

Stakeholder Perspectives on a Culture of Health

KEY FINDINGS

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Preface

SINCE 2013, THE Robert Wood Johnson Foundation (RWJF) has embarked on a pioneering effort to advance a Culture of Health. The Culture of Health action framework is founded on a vision in which “everyone in our diverse society leads healthier lives now and for generations to come.” To put the Culture of Health vision into action, RWJF asked RAND to support the development of an action framework and measurement strategy. This report summarizes the stakeholder engagement efforts that RAND used to inform this work. The findings offered in this report can be used to inform future communication strategies and outreach activities related to a Culture of Health. These should be combined with those findings offered in the RWJF publication *From Vision to Action: Measures to Mobilize a Culture of Health* (2015) and the forthcoming study *Building a National Culture of Health: Background, Action Model, Measures and Next Steps* (Chandra et al., forthcoming).

This report draws on a series of interviews and focus groups that RAND researchers conducted with stakeholders both within and outside the United States. It should be of interest to RWJF, as well as to those individuals and organizations interested in advancing the Culture of Health action framework. Given that RWJF is focused on using the Culture of Health action framework and measures to catalyze national dialogue about content and investments to improve population health and well-being, the report should be beneficial to a range of national, state, and local leaders across a variety of sectors that contribute to health as described by the Culture of Health action framework.

This research was sponsored by the Robert Wood Johnson Foundation and conducted within RAND Health. A profile of

RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health. Anita Chandra leads the Culture of Health work at RAND and is assisted by a large, diverse team of RAND researchers. Questions about this report or the Culture of Health work at RAND may be directed to Chandra@rand.org.

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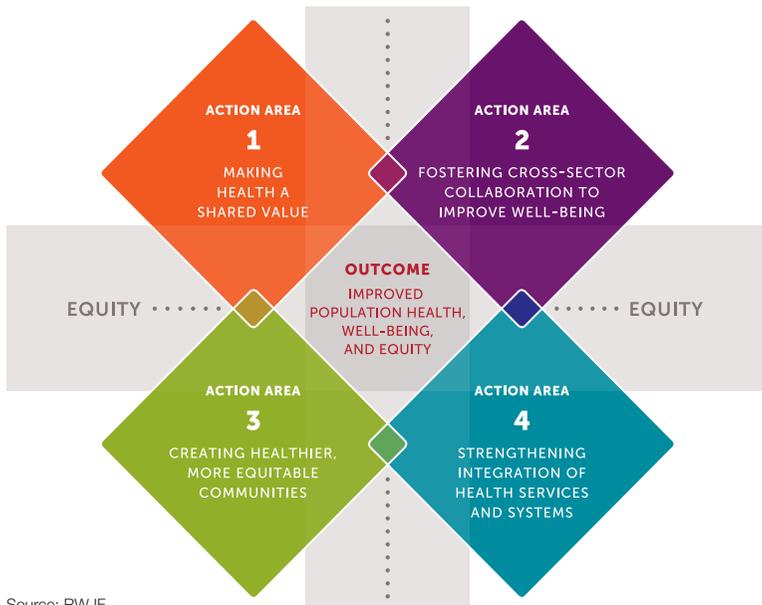
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Summary

IN 2013, THE Robert Wood Johnson Foundation (RWJF) established a new strategic framework, the *Culture of Health* (CoH). CoH is founded on a vision in which “all in our diverse society lead healthier lives now and for generations to come.”

For the CoH vision to be realized, the framework requires a national paradigm shift from one that thinks of health in terms of disease, treatment, and health care toward one that prioritizes well-being broadly. Recognizing this, RWJF asked RAND to help design an actionable path to fulfill CoH goals. The results, a framework consisting of four action areas and measurement strategy, were published by RWJF (2015) and detailed in a forthcoming RAND report, *Building a National Culture of Health: Background, Action Model, Measures and Next Steps* (Chandra, forthcoming). The framework is presented in Figure S.1.

Figure S.1. Culture of Health Action Framework



Source: RWJF

Briefly, the outcome that anchors the vision is presented in the bottom box: *improved population health, well-being, and equity*. This outcome is based on a new paradigm in which keeping everyone as healthy as possible is a fundamental and guiding value in the United States. The first action area in the supporting framework involves *making health a shared value* of society in order to forge a common cause around CoH. This first area is critical to the CoH vision, as all members of a community and indeed, the nation, must work together to become and stay healthy. The second action area, *fostering cross-sector collaboration to improve well-being*, recognizes that multiple aspects in people's lives affect overall health; this action area reminds us that traditional health care organizations and networks will need to work with nontraditional partners, such as education, labor, housing, and food outlets, to achieve CoH. The third action area, *creating healthier, more equitable communities*, is designed to enhance the ability of all members of a community, regardless of economic and health status, to access resources and opportunities needed to lead a healthier life. Finally, the fourth action area, *strengthening integration of health services and systems*, encompasses a commitment to equity that ensures individuals' access to high-quality, efficient, and integrated systems of public health, as well as health care and social services that are capable of meeting the health needs of the American population, across lifespans and "health spans" (i.e., from sick to well).

The research team sought stakeholder input in the course of developing the framework and measures for two purposes: (1) to support the conceptual development of the CoH action framework; and (2) to support the development and use of CoH measures by those doing CoH-related work on the ground. The information and insight gained over the course of stakeholder interviews and small focus group sessions helped inform the CoH framework. However, it should be noted that stakeholder input represents only one component that in-

formed the CoH action framework and measurement strategy process. The process also involved extensive literature review, expert consultation, and iterative prioritization exercises among the CoH team at RAND and RWJF. As such, the findings from interviews and focus groups should be contextualized in broader CoH-related analysis.

Data Collection and Coding Methods

To gather stakeholder input, the team conducted 74 semistructured interviews and eight small focus group sessions within the United States and internationally. The team also attended two community events with CoH focus to gather information. The team sought to collect responses from stakeholders that would have a direct relationship to CoH or are active in bringing about similar changes in organizations. As CoH is a holistic approach to national and community health, stakeholders represented both traditional health providers and caregivers as well as community leaders, innovative organization leaders, and leaders in education, criminal justice, employment, housing, and other fields outside of health that have an impact on people's overall well-being. Stakeholders were recruited from U.S. cities and internationally and included organizations engaged in multiple and diverse CoH initiatives, communities from a mix of health-related community rankings, and diverse geographic regions.

Once collected, insights and other stakeholder input were coded. Qualitative analysis was conducted to reveal themes that applied to the CoH framework as well as each individual action area.

Findings

A summary of findings general to CoH and those specific to each of the action areas can be found in Tables S.1 through S.5. A short discussion of each group of findings follows the

corresponding table. This section ends with a brief discussion of findings related to CoH measurement.

The findings in this group suggest that a large number of stakeholders felt that the phrase “culture of health” was intuitive, appealing, and helped move the conversation beyond health as the absence of disease and exercising or eating right. But some also expressed concerns that the phrase may not be seen as inclusive of all populations, may not translate well to

Table S.1. CoH: Themes from Interviews and Focus Groups

Implementation of the CoH across multiple action areas

- Consider an individual’s larger social context or environment when determining factors that may be influencing his or her health
- Build knowledge of and connection with communities to foster a culture of health
- Work at multiple levels, from individual to organizational to system, to build a culture of health
- The phrase “culture of health” was intuitive and appealing to a large majority of stakeholders, but some stakeholders had concerns about the phrase’s inclusivity
- Provide continued health education and communication to create a shared value of health among all stakeholders
- Political support for policies or interventions that may be costly or unpopular in the short term may be difficult to garner
- Evaluation and data are important to inform a culture of health, but stakeholders reported limited capacity and funding to collect them
- Consider ways to make building a culture of health “good for business” to incentivize strategies to build a culture of health
- Social media data could be useful to track development of a culture of health, but few stakeholders use these data

Table S.2. CoH Action Area 1: Themes from Interviews and Focus Groups

Making health a shared value

- Culturally tailor processes to build a shared value of health; it is not “one size fits all”
- Engage community residents as key partners to promote shared values and social cohesion
- Collaborate with a wide range of organizations to promote shared values
- Train public health professionals on how to change social norms
- Integrate civic engagement activities into health promotion programs to create shared values

other cultures, and may not be intuitively inclusive of traditionally marginalized populations. Stakeholders also emphasized that inclusion of the word “health” in the phrase might lead to the phrase being construed as primarily health-sector work; however, the conceptualization of CoH intends to go beyond that to the whole community and it defines health in a broad way. There were also concerns that the term “culture” can be interpreted as very personal and ingrained and not something that is mutable in the way envisioned by the CoH action framework.

Making health a shared value elicited limited feedback among stakeholders when compared with the other areas in the CoH action framework. There are a number of possible explanations for this. Many said they had never thought of tracking community activation around health and strategies for encouraging individuals to value and prioritize health. Since we spoke to many stakeholders within the health sector, the idea that health is valued and that health equity is important may have been taken for granted. Some stakeholders felt it was more important for the health sector to value the contributions of other sectors than for all to explicitly prioritize

Table S.3. CoH Action Area 2: Themes from Interviews and Focus Groups

Fostering cross-sector collaboration to improve well-being

- Define “prevention” and “health promotion” broadly to help potential collaborators see where they have influence
- Engage a visionary leader, community leaders, and nontraditional partners to build a culture of health
- Clearly articulate economic benefits from cross-sector collaboration for organizations to sustain commitment over time
- Develop strategies to maintain consistent organizational participation in the collaboration, despite staff turnover
- Measuring the extent or quality of partnerships may be a challenge for culture of health initiatives
- Competing priorities and community size can challenge cross-sector collaborations

health. The interviews revealed that these themes may not be a part of the typical strategic thought process for the organizations’ stakeholders represented, or that they are concepts that lie within the foundation of the organizations’ work but are not part of their activities.

For the second action area, nearly half of stakeholders, both domestic and international, cited experience collaborating with partners in other sectors. More than a third underscored collaboration as an integral aspect of building CoH. Stakeholders shared insights on key partners for forming collaborations, how to build and sustain collaborations, and other key lessons learned. In multiple communities, local and state governments are leading efforts to build CoH. Also, stakeholders are collaborating with partners from diverse sectors, and partnerships among health care centers, local businesses and business organizations, academic institutions, nonprofits, and faith-based organizations are leading to creative approaches to dealing with health issues.

Table S.4. CoH Action Area 3: Themes from Interviews and Focus Groups

Creating Healthier, More Equitable Communities

- Develop innovative initiatives to promote equitable opportunities for healthy environments
- Utilize a variety of specific strategies or initiatives to create a social, physical, or economic environment with equitable opportunity for healthy choices
- Strategically used communication, media, and messaging can shape health environments and should be targeted as part of an environmental strategy
- Consider health in all policies, or leverage a broad approach to create a healthy environment

Findings related to the third CoH framework action area suggest there is a shared understanding across both U.S. and international organizations of the importance of social, physical, and environmental factors in improving individual and community health. Many stakeholders discussed the importance of geographic access to social and health services, as well as daily opportunities for individuals to engage in health-promoting behaviors. Overall, stakeholders felt that the public health sector has become more sophisticated in communicating and thinking about the social determinants of health, but more work should be done to train public health professionals to communicate persuasively about social determinants.

For the final action area, there was a collective agreement about the need to integrate the community and patient care and to implement innovative approaches to connecting patients with their health care teams. Some stakeholders discussed their use of data, measures, and information technology as a means to identify needs, assess goals, and to streamline patient-provider interactions. Yet, fragmented data

Table S.5. CoH Action Area 4: Themes from Interviews and Focus Groups

Strengthening integration of health services and systems

- Develop relationships with integrated health initiatives in the community
- Promote proactive strategies, but be aware that shifting funds away from treatment to prevention will be a challenge
- Start by focusing on a specific health need to generate more integrated care collaboration models
- Shift the focus of health care to prioritize delivering quality care and providing an optimal consumer experience
- Coordinate health and other major systems in a community to fit within a broad framework of health promotion

and insufficient infrastructure still pose challenges for many stakeholders. Adequate workforce development, education, and human resources resonated as key elements to promote prevention and healthy lifestyles. Some organizations highlighted the importance of cost-effectiveness of interventions, but others noted that social investors are interested not just in the financial return but also in the value they bring to people's lives.

Findings Related to CoH Measures

Findings from the interviews and focus groups suggested a lack of available measures and existing capacity necessary to evaluate most community health initiatives rigorously and comprehensively. Stakeholders also expressed a need to develop measures specific to each aspect of CoH. Some stakeholders offered a number of recommendations of suggested measures for the CoH action areas, which can be found in Appendix C.

Conclusion and Moving Forward

Together, the findings hold positive implications as well as suggestions for RWJF to consider in moving forward with CoH and implementation of the CoH action framework. As already suggested, the findings suggest that the name of the strategic framework, *Culture of Health*, is both appropriate and intuitive. However, care must be taken when relaying the term “culture,” as this can be interpreted in a variety of ways depending upon the audience.

Findings also suggest that evaluations and data are important to inform CoH, but stakeholders have limited capacity and funding to collect appropriate data, and that measures of shared values and social cohesion were among the most difficult to conceptualize. Additional guidance and support may be needed to convince stakeholders of the value and utility of measures related to cross-sector collaboration. System-level measures of equitable opportunities are unavailable, but are critical to tracking progress and outcomes for this area. Stakeholders also stressed the importance of finding ways to describe both monetary and social values of CoH. Tools such as the Social Impact Calculator (Low Income Investment Fund, 2014) can provide the social value of participation. Monetizing the value is the first step; however, communicating about this value is critical to sustainability of the CoH action framework. Finally, because the CoH framework goes beyond traditional health and health care to include well-being and preventive efforts and all aspects of the environment that contribute to health, CoH leadership should be mindful of pitfalls pertaining to outreach and communication. Without a strong vision and clear-cut communication, strategic frameworks this broad in scope can be challenging. It can be difficult to help stakeholders see their role in the framework and understand “what is in it for them.” Furthermore, it can be a challenge to identify a clear funder, since funders often fund in specific areas.

When analyzed together, the findings also offered a number of recommendations for RWJF to consider moving forward:

- **Leverage existing community capacities to implement and communicate CoH and related efforts.** The findings suggest that for the vision of CoH, community, and cross-sector approach to be achieved, leaders must find ways to integrate with grass-roots efforts led by community residents all the way up to policy-level interventions that affect governance structures and protocols. Expertise will be needed to engage whole communities, promote cross-sector collaboration, navigate political processes, and use an array of communication technologies and media to shift social norms. To fully engage the private sector, RWJF will need to clearly communicate the economic incentives and cost benefits of building CoH.
- **Develop a strong and flexible set of leaders.** Leaders that can help clearly articulate roles and benefits across sectors, navigate “siloesd” funding streams, identify the ways that sector efforts can be better aligned, and find opportunities for nesting health into policies and initiatives will be needed to promote CoH across communities.
- **Enhance CoH capacity to collect, analyze, interpret, and apply data.** Findings suggest challenges in this area, but data, including “big data” that are collected from social media, will be needed. Measures of the benefits of cross-sector collaborations are also critical to the effort. Such data are important if CoH leaders wish to track progress and monitor community-level changes toward CoH adequately.

Abbreviations

CoH	Culture of Health
OECD	Organisation for Economic Co-operation and Development
RS	regional stakeholder
RWJF	Robert Wood Johnson Foundation



1

Introduction

SINCE 2013, THE Robert Wood Johnson Foundation (RWJF) has led the development of a pioneering national action framework to advance a “culture that enables all in our diverse society to lead healthier lives now and for generations to come.” This framework, entitled *Culture of Health (CoH)*, is supported by ten underlying principles (Plough, 2015):

- Good health flourishes across geographic, demographic, and social sectors.
- Attaining the best health possible is valued by our entire society.
- Individuals and families have the means and the opportunities to make choices that lead to the healthiest lives possible.
- Business, government, individuals, and organizations work together to build healthy communities and lifestyles.

- Everyone has access to affordable, quality health care because it is essential to maintain or reclaim health.
- No one is excluded.
- Health care is efficient and equitable.
- The economy is less burdened by excessive and unwarranted health care spending.
- Keeping everyone as healthy as possible guides public and private decisionmaking.
- Americans understand that we are all in this together.

For these ten principles to be accomplished, the CoH action framework requires a national paradigm shift toward well-being from a traditionally disease and health care–centric view of health. Recognizing that paradigm shifts must be brought about through action, RWJF asked RAND to help design an actionable path to fulfill the CoH vision. The results, a framework consisting of four action areas and measurement strategy, were published by RWJF (2015) and will be detailed in a RAND report, *Building a National Culture of Health: Background, Action Model, Measures and Next Steps* (Chandra, forthcoming).

This report documents the stakeholder engagement efforts to support: (1) the conceptual development of the CoH action framework and (2) the development and use of CoH measures by those doing CoH-related work on the ground. The report describes how information from semistructured interviews and small focus group sessions in the United States and internationally was collected, coded, and interpreted by the team. The bulk of the report focuses on key findings pertaining to the overall CoH framework and its action areas. In the future, CoH leadership can consider the findings recorded here in the development of cohesive communication and outreach plans. This work complements additional RAND studies that support RWJF's ongoing CoH efforts; findings here should be taken in the context of these other studies.

CoH Vision and Action Framework: Overview

CoH is designed in part as a response to the critical health and health care choices that face the United States. Currently, the United States spends more on health care than any other nation (Davis et al., 2014; Organisation for Economic Co-operation and Development [OECD], 2013). However, many studies suggest that outcomes and quality are low in this country relative to others; for example, the United States ranks only 26th in life expectancy among 40 of the most developed countries (OECD, 2013). At the same time, a number of studies show that solutions to U.S. health problems might encompass more than reforms to health care systems (Bauer et al., 2014; Galea et al., 2011; Link and Phelan, 1995; Mokdad et al., 2004; OECD, 2013). Such studies indicate that health behaviors and the social and physical environment in which individuals live and work have a stronger influence on health than clinical services alone (Bauer et al., 2014; Braveman and Gottlieb, 2014; Galea et al., 2011; Link and Phelan, 1995; Mokdad et al., 2004; OECD, 2013). Moreover, recent analyses of the relative drivers of health outcomes underscore the need for investment in nonclinical primary prevention (University of Wisconsin, Population Health Institute, 2014). These analyses find that nearly one-third or more of the contributions to mortality and morbidity are driven by behavior (e.g., tobacco use, overweight/obesity), mediated by the lack or presence of equitable access to environmental supports for healthy choices. This suggests the critical need for a fundamental shift in how individuals and communities prioritize supports for healthier behavior.

