbied for legislation preempting local and state government authority to regulate the food retail sector. Government must assert its legitimate role to protect and promote the health of communities through encouragement of voluntary actions by other organizations and by regulation when needed. Regulation is not a dirty word but rather one of several tools to correct market failures.

- *Community engagement is both valuable and presents unique challenges when using a PSE change model.* Community members and community-based organizations (CBOs) are experts about community needs and assets. They contribute innovative approaches to addressing community health issues. They rally support for making PSE changes. However, many CBOs focus primarily on provision of direct services and have limited experience with or interest in PSE approaches. Community leaders may view other issues as more important than chronic disease prevention or support strategies that differ from those proposed by public health experts. Finding common ground, supporting community leadership, and balancing experiential and scientific knowledge are important challenges.
- *Creating PSE change may require advocacy and lobbying.* Yet the bulk of funding comes from government and foundation sources with attendant restrictions on use for advocacy and lobbying.
- *The PSE approach is new for many local health departments.* They need to develop capacity and skills to be successful. Resources are constrained in the current climate of fiscal austerity, presenting tough choices to the local health departments about how to support PSE work focused on chronic disease prevention while maintaining important traditional activities, such as infectious disease control and maternal and child health.
- *Measuring success presents challenges.* The ultimate goals are changes in health behaviors and prevention of chronic diseases, outcomes that can take years to achieve. Intermediate measures of policy, systems, and environment changes are valid metrics.
- *Evidence of the effectiveness of PSE strategies is just emerging.* Many potentially valuable

strategies have not yet been evaluated. Deciding what to do in the absence of clear-cut evidence of effectiveness is a challenge. Implementing evidence-based strategies as well as promising ones and conducting robust evaluations are ways forward.

Making policy, systems, and environment changes to improve health is already transforming our communities into healthier places. Bringing these changes to more communities has great potential for preventing chronic disease and reducing health inequities.

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James Krieger is chief of chronic disease and injury prevention at Public Health–Seattle & King County and clinical professor of medicine and health services at the University of Washington in Seattle, Washington.

Community-Level Obesity Prevention Initiatives

Impact and Lessons Learned

BY ALLEN CHEADLE,
SUZANNE RAUZON,
AND PAMELA M. SCHWARTZ

In the last decade, many US cities, counties, and neighborhoods began implementing community-level initiatives to prevent obesity, systematic efforts targeting a specific geographic area with a portfolio of strategies at multiple levels (e.g., individual, family, community) and across multiple sectors (e.g., school, worksite, neighborhood). Typically, these efforts have focused on implementing policy and environmental changes related to food and physical activity focusing on specific populations, complemented by supporting programs and promotions. Examples of policy changes implemented by community-level initiatives include sugar-sweetened beverage taxes and school policies limiting the availability of unhealthy food in vending machines and cafeterias. Examples of environmental changes include increasing the availability and affordability of healthier food and beverage choices in public venues, increasing the geographic availability of supermarkets in underserved areas, and enhancing the community infrastructure to support bicycling and walking.

A number of large-scale government and foundation efforts aimed at preventing obesity have adopted the community-level initiative as a strategy. These include the W.K. Kellogg Foundation's Food and Fitness Initiative; the Robert Wood Johnson Foundation's Health Kids/Healthy Communities Initiative; the Kaiser Permanente Community Health Initiative; the Department of Health and Human Services Communities Putting Prevention to Work Initiative, funded under the American Relief and Reinvestment Act of 2009; First Lady Michelle Obama's Let's Move Campaign; and the White House Task Force on Obesity. The 2009 Affordable Care Act also includes prevention funding that is supporting place-based initiatives.

Strong support among public health researchers and practitioners for community-level policy and environmental approaches to obesity prevention is re-

flected in major consensus reviews by the Centers for Disease Control and Prevention (CDC) and the Institute of Medicine (IOM). Of the eleven recommended nutrition-related strategies proposed in the CDC review by Dana Keener and coauthors, four target the availability and accessibility of healthier food choices in the community food environment:

1. Increasing the availability and affordability of healthier food and beverage choices in public service venues
2. Increasing the geographic availability of supermarkets in underserved areas
3. Providing incentives to food retailers to locate in and/or offer healthier food and beverage choices in underserved areas
4. Restricting the availability of less healthy foods and beverages in public service venues

The consensus reviews also recommend a number of environmental approaches to promoting physical activity, in particular, changes to the built environment in communities. Five of the nine CDC-recommended strategies call for these changes to the environment: improving access to outdoor recreational facilities; enhancing the infrastructure to support bicycling and walking; locating schools within easy walking distance of residential areas; improving access to public transportation; and zoning for mixed-use development.

The 2005 Institute of Medicine (IOM) Committee on Prevention of Obesity in Children and Youth created a national action plan that identified several immediate steps to address the obesity epidemic, including improving school food environments, promoting more active physical activity during the school day, expanding access to healthier foods in the marketplace, and expanding and promoting opportunities for physical activity across the community. More recently, the 2012 IOM report *Accelerating Progress in Obesity Prevention* took a

step further by: calling for increasing access to places and opportunities for physical activity; reducing unhealthy food and beverage options and increasing healthier food and beverage options at affordable prices; transforming messages in the environment about physical activity, food, and nutrition; expanding the role of health care and employers in obesity prevention; and increasing attention on schools as a focal point for obesity prevention.

But questions remain: Do community-level initiatives work? Have they been successful in changing health behaviors that cause obesity and/or obesity rates themselves? This article reviews the evidence to date on the impact of community-level initiatives to prevent obesity and offers suggestions for both future intervention and evaluation design for this type of community initiative.

Do community-level initiatives work? Have they been successful in changing health behaviors that cause obesity and/or obesity rates themselves?

Evaluation Goals and Challenges

In assessing the contribution of community-level initiatives to the overall obesity prevention effort, it is important to consider their impact on intermediate-term outcomes, such as food and physical activity behaviors, as well as their impact on more long-term outcomes, such as obesity rates and obesity-related chronic illnesses (e.g., diabetes, heart disease). Substantial investments are being made in these initiatives, and there is considerable interest in understanding long-term impacts and the value of the investments.

Unfortunately, there are a number of challenges to collecting definitive information about the long-term impact of community-level initiatives. First, it is challenging to conduct credible evaluations of these initiatives, particularly evaluations that include an assessment of their impact on population-level behaviors and health outcomes. The key longer-term outcomes, especially food and physical activity behaviors, are difficult to measure accurately at a population level, and there are a number of challenges to creating designs and data

collection strategies that can be sensitive enough to detect the relatively small expected changes across a community population and attribute them to the initiative. Second, the field is relatively new, and some of the largest and potentially useful evaluations are currently in progress and results will not be known for several years. A third constraint is publication bias. The accumulation of initiative-level evidence requires that negative studies be published, but reviews consistently find almost all positive studies in the peer-reviewed literature. Some of this bias is likely due to self-selection by researcher/evaluators—if a community-level initiative evaluation shows negative findings, there is little incentive for either the funder or the evaluator to undertake the effort to publish these findings in the peer-reviewed literature. Finally, conducting primary data collection at the population level can be cost prohibitive for a community intervention.

Evidence of Impact

Given the caveat that information about community-level obesity prevention effectiveness is limited, the studies that have been published indicate that the approach can be effective and give us road maps for replication. We conducted a review of the published and gray literature (e.g., unpublished evaluation studies and online initiative descriptions) to identify examples of initiatives that have been or are currently being evaluated. The search was conducted in December 2012 for years 2000 to 2012 using bibliographic databases. A total of thirty-six community-level initiatives that included sufficient detail concerning their intervention and evaluation methods were identified. These included sixteen initiatives that were completed and included population-level outcome results. Another twenty initiatives are either in process or not measuring population-level behavior change. Some of the largest and potentially most useful evaluations are in progress. In particular, many independent evaluations of the CDC's Communities Putting Prevention to Work initiatives are currently being conducted, and a large-scale, retrospective National Institute of Health-funded Healthy Communities Study is using chart reviews to track changes in obesity rates in 268 communities across the United States.

Of the sixteen community-level initiatives for which results were available, thirteen showed positive impacts on health behaviors or obesity rates. Three-quarters of these positive studies were focused on children, typically combining school-based interventions with surrounding community-level policy and environmental changes (e.g., park improvements, increasing healthfulness of offerings in grocery stores and restaurants). Two of the initiatives (one positive and one negative) were state level; the rest targeted smaller geographic communities such as cities or neighborhoods.

Two examples of youth-focused initiatives targeting smaller cities and neighborhoods will help illustrate the nature of community obesity prevention activities as well as the impacts: Shape Up Somerville and the Kaiser Permanente HEAL-CHI initiative in three communities in Northern California.

Shape Up Somerville

Perhaps the best-known community-level obesity prevention initiative is Shape Up Somerville (SUS), a comprehensive community-level intervention involving children, parents, teachers, school food service providers, city departments, policy makers, health care providers, before- and after-school programs, restaurants, and the media (Economos et al. 2007). Using a community participatory process, the intervention activities were developed to influence every part of the community. SUS participated in or conducted one hundred events and four parent forums, trained fifty medical professionals on childhood obesity guidelines and current screening practices, and recruited twenty-one restaurants to become SUS approved. A total of fourteen after-school programs implemented a new after-school curriculum. Various communitywide policies were developed to promote and sustain change, including a school wellness policy, new policies and union contract negotiations that led to enhancements of the school food service, expanded pedestrian safety and environmental policies, the adoption of a healthy meeting and event policy, and a city employee fitness wellness benefit. The SUS interventions resulted in a modest but significant decline in body mass index standard deviation (BMI z-scores) in children in grades 1 to 3 after one year of intensive implementation, an indication of a lower prevalence of obesity among young children, according to a study pub-

lished in the journal *Obesity* by Christina Economos and coauthors.

Kaiser Permanente HEAL-CHI Initiative

The Healthy Eating Active Living—Community Health Initiative (HEAL-CHI) was a five-year initiative (2006–2011) funded by Kaiser Permanente’s Northern California Community Benefit program. Three neighborhoods within larger cities in Northern California were selected through a request for proposal process for five years of funding: Modesto (population 38,400, 54 percent Latino), Richmond (52,900, 45 percent Latino, 29 percent African American), and Santa Rosa (37,960, 41 percent Latino). The emphasis in HEAL-CHI strategies was on policy and environmental change strategies. Examples of organizational policy changes included changing cafeteria policies in schools and worksites to increase the number of healthy entrees and implementing California Standards–based physical activity curriculum during school hours in local elementary schools. Public policy strategies included influencing urban planning via the city general plans (e.g., by adding “health elements” that require a consideration of the health consequences of new zoning and construction). Environmental strategies focused on increasing access to healthy food and changing the built environment to promote physical activity (e.g., increasing purchase or distribution points for fresh fruits and vegetables in the community and changing the infrastructure around schools to promote walking and biking to schools).

Across all three communities, a total of over 41,000 people were exposed to environmental and programmatic interventions in their neighborhoods, worksites, and health clinics; and 17,000 school-age youth were exposed to interventions in their schools. The highest-impact strategies (as measured by the dose or percentage of the population reached and the estimated impact per person reached) targeted physical activity and were implemented in and around schools. These “high-dose” strategies were associated with significant and positive population-level changes in the three HEAL-CHI communities. Using data from a school-based survey, we found that of the nine instances where there were high-dose strategies in place, four of those were statistically significant and favored the intervention. For example, a community that implemented a

high-dose combination of after-school physical activities and a new physical education curriculum saw an increase in the percentage of youth performing vigorous physical activity at least 20 minutes per day from 61 to 67 percent.

Best Practices in Evaluating Impact

As part of our review of the literature on community-level initiatives, we also examined the approaches that have been used to evaluate these initiatives. Based on that review, we recommend using logic model designs that combine estimates of potential impact with pre–post measures of behavioral and other longer-term outcomes. Logic model designs start with a program “theory of change”—that is, the mechanism by which the comprehensive community initiative is intended to achieve its long-term outcomes—and then create indicators for each step in the logic model. In the case of community-level initiatives, the key steps in the logic model are intermediate outcomes (e.g., environmental and policy changes implemented in communities) and longer-term population-level outcomes (e.g., physical activity behaviors, weight, and health status). If the temporal pattern of change is consistent with that specified in the logic model, the intervention is more likely to have been the cause of the population-level changes. An example would be if significant built environment changes are made to facilitate safe walking (e.g., completing sidewalks in neighborhoods), and residents report an increasing upward shift in minutes of daily walking in the years that follow.

