

## Note from the Editor

The first major US city to launch a citywide “Healthy Communities” initiative was Boston, Massachusetts. Under the leadership of Health and Hospitals Commissioner Judith Kurland, the city mounted an ambitious, multimillion-dollar effort to break down the silos among health care providers and engage the community in efforts to improve community health in the broad terms.

Between 1991 and 1995, the Healthy Boston initiative funded about twenty-one community-based coalitions willing and able to address a broad range of issues and challenges—everything from crime to the need for English-language courses—identified by the neighborhood activists themselves. Thanks to the initiative, the coordination of services was improved in the neighborhoods that participated. City agencies and other service providers changed the way they delivered services to be more sensitive to the needs of residents.

Healthy Boston also helped develop new local leadership and encouraged civic participation among communities that had been underserved or less vocal in the past. It also provided bridging social capital among groups and individuals in Boston’s diverse but not always inclusive neighborhoods.

For Judith Kurland, the real measure of Healthy Boston was the staying power of the community coalitions it brought into being. “These organizations, many of them, either succeeded or morphed into other things,” she notes, “so the work continued in other organizations or initiatives. People still talk about Health Boston, and lot of the place-based initiatives today had roots in Healthy Boston. Many of them are the same people, different names, but still Healthy Boston. Most people that were active then are still active, and I do think the rich soil of healthy communities is what made the place-based work possible, whether they know it or not.”

Today there are similar efforts to broaden the meaning of health and engage the community in planning and implementing a range of projects in cities, counties, and states all over the country. We explore some of those efforts in two issues of the *National Civic Review* (NCR), this issue and the Spring 2014 issue.

As Tyler Norris writes in his introductory article, “our objective is to celebrate the twenty-five years of Healthy Cities and Communities in the United States by looking at where this widespread movement started, what it has accomplished, how it is expressing itself today as part of a metropolitan and regional revolution, and its unfinished agenda.”

Over the years, the complexity and breadth of the issues raised in local or statewide initiatives have grown. Some specific issues addressed in these efforts—for example, childhood obesity—have reached the level of national media attention. Others—such as

health equity and designing walkable communities—have become central concerns for city planners, foundations, nonprofit groups, community organizations, and, of course, health care providers. Groups as diverse as the YMCA, the United Way, and the National League of Cities have launched successful national efforts.

It is interesting to note, as political leaders in Washington continue to argue and reargue the merits of the Affordable Care Act, Medicare funding, or Medicaid expansion, how much consensus there is out in the community where representatives of the public, private, and nonprofit sectors have come together to address critical health and quality-of-life issues. As Dr. Len Duhl, a pioneer of the Healthy Communities movement in the United States, recently said to guest editor Tyler Norris: “The simple and revolutionary idea is that the focus is on the community as a whole, not the individual or separate programs. The language changes from ‘me and mine’ to ‘we and us.’”

Boston was an important participant in a first wave of large-scale healthy community initiatives, which also included statewide initiatives in California, Colorado, and South Carolina. The leaders of these initiatives met together in national conferences and traded ideas and lessons in a variety of media and forums.

“Being connected to these other people who had already thought about things I was thinking about, who had different experiences who could inform me—it was wonderful,” notes Judith Kurland, who went on to serve as a regional director of the US Department of Health and Human Services. “In those days you could probably count a dozen people that made up the leadership of the healthy communities movement in America.”

The list of leaders keeps growing, but we would like to dedicate these two issues of the *NCR* to three leaders who, like so many others, invested their life in the health of people and place:

John Parr, PhD (1948–2007): Community leader, policy strategist, president of the National Civic League (1986–1995);

Peter R. Lee, MPH (1948–2012): Community advocate, and Healthy Communities leader in South Carolina and Massachusetts;

Antronette K. Yancey, MD, MPH (1957–2013): College basketball star, UCLA public health professor, and founder of “Instant Recess.”

We would also like to thank Kaiser Permanente for its support in making these two special issues of the *NCR* possible.

Michael McGrath  
Editor

# Healthy Communities at Twenty-Five Participatory Democracy and the Prospect for American Renewal

BY TYLER NORRIS

Since the dawn of settled agriculture and the birth of the first cities, such as Ur and Jericho, there has been a yearning to improve the lot of civilization. Enhancing the well-being of people and place is a timeless and perennial quest. Whether examining ancient mosaics that depict the good life in the cradle of civilization or modern community visions drawn with markers on mural paper by residents gathered in today's multisector collaborative partnerships, one can see common patterns in diverse peoples' ideas of what comprises *quality of life*. This recognition can inform ever-better ways to translate personal aspirations for well-being into collective actions for a healthier and more equitably prosperous United States of America.

Over the sweep of history, one can easily spot recurrent themes in the community and civic sphere. These include a quest for human potentiation and the flourishing of mind, body, and spirit; protecting natural systems that perform life-giving services and from which we draw our sustenance; creating vibrant economic systems that leverage comparative advantage, pay living wages, and shape built environments in which we can thrive; and cultivating ever-better systems of governance that can effectively address complex challenges and deliver on the myriad interests of diverse stakeholders.

It is the growing capacity to innovate and successfully solve problems via collaborative action at the local and regional levels—significantly shaped in the past quarter century by the DNA of the Healthy Communities Movement as it spread across America's cities, towns, and regions—that forms the basis for these special issues of the *National Civic Review* (NCR). It is our premise that learning from, and bringing to scale, some of the most effective community-level actions presents the greatest potential for improving the health of people and place and revitalizing participatory democracy in the process.

## Twenty-Fifth Anniversary of Healthy Communities: Two Special Issues

With this, the first of two special issues of the NCR, our objective is to celebrate the twenty-five years of Healthy Cities and Communities in the United States by looking at where this widespread movement started, what it has accomplished, how it is expressing itself today as part of a metropolitan and regional revolution, and its unfinished agenda. In great part, our goal is to examine the learning to date and to spark a renewed dialogue that can inform a better path forward for communities, as the font of positive change for the nation.

These special issues are designed like a hologram, providing multiple diverse views into a complementary whole. To do so, we have included a series of feature articles, case studies, and essays on a range of themes, issues, and questions associated with healthy communities in the United States. We have sought a balance between inspiring community stories, lessons learned, and the latest critical thinking about strategy, practice, theory, measurement, and cost-benefit.

The themes presented are at the heart of addressing what we must do—more important, *who we must be and become*—to ensure a strong and vibrant third American century. The challenges addressed are among the most complex and vexing we face. The strategies highlighted are among the most promising for navigating a good path forward. The articles that follow are at once practical and inspirational, realistic and bold. They pull back the veil on the underlying causes of some of our most pressing problems and worrisome trends. They point to promising ways forward in the form of innovative approaches, collaborative strategies, and investments at local and regional levels that are producing positive outcomes. They address lifestyle and behavioral changes to what we eat and drink and how we manage our stress. They address

organizational, governmental, and community practices and policies—particularly related to the natural, built, food, beverage, and cultural environments—in which human behavior is shaped. They are contextualized in the socioeconomic context of increasing wealth gaps, in a nation that, over the next couple decades, will no longer have a racial majority. They address the leadership that is required to see positive change through to beneficial outcomes.

A few of the articles in these special issues of the *NCR* touch on the roots of the Healthy Communities Movement—now over 3,000 communities strong—from its inspiring starts in the late 1980s with Healthy Boston, California Healthy Cities, and the collaboration between the US Department of Health and Human Services and the National Civic League. They trace the spread of the movement in diverse locales from Anchorage to Burlington and from California’s Central Valley to the bayous of Louisiana. There are three local-level case stories from the heartland of Iowa, Nebraska, and Missouri and three state-level case stories from initiatives in Colorado, California, and Massachusetts. A few articles touch on national networks that were founded to deepen learning, connectivity, and impact, including the Coalition for Healthier Cities and Communities, the Convergence Partnership, Advancing the Movement, Partnership for a Healthier America, Every Body Walk!, and Designed to Move. There are articles from some of the key organizations that have helped build the Healthy Communities Movement, such as Change Lab Solutions, Community Initiatives, Institute for Alternative Futures, IP3 and the Community Commons, Kaiser Permanente, National Civic League, Nike, Policy Link, Prevention Institute, Public Health Institute, United Way Worldwide, and the YMCA of the USA. We also feature articles from three leading government agencies and three leading philanthropies.

The articles are written by a diverse mix of leaders, drawn from diverse settings reflective of the locally driven nature of the movement. Among the authors are grassroots local leaders, organizational executives, elected and appointed leaders, philanthropists, evaluators, policy and subject matter specialists, technologists and conveners of regional and national networks, and those with a global view. The

articles address lifestyle and behavior, environments and settings, practices and policies, innovations and investment. They feature promising strategies to get more people walking, to improve downtown vitality, to increase access to healthy affordable regional foods, to stem violence, to tackle obesity, and to create community-centered health homes.

Underinvestment in disease prevention and health promotion up front creates a societal misallocation in the end.

### A Nation at Risk

Nearly two and a half centuries into the grand American experiment, the declining health status of significant cross sections of the US population is reflective of, and a contributor to, a growing fiscal, moral, and governance crisis that places the entire enterprise at risk. Unhealthy lifestyles and environments, continuing overinvestment in illness treatment capacity, and systemic underinvestment in the determinants of health and well-being for all are exacerbated by a national political and economic milieu whose pervasive pattern is to privatize gain, socialize cost, and underestimate long-term risk.

Illustrative of this unsustainable arrangement is the rapid growth over recent decades of the medical care sector, which at an annual national spend approaching \$3 trillion, consumes nearly one dollar in every five. Of course on an individual level, we all want everything we can to help our loved ones when they are sick. And yet underinvestment in disease prevention and health promotion up front creates a societal misallocation in the end. This allocation, while tied to jobs and profits in the sector that treats illness as well as those businesses that contribute to it, is increasingly making all American products and services more expensive, is leading to a reduction in long-term benefits for the employed and retired, and is crowding out investment in the very factors that produce health in the first place. Fully 75 percent of this illness spending is for treatment of preventable chronic and related diseases, whose primary antidotes are eating better, moving more, eliminating tobacco, and moderating alcohol—and by changing the environments and incentives that

perversely encourage unhealthy behaviors. Further, the whole arrangement (access to high-quality care for those who can afford it notwithstanding), delivers to the United States, on balance, third-rate population and community health outcomes as compared to outcomes in the developed nations with which we compete economically. In life expectancy, for example, the United States ranks thirty-fourth globally, after Cuba and Chile.

This configuration is contributing to a general hollowing-out of our economy, undercutting the American dream, and is failing to position us for a vibrant third century. Over recorded history, scholars note that even the greatest of empires typically begin their demise within 250 years, primarily due to causes of their own making. What will be the legacy that we pass to our children and generations to come? Will our tenure produce results that are worthy of the vision and sacrifice of our founding mothers and fathers? How can we ensure that the needs of our cities and towns and the pragmatic, results-producing work being implemented at the local and regional levels are not ignored or undercut by an increasingly unresponsive and dysfunctional Congress? How do we create *communities of opportunity* that work for everyone?

### A Healthy Community Immune Response

At the same time, the past quarter century has featured the emergence of widely distributed, localized phenomena of thousands of independent, community-based, multisector, collaborative partnerships serving as innovation labs, working systematically to improve the health and vitality of people and place. As if they were part of a healthy immune response to the challenges enumerated earlier, these initiatives are rooted in the finest traditions of American participatory democracy, producing increasingly positive impacts on a series of complex community-level factors that underlay long-term population health and equitable prosperity in the settings where we live, work, learn, play, and receive care. These positive impacts include:

- Access to healthy, fresh, affordable foods and beverages
- More active forms of transportation and daily physical activity

- A disproportionate focus on health equity and social inclusion for those groups with the highest disease burden
- Meaningful access to life potentiation and providing a family wage—via education, skill development, and connection to opportunity both in the emerging knowledge economy and traditional manufacturing

Further, these local and regional efforts are characterized by compelling modes of civic engagement and social innovation that builds social capital such as trust and reciprocity and are guided by *boundary-crossing leadership* working skillfully across lines of politics, perspectives, sectors, issues, jurisdictions, and generations. In our metropolitan areas, these approaches have fueled an urban renaissance that is the engine of growth and resilience.

More recently, these efforts are being connected, fortified, and invested in by forward-looking regional, state, and national organizations and agencies as well as by diverse funders and social investors. They are gaining access to robust data engines and social engagement platforms with geographic information system (GIS) mapping capability and crowdsourcing to help tell stories, target interventions, track outcomes, facilitate peer learning, and build constituencies for action. The credibility and power of these community initiatives is to a great extent derived from the collaborative approach of their participants, which typically include these groups and more:

- Neighborhood and faith-based groups
- Engaged community residents
- Hospitals and health systems
- Local and national businesses
- Chambers of commerce and economic development authorities
- Community-based nonprofit organizations
- Health and social service agencies
- Private philanthropy
- The media

In an era when the state of our democracy and the prospects for equitable prosperity are challenged by toxic partisanship and the influence of powerful vested interests, this rekindling of resident-engaged local democracy rooted in civility and asset-based,

results-producing creativity is welcome. Our nation is well served by studying the approaches, lessons, challenges, and breakthroughs of these diverse initiatives and finding ways to bring their promising strategies and solutions to scale for the benefit of more people. Further, given that these community-based initiatives are thriving in “red, blue, and purple” communities and states and that they serve to build trust and reciprocity between leaders and organizations working across the lines that too-often divide, this body of *work for the common good* presents a powerful force capable of delivering the political will to set good priorities, mobilize diverse assets, change practices and policies, and make the investments that are critical for population health and American renewal.

As the fifty state experiments play out in the years ahead, we will likely find that the most powerful long-term lever for ensuring affordable and equitable access to care for all is to invest first and foremost in the drivers of the determinants of health and the factors that reduce health disparities.

The United States must surely prioritize attention to the causes and consequences of significant “external” threats—ranging from terrorism and embroilment in regional conflicts, to climate change and the demise of natural systems, to global economic and social dislocation—all of which can be seen both as discrete and interrelated issues. But perhaps the greatest assault on our national security is an internal threat: the health of people and place, with its roots, and many workable solutions, right here at home. While this situation presents a significant set of risks, it also contains solutions to our greatest challenges, providing monumental opportunity.

### Health and Health Care Reform

The Patient Protection and Affordable Care Act (ACA) presents a historic opportunity to increase access to affordable quality medical care services, control costs, and improve population health status. Indeed, as the Institute of Medicine (2013) observes, “Public health practice and health care delivery in the United States share a common goal: longer,

healthier lives for all . . . but the notion of quality in the public health system and more broadly in the multi-sectoral health system—public health, health care, and other partners—has received less attention” (1).

Notwithstanding the debates about the merits of the ACA, having made the choice to address the incentives, finance, and delivery of health care services and to expand coverage for more Americans on the supply side of the equation, we are wise to concurrently address the social, cultural, and economic drivers of our ever-sicker population, which will require more care on the demand side of the equation. These are matters of moral and economic significance for the United States. Indeed, as the fifty state experiments play out in the years ahead, we will likely find that the most powerful long-term lever for ensuring affordable and equitable access to care for all is to invest first and foremost in the drivers of the determinants of health and the factors that reduce health disparities. This lever is likely the ultimate contributor to cost containment. Addressing the issues will require moral courage, changes to practices and policies, and investments that may not be as profitable to some beneficiaries of the current status quo.

### Patterns of Progress

As you read the articles in these two special issues, look for these and other common patterns:

- *Boundary-crossing civic leadership.* Despite whatever divides us, that which connects us is greater still. The leaders of the Healthy Communities Movement emerge from diverse backgrounds and are found in every sector. Their most notable commonality is that they tend to be locally focused innovators and boundary crossers who value and engage participation across lines of politics, partisanship, issue, sector, jurisdiction, and generation. The skills and competencies to lead in this manner can be taught and cultivated and are rooted in humility, compassion, and sharing credit. They are antithesis of the polarizing and egoistic partisanship that too often dominates the headlines, divides the nation, and undercuts a sense of civic efficacy. In other words, it is a form of leadership that improves civic engagement and considers it

a worthy pursuit capable of delivering beneficial impacts for the more than the privileged few.

- *Complementary benefits for collective impact.* A good solution solves many problems. The leaders and initiatives with the most widespread and sustainable support and impact over time practice *systems thinking*. They work to coalesce partnerships that align players that may have *divergent* interests and missions around *convergent* strategies (e.g., practices, policies, and investments). As an example, initiatives to get more people walking and to create more walkable communities appeal to very diverse groups, given their potential to prevent disease, promote health, and reduce costs; improve workforce productivity; drive community economic development and local tax revenues; stimulate youth brain development and improve test scores; improve community safety and security; reduce carbon footprint and use of nonrenewable resources; and improve equity of opportunity by providing greater access for all. Solve for walkability, and you solve for many other issues. A walkable city is a resilient city.
- *A blend of art and science.* Ensuring access to accurate and granular data on current realities, trends, and outcomes over time—combined with effective processes for community meaning making, discernment and implementation—must go hand in hand. The use of GIS data engines and mapping tools that power robust community assessments, linked to an ever-expanding evidence base on what works—can realize their full potential only when applied in locales with enough *civic infrastructure* (collaborative skills, effective decision-making processes, and trust relationships) to drive informed action. Strategies that are inadequately informed by data or are forged outside of meaningful civic engagement may provide short-term fixes but can perversely generate a new set of problems to be solved. Further, delivering positive impact at scale over time requires the community will and accountability to act with a “dose-sufficient” approach of reach (population), intensity (strength), and duration (time).

### A Good Way Forward

As you read the articles that follow in these special issues of NCR, I encourage you to join the authors in follow-up dialogue with the National Civic League,

and on the Community Commons—exploring how vibrant, healthy, resilient communities provide more equitable access to the determinants of health and meaningful opportunity for all and, in turn, contribute to a more vibrant and resilient United States of America.

Even as the increasing burden of preventable disease driven to a great extent by community-level factors leads to greater human suffering and financial strain, collaborative work to reverse these ills presents the greatest potential to increase social inclusion, provide equitable access to opportunity, and result in healthier, more joyous lives.

Together, we are capable of taking a longer-term, generational view, just as a family does when raising children. We can apply whole-systems methodologies to understanding and act creatively on the complex array of interrelated, multicausal issues we face. We can examine the prospective impact of proposed policies and investment on the underlying determinants of health and wealth and move beyond short-term fixes that, at best, merely address symptoms of deeper, underlying issues, leaving the core drivers of the problems intact.

The widely distributed Healthy Communities Movement is a rich resource and national treasure. The nature and outcomes of this movement can be learned from and further mobilized to help shape innovative policy and investment approaches while building the transpartisan, transissue, transregional, and transgenerational constituencies that are requisite to their implementation and continuous improvement.

By improving the health status of all Americans, we have an unprecedented opportunity to take the moral high ground, set the stage for a more robust economic future, and revitalize the processes of civic engagement necessary for a healthy democracy. In so doing, we can invest in a health-producing society where people are not treated as mere consumers of services but rather are engaged as coproducers of health, serving as leaders for a healthier culture and healthier environments. At a time when the public debate seeks consensus on strategies for budget cutting and investments that will build the future, the stories and strategies of this movement

and the local-level strategies they have helped generate point to solutions that are creating measurable results and are appealing to persons across political and other lines. This approach increases resilience, reduces long-term risk, and lays the foundation for a vibrant third American century.

At the founding of the National Civic League in 1894, Theodore Roosevelt, a cofounder and future president of the United States, suggested that for our democracy to thrive we must be actors, not merely critics. The Healthy Communities Movement gives all of us, whatever our perspective or walk of life, a way to do so.

## Reference

Institute of Medicine of the National Academies. 2013. "Toward Quality Measures for Population Health and the Leading Health Indicators." *Report Brief* (July 9). <http://www.iom.edu/Reports/2013/Toward-Quality-Measures-for-Population-Health-and-the-Leading-Health-Indicators/Report-Brief.aspx>.

---

*Tyler Norris led consulting services at the National Civic League from 1989 to 1995 and is the guest editor of these special issues of the National Civic Review. He currently serves as vice president, Total Health Partnerships at Kaiser Permanente.*

---

# Place Matters Health and Healthy Communities at Twenty-Five

BY J. MICHAEL MCGINNIS  
AND ELIZABETH L. ROBINSON

**Place matters.** The places we live, work, play, and journey shape our lives in many ways. This is hardly a novel notion. Nearly 2,500 years ago, Hippocrates observed:

When one comes into a city to which he is a stranger, he ought to consider its situation . . . and the mode in which the inhabitants live, and what are their pursuits, whether they are fond of drinking and eating to excess, and given to indolence, or are fond of exercise and labor.

What is a bit more novel—and in many ways an American invention—is the notion that people could be mobilized to engage their challenges collectively. Recall de Tocqueville’s account from his early-nineteenth-century travels throughout America:

Americans of all ages, all stations of life, and all types of disposition are forever forming associations. . . . [I]n democratic countries, knowledge of how to combine is the mother of all other forms of knowledge; on its progress depends that of all the others. (628)

Until relatively recently, rallying community action to improve health has been largely episodic and reactive—responses to epidemics such as plague, cholera, and smallpox—born of fear and often accompanied by stigma, prejudice, and misdirected action. As popular writers in the nineteenth century turned more focused attention to the role of social conditions as threats to the health and well-being of urban-dwelling populations, science, too, began to look more closely. Over the past half century, a still-growing body of research gave resonance to the notion that society and culture influence population health and that broad-based, communitywide initiatives are central to health improvement.

England’s Thomas McKeown, the Rock Carling fellow at the Nuffield Trust, underscored this point dramatically in his 1976 report illustrating that deaths from common infectious diseases in the United Kingdom experienced their greatest declines as a result of improved sanitation and nutrition, long before the development of related antibiotics and vaccines. As scientific studies during the 1950s and 1960s began to uncover startling connections between behaviors—tobacco smoking and diet—and dramatic increases in leading chronic killers—heart disease, stroke, and cancer—the need for communitywide action and grassroots leadership in public health became impossible to ignore.

Voluntary organizations in North America, such as the American Cancer Society, the American Heart Association, the American Lung Association, and the March of Dimes, developed efforts to marshal thousands of local volunteers for action, initially aimed primarily at research and treatment but increasingly emphasizing early detection and prevention. Public policy also responded. In 1972, the US National Institutes of Health launched the National High Blood Pressure Education Program, and in 1974, the Canadian health minister, Marc Lalonde, issued *A New Perspective on the Health of Canadians*, emphasizing that, of the various fields influencing the health of populations, clinical treatment was far from the most important. Lalonde’s report represented a revolutionary perspective on health, positing community wellness as a social obligation: “Good health is the bedrock on which social progress is built. A nation of healthy people can do those things that make life worthwhile, and as the level of health increases so does the potential for happiness” (5).

In the United States, where traditions of grassroots activism and participatory democracy permeate every aspect of culture, the concept of health as foundational to civic life took root as national



policy with the release in 1979 of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. In both content and process, *Healthy People* represented a national call for community action, involving both scientific and community leaders in its development, underscoring throughout its text the feasibility and necessity of community action, and establishing a bold set of ten-year measurable goals as national—not federal—targets for better health for all Americans.

This special issue of the *National Civic Review* (NCR) celebrates that leadership. It celebrates the evolution of a movement that is built on the notion that fundamental health progress derives not from serial responses to individual threats as they arise to the level of public consciousness but from the communitywide social, environmental, and cultural conditions that matter for health promotion, health protection, and the health services needs of every individual. The sponsorship of this issue by the NCR is particularly poignant, as two former presidents of the National Civic League—Christopher Gates and the late John Parr, both protégés of the late John Gardner, former US Secretary of Health, Education and Welfare—contributed so substantially to the marriage of health and civic leadership as tools vital for broad improvement in the human condition.

As Tyler Norris in his article in this issue notes, it has been twenty-five years now since the first healthy city and community initiatives in the United States were formally launched in synergy with the World Health Organization's 1986 initiative for Healthy Cities, which targeted thirty-four European cities for community-based health interventions, and through its first conference on health promotion, fashioned the Ottawa Charter international goals for health promotion.

Here in the United States, the Healthy Communities Movement initially took root among civic organizations and progressive reformers, outside the traditional bounds of the health care community. Organizations such as United Way Worldwide, the YMCA, and the National Civic League saw the ideology of healthy communities as a way to engage a broad range of stakeholders in initiatives for community health and improvement. In 1989,

the Department of Health and Human Services and the National Civic League partnered to launch and spread healthy cities and communities across the nation, building on pacesetter efforts such as California Healthy Cities and, later, Healthy Boston. The Health Forum and the Health Research and Educational Trust of the American Hospital Association mobilized the health care sector to focus more substantively on community health. In the mid-1990s, dozens of partners came together to form the US Coalition for Healthier Cities and Communities—which later merged with the Association for Public Health Improvement—to bring coordination and collaboration to this rapidly growing network of community initiatives.

