Five percent of Americans, most with poly-chronic disease—many of which are (or may be) preventable—account for close to 45 percent of the massive $2.6 trillion total spent in health care. Over the long term, it’s clear that the only way to flatten the health care spending curve is by investing in wellness and prevention.¹

For the past six months, Hope Street Group, with funding from the Robert Wood Johnson Foundation, convened a core group of diverse stakeholders—ranging from employers, government, schools, and faith institutions to hospitals, universities, non-profits, and media—to consider how to build and sustain a Culture of Health focused on prevention, in efforts to tip the scales on our nation’s health crisis. After further integration of their unique ideas, we sought to a) provide a landscape analysis to identify roles, limitations, and the underlying motivations for each stakeholder to participate in a community health initiative and b) provide principles and recommendations for these stakeholders to consider when stimulating action. For more information on our process and program scope, please refer to Appendix A.

¹ T. Main and A. Slywotzky, The Volume-to-Value Revolution: Rebuilding the DNA of Health from the Patient In, Oliver Wyman Health Innovation Center, 2012.
As defined by the Robert Wood Johnson Foundation, a Culture of Health IS ONE IN WHICH:

1. Good health flourishes across geographic, demographic and social sectors.
2. Being healthy and staying healthy is valued by our entire society.
3. Individuals and families have the means and the opportunity to make choices that lead to healthy lifestyles.
4. Business, government, individuals, and organizations work together to foster healthy communities and lifestyles.
5. Everyone has access to affordable, quality health care.
6. No one is excluded.
7. Health care is efficient and equitable.
8. The economy is less burdened by excessive and unwarranted health care spending.
9. The health of the population guides public and private decision-making.
10. Americans understand that we are all in this together.

Increasing Visibility of Community Health Initiatives

“Seeing a culture of health from a bird’s-eye view means taking in the bigger picture of what defines health in America—how health will always be linked to health care, but also extends to work, family, and community life.”

Risa Lavizzo-Mourey
Robert Wood Johnson Foundation President and CEO

The most organic place for any Culture of Health to start budding is on a localized level, as each community has different needs and resources to address its most critical health interventions. Community engagement can be utilized as a means of connecting these resources. Community engagement, as the Center for Disease Control (CDC) and Prevention has defined it in the context of wellness and health promotion, is “the process of working collaboratively and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people.”

As the CDC notes, “It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members.”

The climate is ripe with burgeoning community health initiatives already underway from multi-sector pioneers that exist in this space. Moreover, the construction of communities that promote healthy living is becoming a spotlight of regional to national attention through collaboratives including LiveWell Omaha and Healthy Living Minneapolis (see next page for other notable examples).

It is also important to highlight the leadership role employers are and could be playing in such initiatives, especially when partnered with Employer Wellness Programs (EWPs) that are actively on the rise. Just over half (51%) of large U.S. employers (those with 50 or more employees) have an EWP, giving nearly three quarters of our workforce access to one. Increasing adoption of EWPs is also trending among smaller employers who might normally lack the resources or bandwidth to run them, driven in part by the growth in outsourcing options for wellness programs and the increasing inclusion of wellness programs in health insurance plans.

Notable and Proven Community Health Initiatives

MiHIA: The Michigan Health Information Alliance, Inc., or MiHIA, is a diverse group of stakeholders collaborating together as a nonprofit organization to improve health and health delivery in central Michigan. This formal community collaboration is designated to build a health care system in which consumers, providers, and payers make decisions based on the value and quality of care.

LiveWell Omaha: Working across several partners, including schools, businesses, faith communities, nonprofits, and government, LiveWell Omaha seeks to cultivate a physical and cultural environment that encourages residents to make healthy choices.

Healthy Living Minneapolis: Healthy Living Minneapolis works on increasing access to healthy foods, reducing smoking, and promoting walkability and bikeability.

Charting the Course: United Way of Metropolitan Dallas and the Committee for the Improvement of Child Health, which was launched by the Dallas Regional Chamber, developed a coalition—Charting the Course—of more than 60 key organizations, community leaders, and stakeholders in the region that are committed to improving children’s health. The group’s task is to collectively develop a strategy for fully engaging the community’s expertise and resources to eradicate childhood obesity in Dallas County by 2020.