To measure the intermediate outcomes of environmental and policy change interventions, we developed the concept of “population dose.” It is a combination of the number of people reached by the intervention and the strength of the intervention needed to change the behavior of those reached.

The intervention strategies being implemented in a community can be grouped into clusters targeting the same outcome measure (e.g., minutes of physical activity) and population segment (e.g., school-age youth or adults/families). For example, strategies attempting to increase minutes of physical activity among school-age youth in a community might include an enhanced physical education (PE) curriculum and Safe Routes to School programs to

encourage walking and biking to school. The dose of a cluster of strategies can be determined by combining the quantitative dose estimate of the individual strategies.

The early evidence from community-level initiatives is that they can be effective in changing obesity-related behaviors at the population level.

Dose of the strategies can then be combined with population-level behavioral data to examine whether higher-dose community change strategies or clusters of strategies are associated with measured population-level changes in the relevant outcomes. The first test of the dose approach was the HEAL-CHI initiative, described earlier, where there was an observed correlation between high-dose strategies and behavior change.

Conclusions and Recommendations

The early evidence from community-level initiatives is that they can be effective in changing obesity-related behaviors at the population level. A number of initiatives, particularly youth-focused initiatives in small cities and neighborhoods, have demonstrated increases in physical activity and healthier eating, and in some cases reductions in obesity rates. However, the evidence is too limited to say whether they can be generally successful across a wide range of communities—that is, whether they are truly an “evidence-based” practice.

Some recommendations emerge from a review of the evidence for both community-level initiatives and individual environment and policy change strategies:

- *Focus on youth in schools.* Most of the successful initiatives and strategies have focused on children and used school-based interventions as major components. Students are a captive population in an institutional setting conducive to making the healthy choice the easy choice, and many school environment and programmatic interventions can reach the whole student body.
- *Cluster strategies.* The most successful initiatives used multiple overlapping strategies targeting the same population and health behavior. For

example, a school-based intervention might include a new PE curriculum, Safe Routes to School program, after-school and recess activities, and playground renovations. This interlocking approach is consistent with the systems perspective recommended by the *Accelerating Progress on Obesity Prevention* report.

- *Sustainable strategies.* Long-term impact will require that the implemented policy and environmental interventions are sustained. Legacy evaluations several years after intervention funding has ended should be carried out to assess both whether the community changes occurred and remain in place and the behavioral outcome changes and reductions in obesity rates have been maintained.
- *Logic model evaluation designs.* Evaluations that link the theory of change to behavioral outcome measures have a greater chance of accurately assessing whether the initiative has had an impact.

In summary, community-level initiatives are a promising approach to preventing obesity and have been demonstrated to be successful on a number of occasions. A focus on thorough documentation of intervention approaches, consistent monitoring of their impact, and widely available reports on progress, including failures, is needed to better understand the conditions required for them to be successful.

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Allen Cheadle is director of the Center for Community Health and Evaluation at the Group Health Research Institute in Seattle, Washington.

Suzanne Rauzon is director of strategy at UC Berkeley's Center for Weight and Health.

Pamela M. Schwartz is director of program evaluation for Kaiser Permanente's Community Benefit Program Office.

Transportation for the Twenty-First Century Designing Healthy Communities and Active Lifestyles with Safe Routes to School

BY DEB HUBSMITH
AND MARGAUX MENNESSON

A study released in spring 2013 by the US PIRG Education Fund shows that after decades of steady growth, US driving rates have slowed and even stalled and that, in the long term, Americans are unlikely to return to driving as much as they did before. The groundbreaking report finds that millennials (the generation of people born between 1983 and 2000) drove 23 percent fewer miles on average in 2009 than they did in 2001—a greater decline in driving than any other age group. Millennials are also more likely than previous generations to want to live in urban and walkable neighborhoods and are more open to nondriving forms of transportation than older Americans.

As millennials grow older and start having families, how will communities evolve to serve the needs of those who value dense, urban neighborhoods and walkable/bikeable centers with less reliance on driving? When safety is paramount to parents, how will cities and towns ensure that children can safely walk and bicycle to and from school and around the community? Safe Routes to School programs will play an integral role in the way cities and towns serve these families now and in the coming decades.

The Imperative

Today, the National Center for Safe Routes to School found, only 13 percent of children walk or bicycle to school—a drastic drop from 1969, when nearly 50 percent of children got to school under their own power. Childhood obesity increased from 4 percent to 19.6 percent between 1969 and 2007, reported Cynthia Ogden and coauthors (2006) in the *Journal of the American Medical Association*, and nearly one in three young people are overweight or obese. Families, schools, and communities are bearing the costs associated with more driving and

less physical activity. School districts and families spend billions on gasoline to get children to school while John Cawley and Chad Meyerhoefer (2012) estimate the total cost of treating obesity at \$190 billion a year, approximately 21 percent of health costs. These are just some of the factors that are leading growing numbers of Americans to walk and bicycle more and give their children opportunities to be healthier and physically active.

Fortunately, Safe Routes to School programs are helping communities and people make healthy choices by making walking and bicycling to school safe, convenient, and accessible. Safe Routes to School programs help communities accomplish their goals by focusing on the 5 Es: engineering, education, evaluation, enforcement, and encouragement. More than 5 million children and 14,000 schools nationwide are benefiting from more pedestrian and bicycle infrastructure and education through Safe Routes to School programs.

The Safe Routes to School National Partnership was founded in 2005 and works to: catalyze support for safe, active, and healthy communities; advocate for policy change that supports Safe Routes to School programs and healthy community design; and leverage expertise, core knowledge, and research that help improve the quality of life for kids and communities. Fire Up Your Feet, a new school-based program of the National Partnership, encourages families, students, and schools across the country to create active lifestyles that inspire our children to be healthy and physically active.

Healthy Kids, Healthy Schools, Healthy Places

As more Americans choose to live, work, and raise families in urban and walkable communities, communities will find the next Safe Routes to School

strategies critical for improving the quality of life and saving lives and dollars.

Public Health and Obesity Prevention

Studies show that children who walk and bicycle to school are more physically active, have lower obesity levels, and are more likely to meet the recommended 60 minutes a day of physical activity than children who are driven or bused to school.

Case Study. Safe Routes to School programs have shown an increase in the rate of children walking and bicycling to school where interventions have been implemented. A 2013 study by Orion Stewart and Anne Moudon of Safe Routes to School programs in five states (Florida, Mississippi, Texas, Washington, and Wisconsin) showed that where Safe Routes to School projects were completed, on average walking increased by 45 percent, bicycling increased by 24 percent, and all active transportation increased by 37 percent.

Improving Safety and Preventing Injury and Crashes

Safe Routes to School projects reduce pedestrian and bicyclist injuries and deaths by implementing solutions that slow vehicle speeds, increase visibility of children walking and bicycling, and make street crossings safer.

Case Study. The New York City Department of Transportation (DOT) evaluated the crash histories near all of the city's 1,471 elementary and middle schools to identify the schools with a high incidence of crashes and those most in need of infrastructure improvements through Safe Routes to School. The DOT prioritized 135 of the highest-risk schools and worked with principals, parents, and community members to identify short- and long-term infrastructure solutions for those schools. After making short-term improvements at all 135 schools, the rate of pedestrian injury during school travel hours decreased by 44 percent while the rate at other schools remained steady.

Reducing Traffic Congestion

During the morning commute, driving to school accounts for an average of 5 to 7 percent of miles traveled and 10 to 14 percent of traffic on the road and costs parents an estimated \$5 billion a year in fuel. The often-chaotic and unsafe environment in front

of schools during drop-off and pickup times can discourage parents and students from walking and bicycling to school.

Case Study. Nearly three-quarters of students at Alpine Elementary School in Alpine, Utah, live close enough to walk to school, but traffic congestion discouraged many families from doing so. After receiving two federal Safe Routes to School awards totaling \$71,500, the school made improvements to reduce congestion and improve safety around the school, including repainting crosswalks, adding school zone signs, installing speed monitor signs, and creating a safe walking path to a rear entrance of the school. Following the intervention, the number of students who regularly walk or bicycle to school has risen from 32 percent to 50 percent, and there are 60 fewer cars commuting to school each day.

Financial Benefits of Walking and Bicycling to School

Many school districts are cutting bus service to compensate financially for rising fuel costs, changing demographics, and decreased general funding for school districts. The loss of bus service creates an opportunity for school districts to promote safety for children walking and bicycling.

Case Study. The city of Wooster, Ohio, secured a \$464,000 Safe Routes to School grant to improve sidewalks and crosswalks around several schools in the district. After building sidewalks, improving school zone signage, enhancing high-visibility crosswalks, and adding signals, the school district will be able to eliminate one full bus route, saving the school district \$49,000 each year.

Increasing Physical Activity through Changes in the Built Environment

The President's Council on Fitness, Sports & Nutrition *Physical Activity Guidelines for Americans Midcourse Report* (2012) established a connection between the built environment and improved public health in recommending active transportation to school as a strategy to improve health and help children reach the recommended sixty minutes of physical activity a day. Studies show that communities that are more walkable and bikeable and have pedestrian-accessible destinations also have higher levels of physical activity. Children who live in neighborhoods with safe crosswalks and sidewalks

are more likely to be physically active than children living in neighborhoods where it is less safe to walk.

Case Study. The city of Des Plaines, Illinois, used \$304,000 in federal Safe Routes to School funding for the construction of new sidewalks, curb extensions, raised crosswalks, and striping improvements. Since making these infrastructure improvements, Des Plaines has seen walking and bicycling rates among students double from 19 percent in 2007 to 40 percent in 2010 while traffic congestion has declined.

The Future of Safe Routes to School

As more Americans shift to living in walkable neighborhoods and choose nondriving forms of transportation, communities will need to invest in new transportation infrastructure to attract young people and their families.

We all have a role to play in designing and building thriving communities. Governments and municipalities can apply for Safe Routes to School and Transportation Alternatives Program federal grants and begin to incorporate Complete Streets policies into their transportation and land use planning processes. They can also explore innovative new strategies to increase physical activity opportunities, such as shared use agreements between a school district and a city or county, to make facilities such as playgrounds, fields, courts, and tracks available to the public outside of school hours. Parents and schools can champion Safe Routes to School programs and engage directly with their community by bringing Fire Up Your Feet programs to their school. Fire Up Your Feet makes it easy and fun to walk and bicycle to school and create opportunities for physical activity in daily life.

The active transportation movement is growing at every level, and Safe Routes to School is at the fore-

front of engaging children, families, and schools. Together, we are leading the way toward designing stronger, healthier, and safer communities throughout the United States.

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Deb Hubsmith is the founder and director of the Safe Routes to School National Partnership and has been a nationally respected leader for Safe Routes and other active transportation advocacy efforts for more than fifteen years.

Margaux Mennesson serves as the communications manager for the Safe Routes to School National Partnership.

Advancing Walkable Communities Retro, In, and Here to Stay

BY SCOTT BRICKER

Walking is one of the earliest defining human traits. It evolved more than 4 million years ago, and today, despite decades of engineering, marketing, and development efforts to make walking obsolete, a new American consciousness about walking is emerging. This consciousness is sparking grassroots groups across the country to push for safe walking environments and to begin changing the development patterns that put automobile travel at the center of our lives.

To provide a snapshot of this emerging movement, to consider some of the key forces behind the increased interests in walking and walkability and highlight national walking opportunities that have the potential to significantly alter who and how much we walk, it might be best to start by asking why there is such an interest in walking, a rather primitive form of mobility, when we live in an age where great technological and scientific advances happen almost daily. Perhaps the most important reason is that the human body is made to walk. There is almost nothing more beneficial we can do for our own personal health than walking. Walking is the most accessible and widely available free intervention to increase physical activity and baseline health. And it is for these reasons that public health and health care providers have gotten so proactive in supporting built environment solutions to public health. For example:

- Blue Cross Blue Shield of Minnesota helped lead an effort to pass a series of Complete Streets policies in the state and communities in Minnesota.
- The Every Body Walk! campaign by Kaiser Permanente has helped lead the development of the Every Body Walk! Collaborative.