In an evolutionary progression that continues today, the Healthy Communities Movement gained strength and momentum through fostering connections among local, distributed health projects and the broad range of state, regional, and national stakeholder groups that play a role in community health. In 2004, through the stewardship of Kate Kraft, Active Living by Design was launched by the Robert Wood Johnson Foundation, bringing programs and leaders from the realms of policy and environmental health into contact with the Healthy Communities Movement. This work, in turn, gave rise to the notion that philanthropies could effect more change by coordinating their community efforts, an idea that was formalized through the establishment of the Convergence Partnership in 2006.

In 2010, Advancing the Movement (ATM) closed the loop from local communities to national policy making and philanthropy by working to connect a network of more than 3,000 Healthy Communities projects with funders, policy leaders, and evaluators working to support and amplify local successes in community health. In the latest phase of the evolution of the Healthy Communities Movement, ATM informed the design of the Community Commons, which gives local initiatives the tools they need to plan, track, and measure progress through open data and geographic information system mapping platforms and to share lessons learned with other communities throughout the nation.

Today, as manifest through the case examples presented in this special issue, healthy community

Future progress in the nation's health is increasingly dependent on our ability and effectiveness in motivating the personal engagement and culture change that has been the goal of the Healthy Communities Movement.

initiatives are improving lives all across the nation—growing in both strength and diversity. In the city of San Francisco, the implementation of Health Impact Assessments in land use and development decisions enables significant community involvement in issues of public safety, sustainability, infrastructure, and housing that are linked to health and healthy behaviors. Work in Minnesota addresses environmental and social health factors among Hispanic immigrants through education, health services, and community engagement. The Colorado Healthy Communities Initiative, which began in 1992 with twenty-nine Healthy Communities programs throughout the state, has spun off activities in many ways and places. It has been the good fortune of one of us (J. Michael McGinnis) to witness, firsthand, the contributions of many of the pioneers of the nation's healthy cities and communities movement, its antecedents, and its partners—those such as the late John Gardner and John Parr, Christopher Gates, Tyler Norris, Mary Pittman, Joan Twiss, Judith Kurland, Joyal Mulheron, Sarah Strunk, Angela Blackwell, Kate Kraft, Kathryn Johnson, other contributors to this issue, and others in the legions beyond. Millions throughout the nation have been touched by their efforts.

Mobilizing communitywide action to improve a community's health environment can take different forms and foci. But the commonality in the aim and strategy of each is the stewardship of citizen-led efforts to identify opportunities, priorities, and strategies. Some of these efforts are categorical—for example, targeted to reducing the prevalence of tobacco use, high blood pressure, sedentary lifestyles, teen pregnancy, or diets high in fat or calories—while some have been targeted specifically to certain diseases and others have been aimed at strengthening the community infrastructure and resilience important to progress across the board. All have recruited leadership from sectors such as business,

education, social services, transportation, retailers, clergy, even barbershops and hairdressers into planning, leadership, and action roles.

Progress has been real and impressive on many dimensions. Whereas virtually no states had clean indoor air laws restricting smoking in 1986, today two-thirds of states have smoking bans in restaurants (most including bars) and in the workplace. Consumption of saturated fat has dropped substantially, as have serum cholesterol levels. Death rates have declined for heart disease, cancer, stroke, and HIV by about 40 percent, 5 percent, 35 percent, and 45 percent, respectively. The Healthy People goals for 1990 of reducing infant mortality by 35 percent over the decade, childhood deaths by 20 percent, adult deaths by 25 percent, and disability among older people by 20 percent were all substantially met or exceeded, and progress has continued. Although factors in these health gains span well beyond the activities specific to the Healthy Communities Movement, none would have been possible without the mobilization of community-based initiatives, resources, and action.

Future progress in the nation's health is increasingly dependent on our ability and effectiveness in motivating the personal engagement and culture change that has been the goal of the Healthy Communities Movement. The nation's most rapidly growing health challenge, obesity and the associated doubling of diabetes death rates over the past twenty-five years, can only be addressed through multifaceted community support and culture change. Problems of substance abuse, depression and stress-related conditions, coping with dementia, and health disparities among population groups cannot be reversed by keeping them behind the closed doors of the afflicted. These are issues that require careful multisectoral community consideration and action.

The spirit of democratization of health leadership and action that lies at the core of the Healthy Communities Movement is also essential for the health care transformation envisioned by architects of the Affordable Care Act (ACA). Today, the cultural and financial norms in health care are centered squarely on, and place the locus of control squarely in, the hands of providers and payers. Yet, coursing throughout the provisions of the ACA is the intent

to center on the values, needs, involvement, and informed decisions of patients. Success in implementing truly accountable care throughout the nation depends not only on success in capturing and acting on the lessons, experience, and strategies of the Healthy Communities Movement, but in blending their goals in a fashion that merges community energies to the benefit of both health and health care.

Tools emerging today make that both possible and necessary. We tend to treat community and population health as separate entities from individual, clinical health care. In reality, they are different points on a continuum, artificially divided by cultural, organizational, and measurement differences. Advances in the digital domain—ranging from electronic health records to geospatial locators and remote site monitoring and delivery devices—enable more precise assessment and targeting of interventions at an unprecedented level of granularity for both individual care and public health. Community Commons exemplifies the power of this approach, providing a digital platform for community mapping and collaboration. With this vastly increased power to use data to identify and engage community and individual health opportunities comes a compelling mandate of equal magnitude to ensure the investment and guidance of an informed citizenry in the process. As illustrated throughout the articles in this special issue of the *National Civic Review*, we have much to celebrate, appreciate, and use—now and in the future—from the pioneers of the Healthy Communities Movement. Place matters, and how we

shape our places for better health matters even more. Through its leadership over the past 25 years, the Healthy Communities Movement has helped us realize and engage this fact, and, in doing so, has both contributed gains we see today and set the stage for progress we can anticipate tomorrow.

## References

- De Tocqueville, A. 2000. *Democracy in America*. 2 vols. New York: Bantam Classics. (Originally published 1835)
- Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. 1979. Washington, DC: US Department of Health, Education, and Welfare.
- Hippocrates. *On Airs, Waters, and Places*. Translated by Francis Adams. <http://classics.mit.edu/Hippocrates/airwatpl.mb.txt>.
- Lalonde, Marc. 1974. *A New Perspective on the Health of Canadians*. Ottawa, Canada: Minister of Supply and Services. <http://www.phac-aspc.gc.ca/ph-sp/pdf/perspect-eng.pdf>.
- McKeown, Thomas. 1976. *The Modern Rise of Population*. New York: Academic Press.

---

*J. Michael McGinnis is senior scholar at the Institute of Medicine and executive director of its Roundtable on Value and Science-Driven Health Care. A former deputy assistant secretary of the US Department of Health and Human Services, his service in public health and disease prevention positions spanned four presidential administrations.*

*Elizabeth L. Robinson is a research associate at the Roundtable on Value and Science-Driven Health Care.*

---

# Role of the National Civic League in Healthy Communities

BY GLORIA RUBIO-CORTÉS  
AND MICHAEL MCGRATH

How did a “good government” organization founded to promote political reform and effective public administration at the local level come to play a leading role in a national movement to promote healthier communities? There is an obvious answer to that question and a more complicated one.

First the obvious: National Civic League (NCL) was founded at a time when the overcrowded, unsafe, and often unsanitary conditions in US cities were becoming a national embarrassment, as documented in muckraking magazine articles and best-selling books like Upton Sinclair’s *The Jungle*, Lincoln Steffens’s *The Shame of the Cities*, and Jacob Riis’s *How the Other Half Lives*.

Some of these conditions were perhaps the inevitable result of the dizzying transformation from an agricultural economy and mostly rural population to an urban, industrial society. But in many cities, political corruption, partisan government, and incompetent public administration were compounding the problem of too-rapid rates of growth.

Consequently, the earliest issues of this journal, originally known as the *National Municipal Review*, featured reports and articles on everything from milk inspection, to garbage collection, to housing, health education, code inspection and town planning. The founders of this organization (NCL) believed that many of the poor conditions facing cities could be addressed by adopting more effective, accountable, and professional management structures.

And they were right. By centralizing local government, adopting civil service standards, professionalizing municipal departments, and eliminating the partisan patronage regimes, reformers did make a difference in improving municipal government and the administration of public health departments. But in doing so, the reformers neglected one important need: a mechanism or incentive system for encouraging grassroots, civic participation.

Historians have long argued that the Progressive Era emphasis on professionalism and expertise carried a downside: It separated ordinary residents from the governance of their communities. With a few exceptions, the party bosses and ward captains weren’t very good (or diligent) when it came to day-to-day management, but they did excel at a certain kind of (not always healthy) civic engagement. The reformers weren’t nearly as effective when it came to these primitive forms of community organizing, imagining somehow that preaching civic virtue to unorganized crowds of busy, disengaged citizens would do the trick. It did not.

So, if the connection between community health and the NCL may have started with the focus on public administration, it didn’t end there. The US Healthy Communities and Cities Movement emerged at a time (twenty-five years ago) when NCL was redefining its mission and asking a new set of questions about how communities did or did not succeed. As if to compensate for its earlier neglect, the NCL shifted its focus from professionalization to matters of inclusion and engagement.

In the late 1970s, when NCL changed the name of this publication from the *National Municipal Review* to the *National Civic Review* (NCR), subscribers began to encounter new concepts, such as “civic infrastructure” and “collaborative problem solving,” and discovered something called the “Civic Index,” a tool that communities could use to assess their capacities for planning, leadership, inclusion, problem solving, and public participation.

NCL began to offer technical assistance to local leaders who were interested in using these new ideas and tools through its Civic Assistance Program, which later came to be known as Community Services. When the US Public Health Service asked NCL to help develop a national “Healthy Communities Initiative,” NCL’s president, the late John Parr, viewed it as an obvious fit for the organization’s

NCL began to use its growing expertise in the field of community engagement and technical assistance to guide civic leaders and health care professionals in developing their own collaborative initiatives.

focus on civic infrastructure, collaborative problem solving, and civic engagement.

NCL began to use its growing expertise in the field of community engagement and technical assistance to guide civic leaders and health care professionals in developing their own collaborative initiatives. “NCL worked with local projects, state networks, and national organizations in developing the specifically civic dimensions of healthy community strategies that often begin more narrowly as service integration dominated by the public agencies, hospitals, and health and human service professionals,” noted Carmen Sirianni and Lewis Friedland in their book, *Civic Innovation in America* (2001). In addition to its civic perspectives and training capacities, NCL brought to the movement “its extensive networks with local government innovators and with national nonprofits beginning to adopt community building models” (174).

Interestingly, Sirianni and Friedland credited NCL with influencing healthy communities in a particular way—in guiding the movement away from the European healthy cities model’s emphasis on formal partnerships between municipal governments and health care organizations, broadening the concept to include the “many different institutional and civic partners” that “did not rely on formal city involvement,” which seems ironic, given the organization’s original focus and connection to municipal government. After joining the movement, NCL began publishing regular articles and case studies in *NCR*, part of a new “Healthy Communities” department edited by Len Duhl and Barry Checkoway.

In those years, it would have been fair to say that NCL staff, board members, and associates were in the forefront of a broader “civic renewal” movement, as cities, counties, regions, and states joined in efforts to engage the public directly in planning, problem solving, and decision making and as foun-

dations began to fund comprehensive community-building initiatives.

These efforts went under different names and had different sources of institutional support, but they embraced a common set of values about how groups and individuals should interact to make their communities stronger and healthier. When NCL began to work with the Colorado Trust to develop a “Colorado Healthy Communities Initiative,” it moved beyond training, advocacy, and publishing to hands-on experience in developing one of the earliest and most successful statewide efforts. Over the years, the Healthy Communities Movement and related networks have grown and adapted and developed in new directions and initiatives. Community health concerns such as obesity and inadequate access to healthful foods have gained national recognition. Antismoking ordinances have become the norm in most cities. Farmers’ markets and natural food stores have grown in number.

National nonprofits, such as the YMCA, United Way, and National League of Cities, have joined health industry giants, foundations, and public health agencies in large-scale efforts to promote healthy lifestyle choices and healthier environments.

In the meantime, the NCL leaders who pioneered the early Healthy Communities initiatives have moved on to other organizations, challenges, and initiatives. John Parr, whose death in an automobile accident in 2008 saddened thousands of friends and colleagues across the country, was a founder of the Alliance for Regional Stewardship. Chris Gates serves as president of Philanthropy for Active Civic Engagement.

Michael Hancock, who facilitated some of the early CHCI meetings, is now mayor of Denver, and guest editor Tyler Norris, who headed NCL’s Healthy Communities program from 1990 until 1995, helped found the Coalition for Healthier Cities and Communities and Community Commons before joining Kaiser Permanente as vice president of Total Health Partnerships. Others who worked in NCL’s Healthy Communities program include Maro Zagoras, who is now president of Desired Outcomes, Inc., and Monte Roulier, who now serves as president of Community Initiatives.

NCL no longer has a separate Healthy Communities program, but the principles and values of the movement inform all of our programs. We have, for example, published dozens of essays, reports, and case studies on healthy communities by leaders in the field, and this marks our second special issue on the topic.

When NCL offers technical assistance to communities in public visioning or strategic planning projects, health is invariably one of the key performance areas and action items. The All-America City Awards, which recognizes towns, cities, neighborhoods, and regions for outstanding civic accomplishment each year, spotlights many innovative efforts to make communities healthier.

In 2013, the awards program focused on community efforts to address the needs of returning veterans, including innovative programs to achieve better health outcomes. In 2014, we are marking the twenty-fifth anniversary of the beginning of the national Healthy Communities Movement with a spotlight on programs that promote walking, biking, moving, anti-obesity, youth and adult programs, healthy eating, play, and health promotion and disease prevention, among others.

From the beginning, the term “healthy communities” carried a double meaning. It referred to community health in the primary definition of physical and mental well-being, freedom from disease, and the like, but also suggested a broader set of values and principles related to the way communities make decisions and address challenges. As then NCL president Chris Gates said in a 1997 article in the *NCR*, “It was clear to us then that it would be very easy

for the healthy communities movement to become engrossed in conversations about how our sick care systems provide services, and that while that topic was clearly a critical part of the discussion, equal attention needed to be given to reducing the demand on the sick care systems of our communities by focusing on the environments that create quality of life” (1).

Or as former NCL chairman John Gardner (2000) once wrote, “A healthy community is an arena in which we learn responsibility to and for others. It is a network of trust and social support that fosters a sense of the common good” (6). At NCL, we are understandably proud of our role in launching healthy communities initiatives across the country. We are also committed to playing a major role in moving healthy communities forward in the twenty-first century.

## References

- Gardner, John. 2000. “National Renewal.” *National Civic Review* 89 (1): 5–12.
- Gates, Chris. 1997. “Note from the President.” *National Civic Review* 86 (1): 1–4.
- Sirianni, Carmen, and Lewis Friedland. 2001. *Civic Innovation in America: Community Empowerment, Public Policy and the Movement for Civic Renewal*. Berkeley: University of California Press.

---

*Gloria Rubio-Cortés is president of the National Civic League and executive editor of the National Civic Review.*

*Michael McGrath is chief information officer of the National Civic League and editor of National Civic Review.*

---

# Leadership for the Public's Health Legacy of the Healthy Communities Movement

BY MARY PITTMAN

Over the last twenty-five years, the Healthy Communities Movement has played a prominent role in re-framing how health is perceived in the United States

The early days of the movement were led principally by people who were engaged in creating broader civic engagement and through the efforts of a small number of health care leaders who were trying to re-define the hospital's role within the community, particularly around community benefit requirements. These public health innovators played a strong role in developing many of the pilots that were executed in partnership with health systems and other providers over the subsequent years. Leading public health organizations engaged their communities in the planning and implementation of projects that were usually grant funded and focused on building specific areas of program expertise. There were few metrics or methods for designing healthy communities in this early period. However, the leaders who were engaged in redefining community health realized that metrics were necessary to measure their progress in whatever focus they had identified. Few of the early pilots were sustained after grant funding ended, but those that did thrive created a strong leadership capacity that facilitated partnering across organizations and sectors and attracted strong local support from government, philanthropy, and business.

## Healthy Communities: A Natural Outgrowth for Public Health

Early on, public health leaders recognized the potential for improving population health by engaging in healthy community work. Public health traditionally has been responsible for assessing, monitoring, and improving the health of the overall population in large health care market areas. Leaders such as David Satcher, MD, who served as the US Surgeon General and then director of the Centers for Disease Control and Prevention (CDC),

understood the power that organizing local communities could have on the health of the nation. He supported the launch of the Coalition for Healthy Cities and Communities and sponsored a convening at CDC in 1995. He pushed the participants to build on the work of public health but to reach outside the governmental sector to engage education, business, and faith-based organizations in the coalition's work. Public health providers have access to vital records and other sources of data critical to community assessments and monitoring community health metrics, which in turn inform other community leaders about strengths and needs of communities. Over the years, the ability and sophistication of public health to collect, analyze, and display data outside of vital statistics, data that capture the social determinants of health, has resulted in more comprehensive health assessments and has allowed for more targeted efforts to address disparities and health equity. As these issues have evolved, new tools and approaches for building healthy communities have crossed over to the fields of city planning and the built environment. Increasingly, leaders in public health are meeting with and collaborating with their professional colleagues in transportation, environmental services, parks and recreation, schools, and agriculture to address problems that cut across governmental agencies and sectors. Approaches such as Health in All Policies and Health Impact Assessments have solidified the methodologies and scientific basis for this new public health work. However, it has taken public health care crises to force the bloom of healthy communities.

## Early Driver for Healthy Communities: Learning from HIV

As a young professional in public health in San Francisco in the early 1980s, I witnessed the way the AIDS epidemic captured attention and focused efforts to improve community health in new ways. Public health had not experienced such an unknown, life-threatening disease in more than a century. All

of the tools of epidemiology, surveillance, laboratory testing, and prevention were turned on their head as new models had to be created to address this epidemic. Fortunately, the public health and clinical care system in San Francisco were integrated, and information and data were able to be exchanged in regular meetings. Further, the local health department leadership evolved from a top-down command-and-control model, which works well during a crisis, to a new, more community-oriented approach. Out of necessity, public health learned to partner with the community in new ways that contributed to new models of education, community planning and engagement, and care.

### **Healthy Communities: Growth by Crisis**

The lessons first learned from HIV were revisited several times over in the new millennium, starting in 2001. The post- 9/11 landscape, in which bioterrorism became an emerging and real threat to American communities, generated a growing awareness by both policy makers and the public that new leadership and an interconnected public health system were needed to respond. Just as the HIV epidemic created community sentinels for tracking the social aspects of the epidemic, the threat of bioterrorism required leaders to engage other sectors in tracking disease outbreaks and responding to threats such as the anthrax-laced letters. The science of public health was ready to address these challenges, but the leadership to fully implement the science required new skills and new roles at the local and state level.

Four years after 9/11, Hurricane Katrina again taxed the public health, health care, and public safety systems. Hurricane Katrina pinpointed the serious lack of interoperability and communications across public health, health care, National Guard, police, and other critical responders. It provided a wake-up call for how disconnected public health was from other key community service providers and decision makers. The challenge of determining who was in charge of what area and how joint decisions would be made led to the further development of new planning models for public health leaders. The new demands created by these health care crises highlighted how the underfunding that had plagued public health for several decades needed to be addressed in order to address emergency preparedness properly. One of the stark realities of Katrina was the lack of equity,

The current challenge facing public health leadership is to determine how to link the social determinants of health and the lessons from healthy communities with health reform.

access, and resources available to the low-income community most affected by the full force of the hurricane and years of neglected infrastructure in their community. Katrina focused the nation on these issues, and public health leaders helped reimagine what a healthy community would be while people from around the country lent a hand to help the displaced residents of New Orleans rebuild their community.

At the base of the current healthy community work is an acknowledgment that the social determinants of health—where one lives, works, plays, and interacts with faith and civic organizations—have a greater impact on how healthy you will be over your lifetime than how often you go to the doctor. Of course, this statement has to be qualified. There are many reasons why we want access to the best medical system possible when we need it. For instance, some people are born with genetic-related illness and disability that may need medical attention. Others develop conditions over their lifetimes requiring medical intervention. What we intend by our shorthand reference to the social determinants is that those things that provide the best possible start to life, that help individuals achieve their highest potential and that avoid preventable illness, should be our priority for creating healthy communities.

### **Public Health Leadership: The Challenge of Health Reform**

The current challenge facing public health leadership is to determine how to link the social determinants of health and the lessons from healthy communities with health reform. The key challenge is how to bridge the gap between the public health focus on preventing disease and creating a healthy environment with the need for preventive and restorative health care. There is a reference in the Affordable Care Act (ACA) to improving population health by focusing on the triple aim of better health, better



care, and lower cost, but the specific details on how to achieve these goals are left out of the legislation—and it is a good thing that they were. The ACA requires greater engagement by public health and community-based organizations in the largest social program created since Medicare. However, it will only be as effective as the level of engagement of public health leaders in its planning and implementation. It is exciting to see new models emerging with greater attention to investments in prevention and public health from savings in health care expenditures.

One of the biggest tasks facing public health is to partner across the clinical–social–public health sectors to create robust testing of the effective new health care models. The next challenge is to generate the long-underdeveloped evidence of the value of equitable healthy environments with engaged communities working for long-term health benefits. Leading in this manner requires new skills and an orientation of building healthy communities that are more equitable and sustainable. Healthy city and community leaders, such as Len Duhl, MD, pushed all of us to think what can be accomplished if we believe that everyone has a role to make the world a more just, equitable place to thrive, and now we have digital tools that make connecting community easier and our actions more transparent. By their nature, digital tools are democratizing data, facilitating organizing, and raising expectations of what we want our communities to be. It will be important to learn how public health can adapt to these new expectations and take a leading role.

Public health has evolved in its approach to building healthy communities: from community engagement, to a public health all-hazards focus, to building resilience and capacity and incorporating health in all policies. The health in all policies framework requires leaders to understand collaboration and how to apply new tools, such as health impact assessments and business models for return on investment. Recognizing the complexity and contextual nature of health, taking time to break it down so it is embraced and understood by all community leaders using new methods of integrating and displaying data, telling evidence-based stories, and engaging communities in the design and planning of research and programs—these approaches are shaping a new kind of public health professional and new models of public health leadership.

All social movements have to have a framework that can encompass the interests and viewpoints of the people involved. Periodically, they must assess the value and contribution that the movement is making to social change. The contributions that leaders of the healthy cities and communities movement have made in the past twenty-five years have had a profound effect and legacy that can be traced to many of our laws and approaches to community-based prevention and environmental change to build healthier communities in the United States.

---

*Mary Pittman is president and chief executive officer of the Public Health Institute.*

---

# California Healthy Cities and Communities Twenty-Five Years of Cultivating Community and Advancing a Movement

BY JOAN M. TWISS,  
TANYA KLEINMAN,  
AND JOSEPH M. HAFEY

“So, you’re trying to change the way people think?” That was the question posed after a description of what the California Healthy Cities Project was setting out to do over twenty-five years ago. “Well, yes we are . . . we want health to be everybody’s business because we know that it is profoundly influenced by our environment, i.e., where we live, go to school or work, recreate, worship, and socialize.”

It was an ambitious experiment, the first health cities program in the United States. It borrowed from the emerging work of the World Health Organization’s Central European region and from Canadian cities and towns, especially the city of Toronto and Quebec. For several compelling reasons, California municipalities were the initial focal point. The rationale included their capacity for:

- Sponsoring public debate.
- Responding to local needs and values.
- Enacting policy.
- Allocating resources for personnel, planning, infrastructure, land use, safety, and enforcement functions.
- Engendering civic pride and a sense of place.

Cities, as permanent entities with constancy of mission, provide fertile ground for the norm change necessary to sustain the work of changing the way people think.

## Program Sponsorship and History

The Center for Civic Partnerships (the Center), based in Sacramento, is the home of the California Healthy Cities and Communities (CHCC) program. The Center is part of the Public Health Institute. Since the program’s inception, very modest funding has been awarded by the California Department of Public Health (previously the Department of Health Services) through a Preventive Health and

Health Services Block Grant. Categorical funding from the Network for a Healthy California, the California Wellness Foundation, and Food for All has also been awarded to the program office for technical assistance and the educational campaign and for re-granting to participating communities.

With a five-year grant from the California Endowment (TCE) in 1998, the CHCC’s expanded program funded twenty sites to engage in capacity building for community health improvement efforts. These communities included unincorporated areas that were geographically or socially isolated and those with populations “at risk” for inequities in health status. In addition, the Central Valley was a region of great interest and significant participation.

In general, CHCC participating communities receive a local assistance award of approximately \$20,000. (Initially, grants were for lesser amounts.) With TCE’s support for the expanded program, these awards ranged from \$25,000 for planning to \$50,000 for implementation with an escalating match requirement each year.

Participating cities have ranged from populations of approximately five thousand to almost one hundred times that number. Unincorporated areas with fewer than a thousand residents have participated. The communities have resident profiles representative of the diversity of California’s demographics and civic personalities. Most have median incomes below the state average, with a sizable number very far below.

