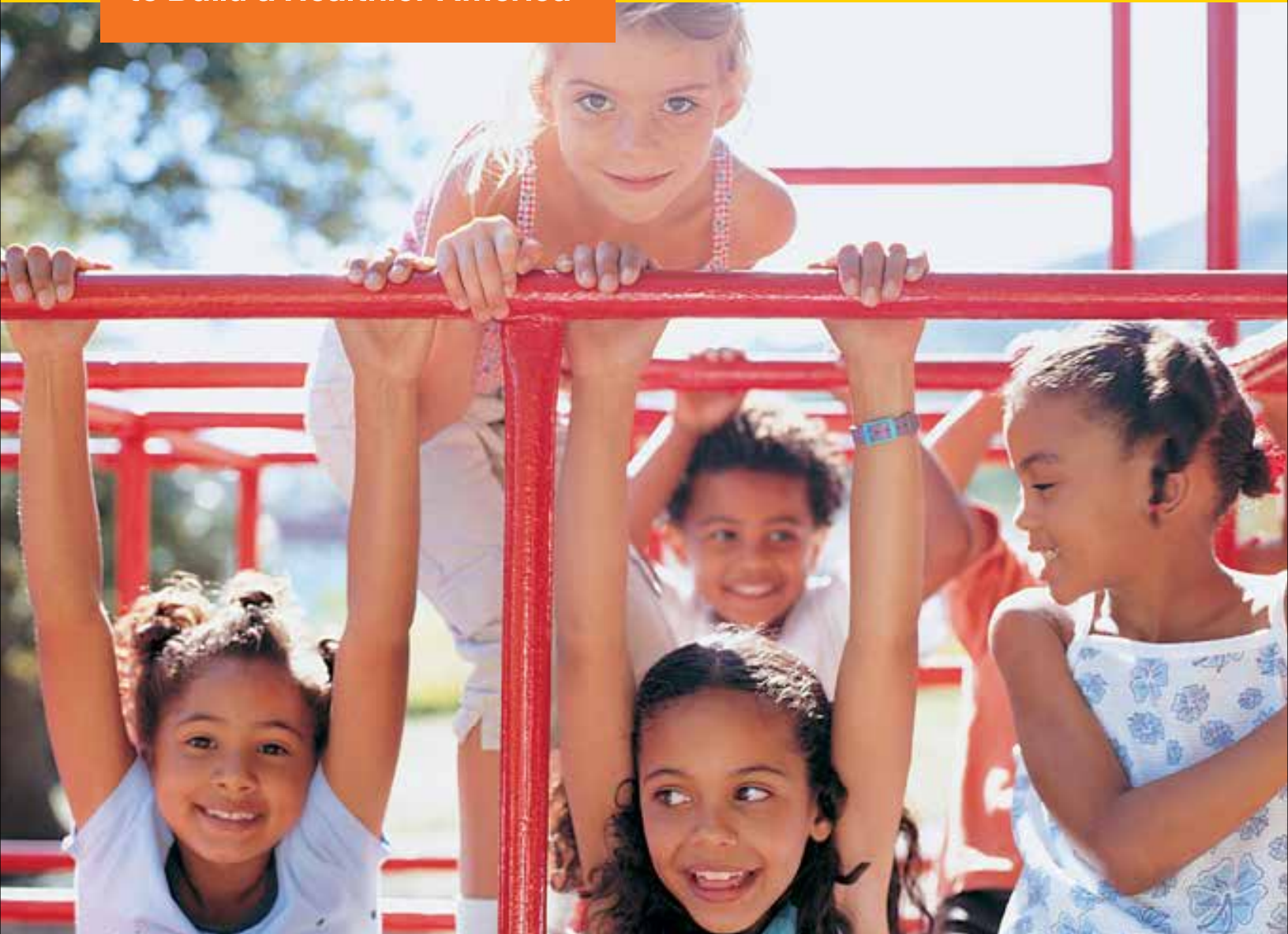


RWJF Commission
to Build a Healthier America



Time to Act: Investing in the Health of Our Children and Communities

Recommendations From the Robert Wood Johnson Foundation
Commission to Build a Healthier America



Robert Wood Johnson Foundation

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The Robert Wood Johnson Foundation Commission to Build a Healthier America (RWJF Commission) is a national, independent, nonpartisan group of leaders created in 2008. In 2009, the RWJF Commission issued a set of influential recommendations for improving the health of all Americans. In 2013, the Robert Wood Johnson Foundation reconvened the Commission to identify actions that should be taken now to support health in communities and during early childhood.

For more information, please visit www.rwjf.org/commission.

Time to Act: Investing in the Health of Our Children and Communities

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Table of Contents

EXECUTIVE SUMMARY

Charge to the Commission **Page 2**

Statement From the
Commissioners **Page 3**

Introduction **Page 5**

Recommendations **Page 15**

A Call for Leadership and
Collaboration **Page 30**

RATIONALE

Unhealthy America **Page 32**

CHAPTER ONE

Investing in Early Childhood
Development **Page 42**

CHAPTER TWO

Integrating Health into
Community Development **Page 60**

CHAPTER THREE

Bridging Health and Health Care **Page 75**

CHAPTER FOUR

Opportunities to Advance a
Culture of Health **Page 89**

Glossary **Page 110**

Resources and References **Page 111**

Charge to the Commission

In 2008, the Robert Wood Johnson Foundation (RWJF) convened the *Commission to Build a Healthier America* to help us find better ways to improve the health of our nation. In their search for solutions, the Commissioners found that there is much more to health than health care and that where we live, learn, work, and play profoundly influence our health. The Commissioners, a national, nonpartisan group of leaders from both the public and private sectors, issued 10 sweeping recommendations aimed at improving the health of all Americans. Their recommendations called for breaking down conventional policy-making silos and creating opportunities for better health in our neighborhoods, homes, schools, and workplaces.

The Commission's work sparked a national conversation that has led to a marked increase in collaboration among a wide variety of partners aimed at addressing the many determinants of health. Eager to build upon this progress, we asked the Commissioners to come together again. I want to thank the Commissioners for their willingness to do so, and for their wise counsel and strong guidance to help advance our transformation to a healthier nation.

RWJF believes that carrying out the recommendations in this report will be essential to building a culture of health—a culture that enables all in our diverse society to lead healthier lives, now and for generations to come. Moving forward, we call on others to join us. Advancing from recommendations to action will require all of us—including business, education, government, and health and health care—to join together with energy, passion, and commitment.



Risa Lavizzo-Mourey, MD, MBA
President and CEO
Robert Wood Johnson Foundation

January 2014

Statement From the Commissioners

We come to this Commission with different backgrounds, experiences, and points of view. Despite our differences, we agree that when it comes to health, the United States must do better. What we are doing is not working. We must find ways to keep more of us healthy and reduce the health care costs that are strangling our economy. It is unconscionable that we spend more than any other country on health care, yet rank at or near the bottom compared with other industrialized nations on more than 100 measures of health.

Since the Commission issued its sweeping recommendations in 2009, we've seen encouraging progress. Positive changes to federal nutrition programs, including updated standards for school meals and the Healthy Food Financing Initiative's success in bringing grocery stores and healthy food options to "food deserts," are squarely in line with what the Commission recommended. Health impact assessments are being used by decision-makers to identify the health impacts of policy decisions and development projects, and more states now have strong smoke-free laws.

This year, the Commission tackled immensely complex matters that underlie profound differences in the health of Americans: experiences in early childhood; opportunities that communities provide for people to make healthy choices; and the mission and incentives of health professionals and health care institutions. We explored these topics against the backdrop of the nation's

recovery from the longest and worst recession since the Great Depression; growing gaps between those at the top of the income ladder and the rest of us; demographic shifts, such as an aging population and the rapidly growing number of young people of color; and further evidence that validates why we must help those who are being left behind and who struggle to be healthy.

We examined programs and systems that were created decades ago and concluded that the complex web of factors that shapes the health of Americans today demands new solutions. We were also forced to confront the reality that the current economy makes new spending difficult, meaning that shared goals, collaboration, and efficiency are more essential than ever.

Throughout our deliberations, we were encouraged by promising examples of cross-sector collaboration and pockets of success across the country. Communities are showing they are willing to pull up their bootstraps and create locally funded, innovative solutions even in these challenging times. Many of these examples are highlighted in the report.

We would not have joined this effort if we weren't hopeful for the future, based on our confidence in the American people's shared values that health is what makes all else possible.

While we don't have all the answers, we can't wait. We know enough to act. And we must act now.

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Introduction

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As Americans, we like to think that we are healthier than people who live in other countries.

That is a myth. In fact, it is a myth for Americans at all income levels, but especially so for those living in vulnerable communities.

Our nation is unhealthy, and it is costing us all through poorer quality of life and lost productivity. Health in America is worse than in other developed nations on more than 100 measures. Thirty countries have lower infant mortality rates and people in 26 countries can expect to live longer than we do.¹ While it is true that the United States spends more on health care than any other country—more than \$2.7 trillion in 2011—part of the reason we spend so much on health care is that so many Americans are in such poor health.²

The key to better health does not lie primarily in more effective health care, although that is both important and desirable. To become healthier and reduce the growth of public and private spending on medical care, we must create a seismic shift in how we approach health and the actions we take. As a country, we need to expand our focus to address how to stay healthy in the first place. This will take a revolution in the mindset of individuals, community planners and leaders, and health professionals. It will take new perspectives, actors, and policies, and will require seamless integration and coordination of a range of sectors

and their work. This shift in thinking is critical for both the health and economic well-being of our country.

As we consider ways to improve our nation’s overall health, we must consider options that will improve opportunities for all, with special emphasis on lifting up low-income children and those who are in danger of being left behind. A stronger, healthier America hinges on our ability to build a sustainable foundation for generations to come.

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To become healthier and reduce the growth of public and private spending on medical care, we must create a seismic shift in how we approach health and the actions we take. As a country, we need to expand our focus to address how to stay healthy in the first place.

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People can make healthier choices if they live in neighborhoods that are safe, free from violence, and designed to promote health. Ensuring opportunities for residents to make healthy choices should be a key component of all community and neighborhood development initiatives.

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Photo: Tyrone Turner

Losing Ground in Health: Life Expectancy

figure 1 In 1980, the United States ranked 15th among affluent countries in life expectancy (LE) at birth. By 2009, it had slipped to 27th place.

1980	Rank	2009
LE = 76.7 Iceland	1	Japan LE = 83.0
Japan	2	Switzerland
Netherlands	3	Italy
Norway	4	Spain
Sweden	5	Australia
Switzerland	6	Iceland
Spain	7	Israel
Canada	8	Sweden
Greece	9	France*
Australia	10	Norway
Denmark	11	Canada**
France	12	New Zealand
Italy	13	Luxembourg
Israel	14	Netherlands
LE = 73.7 United States	15	Austria
Finland	16	Korea
Belgium	17	United Kingdom
New Zealand	18	Germany
United Kingdom	19	Greece
Germany	20	Belgium
Ireland	21	Finland
Luxembourg	22	Ireland
Austria	23	Portugal
Portugal	24	Denmark
Slovenia	25	Slovenia
Slovak Republic	26	Chile
Czech Republic	27	United States LE = 78.5
Poland	28	Czech Republic
Chile	29	Poland
Estonia	30	Mexico
Hungary	31	Estonia
Mexico	32	Slovak Republic
Korea	33	Hungary
Turkey	34	Turkey

Sources: 1980 data for Chile and Slovenia are from UNDESA. *2010 Revision of World Population Prospects*. United Nations Development Programme; 2011. www.un.org/en/development/desa/publications/world-population-prospects-the-2010-revision.html. Accessed December 23, 2013. All other data are from OECD. OECD Stat, (database); 2012. http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT. Accessed May 21, 2013.

*Estimate

**Latest year available for Canada is 2008

Note: Small differences in rank order may not be meaningful because a number of countries are tied at the same value; tied countries are ranked alphabetically.

Recommendations From the Robert Wood Johnson Foundation Commission to Build a Healthier America

We are a Commission whose members bring diverse backgrounds and experience, but one common focus: finding ways to achieve better health for all Americans. We have spent many months exploring the evidence on how to help people live longer, healthier lives. We have come to agreement on three major strategies for improving America's health that reach beyond medical care. We must make great strides in all three of these areas if we hope to dramatically improve the health of all Americans:

1

Make investing in America's youngest children a high priority. This will require a significant shift in spending priorities and major new initiatives to ensure that families and communities build a strong foundation in the early years for a lifetime of good health.

- Create stronger quality standards for early childhood development programs, link funding to program quality, and guarantee access by funding enrollment for all low-income children under age 5 in programs meeting these standards by 2025.
- Help parents who struggle to provide healthy, nurturing experiences for their children.
- Invest in research and innovation. Evaluation research will ensure that all early childhood programs are based on the best available evidence. Innovation will catalyze the design and testing of new intervention strategies to achieve substantially greater impacts than current best practices.

Research clearly tells us that children have a greater chance of achieving good health throughout life if they are raised in families that provide a well-regulated and responsive home environment, benefit from early supports that build resilience by mitigating the effects of significant adversity (such as chronic poverty, violence and neglect), and participate in high-quality early childhood programs. While much emphasis has been placed on the foundational importance of the early years for later success in school and the workplace, we are convinced that an environment of supportive relationships is also the key to lifelong physical and mental health.

2

Fundamentally change how we revitalize neighborhoods, fully integrating health into community development.

- Support and speed the integration of finance, health, and community development to revitalize neighborhoods and improve health.
- Establish incentives and performance measures to spur collaborative approaches to building healthy communities.
- Replicate promising, integrated models for creating more resilient, healthier communities. Invest in innovation.

Historically, community development has focused on planning and building housing, schools, health clinics, and community facilities, but rarely on how the built environment can improve health and lives. People can make healthier choices if they live in neighborhoods that are safe, free from violence, and designed to promote health. Ensuring opportunities for residents to make healthy choices should be a key component of all community and neighborhood development initiatives. Where we live, learn, work, and play really does matter to our health. Creating healthy communities will require a broad range of players—urban planning, education, housing, transportation, public health, health care, nutrition and others—to work together routinely and understand each other’s goals and skills.

3

The nation must take a much more health-focused approach to health care financing and delivery. Broaden the mindset, mission, and incentives for health professionals and health care institutions beyond treating illness to helping people lead healthy lives.

- Adopt new health “vital signs” to assess nonmedical indicators for health.
- Create incentives tied to reimbursement for health professionals and health care institutions to address nonmedical factors that affect health.
- Incorporate nonmedical health measures into community health needs assessments.

Health professionals have extraordinary expertise in treating disease and injury, but in most cases their training emphasizes “patient” care, not assessing all the factors that affect people’s lives and contribute to their overall health. That training also does not focus on integrating public health, prevention, and health care delivery or reward them for striving to address the foundations of lifelong health—factors such as education, access to healthy food, or safe housing—that shape how long or how well people live. A healthier America requires health professionals and institutions to broaden their mindset for improving health to include working with others outside of the traditional medical community. Collaboration with professionals in other sectors will enable an efficient use of shared resources to improve the opportunities for health that communities offer their residents. This shift will also require developing and using new measures of health, as well as designing and implementing reimbursement systems that reward providers for working together and taking other steps to be more effective in enhancing health, not just caring for the sick. To change the actions of health professionals and institutions, it is critical to change their incentives and training to foster improved health beyond the medical exam room.

We Must Act Now

Unless we act now, our nation will continue to fall farther behind, putting our health, economic prosperity, and national security at even greater risk.

- Nationally, nearly one in three children is overweight or obese.³
- As many as three in four Americans ages 17 to 24 are ineligible to serve in the U.S. military, primarily because they are inadequately educated, have criminal records, or are physically unfit.⁴
- Poor health results in the U.S. economy losing \$576 billion a year, with 39 percent, or \$227 billion, of those losses due to lost productivity from employees who are ill.⁵
- Medicare would save billions of dollars on preventable hospitalizations and re-admissions if every state performed as well as the top-performing states in key measures of health.⁶
- More than one-fifth of all U.S. children live in poor families, and nearly half of Black children live in particularly unhealthy areas of concentrated poverty.⁷
- Nearly a fifth of all Americans live in unhealthy neighborhoods that are marked by limited job opportunities, low-quality housing, pollution, limited access to healthy food, and few opportunities for physical activity.⁸

It is time to address these dismal facts. Recent decades have seen major advances in our understanding of how education, income, housing, neighborhoods, and exposure to significant adversity or excessive stress affect health. Our health-related behaviors are shaped by conditions in our homes, schools, workplaces, and communities. Every one of us must take responsibility for making healthy choices about what we eat, how physically active we are, and whether we avoid risky habits like smoking. But when it comes to making healthy decisions, many Americans face barriers that are too high to overcome on their own—even with great motivation.

We must take a clear look at who we are. The country is changing. We are undergoing an unprecedented shift in demographics related to age, race, and ethnicity. By 2043, the majority of U.S. residents will be people of color, who are disproportionately low-income and living in disadvantaged communities. In the U.S., low-income people and people of color generally experience the worst health for reasons that are preventable and that require actions beyond health care alone.

The bulk of this demographic shift is taking place within the population under age 18. At the same time, there are now more Americans age 65 and older than at any other time in U.S. history. The population of those age 65 and older jumped 15.1 percent between 2000 and 2010, compared with a 9.7 percent increase during that same period for the entire U.S. population.⁹ We are seeing a growing demographic divergence between the young and the old, with dramatic growth in the predominantly white older generation (age 65 and older), and a far more diverse younger population.¹⁰

Our recommendations are designed to improve the health of all Americans and to minimize barriers for Americans whose needs are more urgent. This is especially critical in the early childhood years, when children's lifelong behavioral and coping skills are heavily influenced by the environments in which they live. Low-income children must have the same opportunities to be healthy as all children in America, no matter where they live. Leaving them behind would put our nation's well-being and prosperity at great peril.

This report identifies roles that various sectors beyond health care—including business, government, community organizations, philanthropy, financial investors, faith leaders, and community planners—can play. All have a role.

We cannot build a healthier, more prosperous America without addressing the basic building blocks of health promotion and disease prevention. And we cannot continue to indulge in current levels of spending on medical care, especially for treating disease or conditions that could have been prevented. It is time to invest more wisely—in all areas that affect health. This is an investment in our future and generations to come.

Research must continue, but we know enough to act now.



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A child's experiences and environmental influences can affect his or her health well into adulthood.

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Photo: Jordan Gantz

Today's Economic Climate

The period between December 2007 and June 2009 was one of profound crisis for the economy, with the U.S. experiencing its longest and, by most measures, worst economic recession since the Great Depression. In 2007, the property market collapsed, triggering a near meltdown in the financial sector, and the deep recession thereafter saw the median American family lose 40 percent of its wealth.

In 2013, the nation's Gross Domestic Product (GDP) grew around 2.5 percent, and analysts considered recovery from the recession to still be weak. States have struggled to address extraordinarily large budget shortfalls, which have totaled more than \$540 billion combined from 2009 through 2012.¹¹ These shortfalls have been closed through a combination of spending cuts, withdrawals from reserves, revenue increases, and use of federal stimulus dollars.

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Federal budget cuts known as “sequestration” that took effect on March 1, 2013, were projected to impact state and local economies even further. The cuts are expected to reduce projected spending by \$1.2 trillion over the next nine years, split evenly between defense and non-defense spending. Sequestration sliced Head Start and Early Head Start budgets by nearly 5.3 percent, resulting in a services cut for more than 57,265 children and pay decreases or layoffs for more than 18,000 staff across the country, according to the U.S. Department of Health and Human Services.¹²

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Concerned about the country's economic viability, some political leaders have called for strong private-sector growth and entitlement reform. Rising health care-related entitlement costs at the federal and state levels are the fastest-growing components of public budgets. This puts pressure on “discretionary” programs like Head Start at the federal level and on early childhood education programs at the state level.

Those working to create policy change at the federal, state, and local levels must recognize that programs will need to work smarter, with fewer resources and smaller budgets. This will require innovation and collaboration between the public and private sectors, including businesses and philanthropy. Science can show where our dollars have the greatest potential to impact overall health. The country cannot continue spending at the expense of investing in our youngest children and in communities, which makes sense for a healthy future.

Shifting Demographics

America is in the midst of a seismic demographic shift. By 2043, the majority of U.S. residents will be people of color.¹³ Perhaps even more striking is the growing demographic divergence between the young and old, with dramatic growth in the predominantly White older generation (age 65 and older), and a far more diverse younger population. These changes carry tremendous import for policy as the country grapples with how to tackle significant economic strains while attempting to foster a healthy America for generations to come.