Many mayors, developers, real estate agents, and other economic boosters have become engaged in efforts to make their communities more walkable. Numerous studies are showing how the most walkable places hold the highest real estate values and were impacted least and are rebounding quickest

from our waning real estate crisis. A 2011 National Association of Realtors survey showed that most Americans would like to live in walkable communities where shops, restaurants, and local businesses are within an easy walk from their homes (as long as those communities can provide detached single-family homes). The survey also shows that most Americans would choose a smaller home and smaller lot if it would keep their commute time to 20 minutes or less.

The good news for equity and affordability interests is that other studies have shown that although real estate prices, values, and rents are higher, walkable places actually can be more affordable because families can cut household transportation costs by reducing auto ownership.

Other interest groups such as AARP, American Heart Association, and YMCA of the USA have taken on the built environment and continue to focus on walking and walkability, a core need of their constituents, to live healthy, active, and happy lives.

The many benefits of walking have helped catalyze and shape a new walking social movement.

In 1991 two organizers in Portland, Oregon, started the Bicycle Transportation Alliance (BTA) and the Willamette Pedestrian Coalition (now Oregon Walks). In 1998 I joined the staff of the BTA, making it three. Each year the BTA grew, and when I left the alliance in 2009, we had sixteen staff members. Also at that time in Portland (yes, it's a bike town, but it's a walking town too), numerous other bike groups thrived, as did the bike industry. But Oregon Walks was still struggling to pay for their first-ever staff person. Today, three and a half years later, Oregon Walks has two staff members, and the future is bright for advocating for walkability in Oregon and elsewhere.

When I joined America Walks in 2010, well-staffed walking advocacy was seemingly nonexistent in all

but a few select cities—Boston, San Diego, and Atlanta—and was the minor part of the platform of livability groups. But in the past three-plus years I have seen an explosion in communities and states working hard to build their walking portfolio; America Walks itself has grown fourfold. In just eight months, America Walks worked in eight communities/states to help start or strengthen walking collaborations; many more are seeking these services.

This explosion has occurred mainly because many types of organizations, industries, and interest groups are realizing just how important walking and walkability is to *their own* interests and goals, making this truly budding movement of multisectoral partners.

Where can we go from here? Local action is springing up everywhere, and we are seeing national headwinds to spur the efforts.

The US Centers for Disease Control and Prevention, which put science to work in its Vital Signs on Walking reports, calls for “improving spaces and having safe places to walk” to help more people become physically active. On December 5, 2012, America Walks, Kaiser Permanente, Safe Routes to School National Partnership, American College and Sports Medicine, and others hosted the Building Partnerships for Aligned Action for Walking meeting. One hundred forty leaders attended this meeting with the intention of advancing walking and walkability in America. US Surgeon General Regina M. Benjamin announced the proposed Call to Action on Walking—the Office of the Surgeon General’s highest scientific-based action document—which is now under way and received a record number of comments during the public comment period. (Her successor, Acting US Surgeon General Boris D. Lushniak, has clarified his intention to move the Call to Action forward.) As a result of this meeting, a new collective effort, the “Every Body Walk! Collabora-

Ways to Get Engaged

- Endorse the “Vision for a Walkable America”—www.americawalks.org.
- Learn about and share tactics and case studies to advance walkability—www.walksteps.org.
- Share stories about walking and walkability—www.everybodywalk.org.
- Join the Every Body Walk! Collaborative—Have your organization participate in the collaborative—<http://everybodywalk.org/collaborative.html>.

tive,” was formed to advance walkability and walking in America.

A critical outcome of the Every Body Walk! Collaborative’s effort was the 2013 Walking Summit. The summit’s goal was to increase the demand for more walking (behavior and culture change) and the supply of safe places to walk (environmental, policy change) by exchanging learning and mobilizing the diverse leadership, assets, and beneficiaries of the walking movement. The idea of the summit was to coalesce the current base of the walking movement, welcome new players, and strengthen partnerships at local, regional, state, and national levels, including people, organizations, and businesses whose sectors/interests benefit when more people walk and when communities are more walkable.

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Scott Bricker is the executive director of America Walks, a national nonprofit organization making America a great place to walk.

Food and Community A Future Intertwined

BY RENEE GUILBAULT,
LARRY YEE,
AND KAREN SCHMIDT

From a foodie perspective, the last twenty-five years have been exhilarating, some might even say revolutionary. There are gardens growing in many schools and a flagship garden at the White House; celebrity chefs abound, and even some farmers have attained rock star status; people are doing farm-stays for vacations, milking cows and helping with the harvest; and the ratings of the Food Network channel are exploding.

Food has moved to center stage in our culture and collective consciousness. One major positive note is that more and more people are equating good food with good health, and not just to individual health but the health of the larger community as well. Food is coming back home, seeking relationships of trust, well-being, and community.

Yet observers such as Herman Daly and John B. Cobb reckon our food system remains seriously out of balance. “If economics is reconceived in the service of community, it will begin with a concern for agriculture and specifically for the production of food,” they write in their book, in *For the Common Good* (1994). “This is because a healthy community will be a relatively self-sufficient one. A community’s complete dependency on outsiders for its mere survival weakens it. The most fundamental requirement for survival is food. Hence, how and where food is grown is foundational to an economics for community” (p. 268).

Food production and distribution are highly concentrated in the hands of a small number of too-big-to-fail agribusinesses and retail mega-corporations, writes Wenonah Hauter in her book *Foodopoly* (2012). The small farms, ranches, and dairies of a century ago have been replaced by enormous agribusiness concerns, some twenty of which supply most of the food that makes its way into our food chain, and massively concentrated confined animal feedlot operations (CAFOs), which raise animals in appalling conditions to produce chemical-laden meat with questionable health

value and serious environmental consequences. Local butchers and bakers have been replaced by big-box retail superstores, four of which control over 50 percent of all retail food sales. Meanwhile, families and communities have in one or two generations lost a whole history of knowledge and expertise around growing and preparing food.

Although local food sales have grown to an estimated \$7 billion in 2012, they still are an infinitesimal fraction of our \$1.3 trillion food economy. And the vast majority of our food dollars, some 89 percent in 2011 according to the US Department of Agriculture, continues to be spent on manufacturing, packaging, transporting, and marketing processed food products, with only a thin sliver of our food dollar paying for the production of actual whole, real foods—let alone for such foods grown with minimal chemical inputs by well-paid workers within the communities that consume them.

Food insecurity and diet-related chronic illness continue to plague the nation, with disproportionate and reverberating impacts on minority and low-income communities. In a 2012 report for the US Department of Agriculture, Alisha Coleman-Jensen and coauthors found that nearly 15 percent of households in the world’s richest nation experienced food insecurity in 2011, but the rate of hunger in black and Hispanic households was over 25 percent, and approached 35 percent in low-income households. Obesity and type 2 diabetes have reached epidemic proportions across all age, income, and ethnicity groups, but rates are significantly higher in African American and Hispanic communities, which, not coincidentally, are more likely to be located in food deserts with limited access to grocery stores selling fresh, healthy foods.

And our political leaders have thus far utterly failed to adapt our antiquated and dysfunctional national food policy (aka the Farm Bill) to these and other exigencies of the twenty-first century, including climate change, soil loss, and groundwater depletion.

Without a doubt, the centralized industrial food system has achieved amazing productivity and technological advances over the last half century. But along the way, the creation of short-term shareholder wealth has been decoupled from community health, environmental sustainability, and justice, and community self-reliance has been sacrificed to the pursuit of specialization, efficiency, and scale economies.

We believe that the current food revolution is a hopeful harbinger of some remarkable community-level changes in our food and food system to come over the next twenty-five years—changes that are essential to diversify and restore balance and resilience to our dangerously lopsided current system.

Signs of communities retaking control of their food systems are multiplying exponentially around the country. Witness:

- The explosion of farmers markets and community-supported agriculture (CSA).
- The growth of programs, policies, conferences, educational programs, and media on home, neighborhood, and community-based food production, from backyard chickens and neighborhood backyard produce exchanges, to community gardens and gleaning programs, to local seed banks and seed swaps, to mobile slaughterhouses and sustainable meat “hackathons.”
- Individuals rediscovering cooking skills as one of the most valuable assets in managing personal health and wellness, not to mention food costs; and communities investing in community kitchens and kitchen incubators to support the growth of local food artisans and entrepreneurs.
- The emergence of hundreds of local food hub projects around the country, seeking to rebuild the infrastructure that has been lost over the last sixty years to bring local products from small and mid-size farms and food processors to local markets.
- Farm to school and school food programs engaging parents, teachers, administrators, farmers, and communities in bringing healthy, local food into school cafeterias and utilizing school gardens and nutrition education to raise a new generation that understands where food comes from and why good food matters—and that has access to that good food every day.
- Hospitals not only reassessing their internal food service and procurement operations but lever-

aging those efforts to increase communitywide healthy food access via hospital-based farmers markets and CSA.

- Food policy councils giving rise to proactive policies and programs, such as the Good Food for All Pledge, a comprehensive procurement program created by the Los Angeles Food Policy Council and signed onto by the Los Angeles Unified School District, highlighting a holistic approach to sourcing good, fair, nutritious, and sustainable food.
- Initiatives like the Food Commons seeking to weave together threads of sustainable agriculture, new economy, local food, and innovative community-based ownership and finance into a holistic system of infrastructure to support thriving, networked regional food economies.

All of this activity has not gone unnoticed by major players in the dominant large-scale food system. Some are moving proactively toward more sustainable ways of operating. Bon Appétit Management Company, for example, is leading the charge in demanding better practices from the largest producers in the country. One of its current initiatives is phasing out gestation crates from their pork supply by 2015. As Helene York, the company’s director of strategic initiatives, stated in *Civil Eats* (2012), “We are announcing a commitment—even though the products we need aren’t produced in the quantities we need. Why? We’re convinced of one thing: The best chance for change is to stop waiting for everyone else to make the first move. We’re committed to shifting production practices in the marketplace one way or another.”

Retailers—from Costco to Walmart—are responding to consumer demand by expanding their offerings of local and organic foods, and many others are rushing to enter the fast-growing fresh and natural foods segment.

Even policy makers are beginning to take note. In spite of a lack of visible progress on revamping the Farm Bill, national dialogue about commodity crop subsidization is getting louder, the US Department of Agriculture is putting more resources and effort than ever before into supporting regional food systems, and First Lady Michelle Obama is shining a spotlight on the vital connections among health, food access, physical activity, and individual and national prosperity.

That the largest food retailer in the world, Walmart, is utilizing its enormous market power and highly efficient global logistical systems to buy and sell more local and organic foods is, on the whole, a good thing.

But does the presence of “local” produce on the shelves at Walmart equate to a community being able to feed itself?

Is there not some real value to communities investing in and retaining for themselves such a core competency as food production, particularly in the face of increasingly volatile economic, political, and physical climates? What have communities lost by ceding their self-sufficiency to remote corporations whose primary obligations are to still more remote investors and shareholders? More important, what do communities stand to gain, or regain, through the flourishing of home-grown local food movements?

A community-level food system will undoubtedly not be able deliver the same price points as Walmart. But mounting evidence suggests that, across the economic scale, people are ready to pay more for local food that nourishes not only their bodies but their communities.

We believe we are in the midst of a community-rooted food renaissance—the rebirth of food that travels a short and known route from field to plate and accomplishes these things:

- It supports local farmers and farm workers with dignity.
- It keeps dollars circulating within the local economy and creates a ripple of jobs throughout the community.
- It is a genuine expression of local identity and heritage, not a cosmetically engineered imitation.
- It celebrates and enriches cultural and genetic diversity that fits the season and the local environment rather than fighting against them.
- It increases the self-sufficiency of families and the resilience of the community for generations to come.
- It expresses love and care for ourselves, our neighbors, and our planet.