By design, local CHCC initiatives are community driven. They cover the gamut of community life, including various strategies to support healthier eating and physical activity, injury prevention (intentional and unintentional), safe and active transportation, smart growth, neighborhood

improvement, tobacco control policies, and quality-of-life indicators, among others. They span generations from youth to older adults. Local assistance awards come with technical assistance from the Center for planning, implementation, and evaluation as well as how to leverage the award for other resources.

### Methods and Results

The Center's emphasis is always to build capacity and ensure that communities are stronger as a result of their participation in the CHCC program. In a span of twenty-five years, well over one hundred cities and communities, from every region of the state, have participated in the local assistance program or been members of the CHCC Network. The Network is a membership program created for groups interested in the principles and practices of healthy cities and communities.

At the state program level, the Center has strategic partnerships with good government groups (state and national), health care associations, and discipline-specific membership organizations—for example, city managers, park and recreation specialists, city planners, and public health professionals. These groups were vitally important for credibility with the priority audience, leveraging opportunities for training and resource dissemination.

The CHCC program's cyclical model of Inspire, Support, Sustain and Celebrate has been highly effective in laying a solid foundation for community building and community health improvement for years to come. Inspiration comes in the form of an educational campaign and hundreds of presentations, many at venues where the priority audiences already participate.

Support is provided through distance and on-site technical assistance. The Center has developed fifty audience-specific guides, journal articles, and tool kits. These publications and over eighty issues of the CHCC newsletter, *Connections*, have been sent to thousands of locally elected and appointed officials and public health/administration professionals throughout the state. Most publications include the latest data or rationale for why the issue is important, case studies, resources, and local contacts.

Sustainability is fostered through a peer support network, resource brokering and sponsorship of professional education opportunities, and statewide and regional conferences. Keynote speakers have included some of the most highly respected national and international leaders from the fields of public health, smart growth, media, elected office, philanthropy, social welfare, and policy advocacy organizations. In 1993, the CHCC program cosponsored the first International Healthy Cities and Communities Conference held in the United States (San Francisco), which brought 1,600 healthy community advocates together and profoundly influenced the hundreds of Californians in attendance.

Celebration has included statewide awards programs and publications which recognize exemplary achievements that can be tailored to fit multiple community contexts. Over 325 cities have been recognized for efforts to improve livability through groundbreaking tobacco control policies, brown-field redevelopment, community safety and revitalization, among others.

An external evaluation of the CHCC Expanded Program found over one thousand new leadership roles were created in this twenty-site subset alone. In this same group of twenty communities, the CHCC local assistance awards provided an average 8.4 return on investment, leveraging an estimated \$21 million in financial resources in a three-year grant period.

A long-term contractual relationship with the Network for a Healthy California has resulted in local assistance awards, support for numerous conference sessions, and at least seven widely distributed stand-alone publications on improving opportunities for healthier eating and physical activity in communities. Tens of thousands of articles and resources have been shared via print and electronic media. As a consequence, action on the part of municipalities to improve neighborhood environments and policies for better nutrition and exercise has been remarkable.

Among the numerous outcomes of all the CHCC projects are increased fruit and vegetable consumption, decreases in prevalence of adult and youth obesity, improved academic scores as a result of intergenerational tutoring, development of quality-of-life indices that guided policy development and

resource allocation, and incorporation of health elements into general plans. Health-promoting public policies, from tobacco control to healthier food access, have passed in hundreds of jurisdictions. Innumerable physical improvements—for example, community gardens, improved walkways, and bike lanes—have made communities safer and more livable for residents across the life span.

### Impact

Impact can be manifested in multiple ways. The strength of support for the Healthy Cities and Communities movement is one way. The CHCC Network was established in 2000. It has been a way for like-minded communities, local public health departments, and nonprofits to affiliate, or stay connected, with both the state and the international movement. Many members have been active for ten or more years. In addition, when asked in the evaluation of the recent annual meeting the primary reason influencing their participation, the answer, from two-thirds of the respondents was “commitment to Healthy Cities and Communities’ principles.”

During the last two and a half decades, the roles that the many actors have in this work have come into sharper focus. California Smoke-Free Cities (a CHCC collaboration with the state municipal league, health officers association, and a national nonsmokers’ rights organization) worked for six years beginning in 1990 within a state-supported tobacco control network and media campaign to reinvigorate and support an interest in policy as a public health strategy. Today, the conviction that the physical environment and public policy shape and determine opportunities for population health and quality of life is very much in the forefront of our public and political discourse.

Another sign of the movement’s momentum is TCE’s ten-year Building Healthy Communities strategic direction to support the development of communities where kids and youth are healthy, safe, and ready to learn. National philanthropies—Robert Wood Johnson Foundation, Bloomberg Philanthropies, and Rockefeller Foundation—recently announced awards or plans for city-based investments that are testimony to the leverage point that cities offer for improved population health.

### Challenges

Funding insecurity (both amount and length of commitment) is the largest single obstacle the CHCC program has endured. The steady decrease or threatened elimination of the Preventive Health and Health Services Block Grant at the federal level during most of the years the program has been operational has had a hugely deleterious impact. This has been experienced in an extremely acute fashion in the last few years. A threshold of resources with a multiple-year commitment is clearly necessary to engage, and retain, local and statewide partners.

Noncategorical support has been hard to come by, except for the CHCC expanded program funded by TCE. Funders often look to have a distinguishing brand for the work they support. A program that is already operational is challenged to position itself accordingly.

Initially the name “healthy city/community” itself was a barrier. It often connoted more of a health care orientation or individual level of responsibility. Significant progress has been made in understanding its more socio-ecological perspective. Nonetheless, the term sometimes is still used without appreciation of the philosophy and principles at its core.

### Lessons Learned/Confirmed

Among the many lessons learned or confirmed during the past twenty-five years of the California Healthy Communities and Cities experience, ten come to mind.

1. *Leadership and community participation need to be diverse, broad, and deep.* Stakeholders need to come from the essential fabric of the community—education, civic organizations, neighborhood associations, business interests, faith-based groups, and local government (especially planning, community services, and recreation departments) as well as all the other entities that comprise community ecology. In particular, residents must be engaged from the outset. They have invaluable insights for every phase of the work.

Leadership for the community collaboration must be diverse in every way—for example, age, gender race/ethnicity, culture, and worldview.

It is critical to have both planners and implementers. Strong political support, community champions, and alliances with respected organizations are all critical components of success. For example, land use planners appreciate that health leaders can make the case to link better land use to the likelihood of improved health and quality-of-life outcomes.

Good leadership development is characterized by a continual process of renewal. This is often achieved through a committee that is charged with training and recruitment. If it isn't a specific responsibility of an individual or group, momentum will be lost with the inevitable transitions. For long-term sustainability, avoid the perception that the project is tied to any one individual or administration.

2. *Respectful relationships are key to success.* It has been said that everything boils down to relationships. Successful programs have a win-win ethos as the basis of strong partnerships. It is not so much about the given healthy city/community project per se as it is about a commitment to ongoing introspection about what's working, or not, who's benefiting or being adversely impacted, and community regeneration. Every discipline and sector has a different language, culture, and set of incentives that must be respected. It is important to take the time to learn and appreciate their meanings, relevance, and nuances.
3. *Geopolitical context and history matter.* Policy makers are most concerned with that which is in their sphere of control. Data that blurs jurisdictional boundaries will not be readily embraced. Make data accessible and ready to use. Learn how your local government is organized, and appreciate current context. Most of the time, there is baggage between and among public and social sectors that needs to be appreciated and addressed before the real work can begin. In one participating community, the city and county governments were in litigation over a landfill, yet they were able to carve out a zone of collaboration for a multifaceted Healthy City program.
4. *Sound governance and management will foster and maintain momentum.* It is extremely important to establish a strategic orientation—that is, to have a vision and to be clear on

the mission. Second, ensuring effective operational procedures—meeting schedules, publishing minutes, and adhering to good record-keeping /accounting procedures—are the basics of any productive endeavor. Making good personnel decisions and following through with commitments are vital to credibility.

5. *Plans will be embraced when they are home grown and locally driven.* Professionals can name what they see as the community's challenges, based on data and facts, *and* they need to be open to alternative narratives and solutions. If the community's priorities aren't attended to, then the data will be necessary but insufficient as a call to action. Start with where the people are. Build on assets. Connect the dots to the health agenda as the momentum builds.
6. *A regional fishbowl will provide incentives.* The principle of *diffusion of innovation* by Everett Rogers (in his 1995 book *Diffusion of Innovations*) takes on added value when resources are scarce. In the professional realm, finding the 10 percent of the priority population who will embrace the desired change will be a natural bridge to enlisting their peers. Find the creative examples and showcase them. Enlisting a person in a position of influence who has access to, and credibility with, leaders in many sectors and communities can expedite progress. In San Bernardino County, one such champion enthusiastically endorsed the healthy city philosophy and model with business leaders, academics, county supervisors, and school superintendents. One result was a county-funded, multiple-city initiative supported through the general fund with staffing from the sponsoring supervisor's office.
7. *Progress and results need to be reported and celebrated.* Staying visible is a must. Everything from formal communications to mass and social media should be utilized with informal networks engaged as well. Whenever possible, involve elected and appointed officials or their staff in coalitions and task forces and invite them to communitywide celebrations.
8. *Long-term commitment is required.* Planning, implementation, and evaluation are part of a fluid cycle that can't be rushed by arbitrary one-size-fits-all guidelines designed to meet externally driven needs. The initial planning can

take eighteen months or more, depending on the size of the community and complexity of the challenge. Remaining flexible allows for taking advantage of serendipitous events and to adapt as needed. Approach the work as more than a grant-funded or point-in-time activity. Be there for the long haul.

9. *Sustainability needs to be built in from the beginning.* The Center has been involved in numerous population health improvement initiatives both statewide and on a national scale. Consequently, we have designed a ten-step process that defines sustainability as “the continuation of community health or quality of life benefits over time.” Inherent in the CHCC program’s relatively modest financial award strategy is the increased likelihood of communities having “skin in the game.” Developing a plan to sustain community benefits is ideally done more than a year before funding termination.
10. *Evaluation must be transparent and benefit all parties.* Establish a system to continuously track progress and evaluate programs and policies. Checking in on evaluation measures and processes throughout an initiative prevents surprises (and resentments) at the end. Again, assigning an individual or group to be responsible for ensuring that this component stays on track enhances the likelihood that it will happen. Recognize the different drivers that each sector has, and factor those into what will be monitored and reported.

### The Future

Whether the term is cross-sectoral partnerships, collective impact, or something else, we’re talking about a community-building approach that has come of age, not a novel trend or passing fad. Healthy Cities and Communities wasn’t the first, nor will it be the last, incarnation of civic democracy in action. What is certain is that a siloed way of working is anachronistic. The idea of healthy, sustainable, strong, resilient cities has permeated the consciousness of a wide swath of society at the right time. The twenty-first century is poised to be the century of the city. The largest US cities have just recorded population gains that have more than reversed those lost in the last decade. All indications

are that this will continue, especially in international mega-cities.

Planning, implementation, and evaluation are part of a fluid cycle that can’t be rushed by arbitrary one-size-fits-all guidelines designed to meet externally driven needs.

In the United States, 80 million boomers (born between 1946 and 1964) combined with greater longevity overall means that there will be significant demands for affordable and accessible housing and more convenient mobility options. Accordingly, land use patterns will evolve, with smart growth and infill strategies preferred over sprawl. If local governments and their partners do not plan and organize for this demographic shift, they will witness greater infrastructure and service demands and usage, increased costs and resource deficits, and lost opportunities. Conversely, capturing this age dividend will provide greater prospects for social innovation, increased local investment, and community benefit, including civic contributions and intergenerational exchange. The Healthy Cities and Communities model is the ideal vehicle to reengineer our physical environments, in particular, with the concept of cobenefits across the life span.

At an early retreat for representatives from the first ten California Healthy Cities, one of the participants asked, “How will you know when you are successful?” The somewhat off-handed reply was that the term *Healthy City/Community* would be a household word. Well, it certainly has permeated the consciousness of elected officials and professionals in diverse fields, including public health, public administration, planning and community development, in ways we couldn’t have imagined. Numerous foundations, non-profit organizations, and even corporations have embraced a healthy community orientation and philosophy. Community members have always intuitively known what it takes to have a good place to live, learn, work, and play. What the Center for Civic Partnerships and the CHCC program have contributed are some well-traveled road maps for the journey. Visit

us at [www.civicpartnerships.org](http://www.civicpartnerships.org) and enjoy your journey.

*The mission of the Center for Civic Partnerships is to provide leadership and management support to build healthier communities and more effective nonprofit organizations. The Center is part of the Public Health Institute, which generates and promotes research, leadership, and partnerships to build capacity for strong public health policy, programs, systems, and practices.*

## Reference

Rogers, Everett. 1995. *Diffusion of Innovations*. New York: Free Press.

---

*Joan M. Twiss is founding executive director of the Center for Civic Partnerships.*

*Tanya Kleinman is assistant director of the Center for Civic Partnerships.*

*Joseph M. Hafey is president and CEO emeritus of the Public Health Institute.*

---

# California's Central Valley Addressing Disparity in a Region of Abundance—Creating Healthy Communities through Community Leadership Development

BY GENOVEVA ISLAS-HOOKER

In communities where agriculture is the main industry, it can be very difficult to change policies that might affect the existing food system. But in Tulare County, California, where there are literally more cows than people, a local school district banned flavored milk from the school menu. Participants in an innovative community leadership development program began organizing and discussing how they could work to improve the school menu. They formed relationships with the district food service director. They gained seats on the school wellness committee and one of the participants ran for a school board vacancy and won. So when the school wellness committee introduced the policy, it was supported by the food service director and approved by the school board.

The Central Valley of California is the state's fruit and vegetable basket, but ironically, many of the people who live and work there have a staple diet of cheap, unhealthful food. The reasons are varied. Most farm-working families have limited financial resources and live in rural areas, small towns, or unincorporated communities. Many of these communities were established originally as migrant farm labor towns with temporary housing. It is not unusual for these communities to have failing infrastructure, limited amenities, and dilapidated water and sewer systems. Few of these communities have full-service grocery stores, making access to healthy foods a challenge and necessitating travel to larger communities for shopping.

Although circumstances often seem desperate with no light at the end of the tunnel, some of these communities are organizing and creating their own lights. It is an undeniable truth that members of

these communities have to be the drivers of their own solutions, which doesn't mean that they don't need help. People are experts on their own environments and capable of championing their own causes, but in many cases they have adapted to these environments, and it takes some outside help for them to imagine new and different environments. This is the goal of the Central California Regional Obesity Prevention Program (CCROPP)—helping residents imagine and create healthier communities.

## Building Leadership

In 2010, the Robert Wood Johnson Foundation funded CCROPP to create a leadership development curriculum. That curriculum, titled *Powerful People: Building Leadership for Healthy Communities*, was completed in 2013. What we were able to accomplish through this curriculum was the successful training of almost 200 community residents to be agents of change in their communities. Most participants were not individuals with histories of civic engagement. Mostly people with limited incomes and educational achievements, they came from a mix of rural unincorporated communities, small towns, and urban neighborhoods of the valley. Many of the participants were new immigrants, and most worked in farm labor. All were parents, and all had an interest in wanting to make their communities healthier for their children—that was the common thread.

The goal of the curriculum, which the participants themselves helped design, was to teach about the cycle of advocacy and how to engage in it. We targeted future trainers who may be working with similar communities with the focus on creating healthier



communities. The final curriculum has twelve modules; each module contains a session overview, an outline for delivering the session, accompanying presentation, in-class and out-of-class assignments, and session evaluations. The complete package was presented in English and Spanish.

“I never thought I would be speaking in front of one of the largest school districts in the state of California,” said Susana Cruz, a graduate of the leadership program. An immigrant from the Oaxaca region of Mexico, like many others she moved to Fresno in search of opportunity. As someone with limited education, she wanted her children to have every opportunity that she did not, so she started attending parent meetings to learn how to become more involved. One of the projects that she and other participants in the program chose to address was the lack of safe places for her children to play in their neighborhoods. Unlocking the school gate seemed like a solution, but could they actually do it? Susana was timid at first. She considered the request to unlock the school to be slightly audacious, but she began meeting and talking with other parents, then to the school principal, and eventually made a formal presentation to the Fresno Unified School District. Susana Cruz today stands as a champion for her community in helping to establish the first-ever joint-use agreement in the history of the school district.

As a result of the leadership development efforts, some of the participants joined school wellness committees and other governing boards and commissions within their cities. In a few cases previous participants have become elected school board members. Many have been sought after as assets to informing healthy community efforts in similar communities. In Stockton, Ceres, and Merced, participants in the program have become leading advocates for creating safe routes to school in their neighborhoods and communities. Stockton participants have also implemented a walking school bus program at two elementary schools, Van Buren and Hamilton. Plans are under way to implement this project in other district schools.

In Ceres, participants have also worked in tandem with the school to organize a walking school bus to increase the safety of children walking to school. These efforts led Ceres to receive a Safe Routes to

In all communities where the leadership program was implemented, there has been work on some aspect of improving healthy food access, such as healthy corner-store conversion projects, establishment of farmers’ markets, school farm stands, or farm-to-institution policies.

School Non-Infrastructure Outreach and Education Grant to be implemented in five targeted elementary schools this year. Merced has one of the highest pedestrian fatalities in the Central Valley. Participants in Merced conducted assessments, which clearly revealed physical activity challenges and a strong community interest to prioritize pedestrian safety.

In Bakersfield’s Greenfield neighborhood, participants have successfully transformed their local park to afford new opportunities for physical activity for the entire community. Local program participants have developed relationships with the parks and recreation department, the city’s mayor, county public health department, and other key local government officials to transform the park into a place where families walk, run, dance, and play sports. In addition, program participants have advocated improvements in lighting to enhance safety and have also begun to organize and mobilize the community to take part in the beautification of the park, including ongoing cleanups and regular Zumba classes.

In all communities where the leadership program was implemented, there has been work on some aspect of improving healthy food access, such as healthy corner-store conversion projects, establishment of farmers’ markets, school farm stands, or farm-to-institution policies. Fresno and Ceres participants have led the way in the establishment of multiple school farm stands in elementary schools and continue to expand into other neighboring school districts. Merced was instrumental in establishing Electronic Benefit Transfer acceptance at a flea market and developed a ten-step guide to using the program at produce markets. Leaders from Stockton have worked to increase access to fruits and vegetables at a local corner store.

These are just some examples of the community-led efforts that are transforming communities in Central California.

### **Recommendations/Conclusions**

CCROPP aspired to have more community residents become involved in decision making in their communities. We succeeded in cultivating advocates for healthy communities, but there were many other collateral benefits from the program that were unplanned. For instance, entrepreneurial opportunities presented themselves as some of the participants suggested that they could become the meeting caterers or even child care providers; this allowed for some economic benefits for the families we were engaging. With boosted self-confidence, several of the participants went on to complete some formal

education while others obtained gainful employment. The role modeling of civic engagement was a powerful influence on their own families and children, helping to diffuse the information and shaping future advocates.

Every program working to create healthy communities should incorporate some aspect of leadership development in its efforts or partner with programs having that expertise. Investing in community leadership is a vital legacy of healthy communities and the promotion of equity.

---

*Genoveva Islas-Hooker is director of the Central California Regional Obesity Prevention Program.*

---

# People, Places, Partnerships at the Heart of Success in California's Building a Movement of Movements

BY LISA HERSHEY

In 2007, the California Endowment and Kaiser Permanente decided to combine some of their investments and political will and shift from local isolated projects to a convergence approach in the hope of stimulating shared goals, collective action, and greater collective impact as well as accelerating this movement for change. In 2008, California Convergence joined the Healthy Communities Movement in California.

Over the past five years, California Convergence has evolved into a network of people who are passionate about creating healthier communities. Across the state, California Convergence community leaders are working together to determine shared priorities, identify resources, and connect with people and organizations that help fight for—and win—lasting change. California Convergence puts people first, because policies grown from the ground up have a better chance of creating communities where everyone can participate and prosper.

California Convergence unites the people who make decisions that affect California's health and prosperity with the people most affected by those decisions, sparking action that leads to more equitable and safer and healthier communities. California Convergence community leaders identify issues that impact their communities most and work hand in hand with state advocates to advocate for policy change at the state, regional, and local levels. Recently, California Convergence has contributed to the passage of the following legislation:

- Continued Funding for Fitnessgram Physical Fitness Test
- Expanding Safe Routes to Schools
- Health and Equity and Transportation Planning

- Healthy Food Financing Initiative Safe Routes to Schools

California Convergence has movement-building strengths beyond policy change. Kaiser Permanente commissioned the Center for Community Health and Evaluation to conduct an evaluation of California Convergence in 2011. Findings indicated that California Convergence contributed to these impacts:

- Building an authentic base of civically engaged community members through strategic use of leadership development and advocacy capacity building
- Bringing community voices to advocacy events in Sacramento to inform and educate legislators on priorities that improve equity, safety, and health in communities
- Connecting allies across the state to create healthier food and activity environments
- Creating a healthier beverage environment (increasing water access and consumption, decreasing consumption of sugar-sweetened beverages, and changing the conversation about soda)
- Creating and implementing joint-use agreements around the state and supporting local implementation
- Convening potential partners, such as parks and recreation agencies, schools, and families
- Facilitating Safe Routes to School policy implementation
- Encouraging and streamlining applications for complex federal funding opportunities that are focused on environmental and policy change

Through funding opportunities such as Communities Putting Prevention to Work in 2010 and

Community Transformation Grants in 2011, California Convergence has advocated for community leaders to have a seat at the table and play a significant role in the planning and implementation of each program.

California Convergence works locally to strategically support community leaders by sharing resources, offering capacity-building opportunities, and connecting peers and partners across the state. Because California Convergence believes that real change is possible only when all people participate, it works regionally to hold space for individuals and organizations from multiple sectors and fields to address common challenges, learn from each other, and build alliances that have lasting impact. Each member's success is a win for whole network. It also works statewide through its twenty-eight-member Steering Committee that guides and governs the California Convergence network, holds a shared vision, and strategically supports the community-driven advocacy infrastructure that advocates for changes that make a real difference in people's lives.

### Challenges

California Convergence's greatest strengths are also its greatest challenges. California Convergence recognizes that social movements require long-term commitments and collaboration from everyone, including community leaders, multisector partners, and investors and are built off of a great deal of volunteerism, sweat, and tears. For example, it is a strength that many of California Convergence members volunteer their time and energy because they see the value of working together and contributing to the broader movement, but it is a challenge that volunteers and paid partners face numerous competing priorities with their limited resources and can burn out over time.

Roots are planted deeply in community, in the people on the ground, and in history and experience of the multisector, multifaceted strategies and social movements that came before. One strength is that policies grown from the ground up have a better chance of creating communities where everyone can participate and prosper. A challenge is that community issues and funder priorities do not always align; relationships are built on trust and history, and when

investments shift prematurely from the community perspective, trust is broken.

California Convergence grows its branches intricately intertwined with deep partnerships and growing alliances, but sometimes it is difficult to pinpoint the role the organization has played in effectuating a change. The convergence knows that in order to truly grow a movement and have significant and sustainable, collective impact, all players, including investors, need to agree to a shared vision, investments, and measurement.

### Catalyst for Deeper Dialogue and Sustained Action for Impact at Scale: Opportunities for the Future

California Convergence is one of thirteen regional convergences that have grown under the National Convergence Partnership and recognizes the strength of these efforts across the country. Built on the powerful groundwork laid by Healthy Cities and Communities initiatives in collaboration with numerous moving parts, California sees the national and perhaps global opportunity to collectively:

- Build and mobilize an authentic grassroots base of residents who are civically engaged in dialogue and action to improve health and prosperity for all.
- Advance this work through stronger alliances among people from diverse sectors and fields who can collectively invest in communities for economic and social benefits.
- Confirm a shared vision, establish a Health in All Policies framework, and create shared measures to evaluate collective impact.
- Secure new social impact investments and redirect other resources (e.g., governmental) to pay for success to advance equity, social justice, and prosperity for all.

California Convergence holds hope for a vision where every resident has the power and the partnerships to collectively build equitable, safe, and healthy communities where every person participates and prospers.

---

*Lisa Hershey is program director for the Public Health Institute. She is director of the California Convergence Coordinating Office.*

---

# Transforming Communities for Health The California Endowment

BY MARION B. STANDISH  
AND ROBERT K. ROSS

Your weight, cholesterol count, and blood pressure, or any of the methods doctors use to track patients, may be more of an indication of where you live than how you live. Increasingly, research is confirming what many of us intrinsically understood: that your zip code is a powerful predictor of how healthy you are and how long you are likely to live. In fact, there may be as much as fifteen to twenty-five years' difference in life expectancy between neighborhoods in the same city.

If you live in a place that has parks and safe places to play, retail stores selling fresh food and vegetables, access to good jobs and networks of others who have jobs, clean air, schools that set high standards and strive to keep students in school rather than pushing them out, health care resources, social services, and residents who are engaged in civic life, you are more likely to live a longer and healthier life. In contrast, if you live in a neighborhood without these essentials, you are more likely to be injured or killed during a crime, in a car crash, or simply crossing the street. At the same time, living in disinvested places means you are prone to suffer from obesity, asthma, diabetes, heart disease, or a combination of chronic ailments. Tragically, these conditions put you at risk of dying prematurely from a stroke or a heart attack. These are stark reminders that simply providing insurance coverage and better access to quality medical care, while important, will not be sufficient to improve health.