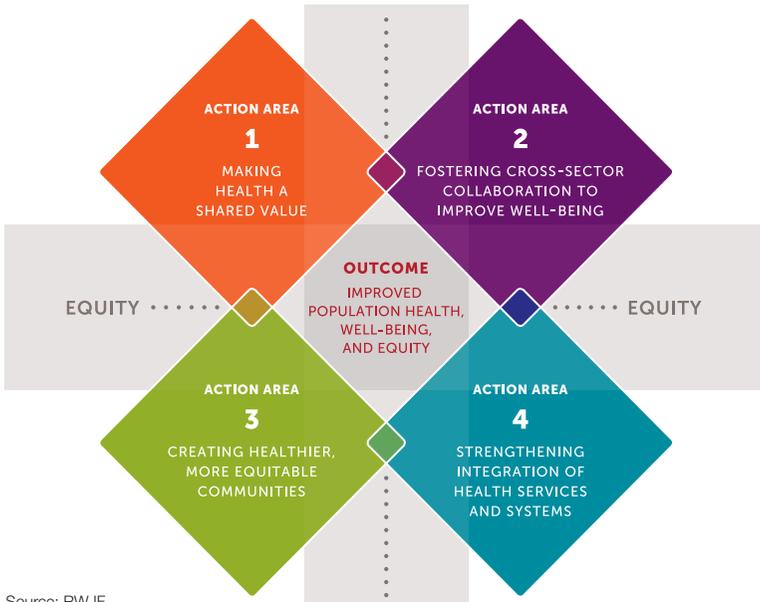
The CoH vision and principles were designed to respond to this emerging understanding as well as the changing landscape of our nation's health and health-related policies. They represent a reexamining of the relationships among all sectors of activity and their role in health. This includes reimagining the health sector as one that achieves balance across the

health, public health, and social service systems to yield the highest value to individuals and communities (i.e., promotes well-being and positive health outcomes). Such a holistic approach requires a coordinated and integrated health sector where the full spectrum of care is considered. The definition of health is reframed in CoH from the negative—not needing to seek health care—to a positive view, integrating all aspects of life to support healthy living.

CoH Action Framework

The analytic processes to move from the ten underlying principles to CoH action framework are explained in detail in other reports (RWJF, 2015; Chandra, forthcoming), but we provide the action framework here (Figure 1.1). The four action areas constitute priority areas of work for the nation and for RWJF, both now and through at least the next generation (e.g., 20 years).

Figure 1.1. Culture of Health Action Framework



Source: RWJF

The first action area involves *making health a shared value* of society in order to forge a common cause around CoH. Many RWJF partners and grantees are likely to find their work supported in this area by members of the Healthy Communities movement, advocates for the policy and environmental changes needed to prevent childhood obesity, and public health advocates who strive to include health in all policies.

The second action area concerns *fostering cross-sector collaboration to improve well-being*. It seeks true collaboration and integration of assets to promote health across traditional health, social, business, economic, and environmental sectors. This area also involves understanding how the systems that support individual and population health operate and how they could be improved and coordinated to operate more effectively. Of course, collaboration and partnerships may not be sufficient alone to improve some of the systems that perpetuate poor health; for example, employment may not increase despite all our partnership efforts. Nevertheless, a community can enhance social service resources, which ultimately may help to address or mitigate the challenges of economic conditions.

The third action area involves *creating healthier and more equitable communities*. It aims to support residents of all communities to reach their best possible health potential by improving the environments in which they live, learn, work, and play (e.g., providing greater access to nutritious and affordable food; active transportation methods, such as bike trails and sidewalks). By drawing on the value placed on health (Area 1) and on cross-sector collaboration (Area 2), actions in this area will help ensure everyone has a fair and equal opportunity to pursue healthy choices, which in turn can reinforce their expectations for what health can be and what well-being is, ultimately producing greater demand for *health* (as distinct from *illness care*).

The fourth action area focuses on *strengthening integration of health services and systems*. This area encompasses

a commitment to equity that ensures individuals' access to high-quality, efficient, and integrated systems of public health, health care, and social services that are capable of meeting the health needs of the diversity of the American population, across the lifespan and across the "health span" (i.e., from sick to well). This area emphasizes general access to and equal opportunity for health care, public health, and social services as essential co-contributors to health and well-being. Further, it addresses the system-level integration and changes that must occur in public health and health care to create an efficient, interdependent system of health and social services.

The framework also highlights the *population health, well-being, and equity* outcomes of the four action areas. We expect to see improvements in access to care and population health outcomes, economic benefits, and indicators that well-being and productivity are flourishing within all demographic, social, and geographic populations. As a result, we also expect that changes in these outcomes will reinforce the value of health and health care, increasing the value that people place on health for all Americans, and the importance of cross-sector collaboration and changes to achieve the value proposition. In this sense, the action and outcome areas of the CoH action framework are fully interactive.

Organization of This Report

This report presents the perspectives and insights from key stakeholders (i.e., traditional health providers and caregivers; community leaders; innovative health organization leaders; and leaders in education, criminal justice, employment, housing, and other fields outside of health that have an impact on people's overall well-being) pertaining to the four action areas in the CoH action framework, as well as the approaches taken to elicit, collect, and code stakeholder interview and focus group responses. In the next chapter, we describe those

methods. In Chapter Three, we present themes and insights garnered from stakeholders that are applicable to the entire CoH action framework. Chapters Four through Seven present findings relating to each of the four CoH action areas. Chapter Eight presents findings related to CoH measurement. Finally, Chapter Nine offers implications from the study that can be considered by CoH leaders and others in the field as they continue to work with the action framework to bring about change.

Several appendixes support this report. Appendixes A and B present our stakeholder interview protocols, which were conducted in the United States and in other countries. Appendix C presents details on specific measures suggested by stakeholders. Appendix D presents details related to frequency and saliency in our coding of the information gathered.



2

Approach to Stakeholder Engagement

THIS CHAPTER DESCRIBES the approach the research team took to elicit, collect, and code stakeholder perspectives related to the CoH action framework. Stakeholder engagement was needed to inform the conceptual development of the CoH action framework and the development and use of CoH measures by those doing CoH-related work on the ground. For the sake of brevity, this chapter is supported by Appendixes A through D, which contain interview protocols, as well data pertaining to frequency and saliency in our coding.

Selecting Stakeholders

As a part of stakeholder engagement, RAND conducted 82 individual or small-group engagement activities to elicit stakeholder feedback on:

- specific activities and strategies that stakeholders were using to foster CoH in the communities or populations they serve (including any strategic or operational guidance they had written) and any barriers or facilitators to their CoH work;
- measures that capture broad health and well-being outcomes relevant to their CoH activities/strategies and any barriers or facilitators to evaluating or measuring their CoH work
- any additional stakeholders the RAND team should speak to about CoH (e.g., experts in measurement, other organizations promoting CoH).

The team also attended two community events with CoH focus.

RAND used a two-phased approach for its stakeholder engagement efforts. In the first phase, the research team shared the CoH vision with stakeholders and then queried them about the strategies/activities they conduct that might contribute to the vision (i.e., all in this diverse society leading healthier lives now and for generations to come), as well as specific measures that could be used to determine whether the CoH vision had been accomplished. Phase 1 was focused on an open-ended elicitation of activities, strategies, and measures to inform the development of the action areas. In the second phase, a draft set of action areas had been developed (based on Phase 1 stakeholder input, as well as a literature review and expert input obtained that is detailed in Chandra [forthcoming]). Phase 2 stakeholders were queried in more detail about a single action area (i.e., the action area most closely aligned with their work) to gather more detail about successes and challenges to implementing specific activities and strategies for each action area, as well as how specific measures of CoH were being used by stakeholders. Figure 2.1 outlines these two phases.

Interviews and focus groups were conducted in 13 U.S. communities, as well as a broader set of U.S. and international

Figure 2.1. Phases of Stakeholder Engagement

Phase 1	<p>Purposes:</p> <ul style="list-style-type: none"> • Obtain broad perspective on CoH activities/strategies and measures • Gather names of additional stakeholders for follow-up (snowball sampling) <p>Approach: 30-minute structured interview and Internet research</p> <p>Dates: June through October 2014</p> <p>Sample: 50 interviews</p>
Phase 2	<p>Purpose:</p> <ul style="list-style-type: none"> • Explore CoH action areas in depth <p>Approach: Focus groups and interviews with stakeholders identified in Phase 1</p> <p>Dates: September through November 2014</p> <p>Sample: 24 interviews, 8 focus groups</p>

regions. RAND strategically convened stakeholders across the continuum of perspectives, from those who may be new to CoH concepts, to those who may be leading organizations or coalitions within communities, which are implementing cutting-edge CoH activities. The research team focused on three primary types of stakeholders, presented in Figure 2.2.

U.S. Stakeholders

Interviews were conducted with stakeholders in 13 communities across the United States: Boston, Mass.; Denver, Colo.; Detroit, Mich.; Kansas City, Mo./Kan.; Los Angeles, Calif.; Louisville, Ky.; Minneapolis, Minn.; New Orleans, La.; Oakland, Calif.; Portland, Ore.; Sacramento, Calif.; Seattle, Wash.; and Washington, D.C. These communities were chosen

Figure 2.2. Stakeholder Relationship to a Culture of Health



because they (1) had organizations engaged in multiple and diverse CoH initiatives, (2) included a mix of health-related community rankings (e.g., high- and low-rated communities according to health outcomes and health factors outlined in RWJF's county health rankings; high- and low-rated communities according to the American Fitness Index), and (3) represented diverse geographic regions.

Initially, snowball sampling was used to identify stakeholders. As a starting point, RWJF provided a table of all the foundation's current and former grantees since 2009. The RAND team narrowed that list down to grantees who were part of national RWJF grant programs, such as Communities Creating Healthy Environments, Leadership for Healthy Communities, Response to Economic Hard Times, Active Living by Design,

Healthy Kids Healthy Communities, Aligning Forces for Quality, and Roadmaps to Health. In addition, the team considered grantees from other national CoH-type programs, such as the California Endowment's Building Healthy Com-

munities program, and reached out to experts within RAND for suggestions resulting in a list of 95 communities that were associated with at least one of these initiatives. RAND and RWJF staff reviewed these communities to narrow the list to a smaller set of communities that reflect broad geographic representation, as well as social and demographic diversity. In addition, the research team sought to include communities that are engaged in multiple health supporting initiatives in order to attract stakeholders with a broad range of experiences.

This process was used to identify stakeholders from 12 of the communities. For the 13th community—Washington, D.C.—a researcher attended three of the Mayor's Health in All Policies task force meetings and held individual discussions with key stakeholders participating in the task force. From this list, the research team selected three organizations from each community for initial interviews. The team selected organizations and programs that represented a broad diversity of initiatives, organization types, and populations served, and whose work included efforts that addressed building CoH.

... the research team sought to include communities that are engaged in multiple health supporting initiatives in order to attract stakeholders with a broad range of experiences.

International Stakeholders

These stakeholders were specifically selected from a larger list of organizations generated by the RAND team. This larger list consisted of organizations identified by (1) nominations

from the team of health-focused and/or community-serving organizations gleaned from organizational experiences and professional networks, (2) referrals and nominations by non-RAND researchers based in the geographic regions of interest, and (3) Internet searches for organizations using the key words “culture of health,” “health in all policies,” “well-being,” and “resilience.” From this list, the research team then selected a sample for each region, aiming for diversity across these factors:

- organization type (e.g., community-based nonprofits, clinics, foundations)
- geographic focus (international, national, regional, local, neighborhood)
- health and well-being target (e.g., social determinants, a specific disease topic such as cancer or HIV, or approach such as increasing access to care or improving quality of care)
- population served (e.g., children, women, or racial and ethnic minorities)
- geographic location
- coverage of the four CoH action areas.

The team also included different organization types and content areas from those that had been covered with the first 13 community stakeholder communities. Organizations where a team member had a direct contact were prioritized because of a higher level of confidence that the organization’s work related to CoH and the greater likelihood of completing interviews with these organizations within the time frame for data collection. Figures 2.3 and 2.4 show the distribution of stakeholders across geographic area and sector. Of note, 51 percent of stakeholders came from the western region of the United States, which may have been a limitation of our snowball sampling approach.

Figure 2.3.
Geographic Distribution of Stakeholders

Percentage of Stakeholders by Region

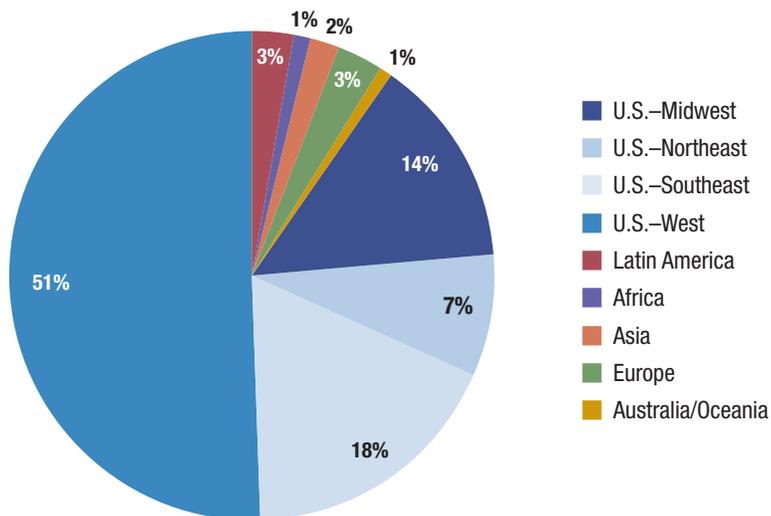
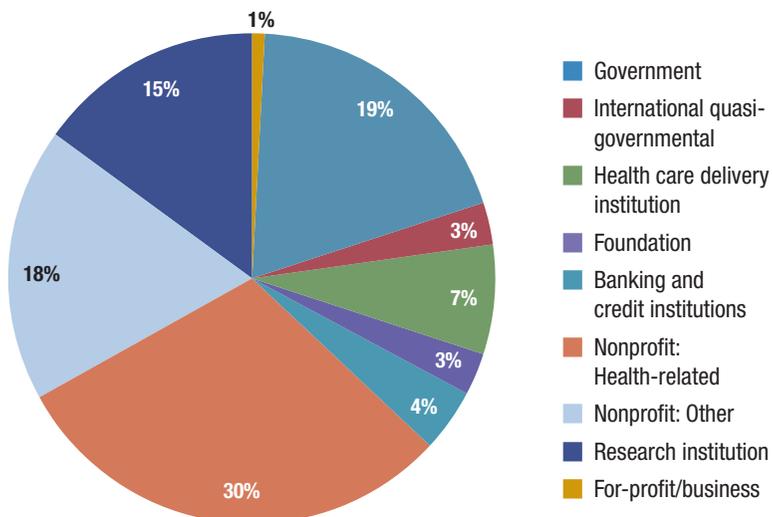


Figure 2.4.
Distribution of Stakeholders by Sector

Percentage of Stakeholders by Sector



Collecting Data from Stakeholders

Interviews

The research team sent an initial outreach email to potential interviewees. For stakeholder interviews in the 13 U.S. communities, 49 of the 77 organizations (Phase 1 = 26 of the 35 organizations; Phase 2 = 23 of the 42 organizations) contacted agreed to phone interviews. For interviews with stakeholders in other domestic and international regions, 23 of the 42 organizations contacted agreed to be interviewed. After organizations responded, the team scheduled a telephone interview between a RAND researcher and/or project manager and a program director or manager from the stakeholder organization. The interviews were exploratory in nature and used open-ended questions to elicit information about what strategies the organization uses to foster CoH in the community and what actions organizations are taking with respect to evaluation or measurement. As mentioned previously, stakeholders were queried about:

- specific activities and strategies that stakeholders were using to foster CoH in the communities or populations they serve (including any strategic or operational guidance they had written) and any barriers or facilitators to their CoH work
- measures that capture broad health and well-being outcomes relevant to their CoH activities/strategies and any barriers or facilitators to evaluating or measuring their CoH work
- any additional stakeholders the RAND team should speak to about CoH (e.g., experts in measurement, other organizations promoting CoH).

Phase 1 stakeholders were queried broadly about activities, strategies, and measures that could contribute to the CoH vi-

sion. In Phase 2, we queried stakeholders in more detail about implementation of activities and strategies for specific CoH action areas, which were in draft form. See attached interview protocols in Appendixes A (Phase 1) and B (Phase 2).

Interviews were semistructured, meaning that interviewers were instructed to tailor the series of questions and the extent of follow-up probes to solicit, systematically but flexibly, the stakeholders' opinions, experience, and advice on supporting and evaluating CoH. All interviewers and note-takers familiarized themselves with the stakeholders and their organizations before each interview and customized the interview protocol accordingly.

Focus Groups

As part of stakeholder engagement, the RAND research team worked closely with community partners identified during the stakeholder interviews to identify and convene an appropriate group of stakeholders for a follow-up or complementary focus group. Eight focus groups took place in five U.S. cities (Sacramento, Louisville, New Orleans, Denver, and Portland). Focus groups involved between three and 11 participants (average = 7.14) and were generally cross-sector engagements, involving representatives of health departments, city planning departments, local nonprofits, members of the business and philanthropic communities, and researchers. Whenever possible, the focus groups were conducted in coordination with a larger CoH-related event, such as the *Federal Reserve Building Healthy Communities* event in Sacramento and the *Oregon Healthiest State* launch in Portland. Insights from such events also have been integrated into this stakeholder engagement report.

As with the interviews, the focus groups used open-ended questions to elicit general information about strategies used to foster CoH and to evaluate progress and outcomes. The groups

also included questions that specifically addressed the action area that best aligned with the particular group of stakeholders. The focus group protocols were streamlined versions of the interview protocols, tailored to the expertise of the organizations represented in each group. To maximize exchange between focus group participants, the protocols were focused more on eliciting barriers or facilitators to CoH work and any barriers or facilitators to evaluating or measuring CoH work.

Analyzing Stakeholder Data

Note-takers and interviewers/moderators took detailed notes during the interviews and focus groups to create a record of each engagement. We also recorded and transcribed focus groups, due to the pace and richness of the conversations. We used the detailed notes and transcripts for analysis. We based our analysis of the interview and focus group data on a constant comparative design to qualitatively identify themes that would describe how stakeholders are building CoH and ascertain measures to assess the progress and outcomes of CoH strategies. To identify themes, team members marked blocks of interview or focus group notes using the comment functionality of Microsoft Word pertaining to the major topical domains of interest outlined in the interview or focus group protocol. From the marked text, team members developed themes and subthemes that corresponded with each of the major domains. Next, team members reviewed the themes and then systematically went through each of the interview notes finding other instances of this theme or subtheme, and generating frequencies and saliencies for each using a combination of the comment functionality of Microsoft Word and a Microsoft Excel spreadsheet containing the code book. To ensure that themes and subthemes were coded consistently, two researchers marked ten interviews and focus groups. Inter-rater reliability was calculated to determine the level of

consistency among researchers using an intraclass correlation (ICC). The ICC was found to be 0.827, demonstrating a high degree of reliability among researchers. A table showing the themes and subthemes used to mark text and the frequency (i.e., number of interviews or focus groups where the theme was mentioned) and saliency (i.e., the total number of times the theme was mentioned across all interviews and focus groups) can be found in Appendix D. Each interview or focus group was counted as one interaction, for a total of 82 interactions, and the frequencies reported in the following chapters are reported as a percentage of all interactions that touched on each theme. Moreover, since the interactions were all semi-structured, not all topics were discussed with each respondent. With that in mind, frequencies should not be interpreted to imply that those who did not mention the theme disagree, rather perhaps that they were not asked about it.



3

FINDINGS: Implementation of the Culture of Health Framework Across Multiple Action Areas

THIS CHAPTER PRESENTS the broad themes that surfaced throughout the stakeholder engagement activities. The themes here are not specific to a single CoH action area; some relate to multiple action areas (i.e., two or more), while others apply to the implementation of CoH framework more broadly. Due to the interconnected nature of the action areas and for the purpose of clarity, we present these findings in a way that is independent of the action areas to which they relate.

These findings touch broadly on the concepts that stakeholders suggested are necessary to address when building CoH, their thoughts about how to motivate and support change agents in communities, and the importance of data and communication in bringing together local stakeholders to build CoH.