The last twenty-five years have witnessed a reawakening of what Wendell Berry eloquently described in “The Pleasure of Eating.” But as Berry noted in

that same essay, “We cannot be free if our food and its sources are controlled by someone else” (p. 229). Food and food production are now major conversations in both public and private sectors. As we harness this incredible moment of convergence across sectors, let us celebrate our accomplishments (preferably around a good meal) and then get back to the good work that needs doing to bring food back home.

As Dee Hock (1999) has said, “In times such as these, it is no failure to fall short of realizing all that we might dream. The failure is to fall short of dreaming all that we might realize” (p. 3).

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Renee Guilbault is the director of operations and service for Compass @ Google, Americas, and serves on the Los Angeles Food Policy Council’s Leadership Board.

Larry Yee is cofounder and coordinating director of Food Commons.

Karen Schmidt serves on the national Food Commons executive team and is director of the Fresno Food Commons prototype project.

The Laboratories of Place-Based Change

BY ROBERT OGILVIE

In recent years, public health agencies all over the country have started working to create places where people can more easily make healthy choices and live healthy lives. Much of this work is modeled after the tobacco control movement, which has focused on changing social and retail environments to help make smoking less socially acceptable and therefore make people less likely to start or continue smoking.

In social environments, such as bars, restaurants, parks, and even multi-unit housing, smoking affects everyone's air quality. In the retail environment, making tobacco products less attractive and available means people—especially teenagers—are less likely to buy them and become addicted.

Public health agencies can take a similar approach when they look at the built environment—man-made structures such as roads, neighborhoods, cities, and buildings in which we conduct our lives. If those elements of a community are designed to promote physical activity in daily life, the healthy choice becomes the easy choice.

Research was starting to show fewer people were being physically active—many people live in places designed for cars. That meant people had to make a conscious choice to be physically active. It was not normal for them to walk or use a bicycle to get around their community. Reversing this trend required changing the built environment so opportunities for active transportation—walking to school, work, or the grocery store, for example—became convenient and safe for people. In addition, neighborhood parks and schoolyards stayed unlocked in the evenings and on weekends so they were accessible to all.

This is not a traditional way for public health departments to work—they have no actual power to change the built environment, so they had to become partners with the redevelopment agencies and planning authorities that did. Public health department staff members also had to develop new expertise in

how built environments are planned for and developed. In some rare cases, public health department employees went to law school or planning school to develop skills and expertise. More often, they wrote proposals to foundations and to state and federal agencies that could fund them to attend conferences and training seminars and to hold their own local meetings and training seminars with partner organizations and local elected officials. They built their skills and relationships bit by bit on the job.

Our organization, ChangeLab Solutions, has been at the forefront of working with public health agencies trying to do this work. With support from the California Department of Public Health, the Centers for Disease Control and Prevention, the California Endowment, the Robert Wood Johnson Foundation, Kaiser Permanente, and the Kresge Foundation, among others, our team of attorneys, urban planners, and policy analysts has worked with and for local government staff members and community advocates to help them become experts on how to work with land use, redevelopment, economic development, and other local agencies to create and adopt policies, ordinances, agreements, and zoning codes to create healthier environments.

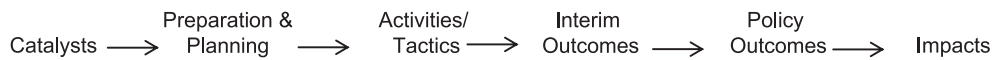
The ChangeLab Solutions Approach

To do our most effective work, ChangeLab Solutions has used an advocacy and policy change logic model adapted by evaluator Nancy Frank from one developed by Julia Coffman at the Harvard Family Research Project. It portrays the multiple elements or stages of a community-based policy change process. The key elements are as shown in Figure 1.

Although this logic model holds true from place to place, our entry point varies from community to community, as does the pace of change and the challenges that arise and need to be overcome.

We have helped address different types of challenges in two places in California: Fresno and San Diego.

Figure 1. Advocacy and Policy Change Composite Logic Model



San Diego is the eighth largest city in the country, with a robust economy based in military and defense contracting and biotechnology research, while much-smaller Fresno is the thirty-fourth largest in the country and is the center of the world’s most productive agricultural region. Both had very high rates of obesity and related chronic disease, and in both places the county public health departments decided to change policy to prevent chronic disease.

Experience had taught them that just encouraging people to live healthier lives through education campaigns was not working, and they needed to create environments that were more likely to lead to a healthier outcome. Whereas the tobacco control movement was trying to change the environment to make the unhealthy choice—the choice to smoke—the hard one, this burgeoning anti-obesity movement was trying to change environments to make healthy choices—being physically active and eating healthy food—easier.

Policy Change in Fresno

Fresno’s catalyst for change happened in 2006, when the California Endowment (TCE) launched the Central California Regional Obesity Prevention Program (CCROPP) “to promote safe places for physical activity, increase access to fresh fruits and vegetables, and support community and youth engagement in local and regional efforts to change nutrition and physical activity environments for obesity prevention” in six, and later eight, counties in Central California’s San Joaquin Valley.

As with Healthy Eating Active Communities (HEAC), TCE’s other place-based, policy-driven obesity prevention program, CCROPP had two components:

1. Engagement of community members and local institutions in environmental change
2. Policy change technical assistance, and advocacy training and support

Governed by the Central California Public Health Partnership, CCROPP is a collaborative venture of the eight county public health department directors, a community-based organization in each county, and an obesity council. In each county, a public health department staff member was designated as a lead member and charged with implementing CCROPP activities and policies in their county.

In Fresno County, Rosemarie Amaral was the CCROPP lead, and we worked most directly with her. There, as in all of the CCROPP counties, Rosemarie faced resistance to some of her new ideas from conservative elected officials, suspicion from disenfranchised community members, and limited resources in a rural county. These challenges meant she and her colleagues could ill afford missteps and needed to work with partners with whom she and the public health department could devise and implement policies to quickly achieve mutual goals.

We brought the Fresno CCROPP team up to speed on the impact of the built environment on health, about health disparities, and about which types of policies could be changed at the local level to create healthier environments. The investments of TCE, the Healthy Eating Active Living (HEAL) program of Kaiser Permanente’s Community Benefits Department, and of the California Department of Public Health allowed experts from ChangeLab Solutions and other organizations—including the Local Government Commission (LGC), the California Center for Public Health Advocacy (CCPHA), the Prevention Institute, and PolicyLink—to come in regularly and train the group on a range of subjects. ChangeLab Solutions staff was also on call to answer Rosemarie’s questions and to develop solutions to the problems she and her colleagues wanted to overcome.

The first big action we took together was drafting language to rewrite a subsection of Fresno’s Municipal Code that banned farmers’ markets. The fact that this ban existed in the largest town of the country’s most productive agricultural county seemed

like an obvious policy change target. In 2008, Fresno adopted a municipal ordinance that amended local zoning codes to include the new language and, at last, allowed farmers' markets to operate. With that success behind her, Rosemarie and her partners turned their focus to the city's neighborhoods.

The HEAL grants the CCROPP team received from Kaiser Permanente helped it build links to community organizations, and Rosemarie and her team decided to develop a relationship with the Burroughs Neighborhood Committee. Rosemarie had given a presentation about the connection between the built environment and poor health conditions in the neighborhood to parents at the Burroughs Elementary School who subsequently comprised the committee. The parents identified changes they wanted the public health department to help make.

Rosemarie noted that it took awhile for the neighborhood to trust the public health department. However, Rosemarie, the public health department, and their partners started building that trust by holding a Spanish-language workshop for the neighborhoods. This effort, which was led by LGC, won over many of the Spanish-speaking residents—traditionally they had felt excluded from the decisions others made about their neighborhood, but, this time, they had the rare opportunity to make decisions themselves.

After the community members identified things they wanted to change, some of them were invited to make a co-presentation to the city council with Dr. Ed Moreno, the director of the Fresno County Department of Public Health. The city council started to make changes after hearing what the neighborhood wanted.

The first change the city council made was to get the transit agency to install bus shelters at bus stops. Fresno can get extremely hot, and bus riders need a shaded waiting area. This simple change energized the community. Next, the public health department got the public works department to repaint all the faded crosswalks in the neighborhood.

Eventually, Rosemarie and others were able to get a joint use agreement signed among the Burroughs Elementary School, the Burroughs Neighborhood

Committee, and the Fresno Unified School District to open school recreational facilities to the community on evenings and weekends. This more sophisticated step would never have been successful if Rosemarie and her team had not laid that earlier groundwork by taking simpler steps toward building more health into the Fresno community. Rosemarie herself also was appointed to be a member of the Fulton Corridor Specific Plan Advisory Committee in downtown Fresno, a first for a staff member of the public health department.

San Diego

At the same time that HEAC and CCROPP were catalyzing change in Fresno, the San Diego Department of Public Health issued a request for proposals for an organization to help write a countywide plan for reducing rates of childhood obesity. The idea for this plan was hatched by two county supervisors, Pam Slater-Price and Ron Roberts, who convinced the San Diego County Board of Supervisors to vote in 2004 "to support the creation, coordination and implementation of a Childhood Obesity Master Plan to end childhood obesity" in San Diego County (p. 2). One of the organizations that was awarded that contract was the San Diego County Childhood Health Improvement Partnership. In 2006, a public-private partnership started working on creating a comprehensive countywide approach to dealing with childhood obesity.

The first version of the plan, published in 2006, was the state's first comprehensive countywide plan to address obesity. As Cheryl Moder, the director of the San Diego Childhood Obesity Initiative noted, this plan also represented the first official recognition in San Diego that infrastructure, land use planning, affordable housing, and transportation policy were all having a significant effect on childhood obesity levels in the county and would have to be addressed to bring childhood obesity levels down.

As with Fresno, San Diego's efforts were supported by Kaiser Permanente's Community Benefits Program, TCE, and others that funded the city's Public Health Department to help it create environments where healthy eating and physical activity were easier to achieve. They also funded ChangeLab Solutions and others to build local knowledge and policy change capacity in San Diego.

Cheryl and her colleagues in San Diego started from a very different place than Rosemarie and her colleagues in Fresno. With such strong support and backing from the county board of supervisors, Cheryl and others were empowered to begin with a more expansive vision than Rosemarie was able to attempt. In San Diego, the list of policy accomplishments of the Childhood Obesity Initiative is long and impressive. Since the adoption of the county-wide childhood obesity action plan in 2007, these health-related policies have been adopted by public sector organizations in San Diego County:

- The City of San Diego passed an Urban Garden Policy and revised ordinances on healthy retail and ownership of bees and chickens.
- The City of Encinitas included a health element in its general plan.
- The City of La Mesa made it easy for people to keep chickens on residential properties and added a health and recreation element to its general plan.
- The San Diego Unified School district passed a resolution to explore community gardens on school property.
- The San Diego Unified School District drafted a shared use license agreement for one pilot at Montgomery Middle School.
- The San Diego Unified School District permitted Springall Academy (a charter school leased from the school district) to enter into a community garden lease agreement with San Carlos United Methodist Church.
- The San Ysidro Unified School District passed a resolution allowing district schools to begin to develop their garden projects.
- The City of La Mesa approved a shared use agreement with Grossmont Union High School District. Although the high school district did not approve the policy, the policy's wording is being used elsewhere.

To accomplish all of this, Cheryl and her staff, like Rosemarie and her colleagues, had to build partnerships with community members, public health advocates, and policy makers across a range of organizations. Because childhood obesity is an issue of concern to so many organizations, Cheryl has been able to get many partners to work together. In doing so, she has made sure to remain neutral and inclusive—not turning any potential partners

away and ensuring a safe venue where people can have honest conversations and build the sorts of relationships and trust needed for successful multi-organizational collaborations.

Riding on this proven policy success, San Diego County's public health department applied for and was awarded a \$32 million Communities Putting People to Work grant from the Centers for Disease Control and Prevention in 2009. The health department wanted to use the funding to enact strategies to reverse the childhood obesity epidemic and prevent/reduce tobacco use, and \$16.1 million was directed at anti-obesity efforts. This was the largest anti-obesity grant given to any county in the country.