Since its establishment in 1996, The California Endowment (TCE) has tested and invested in many efforts to change the odds for those living in communities without the essentials for health. From the Partnership for the Public's Health to Community Action to Fight Asthma, Healthy Eating Active Communities, and the Central California Regional Obesity Prevention Program, TCE has broken new ground in answering the question of how to use health to forge new alliances and work across sectors to achieve the type of comprehensive transformation that is needed for communi-

ties to succeed and, in turn, for residents to be healthy.

Building on our experience, TCE fully appreciates that no single program or intervention, fragmented and scattered across the state and disconnected from broad policy impact, can effectively catalyze transformation in communities, let alone change the health circumstances for all Californians. Comprehensive approaches that invest long term in places, link those places to resources and broad state-level policy and communication efforts, and put residents at the table when decisions over resources and systems change are being made are the essential and often missing elements of our work.

To that end, TCE is investing \$1 billion over ten years to catalyze the transformation of fourteen communities across our state in an initiative called Building Healthy Communities (BCH). An intensive commitment to these specific neighborhoods, matched by support at the regional and state levels to advocacy, organizational capacity building, creation of networks, and communications, will be combined in an effort to scale and spread local success and maximize the impact of key health opportunities.

According to Robert K. Ross, president and chief executive officer of TCE, "It is our intent to have these place-based and 'bigger than place' strategies complement one another and for the moving parts to develop a powerful synergy. At the local level, the BHC communities are engaging multiple sectors to develop innovative efforts to advance health. As these innovative strategies emerge, we're looking for ways to scale the ideas up through policy change and communications at the state and regional levels. Through acting on multiple levels with complementary strategies, we expect to make a greater contribution than if we were to work only at the place level or only through supporting statewide advocacy. This is central to our theory of change. In a sense, it is fair

to consider BHC as a place-based plus community change campaign.”

Rather than beginning our work in communities with a specific health target, the BCH effort began with identifying and investing in key drivers of change. In recognition that the foundation would not be in these communities forever, these investments are aimed at building long-term capacity to inform and influence decisions that will determine community health for the long run. They are also keys to monitoring the implementation of new policies and holding decision makers accountable for partnering to make communities healthy.

Foremost among the drivers is building resident power and supporting grassroots efforts to engage residents in local decision-making forums and campaigns. Enhancing collaborative efficacy by using tools, such as the Health Impact Assessment, health forecasting, and a Health in All Policies framework informs communities, as well as decision makers, about the interrelatedness of health and other issues impacting community. Youth leadership is telling their own stories and forging multicultural understanding and alliances to ensure that young people are fully engaged and provide a vision for the future they want to see. Creating a new narrative for health helps to demystify the concept of the “social determinants of health,” engage likely and unlikely partners, and shape new norms and attitudes about health, especially our understanding that health does not only happen in a doctor’s office and that health is both an individual and community responsibility. Last, TCE recognizes the limits of its investments and therefore is aggressively looking for new partnerships in both the private and public sectors to support educational or economic goals that will be key to sustainability and long-term transformation.

To guide communities in developing their plans and to inform our state-level policy efforts, The California Endowment identified ten broad outcomes that frame what is needed for a community to be healthy and also serve as indicators of progress toward achieving that goal. Four “big results” establish the aspirational health outcomes of the ten-year plan. They are access to quality health care, increased school attendance, decreased youth vio-

lence, and decreased childhood obesity. Communities used these guides to tailor their own localized plans and priorities, negotiating with staff to achieve a shared understanding of what the community-foundation relationship and work would be about.

The California Endowment developed a campaign structure to help organize the work, capture the comprehensive vision of both the place and policy efforts, and, most important, create the conditions needed for collective impact. Health Happens Here became the brand that captured the endowment’s commitment to addressing the social determinants of health. As Dr. Ross said, “If you put the phrase ‘Health Happens Here’ on a photo of a healthy school lunch, or a bike path, or a father and daughter hugging each other, we immediately communicate the norms change we are promoting.”

Three campaigns are incorporated under the broad banner of Health Happens Here. Health Happens in Neighborhoods defines TCE’s work to create places where children, youth, and families can walk, ride bikes and play together, and enjoy safe outdoor spaces that are pollution free. It includes efforts to increase access to healthy food, housing that is livable and affordable, and transit-focused development. The second campaign, Health Happens in Schools, seeks to link health and academic performance in multiple ways, including improving school meals and physical activity programs, engaging parents and children in decision making, and creating a school climate that is positive and respectful of all students and staff. Last, Health Happens with Prevention incorporates TCE’s efforts to use the Affordable Care Act to catalyze a new health system that increases access to high-quality and affordable care and links that care to community resources for preventing disease and promoting wellness.

Three years into Building Healthy Communities, we are beginning to see signs of change in our fourteen places and across the state. While we don’t underestimate the challenges going forward, we have a better understanding of four core ingredients needed to achieve our ambitious goals. First, support for community leaders and residents to build the power and use the knowledge and evidence they will need to promote change for the long run is essential. Second, engaging young people directly in developing

strategies to improve their health will build momentum and, through social media, spread. Third, the message (and the messenger) matters and sends a signal about what you are partnering with community about, what you hope to achieve, and how you intend to achieve it.

Finally, if we are to sustain healthy communities across the state, we will need to deepen our understanding of what is needed in communities. Listening carefully, while at the same time being fully present, transparent, and sharing of the knowledge, experience, and resources that exist

outside of community, is essential. By establishing trust and partnership, it is possible to both dig in for the long run and at the same time seize opportunities. These are the ingredients for transformation that can make healthy communities a reality.

---

*Marion B. Standish is senior advisor to the office of the president of The California Endowment.*

*Robert K. Ross is president and chief executive officer of the California Endowment.*

---

# Building Healthy Communities in Massachusetts

## Key Ingredients and Lessons Learned

BY STEVE RIDINI,  
SHARI SPRONG,  
AND JUDITH FOLEY

Massachusetts has been developing and encouraging healthy communities for more than two decades. A supportive infrastructure was developed through a collaborative partnership between the state Department of Public Health (DPH) and Health Resources in Action (HRiA), a nonprofit public health organization. With DPH as a strategic funder and thought leader in the process, HRiA developed and implemented the state partnership, which oversaw systematic training and mentoring for coalitions across the state that were engaged in health planning at the local level. In addition, DPH provided a system of technical assistance centers, the Regional Centers for Healthy Communities (RCHCs), which assisted the coalitions as they progressed through the process of creating healthier communities. With strong statewide support and hard work on the local level, Massachusetts has grown numerous robust healthy communities coalitions. This process has prepared both the state and localities to understand the current environment and trends, identify and implement evidenced-based/informed approaches based on data, and move forward easily as new opportunities arise.

### Key Ingredients

One of the first ingredients necessary in creating an environment in Massachusetts that was supportive of healthy communities' coalitions were state-level leaders who had a vision and the leadership qualities to inspire and engage others in the Healthy Communities Movement at the state and community levels. One of these leadership qualities was listening to others in state-level positions to be able to address their concerns as well as to community leaders to learn what was working and what was interfering with the communities doing their work. In addition, these leaders were willing to support local decision making, meaning they were willing to

give up some of their control over the coalitions' developmental processes and outcomes. To further support and expand the coalitions, it was important to have champions at all levels, from state and local governments to community leaders, whether formal or informal leaders. These individuals or agencies promoted and encouraged healthy communities processes and helped to create a critical mass of support across the state. DPH also promoted participation in communities initially by setting expectations for DPH-funded providers to become involved in the multisectoral collaborations in their communities, encouraging them to focus beyond just their own programs.

A vital ingredient was the availability of resources, which included both local volunteers, who became engaged in the healthy communities' process and were willing to give their time, and support from the state in the form of training and technical assistance. This support required a system change in the way public health resources were allocated, from issue focused (e.g., chronic disease, substance abuse) to less categorical skill building for teams of coalition leaders and members (e.g., coalition building, data collection and assessment, leadership, planning), so the communities could look at their issues more broadly. Through collaboration between the DPH and HRiA, a partnership was created to provide capacity building with systematic training in the necessary skills and knowledge, so that everyone received the same information, messages, and skill-building opportunities. Training was provided through the Massachusetts Forum for Creating Healthier Communities (Mass Forum), a program of full-day training sessions given one day per month for ten months. Healthy communities' coalitions applied for admission to the program when they had developed local teams representing several diverse sectors of their community. From 2003 through 2010,



An infrastructure is required to ensure both the diffusion of the principles and the skills needed to implement them as well as the sustainability of systems and coalitions.

sixty-eight cross-sector teams from communities across the state convened on a monthly basis to participate in sessions based on nine healthy community principles:

1. A broad definition of “health”
2. A broad definition of “community”
3. Shared vision from community values
4. Quality of life for everyone
5. Diverse citizen participation and ownership
6. Focus on “systems change”
7. Build capacity using local assets and resources
8. Benchmark and measure progress and outcomes
9. Recruit and engage youth to be full partners in community-based efforts

To provide additional support to the coalitions as they implemented what they had learned, DPH also funded a statewide system of technical assistance centers, the RCHCs.

### Lessons Learned

The nine healthy communities principles gave the framework and language for a grassroots movement and the opportunity for the local coalitions to be a part of something bigger to improve population health. With a broad definition of health coming from the World Health Organization, the movement became a catalyst for thinking about the social determinants of health. With support from national healthy communities’ leaders and the introduction of the healthy communities’ framework and principles, local coalitions moved toward developing multisystem partnerships, valuing diversity, implementing systems change approaches, and measuring indicators to determine progress toward outcomes. This has prepared coalitions across the state to easily adapt to new trends or areas of interest. For example, an emphasis on the use of data and indicators has evolved into widespread implementation of research-based strategies, and the focus on valuing

diversity has become the basis for the next level of work in health equity.

A lesson that developed slowly was the acceptance of the amount of time it takes to make changes. People who were involved at various levels would give up on the process and return to ways they had worked previously. These people included leaders at the state level who provided funding cycles that were too short to accomplish the desired changes as well as those in the community who were more comfortable focusing on individual programs than on persevering long enough to change systems. Actually, when this process began in Massachusetts, “systems change” was not a common phrase or idea. Most work was categorical, focused on specific topics or issues. This necessitated a double shift in thinking, first “How do all of our programs work together toward a common vision?” followed by “What systems are interfering with the health of our community and how do we modify or change them so that they become supportive and promote healthy behaviors?” A multisectoral approach is necessary to accomplish change on this scale. The pace and scope of the process and strategies of healthy communities’ coalitions have both shifted to create greater impacts on their communities. This has prepared the communities to address new issues as they arise and positioned them for new opportunities.

An infrastructure is required to ensure both the diffusion of the principles and the skills needed to implement them as well as the sustainability of systems and coalitions. In Massachusetts, DPH provided this structure in a number of ways. Through collaboration with HRiA, the state partnership was funded to provide capacity building to teams representing multiple sectors from communities. Over a period of ten months, the Mass Forum offered interactive knowledge and skill-building training to prepare the participants to implement the principles of healthy communities at the local level. This training process proved to be transformational for participants (e.g., police, town manager, and other officials). Over time, these teams developed a common language and a shared vision for their communities and learned to work together. Initially, the Massachusetts Partnership also arranged opportunities for communities engaged in the healthy communities’ process to mentor other coalitions that were

not as far along, providing rich feedback and ideas to the mentee coalition and opportunities to further deepen their understanding and commitment to the process to the mentor group. Unfortunately, due to state-level funding shifts, these opportunities were not sustained.

Another important part of the infrastructure included a statewide system of RCHCs, funded by DPH. The RCHCs provided technical assistance for the community teams and their coalitions as they implemented the skills and practices from the Mass Forum, answering questions as they arose and supporting them in areas in which they felt less confident (e.g., data collection or analysis, developing indicators to measure progress). Unfortunately, if the infrastructure is withdrawn or markedly diminished, the lesson learned is that, while well-established coalitions may be sustainable, new groups do not have the resources (e.g., funding, training, expert support) necessary to organize and sustain a multisectoral, collaborative effort for social change.

The importance of volunteers cannot be overstated. Coalitions depend on them to accomplish the majority of work, but once a coalition begins to secure funding to implement strategies, a paid dedicated coordinator is needed. Generally the funding makes possible a variety of strategies, and the coordinator is necessary to make sure all of the strategies are moving forward in support of the common vision. Otherwise, a coalition may end up with various committees, each implementing a particular strategy without an overview of how they all work together, without collecting any measurement of success, and without communication systems in place.

### Conclusion

The lessons learned in Massachusetts closely parallel those being currently discussed as a part of the concept of collective impact. As described by John Kania and Mark Kramer in “Embracing Emergence: How Collective Impact Addresses Complexity” (2013), there are certain conditions

that, when present among a cross-sector group of people, can promote lasting solutions for social problems. These include:

- An infrastructure and staff to coordinate the processes and strategies
- A shared vision and joint approach to solving the issue at hand
- Common systems for measuring results and communicating clearly across the members and sectors
- Different activities or strategies across the sectors that are mutually reinforcing and part of a coordinated plan

With these “rules for interaction” in place, solutions and resources can emerge that aren’t known in advance but arise over time through collective vision and effort. This has been true on the state level in Massachusetts as well as in the communities that have developed these conditions locally.

Promoting and supporting principles of healthy communities through coalitions across the state has positioned Massachusetts to effectively address emerging public health issues such as tobacco and obesity prevention through a health equity lens with broad community engagement, multisectoral collaboration, and data-driven systems change approaches focused on impact.

### Reference

Kania, John, and Mark Kramer. 2013. “Embracing Emergence: How Collective Impact Addresses Complexity.” *Stanford Social Innovation Review* 1–7.

---

*Steve Ridini is vice president of Health Resources in Action and head of the Community Health Division.*

*Shari Sprong has worked for twenty-four years as a prevention specialist and assistant director of the Greater Boston Center for Healthy Communities, a program of Health Resources in Action.*

*Judith Foley is special projects director at Health Resources in Action.*

---

# LiveWell Colorado

## Investing in Local Movements to Create Statewide Change

BY MAREN STEWART

Obesity is a growing health and economic crisis throughout the country. Even the leanest state, Colorado, is not immune to this epidemic. The current adult obesity rate of 20.9 percent would have made Colorado the most obese state in the nation just fifteen years ago. If current trends continue, 45 percent of Colorado adults could be obese by 2030.

If you take a look at the statistics on a more local level, you will see that the disparity of obesity in our state is quite profound. Obesity is local in nature and highly dependent on a variety of conditions often resulting from unique characteristics in each area. Several counties, including Bent County and Garfield County, have higher rates of adult overweight and obesity than the most obese state in the nation, with 86 percent and 63.7 percent, respectively.

Obesity is a highly complex issue. It is not simply an outcome of individual choices but also a result of limited access to healthy opportunities affected by environmental, societal, economic, cultural, and political variables that are diverse and unique among our communities.

As a result, while a statewide approach is critical to addressing our obesity epidemic, it will always be—taken in isolation—limited by its capacity to address localized issues. For example, there are challenges with consistent implementation of statewide policies. Likewise, there are complexities with communicating at a statewide level since messages are heard within varying cultural, political, and educational constructs. Consequently, there is a clear need for policies and messages to fit local needs; yet these local efforts must also fit under a larger statewide umbrella in order to gain momentum and strength rather than becoming fragmented and ineffective.

LiveWell Colorado, a nonprofit organization committed to preventing and reducing obesity by promoting healthy eating and active living, was

established to lead this convergence effort in Colorado. Using a supply-and-demand approach, LiveWell Colorado works in collaboration with multisector coalitions and diverse partners to build access to and opportunities for healthy eating and active living within our schools, workplaces, and communities. Ultimately, the goal is to create a culture shift in which the healthy choice becomes the easy, default choice.

LiveWell Colorado executes three primary, integrated, action-based strategies:

1. Investing in multisector community coalitions throughout the state focused on developing and implementing healthy eating and active living strategies
2. Informing and advancing policy efforts at the local, state, and federal levels as well as organizational policy changes in schools and work sites
3. Leading social change initiatives that inspire sustainable healthy individual behavior changes and make the healthy choice the easy choice

A key pillar of LiveWell Colorado's work, the Community Investments strategy offers a bidirectional platform by which our policy and communications strategies are informed and amplified through locally mobilized coalitions, which include resident leaders, local government agencies, community-based organizations, businesses, school districts, and health care providers. To date, LiveWell Colorado has awarded more than \$20 million to thirty-one communities working on healthy eating and active living on the local level. In addition to financial support provided through a unique funding cycle of up to nine years, LiveWell Colorado provides significant technical assistance and opportunities for shared learning and collaborations. Since 2005, the Community Investments program has directly benefited more than 1.2 million Coloradans.

The fundamental construct of the community investments strategy relies on *sustainable and systemic* action because obesity rates will not be shifted in a permanent manner over a period of five to ten years. Rather, change will require a long-term investment and place-based approach that will take closer to fifteen to twenty years. Accordingly, the funding model for LiveWell Colorado Communities is a staged approach that includes four phases:

1. A mobilization and planning phase (up to one year) to mobilize community stakeholders; assess current circumstances, opportunities, and barriers around obesity; and create a multiyear strategic plan laying out the intended outcomes and interventions
2. An early implementation phase (up to three years) to begin to deliver interventions and set conditions capable of creating access and demand for healthy eating and active living (HEAL) behavior-related outcomes
3. An implementation phase (up to three years) to translate interventions into conditions that create access to and demand for specific HEAL behavior-related outcomes and to accomplish demonstrable behavior changes among targeted populations (i.e., youth, low socioeconomic status [SES] families, etc.)
4. An advanced implementation phase (two years) to focus on one or two specific strategies to create sustainable institutional adoption for the HEAL movement in a local community beyond LiveWell Colorado's initial investments

Although the period of time a community spends in each phase can vary, total funding does not exceed nine years and depends on the evolution of community progress. The impetus and origins of the LiveWell Colorado Communities vary vastly, with several having roots in the Colorado Trust's Colorado Healthy Communities Initiative (CHCI), which started in 1992 to assist communities in defining their own vision of a healthy community and in working to achieve that vision. In fact, the work of these communities precedes the existence of LiveWell Colorado, which was initially established as a grant-making collaborative in 2007 and became a 501(c)(3) in 2009 with the support of initial funders—the Colorado Health Foundation and Kaiser Permanente—and in partnership with

Although many of the communities work on similar strategies, the way they go about creating change is unique to their community's needs and circumstances.

the Colorado Department of Public Health and Environment.

From working with local schools to improve students' access to healthy food to creating safer environments in which individuals can be more physically active, LiveWell Colorado communities advance community-level strategies that help make the healthy choice the easy choice for their residents. LiveWell Colorado encourages strong emphasis on strategies addressing healthy food consumption among low-SES communities, school wellness policy implementation, and active transportation infrastructure; however, this is balanced with deference to the unique attributes of the local communities.

Although many of the communities work on similar strategies, the way they go about creating change is unique to their community's needs and circumstances. Likewise, they do not necessarily use traditional public health approaches. The following communities—representing diverse areas of the state—show the breadth of the Community Investments model.

#### **LiveWell Alamosa: Supporting Local Food to Improve Access to Healthy Food**

Established in 2006, LiveWell Alamosa recently turned its community coalition into a nonprofit, the San Luis Valley Local Food Coalition, focused on improving access to healthy local food in its rural community. As a major part of its advanced implementation phase, this change is a reflection of the amount of energy and excitement surrounding the need for local healthy food in the community. There is a concerted effort to increase the number of farmers growing specialty crops while also increasing the demand among consumers to make this a viable business opportunity for the farmers. The coalition continues to gain momentum and improve the

health of its residents by helping to increase the number of local farmers' markets, supporting farm-to-table efforts, and integrating gardening into school curriculum.

#### **LiveWell Fort Collins: Building Capacity to Change Organizational Policy**

Established in 2006, LiveWell Fort Collins has shown tremendous strength in building capacity to change organizational policy that affects healthy eating and active living in its suburban community. LiveWell Fort Collins grew out of the Coalition for Activity and Nutrition to Defeat Obesity, which originated in 2003. From helping the school district pass a mill levy to support physical education in schools to working with the City of Fort Collins to adopt a healthy vending policy for the Parks and Recreation Department, LiveWell Fort Collins is institutionalizing important, sustainable change.

#### **Westwood Unidos: Creating Behavior Change to Align with the Culture**

Established in 2008, Westwood Unidos is the first LiveWell Colorado Community to make significant progress on changing the culture of its urban community primarily composed of Latino residents, many of whom are monolingual Spanish speaking. This advancement has been made by focusing on culturally relevant strategies that empower residents. For example, through a partnership with

community residents, the Colorado Center for Community Development at the University of Colorado Denver, area host sites, and numerous instructors, Westwood Unidos provides more than sixty free Zumba classes per week to hundreds of residents. Before Westwood Unidos introduced the classes in 2010, the neighborhood—where nearly 25 percent of residents live in poverty—lacked access to safe options for active living. Zumba has become a new cultural norm for the community and resulted in increased physical activity for the residents. Additionally, members of the community worked with the city of Denver to secure \$1 million to build a new park that reflects the community's culture. Westwood Unidos is a terrific example of the power of building residents' individual capacity to become resident leaders and key change agents in their community.

These communities provide a glimpse into the collaborative and successful effort under way to make Colorado healthier. Only through a convergence of efforts, in which shared objectives are accomplished across boundaries and among different stakeholders and organizations, will we collectively impact the obesity epidemic and minimize its devastating effects in our communities and throughout our state.

---

*Maren Stewart is former president and chief executive officer of LiveWell Colorado.*

---

# Convergence Partnership How a Group of Philanthropists Broke the Mold and Unlocked the Power of Collaboration

BY JUDITH BELL  
AND LARRY COHEN

Three years ago, leaders of the Mary Black Foundation, in Spartanburg, South Carolina, decided to involve community residents and leaders in setting priorities and selecting funding projects and sought support from the Convergence Partnership, a collaborative of large national funders and healthcare organizations. Together, they kicked off a series of community meetings in an area where up to 40 percent of people live in poverty. The gatherings led to the creation of the Northside Leadership Council, whose fifteen residents now advise the foundation on funding priorities and assume direct leadership roles in new initiatives.

Early in the community discussions, access to healthy food emerged as a critical issue. The community asked, “If ice cream trucks can come into our community, why can’t we produce trucks?” Answering the question led the council to help establish plans for the Northside Community Food Hub, which will provide a permanent home for a farmers’ market, classrooms, community gardens, a café, a catering kitchen, and retail space (set to open January 2014). After securing agreements with the local housing authority and schools to set up the community gardens, the council oversaw the funding and creation of a mobile farmers’ market that accepts electronic benefit cards and brings fresh local food to low-income neighborhoods.

For the foundations and health care organizations that make up the Convergence Partnership, the efforts of the Mary Black Foundation and the Northside Leadership Council are exactly the kind of place-based environmental changes the partnership hoped to catalyze and was proud to support.

## Convergence Idea

It all started a few years earlier when leaders of three organizations—Kaiser Permanente, the Robert Wood Johnson Foundation, and the W.K. Kellogg Foundation—began talking informally, building on early research and engagement that started in 2005 via Active Living by Design. Each felt the limits of what they could do alone to stem the tide of health problems related to unhealthy eating and inadequate physical activity and recognized the need to move upstream to systemic change. They also knew of other foundations doing similar work but largely disconnected from one another.

“We were all planning, or were already making, fairly substantial investments in this area, with a focus on policy, systems and environmental change,” recalls Loel Solomon, vice president for community health at Kaiser Permanente. “We thought there was a big opportunity to more intentionally collaborate—that we could create a whole that was bigger than the sum of our cohorts of grantees.” The conversations grew more serious and in 2007 the Convergence Partnership was born, linking different organizations with a shared action agenda. The three founding partners—Kaiser Permanente, the W.K. Kellogg Foundation, and the Robert Wood Johnson Foundation—eventually were joined by Nemours, the California Endowment, Kresge Foundation, Ascension Health, and the Rockefeller Foundation. The Centers for Disease Control and Prevention (CDC) is the partnership’s technical advisor. Since its founding, the Convergence Partnership has brought its credibility and advocacy efforts, along with more than \$22 million in funding, to advance its vision of healthy people and healthy places through equity-focused policy and environmental change at the local, regional, state, and national levels.

The Convergence Partners embraced collaboration to amplify their impact. This new way of conducting philanthropy not only asked the organizations and advocates on the receiving end of grants to work together but placed similar expectations on the partnership.