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Forty-six percent of today's youth are people of color. The fastest percentage growth is among multiracial Americans, followed by Asians and Hispanics. Non-Hispanic Whites make up 63 percent of the population; Hispanics, 17 percent; Blacks, 12.3 percent; Asians, 5 percent; and multiracial Americans, 2.4 percent. Minorities make up 46.5 percent of the under-18 population, according to the U.S. Census Bureau. By the end of this decade, the majority of youth will be people of color, and, by 2030, the majority of workers under age 25 will be people of color.¹⁴

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Contrast this with the fact that there are now more Americans age 65 and older than at any other time in U.S. history. The population 65 and older jumped 15.1 percent between 2000 and 2010, compared with a 9.7 increase during that same time period for the entire U.S. population. An overwhelming majority of today's seniors are White; just 20 percent are people of color.¹⁵

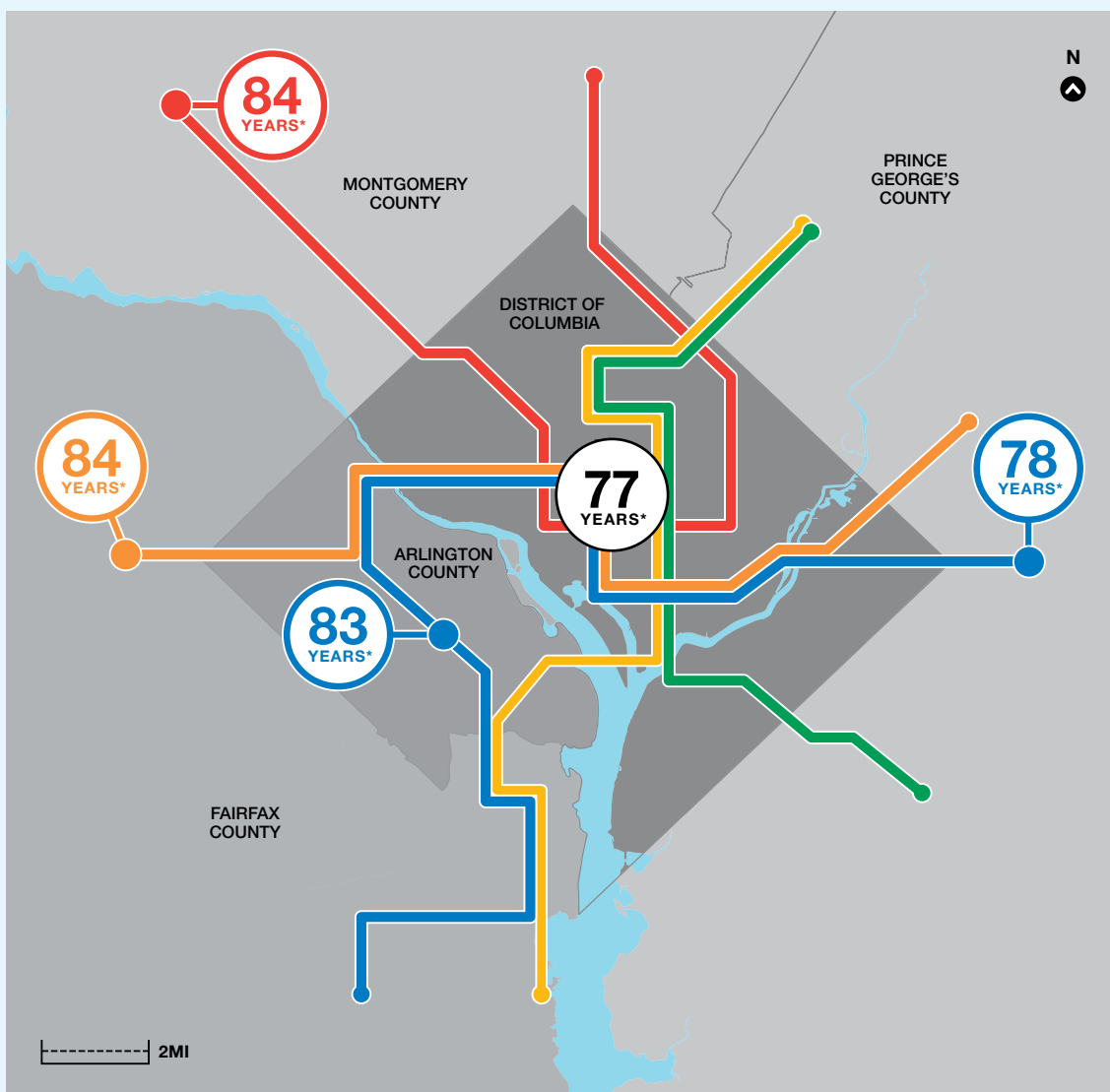
The America of the future will comprise a diverse young population alongside a largely White older generation. This will certainly affect the country's spending priorities and the creation of policies or programs designed to strengthen the nation as it grows. The challenge will be to create a workable balance that enables the country to be competitive now while preparing our young people to achieve health and success in the future.

We must make investments that will allow the country to maximize the potential of all its residents and create a foundation of health for generations to come. This includes investing in early childhood development, revitalizing communities, and ensuring that all children—especially low-income children—have the opportunities they need to thrive.

WASHINGTON, D.C.:

Short Distances to Large Disparities in Health

figure 2 Babies born to mothers in Maryland's Montgomery County and Virginia's Arlington and Fairfax Counties can expect to live six to seven years longer than babies born to mothers in Washington, D.C.—just a few subway stops away.



Source: Prepared by Woolf et al., Center on Human Needs, Virginia Commonwealth University using Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database, released January 2013. Data are compiled from Compressed Mortality File 1999–2010 Series 20 No. 2P, 2013, <http://wonder.cdc.gov/cmfi-icd10.html>.

*Life expectancy at birth

Recommendations

Efforts to improve health have often focused on changing how health care is delivered or reimbursed. But changes to health care alone will not lead to better health for most Americans. As a Commission, we have learned that there is far more to health than health care. Other factors such as education, income, job opportunities, communities, and environment are vitally important and have a bigger impact on the health of our population. We must address what influences health in the first place.

To improve the health of all Americans we must:

- **Invest in the foundations of lifelong physical and mental well-being in our youngest children;**
- **Create communities that foster health-promoting behaviors; and**
- **Broaden health care to promote health outside of the medical system.**

Recommendation 1:

Make investing in America's youngest children a high priority. This will require a significant shift in spending priorities and major new initiatives to ensure that families and communities build a strong foundation in the early years for a lifetime of good health.

A child's experiences and environmental influences can affect his or her health well into adulthood. Toxic stress caused by repeated or prolonged exposure to adversity can lead to physiological disruptions that increase the prevalence of disease decades later, even in the absence of later health-threatening lifestyles. These biological disruptions include elevated stress hormones that can impair brain circuitry, increased inflammation that can accelerate atherosclerosis and lead to heart disease, and increased insulin resistance that increases the risk of diabetes.

Sources of toxic stress include chronic poverty and various combinations of repeated abuse, chronic neglect, neighborhood violence, maternal depression, or a primary caregiver with a substance abuse problem. These factors may be present regardless of whether a child is poor or faces persistent economic insecurity.

There are many ways to protect children from these adverse effects, including fostering stable, nurturing relationships with the important adults in their lives; providing parents and other caregivers the supports they need to help children develop a wide range of capabilities; creating safe, supportive environments; and providing access to high-quality early childhood experiences and development programs.

We see growing demand—not only from families, educators, and public health officials, but also from champions in the realms of faith, science, economics and finance, business, and national security—to invest in healthy child development as an investment in America's future.

The role of providing support for children and families cuts across sectors, including early childhood education, social services, public health, preventive health care, and family economic stability. But too often, their work is siloed. Cross-sector collaboration that adopts an integrated view of a child's needs based on a unified science of development is critical to building a foundation for lifelong health. This collaboration should stretch widely, from maternal health to early learning to public health and community supports to child welfare to planning and zoning.

As a country, we invest significant dollars in K-12 education, health care, and support programs of various kinds. But when it comes to our youngest children, our nation's budget does not match our values or the evidence. The U.S. ranks 25th out of 29 industrialized countries in public investments in early childhood education.¹⁶ We must change our spending priorities to ensure that America's youngest children, from birth to age 5, get the best foundation for a healthy and productive life.

Current science is clear: If children experience toxic stress as a result of significant adversity during the period from birth to the time they enter school, when their brains and bodies are undergoing rapid development, their chances of a successful and healthy future are diminished. This lost opportunity has lifelong effects. We must make support for vulnerable young children a national priority.

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*Some communities are already giving high priority to spending on children—including **Denver** and **San Antonio**, where tax revenues are being earmarked to fund early childhood programs. **Minnesota** recently approved funding for early learning scholarships. And in Salt Lake City, **Goldman Sachs, United Way of Salt Lake**, and the **J.B. and M.K. Pritzker Family Foundation** have formed a partnership to create the first-ever social impact bond designed to expand access to early childhood education through the early Childhood Innovation Accelerator. **Oklahoma** has offered universal access to pre-kindergarten since 1998 and has one of the highest enrollment rates in the country, with 74 percent of all 4-year-olds attending a pre-K program. While the state does not provide specific funding for 3-year-olds, some Oklahoma school districts offer classroom programs for these younger students through a combination of funding sources, including Title I, Head Start, special education, and general district funds.*

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Create stronger quality standards for early childhood development programs, link funding to program quality, and guarantee access by funding enrollment for all low-income children under age 5 in programs meeting these standards by 2025.

Early childhood programs can serve as building blocks for a lifetime of good health, yet access to high-quality programs is inconsistent. Only a small fraction of low-income children are in high-quality programs. They aren't always available, and, when they are, either space is limited or parents are unable to afford them.

State and federal agencies, such as the U.S. Department of Health and Human Services and the Department of Education, should create, strengthen, and enforce quality standards that look beyond the provision of rich learning experiences and include interventions designed to improve health and protect the developing brain from significant adversity that can lead to illness.

While several Head Start performance standards are related to health, state-based early childhood programs seldom assess this dimension, and almost all currently focus on access to health services rather than protection against adversity.

The vast majority of early childhood programs are designed primarily to improve children's readiness for school and later educational success. Although educational attainment is associated with better health later in life, early childhood programs could have a more direct impact on reducing later disease by building the resources and capacities of parents and other caregivers to promote resilience in young children by strengthening their ability to cope with adversity.

New quality standards should address the dangers of toxic stress factors by aiming to reduce its sources and strengthen the adult-child relationships that mitigate its adverse consequences. Prevention efforts are generally aimed at adults and adolescents, but they may actually be most effective in the earliest years.

High-quality programs are essential but not sufficient if all children do not have access to them. In 2011, the U.S. Department of Health and Human Services implemented tougher rules for low-performing Head Start grantees, requiring those who fail to meet specific benchmarks to re compete for continued federal funding. This is one good example of a federal program that is working to address the variable quality of existing programs. A strengthened, improved Head Start should be embraced as a model for others.

We must invest in early childhood programming as seriously as we do in education for children beginning at age 5. This will require reprioritizing programs, and redirecting existing funds from programs that are underperforming or of a lower priority. For example, funding for Head Start or other programs that fail to meet performance standards should be redirected to other early childhood development initiatives that clearly demonstrate their ability to provide high-quality services. No one funding stream can respond to this need. All funding sources—federal, state, community, philanthropy, and private sector—should be tapped.

In a time of economic constraints, all programs and initiatives should be examined for efficiency and strength of outcomes to ensure that we are investing as wisely as possible to meet children's current needs. This includes entitlement programs that can be difficult to sustain and can crowd out spending on other discretionary programming. For example, at the state level, pension programs should be examined for



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Nearly one-fifth of all Americans live in low-income neighborhoods that offer few opportunities for healthy living. In these neighborhoods, job opportunities are scarce; access to adequate housing and nutritious food is poor; and pollution and crimes are prevalent. These factors have a tremendous impact on health.

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Photo: Tyrone Turner

opportunities for greater efficiency and accountability, and for other reforms to help assure that funds are available to support early childhood education.

When the amount of dollars available is finite, the country is forced to prioritize its spending. It is imperative that the country, for both fiscal and moral reasons, put our youngest children first and invest in initiatives that we know will lead to a healthier, stronger America tomorrow. We must invest in our future and we urge prioritizing early childhood programs in difficult decisions about how we spend our money now.

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***Educare** is a network of state-of-the-art, full-day, year-round schools across the country that provide at-risk children from birth to age 5 with comprehensive programs and instructional support that build skills and lay the foundation for successful learning. The goal is to prepare children who are growing up in poverty to enter kindergarten on a par with children from middle-income families. Each Educare network offers unique features tailored to meet the needs of young children and their families in the local community. For example, four Educare schools include or are directly adjacent to on-site health clinics. Additionally, two Educare schools are linked to elementary schools with on-site health clinics. Many provide dental screening, additional nutrition efforts (e.g., “Educook” at Educare Omaha), and efforts to counter obesity.*

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Help parents who struggle to provide healthy, nurturing experiences for their children.

While high-quality early childhood programs help children develop, even children who have access to them spend the majority of their time at home. These settings need to be as supportive and growth-promoting as possible. Some parents may lack the knowledge, capabilities, or resources to provide well-regulated and responsive home environments. Others may not be able to maintain economically stable and secure households. Economic stability is a major factor that can affect early childhood development. Some children live in homes where the stresses of daily life, work, and child rearing make a well-functioning home environment difficult to achieve. These stresses can be high in single-parent families, where there may be fewer resources. However, they may

occur even in families that are not as constrained by resources. Children who are exposed to chronic adversity and unsafe environments—such as personal abuse or violence at home or in their neighborhoods—experience constraints on all domains of their development (including cognitive, physical, social, and emotional opportunities) and are more likely to experience health problems later in life.

Communities should have informal supports and programs that can strengthen families and help them break the cycle of disadvantage that is often passed across generations. For example, child welfare agencies could address the adult impairments in physical and mental health that they encounter through external referral or integrated child-parent services.

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*Boston’s **Crittenton Women’s Union** helps create pathways to economic independence for low-income women and their families by providing comprehensive services, including transitional and supportive housing; job-readiness training; and mentoring services in self-sufficiency. In Los Angeles, **Preschool Without Walls** employs a two-generation approach, engaging parents to serve as their children’s first and lifelong educators by teaching them how to improve their children’s school readiness.*

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Invest in research and innovation. Evaluation research will ensure that all early childhood programs are based on the best available evidence. Innovation will catalyze the design and testing of new intervention strategies to achieve substantially greater impacts than current best practices.

Advances in neuroscience on the biological consequences of significant adversity are radically changing our understanding of how early childhood influences affect lifelong health. Research tells us that children are active learners as soon as they are born, yet public education often does not start until kindergarten. A child’s future depends on both education and health, yet approaches to both are siloed.

It is vital that we incorporate 21st-century scientific knowledge into the development of all supports designed to improve early childhood development. Government and private funders, including philanthropy and business, have an important role to play in ensuring that the best science informs both the scaling of high-quality programming and the development of new ideas. Advances in scientific research have dramatically changed our understanding of how children’s brains develop and how toxic stress can also affect other maturing organs and metabolic regulatory systems in a way that can influence short-term, biological responses and long-term health outcomes later in life. Yet little of this knowledge has been applied in practice. In order to correct this shortcoming, it is critical that we expand our definition of evidence to include scientific concepts that can inform new program models. Success in this endeavor will require an innovation-friendly environment that catalyzes fresh thinking, supports risk-taking, and recognizes the value of learning from interventions that don’t work.

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*The Adverse Childhood Experiences (ACE) study, a collaboration between researchers at the **U.S. Centers for Disease Control and Prevention** and **Kaiser Permanente**, was among the first to establish strong links between adverse early childhood experiences and lifelong mental and physical health conditions, including depression, addiction, heart disease and diabetes. The study, which has involved over 17,000 participants, assesses exposure to 10 categories of early childhood trauma or toxic stress. The higher the score, the greater the exposure, and the greater the risk of negative consequence. In May 2013, the **Institute for Safe Families** and the **Robert Wood Johnson Foundation** hosted the first national summit of professionals who are using the biology of stress and research on adverse childhood experiences to encourage social workers, police, educators, doctors, nurses, and others to apply this knowledge in their work.*

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Photo: Tyrone Turner

Family Structure

The number of two-parent households in the United States has been declining for the past several decades, profoundly affecting the middle class, and our nation's children and their ability to thrive.¹⁷ Over the past 50 years, the income inequality between dual-income and single-income families has grown dramatically. Median incomes among families led by single dads and single moms have stayed the same or declined, falling behind those of married couples. Marital status may account for as much as 40 percent of the growth in income inequality nationally.¹⁸

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*One in five American children is raised in a household headed by a single mother, with another 7 percent raised by a single father. This phenomenon is more common among American-born Hispanics, American Indians and Blacks: More than 50 percent of Hispanic babies and 72 percent of Black babies are born to unwed mothers.*¹⁹

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The decline in marriage is taking place almost exclusively among the poor. Research shows that children raised by single parents are more likely to drop out of high school, be unemployed as teenagers, and less likely to enroll in college.²⁰ Children in single-parent families are more than three times as likely to be poor as children raised in two-parent households. In 2011, 42 percent of children in single-parent families were poor,

compared with 13 percent of children in two-parent families.²¹ Both education and income are linked to better health and longevity.

The dramatic increase in rates of single-parent households has paralleled increases over time in unemployment, underemployment, and low wages among men with low educational attainment. Achieving higher rates of two-parent, married families may require improving educational and employment opportunities for young men as well as women.

Research indicates that improving economic opportunities for males promotes marriage. Experience in the military backs this up. Compared with civilians, men in active-duty military service have higher rates of marriage versus cohabitation, greater likelihood of first marriage, and more stable marriages. These patterns hold for both Black and White men, but are stronger for Blacks than for Whites. This has been associated with opportunities in the military for stable employment, economic mobility, housing, daycare centers, and school-age activity centers.²²

Children in single-family households need not be consigned to a poor start in life, and can indeed thrive. Strong social and family supports, such as high-quality early childhood programs, job and parental skill training programs, and healthy communities that foster healthy choices, can greatly improve a child's opportunities for success.

Recommendation 2:

Fundamentally change how we revitalize neighborhoods, fully integrating health into community development.

There is significant opportunity to dramatically improve the health of our nation by improving the neighborhoods where we live, learn, work, and play. While the Commission believes that efforts should be made to improve the health of all communities, we must prioritize communities where low-income Americans lack opportunities to make healthy choices.

Nearly one-fifth of all Americans live in low-income neighborhoods that offer few opportunities for healthy living. In these neighborhoods, job opportunities are scarce; access to adequate housing and nutritious food is poor; and pollution and crimes are prevalent. These factors have a tremendous impact on health.²³

There is a broad ecosystem of organizations that serve the same “customer,” “client,” or “patient” living in the same neighborhood, but seldom work together to meet that person’s different needs. This includes the public health and community development fields, as well as those organizations that focus on directly improving the health of community residents by connecting them to community supports such as job training, counseling, or child care services. Community leaders can play a vital role in identifying common ground among different organizations and helping catalyze changes that are tailored to meet the needs of the community.

For the past 50 years, the community development sector—made up of nonprofit neighborhood improvement agencies; real estate developers; financial institutions; foundations; and government—has worked to transform impoverished neighborhoods into economically viable communities by planning and building roads; child-care centers; schools; grocery stores; community health clinics; and affordable housing.

But creating healthier communities and lives requires considering the health impacts of all aspects of community development and revitalization, and ensuring that a broad range of sectors work together toward shared goals. This will result in less duplication of effort and smarter use of resources. It will require leadership and action from people who work in public health and health care; education; transportation; community planning; business; and other areas. Public health professionals can provide the “health lens” for community decision-makers. The increased use of health impact assessments provides an example of how this can work.

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Concerned about the effect of high energy costs on children’s health in the wake of Hurricane Katrina, Boston-based pediatricians and researchers conducted a health impact assessment (HIA) to explore the tradeoffs that low-income families face in paying utility bills, the safety risks of using unsafe heating sources, and how health is affected when families are forced to move to lower-quality housing because of high utility bills. The HIA helped policy-makers understand the connection between energy costs, children’s health, and potential Medicaid cost increases. As a result, the state increased funding for the Low Income Energy Assistance Program, and advocates in Rhode Island used the report to advocate for similar changes there.
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Support and speed the integration of finance, health, and community development to revitalize neighborhoods and improve health.

A broad range of organizations work to improve low-income communities. Yet too often, these organizations work separately from each other. To strengthen their efforts and make better use of scarce financial resources, they must work together.

The community development sector should work closely with the public health sector, which offers a nationwide network of health departments and public health workers—along with evaluation and research tools—to help improve coordination among cross-sector efforts.

Ways to support and speed integration include:

- Requiring cross-sector collaboration as a condition of funding.
- Establishing and supporting a nationwide communications network that connects professionals across fields, facilitating collaboration to achieve healthy communities.
- Supporting a platform or clearinghouse where examples, models, evidence-based tools, and metrics can be found and shared.
- Creating a national partnership to support and catalyze work at the intersection of community development and population health.
- Building capacity to offer cross-sector training to increase mutual understanding of each field's approaches, business models, strengths and weaknesses, and uses of financing and policy.
- Developing skills needed for successful collaboration, including ways to engage the community in planning; coalesce around aims; negotiate across vested interests; and tackle policy and financial barriers.
- Broadly promoting successes of cost-effective models for cross-sector collaboration.

Meaningful, needle-moving outcomes will not be achieved without these kinds of efforts. While some effective cross-sector collaboration is beginning to occur, much more is needed.