Consider an Individual's Larger Social Context or Environment When Determining Factors That May Be Influencing His or Her Health

One third of stakeholders (33 percent) expressed that health is something that depends on the quality of environments where people live, work, and play. In particular, they focused their discussion on how socioeconomic circumstances, especially low income and education, negatively affect the health and well-being of families and communities. As one discussant suggested, these social determinants define the culture within which health is created and maintained: "Culture of health isn't . . . just what is happening with the individual medically— [but also includes] education, employment, poverty."

Within this discussion, many stakeholders also mentioned the role that environmental concerns, such as air and water quality, play in health. One discussant stated, "So, we've been working on the health-land use connection since the early '90s, when we started to recognize that the way we were growing was having terrible impacts on health, whether it was from air quality or from obesity, lack of opportunity to have active transportation."

Some clinicians recognized the influence of the environment on an individual's health as both an epiphany about the limits of their own contribution to health and a frustration over their inability to directly address these limits. A discussant said, "We'd give them the counseling and we treat people. We bandaged their wounds. Then we'd send them back out to get the gunshot wounds and deal with the depression, anxiety, and heart disease that they were going to deal with anyway because where they were coming from was not addressing what was really going on." Such frustrations carried over to the public health context. In the words of one discussant, ". . . for a long time we've talked about chronic disease, we've talked

about obesity and all we had focused on was just on telling people, 'OK, you need to exercise. You need to eat healthy,' but not taking into account the environment that they're in, or not being able to actually impact it." Discussants warned that not all sectors discuss or understand these issues as being determinates of health, but remained hopeful that more dialogue about these factors could create a broader understanding.

Stakeholders were able to articulate a number of ways to address environmental contexts, starting first with community stakeholders coming together to identify these contexts and their influence on health. According to stakeholders, doing so creates the opportunity to develop and leverage collaborations to overcome social determinants jointly. One stakeholder suggested that, "I just feel like now I've learned a new way that I can actually work and I don't have to do it all myself. I just need to be a partner and I can share the data that I'm seeing, so that I can help at least the people who are working in these different areas to be informed about how what they do impacts health, and . . . we can work together. We're coming at it from different angles, but in the long run, we're all looking for the same goal, which is to have a healthy community." Public health in particular was seen by several stakeholders as having a role in bringing together stakeholders to share information and work toward these goals.

Thirty percent of stakeholders viewed advocacy and education of organizational partners as an especially important part of building CoH, particularly to push policy changes and implementation of new activities or strategies within communities. As one stakeholder stated, "I think community engagement is really important, and I found that to be a really powerful tool in public health . . . many times, messages might be difficult coming from me . . . if I can get the community engaged in them . . . that is good for me."

Work at Multiple Levels, from Individual to Organizational to System, to Build a Culture of Health

More than one-fourth of stakeholders (27 percent) discussed the multiple levels at which health must be built. From their point of view, building CoH involves not only addressing the multiple determinants of health at the individual level, but also moving toward addressing the various levels within communities that affect health—including peer groups, families, community-based organizations, and the decisions made by policymakers.

The following examples of the key points at each level were pulled from various community stakeholder conversations:

- **Individual:** Empower individuals to advocate for themselves in medical and community settings (build their awareness of the power of their voices, and their capacity to influence decisionmakers). Rely on technology to collect individual-level data about health behavior and disease management.
- **Interpersonal:** Do not underestimate the power of personal relationships and connections to contribute to the success of collaborations. When pushing for policy change, do not ignore the influence of social norms around your issue—use strategic communications to influence public perception as you work with decisionmakers.
- **Organizational:** Be explicit about the steps that organizations in any sector can take to enhance the health of their employees, or those with whom they interact. All organizations should lead by example, creating minicultures of health within their own walls (“practice what you preach”). Doing so not only positively affects the people served by the organization but also sets an example for others, thereby multiplying the impact. As one stakeholder suggested, “It’s a [process of] looking at your own agency

and creating your own culture of health internally before helping others. The [organization's] policies need to be in place to promote health in our communities or [policies that] don't work against efforts in the communities."

- **Community:** Develop a community-wide vision (often relying on shared struggles), build capacity to organize, clarify specific goals, and develop concrete tasks for key stakeholders (develop capacity to advocate); prioritize using resources and influence to create capital in communities (e.g., through small businesses and job creation).
- **Policy/environmental changes and community leadership:** Identify champions in positions of power (e.g., mayors, CEOs), who can mobilize groups of people and lead by example; take a "health and equity in all policies" approach to decisionmaking across sectors to make the healthy choice the easy choice; remain ambitious, but accept opportunities for small policy changes when they arise (e.g., develop a short length of bike path, engage a small group of landlords around smoke-free housing), as well as strategies for addressing barriers to healthy progress.

Build Knowledge of and Connection with Communities to Foster a Culture of Health

The majority of stakeholders commented that involving local, community-level organizations and leaders and soliciting and responding to community-identified needs and priorities were essential to the success of work involving health promotion and well-being. By way of contrast, stakeholders described situations in which an outside organization dictated the issue or the methods, situations that ultimately failed to use resources to their full potential because community goals and existing resources were left out of the equation. One respondent summed this up by stating that leaders need to do a better job of "noticing who is *not* at the table and making a seat for them."

Another component of community-level focus, raised by 22 percent of stakeholders, was the importance of nurturing local leadership, including identifying nontraditional but influential thought leaders within communities, and creating involvement and leadership opportunities for segments of the community that are not represented in existing structures. From their point of view, people and organizations working in communities act as the best change agents because they know the issues and best approaches. Many stakeholders also noted that although it takes time, remaining in relationship with a community could yield important results: If even “a few members of society participate, knowledge and community buy-in spread.” One suggestion was to organize, have clarity around goals/strategies, develop concrete tasks/plans, and have measurable goals. Stakeholders stressed not underestimating the importance of articulating both a broad, inclusive, and ambitious vision, as well as specific and achievable goals (“it’s a spectrum”), and noted that it was crucial to ensure all partners have an understanding of the strengths and weaknesses of others in the collaborative. Moreover, the development of local leadership was seen as a pathway to empowering communities.

There were concerns, however, that local leadership is not enough; it is merely one of many inputs. As one stakeholder stated, “We need the leadership, we need the funding, and we need their support—their verbal support, as well as their elbow grease and emotional support.”

The Phrase ‘Culture of Health’ Was Intuitive and Appealing to a Large Majority of Stakeholders, But Some Stakeholders Had Concerns About the Phrase’s Inclusivity

Nearly one in five stakeholders (17 percent) considered CoH to be both a phrase and an idea. Many adopted the phrase

“culture of health” and used it to describe their work throughout the interviews. A few stakeholders elaborated by describing the status quo in terms of “culture.” For example, one respon-

dent noted, “It’s so important, we need to move from a culture of *health care* to a culture of *health* . . . What exists now is a culture of disease.” Others equated CoH with other terms used by their organization, such as “capable communities or healthy communities.” Stakeholders discussed how CoH represented a fundamental shift in the way in which individuals traditionally defined health as the absence of disease to include the health and wellness of families and communities. From their point of view, health is broader than health care and is about “more than a doctor’s office, more than healthy eating and exercise.”

Stakeholders also were excited to learn about the RWJF’s new vision and pleased that this broad approach to population health is being promoted. A few stakeholders who were not familiar with this type of approach gained an appreciation for it as a result of participating in the interview or focus group, and noted that they left feeling more inspired. For example, a health services researcher from New Zealand noted that even though he focuses on clinical health research, he wanted to get more involved in active transportation issues as a result of the discussion.

On the other hand, 12 percent of stakeholders were concerned that the phrase “culture of health” could be seen as not inclusive of all populations. Several stakeholders offered cautions or reminders for RWJF as the foundation moves forward with this agenda. First, there was a concern about how CoH could be inclusive and extend to marginalized populations that may not feel part of the dominant culture. To have

“It’s so important, we need to move from a culture of *health care* to a culture of *health* . . . What exists now is a culture of disease.”

a broad and inclusive reach, stakeholders recommended that culture change must be from the top down (i.e., changes in policies and funding streams, interest from political leadership and political will to promote CoH) *and* from the bottom up (i.e., “winning hearts and minds”; educating, persuading, and supporting people to live differently day to day).

A second recommendation was to prioritize the inclusion of marginalized populations in the dialogue about CoH, and how *health* may mean different things to different people. Understanding variation in values around health was encouraged as a way to tailor CoH-supporting strategies to the needs and priorities of different groups. Some interpreted the phrase as putting emphasis on purely health-sector work, as opposed to a broad conceptualization of health that has been pursued in communities and other sectors for years (e.g., civic engagement, social justice, violence prevention, economic development). These respondents recommended approaching the strategic framework broadly, such as embedding equity, justice, access, or opportunity in the definition, thus exhibiting a “desire to find alignment and shared goals” with groups doing this work in communities.

Third, several stakeholders cautioned that there are many communities, organizations, and individuals who are actively engaged in creating CoH, but that they would not initially interpret the current definition or phrase as applying to them. This misconception was apparent even when trying to schedule interviews; several stakeholders who were doing what the team considered to be CoH work seemed unsure about whether their experience would be relevant to this project (e.g., policy, urban planning). Consequently, some stakeholders expressed concerns that we make an effort to be clear about the “big tent” of well-being that CoH encompasses. In other words, as one respondent suggested, “Do not develop a narrow definition of what health work is. Understand perspectives of

diverse groups; think about what the community needs and what local groups have been working on for years, including activities the groups may not consider to be health-related (e.g., community organizing, social justice work)."

Finally, a few stakeholders (8 percent) were concerned that the phrase "culture of health" was too health care–centric and argued that it may not translate well to other cultures. One respondent from the United States resisted the idea that CoH could be discerned and implemented from the top down; rather, he emphasized the importance of focusing on one person, then ten people, then a community at a time to incrementally identify and support the components that would support CoH for those people. An international respondent reacted negatively to the term, challenging, "Why not say a culture of well-being?" This respondent felt that using *health*, with all its existing associations (e.g., physical health, health care), as the umbrella term unwisely positioned the health care sector at the center of the strategies that would be developed to support well-being. Another international respondent felt that CoH must respond to local ideas of health—including food, physical activity, and overall lifestyle, which vary across contexts and may not be transplantable between contexts. A minority of stakeholders saw it as imposing culture, and culture is very personal and ingrained.

Provide Continued Health Education and Communication to Create a Shared Value of Health Among All Stakeholders

About 14 percent of stakeholders (one in seven) cited the need for continued education about health directed at the general public, which they felt would address the problem of lack of information or misinformation that persists and would aid CoH. Stakeholders recognized that some messages might seem

basic or are assumed to be common knowledge, but felt that there were large segments of the communities they served that remain unaware. One respondent said, “Many people still don’t understand that their behaviors are putting them at risk for diabetes and that changing these things can impact their odds—they think it’s hereditary or inevitable, but it’s not.”

More than one in ten stakeholders (12 percent) encouraged practical, useful, culturally sensitive consumer education as a way to support uptake of new resources (e.g., nutrition or cooking lessons to go with a new grocery store, promoting the benefits of physical activity with the establishment of a new walking trail). Stakeholders felt that tailored messages to fit the local context and audience would be necessary to effectively diffuse CoH ethos to diverse audiences. For example, an anti-tobacco advocacy group described the importance of tailoring anti-tobacco messages to different groups of adolescents (e.g., smokeless tobacco for rural youth versus cigarette and e-cigarette use for urban youth). To ensure that data are relevant to stakeholders and decisionmakers, effective tailored stories and messages are needed.

Political Support for Policies or Interventions That May Be Costly or Unpopular in the Short Term May Be Difficult to Garner

Addressing policy barriers to building CoH was a theme that arose with 10 percent of stakeholders. From their point of view, addressing policy creates conditions that support health in the first place. But there are a number of issues that may interfere with effective policy work. First, several stakeholders described the perverse incentives created with our current policy framework that forces sectors to focus attention on sector-specific goals and outcomes without regard to the impact on health. Second, a number of stakeholders suggested that

because not all investments in health produce a return, those efforts fail to gain traction among decisionmakers.

Similarly, 12 percent of stakeholders noted that the benefits of health and behavioral interventions or improvements do not happen immediately (i.e., they may only be realized years later) and this lag can create obstacles to building CoH. For example, one stakeholder indicated, “Creating a culture of health takes time and is incredibly complex. We all want to move quickly and implement solutions, but we have learned it is hard to move the needle.”

Some stakeholders suggested that practitioners needed to prioritize steady progress over quick, aggressive change. Historically, advocates of seat belt laws and removing lead in paint and gasoline argued against major interest groups and succeeded in changing the laws, despite the powerful lobbies supporting these interests. Community members and residents, if they engage together, can have significant influence with local decisionmakers. Stakeholders felt that the CoH effort should glean lessons from these hard-fought political battles. Similarly, one stakeholder described the importance of negotiating incremental change to overcome these issues. An initiative they supported would have failed had they tried to move toward universal change (100-percent smoke-free housing); rather they chose to break it up into more digestible components (starting with 16–20 percent).

One in ten stakeholders also described facilitators of policy change. These included working in partnership with stakeholders, having the financial support to take a long-term approach to change, garnering support of key leaders, and providing systematic assessments of the impacts of various policies. A few stakeholders talked about political cycles, and how programs or policies that could not demonstrate substantial change within one administration are inherently difficult to achieve. Another stakeholder described the challenge of working with funders

who want to see short-term outcomes and urged that an important part of the investment in projects is the investment of time to allow changes to manifest. Unfortunately, the subtext of many of these comments was one of conservation of resources. In order to maximize their impact, organizations needed to focus on winnable battles and quickly achievable victories.

Evaluation and Data Are Important to Inform a Culture of Health, But Stakeholders Reported Limited Capacity and Funding to Collect Those Data

Several stakeholders, particularly those working in areas outside of the fields of health care and public health (e.g., transportation, built environment¹), commented that while they appreciate the importance of evaluation and data, they have limited capacity to collect data and engage in rigorous evaluations. In fact, one in five stakeholders (20 percent) stressed the importance of data and evaluation for tracking and decision-making, but more than one in ten stakeholders (11 percent) reported that they are not able to do a thorough, sophisticated, or even appropriate evaluation of their work because they lack the capacity (i.e., data, expertise, workforce). Some of these groups had partnered with universities or others to conduct evaluation work for them, but in general, many stakeholders were unapologetic about the limits of their organizations: They saw their work as within a given scope, and things outside of that scope, such as evaluation, were not places where they could expend much energy. This sentiment spilled over to what organizations felt was their mandate. In response to questions about how data or evaluation might shape their organizational priorities, many stakeholders described the importance of

¹ A *built environment* refers to manmade surroundings, such as infrastructure, parks, and the like (Carlson et al., 2012, pp. 270–284).

data, but admitted that such information would not do much to change organizations' approaches to problems or their focus on specific issues.

With regard to the lack of evaluation, several stakeholders lamented the difficulty of doing continuous high-quality evaluation due to lack of consistent or continuous funding for this type of work. One respondent described a situation that she felt was typical about a follow-up evaluation being cut out of a program as part of statewide budget cuts; it was an easy thing to take out, she thought, and the first thing to go. Other stakeholders talked about grants that covered initial evaluation but ended shortly after the program did, which precluded measuring the longer-term outcomes where many health promotion programs are thought to have important effects. Another example of the financial obstacles to evaluation within an organization was offered by a health care provider, who described the challenge of the cost associated with setting up an electronic health record system—the backbone of evaluation in a medical setting—not being reimbursable within the provider's payment model.

Many community stakeholders discussed a lack of capacity, resources, and available measures to evaluate their activities or strategies in relation to CoH. Some stakeholders seemed to think that environmental and policy changes are “too big to measure” or that outcomes “take too long to change.” Small community-based organizations and nonprofits often rely on short-term grant funding for executing specific initiatives, a model that is not conducive to internal capacity-building around evaluation. Stakeholders described the importance of designing evaluation plans to track interim (short- or medium-term) measures, emphasizing that evaluation of CoH strategies should use an appropriate time frame, given that it takes a long time to change the policies that affect health. Stakeholders also discussed the essential roles that

communication and messaging play in disseminating information and speaking with decisionmakers about measuring and building CoH. In addition, some respondents thought there should be less emphasis on measurement and more emphasis on “boots on the ground,” while other stakeholders, particularly those working in areas outside the traditional boundaries of public health (e.g., the built environment), noted their fields need to emphasize measurement more and build up their evaluation skills. In short, data and evaluation to develop and document evidence-based practices were seen as important. But, stakeholders were limited by their own capacity to collect this information, poor funding to include data-collection efforts into their project work, and were concerned that the time frame for defining what works for funders is too short.

Consider Ways to Make Building a Culture of Health ‘Good for Business’ to Incentivize Strategies to Build a Culture of Health

At least 6 percent of stakeholders described the need to incentivize participation in health promotion (e.g., financially, integrating health into other sectors’ deliverables), and 8 percent described how a business focus on CoH could be attractive to investors. Several stakeholders working in health care talked about market-based solutions to CoH, including both promoting “triple bottom line” sustainable businesses and working with existing mainstream businesses to make “the business case” for fostering health. Some organizations worked with employees and/or unions and employers to improve conditions for people in service or agricultural occupations. Stakeholders spontaneously mentioned employment issues when talking about CoH. For example, in affirming the idea of CoH, one respondent replied, “. . . Health is not just not getting sick or not having a diagnosis, but having a job, a satisfying career . . .”

There were multiple references to social entrepreneurship and socially responsible investing, both in conversations with stakeholders and at events attended by the research team. For instance, the San Francisco Federal Reserve Bank's Healthy Communities Summit included a panel on financing, and the speakers expanded on some of the same points raised by other stakeholders about financing for public health and community development. The speakers discussed how investment strategies that blend public and private funds could be most effective and impactful. They also commented that community organizations need support so that they can grow and be ripe for investment, because there are many investors who are looking for the right organization to finance. In one focus group, participants expressed enthusiasm for these same ideas, and stressed that the private sector has often been left out of CoH conversations in general, leaving the public sector and nonprofits to shoulder the burden on their own.

. . . community organizations need support so that they can grow and be ripe for investment, because there are many investors who are looking for the right organization to finance.

Social Media Data Could Be Useful to Track Development of a Culture of Health, But Few Stakeholders Now Use These Data

Nearly one in ten stakeholders (8 percent) expressed that social media could be promising, and a similar number (8 percent) report collecting or using social media data or other types of big data. Some (4 percent) commented that social media allows interaction with a broader public or more

patients in real time. One stakeholder thought that the “public meeting is dead,” but that social media offers a way to promote community involvement. However, stakeholders find it challenging to keep up with the volume of data and content available, and some spoke of institutional limitations and generational or linguistic divides as influencing the acceptability of social media as a communication channel. Virtually none of the partners we interviewed about “big data” was using this information in very meaningful or innovative ways yet, but some partners expressed data and engagement needs that could be met by social media/big data, including:

- greater access to real-time health behavior data (vs. Behavior Risk Factor Survey or providers’ assessment in appointments)
- real-time and actionable assessment of the patient experience (à la Yelp and Uber)
- ability to evaluate outcomes associated with large-scale policy changes (like a statewide health improvement plan)
- access to the community outside of public meetings and forums
- access to input of traditionally marginalized communities.



4

FINDINGS: Making Health a Shared Value

THIS CHAPTER DESCRIBES the interview and focus group themes related to the first CoH area in the action framework: *making health a shared value*. This area is critical to the action framework as it sets the stage for change; in the CoH vision, all members of a community—and, indeed, the nation—must work together to become and stay healthy. This area elicited limited feedback among stakeholders when compared with the other areas in the CoH action framework. We discuss these limits at the end of the chapter. Yet the interviews did provide important information to consider as the area is further developed, and these are presented below.