Institutionalizing Change

Although a tally of approved policies is one measure of success, there is more to the story of what has taken place in Fresno and San Diego. It is also important to look at the other outcomes of our engagement with the dedicated partners in the communities in which ChangeLab Solutions works.

Helping Partnerships, Collaboration, and Organizational Alignment Grow

ChangeLab Solutions links our technical assistance recipients with other key individuals and groups to enhance their efforts. In many cases, the organizations that we work with have little experience working with each other before we become engaged. With our technical support, new relationships are fostered and common vision, goals, and actions are developed.

Helping New Advocates and Champions Emerge

Through training, ongoing technical support, and the creation of targeted technical assistance materials, ChangeLab Solutions helps advocates and champions take the lead in the local policy development process.

Crafting Salient Messages and Written Products to Address Local Issues

ChangeLab Solutions crafts salient and concrete technical language for use in ordinances,

agreements, responses to legal questions, and proposals. Among the most useful to communities over the years have been these articles and toolkits (see <http://changelabsolutions.org/>):

- “Opening School Grounds to the Community After Hours: A Toolkit on Joint Use”
- “How to Create and Implement Healthy General Plans”
- “Healthy Planning Policies: A Compendium from California General Plans”
- “Seeding the City: Land Use Policies to Promote Urban Agriculture”
- “Getting Involved in Redevelopment: Strategies for Public Health Advocates”
- “How to Use Redevelopment to Create Healthier Communities”
- “How to Use Economic Development Resources to Improve Access to Healthy Food”

Developing the Organizational Capacity of Partner Agencies

Perhaps most important, and most challenging over the long term, is how we develop the organizational capacity of partner agencies. Although relationships have been built, trust has been earned, and policies have been adopted, those successes have to be institutionalized and built on as those agencies proceed with further work.

When asked how she was so successful in Burroughs, Rosemarie identified these key steps:

- Identifying community challenges
- Helping the community figure out intervention strategies
- Inviting those who can help to come and meet with the community so the community can put faces to names and build relationships

- Starting with simple interventions and then getting more sophisticated over time
- Staying in touch and delivering on promises

That last step is going to be the most difficult, particularly as long-term financial support for efforts like these remains difficult to secure in an era of public sector cutbacks. As Cheryl noted, “Policy adoption doesn’t just happen. It has to be driven by an organization that is skilled at moving people and organizations forward.”

Cheryl refers to such organizations as “backbone organizations” and building and sustaining them is the key to institutionalizing policy change in communities. In addition to the aforementioned need for long-term financial support, building and sustaining backbone organizations requires skilled leadership and supportive partnerships. This last part is the role that ChangeLab Solutions plays. By working with partner organization over the long haul and by providing ongoing legal and policy technical assistance, ChangeLab Solutions helps people like Cheryl and Rosemarie stay at the forefront of the community-based policy change process and continue to work to create places where the healthy choice is an easier one to make.

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Robert Ogilvie serves as the vice president for strategic engagement at ChangeLab Solutions. Over the past twenty years he has worked extensively in community development and planning to help improve low- and middle-income neighborhoods.

Communities of Excellence 2026

BY LOWELL KRUSE
AND RICK NORLING

As we mark the twenty-fifth anniversary of the Healthy Communities movement, we note the great progress toward the movement's ambitious goal of achieving measurable improvements in Americans' health status and quality of life. The anniversary—as well as this special issue of *National Civic Review*—also provides the opportunity for a wide-ranging conversation about the movement's agenda and strategy for continuing that progress.

As the leaders of large health care enterprises, we bore a responsibility to run high-performance organizations. It was a fiscal responsibility but a moral and ethical one too. We met this obligation by bringing to our enterprises the Baldrige Performance Excellence Program, established in the late 1980s as a means to boost U.S. companies' sluggish response to rising economic powerhouses elsewhere in the world, primarily Japan. Originally tailored to manufacturing, in the 1990s the Baldrige criteria were adapted for enterprises in the health care and education sectors.

The Baldrige program helps companies examine their practices, benchmark results against the best performers, and map out and execute changes needed to operate leaner, faster, and better, focusing sharply on customers' needs and expectations and following decisions and strategies based on fact.

Achievement of performance excellence based on the Baldrige criteria is a journey—for most, a journey of many years—and is recognized by the Baldrige Award, given annually by the president of the United States to organizations that have demonstrated performance excellence. Winners have included such respected companies as FedEx, IBM, Nestlé Purina Pet Care, Texas Instruments, Ritz-Carlton Hotels, and divisions of Boeing, Cargill, Merrill Lynch, and Xerox.

Our own organizations, Premier, Inc., the largest health care alliance in the country, based in Charlotte, North Carolina, and Heartland Health, an integrated health delivery system based in St. Joseph, Missouri, received the Baldrige Award in 2006 and 2009, respectively. Building Baldrige Award-worthy

organizations reinforced our belief that the health of communities transcends their health care institutions, meaning that to succeed, those institutions must meaningfully engage in their communities.

The Baldrige criteria helped us to achieve this in the organizations we led, and we believe the criteria can be adapted to provide the same for communities—an idea that a team of Baldrige experts from across the nation has endorsed. A systematic, Baldrige-like approach to performance excellence can instill in communities a long-term commitment to harvest best practices, collect and act on performance data, promote collaborative leadership, and continuously improve processes across sectors, generations, and organizations.

Communities of Excellence 2026

That belief leads us to propose a new way for American communities to address the challenges they face in health status and the closely related social determinants of health status—educational attainment and economic well-being. It is an initiative called Communities of Excellence 2026—in anticipation of the 250th anniversary of our nation's founding—that will help communities discover and implement fundamentally new and permanent solutions to these challenges using the model of collaborative leadership and performance excellence already proven to work by some of the nation's leading enterprises.

Communities of Excellence 2026 is adapting the Baldrige criteria and incorporating the Healthy Communities movement's Seven Patterns of Successful Communities to create a framework for community performance excellence, a road map for communities that choose to confront their challenges by adopting a proven course of action that demands high performance and a commitment to achieve and sustain the highest quality of life for their people.

Focused initially on community collaboration and performance excellence in the critical and elaborately interrelated sectors of health, education, and

economic vitality, Communities of Excellence 2026 was established to provide the training, skill building, research, knowledge of best practices, and the coaching resources communities need to engender collaboration across sectors. Communities of Excellence 2026 will help communities outline a baseline of performance, determine assets and challenges, establish community criteria for quality and community goals, and measure progress and enact practices for sustainability. Communities of Excellence 2026 will also facilitate communities learning from each other.

Communities of Excellence 2026 will help communities outline a baseline of performance, determine assets and challenges, establish community criteria for quality and community goals, and measure progress and enact practices for sustainability.

Why the focus on communities? Because despite the importance of federal and state policies and practices, we advance the common good most effectively and durably when we work together in a local community to identify, implement, and sustain improvements that work for that community. Implementing a Baldrige-like standard of community performance excellence will not be easy; unlike the organizations that have successfully adopted the Baldrige criteria, no community has a single broker or agent that can establish new practices and habits. And communities often are more diverse, with more complex cultures, than individual organizations like businesses, schools, hospitals, and others.

The framework of community performance excellence will enable diverse interests and broadly inclusive leadership to formulate and act on a shared community identity and vision. In doing so over the coming decades, such communities will form a growing archipelago across the nation where community performance excellence is achieved and sustained. These will be communities pursuing collaborative strategic plans aimed at achieving bold goals—and measuring progress in ways that both prioritize and inspire further action. They will be communities that consistently outperform others in the nation, and their success will meaningfully influ-

ence others across the country to strive for community performance excellence.

The Path Ahead

The work of implementing the community performance excellence framework will be difficult. We are grateful to our two pilot communities—Rochester, Minnesota, and Northwest Missouri—that will help to test, refine, and perfect the framework. The experiences and first outcomes of the pilot communities will become the foundation upon which Communities of Excellence 2026 will reach out to and engage a second generation of communities to adopt and implement the community performance excellence model.

Americans have a long history of working to make things better. That energy, ardor, and passion are as robust today as ever before. We celebrate this spirit and applaud the efforts of leaders and communities nationwide. To make good the promise of that spirit, we propose a new model of community performance excellence, and we established a nonprofit organization—Communities of Excellence 2026—to help communities achieve it.

As leaders of health care enterprises, we know that health status is inextricably interwoven with educational attainment and economic prosperity. We know that America can again lead the world in these measures of well-being—but only when communities nurture a culture of collaborative leadership across sectors and generations. Only when they commit to continuous improvement everywhere and root their decisions and strategies in fact. Only when they are willing to leave no one behind.

And the work of communities must be to encompass the diverse interests of all residents, to insist on performance excellence, and to coalesce to identify and implement solutions to common problems. In doing so, American communities will continue building on the foundation of democracy and liberty established by our nation's founders.

Lowell Kruse was chief executive officer of Heartland Health, St. Joseph, Missouri, from 1984 to 2009.

Rick Norling was chief executive officer of Premier, Inc., Charlotte, North Carolina, from 1997 to 2009.

Preventing Urban Violence to Save Lives and Foster Healthy Communities

BY RACHEL A. DAVIS

Violence undermines the community experience and is a terrible burden on young people, families, and neighborhoods. US Bureau of Justice statistics reveal, for example, that more than 1.3 million people ages twelve to twenty-four were victims of assault in 2010. Violence disproportionately affects young people of color; the US Centers for Disease Control and Prevention (CDC) found that among African Americans, Hispanics, and Native Americans, homicide is a leading cause of death for youth ten to twenty-four years old. In addition to the devastation that the loss of community members and loved ones yields, violence deeply influences a community's reputation and economic climate. The failure to prevent violence is costly to taxpayers, necessitating large outlays for law enforcement, medical care, criminal justice, mental health care, and social services. Violence also reduces neighborhood business activity, home and property values, and tourism. Conversely, reducing violence is an effective way to stimulate economic development and enhances a community's ability to thrive. Safe communities are key to improved education, housing, and economic opportunities and to reducing associated health problems, such as diabetes, heart disease, asthma, and depression.

Historically, violence has been viewed as either an inevitable aspect of the human condition or as a criminal justice issue. In 2008, Billie Weiss's *Assessment of Youth Violence Prevention Activities in U.S. Cities* confirmed that law enforcement and criminal justice were the most prevalent strategy, and few cities reported using primary prevention to stop violence before it occurs. The tide is shifting. As city and law enforcement leaders are acknowledging that we cannot "arrest our way out of this," the public health model is being recognized as a viable approach that is complementary to criminal justice efforts. UNITY (Urban Networks to Increase Thriving Youth) is an initiative funded by the CDC to advance

a public health approach to address violence affecting youth in large US cities. While cities continue to experience a range of violence problems, especially firearm and gang violence, many are now taking a fundamentally different approach to addressing the problem by focusing on it as a public health issue rather than purely a criminal justice problem. Consequently, cities are shifting toward prevention strategies and not solely relying on intervention or suppression methods.

The public health approach emphasizes the prevention of violence *before* it occurs and fosters strategies that address the safety of the entire community, as opposed to one individual at a time. To accomplish this, strategies address risk and resilience factors at individual, family, community, and societal levels. Risk factors are conditions or characteristics that increase the likelihood that violence will occur (e.g., alcohol use, availability of weapons, academic failure, and poverty). Resilience factors are characteristics that are protective against the likelihood of violence (e.g., positive adult-youth relationships, neighborhood cohesion, and economic opportunity), even when risk factors are present.

Public health-based strategies are preventing violence. Examples include:

- The Cure Violence model has reduced shootings and killings by 41 to 73 percent and retaliation murders by 100 percent, and promoted norm changes in communities. Baltimore's replication program, Safe Streets, reduced overall gun violence and also reduced nonfatal shootings by 44 percent and homicides by 56 percent.
- Communities That Care has reduced crime committed by youth by 33 percent by reducing risk factors and promoting resilience through a coalition-based system.