The partnership committed itself to *a vision* and a *process* to ensure that every community fosters health, prosperity, and well-being for all residents. This vision rests on three key principles:

1. *Equity* as the means to ensure that everyone has the opportunity to participate and prosper
2. *Policies and practices* to create conditions that sustain healthy people and healthy places
3. *Connections* among people across multiple fields and sectors that catalyze and accelerate the work

The process involves partners working together as funders, advocates, and network developers to promote health and equity and to foster environmental change in communities across the country. The partnership works to bring together leaders from multiple sectors—including local and regional funders—to work in concert with each other. The effort creates a “field of fields,” connecting diverse constituencies with a broad, shared vision and convergent strategies. By making grants from a shared pool and coordinating federal advocacy efforts, the partners can speak with one voice, take risks together that an individual institution might not take alone, and advance a shared agenda.

PolicyLink is the program director for the partnership, providing policy support, management, and strategic direction. Prevention Institute acts as key advisor on policy and strategy, and together the two groups develop and implement key components of the work. Financial management and grant-making services for the Convergence Partnership are provided by Tides Foundation.

### **Expanding the Partnership's Work**

From the beginning, the partnership focused on advancing its vision of healthy people and healthy places. Thus, its initial focus was on improving access to healthy food and the built environment, the ways that community design affects health and well-being. One of its first grants was aimed at creat-

ing a national version of the Pennsylvania Fresh Food Financing Initiative, which provides financing to establish healthy food retail outlets in underserved communities throughout the state. In the early days of the Obama administration, the partnership provided critical support to organizations leading efforts to establish the national program eventually called the Healthy Food Financing Initiative, which has leveraged more than \$1 billion to develop grocery stores, co-ops, farmers' markets, and food hubs providing access to fresh, healthy food in low-income communities across the country. The partnership began to see larger opportunities to make a difference and set its sights on the federal farm bill.

The partnership committed itself to a vision and a process to ensure that every community fosters health, prosperity, and well-being for all residents.

### **Expanding the Partnership's Reach**

Broader change required this focus since the farm bill sets national policy for farms and food and has critical implications for the health of communities. The partners reached out to additional funders and established the Food and Agriculture Policy Fund to strengthen ties between a diverse set of interests and support policies spanning food security, food access, and sustainable agriculture. The fund provides grants to organizations and partners that are now, for the first time, working collaboratively to advance four policy targets: (1) healthy food financing, (2) healthy food incentives, (3) protecting and expanding SNAP (Supplemental Nutritional Assistance Program, formerly known as food stamps), and (4) strengthening regional food systems. All of these issues are included in the proposed Senate farm bill.

The partners also focused on linking health and transportation policy advocacy, which is about more than just cars and trucks and could help advance health and equity by supporting transit and increasing opportunities for people to walk and bike. For many of the partners, this was their entry into the transportation arena. The partnership supported alliances, including Transportation for America and the Leadership Conference for Civil and Human Rights, to advocate for health and equity

and the protection of public transit and active-transportation measures. Recognizing that safety required reducing violence and fear of violence, the partnership also supported six city pilot projects where violence-prevention advocates joined groups working to promote physical activity, parks, and transit to shape efforts to foster safe places in neighborhoods.

### **Taking the Model Local and Influencing Federal Programs**

To expand local, regional, and state efforts to advance their vision, the partnership supported the development of regional convergence partnerships in fourteen areas across the country, with more than fifty-five foundations participating. These foundations joined with strategic partners—advocacy organizations, public agencies, and business interests—to advance healthy people and healthy places. Like the national partnership, they engage in joint grant making to advance equity, policy, and environmental change. A community of practice is emerging as the partners jointly learn and advocate for a shared agenda.

As the federal government began to implement aspects of the Affordable Care Act, the Convergence Partnership applied its lessons learned to help shape the design and implementation of programs to advance health, prevention, and equity. One example was the Community Transformation Grants program administered by the CDC. The partners pushed for the program to build in a focus on environmental change and equity, engage strongly with community-based organizations, and promote connection and coordination with other regional efforts to improve community conditions. The program has awarded \$177 million to communities across the country.

### **Creating Funding Opportunities**

The partnership also created an Innovation Fund to support local and regional foundations to improve access to healthy food and changes in the built environment to benefit and engage underserved, low-income communities and communities of color. The \$2 million in Innovation Fund grants provided by the partners to fifteen foundations leveraged an additional \$16 million and led to fifty policy changes and significant shifts in philanthropic practice for greater equity and inclusion.

One recipient was the Northwest Health Foundation, founded in 1997 to advance, support, and promote the health of the people of Oregon and southwest Washington. With Innovation Fund support, the foundation created a new initiative aimed at advancing policy and environmental change strategies to improve health, focused on communities of color and incorporating their leadership. An advisory board of community representatives was convened to design the initiative, review applications, and select grantees. The lead applicant of any proposal was required to be an organization representing one or more communities of color, the first time the foundation had included such a qualification.

The foundation then made seven grants to organizations working in Multnomah County's (in Oregon) most disadvantaged neighborhoods. Grantees used support from the foundation, along with matching funds, to build a new park in one of the most diverse low-income neighborhoods in the city, to open a community garden for African immigrant and refugee families, and to ensure that the Portland Plan, the city's policy framework to guide future physical, economic, and social development, benefits disadvantaged communities.

### **Looking to the Future**

The first seven years of Convergence Partnership experience have reaffirmed the reasons for its creation and demonstrated the value of collaboration. It also has revealed some important lessons about how a shared vision can advance at multiple levels, altering policies and environments to create positive, lasting change.

And for the Mary Black Foundation and the Northwest Health Foundation, acting locally has become a lot easier, with a little strategic assistance from its friends.

---

*Judith Bell is president of Policy Link, a national research and action institute advancing economic and social equity by Lifting Up What Works®.*

*Larry Cohen is executive director of Prevention Institute, a nonprofit research, policy, and action center that works to create healthier, safer, and more equitable communities.*

---



# Advancing the Movement Realizing the Potential of Healthy Communities across the Nation for Preventing Chronic Disease

BY JAMES W. KRIEGER,  
SARAH L. STRUNK,  
AND TYLER NORRIS

Chronic diseases affect almost 50 percent of Americans and account for seven of the ten leading causes of death in the United States. Recent estimates suggest that 75 percent of all health spending is attributable to chronic diseases. The economic burden is staggering, costing the nation more than \$1 trillion a year, including \$277 billion in direct health care costs. At the same time, health inequities—disparities in health that are a result of systemic, avoidable, and unjust social and economic policies and practices that create barriers to opportunity and disproportionately affect people with low incomes and people of color—persist. Preventable health risk factors, such as tobacco use and exposure, insufficient physical activity, and poor nutrition, are driving these inequities and the relentless increase in health spending, and they threaten to overwhelm the health care system. Our nation is struggling with an epidemic of chronic disease, and more effective approaches are needed to address these risk factors.

Concerns about the epidemic and its impact on health, economic vitality, and equity have led to a resurgence of the Healthy Communities Movement during the past decade. Understanding that traditional health education programs and promotional campaigns alone have been ineffective in promoting healthy behaviors, the movement recognizes the important role of built, food, and social environments on people's ability to make healthy choices, the essential role of policy and systems change for creating healthier environments, the need to engage many community sectors, and the importance of addressing health equity.

Pioneering work and investments in large, community-based initiatives, such as Steps to a Healthier US (US Centers for Disease Control and Prevention [CDC]), Healthy Eating, Active Communities (The California Endowment), Active

Living by Design (Robert Wood Johnson Foundation [RWJF]), THRIVE/HEAL (Kaiser Permanente), and Food and Fitness (W.K. Kellogg Foundation) helped increase awareness of the relationship between place and health. A groundswell of local interest in this work and this new funding for community partnerships engaged a range of sectors and advocates, such as public health, health care, urban planning, community development, parks and recreation, transportation, walking and biking advocacy, food systems, social justice, environmental justice, education, faith, local government, business, philanthropy, and more.

Building on the momentum generated by these early initiatives, additional national programs such as the CDC's Communities Putting Prevention to Work and Community Transformation Grants, RWJF's Healthy Kids, Healthy Communities, and YMCA-USA's Healthier Communities Initiatives as well as new state and local efforts helped bolster the movement. Once limited to isolated examples in some of the most progressive areas of the country, by 2010 the number of coalitions engaged in this work had increased exponentially as the evidence base was validated, opportunities for funding grew, and multi-sector partnerships gained experience implementing policy, systems, and environmental change strategies to promote healthier behaviors and create healthier communities. Despite this progress, many local and statewide initiatives operated in a vacuum and were disconnected from sister efforts across the nation. Limited mechanisms for creating a common agenda, coordinating activities, disseminating tools and resources, and sharing lessons learned resulted in inefficiencies and missed opportunities to collaborate and effect comprehensive change.

In addition, many of the technical assistance providers and funders that were supporting the

movement recognized they were not realizing the full potential of their investments thanks to lack of coordination. Communities faced many (often competing) activities and expectations that accompanied their grant-funded work when it was supported by multiple sources. While the Convergence Partnership filled an important role with national, state, and local funders, members of community partnerships working on place-based initiatives expressed a desire to learn from and network with each other. Interest seemed particularly strong among those whose grant funding and technical assistance were ending—and among those who had never received funding at all.

In a short period of time, ATM contributed to the healthy communities movement by mobilizing leaders across sectors and contributing to the development of tools to support learning and networking.

Advancing the Movement (ATM; [www.advancingthemovement.org](http://www.advancingthemovement.org)) was launched in spring 2010 to help coordinate and leverage the impact of these community initiatives. At its founding meeting, a broad cross section of local leaders, technical assistance providers, funders, and key advisors identified the need to build a map of the movement so that like-minded advocates for healthy communities could identify hotbeds of activity and learn from their peers across the country, regardless of their funding status. Other proposed activities included coordinating efforts to address key policy priorities, focusing on health equity, and providing resources to support communities that lacked grant funding.

ATM's initial work focused on developing a map of the movement in order to complement existing efforts and maximize the use of its limited resources. When fully built out in 2012, this became a core part of the Community Commons ([www.communitycommons.org](http://www.communitycommons.org)). Today, the Commons is an interactive mapping, networking, and learning utility for the broad-based healthy, sustainable, and livable communities movement.

In addition to supporting the development and launch of the Community Commons, other early accomplishments included creating and enhancing

partnerships to promote action related to high-priority public health issues. For example, ATM encouraged communities to pledge to implement the inaugural National Prevention Strategy. Similarly, ATM worked with the Trust for America's Health and other partners to help build public understanding and support for the Prevention and Public Health Fund, the primary source of federal funds for healthy communities work. ATM's Policy Committee, which included two dozen public health policy leaders from across the country, began connecting local community leaders with policy opportunities at state and federal levels. And to facilitate the integration of health equity as a core component of all healthy communities initiatives, ATM's Health Equity Committee laid the groundwork for establishing a concrete and ultimately measurable approach to addressing health equity in communities at risk for preventable health disparities.

In a short period of time, ATM contributed to the healthy communities movement by mobilizing leaders across sectors and contributing to the development of tools to support learning and networking.

Given the need to continue to communicate the value of prevention, protect funding for healthy communities initiatives, and support the growth of the movement, the work that ATM helped launch is far from over. A survey of over 1,300 Commons users conducted in early 2012 suggests four areas of focus in which future investment is needed:

1. Increasing networking and peer-to-peer learning among the thousands of healthy community initiatives across the nation. Mechanisms could include online discussion groups facilitated by content experts, listings of communities and leaders with successes and expertise in specific strategies who are available to mentor others in earlier stages of implementation, active matchmaking of communities employing similar approaches, and webinars featuring the work of local communities.
2. Increasing the voice of local communities in dialogue with funders and other national organizations.
3. Increasing the engagement of local communities in state and national investments, practice change, and policy discussions that affect the

health of communities, such as competitive food regulations in schools, the fate of the Prevention and Public Health Fund, transportation policy, and the Farm Bill.

4. Delineating and building consensus around the strategies and community-based agenda needed to achieve health equity and to identify ways to ensure that funders and policy makers adopt health equity as an integral part of these initiatives.

As ATM evolved, we learned many lessons that will help inform the future success of the healthy communities movement and may be instructive in the development of similar efforts. Among the lessons are these four:

1. *Develop a common vocabulary.* Terms such as “advancing,” “movement,” “healthy communities,” and “equity” were defined differently by members of the ATM advisory council and key stakeholders. While this is to be expected, given the many disciplines, sectors, and perspectives represented by the group, building consensus about definitions is important to ensure consistency of mission, focus, and communication as a new initiative takes shape. ATM leadership and the advisory council revisited these terms frequently, especially as new representatives were recruited.
2. *Balance flexibility with a reasonable amount of structure.* From the beginning, ATM was described as “a conversation” in order to avoid creating an unwieldy, expensive, unsustainable infrastructure. Given ATM’s initial focus, this was understandable. However, over time and with changes to advisory council leadership and membership, it became clear that some level of structure was needed in order to clarify roles, responsibilities, and communication paths and that ongoing funding was necessary to support infrastructure activities.
3. *Outreach and mobilization efforts need to account for a range of interests and capacity to engage in policy change and advocacy work.* A variety of opportunities and methods of engage-

ment, tailored to degree of readiness, are needed. For the fewer more-experienced leaders, information about opportunities to weigh in on policy issues and sample messages may be all that is needed. For the many leaders for whom policy and advocacy work is new, more robust support is necessary, including learning advocacy skills, understanding how to work effectively within lobbying constraints, and increasing understanding of the policy issues in play.

4. *Networking and linking require multiple approaches.* While Web-based platforms and the Internet are powerful tools, they do not eliminate the need for outreach, personal communication, and relationship building by leaders and organizers.

Coordination, alignment, and support to the field are more important than ever as more communities engage in healthy communities work even as federal and foundation funding becomes less certain. Local healthy community leaders have identified the type of support they need to sustain and expand their work. Local, state, and national leaders across all sectors have important roles to play in continued efforts to help them advance the movement. Leveraging the connections built through ATM to help fulfill the potential of the Community Commons is a logical next step. While the form this may take is not yet clear, the need is. Everyone needs healthy places in which to live, work, learn and play. These are basic human rights, not amenities for a privileged few.

---

*James W. 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.*

*Sarah L. Strunk is director of Active Living by Design at the UNC Gillings School of Global Public Health in Chapel Hill, North Carolina.*

*Tyler Norris led consulting services at the National Civic League from 1989 to 1995 and is the guest editor of these special issues of the National Civic Review. He currently serves as vice president, Total Health Partnerships at Kaiser Permanente.*

---

# Racial and Ethnic Approaches to Community Health

BY LARK GALLOWAY-GILLIAM

Despite improvements in morbidity and mortality rates for some of the leading causes of death in the United States, the health status of racial and ethnic populations lags seriously behind and is often comparable to that of low- and underresourced nations. African Americans have higher rates of diabetes, hypertension, and heart disease than any other group, and black children are far more likely than white children to visit an emergency department. They have a higher death rate from asthma. Fourteen percent of Hispanics have been diagnosed with diabetes compared to 8 percent of whites; they are 50 percent more likely to die from diabetes as non-Hispanic whites. Hispanic women are diagnosed with cervical cancer at twice the rate of white women. Asian Americans suffer higher rates of certain types of cancer, tuberculosis, and hepatitis B: Cervical cancer rates for Vietnamese American women, for example, are five times those of white women. From 2003 to 2006, the direct and indirect costs of health disparities totaled \$1.24 trillion. This breaks down to a \$309.3 billion loss each year on the local and national economy. Many of these illnesses and diseases are preventable and attributed to the conditions in which people live and work. Despite a decline in segregation over the last fifty years, housing patterns reveal significant and persistent segregation by race. Racial segregation is often compounded by a divestment of public and private resources, a higher concentration of hazardous sites and incompatible uses, fewer health care resources, a lack of access to health-promoting nutrition and physical activity infrastructure, and poverty.

The Racial and Ethnic Approaches to Community Health (REACH) program was designed to develop community-driven interventions and solutions to the disproportionate rates of cardiovascular disease, diabetes mellitus, HIV/AIDS, infant mortality, breast or cervical cancer, and immunization within one or more of these racial and ethnic groups: African American, Hispanic/Latino, Asian Pacific Islander, and Native American/Alaska Natives. It began as a research and demonstration project in 1999

in forty-two communities across twenty-three states and continues today with subawards to ninety communities through six national-level grants. The initial funding supported a partnership with three core partners (a community-based organization, university, and local department of public health) and a multisector coalition to develop a community action plan delineating their local interventions and evaluation activities. Consistent with the healthy cities model, the REACH program addresses inequality in health and urban poverty; the needs of vulnerable groups; participatory governance; and the social, economic, and environmental determinants of health.

Each community determined which racial/ethnic group or groups and which health priority areas should be targeted. Subsequent funding provided support for the implementation and evaluation of the intervention activities around three core areas designed to reduce racial and ethnic health disparities: health education and promotion, clinical and preventive services, and policy and systems change. REACH interventions focus on the root causes and social determinants of health and are by design accountable to, responsive, and reflective of the specific needs of each geographically specific racial/ethnic community. The REACH program has empowered residents to seek better health and actively engage the health, public health, and non-health sector to implement innovative evidence- and practice-based strategies that promote healthier communities.

REACH communities across the country have demonstrated that health disparities are not intractable. They have worked with school districts, city agencies, health care providers, and community members to achieve concrete change in the systems and policies that have contributed to health disparities. In South Carolina's Charleston and Georgetown counties, improvements in the health care education delivery system for self-management of diabetes resulted in a 44 percent reduction in

amputations for African Americans. These improvements were designed and implemented by the South Eastern African American Center of Excellence in the Elimination of Disparities in Diabetes program at the Medical University of South Carolina College of Nursing, a REACH grantee. Similar impacts were achieved through culturally tailored and competent interventions in other communities. In New England, working with community groups and local health care providers, the Greater Lawrence Family Health Center reduced total cholesterol to under 200mg/dL in 71.9 percent of Latino patients with diabetes. Absences were reduced in Boston's schools, there was a 68 percent decrease in asthma-related emergency department visits, and an 84 percent decrease in hospitalizations as a result of the work of the Community Asthma Initiative REACH program.

The REACH program goes beyond health care and seeks to fully integrate health considerations in economic regeneration, community development, and environmental efforts. The Cherokee Choices Program of the Eastern Band of Cherokee Indians works to reduce the risk for type 2 diabetes and cardiovascular disease in rural western North Carolina. They secured an agreement to ban fast food from schools and require approved healthy foods at school events, and they collaborated with the regional food bank to provide supplemental fruits and vegetables for low-income children in the Cherokee school system.

In an effort to reduce disproportionately high rates of nutrition-related chronic diseases such as cardiovascular disease and diabetes, Community Health Councils (CHC) in Los Angeles worked with city planning to introduce land use standards to reduce the proliferation and overconcentration of fast food restaurants. CHC also collaborated with local grocers, community developers, and a charitable foundation to establish California's \$230 million Fresh Food Financing Fund to eliminate food deserts and fight childhood obesity.

The Bronx REACH program brought city, public health, and school officials together to establish a citywide low-fat/skim milk-only policy in New York City public schools, affecting 1.1 million students. The Public Health Institute—Regional

Asthma Management and Prevention program focused on addressing asthma disparities among African American/black and Hispanic/Latino populations in nine counties in the San Francisco Bay Area of California. Working with land use and transportation planners, they were able to secure the passage of new diesel regulations by the California Air Resource Board.

The REACH program goes beyond health care and seeks to fully integrate health considerations in economic regeneration, community development, and environmental efforts.

These are a few of the many success stories in communities facing difficult health challenges. The REACH programs across the country are closing inequities in health. A national behavioral risk factor survey conducted in 2001 and again in 2009 highlights the success of REACH. In the eleven communities that were examined, meaningful improvement occurred in thirty-four of the forty-eight benchmark measurements.

- From 2009 to 2011, cholesterol screening increased among African Americans 74 to 78 percent, Hispanics 58 to 71 percent, and Asians 53 to 72 percent in REACH communities while screening decreased or remained constant among the same population groups nationwide.
- From 2001 to 2009, the percentage of Hispanics who reported having hypertension and were taking medication for it increased from less than half to more than two-thirds.
- During the same period, pneumonia vaccination rates increased from 50.5 to 60.5 percent in black communities, from 46.0 to 58.5 percent in Hispanic communities, from 37.5 to 59.7 percent in Alaskan/Pacific Islander communities, and from 67.3 to 78.7 percent in Native American communities.

The REACH program has been on the cutting edge of innovative policy and systems change to reduce health disparities. At its foundation is the engagement of those who share and are bound together by a geographic area and a set of conditions that impact

how they work, live, and govern. The REACH program stands as a model of the Healthy Cities organizing methodology that engages both policy makers and community stakeholders in a visioning process leading to collective action that reflects their values and a strong sense of ownership. These efforts have resulted in unprecedented partnerships and collaboration across a broad range of sectors and systems. Implementation is based on principles and values related to equity, empowerment, partnership, solidar-

ity, social justice, and sustainable development. Only through a community-driven and led process such as the REACH program can the United States truly develop “healthy cities.”

---

*Lark Galloway-Gilliam is executive director of Community Health Councils, a Los Angeles-based health promotion, advocacy, and policy organization dedicated to building healthy communities.*

---

# Importance of the Private Sector in Creating Healthier Communities

BY LAWRENCE A. SOLER

In Everytown, USA, early childhood education and before-school programs ensure that kids get healthy snacks and meals, little to no screen time, and are physically active at least sixty minutes throughout the day.

In schools, vending machines have healthier options. School lunches are low in added sugars and sodium and include default items such as low-fat milk, water, and fresh vegetable and fruit sides. Gym class or recess is a daily activity.

After-school programs look a lot like early childhood education and before-school programs: healthy snacks and meals, very little screen time, lots of physical activity. Sports teams and dance classes are built to encourage habits in kids that will keep them active their entire lives. Coaches also serve as mentors, and for younger kids, having fun is emphasized more than the goal of grooming competitive athletes.

As parents leave work, they can Google quickly from their phones and find easy, healthful recipe to make for dinner and coupons for some of the items they need. They stop at a grocery store on the way home, where wholesome foods are easy to grab, affordable, and plentiful. As with many families, getting dinner on the table is hectic, but having a store with healthier options nearby makes this feat much easier.

Over the weekend, the kids walk to a new tennis court nearby for free lessons through a US Tennis Association program. As a treat that night, the family has dinner at a local restaurant, where the kids' menu options all come with fruit and veggie sides and 1 percent milk as defaults.

Everytown, USA, exists in an ideal world that many of us are working together to create, whether our daily focus is on policy change, the built environment, or making healthier choices available in the marketplace. Everytown is not possible without the

small changes that are happening in communities around the country every day and have been happening for many years. And our collective goals are not possible without the collaboration of advocates, educators, civic leaders, elected officials, parents, families, and the private sector.

## Making the Healthy Choice the Easy Choice

The Partnership for a Healthier America (PHA) was formed in 2010 to help bring private sector organizations to the table to fight childhood obesity. We were created as part of First Lady Michelle Obama's efforts to end childhood obesity within a generation. She serves as our honorary chairwoman. PHA is a nonpartisan, nonprofit organization that counts former US Senate Majority Leader Bill Frist and Senator Cory Booker as our honorary vice chairs. The Alliance for a Healthier Generation, the California Endowment, Kaiser Permanente, Nemours, the Robert Wood Johnson Foundation (RWJF), and the W.K. Kellogg Foundation helped found PHA and ensured we had the support necessary to hit the ground running.

With this strong foundation, three years later we are proud to say that PHA's more than sixty partners are showing that making healthier choices more affordable and accessible is good for our kids and also good for business. As a convener, we have brought the private sector together with advocates, academics, policy leaders, and others. Each year, we host an annual summit in Washington, DC, where everyone gathers to leave their biases at the door and talk realistically about working together to solve this problem.

The companies and organizations that have joined PHA represent the vanguard of this movement. Their diversity is impressive: They range from Fortune 500 corporations, to small entrepreneurial enterprises, to community organizations influencing the lives of children every day. Each understands the stakes involved and how an organization can do well

for itself by doing good for the public. All also understand that PHA will review and report publicly on their commitments each year. It's worth mentioning that while we have met with hundreds of private sector organizations, we have only sixty partners. It takes a big commitment to join PHA.

Earlier this year, we released our first annual progress report, a glimpse at where each partner stands in terms of meeting the commitments they have made. Here's what we found:

- 2.9 million kids got moving in 2012 as a result of PHA partner commitments.
- More than 500,000 low-access individuals have been served by new or renovated grocery stores so far.
- 141 new or renovated grocery stores or other retail locations have opened in or around food deserts.
- More than \$18 million has been committed in the last 18 months to new retail channels and innovative food distribution programs.

And there is more to come, as new partners join us each year and as others come closer to completing the multiyear commitments they have made to our organization.

### It Takes Everyone

In recent months, childhood obesity rates from New York City, to Mississippi, to South Dakota have dropped. These states and communities have one thing in common: collaboration across organizations, sectors, and disciplines. The simple fact is that healthier communities rely on all of us coming together—particularly when we are talking about challenges as daunting as ending childhood obesity.