Culturally Tailor Processes to Build a Shared Value of Health; Building Shared Values Is Not ‘One Size Fits All’

More than one in seven stakeholders (16 percent) stressed that CoH programs must tailor interventions to the specific characteristics and needs of the community. They should consider implementation differences and that “one size might not fit all.” To achieve a shared vision and shared goal about health, practitioners will have to consider the differing values held by various individuals and organizations in the community. Then, approaches to developing shared values about health can incorporate the appropriate attitudes held in communities. Working to be “culturally keyed in” to a community in this way was cited as a key strategy. One discussant provided the example of a food pantry program that stocked certain types of foods that organizers thought the community would like. By being socially connected to the community and by talking with individual recipients at the food pantry, the organization learned that, based on the community’s culture, there were other foods to stock in the pantry that better suited cultural tastes. Stakeholders further suggested that using the existing momentum toward promoting health in diverse ways and embedding health in all policies both offered culturally tailored approaches to building CoH.

Engage Community Residents as Key Partners to Promote Shared Values and Social Cohesion

More than a quarter of stakeholders (27 percent) were in agreement that community members should be involved as equal partners in promoting shared values and social cohesion. One stakeholder explained that this is not always easy, as there is a tendency to look at people from underserved communities as somehow inferior or, conversely, to romanticize

them and their challenges.

When working with a community to ensure social connectedness among members, stakeholders suggested that it is important to have patience, and to provide direct and clear communication to avoid false expectations when dealing with health-related interventions. Local buy-in from the community is important.

One stakeholder commented, “Staying grounded in what’s happening in families and communities is extremely important.” In other words, being present and visible in the community and being in tune with what is going on there is important for building and maintaining social ties that can influence health.

To achieve a shared vision and shared goal about health, practitioners will have to consider the differing values held by various individuals and organizations in the community.

Collaborate with a Wide Range of Organizations to Promote Shared Values

More than one in ten stakeholders (11 percent) discussed that promoting shared values requires collaboration across diverse sectors and organization types, including indigenous populations, leaders, funders, community innovators, and young people. To promote collaboration among these diverse groups, some with competing interests, stakeholders suggested finding common ground or special interests (i.e., a “win-win”) for each of the stakeholders involved. To help find this common ground, data will need to be translated in ways that everyone can relate to. One stakeholder suggested using social math to present data to lay people, a practice of presenting statistics in a consumable way by putting them in a social context with commonly understood meaning (e.g., the number of school buses

that a city's uninsured children would fill) (Berkeley Media Studies Group, 2015). Stakeholders suggested that CoH activities and strategies could capitalize or partner with organizations with expertise in supporting social connections and fostering collaboration. For example, a stakeholder group in Oaxaca, Mexico, provides a platform for this function through training services, workshops, and rental spaces, thus allowing individuals, organizations, and communities to connect with and learn from others.

Train Public Health Professionals on How to Change Social Norms

One in seven stakeholders (14 percent) noted that for health promotion initiatives to be sustainable, it is important for social norms and perceptions to change along with policies, and that improved communications and messages are required. Public health professionals require more training on communications, messaging, and shaping public perception. One respondent said of public health communications, "In public health, we are so dry! Why are we surprised that no one is finding it exciting?"

Integrate Civic Engagement Activities into Health Promotion Programs to Create Shared Values

Finally, 12 percent of stakeholders highlighted an interesting overlap among civic engagement, fostering a sense of empowerment and purpose, and health promotion activities. One example is how a stakeholder organization used a community garden not only to teach community members how to garden and grow healthy food, but also how to engage in local advocacy around food security, with activities such as writing letters to local leaders. Similarly, at a CoH-related event and during focus groups, stakeholders stressed that it is essential

to foster a sense of purpose and provide spaces for meaningful community involvement, particularly for older adults. Not only does civic and community engagement have the possibility to produce real change and benefit the community's health, but stakeholders indicated that social connections and the sense of purpose that result from being civically engaged can positively and profoundly affect an individual's well-being.

Discussion

Across community and regional stakeholders, *making health a shared value* was the action area stakeholders were least able to describe. There were a number of possible explanations for this. Many said they had never thought of tracking community activation around health and strategies for encouraging individuals to value and prioritize health. We spoke to many stakeholders within the health sector, so it is possible that the ideas that health is valued and that health equity is important may have been taken for granted. Some stakeholders felt it was more important for the health sector to value the contributions of other sectors than for all to prioritize health explicitly (i.e., try to reduce partner perceptions of health sector takeover). The interviews revealed that these themes may not be a part of the typical strategic thought process for these organizations, or that they are concepts that lie within the foundation of the organizations' work but are not part of their activities. Interestingly, one respondent expressed that the social and institutional landscape is not "ready for this kind of culture of health approach." It is hard to sustain work in this area when funders tend to concentrate on a single issue.



5

FINDINGS: Fostering Cross-Sector Collaboration to Improve Well-Being

THIS CHAPTER DESCRIBES the interview and focus group themes related to the second CoH area in the action framework: *fostering cross-sector collaboration to improve well-being*. The CoH vision recognizes that multiple aspects in people's lives affect overall health; this action area reminds us that traditional health care organizations and networks will need to work with nontraditional partners such as education, labor, housing, and food outlets to achieve a national CoH.

As the results presented here suggest, cross-sector collaboration was a common theme among stakeholders, both domestic and international, and was well covered in the interviews and focus groups. The primary themes from stakeholder insights are presented here, followed by a discussion of our findings in this action area.

Define Prevention and Health Promotion Broadly to Help Potential Collaborators See Where They Have Influence

Many stakeholders shared the idea that establishing an explicit and broad vision helps make collaboration successful by enabling collaborators to understand their role within the larger process. This includes enumerating specific goals and objectives to facilitate tracking progress and show small wins (e.g., through a community framework), which was mentioned by nearly a quarter of stakeholders (23 percent). One stakeholder summarized it as “come together to collaborate, identify the problem, and it needs to be a shared problem . . . to achieve a shared vision.”

More than four out of ten stakeholders (42 percent) indicated that the CoH vision should be built based on diverse perspectives. For example, one organization brought together elected officials, public agency staff, community-based organizations, and real estate developers to vet policy briefs and research before strategic plans were developed. This helps ensure that the planning process systematically incorporates the feedback of different stakeholders. To engage a diverse group, stakeholders suggested going through trusted community organizations to identify the right sectors, as well as organizations and people within those sectors, and then reaching out into their network to invite new participants.

Stakeholders also suggested that the vision should identify common motivations or be something that

Many stakeholders shared the idea that establishing an explicit and broad vision helps make collaboration successful by enabling collaborators to understand their role within the larger process.

“everyone feels themselves reflected in” to attract broad membership to the coalition. For example, one approach is to share data on community performance or outcomes with a broad stakeholder group. If partners have pride in their community or a competitive spirit, using health indicator rankings and comparisons to peer communities can spur action. Further, several stakeholders indicated that a holistic approach (vs. a health-chronic disease prevention approach) is a helpful strategy to obtain buy-in in communities that are “less ready” for health promotion messages. In these circumstances, a message is often more powerful if it is not solely about health but also includes messages about other issues that the community has prioritized, such as climate change, transportation, energy, etc.

A smaller proportion of stakeholders (4 percent) cautioned against too broad of an approach, saying coalitions should not try to tackle too many problems, but instead should stay focused and have a clearly articulated vision. They warned that being too ambitious or broad without identifying key milestones and short-term indicators of success can lead to a lack of direction, burnout among members, and dissolution of the collaborative.

Engage a Visionary Leader, Community Leaders, and Nontraditional Partners to Build a Culture of Health

A large majority of stakeholders indicated that successful cross-sector collaborations to build CoH are championed by a visionary leader, such as an influential local figure. This can involve both traditional leaders (e.g., politicians, religious leaders) who have a trusted track record with the community, as suggested by 24 percent of stakeholders, and nontraditional partners who bring unique experiences and resources (e.g., venture capitalists, for-profit companies with a strong tradition of social responsibility) and reach traditionally marginalized populations, as suggested by 17 percent of stakeholders.

Stakeholders also emphasized that collaborations should include organizations with the skills and capacity to implement CoH activities or strategies and who will be doing the work on the ground (i.e., not just the leadership or management). Stakeholders described the benefits of cross-sector collaboration as “a way to operate outside the limitations of any one organization.”

Clearly Articulate Economic Benefits from Cross-Sector Collaboration to Sustain Commitment over Time

More than one in ten stakeholders (12 percent) discussed the importance of articulating the value or economic benefits of cross-sector collaboration. Without a clear understanding of its value, stakeholders reported that organizations are not able to make the case for sustained investment in collaboration. Value can be monetized for both for-profit and nonprofit partners, as such tools as the Social Impact Calculator (Low Income Investment Fund, 2014) can provide social value of participation. Additionally, stakeholders suggested that unintended benefits, such as professional development and networking opportunities afforded by coalition membership, should also be considered when calculating economic benefits.

Develop Strategies to Maintain Consistent Organizational Participation in the Collaboration, Despite Staff Turnover

Stakeholders reported that strong and authentic relationships among organizational partners are critical because they can withstand the staffing changes that often occur at community-based organizations. Securing funding and putting organizational policies and procedures in place that support the collaboration were also mentioned by 4 percent and 17 percent

of stakeholders, respectively, as strategies for maintaining consistent organizational participation in collaboration. This is particularly critical for those CoH initiatives that require persistent and unwavering focus to achieve long-term outcomes.

Measuring the Extent or Quality of Partnerships May Be a Challenge for Culture of Health Initiatives

A small number of stakeholders (4 percent) said collaborations were so complicated and intertwined that they may be impossible to evaluate. Convincing such stakeholders that selected measures relating to the extent and quality of partnerships are comprehensive enough to be useful could be a challenge for CoH measurement. However, while some stakeholders indicated that they observed how collaboration measures might improve partnerships (e.g., illustrate to potential partners the value of collaboration), how these measures fit with CoH broadly was unclear. For example, it was not easy to define who does what and when for CoH, and who “gets credit” in the complexity of creating CoH. Despite this difficulty articulating how to measure collaboration value, the stakeholders offered some measures, which are included in Appendix C.

Competing Priorities and Community Size Can Challenge Cross-Sector Collaborations

One in five stakeholders indicated that collaboration members bring different motivations, timelines, and definitions of success that can challenge the sustainability of a specific partnership. Lack of alignment can result in duplication of efforts and inefficiencies. Given the importance of local context and regular communications, many cross-sector collaborations are difficult to scale; the “bigger the community, the harder it is because there are more stakeholders.” This idea is relevant to large and somewhat diffuse concepts, such

as a CoH, that require concerted focus from multiple stakeholders to realize outcomes.

Discussion

We find that nearly half of stakeholders (46 percent) cited experience collaborating with partners in other sectors, and more than a third (35 percent) underscored collaboration as an integral aspect of building CoH. Stakeholders shared insights on key partners for forming collaborations, how to build and sustain collaborations, and other key lessons learned. In multiple communities, local and state governments are leading efforts to build CoH. Also, stakeholders are collaborating with partners from diverse sectors, and partnerships among health care centers, local businesses and business organizations, academic institutions, nonprofits, and faith-based organizations are leading to creative approaches to dealing with health issues.

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6

FINDINGS: Creating Healthier, More Equitable Communities

THIS CHAPTER PRESENTS the interview and focus group themes related to the third CoH area in the action framework: *creating healthier, more equitable communities*. This area is designed to enhance the ability of all members of a community, regardless of economic and health status, to access resources and opportunities needed to lead a healthier life. Because the CoH vision encompasses a holistic vision of health, the resources and opportunities include access to healthy food, housing, economic opportunities, quality education, and more—as well as traditional health care. The goal of this action area is to inspire communities to enable each individual to achieve his or her highest health potential by improving the overall environment in which they live.

Here, we relay the primary themes from stakeholder insights and follow up with a brief discussion of our findings pertaining to the third CoH action area.

Develop Innovative Initiatives to Promote Equitable Opportunities for Healthy Environments

Many stakeholders stressed that creating a healthy environment requires consideration of elements such as structure, placement of assets, and organizational capacity. More than one-third of stakeholders (35 percent) discussed the importance of using innovative approaches that go beyond traditional health promotion. Examples provided included moving beyond the now-popular “green” workspaces into “healthy” workspaces (e.g., stand-up work stations or meeting spaces); branching into nontraditional funding streams (e.g., public-private partnerships) and involving health in all initiatives (e.g., aligning health promotion with transportation or age-friendly initiatives); not just providing a service (e.g., an urban garden), but linking services with education and skills training; and lastly, expanding interventions from just children to communities as a whole (e.g., through integrated environmental strategies or settings-based interventions that target more than just one health concern, such as weight gain).

Utilize a Variety of Specific Strategies or Initiatives to Create a Social or Physical Environment with Equitable Opportunity for Healthy Choices

In support of these ideas, several stakeholders discussed a range of activities designed to improve equitable opportunities for healthy choices. Some of their initiatives focus on confronting racial and economic inequalities by driving resources into vulnerable communities. Other efforts included promoting complete streets policies, park and green space revitalization efforts, promotion of green infrastructure, and traffic-calming measures. Stakeholders are working on a number of policy-level initiatives, including tobacco taxes and regulation of food and beverages.

The link between health outcomes and social and economic factors emerged as an important objective of a number of organizations. In one community, business leaders, health leaders, and elected officials are brought together to focus on issues of healthy eating, active living, workplace wellness, tobacco use prevention and cessation, and behavioral health.

Specific strategies emerged from discussions centered on the social, physical, and economic environment. One-quarter of stakeholders described successful initiatives focused on the physical environment. For example, one organization focused on farm-to-school programs and safe routes to schools and described their efforts as “layered across sectors.” Another organization’s focus was on housing and racial equality; in yet another interview, we learned of efforts around rezoning to improve access to land for urban agriculture. An additional example of a strategy that focused on the physical environment was “increasing the number of smoke-free-housing policies we have across the city—from affordable housing to high-end housing.” The interviewee said the strategy “helped the public housing portfolio move to smoke-free status.” One innovative initiative came from a stakeholder who described a bicycle strategy with three parts: bike lanes, public bikes (called ECOBICI), and cultural programming where the streets were closed to vehicular traffic every Sunday. The interviewee said, “If you ask people to bike because it’s good for their health, they won’t do it. But if it’s to go to a farmers market (mercado organico), go eat quesadillas, or to see a concert, then they do it.” Also, it is about “making extraordinary things possible, making them ordinary.”

Nearly one in six stakeholders (16 percent) suggested a variety of methods focused on the social environment to increase access to opportunities for healthy behaviors, emphasizing the integration of these opportunities into settings already widely used by community members. Some examples included partnering with afterschool education and workshops, work-

ing with church groups to promote no-fried-food dinners (i.e., “No Fry Zones”), providing drug overdose treatment training and medication for local clinics and police forces, and encouraging urban farms to grow food for the community and sell surplus. Another stakeholder emphasized the importance of relationship-building in this work. She explained, “We have a theory of change, and it’s quite simply that we believe it’s through caring and supportive relationships where people are more inclined and receptive to demonstrate healthy behaviors, which then lead to healthy communities. So we’ve been supporting effective nonprofit organizations like the [YMCA], that are doing wonderful school-time programs and other efforts in the community that are really bringing people together through meaningful relationships. These are things that are based on peer-to-peer or coaching models, mentorships, parent engagement. We really think that the relationship space is a good access point, because kids nowadays are dealing with obstacles and barriers to their health, and they need some help in addressing those barriers before they can even think about eating healthy, exercising, and succeeding in school and life. So that’s kind of the general context for us.” Similarly, a stakeholder from another organization described the importance of community-building within neighborhoods. “It’s about knowing who your neighbors are, about the streets.” Yet the importance of working differently across populations was raised. As one stakeholder explained, there is not a “one-size-fits-all solution for all communities.” Recognizing differences in the built environment and the population may lead to a different formula for different environments.

Strategically Used Communication, Media, and Messaging Can Shape Health Environments and Should Be Targeted as Part of an Environmental Strategy

Sixteen percent of stakeholders—including policymakers and stakeholders from outside health—viewed communication and messaging to be an important tool for broadening the public’s perception of the role of the social and physical environment in supporting health. They also felt it important to generate support for this kind of communication. As one stakeholder described, “There must be a paradigm shift through all of society, the whole of government that recognizes health as more than just health care and understands that supporting a broad concept of well-being must happen across sectors.” To accomplish that, stakeholders described that recognition must be given to how to communicate the important impact of these initiatives. As one stakeholder explained, “people are working on issues rather than at the intersections of issues . . .” In this light, awareness and excitement for issues that may cut across topic areas or traditional sectors must be raised.

Some stakeholders (6 percent) offered a number of promising methods for communicating these ideas well. First, stakeholders suggested that it is important to use communications to energize people. As one stakeholder stated, “Messaging can’t just be social marketing (billboards and PSAs). It’s about crafting and delivering a narrative passionately. People will listen to someone who is passionate, even if they don’t agree.” To combat this, it was suggested that uplifting success stories were important to convey as “hearing about change in other places is motivating and energizing.”

The majority of stakeholders who discussed communicating about the social environmental influences on health reported that health-promotion messages and interventions for health were more effective when they were adapted to the

specific strengths and limitations within a given community. In the examples stakeholders gave, the methods they used for adapting or tailoring messages emphasized consumer engagement, such as testing messages with community members to check whether they apply to their “daily routine,” looking for healthy options that are culturally appropriate for the community, or connecting local farms to supermarkets and the community. One stakeholder described developing communications strategies based on the assumption that there are different target audiences that need to be reached with different messages. To do this, you need to work with your target audience to craft messages. As one participant explained, “The population you’re trying to reach is always the best expert on strategy and messaging.”

Third, participants explained that although data (e.g., the size of the problem, the number of people affected, or the impact of a new strategy) are a critical element of communications, they should be used to support messages rather than be the sole or major component of a communications strategy. As one participant suggested, “. . . data is important, but we need to use it effectively and judiciously. Also, data is not compelling without a message.” In addition, stakeholders were concerned that specific data aren’t always available. According to one stakeholder, “Data is important, but we must consider the message in the absence of data to create a demand for a culture of health.”

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Consider Health in All Policies or Leverage a Broad Approach to Create a Healthy Environment

More than one in ten stakeholders (13 percent) indicated that the “Health in all Policies” movement has brought positive change to the traditional approach of working through health care alone to affect population and individual health. In describing the work of one community-based organization, one stakeholder explained it as “moving toward racial and economic justice . . . economics is at the root of what [we] do,” thus, connecting health care to people and helping them remain part of an economic system are mutually important. Participants further suggested expanding the idea to include “health in all policies, decisions, and actions” in order to capture the full range of avenues that can be leveraged to improve health. As described by one stakeholder, “We really have to convince people of the importance of good policy decisions made in all sectors, because they all have consequences for population health.” For example, one stakeholder—in an organization that does not address health or health care issues—described how “the leadership team [which is composed of] different sectors/department heads, all were required to attend a monthly meeting focused on health.” This has helped to develop health-specific policies within the organization. According to one participant, these monthly meetings have helped the organization engage in discussions that confront issues of equity, the need to address historical and contemporary injustices, and the importance of creating conditions where making the healthy choice was the easy choice across sectors.