To encourage greater collaboration, other leaders—from federal, state, and local departments of housing, transportation, health, and education; private and public financial institutions; philanthropies; and business, agriculture, and community development professionals—should launch similar efforts and support ongoing collaborative mechanisms.

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*The **National Prevention Council**—comprising 20 federal departments and agencies committed to supporting healthy and safe community environments, and clinical and community preventive services—is working to eliminate health disparities. At the local and regional levels, the **Partnership for Sustainable Communities**—cutting across the U.S. Department of Housing and Urban Development, the U.S. Department of Transportation and the Environmental Protection Agency—funds neighborhood development in more environmentally and economically sustainable ways.*

*In **Seattle**, public health and housing leaders are working together to reduce allergens in low-income homes to better control asthma. In **Richmond, Va.**, **Bon Secours Health System** has partnered with the **Local Initiatives Support Corporation** to revitalize the **Church Hill** neighborhood, supporting development of a trash service, coffee shop, a bakery, a hair salon, and a janitorial service. And the **Federal Reserve**, along with the **Robert Wood Johnson Foundation** and others, have held a series of conferences to encourage collaboration between the health and community development sectors.*

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Establish incentives and performance measures to spur collaborative approaches to building healthy communities.

Maintaining current federal funding streams that support community improvements and improved health is vital, but new policy and financing incentives also are needed to break down the silos between health and community improvements.

To encourage more effective collaboration, we must promote balance when an investment of money or resources by one sector generates savings for another. For example, investments in transportation or housing can improve health and generate cost savings to the health care system. One sector invests, but another benefits. Working together provides an opportunity for negotiating how both can benefit. In this case, a portion of the health care savings could be re-invested in additional health-promoting neighborhood improvements to create a virtuous cycle of cost savings and health improvement.



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Clinical vital signs include heart rate, blood pressure, temperature, weight, and height. But other, nonmedical vital signs—such as employment, education, health literacy, or safe housing—can also significantly impact health.

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Photo: Matthew Moyer

Changes in public- and private-sector financial and policy incentives are needed to reward collaboration and to incorporate health improvement strategies into community improvements. Incentives should be tied to demonstrable improvements in areas that affect health, such as improved housing or access to healthy food. Incentives should also be designed to spur private investment and innovation from many sources, including social entrepreneurs and socially motivated investors.

Incentives and cross-sector work will also require new measures that document benefits and are strong enough to affect significant outcomes. They go hand in hand with offering incentives.

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*The **Healthy Futures Fund** developed by **Morgan Stanley**, the **Kresge Foundation**, and the **Local Initiatives Support Corporation** is encouraging community development organizations and community health care providers to collaborate using Low Income Housing Tax Credit equity and an innovative New Markets Tax Credit structure to drive economic development that helps improve health outcomes. The project will support development of 500 housing units with integrated health services and eight new federally qualified health centers through a \$100 million initial investment.*
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Replicate promising, integrated models for creating more resilient, healthier communities. Invest in innovation.

Public and private funders should invest in integrated approaches that show promise or have demonstrated results in creating healthier communities. This will require developing new funding streams, reducing barriers to maintaining and integrating existing funding streams, and promulgating a shared vision of what constitutes success.

It is important to invest in what works, but it is equally critical to fund continued innovation so that a healthy community development field can evolve. For example, public and private funders could establish an innovation fund for community improvement that could be modeled on the Center for Medicare & Medicaid Innovation, which supports the development and testing of innovative health care financing and service delivery models.

While seeking to scale up or replicate promising models, we must recognize that there is no “one-size-fits-all” approach. Communities must determine their own challenges and opportunities and borrow from the best examples, such as Promise Neighborhoods, a U.S. Department of Education program that seeks to improve educational outcomes for students in distressed urban and rural neighborhoods, and Purpose Built Communities, a nonprofit that rebuilds struggling neighborhoods.

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*Instead of attacking poverty, urban blight, and failing schools piecemeal, a group of community activists and philanthropists in Atlanta took on all of these issues at once, becoming the model for **Purpose Built Communities**. All of the distressed public housing units were demolished and replaced with new apartments, half of which are at the market rate. The neighborhood, which once had 1,400 extremely low-income residents, is now home to 1,400 mixed-income residents. As a result of these efforts, the employment rate of low-income adults increased from 13 percent to 70 percent. The neighborhood’s Drew Charter School moved from last to first place among 69 Atlanta public schools and violent crime dropped by 90 percent. The model has been replicated in eight additional communities so far.*

*Another promising model is the \$18 million **ReFresh** “healthy food hub” that **Goldman Sachs**, **JPMorgan Chase**, and **L+M Development Partners** funded in New Orleans with the **Low Income Investment Fund**. Aiming to eliminate food deserts, the effort created a small-format Whole Foods Market offering lower prices, kitchens and facilities for local healthy food enterprises and culinary educational institutions, office space for a local charter school organization, and 10,200 square feet of retail space.*

*For more than 20 years, **Living Cities, Inc.**, has worked to improve the lives of low-income people and the cities where they live by bringing together 22 of the world’s largest foundations and financial institutions to invest in health and community development. The collaborative comprises 20 partners—including the **Citi Foundation**, **Morgan Stanley**, the **Kresge Foundation**, the **Robert Wood Johnson Foundation**, and **Prudential Financial, Inc.**—who have collectively invested nearly \$1 billion in dozens of communities across the country to build homes, schools, clinics, and other community facilities.*
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Recommendation 3:

The nation must take a much more health-focused approach to health care financing and delivery. Broaden the mindset, mission, and incentives for health professionals and health care institutions beyond treating illness to helping people lead healthy lives.

As health care becomes more personalized and prevention-oriented, our nation requires a new approach to health that emphasizes overall well-being and assesses *all* factors in a person's life, even when a person is seeking treatment for *one* specific symptom or illness. Financial incentives are being used to move away from traditional fee-for-service payment to focus on increasing quality while reducing costs. In addition, current health care law changes contain elements that enable initiatives to focus on prevention and keeping people well in the first place. Health professionals, institutions, and payers are recognizing the need to address nonmedical causes of poor health in the places where we live, learn, work, and play.

Health care alone cannot ensure good health. Nonmedical factors play a significant role as well. Health professionals must take an active role in helping their patients become and stay healthy outside of a clinic, hospital, or health care practice by recognizing their nonmedical needs and prescribing referrals that can help patients connect to social or economic resources. For example, a patient may not take insulin as prescribed because he or she has no transportation to get to a pharmacy, or no way to refrigerate it. Other patients may be unable to follow recommendations to eat more fruits and vegetables because they can't get to a supermarket or afford the food.

Under a broader approach that emphasizes overall well-being, a health professional could offer a referral to a transportation service or vouchers to a nearby farmers' market to obtain healthy food.

Connecting patients to supports in the community will require closer links between health care institutions and professionals with public health, social services, and other resources.

This will help form a much-needed bridge between health and health care. For example, health professionals should assess whether patients have access to healthy food; safe and healthy housing; educational opportunities; and job skills training or jobs, and prescribe services in the community that can help address identified needs. This will require training health professionals to identify and address the realities of patients' lives that directly impact health outcomes and costs, and to understand the importance of connecting patients to the community resources they need to be healthy.

Adopt new health “vital signs” to assess nonmedical indicators for health.

Clinical vital signs include heart rate, blood pressure, temperature, weight, and height. But other, nonmedical vital signs—such as employment, education, health literacy, or safe housing—can also significantly impact health. Health professionals and health care institutions must incorporate these new vital signs into their routines to broaden their understanding of factors affecting their patients' health.

Incorporating and adopting new vital signs for health will require partnerships between health professionals and other professionals and organizations in the community that can provide needed services. For example, if a health professional issues a prescription for a healthier diet, that practitioner should be able to direct the patient to a program or service that can fill that prescription. Coordination will be essential for linking patients to services that cannot be provided in the medical office.



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Incorporating and adopting new vital signs for health will require partnerships between health professionals and other professionals and organizations in the community that can provide needed services.

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Photo: Matthew Moyer

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Health Leads, a national health care organization, enables physicians and other health professionals to systematically screen patients for food, heat, and other basic resources that patients need to be healthy and “prescribe” these resources for patients. Patients then take the prescriptions to a Health Leads desk in the clinic, where a corps of well-trained and well-supervised college student advocates “fill” the prescriptions, working side by side with patients to access existing community resources. Health Leads advocates also provide real-time updates to the clinical team on whether a patient received a needed resource, resulting in better-informed clinical decisions. Health Leads operates in 23 clinics—pediatric and prenatal, newborn nurseries, adult primary care, and community health centers—across six geographic areas, all with significant Medicaid patient populations.

The **Medical-Legal Partnership** operates in 38 states to remove barriers that impede health for low-income populations by integrating pro bono legal professionals into care teams to intervene with landlords, social service agencies and others to address health-harming conditions ranging from lack of utilities to bedbugs to mold in rental properties to accessing needed school support services for children.

Medicare’s Care Transitions program—developed by Denver geriatrician and MacArthur Foundation “genius grant” winner Eric Coleman—helps prevent hospital re-admissions by addressing the medical and mental health needs of recently discharged patients with a focus on the determinants of health that often trigger unnecessary re-admissions.

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Create incentives tied to reimbursement for health professionals and health care institutions to address nonmedical factors that affect health.

The Affordable Care Act will accelerate the use of new physician payment mechanisms and incentives, including paying more to providers who deliver better outcomes at a lower cost. Some public and private insurers are already moving in this direction. Government and private insurers should further expand payment reform innovation to include incentives and measures that relate to identifying and addressing nonmedical factors that affect patient health. Such incentives should also reward health professionals, hospitals, and other health care institutions for screening patients for social needs related to health and working with community partners to link patients with resources appropriate to their needs in the community.

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Some insurers have already broadened their work to address nonmedical factors. For example, the **Oregon Medicaid** program has implemented coordinated care organizations, which are similar to accountable care organizations, to facilitate collaboration between health care and social services providers, with the goal of improving community health. In Minnesota, the **Hennepin Health Accountable Care Organization**—created as part of an early Medicaid expansion—is linking Medicaid health services and county-provided social services, such as housing and employment counseling in its **Prescription for Health** program. The federal **Center for Medicare & Medicaid Innovation** has issued a request for proposals for innovative payment systems at the regional or community level that may spur new, more cost-effective ways of paying for and improving population health.

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As a part of engaging public health experts and individuals representing the broad interests of the community, as the law requires, hospitals should engage community leaders and planners, government partners, social services professionals, and others in identifying better ways to address nonmedical factors that can have either adverse or positive impacts on health.

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Incorporate nonmedical health measures into community health needs assessments.

Under current law, all nonprofit hospitals must conduct a community health needs assessment every three years and develop an implementation strategy to address identified needs. The U.S. Centers for Disease Control and Prevention (CDC) recommends that assessments include collecting and using information on social determinants of health.

As a part of engaging public health experts and individuals representing the broad interests of the community, as the law requires, hospitals should engage community leaders and planners, government partners, social services professionals, and others in identifying better ways to address nonmedical factors that can have either adverse or positive impacts on health. The Community Guide by the CDC provides a menu of recommended community interventions.

Examples include establishing measures, such as access to high-quality early childhood programs; recreation centers; job training; or mental health services. The needs assessment also could include community characteristics, such as levels of pollution; job opportunities; or safe public spaces that promote physical activity.

Assessment alone is not sufficient. Hospitals should be strategic and invest in specific community improvements identified through the needs assessment. Especially important are investments to improve access to high-quality early childhood and family support programs and initiatives to foster healthy community development, building a bridge between individual health and community health.

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Boston Children’s Hospital launched “Healthy Children. Healthy Communities” as a first step toward improving community health. Boston Children’s Hospital partners with the community to merge the medical model of care (patient care, research, and teaching) with a public health model of care (prevention, education, and advocacy), in order to offer needed programs and services.

Nationwide Children’s Hospital in Columbus, Ohio, launched “Healthy Neighborhoods, Healthy Families” to remove barriers to the health and well-being of families by targeting affordable housing, health and wellness, education, safe and accessible neighborhoods, and workforce and economic development. **Children’s Hospital Medical Center in Cincinnati** has partnered with community groups to address asthma, accidental injuries, and poor nutrition in the community. And **Seattle Children’s Hospital** partnered with community residents and community organizations to develop the “Livable Streets Initiative.”

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A Call for Leadership and Collaboration



“Achieving better health requires action by both individuals and by society. If society supports and enables healthier choices—and individuals make them—we can achieve large improvements in our nation’s health. Too often, we focus on how medical care can make us healthier, but health care alone isn’t sufficient. We need to cultivate a national culture infused with health and wellness—among individuals and families and in communities, schools and workplaces.”

—RWJF Commission to Build a Healthier America, 2009

Opportunities to Advance a Culture of Health

Creating a culture of health where children have the opportunity to grow up healthy and communities offer opportunities for all to make healthy choices requires involvement from all of us—individuals, thought leaders, business leaders and community developers, education leaders and policy-makers. All have a role to play in ensuring that health is not only a core value, but that health is strengthened by working together, with a common vision.

As a Commission, we outline three critical areas in which leadership and collaboration are needed and offer specific action steps that partners—many of them outside of health care—can take to move the country toward a culture of health.

Recognizing that every community has different assets and challenges, each community must forge its own way forward. Throughout this report, we provide examples of opportunities for leadership and change from around the country, which include:

- Healthy Communities cross-sector work launched by the Federal Reserve Bank of San Francisco between community development and health.
- The U.S. Green Building Council’s movement to show how green building can advance health and well-being through better use of healthy materials, access to healthy food

and clean fresh air and water, and design that encourages physical activity.

- The Low Income Investment Fund’s change in mission and investment strategy to better incorporate health into its work.

This report identifies opportunities for action, highlighting examples of where change is needed and how cross-sector collaboration can make it happen. It identifies opportunities that can be pursued at the local, state, and national levels, across all sectors. Cross-sector collaboration is a strong, swift, and efficient strategy to employ toward improving health.

It is also important to note that individuals from different generations have roles to play in advocating and working for changes to improve health. Recognizing the necessity of good health for future generations, older Americans can

take the lead in demanding that policy-makers invest in health. Young people can also play a powerful role—using new advocacy and communications tools—to help others understand how integral health is not only now but for future generations. While each of us has a personal responsibility to make choices that support good health for ourselves and our families, we as individuals can also catalyze others to do the same and spur larger groups to remove barriers to good health. Every family wants to do right by its children, but some families need greater support to make this happen.

The following section identifies opportunities for improving health, by sector:

Private Sector

- **Businesses and employers** can invest in making their communities healthier places to live and work, recognizing the long-term economic benefits.
- **Financial institutions** can incorporate health improvements into their investment strategies, recognizing the long-term return from investing in early childhood education and creating communities that promote health.
- **Health professionals and institutions** can adopt new vital signs for health and connect patients with services and resources.
- **Health payers** can restructure financial incentives to reward health promotion, not just disease management.

Public Sector

- **State and local government** can make early childhood development a high priority and offer financial and policy incentives for investments in communities that create healthy choices.
- **Federal and state government** can maintain funding streams; continue to lead the way in cross-sector collaboration; streamline reporting requirements; and provide financial incentives for innovation, as well as guard against automatic health care spending, while shifting focus to other areas that greatly impact health.
- **Public health agencies, organizations, and state health departments** can share best practices and partner with other groups to integrate health into efforts outside of health care.
- **Public health care payers** can use financial incentives to reward health promotion.

Nonprofit Sector

- **Advocacy organizations at all levels—local, state, and national**—can demand quality early childhood programs and opportunities, and mobilize cross-sector collaboration to share resources in support of common goals.
- **Community leaders** are particularly critical in advocating for local residents. They often operate from a place of trust and can spur people to action. They uniquely understand local needs, challenges, and potential solutions.
- **Philanthropic institutions** can identify and support innovative models of cross-sector collaboration that integrate health, community building and design, joining with new partners in supporting demonstrations, and recognizing the need for risk-taking in new ventures.
- **Faith leaders** can serve as respected voices in their communities, teaching community members about the value of health.
- **Nonprofit hospitals** can use community benefit assessments to identify ways to improve the overall health of the community.
- **Community development practitioners** can consider health improvement as one goal of their work, seeking out new partners and ensuring that every investment in a low-income community promotes health.
- **Education and early childhood development program leaders** can integrate the latest science into their trainings and curricula, help raise awareness of what constitutes “high-quality” early childhood development, and demand high performance.

Academia

- **Research institutions and universities** can train leaders in developing healthy communities, help create new data and metrics for cross-sector collaboration, and serve as clearinghouses for data. They can also train health professionals to recognize and address the social factors that affect health as part of overall patient care.

Unhealthy America

Despite spending more on medical care, Americans, on average, have worse health and shorter lives than people in other wealthy countries. Our international ranking on health continues to slip, and not only poor Americans and members of racial or ethnic minority groups are affected. Even affluent people and Whites rank low on more than 100 health measures when compared to their counterparts in other countries.

Of equal concern are dramatic differences in health *within* the United States, where health can vary dramatically from community to community. In New Orleans, for example, a person born in the Lakeview area can expect to live 25 years longer than one born near Iberville—just a few miles down Interstate 10 (*Figure 3*). In Washington, D.C., a few Metro stops represent dramatic differences in life expectancy—up to seven years on the system’s Red Line (*Figure 2*).

These place-based differences in health are strongly linked with differences in people’s incomes, educational attainment, and racial or ethnic group.

For multiple measures of health throughout life—including life expectancy, infant mortality, overall health and obesity during childhood—better health is linked with higher levels of income and education. While people in the poorest or least educated groups typically experience the worst health, even middle-class Americans are less healthy than those with greater social advantages. For example, 25-year-old college graduates, on average, live eight to nine years longer than people who have not completed high school. And the contrast is not just between the extremes—they can also expect to live two to four years longer than their counterparts who have attended but not completed college (*Figure 4*).

Dramatic differences in health across racial or ethnic groups are also well-documented. These disparities are often markedly reduced, but not always eliminated, when differences in income and education are taken into account—showing that socioeconomic factors and the experiences of people in different racial or ethnic groups are both important to health (*Figures 5, 6*).

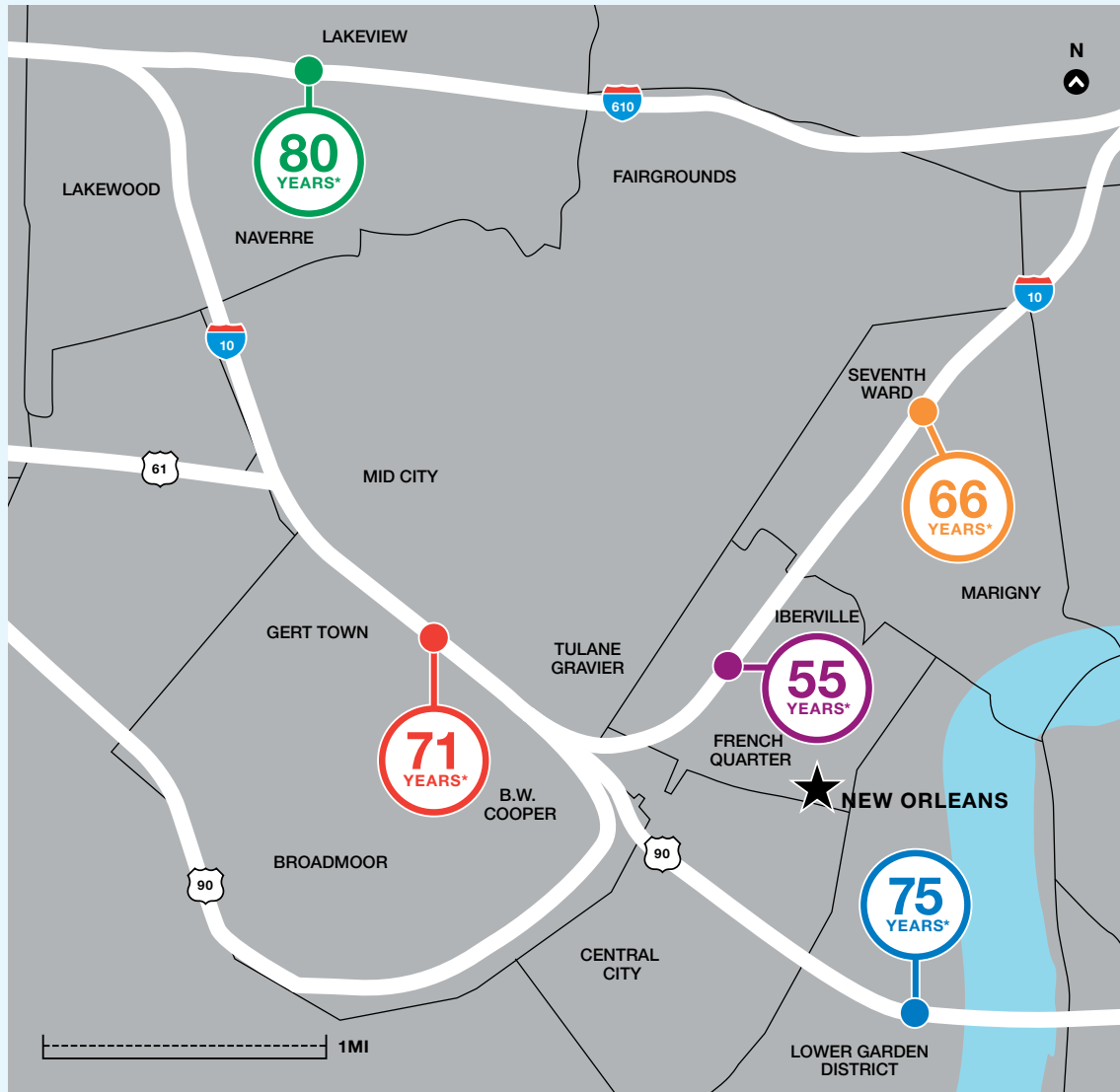
What Do We Know About the Causes of America’s Poor Health?