Philadelphia is a great example of this type of collaboration. Since 1999, the city has participated in the federal SNAP-Ed (Supplemental Nutrition Assistance Program—Education) program. In 2004, the school district implemented healthy vending machine standards. Mayor Michael Nutter has created policies that encourage healthier eating and physical activity. Under the direction of Yael Lehman, the Food Trust is opening access to healthy, affordable food in the neighborhoods that need it most. As a

result of these and many other efforts in Philadelphia, in 2012, a RWJF report found a 5 percent decrease in childhood obesity rates locally.

In the past several years, a strong school system in Mississippi has set nutrition standards for vending machine options. Additionally, more physical activity time and health education programming was enacted in 2007. The state also has adopted healthier standards within child care facilities that operate within the state. According to the same RWJF report, Mississippi saw a 13 percent drop in childhood obesity rates.

Healthier communities rely on all of us coming together.

More promising news came earlier this year, when the Centers for Disease Control and Prevention reported that between 2008 and 2011, nineteen US states and territories saw obesity rates decline significantly. Florida, Georgia, Missouri, New Jersey, South Dakota, and the US Virgin Islands experienced the highest decline, with rates at or above 1 percentage point. Also promising: twenty states and Puerto Rico saw no significant changes—no declines, but no increases either. While we all agree there is much more to do, this news is the first indication that, on a broader scale, obesity rates are beginning to slow.

### Moving Forward

The private sector is a key part of the fight against childhood obesity. PHA's vision for healthier communities is a place where busy parents and families can make healthy choices without thinking twice. That simply isn't possible without large-scale commitments from PHA partner companies, such as Birds Eye, Walmart, Hyatt Hotels, and others.

While these national efforts trickle down locally—in grocery stores, restaurant chains, and community programming—the next step is for communities to take the PHA model and replicate it at the local level. To do this, they must engage small business owners and local or regionally owned companies and organizations that care about the health of their



customers, employees, and neighbors in making healthier, more affordable options available.

San Antonio, Texas, is one of the cities leading efforts like this: Government, schools, and the private sector are working together to create safe places to play; offer healthier, more affordable options in supermarkets; keep school meals nutritious and tasty; and much more. Local private sector organizations like the H-E-B supermarket chain, the YMCA, and USAA are helping lead this effort, bringing resources and options to the table that help make healthier choices easier.

The most recent data on childhood obesity rates are promising, and American families are focusing on this issue as never before. We are moving in the right direction. To ensure our kids live healthier and longer lives than we do, however, this trend must continue. The solution won't come from one simple change; it will come from many simple changes,

some complex changes, and, most important, from collaboration across all levels to create vibrant communities where healthier options are abundant.

## References

Centers for Disease Control. 2013. "Progress on Childhood Obesity." <http://www.cdc.gov/vitalsigns/pdf/2013-08-vitalsigns.pdf>.

Partnership for a Healthier America. 2013. "In It for Good: Partnership for a Healthier America Annual Progress Report." Accessed November 22. <http://ahealthieramerica.org/about/annual-progress-reports/>.

Robert Wood Johnson Foundation. 2012. "Declining Obesity Rates: Where Are We Seeing the Most Progress?" [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf401163](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401163).

---

*Lawrence A. Soler is president and chief executive officer of Partnership for a Healthier America.*

---

# Health Equity The Cornerstone of a Healthy Community

BY LEANDRIS C. LIBURD,  
WAYNE GILES,  
AND LEONARD JACK JR.

Almost ten years ago the Centers for Disease Control and Prevention (CDC) convened a panel of experts to provide input into how public health can advance community health promotion. That expert panel made recommendations that public health could address, including activities related to community engagement and community-based participatory research, training and capacity building, novel approaches to health and wellness including more emphasis on environmental approaches, and expanding the federal investment in community-based activities.

Since the report, CDC has seen a monumental growth in its community-focused portfolio. In the last decade and a half, CDC has worked with over 1,000 communities to address the prevention and control of chronic illnesses. This has included work through such programs as the Racial and Ethnic Approaches to Community Health (REACH), Steps to a Healthier US, Strategic Alliances for Health, Action Communities for Health Innovation and Environmental Change (ACHIEVE), Communities Putting Prevention to Work (CPPW), and most recently the Community Transformation Grants. As this work has progressed, a number of key themes have emerged:

1. The focus on community engagement and community-based approaches has remained a cornerstone of CDC's efforts.
2. There has been a shift from purely health promotion and education interventions to a more comprehensive approach that includes addressing the underlying determinants of health and environmental approaches to make the healthy choice the easy choice.
3. There is increasing emphasis on multisector approaches. This has included bringing community-based organizations, academic institutions, state and local public health, health care, business, and the like together to forge and implement a com-

munity plan for the prevention and control of chronic disease.

4. There is a focus on maximizing the reach and impact of community-based interventions.
5. A fundamental component of CDC's community-based efforts is achieving health equity.

Health equity has been variously defined by public health scholars and practitioners. The US Department of Health and Human Services (2011) defines health equity as "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities." Health equity is at once a call for systematic action to ensure that all groups living within a jurisdiction have access to the resources that promote and protect health *and* a population health goal.

What are the resources that influence health outcomes? The resources include:

- Opportunities for employment and education
- Access to transportation, safe and affordable housing, retail outlets including those that sell affordable and quality healthy foods
- Availability of recreation facilities and health services
- Limited exposure to environmental hazards
- Strong social networks and social cohesion
- Cultural norms and values that support a healthy lifestyle

All have been shown to have multiple effects on health, including impacting the rates of death and disease, low birth weight, and decreased self-rated health. These resources are unequally distributed in the United States by geography, race and ethnicity, income level, and education. In other words, health disparities or inequities are types of unfair health

differences closely linked with social, economic, political, or environmental disadvantages that adversely affect groups of people based on their social position or other socially determined circumstances.

Health equity means striving to equalize opportunities to be healthy by reasonable means. For example, advancing health equity in the community requires:

- Understanding differences in access (e.g., to health care, to healthy lifestyle choices, etc.) experienced by communities.
- Identifying and implementing strategies to alleviate these differences.
- Considering the impact of these strategies on different groups.
- Monitoring unintended consequences of these strategies across different populations and communities.
- Identifying and addressing the differences in levels of participation throughout the community.
- Acknowledging that work toward health equity serves both the interest of the individual as well as the interests of society.
- Mobilizing community engagement and support.
- Overcoming inequitable conditions in the social environment.
- Changing external and internal dynamics of the community to support health (for example, reducing violence and bullying among youth in communities at highest risk; building collaborations across sectors [e.g., with the business sector, urban planners, the criminal justice system, and elected officials] to address health inequities; establishing joint-use agreements with schools to allow access to outdoor tracks, tennis courts, and other facilities for physical activity).

Can we achieve a healthy community without health equity? At the heart of health equity is a commitment to social justice with respect to health. In their book, *Social Injustice and Public Health* (2013), Barry S. Levy and Victor Sidel argue:

Social justice embodies the vision of a society that is equitable and in which all members are physically and psychologically safe. Social justice also demands that all people have a right to basic human dignity and to have their ba-

sic economic needs met. Our commitment to social justice recognizes that health is affected by a host of social factors. It is not possible to address trauma and violence without also wrestling with poverty, racism, sexism, classism, homophobia and all other forms of stigma. Because of this, we cannot ignore deep seated inequalities as we seek answers to problems like violence and trauma. Rather, we must struggle with these problems clearly and honestly. (9)

Health equity means striving to equalize opportunities to be healthy by reasonable means.

According to Richard Wilkinson and Kate Pickett, authors of *The Spirit Level: Why Greater Equality Makes Societies Stronger* (2009), communities that embody social justice tend to experience greater well-being. For example, in some states, life expectancy can vary by as much as fourteen years, based on one's county of residence. Minorities living in resource-poor neighborhoods and communities face higher levels of multiple types of acute and chronic stressors, including stress due to racial and ethnic discrimination. In a 2011 article in *Health Affairs*, David Williams and James Marks write that when policy makers invest in programs to address these inequities and when "the educational, health, social services, labor market, and criminal justice outcomes of these programs are considered, there are remarkably large savings to society" (p. 2053). Thus, not only is health equity only good for the public's health; it also is key to community development and to reducing health care expenditures that are straining state and local coffers.

A decade or more of actions to advance health equity is noteworthy, but much remains to be done. The burden of health disparities in the United States is well documented. Increasingly, there are new theoretical frameworks and research attempting to explain the causes of these inequalities. We have learned from research and programmatic efforts that interventions focusing narrowly on individual behavior alone will yield less improvement in the population's health than what is desired. Evidence supporting the importance of implementing public

health policies that address long-standing underlying causes of health inequities (e.g., unemployment, lack of education, limited access to transportation, limited access to health care, increased exposure to environmental hazards, etc.) is growing. Moving forward, more evaluation and better methods of documenting the impact of various public health policies on observed trends in health are needed. Over time, evaluation of policy-driven approaches to achieve health equity will help us rethink how we define, measure, and monitor health equity. With these data, we can refine strategies designed to increase the impact of PSE interventions. In conclusion, healthy communities initiatives are progressing in their efforts to identify, implement, and evaluate public health interventions from the standpoint of achieving health equity. Future work in this area must continue to clarify mechanisms that help with community health planning, coalition building, employing the right combinations of PSE strategies, and linking evidence and policy making to sustain effective PSE strategies.

Providing local communities with resources, tools, and opportunities for peer-to-peer networking will be instrumental in each community's efforts to reduce the burden of chronic disease and achieve health equity. Advancing the Movement provides a venue to assist communities in their efforts to achieve health and well-being for all.

## References

- Levy, Barry S., and Victor Sidel. 2013. "The Nature of Social Injustice and Its Impact on Public Health." In *Social Injustice and Public Health*, 2nd ed., edited by Barry S. Levy and Victor Sidel, 5–21. New York: Oxford University Press.
- US Department of Health and Human Services. 2011, March 4. "Health Equity & Disparities." <http://www.minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34>.
- Wilkinson, Richard, and Kate Pickett. 2009. *The Spirit Level: Why Greater Equality Makes Societies Stronger*. New York: Bloomsbury Press.
- Williams, David R., and James Marks. 2011. "Community Development Efforts Offer a Major Opportunity to Advance Americans' Health." *Health Affairs* 30 (11): 2052–55.

---

*Leandris C. Liburd is director of the Office of Minority Health and Health Equity, Centers for Disease Control and Prevention.*

*Wayne Giles is director of the Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.*

*Leonard Jack Jr. is director of the Division of Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Atlanta.*

---

# Designed to Move Tackling the Epidemic of Physical Inactivity

BY CAITLIN MORRIS

As economies have developed across the world, physical activity levels have plummeted. Incidental movement, active transportation, and physical labor are fast receding from daily life in much of the developed world. If trends continue, levels of physical activity in the United States will fall by 50 percent in only two generations. The impact extends well beyond our waistlines: Physical inactivity is a major risk factor for a wide range of noncommunicable diseases including stroke, cardiovascular disease, diabetes, and colon and breast cancer.

## The World Is Racing to Slow Down

Inactivity is shortening lives and shrinking wallets.

Conservative analysis reveals that, as a nation, we spend \$150 billion each year to combat the impact of physical inactivity—and its direct costs could double in twenty years. Such costs—whether measured in human or economic terms—are unsustainable and unacceptable. If left unaddressed, the problem will perpetuate and worsen across generations. The children of physically inactive parents are six times more likely to be inactive themselves. They are also likely to underperform in school, be less productive in the workforce, and suffer from substantially higher rates of illness and disease.

So, how do we get there?

## Physical Activity Has Been Marginalized

The returns of physical activity are more substantial than is generally realized. The science is conclusive: Physical activity offers durable and profound benefits to individuals, societies, and economies. But even the science—as represented by a handful of distinct disciplines—often fails to convey in a holistic way the impact of physical activity. The great discoveries being made in the physical sciences, for example, reveal that the direct relationships between activity and cognitive function are not generally part of the

shared conversation among social scientists focused on the unique power of sport/activity to drive community cohesion.

Advocates of physical activity are too often focused on its role as a contributory solution to a narrow problem. As a consequence, physical activity has been (1) incorporated programmatically in a way that fails to leverage its full power and (2) marginalized as a worthwhile investment for its own sake. Physical activity in the United States is most frequently pigeonholed as half the solution to obesity. Youth-based sport development programs promote sport as a means to develop life skills but then often overlook its significant contributions to mental and physiological health. The result: programmatic “silos” and little success in promoting activity as a critical and urgent investment on its own merit.

## Designed to Move: A Catalyst for Change

Combating the problem of physical inactivity requires a fundamentally new approach. To leverage physical activity as a social and economic investment, together we must do two things:

1. *Raise the stakes*, bringing the issue to the forefront of civic, policy, and budgetary debate and positioning it as a pressing issue of human potential.
2. *Unify the field*, aligning the recommendations of advocates, experts, and practitioners under a holistic understanding of the benefits of physical activity for individuals, societies, and economies.

Designed to Move: A Physical Activity Action Agenda represents a collective effort by advocates, experts, practitioners, and governments to champion investment in physical activity. Together, we believe we can break the cycle of physical inactivity if all actors commit to two basic goals:

1. *Create early positive experiences for children (first “ask”).* The first ten years of life are crucial to breaking, or preventing, the intergenerational cycle of inactivity. Children need to understand the importance of, and enjoy, physical activity and sport while they are still developing critical motor skills and forming habits and motivational preferences.
2. *Integrate physical activity into everyday life (second “ask”).* We need to challenge everyday signals and behaviors that reinforce the current norm of inactivity. Enabling everyone to move demands systemic shifts in multiple sectors: from how we design cities, to unraveling misaligned incentives in multiple sectors.

### Building a Designed to Move Community

Designed to Move is only a year old and still evolving. Since September 2012, it has shifted rapidly from being a framework for action coauthored by the American College of Sports Medicine, the International Council of Sport Science and Physical Education, and Nike (with critical input from nearly one hundred global experts and formally championed by thirty-five organizations), to a rapidly growing *global community* intent on delivering on the promise of change. The extent of the viral uptake has been exciting: From small community organizations to royal families, the message—that people are, in fact, “designed to move”—has resonated in both expected and unexpected places.

Nike’s role is evolving along with the community. In addition to doing its part to contribute to the two asks, Nike is committed to supporting the Designed to Move community through communications assets that continue to raise the stakes with key audiences and inspire action and partnering with others to create tools to simplify the implementation of best practices. We are shepherds, not owners, of a community united under a common agenda. The community has no bylaws and no membership dues; it relies on distributed leadership. Designed to Move has enjoyed initial success as a message platform not because it is telling a new story but because it elevates an existing story and tells it more compellingly. Our future success as a community will depend on our collective ability to consistently repeat those messages in the public

dialogue and take coordinated action to achieve the two asks.

Joining the Designed to Move community requires a commitment to only two core goals:

1. Changing the conversation by spreading the message on the merits of investing in physical activity.
2. Operationalizing the framework by actively working to create positive early experiences for children and promoting the integration of physical activity into daily life for all.

At Nike, we will judge Designed to Move not by the size of the community it fosters but by the extent to which new norms are created around the role of physical activity in society. Success for Designed to Move means that children everywhere develop a greater lifelong passion for movement and that physical activity again becomes integral to daily life for all of us—at home, in school, at work, and in the community. These are big aspirations, but they can be deconstructed into manageable indicators and metrics (such as levels of investment in early positive experiences in sport and physical activity, multisector alignment on physical activity plans, and the incorporation of design principles in urban planning).

### A Call to Action: Activity at the Heart of Thriving Communities

As grassroots organizations across the country and around the world work to address a range of compelling civic issues, we hope that Designed to Move’s action agenda, and the community behind it, will engender a fundamental reexamination of the importance of—and the opportunity created by—physical activity as an accelerator of human potential.

For long-term prosperity, great cities must again become active ones. So, please: Spread the word, pool your resources, align your investments against the two asks, and work actively to demonstrate the effectiveness and efficiency of physical activity as a means for effecting durable and powerful social change.

It’s time to get moving again.

---

*Caitlin Morris is senior director for North America, Access to Sport, Nike, Inc.*

---

# Achieving Healthy Communities through Community-Centered Health Systems

BY DAVID D. FUKUZAWA

Thirteen years ago in *Public Health Reports*, Tyler Norris and Mary Pittman (2000) drew on the history of the Healthy Communities Movement to set forth an agenda for the emerging Coalition for Healthier Cities & Communities. The agenda included the recommendation to “align the incentives of health care providers with the public health and Healthy Communities emphasis on improving population health status and quality of life.”

With the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, the possibility of achieving such alignment now seems within reach. While the most visible provisions of the ACA are aimed at increasing coverage to the uninsured, the law also recognizes the importance of prevention and population health in holding down ever-rising health care costs. It also fosters experimentation with new payment methodologies that potentially move the system away from paying for volume (fee for service) and toward paying for value.

This article charts the evolution of the Kresge Foundation’s Health Program and its programmatic goal of reducing health disparities by promoting population health, specifically addressing the conditions and environments that lead to positive health outcomes for all Americans.

## A Bit of Background

The Accountable Care Organization (ACO) is at the core of the ACA experiments. An ACO comprises a group of health care providers, whose goal is to provide coordinated care and achieve improved overall health for its patient population. What distinguishes the ACO from the traditional fee-for-service model is that it aims to achieve cost savings through quality patient care *and* better population health management, which includes an emphasis on prevention. The incentive for providers to keep people healthy is the cost savings that

accrues and can be shared among them. The ACO therefore is structured to meet the goals of the Institute for Healthcare Improvement’s Triple Aim Initiative: to improve the patient experience of care, to lower the per-capita cost of care, and to improve population health.

ACOs, however, are not without their critics. Besides the charge that it’s still too early to determine their effectiveness, many argue that ACOs are still too delivery and provider centric. Better population health, they contend, should refer to the entire community rather than specific populations, such as people with diabetes. They believe better value can be produced by prevention, not more treatment, no matter how good or efficient. Resources are too concentrated on medical services, they add, instead of on upstream determinants.

## Journey toward a Community-Centered Health System

For us at the Kresge Foundation, that critique prompted us to ask what role health care systems could play in improving community-wide population health. That question, first asked three years ago, eventually led us to the conviction that ACA provides the opportunity and challenge to transform the health care system from one primarily focused on delivering services/treatment to one that is focused on population health: a community-centered, upstream-oriented system.

Our journey began with these questions:

- Given their history, what does the experience of community health centers (CHCs) tell us about linking clinical services and the social determinants of health?
- Could we develop a grant-making effort to help build models of community-centered care through a place-based, multisite demonstration project?

- Who are some current health system innovators that are integrating population health strategies into their care continuum?

### Community Health Centers: How Are They Leveraging the Social Determinants of Health?

Dr. Jack Geiger is widely credited for the development of community-oriented primary care, based on his pioneering work in the Mississippi Delta in the 1960s. After opening one of the nation's first CHCs in Mississippi, he quickly recognized that medical care alone couldn't address the lack of clean drinking water, sanitation problems, and malnutrition, all of which were at the root of the community's health problems. The legacy of this work has continued through the creation and expansion of federally qualified health centers (FQHCs). Over the last forty years, FQHCs have become a critical part of the medical safety net, with the National Association of Community Health Centers reporting in 2013 that they serve more than 22 million patients through 9,000-plus locations.

Knowing this, we expected to find a robust record of research. Instead, based on a Kresge-funded study by the Institute for Alternative Futures (IAF), we learned the literature review of the work of leveraging social determinants by CHCs was scant. As of the printing of its 2012 report, IAF had created a database of 176 activities, projects, programs, and interventions by 52 different CHCs, plus several more intensive case studies. This research was carried out in partnership with the National Association of Community Health Centers (NACHC) and involved expert interviews, webinars, and numerous meetings with NACHC leadership and membership.

Some of the key lessons that emerged from the review indicated that:

- CHCs continue to be responsive to wider social and environmental issues that affect the health and well-being of their patients.
- CHCs frequently develop a diverse array of community and social service partnerships to address these issues.
- CHCs are often the first to recognize a problem and provide leadership to tackle it.
- Most of these efforts have not been evaluated.
- Funding is an ongoing and constant problem.

The effort by NACHC and IAF did not end with the report's 2012 publication. In addition to the research findings, the partnership was aware of potential policy and systemic implications that suggested new models of population health care. The "community-centered health home" developed by the Prevention Institute and described by Jeremy Cantor and coauthors (2011) is one example. As a result, the partnership has continued to explore how such models could be more fully developed through opportunities within ACA.

### Developing New Models for Population Health: Safety-Net Enhancement Initiative

The Kresge Health Team's own early hunches about new models of population health led us to launch the Safety-Net Enhancement Initiative (SNEI) in 2009. It is a national demonstration project to develop new models of integrating population health strategies through local partnerships. Kresge is supporting eight sites nationwide. Projects encompass community health centers, health systems, public health departments, and community partners.

The sites were challenged to plan and implement a project with collective impact. Each focuses on a key disparity (common agenda) and includes predetermined evaluation outcomes (shared measurement systems), a set of specific activities (mutually reinforcing actions), an authentic community engagement/collaboration structure (continuous communication), and identification with an "anchor institution" (backbone support organization).

The partnerships are as varied as the places: between a public housing commission and a CHC aimed at reducing hypertension; among a health department, CHCs, and local food organizations to improve maternal and child health; among a local school, the health department, and a CHC to reduce childhood obesity. Some partnerships were led by health systems; some, by CHCs; one, by a health department; and one, by a nonprofit.

The models are equally diverse. Some important, common elements have emerged:

- Identifying and staying focused on a common goal (a community-identified health disparity) was the



first and most constant challenge, given these communities' many issues and problems.

- The partnerships have turned into robust and engaged collaborations, embedded in coalitions that oversee the projects' implementation. Critical to the success of these partnerships has been the involvement and engagement of community members as authentic partners.
- A major impact has been generating greater connectivity and social capital.
- While SNEI did not specifically focus on policy and financing, many of the sites' partners have found ways to sustain the effort through a new awareness of social determinants and new ways of working.

The eight sites will be completing the third and final year of their grant-funded projects by the end of 2013. Three years are obviously not enough time to see either measureable changes in health outcomes or other significant policy and environmental changes. But several sites have already begun to investigate opportunities under ACA to advance their community-centered models. A formal evaluation also will be completed within the next twelve months. It is our hope that these evaluations will be instructive for the field as well as for our SNEI partners and ourselves.

### Survey of Regional Health System Innovators in Population Health

In 2011 we engaged a consultant, Ann Batdorf-Barnes, D.O., MPH, to conduct a study of innovative health systems that were actively addressing upstream determinants of health within vulnerable populations. She conducted the study from June to October of that year. It included three site visits and meetings with leading population health experts.

Batdorf-Barnes's unpublished study put forth this definition of what we were then calling a "population health system": an intersectoral system of care, including medicine, public health, and community resources, that is accountable to improve the health of the whole community by addressing all of the health needs, whether the individual seeks health services or not. It also ensures the conditions within which a person can be healthy by building healthy communities.

Health care systems are moving to create upstream, collective impact structures that are multisectoral, community centered, disparity reducing, and focused on improving population health while not sacrificing patient care quality.

The three sites she visited were Genesys Health System (Grand Blanc, Michigan), Memorial Healthcare System (Hollywood, Florida), and Southcentral Foundation (Anchorage, Alaska). Although space does not allow for a fuller description of what she found, the summary of the key elements of Southcentral Foundation were, in large part, shared by all:

- Think and act on the population (understand the needs of vulnerable populations).
- Redesign the system with integrated care teams based on the expressed needs of individuals in the population (understand the needs of the individual).
- Coordinate care across the health care delivery system.
- Address upstream determinants in the community, reorienting the health system through action on the social determinants of health.

As Batdorf-Barnes explained to me, Southcentral's approach to care extended even to the design of its main facility: The entrance area was large enough to act as a community meeting place, not just a waiting room. The area for action, in other words, was moved from the back to the front of the building. It emphasized that the community health center was above all a **community center**.

### Moving Forward: Building the Field of Community-Centered Health Systems

This article tracks our journey to imagine a new kind of health care system. Over the past few years we also have become aware of many others who are on the same journey. Some of these include recent grantees of the Centers for Medicare & Medicaid Innovation Awards. Collectively, this emerging work has reinforced for us the impression that, around the country, health care systems are moving to create upstream, collective impact structures that are

multisectoral, community centered, disparity reducing, and focused on improving population health while not sacrificing patient care quality.

We believe that these are the elements of a community-centered health system, which includes medicine, public health, and community partners, all holding each other accountable within a partnership structure for achieving greater community health and well-being.

These developments potentially have profound significance for the Healthy Communities Movement because:

- They signal a shift away from a purely downstream understanding of health care.
- They begin to lay out the potential pathways for reallocating the resources with the health care system to address upstream factors of health.
- They suggest new frameworks and structures for communities to engage in building healthy communities.

It is impossible to predict which directions health care reform will take us, especially given the political noise surrounding it. But the future we would bet on—and invest in—is one in which health systems begin to operate outside the walls of patient exam rooms and operating tables to investing in

projects, efforts, and policies that create healthy communities.