Accountable Care Community: The Austen BioInnovation Institute in Akron Ohio’s Center for Community Health Improvement, in response to the nation’s need for a collaborative and shared approach to community health, is leading the effort to usher in a new health culture in the Akron region by developing an Accountable Care Community (ACC). ACC is a new health model which aims to foster collaborations born of shared responsibility among various sectors in order to transform health in Northeast Ohio.

Healthy Eating, Acting Living: Healthy Eating, Active Living (HEAL-SLO) in San Luis Obispo, CA, works across sectors and stakeholders to increase healthy eating and physical activity among residents.

Challenging Barriers for Broader Engagement

Despite the increasing visibility of community health initiatives, there still remain fundamental barriers to mobilization. First, there must be a clear and categorized business case for sustained investment. However, the narrative has not been made strong enough for a natural correlation to be at the forefront of the minds of stakeholders. Improving public health is a core driver for GDP growth in countries around the world, but per capita health care spending in the United States continues to be the highest in the world. The median expenditure among Organisation for Economic Co-operation and Development (OECD) countries is around $3,000 per person, while in the United States, it is more than $8,000 per person. Moreover, for nearly all indicators of mortality, survival, and life expectancy, the United States ranks at or near the bottom among high-income countries.

Framing continued investment as an economic development and competitiveness advantage would be a particularly fruitful way to strengthen the business case for community health initiatives.

Another significant barrier is that public policies and policy departments are not always conducive to normalizing healthy outcomes that would directly align with community health initiatives. Policies that impact food access, food consumption, physical activity, access to educational information, recreational land use, transportation, and community safety must be modified and revamped to have a measurable effect on a community’s health. Policy leaders must aid in shifting the perspective towards health, not just health care and towards prevention, not just disease. This shift must be echoed from the national to the local level to foster investment in the health marketplace instead of solely on health care policies.

Additionally, each community faces different needs and is equipped with different resources—making it difficult for a ‘one size fits all’ approach to achieve sustained impact. All too often, there is a disconnect between the decision makers who manage a coordinated effort and the community’s actual needs. Due to

“We need communities that are designed to promote healthy outcomes, with the healthy choice being the easy choice.”

Marice Ashe ChangeLab Solutions Founder and CEO

5. 2013 Annual Report, America’s Health Rankings, International Comparison, UnitedHealth Foundation.
The top five indicators in the Robert Wood Johnson Foundation report, *Collaboration to Build Healthier Communities*, that prevent collaboration between the health and community development sectors include:

- Inadequate funding and resources
- Lack of shared vision and common goal
- Lack of skilled leadership
- Lack of mutual understanding and respect among partner organizations
- Lack of well-established relationships and communication links with potential partner organizations

the lack of coordination and assessment, most initiatives are not evaluated using an effective feedback loop directly collecting data and connecting the impact from the individuals in the community to the program leads—creating a very siloed effort to shift behavior. Simple tools must be developed for participants to provide consistent input for any initiative to achieve scaled change.

Subsequently, community health initiatives require a multitude of diverse stakeholders to not only initiate dialogue, but also to create a shared language around aligned goals and responsibilities for execution. Often, stakeholders are at a loss as to how to begin this dialogue without one stakeholder taking on full responsibility as the facilitator or coordinator. Referred to as the ‘backbone’ organization, this facilitator of an effective leadership team does not exist naturally, which can cause the initiative to be fundamentally flawed.

Lastly, we must formulate initiatives that support family engagement tactics. For example, in the case of EWPs, surveys indicate that less than half (46%) of the employees at the average large employer actually take a health assessment or screening, a percentage that would likely increase if spouses and families were to intervene. And while family participation increases the likelihood of success with behavior changes, there are limitations with some government policies and privacy regulations that make it risky or impossible for employers to incentivize or track participation. This environment creates an added barrier to the already fragmented business case behind being involved and/or taking a leadership role in a wider community health initiative.

Identifying Stakeholder Roles, Motivations & Limitations

The necessary and most efficient response to breaking down these barriers, amongst other challenges, is to identify a wide range of potential community stakeholders and develop more clarity on aligned roles to more easily assess the environment and opportunity for coordination. Hope Street Group convened over 55 leading employers, health care experts, clinicians, policymakers, health services researchers, foundations, economists, business professionals, and entrepreneurs. We then identified the motivational levers driving each stakeholder to participate in community health initiatives and subsequently, the limitations that sent them braking.