We all must take responsibility to make healthy choices for ourselves and for our families. But for some of us, because of where we live, learn, work, and play, those choices are virtually impossible, with obstacles too great to overcome, no matter how motivated we may be.

Medical care is critically important for maintaining health and treating illness, and behaviors clearly play a key role in shaping health as well. But we have overwhelming evidence that we must look beyond medical care and traditional approaches to changing behaviors in order to improve the health of all Americans.

NEW ORLEANS:
Short Distances to Large Disparities in Health

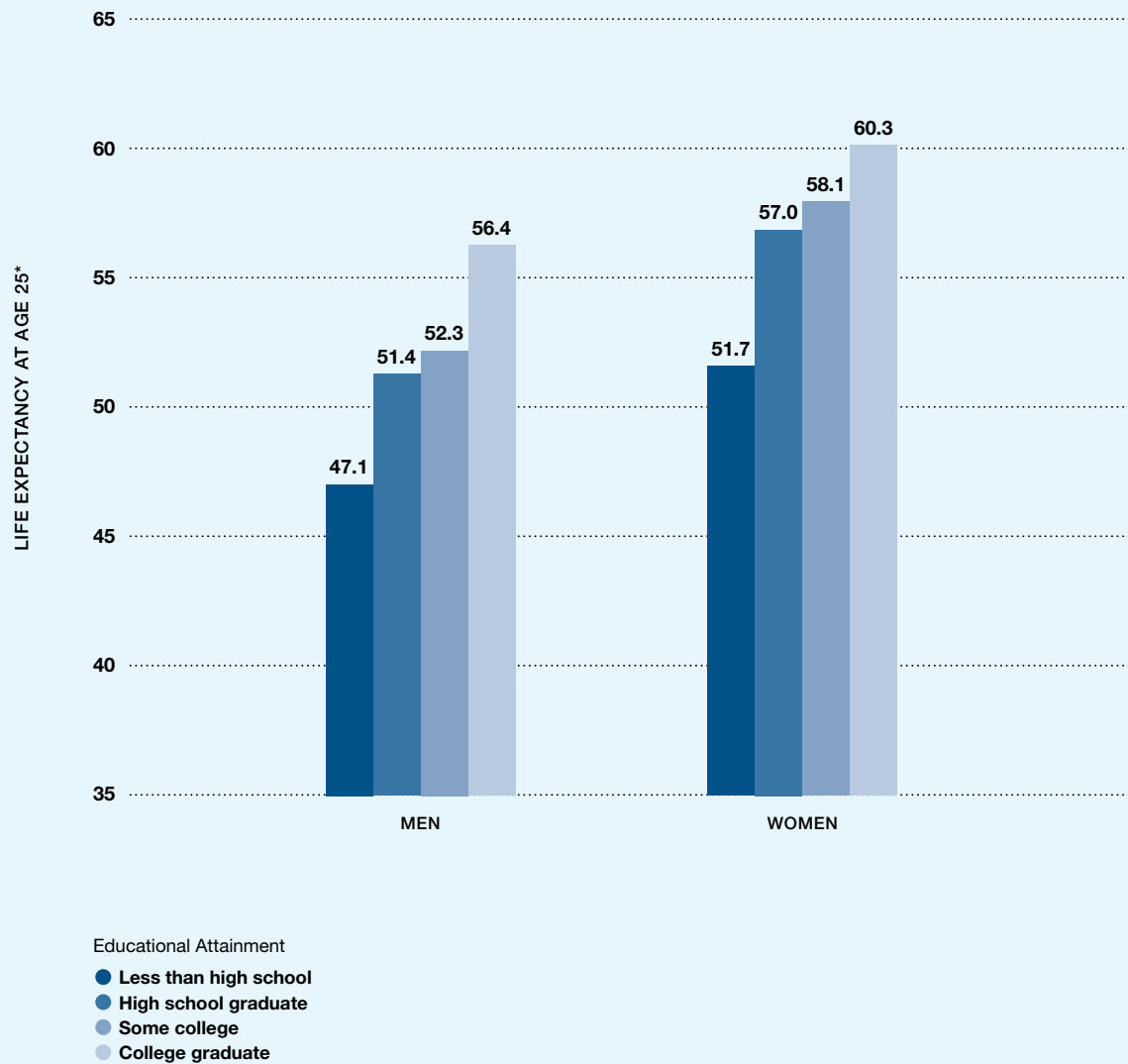
figure 3 The average life expectancy for babies born to mothers in New Orleans can vary by as much as 25 years across neighborhoods just a few miles apart.



Source: Prepared by Woolf et al., Center on Human Needs, Virginia Commonwealth University using Evans BF, Zimmerman E, Woolf SH, Haley AD. *Social Determinants of Health and Crime in Post-Katrina Orleans Parish: Technical Report*. Richmond, VA: Virginia Commonwealth University Center on Human Needs; 2012.
 *Life expectancy at birth

More Education, Longer Life

figure 4 For both men and women, more education often means longer life.* On average, 25-year-old college graduates can expect to live eight to nine years longer than their counterparts who have not completed high school and two to four years longer than those who have attended but not graduated from college.

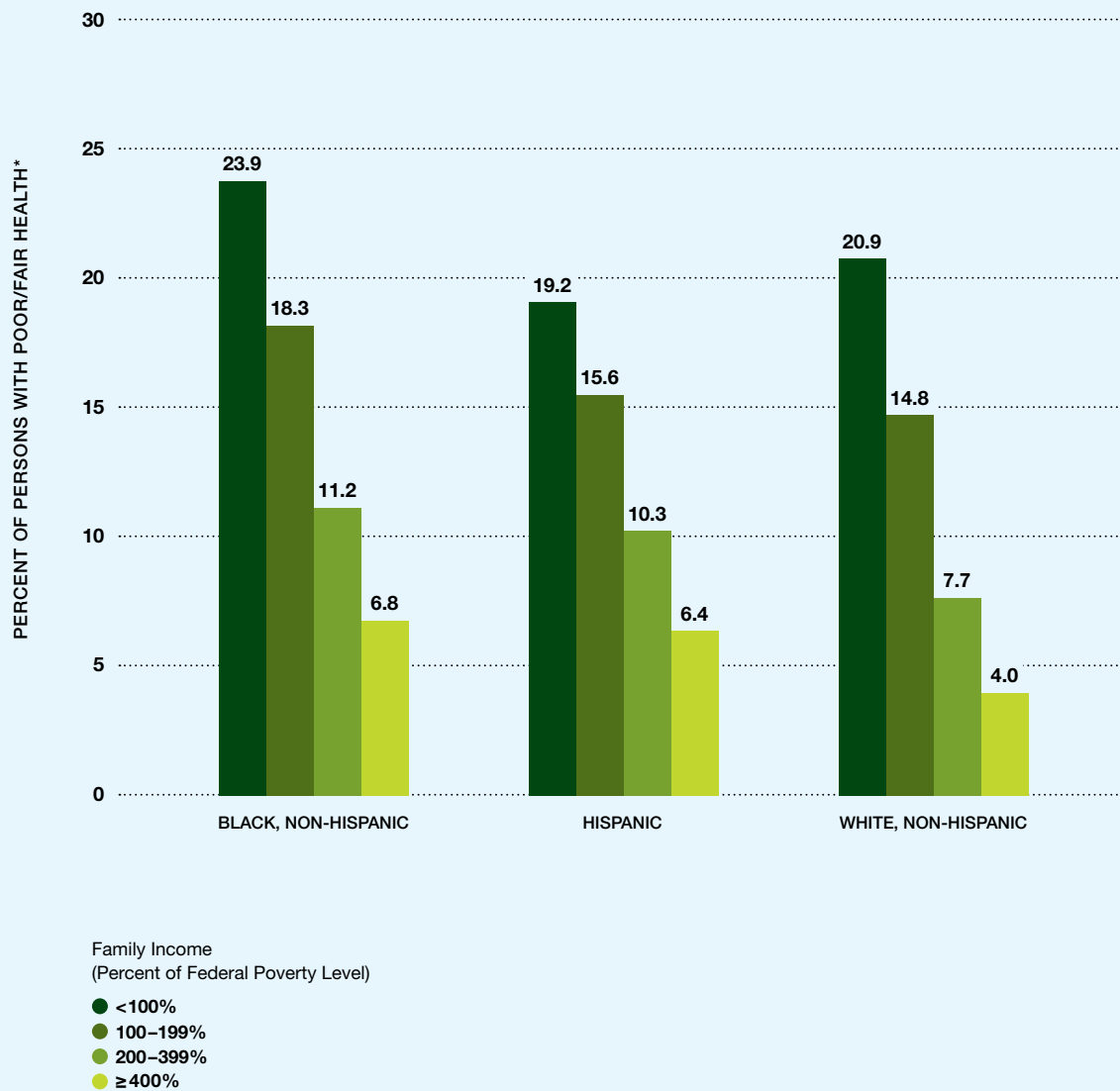


Source: CDC/NCHS, *National Health Interview Survey Linked Mortality File*, 2006. Published in National Center for Health Statistics. *Health, United States 2011: With Special Feature on Socioeconomic Status and Health*. Hyattsville, MD: 2012. www.cdc.gov/nchs/data/hus/2011/fig32.pdf. Accessed November 29, 2012.

*This chart describes the number of years that adults in different education groups can expect to live beyond age 25. For example, a 25-year-old man with a high school diploma can expect to live 51.4 additional years and reach an age of 76.4 years.

Income Is Linked With Health Across Racial or Ethnic Groups

figure 5 Differences in health status by income do not simply reflect differences by race or ethnicity; differences in health by income can be seen within each racial or ethnic group. Both income and racial or ethnic group matter for health.

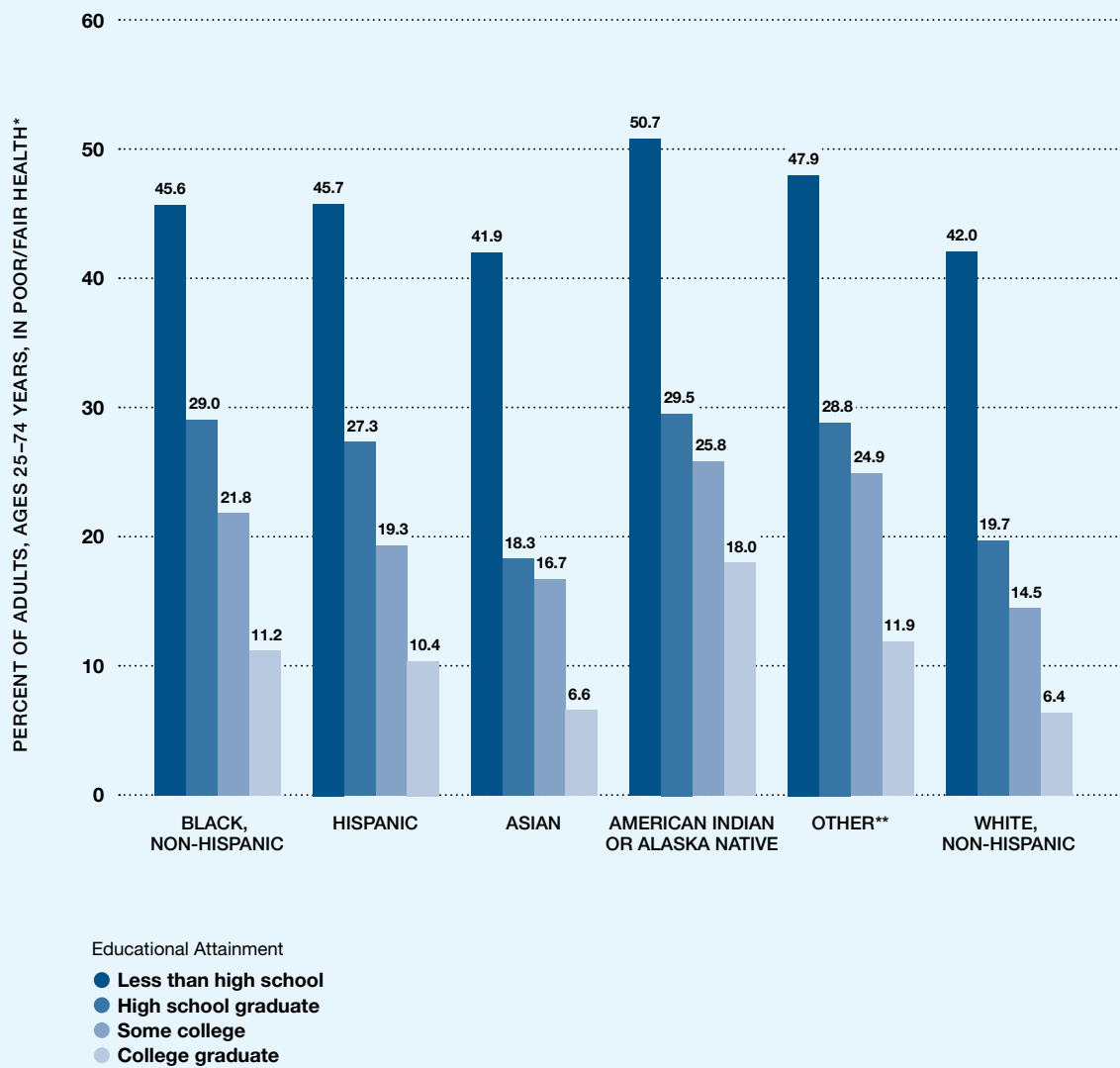


Source: CDC/NCHS. *National Health Interview Survey 2010, Family Core And Sample Adult Questionnaire*. Published in National Center for Health Statistics. *Health, United States 2011: With Special Feature on Socioeconomic Status and Health*. Hyattsville, MD: 2012. www.cdc.gov/nchs/data/hus/2011/056.pdf. Accessed November 29, 2012.

* Age-adjusted. Based on self-report and measured as poor, fair, good, very good, or excellent.

Education Is Linked With Health Across Racial or Ethnic Groups

figure 6 Differences in health status by education do not simply reflect differences by race or ethnicity; differences in health by education can be seen within each racial or ethnic group. Both education and racial or ethnic group matter for health.



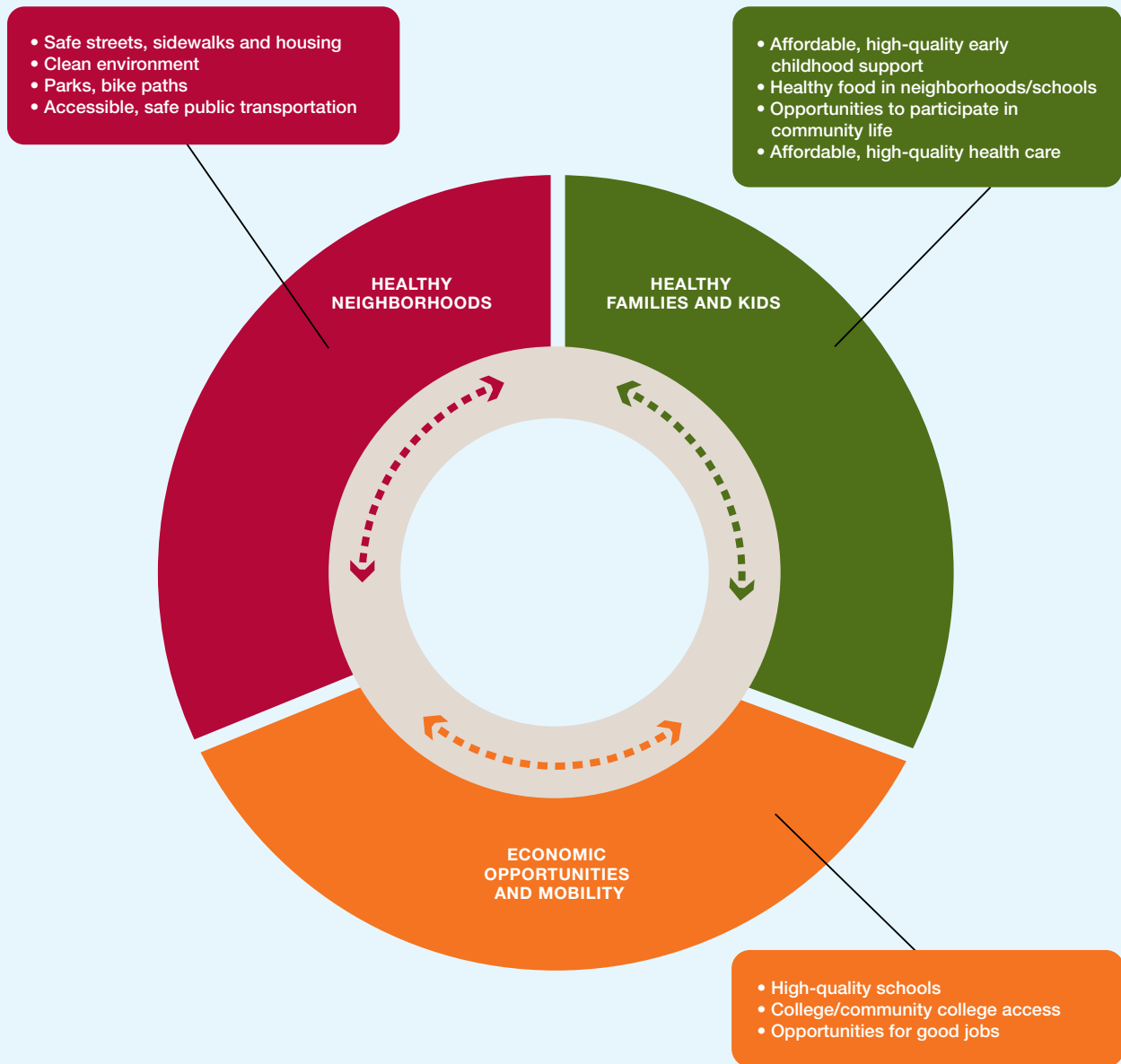
Source: Analyses by C. Cubbin, University of Texas at Austin. Data from Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008-2010.

* Age-adjusted. Based on self-report and measured as poor, fair, good, very good, or excellent.

** Defined as any other or more than one racial or ethnic group, including any group with fewer than 3 percent of surveyed adults nationally in 2008-2010.

Building Communities Where the Healthy Choice is the Easy Choice

figure 7 Healthy neighborhoods, healthy families and kids, and economic opportunity and mobility are interconnected. Building places where healthy behaviors are possible requires a focus on all three.



Source: Andrews, N. *People and Place: A New Vision for Healthy Communities*. Testimony Prepared for the Robert Wood Johnson Foundation Commission to Build a Healthier America. June 2013. www.liifund.org/wp-content/uploads/2013/06/People-and-Place-A-New-Vision-for-Healthy-Communities.pdf. Accessed December 12, 2013.

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We all must take responsibility to make healthy choices for ourselves and for our families. But for some of us, because of where we live, learn, work, and play, those choices are virtually impossible, with obstacles too great to overcome, no matter how motivated we may be.

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Although many questions remain unanswered, current science sheds light on potential causes of the striking differences between the United States and other countries and among Americans in different social groups. The past two decades have seen major advances in our understanding of how social factors—such as adversity and stress in early childhood, characteristics of housing and neighborhoods, income, education, and race and ethnicity—can shape health.

Early Childhood Experiences. Experiences in childhood shape health in adulthood and in generations to come. Adversity and health-harming stress due to poverty, abuse, neglect, neighborhood violence, or the substance abuse or mental illness of a parent or other caregiver can determine whether “good” (healthy) or “bad” (health-harming) genes are expressed or suppressed, with potentially lifelong consequences. Chronic stress during childhood appears to have particularly profound and enduring adverse effects on health throughout life, and can lead to the development of chronic diseases, such as heart disease and diabetes, and to premature death.

Communities. Health and health-related behaviors have been linked with many features of neighborhoods, including: the proportion of people living in poverty; the density of convenience stores, liquor stores, and fast-food restaurants relative to grocery stores selling fresh foods; access to transportation; the condition of buildings; and the presence of sidewalks and places to play or exercise.

Income. A family’s income affects the health of parents and children. More income can increase access to nutritious food and other health-promoting goods and services, and can reduce stress by making it easier to cope with daily challenges. More income can make it possible to live in a safe community with good public schools or to pay for private schools. This can affect a child’s ultimate educational attainment, which in turn shapes job prospects and thus income levels in adulthood, potentially leading to the intergenerational transmission of poverty.