However, to effectively take on a “Health in all Policies” approach, stakeholders suggested that there would need to be greater capacity-building done with community members to help them understand how health is affected by the unique contexts of different settings, and to understand the policy-making process, as well as their own role in affecting it.

Stakeholders also recognized that the actual implementation of health in all policies was not necessarily as easy as it sounded. “I think health in all policy resonates with a lot of people, but from a lot of interactions, that doesn’t always work as well with different groups because they’re like, ‘I’m not here for health, I’m here for a different reason,’” one stakeholder said. To address this concern, stakeholders recommended bringing together data from different social and environmental factors—such as unemployment and neighborhood data merged with health information—to highlight relationships (perhaps also through geospatial mapping). They also raised the importance of bringing together elected officials, public health, land use professionals, and city planners to talk about where and how all of these issues are related.

Of particular importance to 10 percent of stakeholders was the need to integrate or leverage existing, yet nontraditional, community resources (congregations, businesses, etc.) regularly used by community members to offer healthy resources. As described by one interviewee, “If I think about ways that people do come together—and I’m really stepping outside of our systems and public health stuff—I think about [another city], where people do come together and I think we are very fortunate that we have a lot of opportunities and spaces built into our city and culture for that. We have festivals. There are places where people come together. They’re not coming there to talk about health.” As a result of these interactions, an opportunity arises to think about how we can use those resources to improve or maintain health.

Discussion

Findings from the interviews and focus groups suggested there is a shared understanding across U.S. and international organizations of the importance of social, physical, and environmental factors in improving individual and community

health, particularly in enabling individuals to make healthy choices and to engage in health-promoting behavior. Many stakeholders discussed the importance of geographic access to social and health services, as well as daily opportunities for individuals to engage in health-promoting behaviors (e.g., from safe exercise space to safe multimodal transportation choices, such as bike lanes, sidewalks, and public transportation). This is not surprising, given that stakeholders represented organizations that sponsor programs supporting such environments, and individuals who advocate for the creation of health-promoting social and economic conditions in their communities to policymakers and other leaders. Along these lines, stakeholders felt that the public health sector has become more sophisticated in communicating and thinking about the social determinants of health. One respondent noted, “At this point, it is difficult to *not* find connections [between health and different sectors].” In addition, support emerged for the idea that the “healthy choice [should be] the easy choice.”



7

FINDINGS: Strengthening Integration of Health Services and Systems

THE INTERVIEW AND group responses in this chapter address the fourth and final CoH action area, *strengthening integration of health services and systems*. This action area promotes a comprehensive approach to community health. To reach this goal, health care organizations and networks within a community will form strong partnerships among themselves, as well as with public- and private-sector actors to design and deliver services and activities aimed at improving health. This action area aims to build a community's contribution to its overall health, and to influence the development, reach, and implementation of medical treatment, public health, and social services.

Develop Relationships with Integrated Health Initiatives in the Community

More than one in ten stakeholders (12 percent) emphasized the importance of integrated care models for building CoH, and many stressed that health care transformation relies on developing partnerships with those that are currently leading the field in integrated health approaches, including regional hospitals, local providers, local health departments, state and federal advocates, community organizations, and other local stakeholders. For example, as one expressed it, a partnership she observed in her community that included stakeholders with expertise in health care law and health care organizations was better positioned to advocate changes in local health care policy.

Promote Proactive Strategies, But Be Aware That Shifting Funds Away from Treatment to Prevention Will Be a Challenge

About one in 20 stakeholders (4 percent) described how shifting funding away from treatment to prevention in the health care arena is a difficult process and requires “tough decisions” by everyone involved. As one respondent shared, a health system was recently criticized for closing underutilized hospitals in favor of funding more preventive and outpatient care in a rural community. Some stakeholders discussed their concern over perceived imbalances in payer decisionmaking, with particular respect to what they thought was a bias toward spending on pharmaceutical and hospital treatments relative to preventive care, home care, and behavioral interventions.

Some stakeholders (8 percent) emphasized the need for collaborative health teams (that include physicians, nurses, behavioral health specialists, and case managers) to coordinate patient care and link patients to community resources

after hospital discharge. They expressed that the success of this model is based on assembling a diverse set of players to help in decisionmaking—people who are more effective in understanding the full physical, mental, and social needs of patients and better at providing routine follow-up care. To accomplish this, discussants suggested that the health care delivery system will have to restructure its staffing and approaches to patient

care so that patients and nonphysician health care providers are empowered to be active and engaged decisionmakers, and the health care system must change from what they perceived to be the system's current reactive, visit-based model to a more proactive model that anticipates patient needs. For example, several stakeholders suggested empowering patients and their families to collect and use personal health data. Stakeholders also discussed moving toward reimbursement models that incentivize providers financially to be responsible for population health (e.g., value-based care under the Affordable Care Act). This shift would open the door to encouraging providers to incorporate prevention into their practices through such activities as writing prescriptions for fruits and vegetables. One respondent described the broad integration of the Triple Aim (Berwick, Nolan, and Whittington, 2008) into health care decisionmaking “when determining the impact of changes: Does the change improve outcomes, improve the patient experience, and reduce cost?”

Some stakeholders . . . emphasized the need for collaborative health teams (that include physicians, nurses, behavioral health specialists, and case managers) to coordinate patient care and link patients to community resources after hospital discharge.

Shift the Focus of Health Care to Prioritize Delivering Quality Care and Providing an Optimal Consumer Experience

Almost one in ten stakeholders (8 percent) indicated that it is critically important to make consumer experience an integral part of the evaluation of health care quality for this area. To understand the consumer experience, stakeholders suggested strategies for getting meaningful, actionable, and real-time feedback from patients (similar to Uber or Yelp). However, stakeholders also cautioned that these systems needed to account for disagreements between patients and providers about appropriate care decisions. For example, providers should not be penalized for refusing to prescribe antibiotics on demand for inappropriate cases. To optimize the consumer experience, stakeholders suggested that positive, engaged relationships between patients, providers, and care coordinators should be incentivized via payment models and that clinical goals should be reframed in terms of patient goals. For example, why would a patient want to get their diabetes under control? The answer is not necessarily to lower the patient's A1c values, but rather to improve overall function and/or to attain tangible goals, such as taking a trip or engaging in meaningful activities.

Coordinate Health and Other Major Systems in a Community to Fit Within a Broad Frame of Health Promotion

One in ten stakeholders stressed that the linkages and coordination among health care, public health, and other major systems in a community are incredibly important but will require changing the structure of clinical and social service practice. Both the health sector and other systems (e.g., social services) will need to create processes and be incentivized to work together. Stakeholders shared that models from outside

the United States (e.g., Australia) that give geographic communities responsibility and a pot of funding for well-being may be helpful examples from which to draw.

Start by Focusing on a Specific Health Need to Generate More Integrated Care Collaboration Models

A small number of stakeholders (1 percent) commented that by focusing on a specific health need—such as avoidable hospitalizations for patients with chronic conditions—groups with similar interests within the health care sector (e.g., hospitals, clinics, providers, payers) and outside it (e.g., families, public health, employers, community-based organizations) can partner to develop creative solutions to share data, develop a workforce, and create healthy workplace and living environments. Stakeholders emphasized finding partners with a “proven record” of dedication to the community and encouraging buy-in to a collective vision and plan for how to achieve it.

Discussants also suggested that an integrated approach should contain multiple components, including education, mass communication, access to alternative medicine, linkages between health care and social services, and training to promote healthy lifestyles. One stakeholder indicated that this blend of strategies “empower[s] and strengthen[s] resilience or community participation in decisionmaking.”

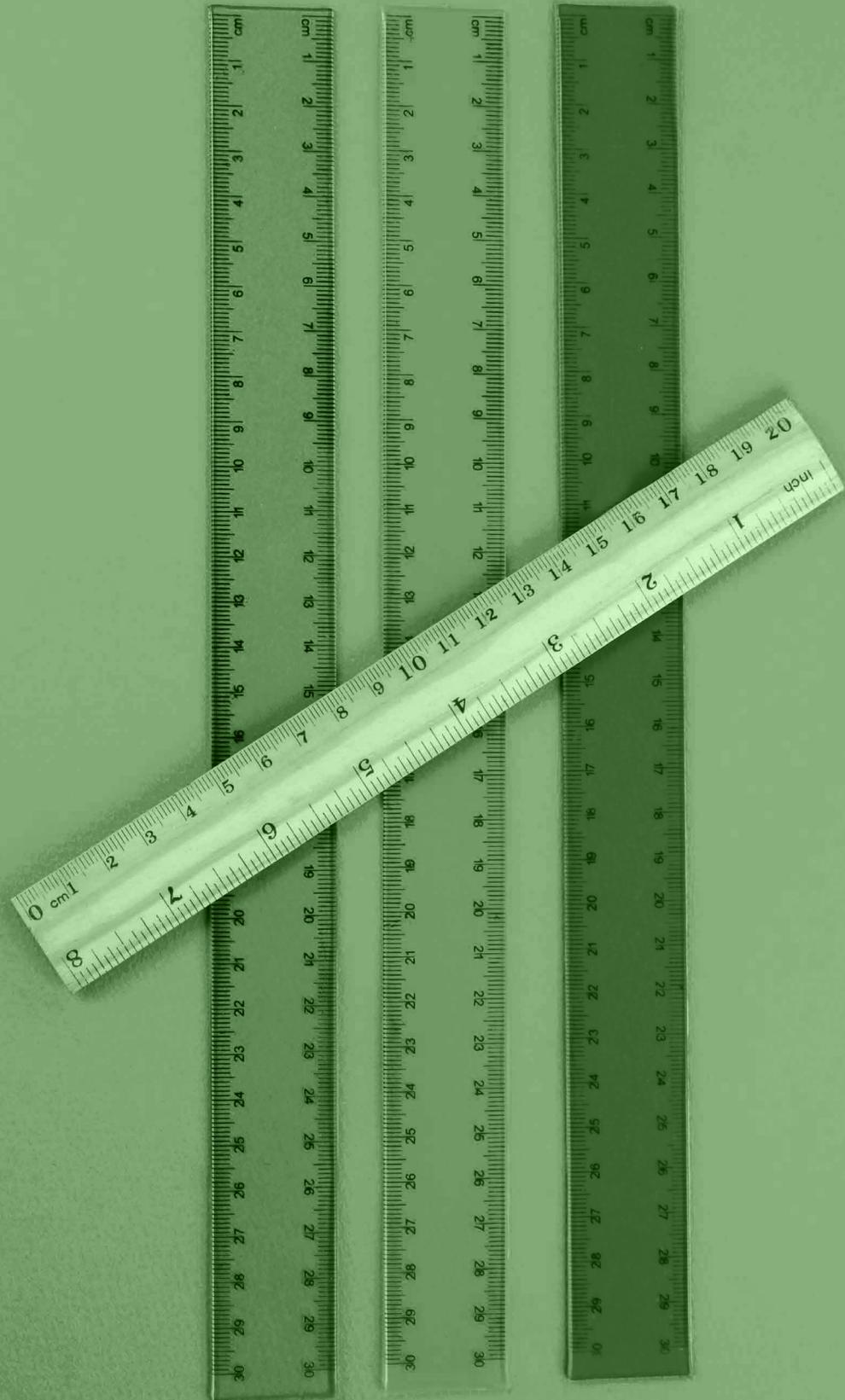
Discussion

Among stakeholders, there was agreement about the need to integrate the community and patient care or to implement innovative approaches to connect patients with their health care team. Some stakeholders discussed their use of data, measures, and information technology as a means to identify needs, assess goals, and streamline patient-provider interactions. Yet, fragmented data and insufficient infrastructure still

pose challenges for many stakeholders. Adequate workforce development, education, and human resources resonated as key elements to promote prevention and healthy lifestyles. Interestingly, some organizations highlighted the importance of cost-effectiveness of interventions, but others mentioned that social investors are interested not only in the financial return but also in the value they bring to people's lives.

In addition to striving to extend high-quality health care to all individuals within a community, stakeholders were breaking ground in this area by bringing new topics into the clinical arena—for example, assessing patients' social connect- edness—and by educating consumers about health care using innovative metrics and web-based tools.

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8

FINDINGS: Measuring the Culture of Health

THIS CHAPTER DISCUSSES themes related to measurement that surfaced throughout the stakeholder engagement activities. These themes are organized by action area and are ordered from those that were most salient (i.e., discussed most frequently by stakeholders during interviews and focus groups) to those that are least salient (i.e., discussed least frequently). As in the previous chapters, we offer a short discussion at the end of the findings.

Measurement Findings Related to Action Area 1: Making Health a Shared Value

As described previously, *making health a shared value* was the area stakeholders were least able to describe across all stakeholder engagements. While stakeholders generally had not previously considered ways to evaluate the components of this

area, they identified areas of focus for developing useful measures, and 17 percent of stakeholders suggested measures to consider for the CoH measurement plan (Appendix C). These included measures of social connectedness, the value placed on health, and civic engagement.

There Is a Need for Better Measures to Capture Community Attitudes and Shared Values Around the Culture of Health in a Real-World Setting

The action area related to making health a shared value is made up of a number of components, such as social connectedness and community activation for health, as well community attitudes. However, stakeholders generated very little discussion about measuring these components. One in 20 stakeholders indicated that there was a paucity of useful measures to track community attitudes and the value that individuals placed on health in their communities. Stakeholders were limited in identifying specific measures and focused instead on explaining a couple of methods for describing success in this area. For example, several discussants simply described the need to identify “best practice terms” for this area. A few others stated that there is a need to define more concretely what success means when creating a shared value of health. In terms of creating specific measures, stakeholders suggested reaching broadly into the community to support the development of measures. One discussant suggested that what is important is “getting community groups involved to take on this issue so it’s . . . not [just a government] agency or funder’s.” In other words, stakeholders hoped for measures that would give communities credit for making any progress toward making health a shared value, rather than focusing on gold standards of community connectedness and collective value placed on health that may not be as meaningful in community settings.

Current Measures Related to Community Activation for Health Are Sparse, But Could Provide Useful Information If Developed

One in ten stakeholders expressed interest in measures to track community activation toward creating CoH. Measures of use to stakeholders fell into two categories: one at the initiative level, such as tracking meeting attendance and feedback from participants; and the other at the community level, such as tracking political participation in health-related ballot measures. Stakeholders discussing these categories of measures spoke about them in the hypothetical or anecdotal sense and also expressed interest in a more formalized set of usable measures. One stakeholder working on policy change for health reported that tracking community activation for health would help “make the case for the type of work they do” and would support their conversations with decisionmakers as they continue to advocate for policy-level interventions.

Despite the Growing Conversation About Health Equity and Addressing Disparities, There Is Still a Need to Develop Measures to Capture the Extent to Which Marginalized Populations Are Involved in Health-Related Decisionmaking

Four percent of stakeholders also discussed a need for additional measures to track the influence of vulnerable populations; however, only one stakeholder was specific about the types of indicators that would be useful to operationalize participation by marginalized populations in health programming, suggesting questions such as “How many men of color have you enrolled [in the program]? How many youth have you engaged in an advocacy action?” Most stakeholders emphasized the influence of those in leadership positions, mentioning measures of representative democracy (see Appendix C) and more-qualitative assessments of the process of community members taking on leadership roles in health initiatives.

Measurement Findings Related to Action Area 2: Fostering Cross-Sector Collaboration to Improve Well-Being

As collaborations to build CoH proliferate, there is an increasing need to develop and disseminate measures of collaborative participation, quality, and impact. Stakeholders focused heavily on the process of forming and maintaining collaborations and provided only moderate insight into measures of this area. Overall, 17 percent of stakeholders suggested specific ways of measuring the components of the area (Appendix C), including tracking funding streams, keeping tabs on collaborative activity on a large scale, and monitoring collaboration participation and impact. A few stakeholders described the need for additional measures as illustrated in this section.

As Collaborations to Improve Well-Being Are Increasingly Common in Communities, Stakeholders Are Feeling Pressure to Measure the Ways in Which Various Sectors Are Contributing

More than one in 20 stakeholders (7 percent) expressed a need for more or better measures to track the contributions of different sectors to health-promoting activities. The various perspectives, benchmarks, and mandates that each sector brings to the collaboration make agreeing on a shared metric of the extent of contribution difficult. Stakeholders warned about one sector dictating these metrics, recommending that “new ways to measure [contributions should be generated] through a collaborative process.” Specific ways in which stakeholders are doing this relate to relying on expert evaluation partners such as universities and think tanks, as well as tracking outcomes that are of interest across sectors (e.g., use of active transportation, affordable housing). A primary care physician described ways of surveying patients about the extent

to which they observe collaboration between service providers they see (e.g., “How many people are involved with helping you find housing, transportation, health care? Do you have a sense that they talk to each other?”) but echoed the need for developing a process and platform to gather these measures.

Measuring the Extent or Quality of Partnerships May Be a Challenge for Culture of Health Initiatives

A few stakeholders (4 percent) expressed a need for additional measures to track the quality of cross-sector partnerships, but some said collaborations were so complicated that they may be impossible to measure. Convincing stakeholders that selected measures are comprehensive enough to be useful across communities could be a challenge for CoH measurement. Some stakeholders indicated that they observed how measures might improve collaboration (e.g., show potential partners the value of collaboration); however, the difficulty will be in tying these measures back to CoH. For example, stakeholders were concerned that it may not be easy to define who does what and when for CoH, and who “gets credit” in the complexity of creating CoH. Stakeholders also expressed that some of this challenge stems from the disparate indicators used by different sectors, leading stakeholders to lament that “there are no shared benchmarks among partners” they work with. Collaborations are beginning to align on shared definitions of success, but there is still a need for widespread adoption of “the logic model approach,” including the quality of participation by each sector as a key input.

Measurement Findings Related to Action Area 3: Creating Healthier, More Equitable Communities

Many stakeholders described ongoing efforts to create healthier, more-equitable communities, and almost one in three

(29 percent) mentioned existing measures for tracking those changes (Appendix C). Suggested measures for this area related to food access, the built environment, and economic opportunities in neighborhoods. However, there was a “black box” identified for measuring points along the process from policy changes, to environmental changes, to changes in health behavior, to changes in health outcomes, primarily in the linkages between environmental changes and health outcomes. Some stakeholders have begun to illuminate the black box, while others are resigned to what they see as an insurmountable challenge to measurement in this area.

Stakeholders Struggle to Find Measures to Make the Link Between Changes in the Environment to Behavior and Other Outcomes

Despite the prevalence of environmental changes targeted at health promotion, only 8 percent of stakeholders described a need for measures to help them track the impact of these changes on proximal and distal outcomes. Stakeholders who are making progress in this area described their process for identifying outcomes of interest. Some emphasized the value of community relevance, saying “measures need to be at a usable level—at the scope at which people live their lives.” Others took a small-wins approach, using existing, process-oriented measures of their outputs, such as capital improvement projects completed. Still others rely on measures of value to their partners, such as existing health outcomes tracked by the state health department (e.g., body mass index, tobacco use), or return on investment (e.g., from bike path construction), which is important to the business communities. While these measures helped stakeholders get traction with partners, it is sometimes difficult for the public health sector to monetize its impact. “I mean, if you put a bike lane down, that’s not going to equal a dollar figure . . . [not like] you put

it down for \$10 and you're going to get \$20 worth of usage." If stakeholders had additional measures for this area, it would support their belief in the impact of environmental context on health, showing that "it's not a choice if there's not a choice. If I don't have street lighting or a track, I don't have a choice to do physical activity."