## References

- Batdorf-Barnes, Ann. 2011, November. “The Kresge Foundation Population Health Project: Final Report.” Unpublished manuscript. The Kresge Foundation, Troy, MI.
- Cantor, J., L. Cohen, L. Mikkelsen, R. Panares, J. Srikantharajah, and E. Valdovinos. 2011, February. *Community-Centered Health Homes: Bridging the Gap between Health and Community Prevention*. Oakland, CA: Prevention Institute.
- Institute for Alternative Futures. 2012. *Community Health Centers Leveraging the Social Determinants of Health*. Alexandria, VA: Institute for Alternative Futures.
- Institute for Healthcare Improvement. “IHI Triple Aim Initiative.” <http://www.ihf.org/offerings/Initiatives/TripleAim/Pages/default.aspx>.
- National Association of Community Health Centers. 2013. “About Our Health Centers,” Accessed September 19. <http://www.nachc.com/about-our-health-centers.cfm>.
- Norris, Tyler, and Mary Pittman. 2000. “The Healthy Communities Movement and the Coalition for Healthier Cities and Communities.” *Public Health Reports* 115 (2–3): 118–24.

---

*David D. Fukuzawa is the Kresge Foundation’s program director for Health.*

---

# Dove Springs and GAVA Ten Lessons about How to Fight Childhood Obesity in a Single Zip Code

BY ALIYA HUSSAINI

*Sustainability and impact.* That's what we were driving for when, in 2012, the Michael & Susan Dell Foundation launched an initiative focused on a cross-sector effort to improve the health of children and families living in a single zip code in an Austin, Texas, community known as Dove Springs. Six months into implementation of what will be a multiyear effort, we still have much to learn about how to bring targeted programs to bear in affecting the health outcomes of a single community—and about what those health outcomes will be. We have, however, already gained enormous insight into what it takes to give our place-based efforts the best chance of success.

## Lesson 1: The Search for Stickiness

The Dove Springs initiative, which is extremely localized, represents a somewhat radical shift in the foundation's approach to preventing childhood obesity. In earlier years, our obesity prevention efforts were focused on long-term investments in coordinated school health in large urban school districts. We worked with the strongest partners we could identify, using multicomponent efforts, and funded districtwide implementations over periods of time that ranged from four to six years. Given our institutional strengths, this strategy made sense. But the school-based approach also included built-in limitations: At the end of the day and at the end of the year, children leave school and go home. Even if we succeeded in our mission of transforming schools into meccas of healthy environments and behaviors, we could still fail in our ultimate goal of preventing obesity. We knew that if we really wanted to meet our ultimate goal, we needed to tap broader networks, starting with families and extending into the neighborhoods where they lived.

So we began to look for ways to cast our net wider. For example, we provided funding to the Food Trust, which was working to change corner store environments in Philadelphia. Researchers there had found that 53 percent of students in the community shopped at corner stores once a day, five days a week, purchasing 356 calories before or after school. By empowering students to advocate healthier options in those corner stores, the Food Trust pioneered an innovative approach to community change. We also funded the Consortium to Lower Obesity in Chicago Children. Efforts there focused on a range of environmental factors (from lack of access to healthy foods such as produce, to unsafe streets, to abandoned houses and lots) that prohibited healthy behaviors in particular communities.

As results came back from our partners, we saw pockets of success in our quest to decrease obesity prevalence. In some cases, that success was fleeting. In others, we saw more stickiness, particularly when schools partnered with community members, parents, and other localized supporters. Based on these findings, we began visiting communities that worked across sectors—for example, schools that partnered with food retail strategies and safety interventions. We also visited Houston, Texas, and Santa Ana, California, where community members, tired of waiting for improvements, had transformed into leaders and begun actively pushing for healthier environments. Our working hypothesis was that sustainability was closely tied to skin in the game. Efforts driven by community members themselves—those with the most to lose and the most to gain from the efforts—were the most likely to take root and succeed. Through this fieldwork, we began to understand, at a broad level, which types of interventions worked in specific communities and which did not. We also began to articulate ways to measure success.

## Lesson 2: Opportunism Is a Good Thing

As those of us working on the foundation's US health portfolio became more and more convinced that place-based work might hold the keys to change, we had an aha moment. The Central Texas (CenTex) portfolio is the longest-standing grant-making portfolio at the foundation. The foundation's work in Central Texas has been dedicated to improving safety, education and literacy, family stability, and health care access for families in the region for twelve-plus years. The team has built incredibly strong relationships that have been tested and reshaped over the years and also has tremendous knowledge of local partners, resources, and challenges.

Back at home after our cross-country research journeys, the health team began to lean out of our cubicles and eye our Central Texas portfolio colleagues a few cubicles down. The initial idea seemed simple: Rather than geographically diffuse efforts with some bright spots of success, we would focus, go deep, and get connected at home. We would identify a single zip code and combine forces to drive change. The project would benefit from the health team's national expertise and from the CenTex team's knowledge of local neighborhoods, leaders, and organizations. And we were more than a little opportunistic: Maybe the CenTex team would double down on key investments to support the work.

It has been a long time since the initial idea emerged. As we refined it, we began to drill into complexities, starting with the very nature of place-based work: its irrevocable specificity. We knew a lot about how Chicago, Philadelphia, Houston, and Santa Ana had approached efforts. What was less clear was how lessons learned in one community could be replicated in another. So, in addition to setting the direct goal of launching a project at home, we set a second but no less important goal: identifying architectures, connections, and tools that were flexible enough to be programmatically applied to systems change work in other communities.

## Lesson 3: Do the Legwork

The first task we faced was deciding where to work. A few qualifying factors were clear. The first was scale of need. Where were kids and lifestyles most

unhealthy? We used local data maps provided by Children's Optimal Health, an Austin-based organization that uses data mapping to visualize the health of neighborhoods, and quantitative inputs from city, state, and national data sources to identify the communities with highest need. Key indicators included obesity prevalence and lack of access to healthy food and safe places to engage in physical activity. That step was straightforward. We then combined those data with our own insights into and knowledge about the quality of schools and the strength and quality of community-based organizations in the neighborhood. We also made note of potentially aligned funding sources to sharpen the picture. This information-gathering effort enabled us to narrow in on five potential neighborhoods.

The initial idea seemed simple: Rather than geographically diffuse efforts with some bright spots of success, we would focus, go deep, and get connected at home. We would identify a single zip code and combine forces to drive change.

The final step in the process was more complex and labor intensive: It required that we understand, in detail, how the statistics manifested themselves on the ground. It required that we do a great deal of legwork to evaluate which communities had the capacity—in terms of infrastructure, neighborhood leadership, community engagement, and more—to adopt, drive, and sustain change. We went on endless community visits and tours. We conducted interviews with key neighborhood residents and had discussions with community and city leaders. Part of our search for the right community included conversations with key city department personnel and officials. We talked to city councils, parks and recreation departments, health and human services personnel, and others.

All roads led us to 78744, also known as Dove Springs.

## Lesson 4: Trust Is Earned

Dove Springs had the highest youth obesity prevalence and highest youth delinquency rate in the city.

It also had a reputation: The neighborhood was known for advocacy. Tight knit, with easily identifiable leaders, a well-defined community agenda, and a number of trusted and well-structured community organizations, the community had the capacity to achieve change. Community members already had experience advocating for better health care access, additional bus routes, improvements to address safety and crime susceptibility, and more. Community leaders were organized, and they were advocates. They were exactly who we were looking for.

Given Dove Springs' high-need profile, we weren't the only ones who felt that way. Plenty of other organizations wanted to change the neighborhood for the better. It had been visited, surveyed, and needs-assessed fairly routinely. So perhaps it shouldn't have been a surprise that, when we first told a few key leaders that we had selected Dove Springs as the neighborhood where we would launch the GO! Austin/VAMOS! Austin (GAVA) project, we received a chillier reception than we had hoped. The leaders had spent years cultivating community relationships. GAVA was going to have to earn these leaders' trust before they went before the larger community and gave us their endorsement.

#### **Lesson 5: Transparency Isn't the Same as Alignment**

A major step toward earning trust was being clear about our goals. From the outset, GAVA was transparent about its scope of work, which had a relatively narrow focus. The goals were to:

- Improve the health of the community by improving access to nutrition and physical activity throughout the community.
- Provide families, neighbors, and schools with the resources to improve access to healthier lifestyle choices.
- Reduce obesity rates, especially among children.
- Motivate, empower, and engage community leaders and residents to lead and sustain the work needed to achieve our common goals.

GAVA was equally clear about its approach: The initiative would have dedicated employees housed in the neighborhood and committed to fully partnering

with lead neighborhood organizations. GAVA was fully committed to actively seeking community input about the challenges community residents wanted to prioritize and to bearing in mind what community members had the energy and capacity to work on. If priorities were within GAVA's scope, the initiative would support their efforts directly. If not, it would connect community members with organizations that could help them.

Given the complex causality of obesity, maintaining a tight focus was absolutely critical to GAVA's effectiveness. However, this tight focus also created a barrier to establishing trust with community leaders, who, based on community input, were actively advocating for increased health care access and increased mental health services. Although tangentially related to GAVA's mission, these issues would not be central to its efforts. We had to engage community leaders in several rounds of conversations to determine whether the neighborhood had the energy and desire to work on GAVA goals. It did.

#### **Lesson 6: Establish Guardrails; Encourage Participation**

Unsurprisingly, initial meetings among GAVA personnel and community leaders didn't always go as expected. The first meeting at which GAVA presented its model, carefully documented via multiple versions of a PowerPoint presentation (complete with animation and artwork), ran well over the allotted one-hour meeting. After three hours of back-and-forth, the original GAVA structure was unceremoniously laid to rest. The new version, supported by neighborhood leaders, laid out a more inclusive leadership structure. It envisioned a large, broad-based neighborhood coalition, led by a team of three organizations working in the neighborhood and implementation teams that were small and nimble but inclusive of a full range of actors. Each team would be composed of neighborhood residents and stakeholders from city agencies and nonprofit organizations already working in the neighborhood.

Within this structure, GAVA sought to create a process that balanced community participation (which was absolutely critical to the project's ability to succeed in the Dove Springs neighborhood) and clear

parameters for action (a critical enabler for the goal of creating a framework for successful placed-based work elsewhere). The tool GAVA developed for balancing flexibility and consistency is a “menu” of evidence-based interventions. Used during the planning process, this menu enables community members to identify sectors in which to work (e.g., schools, parks, food access, etc.). It then lays out a selection of evidence-based strategies they can employ. Once they’ve selected sectors and strategies, they develop action plans—complete with clear lines of accountability, timelines, and milestones—for how to accomplish those strategies. At every step, GAVA provides evaluation guidance and helps to crystallize requirements for implementation and success.

Using this tool, the Dove Springs community coalition decided to work in five sectors in the neighborhood: schools, community food access, community safety and physical activity, early childhood, and out-of-school time. Because of the complexity of work within each sector, GAVA launched its initial efforts in the three sectors that could leverage the experience the Michael & Susan Dell Foundation had in-house and that the neighborhood was most poised to engage in: schools, community food access, and community safety and physical activity. This type of pragmatism and course correction is a key to GAVA’s ability to stay the course long term: We didn’t plan to start with only three sectors, but it was what GAVA leaders decided they could handle most effectively, so it was the smarter choice.

### **Lesson 7: Good Community Managers Are Like Unicorns—But More Important**

The complexity of maintaining alignment across several diverse teams demands active and skilled project management. Effective community managers are members of a rarer breed—the unicorns of public health work. Depending on the neighborhoods where they work, they must be at least bilingual. They must have deep knowledge of and ties to the neighborhood and the ability to navigate the corridors of local power. They have to be able to transition easily from grassroots to city hall and be equally effective in both environments. They have to be capable of organizing and lead-

ing large community meetings, of speaking with local elected officials, and of forming bonds of trust with neighborhood leaders. And, of course, they have to be comfortable with data collection and analysis.

After an extensive search, GAVA found and hired one such unicorn. For all his skill-nurturing relationships, cultivating bonds of trust, facilitating meetings, providing guidance on action plans, and keeping work on task and on time, the unexpected still crops up. Not least has been the sheer amount of work, coordination, and time required to implement action within each sector. The effort to organize the activities of the many partners within any given team, let alone across teams (while also keeping track of progress and adjusting course as necessary), has been tremendous. Nowhere has this been more true than in our schools sector, where partner after partner is working to improve the neighborhood’s high-need, low-performing schools. Programming, support, and stakeholders abound. From the schools’ perspectives, that outpouring of effort is fantastic—at least in theory. In reality, coordinating the various initiatives poses challenges for even the most accomplished, multitask-loving school principal.

Rather than amplify the complexity, the GAVA schools team set out to address it, designing an approach that would help school leaders organize the abundance of aid. Under that approach, each individual school in Dove Springs generated an action plan based on self-defined goals. The GAVA school team’s role then became identifying ways that partner organizations can help schools meet those goals, helping to ensure that timelines are met and to troubleshoot and course correct if barriers arise.

### **Lesson 8: Capitalize on What’s Already in Place**

Schools aren’t the only Dove Springs sector that’s attracted an abundance of aid—a fact that both benefited and challenged GAVA in its early days. Benefit: One city council member is particularly passionate about obesity prevention in Dove Springs. Her staff has helped GAVA navigate more effectively the sometimes tortuous road to get things done at the city level. Challenge: The sometimes-hidden

conflicts in seemingly similar programs. One key example involved food access. GAVA partnered with local nonprofits to train local youth to operate a mobile farm stand to bring more fruits and vegetables into the neighborhood. In the interest of providing a more diverse selection of produce, GAVA searched for additional fruit and vegetable suppliers. Based on GAVA's broad goal of providing residents with increased access to healthier foods, someone could (in theory) drive to the local Costco, buy a case of peaches, and sell them at a slight markup to neighborhood residents. The goal of a key partner organization running the food stand, the Sustainable Food Center, was narrower: enhancing access by bringing more *local* produce into the neighborhood. Working through that particular wrinkle required time and patience.

The strategy of capitalizing on what's already there has helped us hone in on ways to incorporate GAVA work into existing neighborhood processes. For instance, the neighborhood's contact team, which works with the city of Austin's neighborhood planning area, has been engaged on safety issues for many years. GAVA's safety and physical activity working group has joined the contact team's monthly meetings, activities, and partners, which has been hugely beneficial in terms of streamlining GAVA's organizational lift, sharing resources and connections, and minimizing meeting overload for engaged residents. It has also allowed GAVA to benefit from a partnership with an existing and trusted neighborhood entity rather than building one anew. Similarly, GAVA's food sector has partnered with a local advocacy organization that trains *promotoras*, or community health workers. The organization has a specific calendar of advocacy and outreach. For instance, in July, it conducted outreach around improved food inventory in neighborhood stores and trained the *promotoras* to increase demand among families for healthier options.

Partnership with existing neighborhood structures, leaders, and strategies enhances the likelihood of sustainability, but there are, of course, natural limits to this strategy.

One of the early lessons in sustainability came about as the result of well-intentioned, but inefficient, outreach. GAVA's initial focus on alignment and pre-

senting a united front to city officials led leaders to try to sweep up all other related organizations into the initiative. The tactical error quickly became apparent. Asking established organizations to involve GAVA in all conversations with city officials didn't promote empowerment and community leadership—it simply created complexity. The smarter approach has been to stay apprised of other organizations' engagements with city officials and to align as it makes sense.

GAVA partnered with local nonprofits to train local youth to operate a mobile farm stand to bring more fruits and vegetables into the neighborhood.

### Lesson 9: Evaluation Is Not an End in Itself

Both the Michael & Susan Dell Foundation and GAVA are committed to performance evaluation. We need to know what works in order to improve it, replicate it, and understand it. But (and it's a big but) we can't fall into the trap of measurement for measurement's sake. We don't want to spend more time documenting a community connection than making one. Still, we remain determined to learn as much as possible about the process, outputs, and long-term outcomes of our work.

That said, GAVA has an enormous number of overlapping initiatives and efforts. Evaluating the program as a whole is daunting. How do we assess the individual and collective impact of so many moving pieces? How can we understand the partners, systems changes, and access points critical to the project's success? To answer these questions, both organizations have sought from the beginning to design appropriate evaluations that come at the challenge from multiple angles.

One set of tools seeks to provide enough efficiency and simplicity that the information can be easily interpreted and fed back into the implementation in order to course correct our efforts.

One set of evaluations will measure downstream outcomes like obesity prevalence in the neighborhood and nutrition and physical activity behaviors and attitudes. These evaluations will include a

cross-sectional and longitudinal study that follows a group of Dove Springs residents and control families over the course of five years.

Another set will assess leading indicators, such as access points for healthy food and physical activity: their relationship to housing density in the neighborhood, their quality, their utilization. Other leading indicators include leadership development and the development of key relationships between individuals and institutions.

### **Lesson 10: Celebrate Wins and Keep the Focus Where It Belongs—On the Community**

Six months into the first GAVA implementation, detailed wins in terms of leadership building, institutional and organizational relationships, and health outcomes have yet to be assessed.

The community has, however, seen some key and tangible wins. These include a new mobile market that sells local fruits and vegetables and the creation of one-year action plans from five of six elementary schools and the one middle school in the neighborhood. Virtually every park in the neighborhood has been adopted by neighborhood residents, who are now informed of and contribute to park-level plans. We've seen the launch of a new soccer league, coached by parents and including more than 200 students from the neighborhood. We've also seen change at the city level. The city's parks and recreation department has created a new GAVA team to respond to community requests. Community residents successfully advocated for the installation of new lighting at a local elementary school park so families can safely use the facilities after dark. Based on community input, the department revisited a decision to demolish a vandalized park and decided instead to rebuild and improve it. Funding partners have contributed hundreds of thousands of dollars to implementation of GAVA-related efforts and, perhaps more important, have begun to

align and coordinate their neighborhood work with GAVA's. GAVA, meanwhile, continues to gather potential partners, including Capital Metro, the city's municipal transportation service, which is willing to consider installing additional bus shelters and modifying the frequency and location of stops in the neighborhood.

We still have a long way to go. We are still learning how to achieve efficiency and alignment. We are still learning how to best communicate with our partners and potential partners. And we are still evaluating how we can extrapolate the knowledge we gain into a "recipe book" for use in other communities. As the project matures and evolves, both GAVA leadership and the foundation team must maintain a firm focus on sustainability. In the short term, that means nurturing community engagement in the process. In the longer term, it means protecting against gentrification and ensuring the continued community ownership of the neighborhood that residents are working so hard to improve—no small task in a real estate market as heated as Austin's. There will doubtless be many bumps along the way, but for now we are growing and connecting and seeing exciting shifts—perhaps most important in the makeup of those who feel empowered to drive change. Neighborhood residents who weren't previously engaged have transformed into community advocates. Established neighborhood advocates have blossomed into true community leaders. That change alone is enormously heartening. If there's one thing we've learned in all our work to prevent childhood obesity, it's this: Change happens when community residents come together to demand and work toward a healthier future of their own design. It's a thrill to see such a movement begin to take hold on the foundation's home turf.

---

*Aliya Hussaini is team lead, US Health at the Michael & Susan Dell Foundation.*

---



# Social Impact Investing at the Intersection of Health and Community Development

BY LISA RICHTER

As cities and health policy makers look to build communities where “the healthy choice is the easy choice,” an important, sometimes overlooked partner is the private social impact investing sector (impact investing).

With aggregate US investing volume of in the tens of billions per year, impact investors include foundations, health systems, banks, pension funds, insurance companies, faith-based organizations, corporations, and individuals who seek measurable social and environmental benefits along with financial returns on investments. Government is a frequent partner, through conducive policy and credit enhancement—complementary grants, technical assistance programs, loan guarantees, insurance, and/or tax incentives that reduce investment risk for the private sector.

## History and Benefits of Impact Investing

Impact investing got its start in the late 1960s, when officers at the Ford and Taconic Foundations determined that grants alone could not mobilize the type and scale of capital needed to spark redevelopment in the nation’s blighted urban and rural low-income areas.

Early investments backed organizations we now understand as advancing positive determinants of health: affordable housing developers, minority and rural small businesses, nonprofit community health centers and arts organizations that were increasing opportunities in underserved communities but were deemed too risky to obtain capital from conventional sources.

Gradually, impact investors applied the strategy in additional sectors: environmental conservation, green building and businesses, education (particularly high-quality charter schools), microenterprise, and asset-building financial services.

They also spawned a sector of community development financial institutions (CDFIs), mission-driven financial intermediaries that often partner with foundations, banks, and others to implement impact investments. Certified by the CDFI Fund, an agency under the US Department of Treasury and operating in all 50 states, CDFIs have more than \$30 billion in assets under management. With a primary mission of community development in distressed areas, they include domestic banks, credit unions, loan funds, and venture capital funds that combine technical assistance with financings.

Impact investing is a powerful tool to support organizations at the intersection of health and community development in achieving sustainability and scale.

Impact investors benefit from the ability to:

- Leverage grants and public subsidy by mobilizing much larger amounts of capital from a range of partners, including foundations, banks fulfilling the Community Reinvestment Act (CRA; a federal law requiring banks to invest throughout their service areas, including the low- to moderate-income portions), health systems, faith-based investors, and corporations.
- Recycle charitable dollars in impact investments.
- Test new approaches at a larger scale than might be possible through grants. Within the health arena, impact investments represent a resource that can pilot prevention and health promotion models at a time when public health budgets have scant resources for innovation.
- Invest in a broad range of change agent partners: Impact investments allow for foundations to make charitable investments in for-profit companies, provided that the use of proceeds is charitable. Examples include companies that are innovating technology that improves access to high-quality, affordable care for vulnerable

populations or that prepare nutritious school lunches for schools with high proportions of low-income students.

Qualifying recipients benefit from:

- The ability to grow or scale their organizations through larger sums of capital than they can access through grants alone.
- The ability to sustain their operations through timing gaps in receiving reimbursements and payments for services rendered.
- The ability to move forward on time-sensitive projects that require more capital than can be raised quickly through grants.
- Organizational discipline to qualify for, manage, and repay the investments that they receive from impact investors.

Society and capital markets benefit from:

- A source of patient and flexible capital that allows testing of new business models through the early stages. Efficient use of charitable resources, given a focus on results as well as recycling charitable capital.
- Sustainable social sector organizations that are accountable to their socially motivated investors.

Despite these benefits, impact investing is not a cure-all. Like grants, qualifying investments satisfy a social thesis that makes a case for how the investment advances the investor's mission or social goals. Unlike grants, they also satisfy an investment thesis demonstrating a reliable repayment source. Repayment sources can include earned revenues, pledged grants, planned savings (such as through energy efficiency or co-locating with other organizations), or capital appreciation (such as a for-profit business that grows and increases in value). Grants and subsidy remain critical tools both in preparing the market for impact investing and in supporting the range of important community activities that may not—and perhaps should not—have a repayment source.

#### Impact Investing with a Healthy Communities Lens

Despite the success and increasing prevalence of impact investing, the strategy remained little used by health funders until recent years. Interest is now

growing rapidly, with health funders and CDFIs financing innovative organizations in health care, health coverage, and healthy communities. Their investments are attracting co-investment by banks fulfilling the CRA and by nonprofit health systems exploring new ways to target community benefit dollars—a potential source of billions in additional, annual capital.

Many of these investors base their strategies on some form of community health needs assessment (CHNA), and it is useful to review what types of investment opportunities such an assessment can identify.

The County Health Rankings (CHR) program (<http://www.countyhealthrankings.org>) is collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute that helps communities create solutions that make it easier for people to be healthy in their own communities, focusing on specific factors that are known to affect health. Using the CHR model as a framework, we understand that some 70 percent of morbidity and mortality are driven by health factors within a community. As detailed later, this figure includes the physical environment (10 percent), social and economic factors (40 percent), and clinical care (20 percent). By investing in ways that make “the healthy choice the easy choice,” we can support residents in the remaining factor—health behaviors (30 percent), which includes tobacco use, alcohol use, diet and exercise, and sexual activity.

Using the CHR model, examples of health-promoting impact investments are presented next.

#### Physical Environment

CHR attributes 10 percent of health outcomes to the physical environment, including environmental quality (including particulate matter and clean drinking water) and the built environment (including access to fresh foods and recreation).

**Environmental Quality.** The Kresge Foundation and the MetLife Foundation have partnered with CDFIs such as the Local Initiative Support Corporation and Enterprise Community Partners to finance housing that uses healthy home-design principles to build smoke-free, low-volatile organic compound (VOC)

homes that control asthma and respiratory triggers and avoid harmful radon, mold, carbon monoxide, and nitrogen dioxide exposure. While up-front costs are higher per unit, these costs can be recouped with one night of emergency hospitalization saved for an acute asthma attack.

Also contributing to better environmental quality is the trend toward transit-oriented development. The John D. and Catherine T. MacArthur Foundation and Rose Community Foundation invested in Denver's Mile High Connects Transit-Oriented Development Fund.

**Clean Drinking Water.** The McKnight Foundation provided financing to help acquire and protect threatened wetlands. The transactions incorporate mechanisms to ensure watershed conservation and clean water by downstream users (e.g., municipalities, utilities, companies) and/or payments by public agencies to upstream communities (e.g., farmers, ranchers) and land preservation organizations to cover the costs of ecological restoration and protection of watersheds that supply regional water.