Education. Higher educational attainment can increase knowledge, problem-solving, and coping skills, enabling people to make and maintain healthier choices. Education may also have powerful health effects by determining job prospects and thus earning potential. And education may also influence health through psychosocial pathways, by shaping people’s social networks and perceptions of their own social status, for example. We now know that education in early childhood—long before kindergarten—powerfully shapes children’s readiness to learn and thus is a crucial determinant of educational attainment, particularly for children in low-income families.

Racial or Ethnic Group. Racial or ethnic differences in health can be explained in large part by socioeconomic advantages and disadvantages—differences in income, education, and neighborhood features—that are the persistent legacy of discrimination. Chronic stress related to experiences of racial bias may also contribute to ill health, even without incidents of overt discrimination, and even among affluent and highly educated people of color.



Photo: Tyrone Turner

Still the Land of Opportunity?

For a long time, the United States has prided itself on being the “land of opportunity,” where motivated and hard-working people could succeed, despite being born poor. That belief is the essence of the American Dream.

But the American Dream is quickly becoming unattainable for many as the gap grows between the bottom and the top of the economic ladder. Economic mobility is a strong indicator of how long and how well a person—and his or her children—will live. Lack of economic mobility creates a cycle of disadvantage that is passed on—and that can accumulate—from generation to generation, with likely adverse social and economic consequences for all Americans.

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Overall, the U.S. has fallen behind other developed countries as the land of opportunity. Compared with Americans, twice as many people in Canada and Australia are able to increase their financial status.²⁴ Within the U.S., economic mobility varies dramatically from place to place. Where people live may affect whether they can escape poverty and achieve good health, regardless of how hard they try.
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For example, in Salt Lake City, San Francisco, Seattle, and Pittsburgh, residents are far more likely to move from the bottom fifth to the top fifth of the income scale during their lifetimes than their counterparts in Atlanta, Charlotte, and Indianapolis—cities where fewer than 5 percent of children born to families in the bottom income quintile reach the top quintile as adults. For the most part, Americans raised in the top and bottom of the economic ladder are likely to stay there as adults, according to the Pew Mobility Project.²⁵ Overall, cities with less upward mobility are more economically and racially segregated and have lower-quality schools and higher proportions of single-parent families.

Internationally, the U.S. ranks behind every other developed nation on income inequality, a measure of the gap between the rich and the poor.

The American Dream does not have to die: There is good reason to believe that income mobility can be greatly increased if communities have greater access to high-quality early childhood programs, mixed-income housing, supportive services for families, and access to good jobs and education opportunities. Increased economic mobility can help ensure that the next generation will live longer, healthier lives.

Opportunities for health early in life can set children on the path to healthy lives. Health is transmitted across generations as families with greater social and economic advantages pass those advantages on to their children, through inherited wealth and educational opportunities that affect later earning potential. In contrast, children from families disadvantaged by income, education, or racial or ethnic inequality are more likely to grow up in health-damaging conditions that lay the groundwork for poorer health throughout life. They are more likely to experience social disadvantage as adults and as parents providing for their own children, continuing a vicious cycle of social disadvantage and poor health.

What Do We Need to Do Differently to Improve America's Health?

To improve health, we need to think more broadly, for example, about the policies that will improve the economic and social factors that shape people's lives.

Many of the social support strategies developed to help America's most vulnerable families were created decades ago and don't adequately address 21st-century problems. And too many of our current investments reflect these outdated approaches. For example, research tells us how critical learning is from birth to age 3, but public education typically starts at age 5. Yet, we know that children who attend preschool are more likely to stay in school, go on to have jobs and earn more money—all of which are linked to better health. Similarly, many of our strategies to improve low-income communities were developed 40 or 50 years ago and are focused on inner cities, despite the fact that disadvantage has increasingly moved into the suburbs. And when we visit a health professional, we are typically checked for heart rate, blood pressure, temperature, weight and height, but are rarely asked about potential barriers to health such as lack of a job, housing, or access to healthy food.

Improving America's health will require a dramatically new approach that accounts for knowledge gained over the past several decades.

Is Poor Health Threatening the American Dream?

The "American Dream" envisions a nation where each of us can achieve a better life than we were born into, if we work hard. But this assumes that we all have access to a good education; jobs with incomes to meet our basic needs; family supports when we face overwhelming challenges; and health care to keep us well. As disparities in education, income, and health widen, the "American Dream" is becoming unachievable, especially for those who live in neighborhoods with limited access to a good education; safe and affordable housing; opportunities for jobs; and transportation to get to work. In the United States, opportunities for health increasingly vary from ZIP code to ZIP code.

Opportunity is even further out of reach for some: Children in single-parent households are particularly unlikely to escape poverty as adults. Compared to children raised with two parents, children raised by single parents are more likely to drop out of high school, be unemployed as teenagers, and less likely to enroll in college.²⁶ Children in single-parent families are more than three times as likely to be poor than children raised in two-parent households; in 2011, 42 percent of children in single-parent families were poor, compared to 13 percent of children in two-parent families.²⁷

All of these factors are inextricably linked to greater economic mobility and better health. For the most part, Americans who are raised in the top and bottom of the economic ladder are likely to stay there as adults, according to the Pew Economic Mobility Project.²⁸

Today, the "American Dream" may actually be easier to achieve in Canada or Australia, where twice as many people as in the United States are able to improve their economic status.²⁹

It Is Time to Act

These problems won't get better on their own—the time to act is now. After many months of delving deeply into what affects health outside of health care, we are convinced that this country needs to focus on: prioritizing investments in America's youngest children; fostering collaborative, public-private partnerships to spark healthy community development; and making it easier for health professionals and health care institutions to go beyond treating illness alone to helping people live healthy lives. This report is intended to inform and guide these necessary changes.

Investing in Early Childhood Development



Recommendation 1:

Make investing in America’s youngest children a high priority. This will require a significant shift in spending priorities and major new initiatives to ensure that families and communities build a strong foundation in the early years for a lifetime of good health.

Problem

Despite clear evidence showing the importance of positive early childhood development experiences for lifelong health and well-being, this country does not make spending on our youngest children, from birth to age 5, a high priority.

The United States ranks 25th out of 29 industrialized countries in public investments in early childhood education. As a country, we invest far more money in education for grades 6 through 12 than in early childhood, even though research shows that 90 percent of a child’s brain capacity is developed by age 5 long before many children in this country ever walk through a kindergarten door (*Figure 8*). Research also shows that experiences in the earliest years—including growing up in a well-regulated and responsive home environment, living in a safe neighborhood, and having access to high-quality early childhood programs—can greatly impact long-term health and affect the health of generations to come.³⁰

Investments in young children should be viewed as critical building blocks for lifelong health and for the nation’s future. Testimony and research presented to this Commission in June 2013 demonstrate that development of high-quality early childhood programming is vital, not only to enhancing school readiness and later academic performance for children, but also to building a strong foundation for health. These programs can also play a role in ameliorating harmful effects of chronic adversity on children’s learning ability, behavior, and physical and mental health.

The American Academy of Pediatrics describes toxic stress as “severe, chronic stress that becomes toxic to developing brains and biological systems when a child suffers significant adversity, such as poverty, abuse, neglect, neighborhood violence, or the substance abuse or mental illness of a caregiver.”³¹

Advances in neuroscience explain how early childhood experiences and exposure to toxic stress can “get under the skin” and cause physiological changes in children’s brains and bodies that affect lifelong outcomes in health and well-being. Toxic stress and resulting physiological changes are strongly linked to an array of health outcomes, including heart disease, stroke, hypertension, diabetes, obesity, smoking, drug use, and depression. They affect the developing brain and the immune system.

Intervening in early childhood can break the cycle of health disadvantage into adulthood and across generations.

What’s Needed?

Significant and sustained investment will be needed to ensure that our nation’s most vulnerable young children benefit from high-quality early childhood developmental services and family supports. This will require a shift in

spending priorities, including a redirection of federal, state, and local dollars from underperforming programs. As University of Minnesota economist Arthur Rolnick told this Commission in June 2013: “Compared with the billions of dollars spent each year on high-risk economic development schemes, an investment in early childhood programs is a far better and far more secure economic development tool.”³²

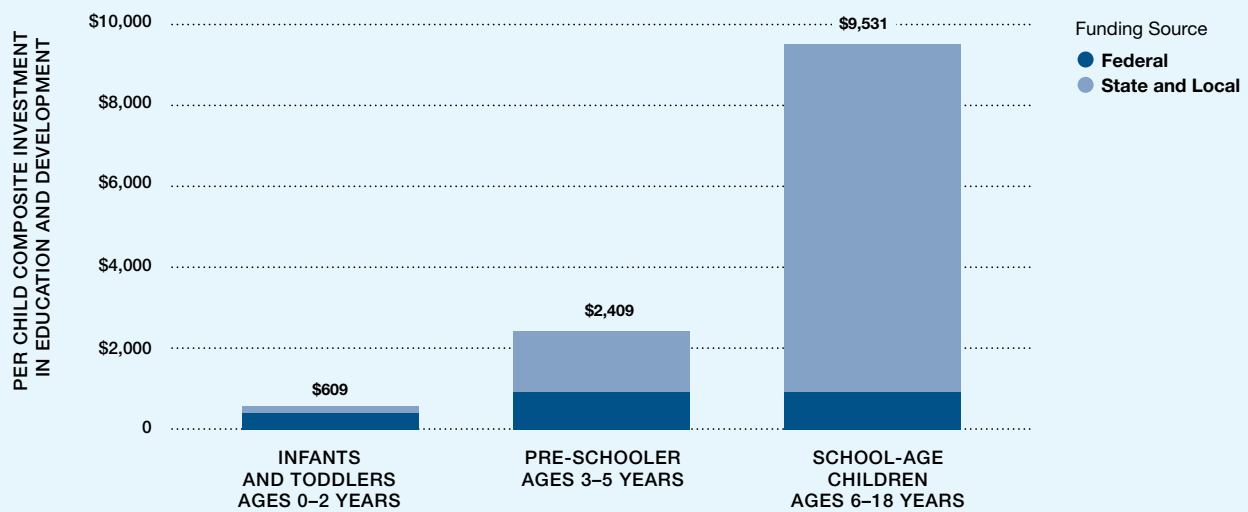
According to estimates, the rate of return on effective early childhood development programs that focus on high-risk families ranges from \$3 to \$17 per dollar invested.³³ Not surprisingly, financing is the biggest barrier to increasing access and improving outcomes, especially as our nation struggles to overcome a significant economic recession and debates how to continue funding large, established public programs in the health arena.

Despite these challenges, calls for investment in early childhood have been growing, as evidenced by President Barack Obama’s push for an early childhood initiative and repeated calls by business to invest in this area. According to Ready Nation, a national coalition of business leaders who support early childhood policies to strengthen the U.S. economy and workforce: “The evidence is undeniable. Quality early childhood programs, including early education and home visiting/parent mentoring, will help close the achievement gap, reduce social costs, and increase adult productivity. Investing in these programs, especially for disadvantaged children, is fiscally responsible because they pay for themselves.”³⁴

Additionally, in 2014, a committee of the Institute of Medicine and National Research Council will examine how the science of child development can better inform

We Do Not Prioritize Spending on Our Youngest Children

figure 8 Federal and state spending on children in all 50 states and the District of Columbia is largely directed at school-age children, despite clear evidence showing the importance of early child development experiences.



Source: U.S. Census 2000 and American Community Survey 2006

workforce and education systems to support children's health, development, learning, and school success from birth to age 8. It is anticipated that committee members will pay particular attention to research on income inequality, race and disadvantage; learning environments in the home and in schools; adult learning processes for teaching children; and developing a workforce that can support children's learning and growth from birth to age 8.

Giving our children a solid start will require concurrent efforts on many fronts, including:

- Making investments in America's youngest children a high priority.
- Creating and strengthening standards for high-quality early childhood development programs.

- Linking funding of any programs or services to performance on health-related measures.
- Guaranteeing access to high-quality early childhood programs for all low-income children under age 5 by 2025.
- Offering programs and resources to families to enable them to provide healthy, nurturing experiences for their children at home.
- Ensuring that all early childhood development and family support strategies are based on solid evidence.
- Using early childhood programming and social supports to ameliorate the harmful effects of toxic stress.
- Fostering cross-sector collaboration that takes a comprehensive view of a child's needs and stretches wide, from maternal health to early learning to public health and community support to child welfare to planning and zoning.

ROI on Early Childhood Investments



Early childhood-development programs that focus on at-risk families show **returns ranging from \$3 to \$17** for every dollar invested.

Source: Grunewald R, Rolnick A. An Early Childhood Investment with a High Public Return. Federal Reserve Bank of St. Louis. 2010. <http://www.stlouisfed.org/publications/re/articles/?id=1987>. Accessed November 8, 2013.

Recommendation

Create stronger quality standards for early childhood development programs, link funding to program quality, and guarantee access by funding enrollment for all low-income children under age 5 in programs meeting these standards by 2025.

High-quality early childhood programs are critical building blocks for a lifetime of good health, helping children enter kindergarten ready to learn, and making them more likely to stay in school and attend college. Children who aren't ready for kindergarten are half as likely to read proficiently by third grade³⁵—and children who are not reading proficiently by third grade are four times more likely to drop out of high school.³⁶ Educational attainment is strongly linked to health.

These programs, done well, can confer a lifetime of benefits on children, especially those from disadvantaged families, and can have a direct impact on health by helping mitigate the effects of toxic stress that many low-income children face.

However, only a small fraction of low-income children are in high-quality programs.³⁷ Few such programs are available, and, when they are, either space is limited or parents are unable to afford them. It is imperative that all children have access to high-quality programs, but we must first work to ensure that all programs offered meet consistent high-quality standards and include components aimed at improving lifelong health.

The importance of health-related outcome measures cannot be overlooked. According to the National Association for the Education of Young Children, early childhood development programs “have too often taken fragmented, piecemeal approaches to the complex issues facing children and families.”³⁸

A study by the Center on the Developing Child at Harvard University, National Forum on Early Childhood Program Evaluation, and National Scientific Council on the Developing Child concluded that specific characteristics of high-quality early childhood development programs include:

- Highly skilled teachers
- Small group sizes with low child-teacher ratios
- Age-appropriate curricula and stimulating materials provided in a safe physical setting

- A language-rich environment
- Warm, responsive interactions among staff and children³⁹

But leaders in early childhood development programs are beginning to expand their definitions of “high quality” by incorporating broader assessment measures that address health and social factors that powerfully influence health.

For instance, Head Start performance standards include several measures related to health, including whether a child has access to health care and whether a child is up to date on preventive and primary care.⁴⁰ And Educare, a network of full-day, year-round schools for at-risk children up to age 5, has several sites that incorporate access to dental screenings, on-site health clinics, and nutritional services.

Linking Funding to Program Quality

Federal, state, and local governments; private funders; communities; and parents must demand that early childhood development programs meet the highest quality standards, and that measures address not only health but the nonmedical factors that affect health.

Stronger quality standards should include:

- Process measures tied to standards of success (e.g., teacher credentials and adult/child ratios)
- Health-related outcome measures that assess educational progress including cognitive, physical, social and emotional development, kindergarten readiness, and health status
- Social well-being measures related to factors that affect health, including safe housing, access to healthy food, and exposure to toxic stress

Funding for early childhood programs should be tied to high performance. Evidence shows that tying funding to high quality can motivate poor performing programs to improve.

Families enrolled in programs that do not improve may face a disruption in services, but the goal is to improve quality.

Created in 1965, Head Start provides early learning services to preschoolers in low-income families through grants to nearly 1,600 local community organizations. In some areas, Early Head Start also serves infants, toddlers, pregnant women, and families with incomes below the federal poverty level. In addition to education and cognitive development services, Head Start programs provide comprehensive services, such as health, nutrition, and other services determined to be necessary by family needs assessments.

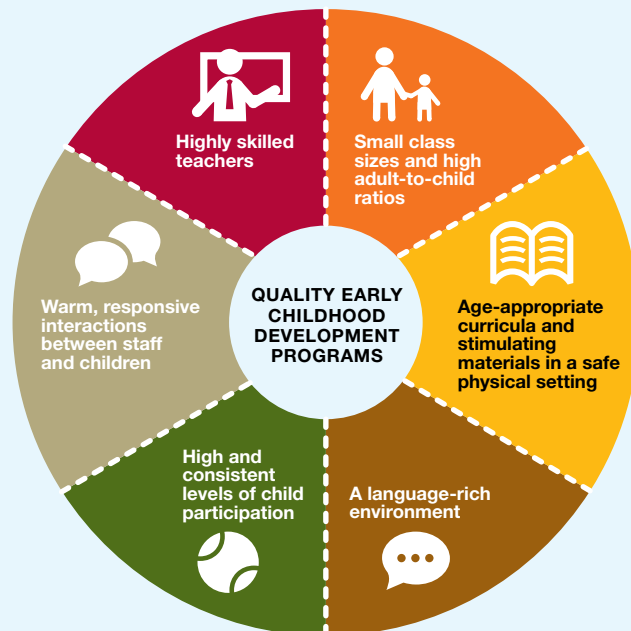
In 2010, an assessment released by the federal government found the quality of Head Start programs to be inconsistent.⁴¹ The evaluation found that while, on average, having access to Head Start resulted in more positive experiences, the experiences of children and the services they received varied. As a result, in November 2011, the U.S. Department

of Health and Human Services implemented tougher rules for low-performing Head Start grantees. The new rules require grantees that fail to meet benchmarks to re-compete for continued federal funding if deficiencies are discovered in their onsite reviews; if they fail to establish and use school-readiness goals for children; or if children perform poorly in the classroom.

State and federal agencies should strengthen and enforce quality standards for early childhood development programs, including Head Start, to reach beyond the provision of rich learning experiences. They should build on existing knowledge and evidence to incorporate interventions designed to protect the developing brain from significant adversity that can lead to poor outcomes. Just as the federal government can link funding to performance standards for Head Start, states and communities should use systematic criteria to link funding to performance on a broad range of measures for other early childhood programming.

Early Childhood Program Quality Measures

figure 9 Specific characteristics of quality early childhood development programs include a broad array of components.



Source: *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*. Center on the Developing Child. http://developingchild.harvard.edu/resources/reports_and_working_papers/policy_framework/. Accessed December 23, 2013.

Promising Approaches

As stronger standards for high-quality early childhood programs are developed, several promising models are worth examining:

Educare is a network of state-of-the-art, full-day, year-round schools across the country providing at-risk children from birth to age 5 with comprehensive programs and instructional support that build skills and the foundation for successful learning. The goal is to prepare children who are growing up in poverty to enter kindergarten on a par with children from middle-income families. Program evaluations show that Educare children have more extensive vocabularies and are better at recognizing letters, numbers, and colors than non-Educare peers (*Figure 10*). Educare-enrolled children also develop strong social skills, including self-confidence, persistence, and ways to manage frustration.

Four Educare schools include or are directly adjacent to on-site health clinics, and two others are linked to elementary schools with on-site health clinics. Many provide dental screenings, additional nutrition efforts, and efforts to counter obesity.

Georgia's Pre-K Program was the first to offer pre-kindergarten, free of charge, beginning in 1993 under Governor Zell Miller. Financed through lottery funds, the program initially provided pre-kindergarten programs for at-risk 4-year-olds. In 1995, the program was expanded beyond at-risk children to include all eligible 4-year-olds in the state. In March 1996, the Georgia General Assembly created the Office of School Readiness, a department that administered the pre-K program, federal nutrition programs, and other early intervention services. This department became Bright from the Start: Georgia Department of Early Care and Learning in 2004.

Oklahoma's Universal Pre-K Program, created in 1998, the program enrolls 74 percent of the state's 4-year-olds and is funded by the state's school finance formula. Public school districts may subcontract with other classroom providers, allowing the program to operate in a variety of settings, including private child-care centers and Head Start programs. All Oklahoma pre-K teachers must hold at least a bachelor's degree and be certified specifically in early childhood education, in addition to following research-based curricula in the classroom. While the state does not provide specific funding for 3-year-olds, some Oklahoma

school districts offer classroom programs for these younger students through a combination of funding sources, including Title I, Head Start, special education, and general district funds. Multiple studies have shown that Oklahoma's effort has improved children's academic, cognitive and social-emotional development, which researchers attribute to a strongly supported early learning program with higher standards. According to a 2008 study, children who attended a Tulsa pre-K program entered kindergarten nine months ahead of their peers in reading, seven months ahead in writing, and five months ahead in math.⁴²

The Abbott Preschool Program in New Jersey provides children ages 3 and 4 in low-income school districts with high-quality early childhood education. The program operates in a variety of settings, including public schools; private child-care centers; and Head Start agencies, and meets quality benchmarks, including certified teachers; low child-teacher ratios; and research-based curricula. Abbott Preschool programs receive funding through a state school funding formula adopted in 2008—the School Funding Reform Act—at a per-pupil cost of \$7,416 for children in Head Start programs, \$11,506 for children enrolled in district programs, and \$12,943 for children enrolled in community child-care provider programs. The program has shown results across all measures of children's learning, leading Abbott students to significantly outperform their peers in early math skills, oral language, and conceptual knowledge. One year of participation in Abbott closed more than 50 percent of children's achievement gaps with respect to vocabulary and early literacy skills. Moreover, two years of participation in Abbott roughly doubled the gains at second grade on most measures.⁴³

StriveTogether brings together educators, nonprofit organizations, philanthropies, businesses, government agencies, political leaders, and others to pursue common goals for improving education from early childhood through early employment. Since 2006, StriveTogether has helped communities in 34 states and the District of Columbia. In Cincinnati, StriveTogether worked with the school department and a local United Way program to assess the readiness of every student entering kindergarten.