Measurement Findings Related to Action Area 4: Strengthening Integration of Health Services and Systems

Suggestions for measures of a reenvisioned health care system were plentiful and cited by nearly one in five stakeholders (19 percent), but not much in use currently. Most of these suggestions revolved around balancing measures of reduced cost, improved patient experience, and improved health outcomes. As with the other action areas, stakeholders indicated that additional measures are needed to evaluate the U.S. health system within CoH. Stakeholders also warned that robust measurement in this space would require significant process changes in the health care system.

There Is a Need for Better Measures That Capture the Prevention Side of the Prevention-Treatment Balance in an Evolving Health Care System

Stakeholders commonly identified health care costs as an indicator of the emphasis placed on treatment in the health care system. However, 2 percent of stakeholders indicated that there was a need for more or better measures to capture the balance across prevention- and treatment-focused systems. Stakeholders were divided about whether primary outcomes should be based on costs or health status, and they saw challenges with both. On the cost side, stakeholders lamented that "[economic] prevention success measures are hard to show,"

and, moreover, that health equity is difficult to support with a business case, since beneficiaries are inherently members of a minority. On the health outcomes side, stakeholders described a need to evolve measures to capture well-being as opposed to being “stuck in a paradigm of measuring chronic disease outcomes, such as diabetes, asthma, [and] hypertension.” Some stakeholders defended the importance of both, though few were engaged in comprehensive measurement of health care costs and health outcomes.

Measurement Findings That Cut Across Culture of Health Action Areas

Stakeholders identified a few themes related to measurement that cut across the four action areas. These themes relate to developing system-level measures of CoH-related initiatives, identifying measures that encourage competition between communities, and building capabilities and frameworks for utilizing social media data as a means of measuring progress toward CoH. Additionally, 20 percent of stakeholders suggested measures that relate to evaluating CoH generally, or cut across action areas (Appendix C).

System-Level Measures Are Needed to Track the Progression from Health Opportunity to Actual Change in Conditions That Will Consistently Improve Population Health

More than one in ten stakeholders (13 percent) were concerned about a lack of system-level measures of outcomes. Stakeholders wanted measurement at various points along the progression through a system (e.g., educational system) to an individual outcome (e.g., understanding of health promotion). Challenges to performing this type of evaluation in the status quo relate to the comprehensive nature of system-level changes. For example, one stakeholder stated, “[For the system

outcome of] not getting diagnosed with a certain disease, [variables include] employment, re-entry into the hospitals, use of transportation systems, car ownership, distances to get to appointments, farmers markets. The metric has to look at a number of points along the system.” Moreover, at many of these points, accurate measures do not exist. For example,

for interventions aiming to improve nutrition through multiple entry points, it is “hard to get accurate data on what people are eating.” For measures that do exist, logistical and bureaucratic barriers hinder evaluation efforts, causing stakeholders to say that while the “state department of public health collects data, [they] are always a few years behind in their reporting.” Finally, issues of time frame and evaluation capacity are in play because stakeholders largely think that systemic changes take a relatively long time to have measurable impact, and have limited resources to measure these changes. However, stakeholders stressed the importance of coming up with viable systemwide measurements for capturing whether healthy opportunities translate into healthy choices, and ultimately into population-level health.

These data could then be used to foster a competitive spirit between cities, neighborhoods, and towns by using them to track progress and motivate change. Stakeholders also indicated that there was a need for widely disseminated indicators or measures that could create competition among communities to build CoH. One example provided was creating competitions between cities with bike-share programs by

. . . stakeholders stressed the importance of coming up with viable systemwide measurements for capturing whether healthy opportunities translate into healthy choices, and ultimately into population-level health.

tracking which cities have more users, which would also lead to population health benefits from increased physical activity. Additionally, stakeholders described utilizing a competitive spirit around non-health data as an entry point to conversations about health. “[Our city] has a horrible youth unemployment rate. Did you know it’s connected to this broader goal?” Finally, some stakeholders have had success partnering with the business community (e.g., Chamber of Commerce, large employers) by making the economic case, for example, for having superior health outcomes to peer cities, citing lower costs to insure workers. Overall, stakeholders express a need for indicators or measures that can create competition among communities to “get healthy.”

There Is Promise in Using Social Media and Big Data for the Measurement of Culture of Health on a Large Scale, But Outcomes Identifiable with Big Data Are Not Yet Operationalized

Most stakeholders were not engaged in thinking about social media for CoH measurement, and only 2 percent of stakeholders described a need to evolve measures in this area. However, those who did discuss this emerging methodology suggested taking cues from such companies as Uber and Yelp, which rely on social media-like models to collect real-time, actionable feedback. However, these same stakeholders also emphasized the distinction between for-profit companies and the health sector, a refrain that was echoed by others. Without a role carved out for mining, managing, and analyzing big data, organizations become overwhelmed and “they can’t keep up with all of it.” Findings from stakeholder engagement suggest that user-friendly measures that draw from big data would be useful for evaluating widespread changes in CoH.

Discussion

Overall, findings from the interviews and focus groups suggested a lack of available measures and existing capacity necessary to evaluate most community health initiatives rigorously and comprehensively. Stakeholders offered a number of recommendations regarding suggested measures for the CoH action areas (found in Appendix C). But stakeholders also expressed a need for measures to be developed to evaluate aspects of creating CoH.



9

Summary and Implications for Culture of Health Strategic Framework

A SUMMARY OF FINDINGS general to CoH and specific to each of the framework action areas can be found in Table 9.1. Stakeholder engagement efforts confirmed that CoH is a concept that the majority of stakeholders understand and are willing to support. The implications listed here outline important process issues that RWJF should consider as they are designing their plans to support the CoH vision and implement activities in each of the action areas. In particular, quality data and guidance as well as technical assistance to interpret and apply the data to local initiatives are critical priorities mentioned by the majority of stakeholders. However, few stakeholders were engaged in any data collection or evaluation efforts that would systematically capture most of the CoH measures under consideration or that may apply to the CoH action framework.

Table 9.1. Themes Identified from the Interviews and Focus Groups

Category	Themes Identified
Implementation of CoH framework across multiple action areas	<ul style="list-style-type: none"> • Consider an individual’s larger social context or environment when determining factors that may be influencing his or her health • Build knowledge of and connection with communities to foster a culture of health • Work at multiple levels, from individual to organizational to system, to build a culture of health • The phrase “culture of health” was intuitive and appealing to a large majority of stakeholders, but some stakeholders had concerns about the phrase’s inclusivity • Provide continued health education and communication to create a shared value of health among all stakeholders • Political support for policies or interventions that may be costly or unpopular in the short term may be difficult to garner • Evaluation and data are important to inform a culture of health, but stakeholders reported limited capacity and funding to collect them • Consider ways to make building a culture of health “good for business” to incentivize strategies to build a culture of health • Social media data could be useful to track development of a culture of health, but few stakeholders use these data
Making health a shared value	<ul style="list-style-type: none"> • Culturally tailor processes to build a shared value of health; it is not “one size fits all” • Engage community residents as key partners to promote shared values and social cohesion • Collaborate with a wide range of organizations to promote shared values • Train public health professionals on how to change social norms • Integrate civic engagement activities into health promotion programs to create shared values

<p>Fostering cross-sector collaboration to improve well-being</p>	<ul style="list-style-type: none"> • Define “prevention” and “health promotion” broadly to help potential collaborators see where they have influence • Engage a visionary leader, community leaders and nontraditional partners to build a culture of health • Clearly articulate economic benefits from cross-sector collaboration for organizations to sustain commitment over time • Develop strategies to maintain consistent organizational participation in the collaboration, despite staff turnover • Measuring the extent or quality of partnerships may be a challenge for culture of health initiatives • Competing priorities and community size can challenge cross-sector collaborations
<p>Creating healthier, more equitable communities</p>	<ul style="list-style-type: none"> • Develop innovative initiatives to promote equitable opportunities for healthy environments • Utilize a variety of specific strategies or initiatives to create a social, physical, or economic environment with equitable opportunity for healthy choices • Strategically used communication, media, and messaging can shape health environments and should be targeted as part of an environmental strategy • Consider health in all policies or leverage a broad approach to create a healthy environment
<p>Strengthening integration of health services and systems</p>	<ul style="list-style-type: none"> • Develop relationships with integrated health initiatives in the community • Promote proactive strategies, but be aware that shifting funds away from treatment to prevention will be a challenge • Start by focusing on a specific health need to generate more integrated care collaboration models • Shift the focus of health care to prioritize delivering quality care and providing an optimal consumer experience • Coordinate health and other major systems in a community to fit within a broad frame of health promotion

Implications

Next, we highlight some of the specific implications for RWJF's CoH strategic framework, then conclude this chapter with a brief summary and description of next steps.

'Culture of Health' Is a Phrase That Generally Resonates Well with Stakeholders

Overall, a larger number of stakeholders felt that the phrase "culture of health" was intuitive and appealing and helped move the conversation beyond health as the absence of disease and beyond just exercising or eating right. But some also expressed concerns that the phrase may not translate well to other cultures and was not intuitively inclusive of traditionally marginalized populations. Stakeholders also emphasized that the inclusion of the term "health" in the phrase might lead to it being seen as primarily health-sector work; however, the conceptualization of CoH intends to go beyond health to the whole community and conceptualizes health in a broad way (inclusive of equity, civic engagement, etc.). There were also concerns that the term "culture" can be interpreted as very personal and ingrained and not something that is mutable in the way envisioned by the CoH initiative. Given the broad conceptualization of CoH and its focus on equity and cross-sector collaboration, finding a way to clearly articulate these key concepts and their impact on CoH will be critical for RWJF. The action framework and associated measures are one method RWJF could use to articulate these drivers. Additionally, tailoring the strategies to specific local cultures and contexts could help address these concerns and increase the relevance of local CoH initiatives.

. . . stakeholders felt that the phrase "culture of health" was intuitive and appealing . . .

Additional Work Is Needed to Generate Measures to Support Data Collection and Evaluation of the Culture of Health

Findings also suggest that while evaluation and data are important to inform CoH, stakeholders have limited capacity and funding to collect these data. We found very few stakeholders collecting any data relevant to the CoH action areas. In particular, stakeholders indicated that measures of shared values and social cohesion were among the most difficult to conceptualize. Findings suggest that additional guidance and support may be needed to convince stakeholders of the value and utility of measures related to cross-sector collaboration. System-level measures of equitable opportunities are currently unavailable but are critical to tracking progress and outcomes for this area. Stakeholders had the greatest number of suggestions for measures of health care; however, few were being utilized particularly to capture the full consumer experience or integration with public health and social services. Not only is measurement development work needed to support local CoH initiatives, guidance and technical assistance to interpret and apply these data to continuous quality improvement efforts also may be needed.

Diverse, Cross-Sector Collaborations Are Among the Most Commonly Cited Mechanisms for Building a Culture of Health

Almost all of the stakeholders we spoke with worked across sectors, or advocated for cross-sector collaborations, in doing CoH-based work. One of the most common themes was the importance of a diversity of partners in building CoH. This includes traditional health and health care partners, as well as nontraditional organizations (e.g., business, banking). Partnerships are also needed vertically, from top leadership down to

the local community resident. Engaging both traditional leaders (e.g., politicians, religious leaders) and influential leaders, such as community champions (e.g., well-respected elders) is also vital to building credibility for CoH initiatives.

Finding Ways to Explain and Measure the Value of Building a Culture of Health Is Integral to Sustainability of the Framework

Across multiple areas, stakeholders discussed the importance of finding ways to describe both the monetary and social value of CoH. For-profit institutions may be interested in return on investment or monetary measures of value; nonprofit institutions may be more interested in the social value. Being able to clearly communicate and measure this value was considered integral to improving participation in and garnering support (both monetary and nonmonetary) for CoH initiatives. Tools like the Social Impact Calculator can provide social value of participation. Monetizing the value is the first step, but communicating about this value is critical to sustainability of CoH initiatives. Stakeholders suggested that communications will need to be “passionate,” “motivating,” and “energizing”—qualities that were noted as often absent from traditional public health communication campaigns. In addition, communications will need to be tailored to community audience(s)—and while incorporating data can make the message stronger, data on their own are “not compelling without a strong message.”

Expanding the Scope of Health Beyond Health Care Is Imperative for Culture of Health Initiatives, But Comes with Some Potential Pitfalls That Should Be Considered

Stakeholders agreed that CoH goes beyond traditional health and health care to include a greater focus on proactive and clinical prevention efforts, but also a broader scope to include all aspects of the environment that contribute to health,

including community prevention and health promotion efforts. In this way, CoH aims to expand the scope of health initiatives to include policy-, community-, and system-level efforts to prevent and treat disease, as well as to include interventions that promote community and individual well-being, broadly defined. Specifically, stakeholders suggested that CoH initiatives focus on the individual, interpersonal, organizational, and community levels, as well as policy and environmental changes (e.g., health in all policies) and community leadership (e.g., mayors, CEOs). While stakeholders considered this an important and defining paradigm shift for CoH initiatives, many also cautioned that without a strong vision and clear-cut communication, a strategic framework this broad in scope can be challenging. It can be difficult to help stakeholders see their role in the framework and understand “what is in it for them.” It also can be a challenge to identify a clear funder, since funders often operate in specific areas (i.e., silos).

Limitations

The findings summarized in this brief report represent only one component informing the CoH action framework and measurement strategy process. As such, the findings from interviews and focus groups should be contextualized in the broader analysis. First, the comments from stakeholders represent engagement from individuals and organizations that may be more inclined to discuss CoH topics. The team made a concerted effort to represent “unusual suspects” by identifying and engaging those outside of the health sector using broad well-being–related search terms, such as “resilience,” and using snowball sampling methodology in our communities of interest, particularly through the Phase 2 interviews. However, we still may not represent those who require more engagement to fully invest in the CoH action framework and its objectives, including members of the business community.

Second, as noted throughout the report, some areas of the CoH action framework were easier or more tangible for stakeholders to discuss, primarily because some concepts in the model have greater history and profile and represent comparatively well-treaded territory. As such, areas such as *making health a shared value* may benefit from additional or different stakeholder approaches (e.g., scenario-based design, narrative-based elicitation techniques) to capture core sentiments that can inform an RWJF communication strategy. On the other hand, areas such as cross-sector collaboration surfaced somewhat common themes about the challenge of partnership, but did not articulate exact roles and responsibilities for specific sectors. Some of these insights will be gleaned from concept-mapping efforts, which are represented in another report.

The findings summarized in this report related to measurement are limited by a number of factors. First, themes related to measurement may be overrepresented due to explicitly asking stakeholders for measures that related to initiatives or topics of conversation during interviews. Relative frequency of these measurement themes to other themes in this report should be interpreted with caution. Second, specific measures listed are limited to what stakeholders could recall in the context of an interview. If contacts had been explicitly told to prepare talking points related to evaluation and specific measures they use, more suggested measures might have been elicited. Third, many of the stakeholders we spoke to held leadership roles at their organizations. They may delegate evaluation to other staff members.

Next Steps and Conclusion

As described at the outset of this report, findings from this study will be used to inform the first set of CoH measures and broader communication about the CoH action framework. Specifically, communications should build from the themes

in this report, as well as those noted in *Building a National Culture of Health: Background, Action Model, Measures and Next Steps* (Chandra et al., forthcoming), to develop a cohesive and accessible narrative for the CoH action framework.

Health and health care is at a crossroads in the United States. RWJF is spearheading the CoH initiative to redefine what it means to get and stay healthy. Feedback gathered from stakeholders, using interviews and focus groups, described in this report, has informed the four action areas that are the priorities for building CoH:

1. making health a shared value
2. fostering cross-sector collaboration to improve well-being
3. creating healthier, more equitable communities
4. strengthening integration of health services and systems.

In particular, the interviews and focus groups provided feedback on processes to achieve each of the action areas, as well as areas for measurement that could be used to chart progress in each action area. Together, these four action areas are intended to focus efforts and provide a course of action to achieve the CoH vision to enable everyone “in our diverse society to lead healthier lives, now and for generations to come.”

In summary, these findings suggest that realizing the vision for CoH requires broader community-level approaches that engage a more diverse array of cross-sector collaborators and cut across levels from grass-roots efforts led by community residents all the way up to policy-level interventions that affect governance structures and protocols. The success of these approaches will come from leveraging existing community capacities—including civically engaged residents, socially responsible businesses, and a more skilled public health workforce—and from integrating health into the full array of

community-level initiatives. Engaging the whole of community, promoting cross-sector collaboration (e.g., navigating competing priorities of multiple organizations), navigating political processes (e.g., to follow through on policy interventions), and using an array of communication technologies and media to shift social norms are among the skills required for the public health workforce to shift communities toward CoH. To

fully engage the private sector, RWJF will need to communicate more clearly the economic incentives and cost and benefits of building CoH. A strong and flexible set of leaders will also be needed—leaders that can help clearly articulate roles and benefits across sectors, navigate “siloed” funding streams, identify the ways that sector efforts can be better aligned, and find opportunities for nesting health into policies and initiatives. Given the emphasis on equity as a key driver of health, initiatives also will have to shift away from the focus on just health disparities, recognizing that these inequities are created by political, social, and economic inequities, and as such will require approaches that not only encompass but go beyond the social determinants of health. Enhanced capacity to collect, analyze, and interpret and apply data (including big-data sets, such as social media data and measures of the benefits of cross-sector collaborations) will also be needed if we are to adequately track progress and monitor

A strong and flexible set of leaders will also be needed—leaders that can help clearly articulate roles and benefits across sectors, navigate “siloed” funding streams, identify the ways that sector efforts can be better aligned, and find opportunities for nesting health into policies and initiatives.

community-level changes toward CoH. RWJF's CoH strategic framework is based on the premise that being healthy is more than just the absence of illness; it is defined as taking advantage of opportunities in the community to thrive and prosper. The suggested action areas and framework, as well as the implementation strategies, represent a paradigm shift toward well-being.

APPENDIX A:

Phase 1 Stakeholder Interview Protocol

Semistructured Interview Protocol for U.S. and International Organizational Leaders

Prior to phone interview, interviewer should review organization website and notes in the regional stakeholder (RS) spreadsheet to answer these questions:

1. Generally, what kind of work does this organization do?
2. What population(s) does this organization work with?
On what level do they work (e.g., individual; institutional, such as school or health care center; community; city; country; internationally)?
3. What role does the interviewee hold in the organization?
What branch of the organization does he or she work in?
4. Are any of the interview questions especially relevant?
Not relevant?

5. Which of the four CoH areas does the organization's work best align with (start with what is in RS spreadsheet, but confirm with other documents)? Which measure(s) should I ask them about?

Introduction

Thank you for taking the time to talk with us today. In case you are not familiar with RAND, our organization is a nonprofit research center that conducts public policy research. This RAND study is funded by the Robert Wood Johnson Foundation to understand the factors that contribute to a culture of health in the United States.

(For organizations outside the United States: The Robert Wood Johnson Foundation is a philanthropic organization that supports health and health care in the United States.)

We can think of Culture of Health in this way: **A Culture of Health exists when expectations about the high value of health are shared across sectors, and when individuals and organizations have the capacity to:**

- promote individual and community well-being (as defined by *physical, social, and mental health*)
- create physical and social environments that prioritize health
- support access to opportunities for healthy living and high-quality health care for everyone.

This project eventually will lead to a strategy for supporting greater action to improve health in the United States. Feedback from health experts around the globe is essential to gaining a broad view of a culture of health and we greatly appreciate you taking the time to talk with us today.