Refer to the checklist on pages 10-11 for a landscape visual of shared roles, motivations, and limitations highlighted during our convenings. The purpose is to provide not only the commonalities to drive initial engagement and goal setting, but to connect stakeholders based on their needs and limitations (e.g., connecting institutions with limited staff capacity to the stakeholders who could offer staffing, expertise, or volunteers; identifying and aligning funding resources, direct or indirect, with those who have limited funding and resources; and coordinating those who have expertise on the issues to those who could broadly disseminate the information to the public).

Perhaps most important is to understand why each stakeholder would be motivated to engage in a community health initiative. Each would require significant undertaking and increased capital, most often in the vein of precious financial and human resources. However, we uncovered that there exist many motivational levers for potential collaboration across stakeholder groups. Although the direct impact, gratification, and recognition attributed back to the specific stakeholder will consistently be a driver, many of our stakeholders were more concerned with investing in their community’s economic growth and specifically, talent retraction for a more productive workforce. Spanning government to employers to the economic development community to universities, this was a motivation that many not only felt connected to, but responsible for.

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Ideas for Collaboration: K-12 schools with limited budgets could get sponsored by a large employer to grow a garden at school, which in turn could generate media coverage. The expertise of a local civic nonprofit and public health department on child obesity could aid state or local governments in crafting a new regulation on consumption or incentivizing to buy local food products. Urban planning departments could work alongside of community development finance institutions on zoning and acquiring approvals for healthy planning. Chambers of Commerce could incentivize and build momentum amongst their employer network to volunteer with nonprofits and schools educating on health and change behavior. Foundations, K-12 schools, and universities could coordinate wellness initiatives across their environment to incorporate institutionalized activities like walk or bike-a-thons. Community organizers could help policy leaders distribute educational information to the public on diet, exercise, tobacco, breastfeeding, etc. There are a multitude of ways that community stakeholders could act as an interconnected web of change agents to tip the scales on our nation’s health crisis.

Shifting the landscape to a Culture of Health is a shared endeavor and every stakeholder has multiple roles to play. A number of stakeholder roles overlap—from media and philanthropies that act as mass scale advocates of public awareness to the community organizers and local nonprofits working to mobilize at the grassroots level. Employers, local government, and nonprofits (as in the case of the aforementioned LiveWell Omaha initiative) were identified as potential “backbone” organizations for launch and project management.

There also exist a number of stakeholders that would have direct influence on essential policy changes and/or incentives if effectively coordinated, which could lead to longer term focus and sustained investment for health throughout a community. Simultaneously, it is important to harness leadership or political clout to recruit and build momentum with other identified stakeholders that traditionally would not be involved. The limitation that presents itself in this scope is sustained leadership. In many cases, it is a politician or appointed official driving efforts in a community and due to standard electoral changes, his/her programs are not deemed a priority and are dropped when new officials are elected (unless an initiative has already been well established). Coupled with this limitation is the challenge that when there is an unstable or specific issue-driven political climate, there are little funds or attention remaining for this type of initiative in the public sector. However, this is an opportunity for other stakeholder groups to intervene and carry the torch so that a promising initiative doesn’t die out prematurely.

We also identified that the best employer-driven or public/private partnerships connect on some type of aligned public goal or resonate with a high volume of employees. In these partnerships, the direct investment in the community is apparent. But one overarching limitation among a number of stakeholders is competing priorities and demands for funds. For example, increasingly employers are investing in corporate responsibility programs and must compete with other social needs such as education, housing, and food security—making it difficult to address health as the number one priority. The financial resources needed to sustain these partnerships are thus not easily earmarked to do so. However, this is where the expertise of policy experts who subscribe to a holistic systems approach to social change could be leveraged. Stakeholders do not need to choose between priorities, but rather need to see the interconnectedness of all these “social determinants of health” in driving improved outcomes.

The most fundamental piece of shifting consciousness towards a Culture of Health is the will to work together and redefine health in the collective context. The checklist of potential stakeholder roles, motivations, and limitations that follows simply serves as a baseline for identifying areas of symbiosis across a community’s vital ecosystem. Employers could access resources to more effectively implement the behavior changes that will lead to decreased health expenditures, while an array of stakeholders could act as essential conveners to spur the shared goals and commitments critical to making collective impact.
### Stakeholder Checklist

#### ROLES
- ‘Backbone’ organization
- Core convener
- Source of funding
- Staff provider
- Expertise provider
- Policy maker
- Policy and change advocate/influencer
- Public awareness/community educator
- Media champion
- Volunteer capacity
- Key engagement partner or stakeholder recruiter
- Provider of location/physical space
- Centralizer and disseminator of best practices
- Critical to feedback loop
- Implementer of change behavior or provider of support