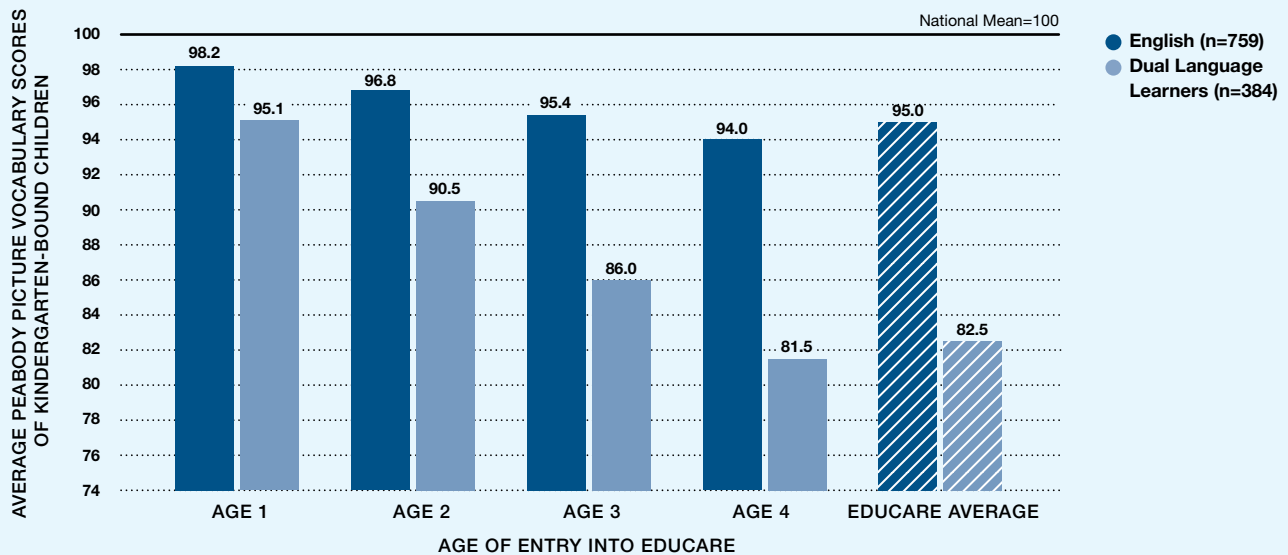
Subsequent work led to a 9 percent increase in kindergarten readiness over four years in Cincinnati, where progress had been stagnant for years. Similar gains have been realized in Newport, Ky., and Covington, Ky.⁴⁴

The Pre-K Counts Program, established by the Pennsylvania Department of Education, makes pre-kindergarten opportunities available to children and families across the state, providing families with a choice of pre-kindergarten options in Head Start, a school, or child-care center. The program builds on the work of the Pre-K Counts Public-Private Partnership for

Educational Success, a three-year, public-private project funded by leading Pennsylvania foundations and supported by the Commonwealth of Pennsylvania. Early results from the Pre-K Counts public-private initiative found that children’s early learning improved. At the beginning of the 2010–2011 school year, fewer than one in four of the 11,500 children in Pennsylvania Pre-K Counts classrooms had age-appropriate skills; by the end of the year, approximately three in four Pre-K Counts children showed age-appropriate language, math, and social skills.⁴⁵

More Years in Educare, Better Prepared for Kindergarten

figure 10 Children from both English- and Spanish-speaking homes who enter Educare before age 2 score over 98—near the national average (100) and exceeding the typical scores of at-risk children.



Source: *Educare Implementation Study Findings*. August 2012. University of North Carolina Chapel Hill Frank Porter Graham Child Development Institute. www.educareschools.org/about/pdfs/Demonstrating-Results.pdf. Accessed December 12, 2013.

We Must Act Now

To ensure that early childhood programs are consistent and of the highest quality, federal and state governments must create and enforce the development of stronger quality measures and tie funding to performance. Educators and practitioners must recognize the importance of programming that addresses all aspects of a child's life.

- State and federal agencies should create, strengthen, and enforce quality standards that also include measures of health.
- States should create consistent standards for all early childhood programs that receive public funding.
- New quality standards should address components known to help mitigate the negative effects of toxic stress that can adversely affect a child's brain development and long-term health.
- Educators and program developers should incorporate the latest science when developing new standards and programming.
- Public, philanthropic, and private funders should partner to provide necessary funding for innovation; collaborative ventures across sectors; and the creation of effective, scalable, and sustainable services for children and families.

Currently, Head Start programs are permitted to provide direct health services, serve as a broker of health services, or some combination of the two. Such services may include helping families find a medical home; locating funding for health services; working with local Medicaid and State Child Health Insurance Program agencies to determine a child's eligibility for medical assistance; or tracking health services.

Because social factors are so closely linked to early childhood development, Head Start and other programs could help identify and track these factors in a child's life, including whether parents have jobs and safe housing or whether children have access to healthy food. These programs could help connect children and families with other services in the community, such as Medicaid; Special Supplemental Nutrition Program for Women, Infants and Children (WIC); SNAP (food stamps); job training; and parent mentoring programs.

Ensuring Access to High-Quality Early Childhood Programs for All Low-Income Children

While creating high-quality programs is critical, we must also make sure that every child has access to these programs by funding enrollment for all low-income children under age 5 by 2025. Currently, two major factors prevent access to enrollment: the lack of program availability and high costs.

In particular, low-income children, as well as children living in rural areas and tribal areas, have difficulty accessing early childhood programs. Rural and Native American communities face unique challenges providing high-quality preschool programs, due in part to economic barriers that are intensified by geographic isolation. Rural and tribal school systems also rely more heavily than others on federal education funds, with fewer private and philanthropic dollars to support high-quality early childhood programs. **Save the Children's Early Steps for Success** program is designed specifically for rural areas. Through home visits, book exchanges, parenting groups, and an emphasis on transition to school, Early Steps staff members help children with language and social and emotional development, and equip parents and caregivers with the skills to successfully support children's growth. Additionally, **Educare** is opening a site in Winnebago, Neb., 80 miles north of Omaha, which will be the first Educare program to serve a Native American community.

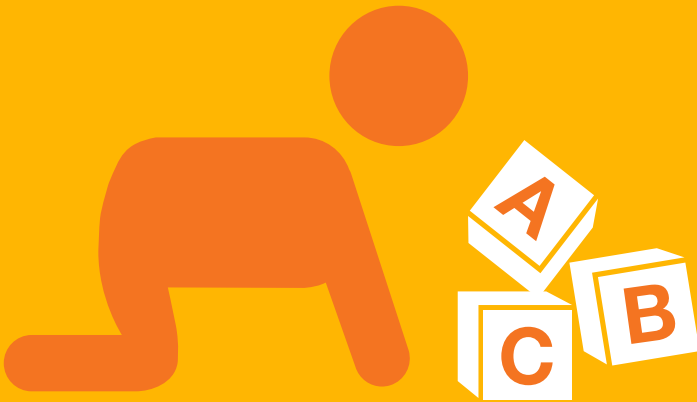
Funding for high-quality early childhood programming should be on a par with public education funding that begins for children at age 5. This will require reprioritizing programs, and redirecting existing funds from programs that are underperforming or considered to be a lower priority. No single funding stream can meet this need. Instead, all funding streams—federal, state, community, philanthropy, and private sector—will need to be tapped.

Estimates for funding early childhood programming for low-income children range from \$8,300 to \$15,000 per child per year.⁴⁶ This would require substantial public- and private-sector investment. Head Start already serves nearly one million children and pregnant women in their homes at a cost of \$8 billion annually, or \$8,331 per child.⁴⁷

Existing federal and state investments in young children and families should be re-assessed, and where there

is ineffective use of current funding, funds should be re-allocated to provide access to high-quality child development programs for low-income children. In addition, states should have flexibility to determine how to expand access to high-quality early childhood programming. They should consider ways to coordinate public funding from multiple sources—federal, state, and local—to ensure that every dollar is well-used.

Children Most in Need of Early Childhood Programs May be Least Likely to Access Them



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Fewer than half of the children eligible for Head Start are able to access this comprehensive early childhood program designed to serve children living in families at or below 100% of poverty.
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Fewer than 4 percent of at risk children under age 3 receive Early Head Start services.
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Source: Rasmussen, J. *Leveling the Playing Field: The Value of Investing in Early Childhood Practice, Policy, and Knowledge*. Testimony Prepared for the Robert Wood Johnson Foundation Commission to Build a Healthier America. June 2013.

Promising Approaches

Recognizing that there is no cookie-cutter approach to funding access to high-quality early childhood development programs, we reviewed several that use a variety of funding sources:

- **State-Funded Scholarship Programs: The Saint Paul Early Childhood Scholarship Program**, created in 2008 by Federal Reserve Bank of Minneapolis economists Arthur Rolnick and Rob Grunewald and the Minnesota Early Learning Foundation, was a four-year pilot program that offered early childhood education scholarships for at-risk children. Parents received access to home-visiting mentors and to a four-star rating system so that they could assess programs and decide for themselves which programs best met their children's needs. Children who participated showed significant gains in kindergarten readiness measures, including vocabulary, phonological awareness, print knowledge, and social competence. In addition, the program's rating system convinced more than 400 early education providers in the pilot areas to voluntarily improve quality. Since the pilot ended, Minnesota has approved funding for early learning scholarships. Going forward, the Minnesota Department of Education estimates that 4,000 scholarships per year will be awarded to families with young children, representing approximately 9 percent of eligible children in the state.

In testimony to this Commission, Rolnick proposed creating a permanent scholarship fund to enroll low-income children in quality early childhood development programs. He estimates that the total resources needed for an at-risk child 3 or 4 years of age would be about \$10,000 to \$15,000 per year for a full-day program that includes parent mentoring. He estimates that a one-time outlay of \$1.5 billion—about the cost of two professional sports stadiums—would create an endowment that could provide scholarships for all low-income children in Minnesota.⁴⁸

- **Local Tax Funding:** Denver voters approved a ballot measure in 2006 that sets aside a percentage of Denver sales tax revenue to fund the **Denver Preschool Program**. Since January 2007, the city has collected approximately \$10 million per year for the program, the vast majority of which goes directly to the students' education through tuition credits and quality improvement funding for preschools. The typical Denver Preschool Program family receives \$254 to \$283 per month to help pay for preschool; two-thirds of Denver Preschool Program families report annual family incomes of less than \$30,000. The Denver Preschool Program has quickly grown to become one of the most highly enrolled programs of its kind anywhere in the country; 70 percent of Denver's 4-year-olds participate each year.⁴⁹

Similarly, San Antonio voters approved a sales tax increase of one-eighth of a cent to offer high-quality, full-day preschool to 4-year-olds in the city. The plan, "**Pre-K 4 SA**" (pre-kindergarten for San Antonio), is a partnership between the city of San Antonio and seven San Antonio Independent School Districts, representing 90 percent of the preschool-age population in the city. The city's sales tax increase, which took effect April 1, 2013, is expected to generate about \$32 million annually and will pay for four new full-day pre-kindergarten centers, workforce training for early childhood educators, and grants for schools to expand preschool programs in San Antonio.⁵⁰ The tax increase is estimated to cost less than \$8 per year for median-income San Antonio households.⁵¹

- **Social Impact Bonds:** Goldman Sachs, United Way of Salt Lake, and the J.B. and M.K. Pritzker Family Foundation have formed a partnership to create the first-ever social impact bond designed to expand access to early childhood education through the early Childhood Innovation Accelerator. The investment supports a preschool program intended to reduce the need for special education. The success will be measured by the level of cost savings when children do not need to use special education services, which are financed by the state. Also known as pay-for-success bonds, social impact bonds help governments test innovative ideas for tackling social issues when they cannot come up with the money up front.

- **Re-examining how—and when—we spend public education dollars.** Thoughtful educators have asked whether, given the new research on the fast pace of brain development among young children, we would be better served to take our 13 years of public education money and drop it down the age range by a year or two. In 2011, for example, then Dallas Independent School District Superintendent Linus Wright proposed eliminating 12th grade, noting: “We need more early childhood education because we need to get to kids at 3 and 4 years old, and eliminate the 12th grade to pay for that.”⁵² Outright elimination of 12th grade might not be a solution, at least not immediately, because there remain at least some students who are still struggling to master the skills they will need after high school. Many others, however, are taking at most one or two classes. Others are taking college-level courses

via Advanced Placement, International Baccalaureate, and concurrent enrollment in college. Education leaders could accelerate the latter trend for students in good academic standing who pass Advanced Placement tests, saving those students time on the path to a college degree and recapturing some of the funding for early childhood programs.

- **Business Leaders Spearheading Investment.**

Ready Nation is a national coalition of business leaders who support early childhood policies that strengthen the U.S. economy and workforce. Ready Nation has spent the past seven years building a business case for early childhood investment and engaging business leaders nationwide to make that investment a reality. Following an initial research phase where the economic benefits of early childhood programs were identified and methods for financing them explored, Ready Nation began to mobilize business leaders to advocate for early childhood investment in their own communities, cities, and states. Ready Nation offers webinars, business leader summits, new economic evidence, training for advocates, sample op-eds, and presentation materials to help business leaders and advocates engage others. Ready Nation has worked with businesses communities in 30 states. In 2010, AT&T California President Ken McNeely helped lead a successful effort to expand pre-kindergarten and, in 2011, the Vermont Business Roundtable was essential in helping the General Assembly pass a bill expanding pre-K to all of the state’s children.

We Must Act Now

Given current economic constraints at national, state and local levels, focused attention will need to be given to re-examine funding priorities, seek multiple funding streams, and explore innovative financing options. We have noted that augmenting these funding streams may require making difficult choices given limited resources at all levels of government, but we believe that the benefits relative to the costs mean that steps like these must have higher priority in public-funding decisions. More funding will be urgently needed, but there are different ways to get there. Steps to be explored:

- Financing and technical assistance should be provided to communities that lack high-quality early childhood education programs, to help them develop more effective programs and compete effectively for available resources.
- Federal, state, and local governments should re-examine how existing dollars are allocated, placing high priority on programs that can improve the health of our youngest children.
- Additional strategies for maximizing existing funds spent on education should include an examination of how current public school funding is allocated to explore re-use of funds, such as:
 - Include all low-income children enrolled in at least half-day, high-quality pre-kindergarten programs in state Title 1 funding formulas.
 - Capitalize on the increasing number of students who complete college courses while still in high school by creating a new incentive program that would allow school districts to keep the average daily attendance for high-performing students who complete high school and enter college early. Saved dollars could be distributed evenly to expand pre-kindergarten slots for low-income kids; provide extra instructional time for children who enter high school behind; and to offer college scholarships.
 - Investigate allocating federal matching dollars for expanded state and local pre-kindergarten for low-income children.
 - States could seek federal matching dollars to provide incentives for public and private collaboration. Some successful and promising models have matched or leveraged public spending with philanthropic and corporate funding.

Recommendation

Help parents who struggle to provide healthy, nurturing experiences for their children.

While high-quality early childhood programs help children develop and build skills to thrive, even children who have access to them spend the majority of their time at home. These settings also need to be as supportive and growth-promoting as possible.

All parents want the best for their children. However, some parents may lack the knowledge, capabilities, or resources to provide well-regulated and responsive home environments. Others may not be able to maintain economically stable and secure households. Economic stability is a major factor that can affect early childhood development. Some children live in homes where the stresses of daily life, work, and childrearing make a well-functioning home environment difficult to achieve. These stresses can be high in single-parent families where there may be fewer resources. However, they may occur even in families that are not as constrained by resources. Children who are exposed to chronic adversity and unsafe environments, such as personal abuse or violence at home or in their neighborhoods, experience constraints on all domains of their development (including cognitive,

physical, social, and emotional opportunities) and are more likely to experience health problems later in life. It is important that all children receive the support they need to achieve their developmental potential.

Communities should have informal supports that strengthen families and help them break the cycle of disadvantage that is often passed across generations. Family support programs can act as buffers for children experiencing chronic adversity and can help provide stability while strengthening parents' abilities to meet their children's developmental needs.

To help strengthen home environments, family support initiatives should:

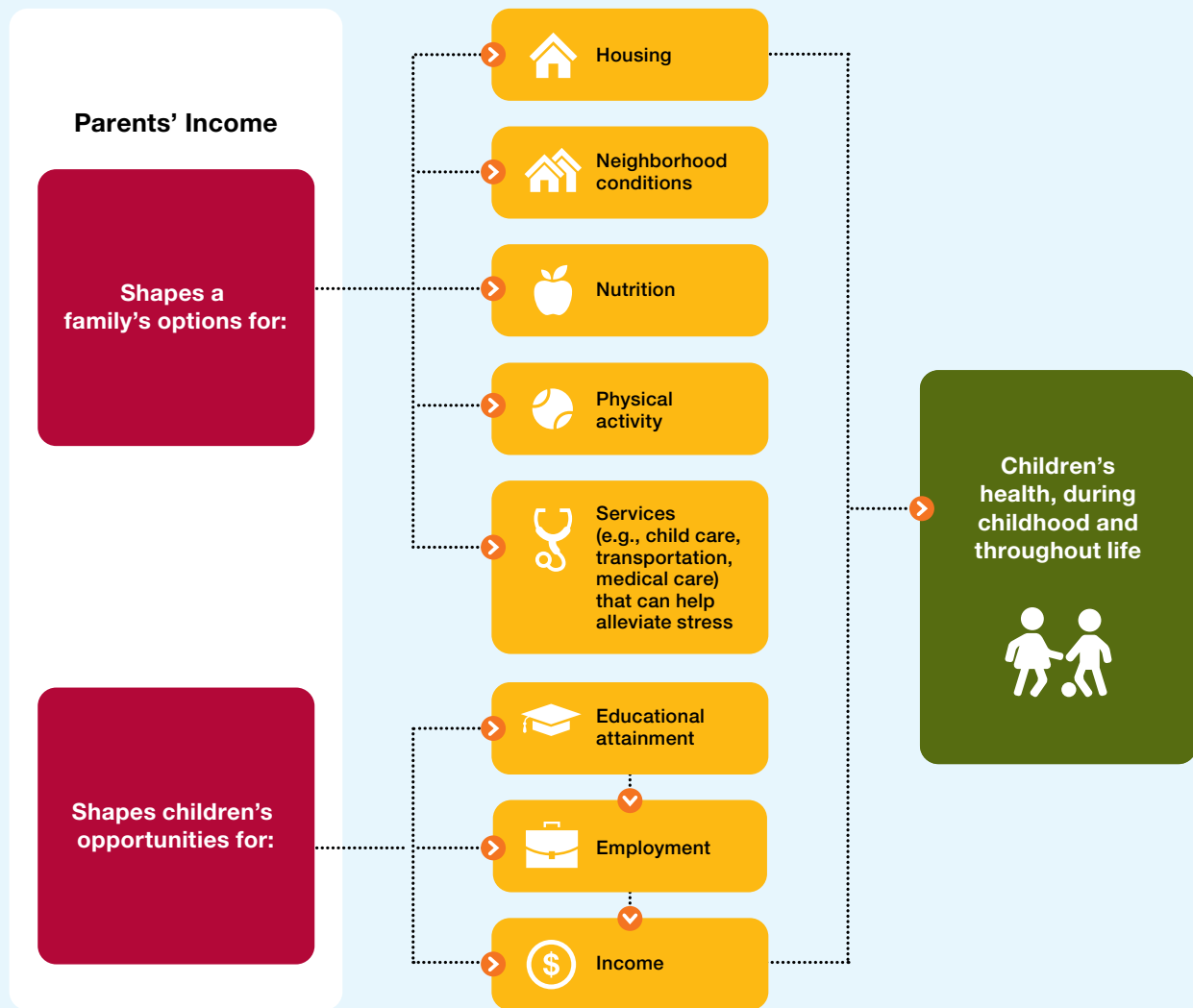
- Begin in the prenatal period.
- Teach parenting skills.
- Integrate social and health supports into existing programs if they do not already exist.
- Mentor vulnerable young adults in providing stable home environments by teaching life and job skills.



Photo: Paula Lubens

Parents' Income Can Affect a Child's Chances for Health Throughout Life

figure 11 Parents' income can affect children's chances for health by shaping options for living conditions and educational chances, which in turn shape their income and living conditions as adults.



Prepared for the Robert Wood Johnson Foundation Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco, 2013.