- Neighborhoods with Business Improvement Districts saw a reduction in all violent crime by 8 percent and robbery by up to 27 percent.
- Universal school-based violence prevention strategies can reduce violence by 15 percent in six months. Beyond individual programs, communities need strategy and coordination across multiple sectors. In the UNITY Assessment, cities with the greatest coordinated approach also had the lowest rates of violence affecting youth. The Prevention Institute's UNITY RoadMap (2008) identifies the essential elements that communities can put in place. It describes the *who* (high-level leadership, community engagement, staffing/coordination), *what* (prevention strategies, communication, training), and *how* (strategic plans, data and evaluation, adequate funding) to effectively prevent violence and sustain efforts.

Minneapolis is one locale where these elements have come together. In 2006, the city implemented a public health-based blueprint: (1) connect every young person to a trusted adult; (2) intervene at the first sign of at-risk behavior; (3) restore youth who have gone down the wrong path; and (4) unlearn the culture of violence. Over the next two years, Minneapolis saw a substantial drop in juvenile crime in its most violent neighborhoods. Following this success, the plan was expanded to the twenty-two neighborhoods most impacted by violence in 2009. Homicides of youth decreased by 77 percent over three years, and in 2010 the number of people under 18 years old either suspected or arrested for violent crime dropped to the lowest it had been in a decade.

Violence is a leading cause of injury, disability, and premature death. Further, it shapes and defines communities and is detrimental to achieving a healthy

community. Consequently, preventing violence is essential to promoting thriving, healthy communities. It facilitates community cohesion and participation, fosters neighborhood improvements, and encourages employment and educational opportunities. As communities focus on implementing effective strategies and coordinated approaches, they will become safer and healthier. As Lieutenant Michael Sullivan of the Minneapolis Police Department explained in an interview with the author, "The public health approach works. It's working right here in my city where we reduced violence by 40 percent in just two years, and then brought it down another 20 percent. We didn't do it by increasing arrests. We did it by giving young people opportunities to thrive."

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Rachel A. Davis is managing director of the Prevention Institute.

Community-Centered Health Homes Engaging Health Care in Building Healthy Communities

BY LESLIE MIKKELSEN,
LARRY COHEN,
AND SONYA FRANKOWSKI

In Oakland, California, a comprehensive community clinic called Asian Health Services initiated a campaign to prevent traffic-related injuries after an elderly community member was hit and killed by a car. Youth from the clinic's leadership program conducted research, including mapping of crash locations and photo documentation of pedestrian-vehicle conflicts, such as autos blocking crosswalks or turning in front of pedestrians. They presented their findings to the city council, and their local council member used these data to secure funding from the Caltrans Environmental Justice grant program to plan street improvements. This led to the implementation of a pedestrian scramble (all traffic is completely stopped during a red light, and pedestrians are able to cross the street in any direction, including diagonally) in a few key intersections, which reduced conflicts by nearly 50 percent, ultimately reducing risks for death and injuries.

This example illustrates the value of health care/community partnerships. Asian Health Services played a critical role in bringing a very important medical condition—traffic-related injuries and fatalities—to the attention of city leaders. The solution to prevent these injuries was designed in partnership with the Oakland Chinatown Chamber of Commerce, the Oakland Pedestrian Safety Project, City of Oakland council members, and the city's public works staff. The potential Healthy Communities benefits are far-reaching. Health and quality of life benefit through the prevention of devastating injuries and fatalities. Also, safer streets encourage more pedestrians; higher rates of walking help prevent and control diabetes, cardiovascular problems, and other chronic diseases; and economic benefits result from a reduced demand for high-cost trauma and rehabilitative care, lower need for police services, and greater patronage of local retail and services.

Envisioning a Community-Centered Health Home

Conversations with Asian Health Services and other medical care organizations that regularly step outside their clinic walls to find solutions to health problems inspired the Prevention Institute to describe a coordinated set of practices to systematically connect medical institutions to broader community-level environmental change that we call community-centered health homes (CCHHs). This concept intentionally expands on the related emphasis of the Affordable Care Act on medical homes (better care coordination at an individual patient level) to describe practices that can link the medical system with community action to address the underlying determinants of illness and injury to improve the health of an entire community. The model builds on pioneering work in community-oriented primary care at the heart of the establishment of the nation's first community health centers in high-poverty communities in the 1960s.

A CCHH not only acknowledges that factors outside the health care system affect patient health outcomes but also actively participates in improving those factors in order to improve health and safety for all residents. The defining attribute of the CCHH is translating high-priority medical conditions into active involvement in community advocacy and change. In recent years, as practitioners look to heighten their impact on their patients' well-being, more and more health care providers and institutions have moved closer to this model, although they still remain a distinct innovative minority. The CCHH provides high-quality health care services while also applying diagnostic and critical thinking skills to the underlying factors that shape patterns of injury and illness. By strategically engaging in efforts to improve community environments, CCHHs can improve the health and safety of their patient population, improve

health equity, and reduce the need for medical treatment.

The defining attribute of the CCHH is translating high-priority medical conditions into active involvement in community advocacy and change.

On the health care side, the skills needed to engage in community change efforts are closely aligned with the problem-solving skills providers currently employ to address individual health needs. It is a matter of applying these skills to communities. Specifically, with patients, practitioners follow a three-part process: collecting data (symptoms, vital signs, tests, etc.), diagnosing the problem, and undertaking a treatment plan. The CCHH functions in a parallel manner by developing capacity and expertise to follow such a three-part process for addressing the health of the community, classified as *inquiry*, *analysis*, and *action*.

For example, this approach is being applied to prevention of childhood asthma attacks in Cincinnati, Ohio. Nearly all children under twelve who need emergency asthma care in Hamilton County end up at Cincinnati Children's Hospital Medical Center. During inquiry, Cincinnati Children's Hospital Community Health Initiative staff mapped the addresses of patients and identified geographic clusters of these children in the metropolitan area. Through analysis, the hospital, working with the Cincinnati Health Department and the city's building department, found overlapping clusters of building code violations correlating with patients' residences. Based on the strong evidence linking poor-quality housing to asthma morbidity, the hospital partnered with the Legal Aid Society of Greater Cincinnati to take action to pressure landlords to improve the housing conditions and ensure that asthma triggers were addressed. Efforts ultimately revealed nineteen buildings in disrepair all owned by a single landlord. Through this experience, the following practice has been institutionalized: The electronic health record template prompts hospital staff members to ask about the housing conditions of any patient admitted for asthma-related complications. This allows researchers to identify emerging hot spots and to

develop effective prevention and remediation strategies. A formal relationship between Children's Hospital and the Cincinnati Health Department allows doctors and families on the inpatient unit to initiate home inspections. A second partnership with the Legal Aid Society ensures that housing violations can be addressed.

Creating a Health System: Integrating Health Care and Healthy Communities

It seems fitting to be celebrating the anniversary of healthy communities at the same time the United States is reaching major milestones in the implementation of health reform. Both herald major changes in US approaches to health, and effectively integrating medical care reform with Healthy Communities efforts can be truly transformational. After twenty-five years, Healthy Communities approaches have helped catalyze a new way of thinking. New approaches and resources are emerging. There is widespread recognition that many of the chronic diseases and injuries accounting for more than 75 percent of the nation's increase in medical care expenditures are preventable through attention to such underlying determinants. Research has identified underlying community determinants linked to many preventable conditions, and these community factors explain inequities experienced in communities of color and low income. The National Prevention Strategy, an important element of the Affordable Care Act, engages virtually every key government sector, from transportation to housing to agriculture, in advancing community health. Community-level prevention efforts, including community transformation grants, are now an integral component of health reform, signaling the recognition that the burden on the health system, and its inequities, can be reduced by better aligning resources to address the factors that shape health and safety outcomes. This alignment alleviates the frustration of clinicians who feel powerless to change the social circumstances that shape the health of their patients. Through community transformation grants and other HCC efforts, private and government funded, a strong set of organizational practices and public policies have emerged that can be employed to change community environments and advance equity.

We have a singular opportunity to re-envision our national approach to health and shape a quality health system that meets the needs of all. The health and well-being of individuals depend on both quality coordinated health care services and community conditions that support health and safety. This coordinated thrust will produce the most effective, sustainable, and affordable health solutions, and simultaneously advance community health—a fitting opportunity for a twenty-fifth anniversary.

Leslie Mikkelsen is managing director of the Prevention Institute.

Larry Cohen is founder and executive director of the Prevention Institute.

Sonya Frankowski is completing her master's of public administration in health policy at New York University's Robert F. Wagner Graduate School of Public Service.

Public Policy Transforms When Health Expertise and the Public Come Together

BY MARTY KEARNS
AND ELIZABETH BROTHERTON-BUNCH

Public health is a discipline that focuses on improving the lives of individuals by changing public policy and social norms. Those working in public health space are motivated by science that finds certain behaviors and policies cause people to be sick. But even the most convincing science is not enough to create real, lasting change. The most effective and transformative public health work also rallies people to act on the scientific evidence. Public health leaders must rely on grassroots support to achieve their goals and create a healthier world.

At Netcentric Campaigns, we regularly work on evidence-based public health projects that rely on both scientific data and grassroots and social media support to achieve change. This article discusses a few important lessons we have learned about grassroots advocacy in the age of connectivity.

Policy Makers Expect Public Support for Important Policy Change

Public health is dominated by policy experts and scientific researchers, and for good reason. In order to make the policy and environmental changes needed to advance health, advocates must be backed by sound science and clear reason. But public health advocates also need the backing of the public and often rely on social media and grassroots mobilizing to build support.

To be successful, advocates need to know their audience and then figure out how to reach and engage them.

For example, public health advocates worked for years to convince the Board of Health in Allegheny County, Pennsylvania, to pass stronger air quality guidelines. They talked with policy makers, they nailed down their facts. As time went on, the science driving their push to establish guidelines only became stronger.

But the advocates kept hitting roadblocks. What they needed to do was make an impact.

In the weeks before the Board of Health was scheduled to vote on the guidelines in 2012, Netcentric Campaigns worked with the public health advocates to circulate an online petition to gather signatures from local residents who supported the proposed guidelines. More than eight hundred people affected by the county's air quality signed on.

The day of the hearing finally came. As the board began work on the guidelines, an advocate walked up and dumped more than eight hundred surgical masks across the hearing table. Each mask had the name of a local petition signer on it, representing someone whose health was negatively impacted by air pollution—and whose life would be improved if the new guidelines were passed.

It was a powerful visual. The story was even picked up on local news. Yet the board still opted to defer the vote.

But that only motivated the advocates to work harder to gather grassroots support. They continued to gather signatures and urged their newly recruited supporters to keep pressuring the board.

In November 2012, the scientific evidence and outcry of the public finally drove the Allegheny County Board of Health to pass stronger air quality guidelines.

Building Public Support Requires a Disciplined Approach to Grassroots Work

Achieving grassroots success in the public health space is not as simple as gathering a couple hundred signatures, however. It is important to know how the grassroots works.

There are essentially two kinds of people working in the advocacy space: organizers and mobilizers. Both are needed to achieve success.

There are essentially two kinds of people working in the advocacy space: organizers and mobilizers.

Organizers bring people together and create community among the people they gather. They are the folks who hand out flyers, canvass door to door, and organize meetings at local recreation centers. Their mission is to create community among neighbors and elevate the needs of the community, and then work alongside the community to address those needs. Mobilizers, meanwhile, aim to attract participation as part of a larger advocacy campaign, offering potential participants an inspiring set of goals set by others, along with a clear way to help achieve those goals.

Although they operate differently, both organizers and mobilizers are essential for advocacy. Public health history is full of stories of both types of grassroots success. Organizers have the pulse of the needs of communities, while mobilizers can generate the mass support that often is needed to move an issue forward.

Engagement Strategy Should Dictate Use of Social Media

Social media can be overwhelming. Fit your message into 140 characters on Twitter! Use pictures on Pinterest! Do both on Facebook! But the basic approach to public health advocacy is not different in the age of connectivity. Although the way to listen and deliver the message has changed, the overall goal remains the same: help people to take action to support a useful shift in policy. In order to successfully merge social media and grassroots advocacy, it is important to function as both an organizer and a mobilizer.