#### MOTIVATIONS
- Part of core mission or relates to mission
- Public/community relations or public recognition/praise
- Securing help with fundraising or additional sources of funding
- Improved ability for recruitment of talent/members/faculty
- Increased political support/popularity
- Direct/measurable impact
- Desire to reduce health spending/costs
- Happier/more productive lifestyle
- Realization of ROI in economic development and GDP

#### LIMITATIONS
- Lack of funding/limited funding/budget constraints or inconsistency
- Staff capacity
- Competing priorities
- Dependent on favourable political/business climate
- Political pushback or electoral transitions
- Lack of effective community assessment tools
- Difficulty with change behavior
- Unease/disconnect of collaborating with other institutions or stakeholders

### Chambers of Commerce/Economic Development
- Community Organizers
- Employers
- Community Development
- Finance Institutions
- Faith Institutions
- Hospitals
- Individuals/Families
- Federal/State Government
- K-12 Schools
- Joint Government
- Rural/Urban
- Public Health
- Urban Planning
- Public Health Department
- Philanthropies/Foundations
- Universities
- Stakeholders
Recommendations for Stimulating Action

After thorough examination of these shared roles, motivations, and limitations, we generated the following initial principles and recommendations for stakeholders to consider when constructing a community health initiative.

Spark Collaboration and Motivation Through Language:
Language is a critical tool for effectively framing the issue and building a campaign to motivate the paradigm shift towards the unilateral advancement of health. There must be a shared language and a marketing campaign to encourage various stakeholders to collaborate and take a leadership role in the initiative. To stimulate progress, it is necessary to identify the common denominators—as referred to in the checklist—between all stakeholders and recruit either a third, neutral party or identify an existing stakeholder to act as the ‘backbone organization.’

A related option is to structure a Steering Committee consisting of motivated individuals and experts (e.g., from a Chamber of Commerce, an employer, and/or a nonprofit) who could tap into their current network to build credibility and support around the initiative.

Accordingly, we recommend that stakeholders:

CREATE a diverse steering committee or council (making sure representation is inclusive of groups faced with health/economic disparities)—possibly by nominations and confirmed through voting—and publicize mission and impact to enhance accountability

ENLIST third party facilitators or ‘backbone’ organization to bid pro bono due to public recognition for the winning proposal, or employers and/or foundations could pay for this service

Create Opportunities for Stakeholder Engagement:
The ‘backbone’ organization would first create a leadership group with community representatives at the table. There needs to be significant time spent on uncovering the common ground, articulating what matters most to each party so that a priority list can be generated. Based on this list, the group would identify new or existing resources to launch an initiative and directly connect progress and accountability back to core leads.

Without spending the proper time on identifying the commonalities upfront as a combined group, there is little hope for a sustained effort. Once this is done, the group would need to create a strong, broad media campaign to influence others in their community to join the cause and use applications, promotional items, and resources to support success.

Accordingly, we recommend that stakeholders:

RECRUIT thoughtfully (through steering committee or council) other stakeholders critical to implementation and specific to the community’s needs

CONVENE in-person and online to confirm shared vision, goals, and baseline metrics, putting time and effort into building out a work plan

INVOLVE a marketing expert or firm early in the process, building ‘skin in the game’ for pro bono services for launch campaign if possible

CREATE a marketing committee to discuss and deliver best tools to enhance the community’s knowledge base and participation

ENGAGE entrepreneurs in the community and apply their knowledge and skills to scale best practices

MAKE the issue nonpartisan

Engage the Community:
To effectively engage the community, it is important to use various tools of outreach, including mobile technology, social media, traditional media, and human capital, so that a common understanding and need on the issues is generated. If this is done correctly, the core leads will be able to access resources to run experiments that have buy-in from the community (making sure effective branding is utilized so good programs don’t get overlooked).

After these experiments, it is key to find out the lessons learned and share best practices with communities to create an effective feedback loop. It is critical that leaders not blindly adopt, but rather adapt lessons to other communities, and that such actions be eventually translated to policy to scale the change that is working.

Accordingly, we recommend that stakeholders:

LEVERAGE technology and social media to accelerate smart outreach processes and provide a clearer path to true assessments and feedback

ENACT multi mobile user assessments, making it easy for the community to engage and be flexible

COORDINATE educational opportunities regarding health and change behavior through institutionalized systems and networks such as schools, churches, community organizations, etc.