Promising Approaches

Expert testimony provided to the Commission described promising models to strengthen adult capacities and skills, leading to increased economic upward mobility and family stability. This is an exciting opportunity to improve lives across generations. Such examples should be piloted, evaluated in additional settings, and potentially expanded or replicated:

Crittenton Women's Union (CWU) is a Boston-based organization that helps low-income women and their families achieve financial stability and self-sufficiency. Created in 2006 from the merger of two of Massachusetts' oldest nonprofit organizations, CWU's direct service programs include transitional housing for more than 400 homeless families a year; supportive housing for young, high-risk parents and domestic violence survivors; job-readiness training; and mentoring services in self-sufficiency. Since its inception, CWU has tracked the outcomes of 45 families at its South Boston and Cambridge sites. In fewer than four years, these families achieved the following positive results:

- Increasing average hourly earnings by 36 percent, from \$14.51 per hour to \$19.72 per hour. One-fifth of participants achieved their "goal job," which was a full-time position paying \$45,000 to \$50,000 per year.
- Increasing average household savings from zero to \$1,345.
- Achieving an average of 1.5 major child-related goals in the past year, such as charter school enrollment, completion of family therapy, or child acceptance into college.⁵³

Los Angeles-based **Preschool Without Walls** brings the classroom to children and their parents—in parks, libraries, and recreation centers in low-income communities.

The program focuses on families who previously resisted participation in wellness and early childhood learning programs based in centers or schools. Teachers create lessons that incorporate the unique attributes of each classroom setting, sharing bilingual lessons with parents and children to explore both core competencies (colors, days, and times) and specific themes (culture, art, and science). Parents learn how to teach their children in these classes through such activities as asking open-ended questions and engaging in hands-on activities.

In addition, Preschool Without Walls reaches out to isolated teenage mothers and parents who are not sending their children to school. Instead of sending a social worker to knock on parents' doors, the program sends volunteers who are linked with families through church or high school. Through intensive outreach and emphasis on parental involvement, Preschool Without Walls has improved school readiness while empowering parents to serve as their children's first and lifelong educators.

The program is an example of an initiative that is helping more than one generation at a time, providing skills to parents, and creating learning, health, and wellness opportunities for children.

We Must Act Now

While a broad array of promising interventions exists to support families, they are not always coordinated across agencies or sectors. Adult and family needs vary, requiring an integrated mix of supports and cross-sector collaboration to be most effective.

We must not assume that existing interventions with parents and families are sufficient, even at established early childhood development programs.

- Performance standards for early childhood programs must include explicit measures of effective parental involvement and address how families are empowered and supported.
- Outcomes should include shorter-term, more proximal indicators of success related to health.
- We should reach out to high-risk young adults and provide support for them to achieve success.

Recommendation

Invest in research and innovation. Evaluation research will ensure that all early childhood programs are based on the best available evidence. Innovation will catalyze the design and testing of new intervention strategies to achieve substantially greater impacts than current best practices.

Advances in neuroscience on the biological consequences of significant adversity are radically changing our understanding of how early childhood influences affect lifelong health, although little of this knowledge has been applied.

It is vital that we incorporate 21st-century scientific knowledge into the development of all supports designed to improve early childhood development. Government and private funders, including philanthropy and business, have an important role to play in ensuring that the best science informs both the scaling of high-quality programming and the development of new ideas. Advances in scientific research have dramatically changed our understanding of how children's brains develop and how toxic stress can also affect other maturing organs and metabolic regulatory systems in a way that can influence short-term, biological responses and long-term health outcomes later in life. Yet little of this knowledge has been applied in practice. In order to correct this shortcoming, it is

critical that we expand our definition of evidence to include scientific concepts that can inform new program models. Success in this endeavor will require an innovation-friendly environment that catalyzes fresh thinking, supports risk-taking, and recognizes the value of learning from interventions that don't work.

We must work smarter, ensuring that our investments pay off. There is no one right way to strengthen families and the communities where they live. What works varies across place and across time. But as needs and evidence change, strategies also must evolve. The way we structure education, largely beginning at pre-kindergarten or kindergarten, has not changed for decades, even though we now know how important it is to reach children before age 5. And education and health are still siloed, even though we know that a child's future depends on education and health, not one or the other.



Photo: Tyrone Turner

Promising Approaches

The **Adverse Childhood Experiences (ACE) study**, a collaboration between researchers at the U.S. Centers for Disease Control and Prevention and Kaiser Permanente, is a good example of the type of research that needs to be done. The ACE study was among the first to establish strong links between adverse early childhood experiences and lifelong mental and physical health conditions, including depression, addiction, heart disease and diabetes. The study, which has involved over 17,000 participants,

assesses exposure to 10 categories of early childhood trauma or toxic stress. The higher the score, the greater the exposure, and the greater the risk of negative consequence. In May 2013, the Institute for Safe Families and the Robert Wood Johnson Foundation hosted the first national summit of professionals who are using the biology of stress and research on adverse childhood experiences to encourage social workers, police, educators, doctors, nurses and others to apply this knowledge in their work.

We Must Act Now

Discovering new ways to improve health through early childhood intervention requires exploration, risk, trial, and permission to fail on the way to breakthroughs. These factors are rarely compatible with government funding requirements, yet they are essential to innovation. Opportunities for innovation include:

- Private funders, including philanthropy, should support initiatives designed to help our youngest children in efficient, effective, affordable ways. This will require investing in science and new approaches.
- The federal government should create a center devoted to innovation in early education and pre-K through 12th grade, similar to the federal Center for Medicare & Medicaid Innovation, which supports innovation in health care delivery.
- Researchers should explore new ways to strengthen children's resistance to toxic stress. Funders should include mechanisms to spread research and development results and promulgate best practices.

Integrating Health Into Community Development



Recommendation 2:

Fundamentally change how we revitalize neighborhoods, fully integrating health into community development.

Problem

Even more than what happens inside of a medical exam room, health depends on where people live, learn, work, and play. Do their neighborhoods provide access to nutritious food, transportation to get to work, healthy and affordable housing, and parks and places to play and exercise to help them stay fit? Factors such as these and many others play an enormous role in our ability to make healthy choices. In fact, when it comes to health, your ZIP code may be more important than your genetic code.

There is a significant opportunity to change how we revitalize neighborhoods, which is especially important for low-income neighborhoods, where nearly one in five Americans—about 52 million people—live. Low-income families must have the same opportunities to be healthy as other families in America, no matter where they live.

The importance of investing in communities by planning and building roads, child care centers, schools, grocery stores, community health clinics, and affordable housing has been recognized for a long time, yet we are only beginning to understand how activities in these sectors are tied to health outcomes, such as obesity rates or the occurrence of chronic disease. For example, a September 2013 study found that children who live in “walkable” places get significantly more exercise—46 percent more—than their peers who live in suburban areas that are designed for driving.⁵⁴

Everyone should live where healthy choices are possible, yet in many communities, the challenges can be especially significant.

Imagine the doctor who advises an overweight patient to get outside and exercise more, starting by walking. Then imagine the patient who lives in a community where no safe spaces for physical activity exist. Not accustomed to thinking about health or community safety as part of their work, community development practitioners can play an important role in creating such spaces in low-income neighborhoods.

Both the community development and health sectors aim to improve the lives of residents in low-income neighborhoods, but they are often focused on different elements. These sectors do not always have the knowledge, language, leadership, or tools to work together and their funding is siloed, making collaboration challenging.

The problem is not lack of efforts to improve neighborhoods—in fact, there is a broad ecosystem of organizations with the same “customer,” “client,” or “patient” working to improve communities and the lives of their residents. The problem is that these organizations work together too infrequently. This includes the community development field—comprising nonprofit neighborhood improvement agencies; real estate developers; financial institutions; foundations; government; and organizations that focus on directly improving the lives of neighborhood residents, connecting them to community resources such as education, job training, counseling, child care, or health care services.

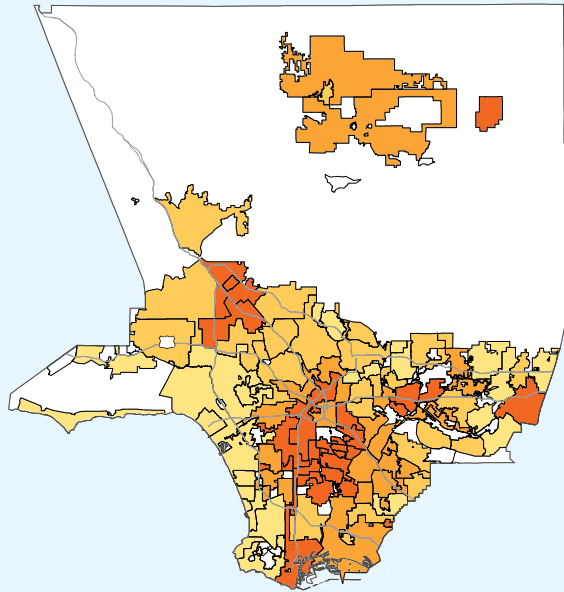
Lack of coordination or connection creates duplication of effort when multiple organizations are working separately to address overlapping needs and is an inefficient use of resources.

Commissioners reviewed public- and private-sector integrated community improvement models, many of which are described in this report. Each model builds on the challenges and strengths of its community, working in different ways, but what all these models have in common is their comprehensive view of residents’ needs. Each model addresses multiple factors that can have an important impact on health, such as access to high-quality early child development programs, schools, health care, transportation, jobs, healthy food, safe streets and housing, and spaces for physical activity. However, testimony provided to the Commission in June 2013 emphasized the disconnect among the various partners involved in neighborhood revitalization, community development, and health. This disconnect manifests itself through siloed policies, planning efforts, funding streams, data, and evaluation metrics.

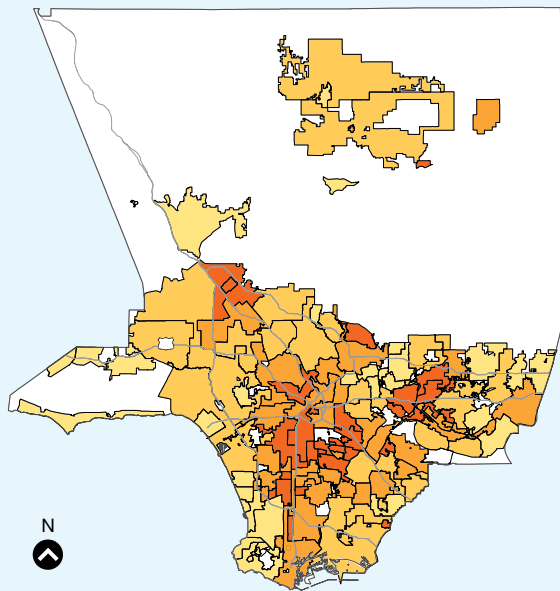
Many Communities Face Multiple Barriers to Good Health

figure 12 Economic Hardship and Poor Health: Often Concentrated in the Same Communities.

ECONOMIC HARDSHIP INDEX BY CITY/COMMUNITY, LOS ANGELES COUNTY, 2009



CHILDHOOD OBESITY BY CITY/COMMUNITY, LOS ANGELES COUNTY, 2009



0 2 4 8 MI



- 1st quartile (lowest)
- 2nd quartile
- 3rd quartile
- 4th quartile (highest)
- Other LA County

Prepared by Los Angeles County Public Health, Office of Health Assessment and Epidemiology, Epidemiology Unit, November 2013.

.....

Leaders—from federal, state, and local departments of housing, transportation, health and education; private and public financial institutions; philanthropies; and business, agriculture, and community development professionals—must understand the importance of integration and collaboration.

.....

What's Needed?

There is growing knowledge about the importance of neighborhood conditions for health. Now, public- and private-sector leadership and support are needed to identify common goals and speed integration and collaboration.

Leaders—from federal, state, and local departments of housing, transportation, health and education; private and public financial institutions; philanthropies; and business, agriculture, and community development professionals—must understand the importance of integration and collaboration. Additionally, community leaders can play a vital role in identifying common ground among different organizations and help catalyze change that is tailored to the needs of the community.

The first step is increasing awareness of why integration is critical. For example, urban planners, policy-makers, social service providers, and others must understand how integrating health into their work will help them reach their own goals. Public health professionals can provide the “health lens,” working with community decision-makers. In 2009, this Commission recommended using health impact ratings to assess the projected effects of community improvements on community health.

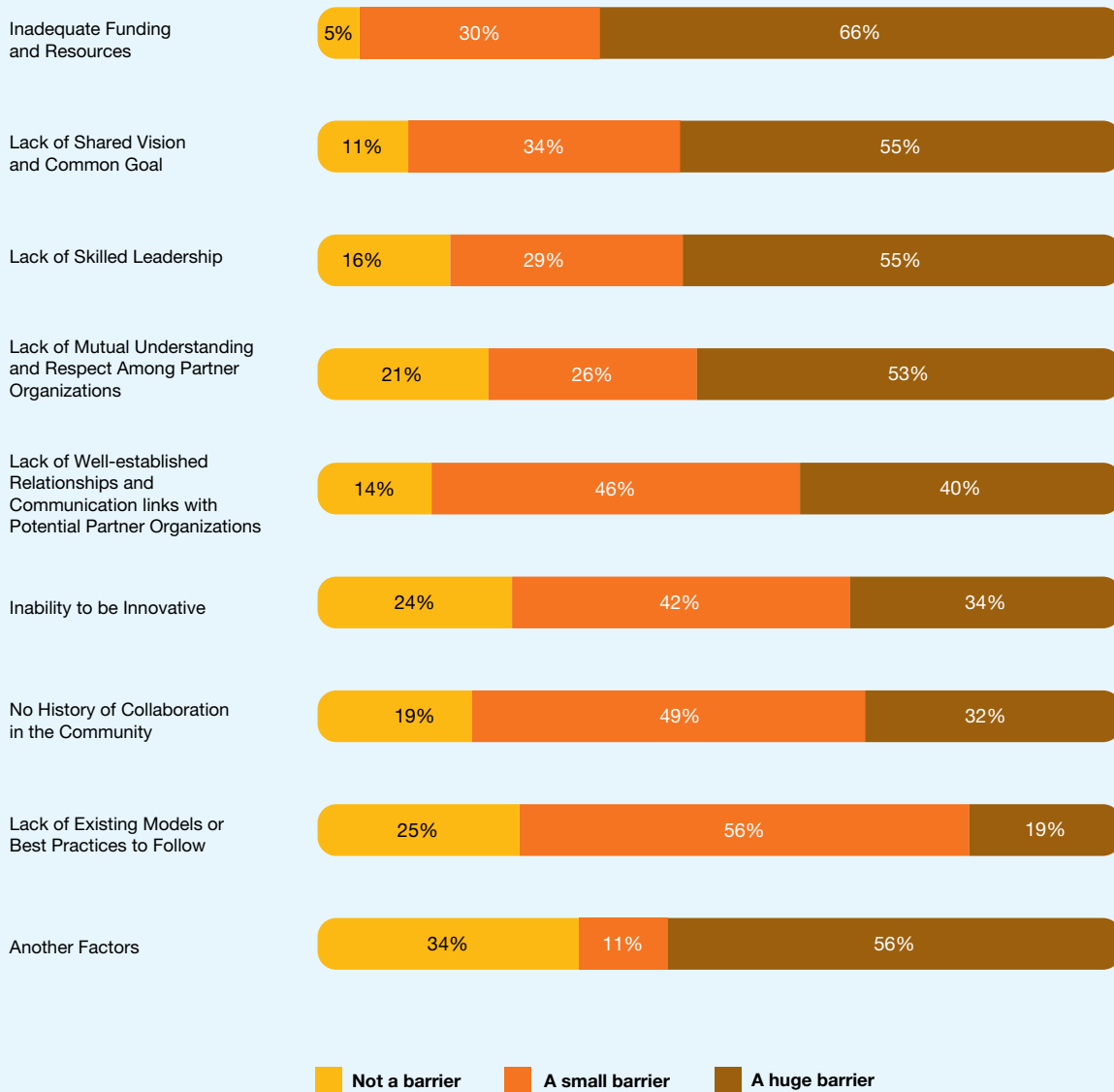
Identifying and reducing the barriers to collaboration and rewarding integrated approaches will be critical. Better integration also means creating new incentives and performance measures to spur collaboration and innovation and to replicate successful approaches to creating healthier communities.

Other leaders must join this effort, including federal, state, and local departments of housing, transportation, health, and education; private-sector finance organizations; and community development professionals. To begin, leaders in these fields must recognize the benefits of combining forces rather than working separately toward common goals. They must understand each other’s work and have the knowledge and skills to work together, as well as the tools to integrate health improvements into community development and neighborhood revitalization efforts.

Local organizations are critical, since the most effective engagement efforts involve cross-community coordination and facilitation by a lead organization or leader from within the community, and the use of metrics to inform and track outcomes. Community engagement should be broad— involving leaders in government, business, health care, public health, health insurance, early childhood and K–12 education, philanthropy, corporate finance, and faith-based organizations—and it should be meaningful.

What's Preventing Collaboration Between the Health and Community Development Sectors?

figure 13 A 2013 survey found that while collaboration between the health, finance and community development sectors is occurring, barriers to collaboration remain and can be reduced.



Collaboration to Build Healthier Communities: A Report for the Robert Wood Johnson Foundation Commission to Build a Healthier America. June 2013. http://rwjf.org/content/dam/farm/reports/surveys_and_polls/2013/rwjf406479. Accessed December 12, 2013.

Recommendation

Support and speed the integration of finance, health, and community development to revitalize neighborhoods and improve health.

Organizations within the health and community development sectors likely realize that traditional approaches are inadequate for today's multifaceted challenges in revitalizing neighborhoods and improving health. For example, many of our nation's community development strategies and public health strategies are decades old and do not take each other's work into account.

We must leverage the skills and resources of the many sectors and organizations that are already working to strengthen communities and make them healthier by supporting and speeding the integration of finance, health, and community development.

A June 2013 report, *Collaboration to Build Healthier Communities*, prepared for the Commission, describes findings from a survey of professionals in the fields of health care, public health, early child care, education, human services, housing, transportation, and community development finance. While the majority of respondents said they had worked with other sectors in the previous 12 months, the survey found that lack of resources, shared vision, skilled leadership, and mutual understanding and trust can create barriers to successful collaboration. To facilitate and speed collaboration, the report recommends:

- Developing national-level leadership in order to build the network of partners across sectors and support for enhanced cross-sector communication and sharing of information and best practices.
- Building capacity by creating opportunities for cross-sector technical knowledge and skills acquisition through conferences, workshops, webinars, and online resources.

- Creating a data clearinghouse of current evidence, metrics and evaluation tools, financial models, and case studies of successful cross-sector projects (*Figure 13*).

There are leaders showing the way. The San Francisco-based Low Income Investment Fund, a community development financial institution, has reshaped its strategic plan—the vision, goals and strategy—around the idea of investing to create healthy communities and families. Federal Reserve Banks, the Robert Wood Johnson Foundation, and others have hosted a series of Healthy Communities conferences to bring together community development, finance, and health leaders to learn more about each other's work and find opportunities for collaboration.

Other leaders in supporting the integration of finance, health, and community development include the Kresge Foundation, California Endowment, the Alliance for a Healthier Generation, and the Clinton Health Matters Initiative. Federal, state, and local government agencies are also playing a role in this movement.

In addition to domestic examples, we should learn from models of cross-sector integration that have worked in other developed nations, with success in improving health outcomes. For example, the Ministry of Social Affairs and Health of Finland has published a book called *Health in All Policies: Seizing Opportunities, Implementing Policies* that identifies practical opportunities and challenges for helping policy-makers and leaders see the value of giving high priority to health in all policies—not just health-sector policies—and understand how to implement these kinds of policies in communities.

Promising Approaches

In Richmond, Va., **Bon Secours Health System** and the **Local Initiatives Support Corporation** (a national organization committed to helping community residents transform distressed neighborhoods into healthy and sustainable communities) are integrating efforts to revitalize communities through the Supporting East End Entrepreneurship Development (SEED) effort to revitalize the Church Hill neighborhood. By providing funding for economic development through an annual business awards program, SEED is creating jobs and economic opportunity, which are linked to better health.

In **Oakland, Calif.**, transit and environmental justice organizations, health services, and housing and economic development agencies are using a health impact assessment to evaluate the effects, specifically on affordable housing and pedestrian safety, of proposed development near the Lake Merritt Bay Area Rapid Transit station. In 2010, six local community organizations collaborated to ensure the planned revitalization effort addressed concerns around pedestrian safety and affordable housing. This initiative arose in response to the use of data by community advocates to illustrate how public transit, affordable housing, and job creation affect health.

In Washington, **Seattle and King County** public health practitioners are working with city officials to make it easier for residents to make healthy choices by developing biking and walking paths, improving physical education programs in schools, and making it easier for WIC recipients to shop at farmers' markets and for corner stores to sell fresh produce. In neighborhoods where smoking rates were high, health officials are collaborating with housing officials to create tobacco-free housing units and smoke-free park rules.