Consent

Before we begin, I want to assure you that your responses to our questions are held in strict confidence. Any research reports will include your feedback combined with several other experts' feedback; there will be no personally identifying information. No specific organizations will be named in our reports. If we quote you, we will not identify you or your specific organization by name.

We would like to take notes during this conversation to ensure that we can capture all of your important feedback. We will destroy the notes at the end of the project. Is this OK with you?

Let me remind you that your participation is voluntary and if you are uncomfortable with any questions that are asked, please feel free to not respond to the questions. We estimate that the interview will take about 45 minutes to cover all the different aspects of your work.

Do you have any questions before we begin? [*Answer any questions and then proceed to interview.*]

Questions

1. I understand that your organization does _____ [*describe type of work*] with _____ [*populations*]. In thinking about this concept of CoH [*repeat definition if needed*], what are you and/or your organization **working on** with respect to fostering CoH in the communities or populations you serve?
2. [*If they mention something that sounds especially relevant:*] Do you have any **documents** that outline your **plans** or describe your **efforts** related to the idea CoH?
3. In your work, do you ever collaborate with organizations or people from different sectors in relation to CoH projects? (*Examples of sectors include business, education, faith-based, government, health, etc. Can point out*

examples from pre-research) If so, how have you been able to make it successful?

4. Who are **other experts** that you recommend we speak with to learn more about the CoH-type work in *(name of community, region or state)/(in the content area that this organization is working)*?
5. In thinking about the CoH-type work that you do *(can give example)*, how do you **measure** broad health and well-being outcomes? What measures do you use, or would you use?
6. Our team is working on identifying tools to measure CoH; for example, whether CoH exists in a community, or how successful a strategy to build CoH has been. One tool we identified is _____. If you had this kind of information available, either for your community *(or other region)* or more generally, would this be useful for you? *(If yes)* How would you use it? *(If no)* Why would it not be useful? What would make it more usable for you?
7. Who else in your community/Who do you know who has experience with **measurement or evaluation** in the area of CoH?
8. What have been your lessons learned about how to create CoH?

APPENDIX B:

Phase 2 Stakeholder Interview Protocol

Semistructured Interview Protocol for Organizational Leaders

Introduction

Thank you for taking the time to talk with us today about your work building healthy communities. We will ask you questions about how you conceptualize health promotion and well-being and the priorities and key activities you think are needed to drive community health. We will also ask you about any measures you have in place to monitor or evaluate your community's path to health, and the thought process that led you to those measures.

Our discussion today is part of a project by RAND. In case you are not familiar with RAND, our organization is a non-profit research center that conducts public policy research. This study is funded by the Robert Wood Johnson Foundation,

or RWJF, to understand the factors that contribute to a culture of health. In order to do this, RWJF would like to learn more about how communities are creating healthy conditions that support individual, family, and overall community health and well-being. This project eventually will lead to a strategy and a way of measuring a culture of health, which RWJF would like to offer to communities to support greater action to improve health in the United States. Feedback from community leaders like you is essential to this study and we greatly appreciate you taking the time to talk with us today.

Consent

Before we begin, I want to assure you that your responses to our questions are held in strict confidence. Any research reports will include your feedback combined together with several other community leaders' feedback. We may name your initiative or organization, but will only report feedback in aggregate. If we quote you we will not identify you or your specific organization by name.

We would like to take notes during conversation just so that we can capture all of your important feedback. We will destroy the notes at the end of the project. Is this OK with you?

Let me remind you that your participation is voluntary and if you are uncomfortable with any questions that are asked, please feel free to not respond to the questions. We estimate that the interview will take about an hour to cover all the different aspects of your work.

Do you have any questions before we begin? [*Answer any questions and then proceed to interview.*]

Questions

[*Note to interviewer, start with initial questions. Then, proceed to the area-specific questions for the single area that we pre-identified for that community. End with the wrap-up questions.*]

Based on their knowledge, there may be questions that you choose to skip.]

INITIAL QUESTIONS

- What are you and/or your organization working on with respect to fostering CoH (or work supporting health and well-being) in your community?
[As follow-up, try to push the interviewee a bit to discuss unique/out-of-the-box elements]
- What do you consider to be the **most important or unique elements** that have allowed your organization to move toward fostering CoH?
- Do you have any documents that outline your plans or describe your efforts related to the idea of a culture of health?

Thank you, now I would like to ask you some specific questions about how you implemented and measured activities in your community.

[Proceed to the area-specific questions, using the area we identified as the community's strength/approach to building CoH. These questions reflect areas highlighted in the recent measures workbook as gaps/unanswered questions.]

ACTION AREA: MAKING HEALTH A SHARED VALUE

Process

1. What strategies have been effective in bringing individuals together to participate in health promoting or health activities?
Probe: If stakeholders discuss broadening the focus of collaborations in order to attract different sectors, try to push them to identify HOW they are doing this (e.g., Are they redefining health in these collaborations? Are they specifically not discussing health?)
2. What strategies have worked to improve individuals' view that their health is (or health-promoting activities

are) important or a priority? What about to improve the value that individuals place on being healthy?

3. What types of community partners do you need (e.g., advocates, champions, leaders) to implement these strategies and what works best to engage these partners?
 - a. What role do they play in implementation?

Push stakeholders here to describe the characteristics of environments that foster collaboration and innovation among these partners (e.g., Action Labs, No Bad Ideas sessions, “nontraditional” partners with new, fresh ideas)

Measures

4. How should we capture the extent to which the voices of traditionally marginalized populations are present in health-related decisionmaking in your community? Are there measures that will tell us about the distribution of marginalized populations in your community?
5. How should we track the activation of community processes to advance health? Are there process indicators that will tell us if a community is active in this space? What about interim outcomes?
6. What kinds of measures or indicators would suggest that there is broad community investment in health and well-being? More specifically, what types of measures best capture community attitudes and shared values? What behavioral indicators would suggest community investment?

[Proceed to the miscellaneous and wrap-up questions.]

ACTION AREA: STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

Prevention vs. Treatment

7. What strategies have worked in your community to move toward achieving a better balance between prevention

and health promotion on the one hand and care for acute issues and chronic diseases on the other?

Probe: if a respondent discusses the health care system/ primary care providers, probe how we can get providers (or other members of the health care team) more involved in prevention in the context of their practices/appointments

[Note, if asked why this is important, you can share that—ideally, Culture of Health efforts will move the nation toward more primary prevention and health-promoting behavior, while supporting the timely use of treatment for acute and chronic issues.]

8. What would be a good way to measure balance across prevention- and treatment-focused systems? (E.g., a ratio of service use and service capacity? A spending ratio between health and social services, or between prevention and acute care?)

New Structures and Delivery Models

9. We want to understand the value and benefits of new health care structure and delivery models such as accountable care organizations (ACOs) and patient-centered medical homes (PCMHs). In thinking about the health care system in your community, what might be some likely outcomes and benefits of ACOs and PCMHs?
10. How can we *measure* those outcomes and benefits?

Consumer Experience

11. If we want to better understand the consumer's experience with health care, what kinds of things should we consider (e.g., better engagement strategies, different models of care)?
 - a. How can we *support* consumer engagement in health care decisionmaking?

- b. How can we *measure* consumer engagement in health care decisionmaking?

Linkages with Other Systems

12. Consumers often use several systems to address their health needs, which make linkages and coordination among health systems and other systems, such as social services, essential. How can we *support* that kind of linkage and coordination?
13. Currently, we lack measures for those kinds of linkages. What would be a good way to measure coordination or integration with nontraditional health systems, particularly social services?

Nontraditional Spaces

14. We want to learn more about health opportunities in nontraditional spaces, such as retail clinics. First, in considering what this “nontraditional spaces” category looks like in your community, what types of locations and services are the most important to consider? (What falls into this category?)
15. Beyond the mere availability or density of these options, how should we capture utilization?
16. Also, how should we address coordination with providers working in nontraditional spaces? What about the question of the quality of services and outcomes?

[Proceed to the miscellaneous and wrap-up questions.]

ACTION AREA: FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING

Process

17. What other collaborations designed to improve health are occurring in your community?
18. In the collaborations with which you have familiarity,

how have the partners been able to achieve buy-in from leadership to participate in the partnership?

19. What mechanisms ensure that collaboration partners stay engaged?
 - a. Are there mechanisms specific to the structure of the partnership?
 - b. Are there mechanisms specific to the community or public policy? (E.g., In your community, are there examples of where public policy has played a role in supporting the investments of nonhealth sectors into health or where they have supported collaborations?)

Measures

20. How are the contributions of different sectors to health measured in your community?
Probe: If respondent conceptualizes partnerships/collaborations as an exchange of value: How do you define or measure (or would define or measure, if you could) the value of each contributor?
21. Does your community measure the quality of participation in collaborative activities?
22. If so, is your community tracking the interactions among partners (e.g., trust) or the structure of the partnership (e.g., all members participating as equals)?
23. What conditions or activities in your community support collaborative activities to improve health?

[Proceed to the miscellaneous and wrap-up questions.]

ACTION AREA: CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES

Process

24. In what ways has your community worked to create a physical, social, or economic environment with equitable opportunity for healthy choices?
 - a. What initiatives have been successful?

25. The first step in improving healthy choices and environments is coming to a mutual understanding across sectors (community members, health care, public, commercial, etc.) of the role of the social, physical, and economic environment in health. How would you describe the process of multisectorial groups coming to this understanding?

[Note: This question is not getting at action toward improving environments at this point, just process of coming to an agreement about the importance of improved/equitable opportunities for healthy environments.]

Probe: If stakeholders discuss broadening the focus of collaborations in order to attract different sectors, try to push them to identify HOW they are doing this. (E.g., are they redefining “health” in these collaborations? Are they pushing partners to consider themselves a part of health work? Are they specifically not discussing health and letting other sectors think about it in their own terms?)

26. Thinking about social, physical, and economic environmental factors that influence health individually:
- a. Which do you think are best and least understood across sectors, and why?
 - b. For those that aren't as well understood, what success have you had at improving collaborators' (health and nonhealth) understanding of the importance of social/physical/economic factors?

*[Note: If interviewee needs examples from each category:
Social: Social cohesion, human services, religious institutions*

Physical: Built environment, sidewalks, active transport, access to healthy foods

Economic: Socioeconomic characteristics, employment, land-use mix (residential, commercial)]

27. There is sometimes a challenge in getting nonhealth sectors (e.g., schools, businesses) to focus on health

because they have competing priorities and sometimes little incentive. What has been your process for getting these partners involved and creating a demand for environmental changes?

28. *[Ask this question only for those interviewees who have cited successes with changes to policy/actual environmental changes in their communities]* Can you describe the process of working to identify, prioritize, and implement environmental improvements/policies that promote health?

Measures

29. It is often difficult to measure the association between changes in the environment and changes in health. *[An example if needed: For example, does increasing access to healthy foods change peoples' diets?]* What success have you had with measuring the health impact of environmental changes and/or policies?
30. What measures have you used?
31. Many aspects of the environment have traditionally been measured with proxy measures (e.g., segregation data as a proxy for proxy of social justice or equity in a community, retail food environment indices as a proxy for access to healthy options). What proxy measures have you successfully used?
[Note: Could be physical, social, or economic changes]
32. Beyond getting nonhealth sectors involved in environmental changes, it is often even more difficult to get them involved in measurement of those changes and the impact of changes.
- a. What success have you had with **working across sectors** to measure environmental changes and/or policies?
 - b. Are there measures that you have used successfully with these partners?

[Proceed to the miscellaneous and wrap-up questions.]

MISCELLANEOUS QUESTIONS (BIG DATA)

33. One area that we are exploring for the CoH measurement plan is the use of “big data” for capturing attitudes, beliefs, and behaviors related to health. Big data includes data mined from social media networks (e.g., Twitter, Facebook), Internet search data, etc. Do you have any experience with using this type of data in your community, or know anyone who does? If so, how are you using this information?
34. If not (or if so), what data from these sources would be useful in the future?

WRAP-UP QUESTIONS

35. Scenario question: Imagine you had two investments you could make in your community (they can be large!). Where would you put your money to support building CoH?
36. Is there anyone else from your community, or that does work similar to yours, that we should talk with?
 - a. Anyone with experience with measurement or evaluation in the area of CoH?
 - b. Any other community leaders working on building CoH?
 - c. If we reach out to these contacts, is it OK with you if we let them know you referred us to them?

THANK YOU

Thank you very much for your time. Your feedback has been extremely valuable to us. If I look back at my notes and notice I have a question, would it be OK if I contacted you back? You have my contact information [*or give it to them*]; feel free to reach out if you have any questions in the future.

APPENDIX C:

Specific Measures Identified by Stakeholders

Action Area 1: Making Health a Shared Value

Measuring the value placed on health

- Outreach and listening to consumers/communities were mentioned as ways to identify gaps and opportunities for health promotion (e.g., via community listening sessions; “America Speaks” model; community impact surveys).
- To measure the value of health:
 - Keep tabs on federal Notice of Funding Announcements for diverse health promotion initiatives.
 - Assess quality of life via community impact surveys.
 - Assess the existence/quality of “nontraditional alliances” working on community improvement (e.g., Marxist organizations working with social service agencies; youth and health care providers working together).

Measuring social connectedness

- One stakeholder suggested using items and concepts presented by Robert Putnam in *Bowling Alone* to measure social connectedness.
- Another stakeholder presented the idea of expanding the scope of what is typically covered in a primary care appointment to assess metrics such as social connectedness and support.
- Discussions included emphasis on paying attention to such indicators as social capital so as not to overlook the traditionally “intangible” (or unmeasured) benefits that community well-being provides.
- Another method mentioned was tracking numbers and frequency of attendance at trainings/talks and other events that share information about the community. The amount of information-sharing in a community may be a good indicator of social connectedness within that community.

Assessing civic engagement (related to health)

- To assess civic engagement measure, examine:
 - Voter registration among disadvantaged populations (e.g., via a ratio of food stamp recipients who are registered to vote out of total recipients).
 - Voter turn-out (e.g., exit polling when health/equity-related ballot measures are under consideration).
- Consider the lens of reflective democracy (e.g., wholeads.us database: demographics of elected officials at all levels, local to federal) and the representativeness of officials in elected office.
- Collect data on the individuals who take the initiative to contact the organization about a project in which they are interested, on requests for opening branches of the organization within their community, and on any contributions they make themselves for events related to the organization.

Action Area 2: Fostering Cross-Sector Collaboration to Improve Well-Being

Collaboration process indicators: What do collaborations look like and how are they functioning?

- Collaborative membership indicators generally describe the composition of the membership: Who is a part of the collaboration? Which organizations are (not) participating? Is the Department of Public Health involved? What percentage of board chairs is from the private sector?
- Number or diversity of conversations look at the types of conversations that are going, being captured qualitatively and by observation: Observe interactions at the first and subsequent meetings, e.g., training, to learn if people are talking to those they do not traditionally work with. There is also tracking of interactions among partners; number of partner affiliates; number of partners who are urban, rural, etc.
- Process evaluations of partnerships in progress: Stakeholder mobilization/recruitment, partners' motivation for participating, definitions of success and failure, the value each partner brings to the others (each member would have their own indicators here).
- Member involvement: Assess the attendance and participation at collaborative meetings.
- Measures of activities conducted by the collaborative: These include the number and type of activities, as well as the frequency of meetings, to determine how active the collaborative is.
- Sustainability of the collaborative: Funding sources, activities with the explicit aim of sustainability (communication activities), collaborative coordinator tenure, board structure, committee structure.
- Network mapping: Who do you know? Who do you work with?

- For successful policy changes: Who worked on the policy? How did that coalition form?

Collaboration outcome indicators: How we could determine what collaborations have been able to accomplish in the short term and how these data can be used.

- Number of grant applications/task forces coming out of those initial collaborations.
- Data that were collected as a result of collaboration; for example, schools and transportation collaboration to understand travel.
- Exposure/media coverage of findings produced by the collaboration. (For example, one organization put out a series of key statistics that have been picked up by various groups all over the region; i.e., 19 percent of all trips are made on foot or bicycle, 34 percent of students walk/bike, 38 percent of roadway fatalities are walk/bike, <1 percent funding goes to walk/bike. Public awareness of these indicators is especially important to change social norms around health behaviors.)
- Measures to determine if community organizing work is effective:
 - Number of affected people
 - Whether the advocated policy or procedural change is approved or implemented
 - How well the policy or procedural change is enforced
 - Whether there has been a change in public dialogue about the issue.

Measuring the impact of collaborations

- Number of policies passed and number of policies that have successfully changed health behavior
- Retail Food Environment Index
- A hypothetical indicator that combines food environment,

walkability, bikability, shade, etc., to create a comprehensive measure of a health-promoting environment

- A measure of business investment in communities; e.g., funding to low-income communities that resulted from nontraditional partnerships
- Tracking money that has been redirected into communities as a result of economic development work (e.g., inclusive employment practices at for-profit companies, success of small businesses offered low-cost loans to operate/hire in the community)
- In the context of health care delivery: Did increasing care coordination and implementing electronic health records across the health system actually improve outcomes? Were resources used more efficiently than with the previous model?

Capturing other anecdotal measures in use for collaboration, but transforming them into measures

- Anecdotal feedback can provide useful information on how well partners are working together, but could be transformed into a more quantitative measure.
- Community foundations have a sense for existing collaborations within their portfolios and communities.
- National organizations (e.g., national bike-pedestrian advocacy group, urban Indian organization coalition) may have an idea of the type of work being done on the ground in their sectors.
- Qualitative measures such as the composition of partners to determine the level of engagement (e.g., Chamber of Commerce participation indicates business leaders involved) can also provide useful information if collected consistently.

Measuring the existence of collaborations on a large scale

- Track language in funding announcements for “preferences given to those with a community partner.”

- Gauge extent to which agencies in different sectors share performance goals (e.g., Housing and Urban Development and Veterans Affairs aiming to end veteran homelessness).
- Measure number of collaborations based on the number of memoranda of understanding between organizations for specific health issues.

Action Area 3: Creating Healthier, More Equitable Communities

Assessing the built, social, and economic environment

- The Limited Supermarket Access (LSA) measure is noted as a useful mapping tool to identify areas with limited supermarket access.
- The Transportation Industry Mapping System provides information at the street level about accidents in California. This granular information is useful to point out problem areas and for targeting interventions.
- The Retail Food Environment Index (RFEI) encompasses both healthy and unhealthy aspects of the food environment.
- One stakeholder used pictures as a measure of social environment and residents' engagement with the community.
- Measure physical changes in the community: Policies passed (and compliance with policies)—zoning ordinances, smoke-free areas, complete streets ordinances, number of parks, miles of bike paths/complete streets, number of trees, tobacco sales and marketing, grocery stores and the Retail Food Index, existence of health-promoting institutions; pollution in different localities (e.g., CalEnviroScreen)
- Capture social indicators including disproportionality in the criminal justice system (by race/ethnicity), crime rates by geography.
- Track lifestyle and related behaviors such as the mode of

transportation to work and bike share usage data. Existing surveillance initiatives (e.g., regular statewide tobacco survey, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System) may be sources for possible measures.