FACILITATE volunteer opportunities, perhaps launched or coordinated through regional employers, to survey/assess the community via events, campaigns, or going door-to-door

ALIGN employer education social responsibility programs to broader health endeavors

CREATE a clearinghouse for community resources so there is a one-stop place to get information for engagement

IDENTIFY and recruit employers to highlight proven strategies and evidence based best practices on safety, health benefits, community engagement, volunteerism, tobacco free workplace policies, family friendly policies, etc.

PERSONALIZE the message and outreach methods using hand-written notes and photographs, making the content more attention grabbing

STRENGTHEN policy advocacy efforts and influence by engaging the community in the process

ENSURE that local public policy is closely aligned with the desired health outcomes
Identified Best Practices to Stimulate Community Health Initiatives

Companies need to be creative and build wellness programs dependent on a company’s own culture (i.e., what works for one might not work for another).

Employers must take a role within their community to spur leadership to cultivate a Culture of Health.

Community stakeholders need to encourage and advocate for policy changes, not just good projects, as policy changes are more sustainable.

Localities need to weave departments and systems together to further and sustain collaboration.

Stakeholders need to leverage motivations to work together.

Solutions need to be solved at a systemic level, not as one-time interventions.

Stakeholders have to identify and embed health into how they operate and do business to fundamentally shift the health behavior of those in their communities.

Collaborative models need to focus on those with the most disadvantages and barriers to success—if we can solve for those barriers, we solve for everyone.

There should be more accountability and return on capital.

Unlock Resources to Fund Initiatives:

The following provide high-level options to further flesh out the principles and recommendations for stimulating action. Before each, Hope Street Group recommends continued dialogue to dive deeper into the landscape, roles, and recommendations provided in the paper to further define the structure and determine the most important information for collective engagement. It is critical to identify and connect a diverse network—from experts at the national level to practitioners and change agents on the ground, coupled with cases studies focusing on system wide change—to identify the best practices and together, integrate the players for a true chance at scaled change. It is vital to not replicate the good efforts that are happening in pockets across the country, but leverage that work together for catalytic system change. Beyond this initial next step, the following are recommendations to test partnership developments, learnings, and impact.

These recommendations must be tested in a very practical sense to understand and track the process including challenges, loopholes, and missing elements of partnership engagement. To test effectively, we propose the following three tangible projects:

1. Partner Pilots: Partner with specific city departments to pilot the ideas and collaborative techniques highlighted above, convening institutions already laying the ground work but offering additional resources for outreach and partnerships, with a lens towards engaging employers, technology entrepreneurs, and local economic developers to drive and sustain impact that promotes vitality. A secondary step includes sharing the lessons learned through data collection and synthesis, and problem solving with a wider health network so that resources can be invested in what we know works.

2. Playbook: Create a Playbook or guide of best practices with clear instructions and examples to stimulate initial stakeholder dialogue and recommendations for sustaining community initiatives. Essentially, the Playbook would involve the construction and ongoing support for a toolkit for community representatives and local leaders to spur progress in their locality on enhancing a Culture of Health. This Playbook would allow for other institutions and organizations to post lessons learned and identify barriers, best practices, and both traditional and nontraditional partners—operating as a clearinghouse to break down the elements of scaled initiatives that have been effective.

A secondary component of this effort is to expand the research to design and implement a transferable model that would be shared with a network of communities aligned to health and well-being.

3. Leverage institutions that have community engagement offices to pilot and refine a case for repurposing them: Convene content expert stakeholders who codify proven best practices through online efforts (Playbook) or in-person. Profile and engage the sorts of people who can effectively galvanize and lead health transformations in a community and articulate the clear value proposition and case for why this sort of engagement is high value-added. Present this case for expanding proven interventions that yield results—through membership organizations with significant reach to leaders and decision-makers who already employ community engagement personnel—to get them on board with repurposing resources towards activating and accelerating a transferable model. Facilitate and test this approach in a pilot with a select group of stakeholders, and then refine and replicate it with several other similar membership organizations.

Accordingly, we recommend that stakeholders:

**LAUNCH** unique partnerships—for example, between medical colleges who have financial capital and engagement officers who can formulate effective distribution models—and package depending on a community’s needs

**ASSESS** current resources across community stakeholders, repackaging message to align with broader economic impact and community reinvestment initiatives

**BUILD** a peer network to communicate resources and best practices via regional hospitals, public health departments, community organizers, etc.