**Healthy Food Access.** CHR includes access to healthy food in this category. The federal Healthy Food Financing Initiative is mobilizing millions in impact by investing to finance a range of health food outlets in the underserved urban and rural areas known as food deserts. Between 2011 and 2012, the federal CDFI Fund awarded over \$47 million to nineteen CDFIs around the nation to jump-start their financing for this purpose. The program was originally designed by the Philadelphia-based CDFI, the Reinvestment Fund (TRF). TRF discovered that bringing fresh food markets to underserved communities not only improves nutritional choices, it also creates jobs, spurs additional local economic development, and contributes to local property values.

**Recreation.** The David & Lucille Packard Foundation pioneered impact investing for environmental conservation in the 1980s. In the mid-1990s, the Ford Foundation provided a \$2.5 million program-related investment to the Trust for Public Land for its Green Cities Initiative that helped to secure and upgrade parks in urban areas around the nation with low park acre-to-people ratios. Prudential Insurance, Bank of America, and the Clark, MacArthur,

and Metropolitan Life Foundations provided additional loans.

#### **Social and Economic Factors**

With a 40 percent bearing on health outcomes under the CHR model, social and economic factors include education (10 percent), employment (10 percent), income (10 percent), family and social support (5 percent), and community safety (5 percent). Impact investors directly and/or indirectly fuel improvements in each of these areas.

As examples, the Bill & Melinda Gates Foundation made impact investments in the form of loan guarantees for bond financings for high-performing charter management organizations serving primarily low-income children of color. The guarantee substantially lowered the cost of financing, allowing the organizations to channel savings into improving the educational experience.

The W.K. Kellogg Foundation made an equity investment in Acelero Learning, a for-profit Head Start program manager with a model that attracts and retains superior teachers and wraps services such as dental care around core early childhood education. Many impact investors have invested in CDFIs that are lenders to quality child care providers, including the Low Income Investment Fund, IFF, the Self-Help Credit Union, and the New Hampshire Community Loan Fund.

#### **Clinical Care**

CHR attributes 20 percent of health outcomes to clinical care—both access (10 percent) and quality (10 percent).

**Access to Care.** Impact investors, such as Dignity Health and the California Endowment, have provided significant capital to community health centers around the nation, including Federally Qualified Health Centers and look-alikes. Working with CDFIs such as NCB Capital Impact, Capital Link, and others, these investors have financed construction of new clinics, upgrading of facilities and equipment including information technology, and working capital that keeps clinics in operation when state reimbursements are slow. The California Health-Care Foundation's Health Innovation Fund provides financing for technologies that provide new or more

timely access to 100,000 Californians and/or deliver \$25 million in annual cost savings to the California health care system.

**Quality of Care.** The Abell Foundation invests venture capital in medical and clean tech companies that will locate and create jobs in the city of Baltimore. One successful investment was in Visicu, sold to Philips eICU Program. The technology clinically transforms the intensive care unit, using a proactive care model that addresses growing physician and nurse shortages while dramatically improving quality of care.

### Public–Private Partnership to Advance Health Equity with Impact Investments

With roots in social justice and community development finance, impact investors continue a long tradition of countering inequity and disparity. Absent these socially motivated investors, the conventional flow of capital itself may reinforce disparity. Conventional investors tend to seek large, standardized investment opportunities, and the capital needed in low-income communities is typically in smaller amounts and for investees who, while often credit-worthy, present “nonconforming” features, such as a focus on low-income customers, an innovative product or process, a weak balance sheet (cash or other assets on hand), or a lack of credit history. The partnerships between impact investors and CDFIs are particularly effective in countering this disparity by providing financing to organizations, projects, and households that help to ensure that all Americans have equitable access to the opportunity for a long, healthy, and fulfilling life.

Building on the early successful track record of impact investing requires cooperation among philanthropy and the public and private sectors. Philanthropy can provide early-stage, subordinated (higher-risk), and patient investments to spur innovation, demonstrate the viability of new initiatives, and attract co-investors. Complementary grants from philanthropic sources including health funders can fund the technical assistance that prepares organizations to effectively deploy impact investments, develop effective health-related impact metrics, and report on health-related impact. Philanthropy’s active participation in monitoring impact investments can help ensure that these investments

achieve their social, environmental, health-related, and financial objectives.

Government can create an enabling environment for health-related impact investing, particularly in the low-income communities and critical phases of the life span where disparity creates the greatest opportunities to mitigate health risks and rein in health care expense. Conducive policy (programs and grant criteria that prioritize low-income communities and vulnerable children, the disabled, and the elderly) and resources that promote, incentivize, and minimize the risk of private sector investment in these communities and populations can help the nation to fulfill its health equity and health care cost containment goals.

With roots in social justice and community development finance, impact investors continue a long tradition of countering inequity and disparity.

Private sector, conventional investors are needed to provide the largest amounts of capital. They can also provide insight on how to create efficient investment structures and processes. Through corporate social responsibility (CSR) and creating shared value initiatives, corporations can further align their operations in ways that reinforce healthy communities, whether through minimizing their carbon footprint, operating a vibrant minority supplier program, or sponsoring local health promoting initiatives, such as bike-share programs. These investments of brand as well as financial capital often contribute to the financial sustainability of community partners, in some cases strengthening their ability to attract impact investments.

### Recommendations

Fully realizing the potential of impact investing for improving health outcomes, reducing disparity, and containing health care costs calls for additional, specific actions by local and national health policy makers and practitioners. These actions include:

- Develop familiarity with the field of impact investing, including its business models,

terminology, major institutions, and major federal and local programs.

- Convene local public health, health care, community development, philanthropy, and impact investing actors to ensure that potential partners in each field understand and can align with the goals, services, funding, and financing requirements for the others.
- Consider forming a local joint task force between health and community development leaders to prioritize collaborative effort that can improve local population health status using the CHR as a baseline and reference tool. This includes exploring ways to engage impact investors in providing financing to local organizations and projects that foster positive social determinants of health and/or increase access to quality health care for vulnerable populations.
- Consider ways to leverage health system community benefit obligations by promoting partnerships between health systems and community-based organizations. Explore the potential for health systems to become impact investors in local community development projects via their community benefit or other CSR programs.
- Apply knowledge of the impact investing landscape to refer promising early-stage community-based health organizations and projects to appropriate sources of technical assistance and potential financing, such as local CDFIs or community-oriented banks.

- Convene or participate in efforts to quantify health benefits from local community development projects. This could include applying established health impact assessment tools or engaging local academic institutions to establish and document relevant health metrics for local community development projects. Such metrics can help to attract both grant and investment dollars needed to sustain and scale successful programs.

### Conclusion

Impact investors represent a valuable, often untapped partner to cities that are committed to building communities where all Americans have access to a long, healthy, and fulfilling life. Often working in partnership with intermediaries, such as CDFIs that are focused on serving low-income communities, and increasingly focused on bringing a health lens to their work, impact investors can channel billions of dollars annually to help build communities where the healthy choice is the easy choice. While impact investing is not an appropriate source of financing for all local needs, it can leverage public and private grants, providing critical resources to sustain and scale a range of health promoting projects and organizations.

---

*Lisa Richter is cofounder and principal of GPS Capital Partners.*

---

# The Y and Healthy Communities Driven by Mission

BY MONICA HOBBS VINLUAN,  
MATT M. LONGJOHN,  
AND KELLY KENAI GRUNIG

Many people think of the YMCA as a building, a place where they can find swimming lessons, group exercise classes, and fitness equipment, but it is so much more. The Y also leads local and national initiatives designed to have a broader impact and create lasting change. One such example is the Healthier Communities Initiatives of the YMCA of the USA (Y-USA).

In fact, building healthy communities has always been at the core of the YMCA's mission, dating back to the days of the Industrial Revolution when it was a place for young men to gather for fellowship and fitness. Today the Y supports people from all walks of life to improve and maintain their health and well-being and is building healthy communities in a variety of ways: changing our own environments to educate people about healthy behaviors and make healthy choices more accessible; offering evidence-based programs that target individual behaviors to reduce risk; and convening leaders in communities to influence strategies and policies that create healthier environments so everyone has access to opportunities for healthy living. With its broad reach (nearly 80 percent of US households are within five miles of a Y facility), experience as a convener, and ability to bring initiatives to scale, the YMCA is a valuable network in efforts to help our communities grow and thrive.

## The Y's Healthier Communities Initiatives

In 2004, Y-USA launched its healthier communities work with Pioneering Healthier Communities (PHC)—supported by the Centers for Disease Control and Prevention (CDC). This initiative connected local Ys to a variety of stakeholders to catalyze policy change and empower those communities with proven strategies that help them achieve change. PHC was the signature initiative in the Y's Healthier Communities Initiatives. Since the launch of PHC, several other Y initiatives have emerged:

- *Action Communities for Health, Innovation, and Environmental Change (ACHIEVE)*. Funded by CDC from 2008 through 2012, ACHIEVE sup-

ported local health departments, parks and recreation departments, and YMCAs in advancing strategies focused on preventing chronic diseases and related risk factors.

- *Statewide Pioneering Healthier Communities*. In 2009, Y-USA received funding from the Robert Wood Johnson Foundation to launch a statewide PHC policy change initiative at the local and state levels in six states and thirty-two communities over a period of five years to address the childhood obesity epidemic through policy and environmental changes that will have implications for communities, states, and the nation. Recently, fourteen additional alliances have launched leadership teams to focus on state-level strategies and interventions.
- *Community Transformation Grants (CTG)*. In 2012, Y-USA became a national network partner in CTG, a CDC initiative developed to support public health efforts to reduce chronic diseases, promote healthier lifestyles, reduce health disparities, and lower health care costs. Y-USA's CTG efforts focus on programs and strategies that promote the health and well-being of individuals in their communities, with a specific emphasis on African American and Hispanic individuals.
- *Racial and Ethnic Approaches to Community Health (REACH)*. In October 2012, Y-USA became the newest partner working with CDC on REACH. This initiative is focused on improving health and eliminating disparities related to chronic disease in racial and ethnic groups across the country. The community teams convened through this effort work in areas of the country with the highest burden of disease, with a particular emphasis on Black/African American and Hispanic/Latino communities.

As of July 2013, 240 Ys and twenty states are engaged in Y-USA's Healthier Communities Initiatives. A recent sample of 175 of those sites indicated they have implemented and influenced nearly 36,000 actions and strategies. Each of these community enhancements has been designed to make

communities healthier, including helping families put healthier food on the table by bringing fresh fruits and vegetables to neighborhoods where there are no healthy food options; giving parents peace of mind when they let their kids walk to school by making safe routes to schools possible; and helping to keep a generation of kids healthier by working with schools to increase physical education and physical activity during the school day. These enhancements are just the tip of the iceberg.

Across all of these initiatives, Y-USA re-grants dollars from government, foundations, or corporate funders to local Ys or state alliances of Ys. Y-USA provides a framework for success, training, and a modest amount of money to get the communities going. After a short time, Y-USA continues to provide technical assistance with the goal of the local or state leadership teams achieving sustainability without further grant funding. On average these sites have been able to raise \$5.96 for every federal or private dollar received. Each year, Y-USA convenes all sites to provide peer-to-peer learning opportunities and networking through a learning institute.

### **Bringing Programs and Policy Together to Build Healthier Communities: Community Transformation Grants**

In 2012, Y-USA received funding from CDC to become a national organization participating in the Community Transformation Grant (CTG) program. The Y's CTG efforts brought together three core elements of the Y's healthy living work—organizational change, community change, and chronic disease prevention programming—to have a broader impact on the communities that were participating. Also to be noted, the Y's CTG work has a special focus on health equity and removing barriers to opportunities for healthy living in the communities that need it most.

In addition to engaging in policy, systems, and environmental change work, Ys participating in CTG also focus on coordinating and linking systems among health care providers, clinical settings, and community-based organizations to help guide individuals to prevention efforts/programs, such as the YMCA's Diabetes Prevention Program. The CTG community teams are enhancing local efforts to

implement communitywide strategies that create environments in early childhood and after-school settings that ease the adoption of healthy eating and physical activity standards—all with an emphasis on locations serving African American and Hispanic populations.

The adoption of the healthy eating, physical activity standards within our child care and after-school programs is part of the Y's commitment to First Lady Michelle Obama's efforts to reduce childhood obesity.

The YMCA's Diabetes Prevention Program is based on National Institutes of Health research, which showed that programs designed to help people lose weight and increase physical activity could prevent or delay nearly 60 percent of new cases of diabetes. Another study—this one by the Indiana University School of Medicine—found that the YMCA could effectively deliver a group-based lifestyle intervention for about 75 percent less than the cost of the original diabetes prevention programs. This research also highlighted the ability of the Y to take the program to scale nationally. Just three years ago only two Ys in the country offered this program in a handful of sites. Today there are more than 569 class locations across ninety-one communities in thirty-five states, and 1,295 lifestyle coaches are trained to deliver the program. Because the program is portable, the intervention is offered in sites throughout a community—not just at a Y.

Programs such as this show how the Y can play an integral role in the nation's health care system. With the limited time physicians have to provide lifestyle changes support to patients, the Y is a good adjunct provider to help patients get the support they need to reduce obesity and chronic disease. CDC is also funding the Y to scale up an evidence-based arthritis control program and a falls prevention program.

The adoption of the healthy eating, physical activity standards within our child care and after-school programs is part of the Y's commitment to First Lady Michelle Obama's efforts to reduce childhood obesity. The Y is one of the nation's largest nonprofit

providers of early child care and after-school programs. In 2011, the organization declared it also wanted to be the healthiest. Many Ys across the nation had already been involved in efforts to change the environments in settings where children were cared for, but this commitment instituted a consistent standard. In addition, these Ys will be leaders in their communities to encourage other early childhood and after-school providers to adopt similar standards, having an even bigger impact on children across those communities and across the nation.

### Role Model for a Movement

Although many national, state, and local organizations are doing outstanding work in the Healthy Communities Movement the multisectoral, teach-them-to-fish model of Pioneering Healthier Communities has been replicated and scaled by CDC through initiatives such as ACHIEVE, Communities Putting Prevention to Work, and CTG programs.

In addition to serving as conveners in local communities and states, the Y has been successful in bringing together other national networks to help advance the Healthier Communities' movement. From the beginning, the Y engaged other national organizations in the work—first as expert advisors, then through the Healthier Communities Roundtable. The roundtable serves as a forum for organizations engaged in the Healthy Communities movement to come together to share technical assistance resources, strategize around emerging policy trends, and develop shared sustainability and evaluation measures. Over the years, the roundtable has grown to fifty-three national organizations connecting

together to strengthen the support and evolution of healthy communities efforts across the country. In addition, in 2011, Y-USA convened a health equity panel to advise, guide, and inform our healthy communities work. This panel recently combined efforts with the Roundtable to support more equitable communities.

### Working Together to Achieve Our Goals

Some might be surprised to learn that the Y engages in community health at such a deep level. But the truth is that this work is at the core of who we are. It always has been. Our current path reflects an evolution of years of supporting individuals and communities and responding to their needs. Today is no different.

With health care costs continuing to rise and a health care system that is stretched to the max, national networks like the Y must step up and utilize their expertise and their reach to reduce some of the burden. The Y's experience and proven impact has told us it's possible when we coordinate our talent and resources. If we all work together, there are no limits to what we might accomplish.

---

*Monica Hobbs Vinluan is the project director of Healthier Communities Initiatives at YMCA of the USA.*

*Matt M. Longjohn is the national health officer of YMCA of the USA.*

*Kelly Kennai Grunig is the communications director of YMCA of the USA.*

---



# United Way, Healthy Communities, and Collective Impact

BY STACEY D. STEWART

Today, every child in Toledo, Ohio's public schools can eat a healthy breakfast at school—for free. With more than 25 percent of its population living in poverty and 37 percent dropping out of high school, this change can help Toledo become a healthier community, in every sense.

What's more, the struggling neighborhood of Toledo's Central City has seen a 1,250 percent increase in low-wage families shopping at local farmers' markets, the planting of 170 urban gardens, safer and more walkable routes to school for kids, more bike lanes, free immunizations for all kids, and free dental and vision screening in thirty-three schools.

These positive changes for the city of Toledo are partly a result of new innovative approaches and partnerships championed by the United Way of Greater Toledo. The United Way realized a few years ago that its old business model of funding local organizations was underwriting good causes but not creating lasting community change.

Today, Toledo's United Way is more deeply engaged with its community; is co-creating community-based change strategies with a wider diversity of people and organizations; and is bringing the community together around a common vision, common agenda, and a common path forward.

Many similar stories of inspiration and results can be found across the U.S. network of 1,200 state and local United Ways. United Ways are bringing people together—from all across the community—with passion, expertise, and resources to build stronger, healthier communities where everyone can thrive.

## United Way and Collective Impact

We call it *collective impact*. It's another way of describing how United Way mobilizes a community around a pressing issue like health: bringing diverse partners together to focus the community's attention

on the end game, enlisting everyone in the solution, and aligning resources to support the end game.

That's why we put a stake in the ground back in 2008. United Way stepped up to be part of community solutions in a different way. We set out benchmarks of long-term success. We focused on education, income, and health because those are building blocks of a good quality of life—and the pathway to opportunity. Our collective aspiration is to reduce high school dropout numbers, increase the number of Americans leading healthy lives, and increase financial stability for low-wage families.

The three building blocks of opportunity are intertwined, of course. A good education is essential to getting a good job with health benefits. An income that can cover today's needs and save for tomorrow solidifies a family's foundation. Good health helps children succeed at school and adults at work. Remove any one building block, and the other two topple. Build them all up, and we have a strong foundation for success.

Today, America has the highest high school graduation rate since 1976, although the achievement gap still exists. We're also making headway in reducing childhood obesity, but there's more work to be done to help adults live healthier lives. We're finding new ways to develop a world-class workforce, but in the wake of the recession, it's even more challenging for working families to move from an economic tightrope to a secure financial path.

Big goals require big changes. Not just in what we say but in what we do and how we do it. For United Way, that means working with partners to:

- Frame community-wide conversations that tap into collective concerns and aspirations.
- Elevate critical issues.
- Create solutions in which everyone—everyday citizens as well as community organizations—can take part.

- Enlist and mobilize more people to join the cause and take meaningful action, like volunteering as reading tutors to first graders, speaking out for children’s health insurance, or helping to fund safe playgrounds in struggling neighborhoods.

### Creating Healthier Communities, One Neighborhood at a Time

More and more United Ways are part of making these community changes. Much of our network has targeted a community priority for action, and many are putting a stake in the ground with partners. Since 2008, the percentage of United Ways creating reinforcing community strategies—and seeing results—has increased by half.

United Way can’t do it alone, and sector leaders can’t do it alone either. We need everyone engaged in this work. It will take all of us.

#### Community Engagement

Like many United Ways, United Way of Greater Toledo started its change effort by listening to citizens in its community. Its leaders began an intentional process of reaching out and listening to find out what residents, community leaders, and organizations thought mattered most for Toledo’s future. While education was everyone’s top concern, there wasn’t a robust community coalition in place to tackle the issues that undercut kids’ learning.

United Way was well positioned to lead a thoughtful assessment process, using both quantitative data—from sources like the Robert Wood Johnson Foundation’s *County Health Rankings*—and qualitative data from community conversations with residents, educators, community organizations, and corporate partners. At the end of the day, the problem was clear, but the leadership response was not.

Seeing this gap, United Way reached out to engage key stakeholders in this community-wide work and made sure that data drove the debate. Not everyone understood that high school graduation rate is a key social and economic determinant of health (and is a leading health indicator for Healthy People 2020, a ten-year goal-setting effort launched by the US Department of Health and Human Services), although leaders intuitively understood the linkage between graduation and financial stability.

The United Way led a multisector coalition in the Greater Toledo area, which decided to tackle the high school dropout problem. Such a commitment meant a collective pledge to tackle the many issues struggling kids face, including hunger and homelessness. With growing community support and a focus on promising practices, United Way and its partners developed a plan to establish select schools as community hubs. Schools that serve as a neighborhood hub are user-friendly places for students and families to get connected to resources, referrals, and services that strengthen families and neighborhoods. Now, with four schools serving as community hubs, families are getting access to preventive health and mental health services, tutoring, tax preparation, GED classes, and housing and employment resources.

#### Cross-Sector Collaboration

For United Way, collective impact work is about bringing the community together to be part of the solution, whether that’s through financial support, advocacy, or volunteering.

Santa Cruz, California’s community collaboration, Go For Health!, shows how cross-sector collaboration and youth empowerment can spur such change. Go For Health! was convened by the United Way of Santa Cruz County, the Children’s Network, and other organizations concerned about rising childhood obesity. Some 150 agencies came together to look at proven solutions, beyond nutrition education and direct services. The cross-sector coalition created a comprehensive plan, stressing healthy eating and regular physical activity. Go for Health! is working with schools, youth groups, parents, health care professionals, local media, local markets/businesses, city planners, and local/state policy makers to carry out the plan. Results so far include:

- Passage of city ordinances affecting restaurant food standards.
- The creation of school wellness policies with comprehensive language around nutrition and physical activity for each school district.
- City adoption of five recommendations for incorporating safe, walkable, and bikeable streets into its development plans.

Collaboration, community engagement, and data are cornerstones of this work, but it can be messy.

Diverse stakeholders can struggle to identify priorities and strategies to implement together. But with continued dialogue, community input, and a commitment to work together, results are within reach.

In Milwaukee, the community has come together to bring the teen pregnancy rate down for four consecutive years. The United Way of Greater Milwaukee mobilized the business community around this issue and catalyzed critical partnerships between schools, community organizations, the Milwaukee Health Department, and media leaders. Here's what they did:

- Developed the Healthy Girls project, which helps young people understand consequences of teen pregnancy while teaching skills needed to cope with social pressure to engage in sexual activity.
- Formed a partnership among the United Way, the Medical College of Wisconsin, and Children's Hospital of Wisconsin to develop Baby Can Wait, a youth-focused Website with medically accurate, age-appropriate content on preventing pregnancy and promoting healthy relationships.
- Revised the human growth and development curriculum for the schools, led by Milwaukee Public Schools, United Way, and community leaders. Community residents were invited to review the materials and make suggestions about content, and teachers were trained in the new curriculum.

### Connecting the Dots

Many United Ways are using tools developed by the Robert Wood Johnson Foundation, the University of Wisconsin, and the Prevention Institute to build healthier communities, integrating health strategies into other neighborhood-based community work. United Way Worldwide is the first Roadmaps to Health National Partner, equipping the United Way network with data (on factors that influence our health, such as smoking prevalence, obesity, unemployment, and graduation rates) to help them improve community outcomes.

That kind of integrated approach is making a difference in Salt Lake City, where the United Way of Salt Lake and its partners are integrating services to make it easier for people to get the help they need

without having to navigate a maze of confusing bureaucratic offices, procedures, processes, and forms.

Many United Ways are using tools developed by the Robert Wood Johnson Foundation, the University of Wisconsin, and the Prevention Institute to build healthier communities, integrating health strategies into other neighborhood-based community work.

One area of focus is South Salt Lake City, with a very diverse population of immigrants and refugees (speaking more than twelve languages), high youth poverty rates (33 percent), and low high school graduation rates (61 percent).

The integrated approach is embodied in the Promise Partnerships initiative, comprised of nine one-stop centers in which public, private, and nonprofit agencies weave together services and supports in a user-friendly way to help struggling families with education, financial stability, and health issues in their neighborhood.

These one-stop centers are located in schools, apartment complexes, mobile homes, and other community facilities. Similar to Toledo's school-based community hubs, they create a web of support for the entire family by providing access to a wide range of educational programs, social services, health resources, basic needs programs, and services.

The emphasis on starting early to help kids come to school healthy and ready to succeed is paying off:

- More kids are getting preventive health services—36 percent more kids were immunized this year, including shots needed to start school.
- The overall youth crime in South Salt Lake over the last three years has dropped 30 percent in the last three years.
- Low-income kindergarteners are only 2 to 5 points behind in language arts and math (compared to 22 to 28 points previously). Far fewer kids are being referred to special education services, saving state education coffers \$1.4 million.
- Some 51 percent more households are getting free

tax help and earning Earned Income Tax Credits, which helps strengthen their financial position.

Across America, United Ways are hard at work building healthier communities. Collective impact, and the mission-critical nature of deeper collaboration, is an important way to get us there. If you are not already working with your local United Way, we want to join with you. It will take all of us working together to improve people's lives and the resilience of our communities.

#### **About United Way**

United Way is a worldwide network in forty countries and territories, including more than 1,200 lo-

cal organizations in the United States. It advances the common good, creating opportunities for a better life for all by focusing on the three key building blocks of education, income, and health. United Way recruits people and organizations who bring the passion, expertise, and resources needed to get things done. LIVE UNITED® is a call to action for everyone to become a part of the change. For more information about United Way, please visit: <http://www.LIVEUNITED.org>.

---

*Stacey D. Stewart is the US president of United Way Worldwide.*

---