An organizer needs to scale the way a community working on an issue comes to know each other. Public health organizers can leverage social media to listen loudly and gather lots of community input into a discussion of health policy and better understand

the concerns of people to shape communications and policy on public health data and determine how to deploy public health resources. Organizers can be both big and small—or in one example, massive. Google helps the Centers for Disease Control and Prevention (CDC) listen as an organizer with its Flu Trends tool. Flu Trends aggregates Google search inquiries to make pretty accurate predictions about flu activity. So, when there's an uptick in searches for "flu" in a region, Google compares those searches with traditional flu surveillance systems and can provide predictions of where, and how severely, the flu might strike. The CDC can then warn doctors and help regions prepare for the impact of the outbreak.

Public health advocates without access to Google's resources also can utilize social media to function as organizers. When childhood obesity advocates wanted to spread the word about the importance of healthy school snacks and beverages in spring 2013, they held weekly Tweet chats using the #Food-Fri hashtag. During the chats, experts responded to questions with information as to why improved nutrition standards for school snacks are so vital for kids' health, and members of the public had an easy way to join the conversation.

Public health mobilizers, meanwhile, often use social media to scale an advocacy campaign. Petition-based Web sites, such as Change.org and Care2, allow users to mobilize significant public support for an advocacy effort in a centralized place. Meanwhile, utilizing Twitter, Facebook, Pinterest, and other channels to broadcast messages that include specific calls to action can generate additional public support.

In summer 2012, mobilizers turned to social media to boost support for the plan of New York City's mayor, Michael Bloomberg, to limit the size of sugary drinks sold in many city venues to sixteen ounces. Bloomberg's proposal had generated major backlash from the restaurant and beverage industries, and the public health community needed to send messages of support for the plan to the city's Board of Health. Working with a New York-based leader from our PreventObesity.net network, Net-centric Campaigns utilized Change.org, Twitter, and Facebook and generated roughly 25,000 messages of support.

PreventObesity.net is a unique advocacy network that functions in both the organizing and mobilizing role. For example, a weekly newsletter serves to connect the network's more than 3,200 advocacy leaders, who also regularly interact with one another at conferences and other events. Meanwhile, those leaders are able to access a grassroots supporter e-mail list of more than 300,000 people to mobilize public support for specific, large-scale campaigns.

In 2013, the US Department of Agriculture (USDA) unveiled proposed nutritional guidelines for snacks and drinks sold in schools and opened a sixty-day public comment period to gather feedback. Health experts considered these guidelines crucial to the effort to reduce childhood obesity rates, as students consume up to half of their daily calories at school.

Organizers and mobilizers needed to work together to ensure the USDA would take the next step and implement the guidelines.

In this case, the organizers were the public health experts who had spent decades lobbying the federal government to create guidelines for school snacks and beverages. They had the on-the-ground knowl-

edge and scientific expertise needed to advance the issue. However, to ensure it would be successful, those organizers needed the help of mobilizers.

Mobilizers across the childhood obesity movement utilized the power of the online space to send messages to the USDA backing the proposed nutritional guidelines. They posted action alerts and online petitions to gather names and letters of support, spreading the word on social media Web sites such as Twitter, Facebook, Pinterest, and even LinkedIn.

By working together, organizers and mobilizers gathered nearly 250,000 letters of support to send to the USDA. As a result, the USDA announced its interim final rule for school snacks and beverages in June 2013.

Marty Kearns is the founder and president of Netcentric Campaigns, a nonprofit that transforms advocacy for foundations and nonprofits by building networks of people to move change forward.

Elizabeth Brotherton-Bunch is content strategy manager for Netcentric Campaigns.

What Can Federal Officials Do to Support Healthy Communities?

BY REGAN CRUMP

As a federal public health official who has been observing, learning about, and contributing to the Healthy Communities movement since 1998, I am convinced that although we have had mixed results with a variety of challenges, we have made some significant progress. What is most exciting now is the emerging array of opportunities to bring better health to more people at a lower overall cost when we all work together. In this article, I review several examples of alliances that worked, propose a way to overcome some of our perennial challenges, and clarify what can be harnessed to catalyze more meaningful planning, more powerful joint investments, and sustained action for the benefit of the American people. Past experience suggests that continued public sector engagement and a resurgence of our nation's twenty-five-year-old Healthy Communities movement will contribute even more to the prosperity of our nation than many imagine possible.

What Has Worked

In 1998, federal officials in the Department of Health and Human Services (HHS) were deeply involved with the Coalition for Healthier Cities and Communities. I represented the Health Resources and Services Administration (HRSA), along with colleagues from the Office of Disease Prevention and Health Promotion (ODPHP) and the Centers for Disease Control, on the Coordinating Council for the Coalition. The national coalition was an organization composed primarily of private sector leaders, including state affiliates and over a hundred community-based coalitions. The ODPHP developed a publication on healthy communities, the HRSA and CDC purchased and distributed community dialogue guides developed by the coalition, and HRSA awarded a grant to support coalition efforts in public health and brought a number of community-based organizations with grants into healthy community coalitions. Building public-private coalitions that leverage federal, state, and local investments; producing standard- or process-setting publications; conducting train-

ings and practice exchange convenings to support healthy communities—these are strategies that work.

In 1999, a group of managers in the HHS attended training on enlightened leadership led by Doug Krug, author of the books *Enlightened Leadership* (1994, with Ed Oakley) and *The Missing Piece in Leadership* (2012). We learned principles and practices to use in our own signature style to run more effective campaign style meetings, develop bold goals, and enroll six hundred communities in a partnership called the Campaign for 100% Access and 0 Disparities. The practices refined by Dennis Wagner of HHS were simple concepts, such as “framing” to gain participant agreement on using an open “yes and” mind-set as opposed to a “yes but” mind-set during meetings, always harnessing the “Net Forward Energy” in conversations, and acknowledging the power of an “abundance” perspective rather than the stagnation of a scarcity perspective. We agreed to always conduct real work when convening—real work consisting only of making offers, making requests, making commitments, or delivering on commitments. Our campaign approach was to identify communities that were successfully eliminating disparities or increasing access to care without new assets and have them serve as benchmarks, inspiring other communities that wanted to replicate that success in themselves. We used a limited amount of federal funds to orchestrate “performance partnerships” to coordinate the campaign for a set number of communities. Incentivized community groups started by developing a clear but audacious goal (the what), followed by developing broad agreement on “the how.” This approach won the Business Solutions in the Public Interest Award in 2000 through a competition sponsored by the Government Executive, Visa USA, and US Bank. The use of this “signature style” for conducting meetings, enrolling communities in campaigns, setting clear and audacious goals, and use of community benchmarks is a strategy that works.

From 2001 through 2005, the Healthy Communities Access Program (HCAP) was funded by HHS. It provided assistance to communities and consortia of health care providers to develop integrated community health care delivery systems and coordinated health care services for individuals who are uninsured or underinsured. This program spawned 193 healthy community coalitions that provided access to care for over 500,000 uninsured individuals. As the program drew to a close, federal officials and private sector organizations active in the HCAP program met to devise an approach that would sustain the effort with an emphasis on health, wellness, and equity. That led to formation of Communities Joined in Action (CJA). The mission of CJA is to mobilize and assist community health coalitions in their pursuit of better health for all people at less cost. This private, nonprofit membership organization has enrolled nearly 200 community health coalitions, each committed to improving health, improving access to care, and eliminating disparities in their communities. CJA facilitates rapid dissemination of innovations across communities, provides access to technical resources and peer mentors from model communities, and hosts conferences for sharing of best practices. This type of networking, technical assistance, and knowledge transfer function works. For information, go to: <http://cjaonline.net>.

The Federal Health Futures Group is a cadre of aspirational and strategic thinkers from the US Air Force, Army, Navy, Public Health Service, HHS, and the Veterans Health Administration who meet and plan regularly. For several years, they have envisioned strategic approaches to optimal US health twenty to thirty years ahead. By 2012, the group had evolved to include participants from the Office of Personnel Management, the Office of Management and Budget, and several private sector leaders outside the health sector. They began taking proactive steps to realize the optimal future. During an April 30–May 1, 2013 Interagency Health Leadership Roundtable attended by eighty national health sector leaders, there was agreement that health is both a national security issue and a national imperative. Participants agreed to work together on: (1) moving the national conversation from health care to health and wellness; (2) aligning a cohort of meta-leaders in the federal health sector; and (3) promoting healthy eating, physical fitness, and

prevention of substance abuse for all youth in addition to the beneficiary population that each participating organization is responsible for serving. What works is their determination to build a broader health and wellness sector and focus national public attention and effort on the health and prosperity of our nation. We can all aspire to America being the healthiest nation in the world by 2025.

Health is both a national security issue and a national imperative.

Overcoming Challenges and Seizing Opportunities

The Affordable Care Act presents state and local health system leaders and healthy community advocates with one of the greatest opportunities for advancing health and wellness since the advent of Medicare. It also challenges us to overcome the heightened competition and political divisiveness so that public and private sector organizations can leverage social, economic, education, housing, recreation, and health-related resources for healthy communities and a healthier nation.

Collaboration between public and private sector organizations has been challenged by overly cautious interpretation of regulatory limitations, by private sector mistrust of government intentions, and through disruptive changes in policy and organizational position when leaders change. These challenges have been overcome when there was mutual clarification of common goals, unification of political will, and the occasional signed memorandum of understanding.

Coalitions of Healthy Communities have proven very helpful in sharing lessons learned, technology solutions, and the provision of mutual support. They often have struggled with funding because public and philanthropic investors demand tangible results from the coalitions instead of acknowledging the qualitative and quantitative impacts of the individual organizations and local collaboratives these coalitions support. National prosperity demands that the public sector join in sustaining the convening, knowledge transfer, and

mutual support that has served healthy communities so well so far.

Federal and state programs for recreation, nutrition, housing, education, health, and safety have a clear public purpose: to serve the taxpayer citizens of their jurisdictions. In service to our democracy and our people, governments need to align those public purposes with the will and declared need of communities. We cannot afford to use authority, power, and position in a way that separates government from communities and the people. Realizing that our purpose as government officials is to use the resources entrusted to our care for bettering the life, liberty, happiness, and health of the American people requires a closer connection and acceptance of community engagement.

Opportunities to Harness Going Forward

We need to unleash the evolving cadre of collaborative or meta-leaders in the health and wellness sector to build bridges, partnerships, and coalitions and to catalyze the revitalization of the Healthy Communities movement. These leaders are both in government and in the private sector. You can identify collaborative health and wellness meta-leaders by their ability to lead, leverage, negotiate, and drive positive action and population health outcomes across organizational boundaries. We need to support the “Wellness Initiative for the Nation,” which is focused on enabling community success, creating well-being, human flourishing, and national prosperity. Human flourishing as described by the Samuelli Institute is what healthy communities seek for residents. Core components of human flourishing include psychological resilience, social cohesion, optimal nutrition, safe substance use, regular physical exercise, and optimal sleep. The evolving “Wellness Initiative for the Nation” will strive for Aaron Antonovsky’s (1979) “salutogenesis,” an approach focusing on factors that support human health and well-being rather than on factors that cause disease.

Going forward, we need to support and consider how to align healthy community and health equity collaborative networks such as these:

- National Partnership for Action (NPA) to Achieve Health Equity—<http://minorityhealth.hhs.gov/npa/>

- Advancing the Movement—www.advancingthemovement.org
- Communities Joined in Action—www.cjaonline.net

Our country would be well served if everyone reading any article in this special issue were to align forces around a “National Wellness Agenda” built from guidelines and objectives in the National Prevention Strategy, the National Quality Strategy, Healthy People 2020, and the National Stakeholder Strategy of the NPA. Taken together, these documents provide a road map and a scorecard for healthy communities, healthy states, and a healthier nation. We actually can achieve the vision of being the healthiest nation on earth by the year 2020 or 2025 if we collectively commit now, make offers of assistance to like-minded people and organizations, make requests for the resources and policies that are truly needed despite previously perceived boundaries, and simply deliver on all the commitments made to commonly held objectives. Having worked with federal officials in HHS, the Department of Defense, Department of Education, Department of Housing and Urban Development, and now in the Department of Veterans Affairs, I know that the best public service is servant leadership, grounded in our values and American dream, achieved through civic action on clear goals that can be achieved only by working together. There is no better time than now!