**CONNECT** private capital with public/government funds

**ESTABLISH** a structured and appointed leadership council or health governing board to manage the local initiative and translate outcomes to appropriate funds

**BASE** efforts as a long-term, regional economic benefit

Recommended Testing Options

**Testing Options**

The following provide high-level options to further flesh out the principles and recommendations for stimulating action. Before each, Hope Street Group recommends continued dialogue to dive deeper into the landscape, roles, and recommendations provided in the paper to further define the structure and determine the most important information for collective engagement. It is critical to identify and connect a diverse network—from experts at the national level to practitioners and change agents on the ground, coupled with cases studies focusing on system wide change—to identify the best practices and together, integrate the players for a true chance at scaled change. It is vital to not replicate the good efforts that are happening in pockets across the country, but leverage that work together for catalytic system change. Beyond this initial next step, the following are recommendations to test partnership developments, learnings, and impact.

These recommendations must be tested in a very practical sense to understand and track the process including challenges, loopholes, and missing elements of partnership engagement. To test effectively, we propose the following three tangible projects:

1. **Partner Pilots:** Partner with specific city departments to pilot the ideas and collaborative techniques highlighted above, convening institutions already laying the ground work but offering additional resources for outreach and partnerships, with a lens towards engaging employers, technology entrepreneurs, and local economic developers to drive and sustain impact that promotes vitality. A secondary step includes sharing the lessons learned through data collection and synthesis, and problem solving with a wider health network so that resources can be invested in what we know works.

2. **Playbook:** Create a Playbook or guide of best practices with clear instructions and examples to stimulate initial stakeholder dialogue and recommendations for sustaining community initiatives. Essentially, the Playbook would involve the construction and ongoing support for a toolkit for community representatives and local leaders to spur progress in their locality on enhancing a Culture of Health. This Playbook would allow for other institutions and organizations to post lessons learned and identify barriers, best practices, and both traditional and nontraditional partners—operating as a clearinghouse to break down the elements of scaled initiatives that have been effective.

A secondary component of this effort is to expand the research to design and implement a transferable model that would be shared with a network of communities aligned to health and well-being.

3. **Leverage institutions that have community engagement offices to pilot and refine a case for repurposing them:** Convene content expert stakeholders who codify proven best practices through online efforts (Playbook) or in-person. Profile and engage the sorts of people who can effectively galvanize and lead health transformations in a community and articulate the clear value proposition and case for why this sort of engagement is high value-added. Present this case for expanding proven interventions that yield results—through membership organizations with significant reach to leaders and decision-makers who already employ community engagement personnel—to get them on board with repurposing resources towards activating and accelerating a transferable model. Facilitate and test this approach in a pilot with a select group of stakeholders, and then refine and replicate it with several other similar membership organizations (e.g., academic medical centers, community hospitals, universities, schools of public health, and conferences of mayors).
Conclusion

All community stakeholders, despite competing priorities and varied motivations, share a vested interest in tipping the scales to reverse the downward spiral of our nation’s health spending on chronic diseases. Yes, there are very real and seemingly concrete barriers that exist in this space, which is why no one stakeholder can act without solidarity to achieve collective impact. We must work together to accelerate the growth of a Culture of Health by:

- Tectonically shifting the way we view the issue of strengthening health from solely an individual concern to a broader community endeavor
- Realigning decision-making at the higher level to connect back to what communities actually need
- Creating a marketplace and modifying financial resources that value health and outcome-based evidence
- Constructing wellness programs that are built from best practices, with the integration of wellness needs that focus on the family and community
- Linking funding and investment to actual outcomes, with investors and government partnering to change the initiatives that aren’t working
- Re-envisioning the definition of health and what benefits are reimbursed to be based on prevention rather than post-illness treatment

The foundation for any success must be embedded in community engagement. Indeed we’ve placed great emphasis to spur a broader and continued dialogue around engaging community stakeholders as a critical force to drive the next frontier of preventative efforts. We must next move towards a piloting phase, followed by a more prescriptive phase—identifying best practices and developing a keen understanding of the partnership engagement elements to make them scalable—so that various communities can implement them successfully.

It is our hope that the ultimate development of a transferable model could lead to systemic behavioral change, transforming communities drained by health care spending into ones that flourish through prevention and collaboration, enabling a Culture of Health to take root across the country.