- An equity profile by PolicyLink and the Program for Environmental and Regional Equity for the Mid-America Regional Council included demographics, economic vitality, readiness for the 21st century economy, and connectedness among residents and neighborhoods.
- One stakeholder uses certain measurements of resources, such as parks; improvements in existing resources, such as improved lighting on streets; increased or improved policies related to healthy living, such as policies to support parks or complete streets; and changes in resident attitudes and health behaviors.
- The Community Healthy Living Index (CHILI) is used to assess community-level support for healthy living. It includes tools to assess child care, schools, and workplaces, as well as neighborhoods and the community at large.
- The California Department of Public Health, in collaboration with the University of California, San Francisco, created the Healthy Communities Framework and proposed indicators to measure these areas: meeting people's basic needs (food, health care, water, etc.), environment, economic development, equity, and social relationships.
- Building Healthy Communities Sacramento is focusing on measuring both adult's and children's access to health care.
- The County Health Rankings include length and quality of life, health behaviors, clinical care, socioeconomic factors, and physical environment as ways to measure community health and well-being on a county level and identify areas for improvement.
- The 5210 child obesity prevention framework (five or more servings of fruit and vegetables, two hours or less of screen

time, one hour or more of physical activity, no sugary drinks per day) was mentioned as an approach that lends itself well to evaluation.

- The Social Progress Index captures areas of social progress including basic human needs (e.g., nutrition and basic medical care, personal safety), foundations of well-being (e.g., health and wellness, ecosystem sustainability), and opportunity (e.g., personal rights, tolerance, and inclusion).

Capturing the policy/investment/governance environment

- Examine whether a health promotion policy passes and whether it is implemented correctly and consistently. It is also valuable to monitor policies that might create barriers to healthy choices and environments (e.g., disconnected urban design).
- Many of the organizations we spoke to use Efforts to Outcomes software to keep track of key metrics.
- Insight Center has an Elder Economic Security Index (undated-a)
- Insight Center also leads a Metrics Matter for Economic Security development initiative that contains some suggested economic metrics (undated-b)
- Track information on whether or not states or local governments implemented certain policies and policy effects on health outcomes. There is also concern about evaluating policies already in place because it adds responsibility to schools and communities that are already overburdened. Measurement should involve questions that are simple to answer and track.
- Collect indicators such as economic inequality (e.g., Gini coefficient), workforce diversity, census tract poverty levels, educational attainment, property values, tobacco tax, credit scores of community members, prevalence/reliance on predatory lending organizations (e.g., payday lenders, check cashing centers).

- Track changes in health care utilization (e.g., asthma-related ER visits, ER visits due to homelessness); morbidity (chronic disease) and mortality; and quality of life.

Action Area 4: Strengthening Integration of Health Services and Systems

Using data for planning, research, and operational re-design

- Use mapping by ZIP codes to identify target populations and organizations working in those communities.
- Consider adverse childhood experience, as it can predict health spending, utilization, obesity, smoking, homelessness, and drug use.

Measuring the extent to which education, policies, and environment play a role in addressing community needs can be difficult

- Look at policies that promote translation and availability of information for populations speaking limited English in various settings as an indicator of “language accessibility.”
- Work “to get wait time and travel times into contracts with service providers to get proxies of adequate networks.”

Examining health literacy

- Having a measure of health care system literacy would be useful in understanding if cultural knowledge around preventive care is shifting.

Capturing inappropriate use of health services

- Having a way to measure/anticipate inappropriate use of health services would be useful. Relatedly, one stakeholder suggested charting the proportion of emergency department visits that could have been taken care of by a primary care provider.

Assessing patient care

- Measure quality and satisfaction for end-of-life patient care by incorporating information on safety, well-being, health, and social networks.

Capturing other measures currently in development

- Health plans in some communities are undergoing a transition from measuring disease to measuring health. Some potential metrics in development/early phases of implementation:
 - Centers for Disease Control and Prevention's Healthy Days measure (also a potential measure for the outcomes area)
 - PROMIS® measures as a way to measure health and quality of life holistically (Carle et al., 2015)
 - Patient-reported outcome measures and how they relate to patient goals (health and not health related).
- Social service organizations have measures for linkages between systems, such as rates of homelessness to shelters/housing, or linkages of those in social services to the health care system. There are ways to correlate reductions in emergency department visits to appropriate linkages to care. Another method could involve asking patients and providers how well they think services are connected.
- Tracking health care costs (e.g., Medicaid and Medicare cost data) and changes in costs under different delivery systems/health care models and measuring differential investment in prevention and health care (e.g., work by Glen Mays at Kentucky) will be key measures to develop in the future. However, "prevention" is often not considered broadly enough. In the Culture of Health model, consider lumping education, transit, housing, etc., in with public health in the concept of prevention.
- Healthcare Effectiveness Data and Information Set measures can provide useful information on provider performance.

Using technology to integrate patient information and care

- This can be done through patient portals, telemonitoring, automated reminders for preventive visits or screenings, or establishing a centralized repository of health records where physicians can access all the patient’s records from one location.
- Some are using “real-time monitoring through mobile phones,” while others focus on “health technology assessment work [that] looks at where we are most effective to maintain a person’s quality of life and improve it.”
- Telemonitoring for management of chronic diseases is also occurring.

General and Cross-Cutting Measurement Suggestions
Related to Building CoH

Specific measure suggestions related to CoH

- The 39 indicators in the Let’s Get Healthy California Task Force Report
- CHIS (California Health Interview Survey) data for local projects
- Bluezone Project Indicators
- Healthways Indicators
- CDC (Centers for Disease Control and Prevention) Worksite Wellness Card
- Progress in policymaking process
- Return on investment for worksite wellness programs
- Measures related to specific populations or areas of focus
 - For early childhood work: Number of children ready for school, number of organizations in a county promoting/providing early childhood services, number of children screened
 - For nutrition work: 5210 measure; WIC (Women, Infants, and Children) data and obesity; Using electronic medical records to track body mass index.

Advice for measurement of initiatives that contribute to CoH, including methodological considerations

- Keep track of the time frame required for policies to change, as these type of changes often take a long time to have an effect.
- Track health impact statements and assessments as measures of whether public decisionmaking is helping or hurting public health.
- Most of the effective measurement is done at the local level, since community members understand local conceptions of health.
 - Participatory methods of data collection are another way to engage the local community in creating CoH.
 - Participatory methods include interviews, Bellwether interview methodologies, informal one-on-one conversations, and photovoice projects. Pictures and storytelling are often effective when communicating with community members.
- Use software such as Efforts to Outcomes to track quantitative and qualitative process measures (within an organization).
- Start with existing standards of measurement, including the time frame in which change is expected. This will help establish realistic objectives, as well as a plan to track progress toward them.
- There is a lot to measure in media communications.
- Keep environmental and social justice “in the formula.”

Recommendations for using specific measures as ways of communicating about CoH

- When speaking to cross-sector groups about health, life expectancy is a good way to tell the community story about place and health.
- One way to get buy-in from non-health sectors is to use general “measures” of community well-being: “One thing

that I tried to sell the people is, ‘what kind of community do we want to live in?’” This includes explicitly stating the argument for health equity: “You know, do we want to live in a community with the other side of the tracks? I don’t want another side of the tracks. I just want us all to have all good schools and all good clinics and all good housing.”

- Rely more on “evidence” than data to tell the story: “. . . I think that we need to have the data but that’s not actually going to be what convinces people. It is going to be like evidence . . . This community looks different . . . this school looks healthier.”

APPENDIX D: Summary Table of the Frequency and Saliency of Themes Coded

Theme	Code	Number of Interviews or Focus Groups That Mentioned Theme (%)	Total Number of Times Theme Was Mentioned Across All Interviews or Focus Groups
Domain 1: Conceptual Development of the CoH Action Framework			
Concept of CoH is intuitive, important, or appealing to stakeholders	INTUITIVE	14 (17%)	16
Phrase “ <i>culture of health</i> ” would not be seen as inclusive of all stakeholders	NOTINCLU	10 (12%)	14
Phrase “ <i>culture of health</i> ” too health-centric or focused and could marginalize some stakeholders	HLTHFOCUS	7 (8%)	9

Local community (organizations and residents) leadership is essential for fostering CoH	LEAD	18 (22%)	55
Work on multiple levels from individual to organizational to system to build CoH	LEVELS	22 (27%)	23
Data and evaluation are needed to inform tracking or decisionmaking related to CoH	DATA	17 (20%)	32
Data and evaluation are not being collected/ conducted because of limited capacities and other conditions	NODATA	9 (11%)	16
Difficult to garner support for policy interventions because CoH strategies may be costly in the short-term and/or may not return on investment during a traditional political cycle	POLBAR	6 (7%)	13
Suggestions for how to overcome the barriers to policy interventions (goes hand-in-hand with POLBAR)	POLFAC	8 (10%)	16
CoH interventions and changes take a “long” time to show returns	TIMEFRAME	10 (12%)	12
Need for continued education and outreach about health directed at the general public to generate CoH	EDUC	12 (14%)	25
Need for culturally sensitive or locally tailored education to the public to improve the uptake of CoH messages	CULEDUC	10 (12%)	23

Practices specific to including marginalized populations in the conception and operationalization of CoH	INCLUDE	18 (22%)	35
Need to include incentives that show that health and promoting CoH is “good for business”	BUSINESS	5 (6%)	15
Business focus on CoH is aligned with or demonstrates social entrepreneurship or responsibility	RESPONSIBILITY	2 (2%)	2
Business focus on CoH may be attractive to investors	ATTINVEST	7 (8%)	12
Advocacy and education of organizational partners are an important part of building CoH, particularly to push policy changes and implementation of new activities or strategies	ADVOCACY	25 (30%)	62
Leveraging new technologies (e.g., health, information technology, etc.) is a key part of building CoH (Note: should not be used for social media or big data)	TECHNOLOGY	11 (13%)	16
Need to consider individuals’ larger social context or environment when determining factors that may be influencing their health	ENVCONTEXT	27 (33%)	46
Social media and big data are powerful tools that should be leveraged for CoH	SOCMEDIA	7 (8%)	10
Partners reporting that they collect or utilize social media or big data	BIGDATA	7 (8%)	9

One reason to use social media or big data is because they give you access to real-time health behavior or patient-experience data	REALTIME	3 (4%)	3
Another reason to use social media or big data is that when aggregated they tell a powerful story of the impact of policy changes or other CoH efforts	AGGREGATE	3 (4%)	3
Domain 2: CoH Implementation Processes			
<i>Action Area 1: Making health a shared value</i>			
Example of an initiative or activity focused on promoting social cohesion or shared values	EXP-SVSC	17 (20%)	30
Strategies that have worked to improve individuals' view that their health is (or health-promoting activities are) important or a priority or to improve the value that individuals place on being healthy	INDPRIORITY	12 (14%)	16
Need to make health a priority in other sectors (e.g., transportation, education) if it is to become a shared value	ORGPRIORITY	9 (11%)	15
A major goal of the CoH initiative should be fostering a sense of community or social cohesion	SOC	8 (10%)	11
Need for a common and shared language and understanding of what building a culture of health is trying to accomplish	LANGUAGE	9 (11%)	24

Need to build new skills among health professionals to engage in CoH activities, such as discussions about social norms	NEWSKILLS	12 (14%)	17
Need to culturally tailor CoH process use to create shared values—it is not a one size fits all process	TAILOR	13 (16%)	24
There is overlap between a community's civic engagement and its CoH activities to promote social cohesion/shared values – need to activate or leverage this civic engagement to maximize CoH work	CIVICENG	10 (12%)	15
Need to empower and integrate resident perspectives, as well as those of experts, into CoH activities promoting shared values and social cohesion	BOTTOMUP	22 (27%)	41
<i>Action Area 2: Fostering cross-sector collaboration to improve well-being</i>			
Example of an initiative focused on promoting cross-sector collaboration	EXP-MSD	38 (46%)	66
Cross-sector collaboration essential or important to building CoH	COLLABIMP	29 (35%)	41
Need a broad and diverse range of collaborators to make CoH effort successful	DIVERSECOLLAB	35 (42%)	58
Defining prevention and health broadly helps bring in more collaborators	BROADLANG	15 (18%)	25
Need to define some common motivations or shared goals among collaborators to attract diverse stakeholders	COREMOTV	19 (23%)	39

Need to be cautious of being overly broad, a narrow focus may help to improve clarity of messaging, establish a clearer direction, etc.	NARROW	3 (4%)	3
Need for traditional leaders (e.g., politicians, religious leaders) and governmental support to engage with CoH efforts	TRADLEAD	20 (24%)	42
Need for nontraditional partners to take a leadership role on CoH efforts (e.g., venture capitalists, for-profit companies)	NONTRADLEAD	14 (17%)	23
Need to articulate the economic benefits for cross-sector collaboration to sustain commitment to CoH over time	ECOBENEFIT	10 (12%)	17
Need for strategies to maintain consistent participation in CoH efforts over time (e.g., continuity plans to withstand staffing changes)	CONSTPART	14 (17%)	17
Competing priorities, motivations, timelines, etc., can challenge cross-sector collaboration	COMPRIORITY	17 (20%)	25
May be difficult to measure the extent or quality of partnerships and their impact on CoH efforts	MEASPART	3 (4%)	6

Description of practices for supporting collaborations between the health care/ public health sectors and other sectors, including partnerships with stakeholders that are leading the field in integrated health approaches	PARTSTRATGY	27 (33%)	69
Need funding to support collaboration	MSCFUND	16 (19%)	29
Strategies for identifying which stakeholders are the key partners to bring to the table	IDPART	13 (16%)	23
Strategies for developing consensus across sectors on the roles that different environments (e.g., social, physical, and economic) play in supporting health	PARTAGREE	8 (10%)	20
<i>Action Area 3: Creating healthier, more equitable communities</i>			
Example of an initiative focused on promoting equitable opportunity for healthy choices and environment	EXP-ENV	29 (35%)	53
Description of successful prior initiatives that communities have used to create a physical environment with equitable opportunity for healthy choices	STRATENV-PHY	21 (25)	56
Description of successful prior initiatives that communities have used to create a social environment with equitable opportunity for healthy choices	STRATENV-SOC	13 (16%)	19

Description of successful prior initiatives that communities have used to create an economic environment with equitable opportunity for healthy choices	STRATENV-ECO	12 (14%)	19
Communication, media, and messaging play an important role in shaping the environment and should be targeted as part of an environmental strategy	ENVCOMM	13 (16%)	27
Description of activities to shape communication/ media messages	COMMMSG	5 (6%)	5
Description of activities to address advertising related to health risk behaviors	COMMRISK	0 (0%)	0
Need to consider health in all policies or leverage a broad approach to create a healthy environment	HLTHALLPOL	11 (13%)	16
Need to integrate or leverage existing, yet nontraditional, community resources (congregations, businesses, etc.) regularly used by community members to offer healthy resources	INTEGRATENV	8 (10%)	8
<i>Action Area 4: Strengthening integration of health services and systems</i>			
Example of an initiative focused on promoting quality, efficiency, or equity in health/health care systems	EXP-HCQ	26 (31%)	50
Equity and overcoming barriers for all community members is a foundation to building CoH	EQUITYIMP	20 (24%)	29

Strategies that have worked in the community to move toward achieving a balance between prevention and health care services	BALPREV	5 (6%)	8
Specific mentions of changing the balance in funding to achieve better balance between prevention and health care services	BALFUND	3 (4%)	3
Specific mentions of changes to staffing needed to encourage better balance between prevention and health care services	BALSTAFF	1 (1%)	2
Focusing on a single health need may help to identify strategies for more-integrated care	FOLLOWNEED	1 (1%)	1
Need to use a more-integrated care model (alternative medicine, social services, prevention) to build CoH	INTGMODEL	10 (12%)	16
To improve care system to better promote CoH, need better coordination between health and other major systems in a community	CARECOORD	7 (8%)	9
Describes an actual example of a new or innovative integrated or reenvisioned health system or model being used by one of the communities	INTGEXMPL	9 (11%)	15
Describes the value and benefits of new health care structure and delivery models such as accountable care organizations and patient-centered medical homes	ALTMODEL	6 (7%)	9

Need to track and improve patient experience and engagement; need to balance this with quality-of-care improvements	PATIENTEXP	7 (8%)	11
Need to support linkages between the health care system and other social and public health services	CARELINK	8 (10%)	15
Need to offer care in nontraditional spaces, such as retail clinics; and coordinating care accessed here with other services	ALTCARE	3 (4%)	3
Domain 3: CoH Measures			
Need for more or better measures to track the progression from health opportunity to actual change in the health environment	MEAS-ENV	7 (8%)	8
Need for more or better measures to capture the balance across prevention- and treatment-focused systems	MEASBAL	2 (2%)	2
Need for more or better measures to capture community attitudes and shared values around the culture of health	MEASSVSC	4 (5%)	5
Need for more or better measures to track the contributions of different sectors to health measured in the community	MEASSECTOR	6 (7%)	6
Need for more or better measures to capture system-level changes that lead to an improved CoH	MEASSYS	13 (16%)	16

Need to identify measures or methods for capturing the extent to which the voice of traditionally marginalized populations is present in health-related decisionmaking in communities	MEASMARG	3 (4%)	3
Need to identify indicators or measures of community activation around health issues	MEASACTV	8 (10%)	14
Need to identify indicators or measures that can create completion among communities to 'get healthy' or build CoH	MEASCOMP	6 (7%)	6
Need to identify indicators or measures of the quality of interactions by different sectors	MEASPARTQL	3 (4%)	4
Need to identify indicators or measures of the stakeholder capacity for evaluation	MEASEVAL	1 (1%)	1
Need to identify indicators or measures that use social media for tracking progress on CoH efforts	MEASSOCMED	2 (2%)	2
Specific measure suggestion or feedback on RAND-proposed measure for the health environment measures	SUGMEAS-ENV	24 (29%)	56
Specific measure suggestion or feedback on RAND-proposed measure for the cross-sector collaboration measures	SUGMEAS-MSC	14 (17%)	27
Specific measure suggestion or feedback on RAND-proposed measure for the shared values and cohesion measures	SUGMEAS-SVSC	13 (16%)	26

Specific measure suggestion or feedback on RAND-proposed measure for the measures of health care quality, efficiency, etc.	SUGMEAS-HCQ	16 (19%)	29
Need to identify indicators or measures that use social media for tracking progress on CoH efforts	MEASSOCMED	2 (2%)	2
Specific measure suggestion or feedback on RAND-proposed measure for the health environment measures	SUGMEAS-ENV	24 (29%)	56
Specific measure suggestion or feedback on RAND-proposed measure for the cross-sector collaboration measures	SUGMEAS-MSC	14 (17%)	27
Specific measure suggestion or feedback on RAND-proposed measure for the shared values and cohesion measures	SUGMEAS-SVSC	13 (16%)	26
Specific measure suggestion or feedback on RAND-proposed measure for the health care quality, efficiency, etc., measures	SUGMEAS-HCQ	16 (19%)	29
Specific measure generally applicable to CoH, but does not fit in area	SUGMEAS-GEN	17 (20%)	25

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Since 2013, the Robert Wood Johnson Foundation (RWJF) has embarked on a pioneering effort to advance a Culture of Health. The Culture of Health action framework is founded on a vision in which “everyone in our diverse society leads healthier lives now and for generations to come.” To put the Culture of Health vision into action, RWJF asked RAND Health to support the development of an action framework and measurement strategy. This report summarizes the stakeholder engagement efforts that RAND used to inform this work. It draws on a series of interviews and focus groups that RAND researchers conducted with stakeholders both within and outside the United States. It should be of interest to RWJF, as well as to those individuals and organizations interested in advancing the Culture of Health action framework. Given that RWJF is focused on using the Culture of Health action framework and measures to catalyze national dialogue about content and investments to improve population health and well-being, the report should be beneficial to a range of national, state, and local leaders across a variety of sectors that contribute to health as described by the Culture of Health action framework.



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