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Regan Crump, DrPH, is director, Office of Strategic Planning and Analysis for the Veterans Health Administration, Department of Veterans Affairs.

The Futures of the Healthy Cities and Communities Movement

BY CLEM BEZOLD
AND TREVOR HANCOCK

The Healthy Cities and Communities approach is an exercise in futures thinking; at its best, it asks the deceptively simple question—“What would our city/community be like if it were more healthy?”—and then sets out to answer that question by establishing a vision of a preferred future and working to create that future.

The Healthy Cities and Communities movement around the world brings together local leaders and organizations to pursue better health in their communities. Better health involves equity, sustainability, and participatory governance. It also requires the recognition that, according to the World Health Organization, health, particularly the social determinants of health, is shaped by the distribution of money, power, and resources at global, national, and local levels. The forms that these local efforts have taken over the course of twenty-five years vary widely, as do their funding, duration, focus, and results. Yet as the articles in this issue of the *National Civic Review* reveal, they have done many good and some amazing things in those years. So, what might this movement accomplish in the *next* twenty-five years, and what are some of the challenges and opportunities it might encounter?

In a nutshell, there are four sorts of futures:

1. *The probable future*, what most people and organizations think will likely happen, often described as “business as usual,” in which life continues much as it is, but more so. (However, in some cases, the probable future is seen as more of a gloom-and-doom or even doomsday scenario.)
2. *The possible future*, all the things we can dream of, our flights of fancy, often straining the limits of imagination, even defying the known or accepted laws of physics; think science fiction.
3. *The plausible future*, a narrower zone within the realm of possible futures, more constrained by what we think is reasonable but well beyond what we think is probable. Usually, a set of quite detailed scenarios are developed that range across

the good news, the bad news, the same old news, and some form of transformative change.

4. *The preferable future*, the way we would like the future to be for ourselves and our descendants. Usually it is either one of the plausible scenarios or, more often, a combination of elements from two or more scenarios; our preferences express our values.

In our thirty or more years of working as health futurists, sometimes together, we have focused on these latter two: exploring alternative scenarios of plausible futures and helping people create visions and scenarios describing their preferred future. We use these two approaches because we believe that if people explore and understand some of the forces that shape us and the range of alternative futures we face, they are better able to make choices about their own future and then work to create it. In this article, although somewhat constrained by space, we do the same for the Healthy Cities and Communities movement as a whole.

Major Forces Shaping the Future

One of our guiding principles has always been that the tail does not wag the dog; the health care system in the future, for example, will reflect the society of which it is a part. So, a high-tech society will have a high-tech health care system, while in a declining or collapsing society the health care system will also be declining or collapsing. The same is generally true for the Healthy Cities and Communities movement; it will reflect the state of society, the value that society places on health, the health status of the society and community, and especially the state of cities and local governments. Changes to these parameters over the next few decades constitute the driving forces that the HCC movement will need to address, accommodate to, and, perhaps, shape.

What are the forces that will shape the Healthy Cities and Communities movement? While there is always great uncertainty, especially looking far out

into the future—twenty to thirty years or more—some of the major forces are readily apparent:

- *Societal forces* such as population growth, urbanization and the growth of slums, housing conditions, and food security
- *Economic forces* such as economic growth and inequitable income and wealth distribution
- *Environmental forces* such as climate change and loss of biodiversity
- *Political forces* of concentrated power yet growing participation and disruption
- *Technological forces* including, ultimately, sustainable renewable energy production and storage, smarter Internet, and social media

While many of these effects are negative, cities also represent tremendous opportunities to improve health. They are generators of economic opportunity and sources of innovation and creativity, and their concentration and population density enable them to be generally more environmentally sustainable on a per capita basis and to provide services efficiently. Indeed, it is worth recalling that in many cases—from anti-tobacco laws to sustainability, from taking action on fast foods to participatory budgeting—it is the cities that have led the way, not provincial/state or national governments. Cities often are the incubators of social and political change; they take global thinking and act locally.

Positive trends that we see occurring now in leading cities and that are likely to grow include:

- The realization that “healthy community” efforts can prevent, slow, or at times reverse the increasing prevalence of chronic disease and the epidemic of obesity and their increased costs
- More health-conscious political leadership in communities
- The growing awareness, at least in some sectors, of the importance of equity or fairness, including health equity—healthy community efforts move upstream to shape the social determinants of health
- An understanding of the health implications of unsustainable development
- A broadening of the ideas of participatory democracy, including the use of social media

- Employers and businesses seeking better health conditions for their employees because it makes good business sense

In the United States, some unique developments are worth noting:

- Nonprofit hospitals and health care providers providing support for healthy community efforts, often as part of their required local community benefit contributions.
- Support for HCC efforts by national foundations, such as the Robert Wood Johnson Foundation and the Kellogg Foundation, as well as local foundations, particularly “conversion” foundations (those endowed by the proceeds of the sale when a not-for-profit hospital is sold to or converted to a for-profit entity).

What this all means for cities and for the health of their populations will depend on how cities, their governments, and their citizens respond to these challenges and opportunities. It will also depend on how regional and national governments, the private and nonprofit sectors, and international organizations respond.

Scenarios for the Healthy Communities Movement

In this section, we suggest how cities and the Healthy Cities and Communities movement might respond to a couple of different, plausible—but not preferable—futures. At the end, we discuss how we *hope* it will respond—that is, our vision for a healthier future. We do so by using the aspirational futures approach developed by the Institute for Alternative Futures in the 1980s in conjunction with Trevor Hancock. This approach calls for an “expectable” or “most likely” scenario that extends present trends into the future; a “challenging” scenario that explores some of the things that could “go wrong”; and one or sometimes two “surprisingly successful” or “visionary” scenarios.

Scenario 1: Most Likely/More of the Same: The Healthy Communities Movement Is Getting By

Given the array of negative forces noted earlier, the prospects are not good for the populations of many cities, especially the poor populations and those who live in the cities of low- and middle-income countries. They will continue to face significant

environmental, social, and economic challenges. Yet even in the wealthier countries, cities will face many of these same challenges. Some will manage these challenges well; others will not and may even succumb to them.

Strong political leadership, inspired community action, civic-minded private sector investment, and committed nonprofit, faith, and academic organizations can create pockets of excellence and best practice that others can emulate.

But the good news is that cities can respond effectively to these challenges. Strong political leadership, inspired community action, civic-minded private sector investment, and committed nonprofit, faith, and academic organizations can create pockets of excellence and best practice that others can emulate. Examples abound of empowering and mobilizing communities to create effective community economic and social development initiatives; of developing public policies that favor the disadvantaged by ensuring that basic needs are met for all, that create environmentally sustainable urban development, and that establish supportive environments for health; and of creating meaningful, healthy work that pays a decent wage.

However, in this scenario, these initiatives remain the exception rather than the rule, isolated initiatives born of unique circumstances and special people, beacons of hope, but not taken to scale, not widely disseminated or adopted systematically and supported nationally or by provincial or state governments. In such a situation, the Healthy Cities and Communities movement remains underfunded, somewhat marginalized, and trying hard with very limited capacity to nurture and disseminate the innovations that seem to work or have promise. There is no strong national or international network or organization, so lessons are not easily transferred from one part of the world to another or even from one city to another within the same country.

Scenario 2: What Healthy Communities Movement?

In the face of multiple challenges and crises, cities struggle to maintain even basic services—and many

do not succeed. In the face of this declining capacity, the city fractures into well-off, walled-off communities and the rest; the middle class is essentially hollowed out, and society becomes quite polarized. The poor and the underemployed are kept dependent and subservient and distracted with social media and other means of entertainment (a classic bread-and-circuses approach first perfected by the Romans two thousand years ago). This approach is complemented by a strong authoritarian and repressive regime, including the extensive use of electronic surveillance, that keeps the lid on most social unrest most of the time. Those who can do so, leave—the rich to better places, the poor to the countryside, where they hope to grow their own food, find water, and the like. Moving back is easier in the recently urbanized cities of low- and middle-income countries, where these populations still have some rural connections and related skills. For the long-urbanized underclass in the cities of high-income countries, however, getting out is more difficult, if not impossible.

In such a situation, there is little or no support for a Healthy Cities and Communities approach. If there is, it is largely subverted to be a protective mantle for the rich, aiding and abetting the repression and social control needed to keep the elites safe and healthy. Concern for social and health inequality is minimal, and the last thing the elite want is an empowered and mobilized underclass; they want the underclass pacified and repressed instead. Ecological sustainability is also subverted, conserving resources so they can be used by those who can afford them; they cream off the best while ensuring there are just enough of the poorer-quality resources (food, water, materials) to keep the underclass satisfied.

In such a future, international institutions and networks will be concerned largely with managing crises, preventing massive social unrest, and controlling migration from damaged to less-damaged nations and regions; there will be no appetite for movements such as HCC.

Scenario 3: Surprisingly Successful/Visionary: The Healthy Communities Movement Is Flourishing

National and provincial/state governments around the world catch up with the cities, which have had a strong emphasis on measuring quality of

life rather than economic development. Governance at all levels becomes human-centered and ecologically bound, with the approach being the maximization of human development and social equity within the constraints of natural ecosystems. Local economies move toward self-sufficiency and co-production. Cities adopt the best practices gleaned from the first twenty-five years of experience in the global HCC movement:

- A Healthy City plan created by municipal governments in partnership with private, nongovernmental, faith, academic, and other sectors brought together in a municipal Healthy City Leadership Council.
- A Healthy City Office within city government to support a whole-government approach across municipal government that facilitates health impact assessments and the creation of healthy public policies.
- Support for local Healthy Community/Neighborhood organizations, especially in disadvantaged communities, that bring people together to improve the conditions for health in their own communities.
- Participatory democracy using social media and the crowdsourcing of policy; participatory budgeting is adopted by many communities with regularized input and a growing percentage of citizens taking part.
- As advanced economies transform and many jobs are lost to automation and expert systems, alternative economics emerge that reinforce

healthy communities—these include urban gardening, aeroponic household food production, co-production/time-dollar exchange of time/services, and growth of local and alternative currencies.

In such a context, the Healthy Cities approach becomes central to the governance of cities and of nations. National and provincial/state governments strongly support this approach without imposing it, which would be counter to the entire ethos of the approach. They support and fund the creation of arm’s-length regional, national, and international networks that are often but not always aligned with or part of municipal associations. These well-funded networks act as facilitators, coaches, and knowledge brokers, sharing best practices widely and undertaking evaluation and performance improvement.

Conclusion

We cannot predict the future, nor can we fully control it. However, the future does not just happen to us. We are not victims of the future, but together we are shapers of our own futures. What can we do to make the “preferred future” more likely? The Healthy Cities and Communities movement needs to take a long, hard, realistic look at the future challenges we face, then create a vision—remembering that “Vision is values projected into the future”—and work, along with others whose values and vision are aligned, to create more sustainable, more just, and healthier communities.

Table 1. Proportion of Population Urbanized (2012 and 2014) and Proportion of Urban Population Living in Slums or Informal Settlements

Region	% Urban Population 2012	% Urban Population 2040	% Current/Recent Urban Population in Slums
Global	53	64	36
Latin America	79	85	24
North America	82	87	6
Europe	76	80	6
The Arab World	57	66	n/a
China	52	73	29
Sub-Saharan Africa	37	51	62
India	32	46	29

Sources: World Bank Data—Urban development (2013); United Nations, Department of Economic and Social Affairs, Population Division (2012); WHO and UN Habitat (2010); Urban Trends: 227 Million Escape Slums; Based on UN Habitat data for “developed regions.” Source: WHO and UN Habitat (2010); Millennium Development Goals Database, United Nations Statistics Division; UN Habitat. State of the World’s Cities 2010/2010/2011; Millennium Development Goals Database, United Nations Statistics Division.

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Clem Bezold is chairman and senior futurist of the Institute for Alternative Futures.

Trevor Hancock, one of the founders of the Healthy Cities and Communities movement, is a public health physician and health promotion consultant and currently a professor and senior scholar at the new School of Public Health and Social Policy at the University of Victoria