We need to aggressively shape the healthcare industry around a definition of health that goes beyond the treatment of illness.

Ryan Armbruster
UnitedHealth Group
Vice President, Innovation

Appendix A

Project Origin

Hope Street Group’s health program is founded on the principles of systemically addressing health-related issues, including rising costs and decreasing quality delivery, by focusing upstream and in prevention. In a former project, Using Open Innovation to Reinvent Primary Care, we examined the reorientation of care towards prevention, wellness, and active disease management. We started this project by evaluating the landscape from the employer wellness perspective and working closely with the Health Enhancement Research Organization (HERO).

To make a significant and sizeable impact on our national health and health care quality and cost challenge, it was imperative that we first glean further understanding on how to effectively engage employees to increase their participation in EWPs and make them worthwhile for employers to sustain. Amongst successful EWP programs, some common best practices, as outlined from our employer network, for increasing participation in screenings are:

1. offering an incentive,
2. conducting a needs assessment,
3. having strong senior leadership participation,
4. using branded communications,
5. having the employer’s health insurance benefits be supportive of taking a health assessment.

After employers reported programs with wide-reaching branded communications that included spouses and families as the single most significant lever for success in reducing their health care costs and after reviewing evidence suggesting that families receive most of their information about healthy lifestyles from other family members, friends, and neighbors, it became increasingly clear to us that this larger community can and must play a critical role in improving health outcomes. Yet we found little information on how to engage the community.

This spurred a vital need to hone the data around wider communication, family engagement tactics, and specific populations that trend towards high risk for effective implementation of behavior changes. Coupling the data and results from an interactive community pilot we conducted with a social venture, Grow Your Family Strong, we pinpointed the very real challenges to healthy living that families face in the home environment. We then shifted our lens to the larger community stakeholder angle to set the framework for a much deeper initiative.
Process
Hope Street Group’s unique value is collaboration. Soliciting diverse perspectives from participants across all sectors, we convened over 55 leading employers, health care experts, clinicians, policymakers, health services researchers, foundations, economists, business professionals, and entrepreneurs. Each participant offered ideas through in-person dialogue—either individually through interviews and surveys or collectively through our convenings.

We convened our first meeting in January 2014 with seven employers alongside five experts, representing constituent groups, entrepreneurs, and other stakeholders, to identify successful EWPs that encourage community engagement. The group agreed that employers have a defining role; however, the discussion resulted in identifying three critical barriers to address as next steps: 1) getting past policy that limits spousal and dependent participation in EWPs, 2) knowing that this must be a collaborative community effort, but expressing uncertainty over who is responsible for leading and coordinating (who are the players and how do you incentivize for action?), and 3) framing wellness as a regional economic development business case.

We then conducted individual outreach and 25+ interviews and surveys with the January group and others identified at the dinner to provide analysis and trends on: 1) community collaboratives, 2) the traditional and nontraditional stakeholders involved, 3) the barriers facing the stakeholders, and 4) the motivations for the identified stakeholders to lead and/or be invested in community health initiatives. This information was critical in setting the context for the April Colloquium meeting.

We convened our second meeting with some of the participants that had attended in January, alongside 40 other various health experts and practitioners, community stakeholders, entrepreneurs, and the business community at our Annual 2014 Colloquium in April to discuss: 1) the varying perspectives and inputs for a strong Culture of Health, 2) the magnitude of barriers, 3) agreement on the roles and motivations of identified stakeholders from research (and new additions), 4) constructive solutions and recommendations to constitute a Culture of Health, and 5) tangible next steps to test recommendations, with a lens towards motivating employers/businesses while connecting with on-the-ground community representatives. This group developed initial principles of the ‘why, what and how’ of how leadership stakeholders should coordinate efforts in a community.

From this process, we developed the recommendations included in this paper.

Appendix B
The following people participated in either a convening, survey, or interview for this project. The paper is based on the collective input of these participants; it does not represent any one individual or agreement on the final paper and recommendations. Hope Street Group is greatly appreciative of the candid feedback and discussions of all those involved in this process.

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Ryan Armbuster, Vice President, Innovation, UnitedHealth Group
Marnie Ache, JD, MPH, Founder and CEO, ChangeLab Solutions
Cathy Boase, MD, Chief Health Officer, Dow Chemical
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Lori Benson, Vice President, Healthy Lifestyles, YMCA of Greater New York
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