Concerned about effects of high energy costs on children's health in the wake of Hurricane Katrina, **Boston University**-based pediatricians and researchers conducted a health impact assessment (HIA) to explore the tradeoffs that low-income families face in paying utility bills, the safety risks of using unsafe heating sources, and how health is affected when families are forced to move to lower quality housing because of high utility bills. The HIA helped policy-makers understand the connection between energy costs, children's health, and potential Medicaid cost increases. As a result, the state increased funding for its Low Income Energy Assistance Program, and advocates in Rhode Island used the report to advocate for similar changes there.

Place Matters is a national initiative of the Joint Center for Political and Economic Studies funded by the W. K. Kellogg Foundation that aims to reduce health disparities in participating communities through shared learning experiences. This national learning community consists of 19 Place Matters teams working in 27 jurisdictions. The program assists participating multi-sector, transdisciplinary teams in developing and implementing community-based strategies for addressing the complex root causes of health disparities. Addressing upstream causes of health (for example, employment, education, poverty, and housing) is at the core of the program's work.

The National Prevention Council has modeled how to integrate health improvements across sectors. Twenty federal departments and agencies with representation on the Council have committed to supporting tobacco-free environments; expanding access to healthy, affordable foods; and identifying additional opportunities for considering prevention and health. An action plan released by the Council in 2012 detailed some 200 prevention and wellness actions currently underway at federal departments and agencies aimed at improving quality of life, eliminating health disparities, promoting healthy behaviors, and creating health-promoting social and physical environments. Some states and counties have launched similar multi-agency initiatives that incorporate health-related factors into a more holistic approach to decision-making.

Three federal agencies—the Department of Housing and Urban Development, the Department of Transportation and the Environmental Protection Agency—created the **Partnership for Sustainable Communities** in 2009 to help neighborhoods around the country develop in more environmentally and economically sustainable ways. Through its collaboration, this Partnership focuses on areas such as increasing transportation options, promoting affordable housing, leveraging federal policies and protecting the environment. They coordinate infrastructure investments across these sectors. In June 2013, the Partnership released the Sustainable Communities Census HotReport, a data analysis tool that allows community leaders and residents to determine their community's sustainability performance.⁵⁵ The Partnership has also convened regional roundtable discussions and supports the Governor's Institute on Community Design.

We Must Act Now

Strategies for supporting and speeding these kinds of efforts include:

- Requiring cross-sector collaboration as a condition of funding.
- Establishing and supporting a nationwide communications network that connects professionals across fields to achieve healthy communities.
- Supporting a platform or clearinghouse where examples, models, evidence-based tools, and metrics can be found and shared.
- Creating a national partnership to support and catalyze work at the intersection of community development and population health.
- Building capacity through cross-sector training to increase mutual understanding of each field's approaches, business models, strengths and weaknesses, and uses of financing and policy.
- Developing skills needed for collaboration to be successful, such as how to engage the community in planning, coalesce around aims, negotiate across vested interests, and tackle policy and financial barriers.
- Broadly promoting successes of cost-effective cross-sector collaboration models.



Photo: Lynn Johnson

Recommendation

Establish incentives and performance measures to spur collaborative approaches to building healthy communities.

Creating meaningful policy and financing incentives, along with performance measures tied to meaningful health improvements, will go a long way toward spurring collaborative approaches to building healthier communities.

Policy incentives should encourage collaboration and remove barriers to doing so, which will require breaking down administrative and regulatory barriers at all levels of government.

Public- and private-sector funders—typically government, financial institutions, and foundations—should reward cross-sector, holistic approaches and transformational outcomes. These incentives should be designed to spur private investment and innovation from many fields, including social entrepreneurs and socially motivated investors.

A private-sector example of such an incentive is the **Healthy Futures Fund**, developed by Morgan Stanley, the Kresge Foundation, and the Local Initiatives Support Corporation, which is encouraging community development organizations and health care providers to collaborate using Low Income Housing Tax Credit equity and an innovative New Markets Tax Credit structure to drive economic development that helps improve health outcomes. The project will support development of 500 housing units with integrated health services in hard-hit urban and rural communities and eight new federally qualified health centers through a \$100 million initial investment.

Another example is the pay-for-success model, such as social impact bonds, that pay for successful outcomes such as improvements in housing or health. Through this model, private investors provide low-interest loans for social or environmental interventions and investors are repaid through savings generated—however they are only repaid if the program is successful. The federal government and the states of Connecticut, Massachusetts and New York, as well as Cuyahoga County, Ohio, and Fresno, Calif., are exploring social impact bonds. President Obama’s fiscal year 2014 budget includes a new \$300 million **Pay for Success Incentive Fund**, along with \$185 million to support nine new pay-for-success pilots in four agencies.

According to an October 2013 article, “Funding Holistic Community Development With Pay for Success,” by Ian Galloway of the Federal Reserve Bank of San Francisco:

“Pay for success can pay for holistic, collaborative community development because it captures disparate benefits and enforces accountability. It brings together organizations that often work in isolation and encourages client service that can better lead to outcomes, rather than just outputs. It aligns incentives and assigns roles: Who is responsible when a community falls through the cracks? Who is responsible when it succeeds? ... Most importantly, however, pay for success offers a way to pay for transformational outcomes, not just programs, like reductions in poverty and crime or increases in employment and graduation rates—in other words, success worth paying for.”⁵⁶

Note: The April 2013 issue of the *Community Development Investment Review* is devoted to the topic of pay-for-success financing.⁵⁷

We must ensure that there is an even balance when one sector invests money or resources that generate savings for another. For example, investments in transportation or housing can improve health and generate cost savings to the health care system. One sector invests, but another benefits. Working together, there is an opportunity to negotiate how both can benefit. In this case, a portion of the savings could be re-invested in more neighborhood improvement to create a virtuous cycle of cost-savings and health improvement.

Creating new incentives for cross-sector work will also require new measures that document benefits and are strong enough to affect significant outcomes. They go hand in hand with offering incentives.

A concerted effort is also needed to identify, further develop, and test a range of health-related success measures that build on what’s already available. Potential measures include:

- Effective process/structure measures for cross-sector development initiatives.
- Implementation and evaluation measures.
- Measures that assess proximate or real health impacts in the near and intermediate terms.

Promising Approaches

The California Endowment's **Building Healthy Communities** initiative is improving employment opportunities, education, housing, neighborhood safety, unhealthy environmental conditions, and access to healthy foods in 14 communities across the state. Over the next 10 years, the Endowment will work with schools, local governments, business leaders, neighborhood groups, and individuals to create healthy and safe environments for the families that live there. For example, in the Long Beach community, the Endowment is working with the local school district to prepare youth for higher education. In the Boyle Heights community, partner organizations are working with elected officials to help residents own homes. The program will invest hundreds of millions of dollars to improve health throughout the chosen communities and encourage those living there to think about health in a more comprehensive way. To measure success, the Endowment and its community partners will look at outcomes related to improvements in childhood obesity, youth violence, and school attendance rates in the target communities.

Community Transformation Grants (CTGs) from the U.S. Centers for Disease Control and Prevention (CDC) to government agencies, tribes and territories, nonprofit organizations, businesses, and communities seek to reduce chronic disease. In 2011, CDC awarded \$103 million to 61 state and local government agencies, tribes and territories, and nonprofit organizations in addition to giving almost \$4 million to six national networks of community-based organizations. In 2012, the CTG program expanded to award approximately \$70 million to communities to implement broad, sustainable strategies. Awardees are engaging partners from multiple sectors, such as education, transportation, and business, as well as faith-based organizations. These programs will reduce health disparities and expand preventive services that will directly impact about 9.2 million Americans. The CTG program is expected to improve the health of more than 4 out of 10, or 130 million, Americans.⁵⁸

Joint-Use Agreements—legal arrangements between a city or county and a school district stipulating that facilities can be shared—are examples of policy incentives that create shared community spaces like school athletic facilities and fields, city recreational centers, playgrounds, and gyms. These types of arrangements can help keep costs down and communities healthy. According to a 2012 Bridging the Gap report, nearly 93 percent of schools had some type of joint-use agreements in place with their community, however many were vague.⁵⁹ The report's authors recommended that, for joint-use agreements to work most effectively and give people better access to physical activity in their communities, they should specify how the agreement will be managed on an ongoing basis.

In Hawaii, a joint-use agreement between the Honolulu Department of Parks and Recreation and a large high school permitted use of the school facilities, providing new opportunities for physical activity, including senior fitness classes, adult fitness and recreation programs, and teen strength training. The costs of additional school facility use were included in the agreement.

In Redwood City, Calif., a joint-use agreement between city and school officials stipulates not only which facilities may be shared but also who is responsible for maintenance, scheduling, and training new employees on the rules of the agreement. In addition, the agreement includes twice-yearly meetings for all parties to evaluate the agreement and discuss challenges and potential improvements, creating a living agreement that will allow city and school leaders to adjust as needed to meet the needs of all stakeholders.

We Must Act Now

Strong metrics related to community health improvement goals should be incorporated into budgeting and implementation planning. This combined use of measures with financing incentives would encourage cross-sector partners to adopt an integrated approach to achieving community improvements. Actions for accomplishing this include:

- Requiring tracking and evaluation as a condition of receiving federal and state grants.
 - Providing technical and other assistance so that communities lacking key infrastructure can come together to plan and make improvements.
 - Urging governors, county, and city officials to devise and support funding streams that blend public and private sector sources at state and community levels, especially for smaller and medium-sized communities. These should support the integration of local municipal facilities in mixed-income, mixed-use neighborhoods and the adoption of smart-street models that are characteristic of healthy communities.
- Incentivizing collaboration in zoning, transportation planning, and investment in infrastructure, parks, public works, municipal facilities, and service delivery models.
 - Specifying a limited number of the same cross-cutting performance measures—including proxy measures for health (such as improved access to public transportation, walkable neighborhoods)—in award requirements for federal, state, and local funding related to community development (e.g., parks, transportation, and schools).
 - Rewarding successful cross-sector accomplishments, such as establishing a competition to recognize community development approaches that improve health.



Photo: courtesy of Safe Routes To School National Partnership/Stephanie Turner.

Recommendation

Replicate promising, integrated models for creating more resilient, healthier communities. Invest in innovation.

Commissioners reviewed public- and private-sector models for creating more resilient, healthier communities, some of which are described in this report. Each model builds on the challenges and strengths of its community, working in different ways; but what all these models have in common is their comprehensive view of residents' needs. Many address multiple factors that can have an important impact on health, such as access to high-quality early child development programs, schools, health care, transportation, jobs, healthy food, safe streets and housing, or spaces for physical activity.

While seeking to scale up or replicate promising models, we must recognize that there is no “one-size-fits-all” approach. Communities must determine their own challenges and opportunities and borrow from the best examples, such as Promise Neighborhoods, a U.S. Department of Education program that seeks to improve educational outcomes for students in distressed urban and rural neighborhoods, and Purpose Built Communities, a nonprofit that rebuilds struggling neighborhoods.

We Must Act Now

Public and private funders should invest in integrated approaches that show promise or have demonstrated results in creating healthier communities. This will require developing new funding streams, reducing barriers to maintaining and integrating existing funding streams, and promulgating a shared vision of what constitutes success.

It is important to invest in what works, but it is equally critical to fund continued innovation so that an integrated healthy community development field can evolve. For example, public and private funders could establish an innovation fund for community improvement that

could be modeled on the Center for Medicare & Medicaid Innovation, which supports the development and testing of innovative health care financing and service delivery models. Philanthropy can provide more flexible opportunities for the trial and failure inherent to innovation.

Regardless of the strategy, breaking down silos that have separated health and health care from other areas of policy-making requires strong leadership at the highest levels—nationally, and by mayors and governors—and not just from within the health and community development sectors. We expressly call for this type of leadership in Chapter Four of this report.

Promising Approaches

Houston's **Neighborhood Centers, Inc.**, is an example of an organization that has successfully blended funds from more than 30 federal programs, working in partnership with other nonprofits to deliver services in more than 60 sites across the region. The organization operates an annual budget of approximately \$275 million from dozens of federal, state, and private funding sources. However, to do so, Neighborhood Centers has committed significant resources to its administrative capacity to maintain contracts and grants and keep up with evaluation reporting requirements. Neighborhood Centers supports community development in and around the Houston region through partnerships with other nonprofits by bringing resources and education to low-income communities. In the Gulfton/Sharpstown community, Neighborhood Centers worked with residents to create the Baker Ripley Community Center. In its first year-and-a-half of operation, the center served 23,000 people. It offers a wide range of services from family health and wellness programs to leadership classes to immigration workshops and courses in economic development. The center integrates education, financial opportunity, health services, and performing and visual arts into one site. This has resulted in savings for the community, improved school graduation rates, reduced juvenile crime, and increased interest in living in Gulfton/Sharpstown.⁶⁰

For more than 20 years, **Living Cities, Inc.**, has worked to improve the lives of low-income people and the cities where they live by bringing together 22 of the world's largest foundations and financial institutions to invest in health and community development. From Morgan Stanley and the Kresge Foundation, to the Robert Wood Johnson Foundation and Prudential Financial, Inc., Living Cities has built a unique platform of partnerships to redirect public and private resources, and help communities build homes, schools, clinics, and other community facilities. To date, members of the collaborative have shaped federal funding programs and collectively invested almost \$1 billion in dozens of communities across the country.

Mercy Housing recently collaborated with the San Francisco Redevelopment Agency, the San Francisco Department of Public Health, and the San Francisco Public Library to build the Mission Creek Senior Community, a mixed-use housing development that combines an adult day health center for low-income seniors with 140 apartments and the city's first new branch library in 40 years. The adult day health center, which is visited by more than 50 seniors every day, provides medical care, occupational and physical therapy, social services, and even lunch to the building's residents and people in the neighborhood. The city of San Francisco reports that the Mission Creek Senior Community saves the city nearly \$1.5 million a year in avoided nursing home costs for its residents. Most importantly, residents may enjoy a better quality of life.

Magnolia Place Community Initiative is a large and diverse network of more than 70 organizations, including the Los Angeles school district and police department, the University of California-Los Angeles, local food banks, and small grassroots organizations, working together to create full-scale community change to ensure that the 35,000 children within a five-square-mile area achieve success on measures related to health, education, family relationships, and economic well-being. The network will work to strengthen individual, family, and neighborhood "protective factors" that are the buffers that help individuals find the resources/strategies to function effectively, even under stress. These include parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and children's social and emotional competence.

Purpose Built Communities is modeled on the redevelopment of Atlanta's East Lake neighborhood, which was once known for its poverty and sky-high crime rates, but today is nationally recognized for community revitalization. In 1995, instead of attacking poverty, urban blight, and failing schools piecemeal, a group of community activists and philanthropists took on all of these issues at once. All of the distressed public housing units were demolished, and replaced with new apartments, half of which were market rate. The neighborhood, which once had 1,400 extremely low-income residents, is now home to 1,400 mixed-income residents. As a result, significant changes have occurred:

- The employment rate of low-income adults increased from 13 percent to 70 percent.
- The neighborhood's Drew Charter School moved from last to 1st place among 69 Atlanta public schools.
- Violent crime dropped by 90 percent.⁶¹

The model is now being replicated in eight communities across the country. Each project is designed to address the needs of the community, but all share three key features:

1. Quality mixed-income housing aimed at breaking up concentrations of poverty;
2. An independently run cradle-to-college educational approach for low-income children that also attracts middle-income families to schools; and
3. Community facilities and services that not only support low-income families but also bring neighbors together and create a sense of community.

The Low Income Investment Fund's **ReFresh Project**, which launched in New Orleans in May 2013, is the first development in the nation to house healthy and fresh food retail options under the same roof with a broad range of organizations and programs designed to promote positive health outcomes and healthy behaviors. The new development, which has taken over an old grocery building in the city left vacant following Hurricane Katrina, combines direct services and goods with education, training and outreach. The goal of ReFresh, created under a partnership between Broad Community Connections (BCC), a local nonprofit, and L+M Developers, a New York-based firm that specializes in low-income and market-rate housing, is to build a healthier community in a historically underserved area of New Orleans. Although a major goal is to offer better food options to residents, the partners recognized that what was needed was a transformative project that would engage the community and anchor economic and community development. BCC and L+M believed that simply placing a fresh food retailer in an underserved community with a preponderance of unhealthy food options would not change the community's health.

Purpose Built Communities Results



The employment rate of low-income adults increased from **13 to 70** percent.



650 housing units were demolished and replaced with 542 apartment homes for mixed-income residents.



The neighborhood's Drew Charter School moved from last to first place among 69 Atlanta public schools and violent crime dropped by 90 percent.



1,400 extremely low-income residents (more than half on welfare) to 1,400 mixed-income residents.

Source: *Inside Atlanta/ East Lake: Achieving our Goals. Purpose Built Communities.*
<http://purposebuiltcommunities.org/success-stories/east-lake-atlanta/planning-progress/>. Accessed December 13, 2013.

We Must Act Now

Spreading the implementation of successful integrated approaches for creating health-promoting communities will require a broad array of actions that include:

- Developing new funding streams.
- Reducing barriers to maintaining and integrating existing funding streams.
- Promulgating a shared vision among public and private funders of what constitutes success.
- Encouraging innovation and a focus on promising approaches and best practices in community development and public health.
- Establishing an innovation fund for community improvements similar to the Center for Medicare & Medicaid Innovation. Such a fund could be created through the National Prevention Council.
- Using evidence-based principles to guide community planning and implementing improvements.
- Replicating successes across communities.
- Raising the visibility of cross-sector approaches to improving health in communities.
- Strengthening a focus on health outcomes and measuring health status as indicators of success.



Photo: Tyrone Turner

Bridging Health and Health Care



Photo: Andrew Lichtenstein

Recommendation 3:

The nation must take a much more health-focused approach to health care financing and delivery. Broaden the mindset, mission, and incentives for health professionals and health care institutions beyond treating illness to helping people lead healthy lives.

Problem

Health professionals are adept at treatment of a vast range of diseases, injuries, and other medical conditions. But their training and health care delivery incentives do not emphasize addressing the root causes of health problems that occur outside of the health care system—factors such as education, access to healthy food, job opportunities, safe housing, environment, and toxic stress—that fundamentally shape how long or well people live.

Research in this report, as well as the Commission's *Obstacles to Health Report* issued in 2009, document how great an impact income, education, environment, and other factors can have on a person's ability to make healthy choices and live a long, healthy life. In order to improve the health of all Americans, we must address these factors alongside existing efforts that focus on system changes in how health care is delivered and financed.

There is no question that these efforts to change the health care system are needed. America spends more than \$2.7 trillion annually on health care, more than any other nation.⁶² Health care costs are a rapidly growing part of federal and state budgets. Yet many Americans—including those with health insurance, a college education, and higher incomes—are less healthy than people in other developed countries. A vast portion of those dollars is spent on treatment. Far fewer dollars are invested in initiatives and social supports designed to keep people healthy in the first place or connecting patients to needed social supports and services.

Health care is critical to health, but health care alone is not sufficient. Patients must also have social and economic resources in the community that address the underlying causes of health. Making patients aware of these resources and how to access them could greatly improve patients' health, as well as the health of the community.

Health care researchers, institutions, and professionals are beginning to consider how social factors are impacting their ability to successfully treat patients, as well as their impact on costs. A recent federal Agency for Health Research and Quality report found that 1 percent of those with multiple chronic illnesses accounted for 21 percent of all health care spending in 2010. The top 5 percent of health care utilizers generated 50 percent of all health care spending.⁶³

A great deal of avoidable use of health services and unnecessary health care costs are related to lack of patient access to supports in their own communities and preventable hospital re-admissions. For example, if a dialysis patient doesn't have access to transportation or can't pay \$20 for a cab ride to a routine dialysis appointment, that patient may face re-admission to the hospital, with thousands of dollars in related treatment costs. Diabetics may need insulin shots, but they can also improve their health with access to healthy food. Community supports and resources could help them access healthful food.

What's Needed?

Our nation must take a radically different approach to achieving health. Given the research and emerging evidence, the Commission is calling on health care institutions and those who train, employ, and reimburse health professionals to broaden their approach and establish standards and incentives that reflect how health is shaped by where we live, learn, work, and play. Specifically, we need to:

- Expand the country's understanding of all the elements—including those outside of the health care system—needed to achieve good health.
- Broaden the current approach to health care beyond treating disease and injury to addressing the underlying causes of poor health that exist at home, in school, in the community, and at work.
- Stress closer links or a bridge connecting the work of health professionals and institutions to that of public health and other social and economic resources in the community.

The health care system must acknowledge and systematically address those realities of patients' lives that directly impact health outcomes and costs. It must also use all its resources—tools, workforce, and physical infrastructure—as a gateway to connect patients to the community resources they need to be healthy. And it must create the financial incentives needed to make this new paradigm work.

The goals of value-based care—improving quality while reducing costs—cannot be achieved without addressing patients' social needs. For that reason, momentum is growing to expand new models of financing to support better results and greater value that should be expanded even further. These efforts should require health professionals and institutions to work with other organizations in the community to connect patients to social and financial resources that can help improve their health and wellness. The Patient Protection and Affordable Care Act (ACA) creates new opportunities for initiatives to focus on prevention and keeping people well in the first place.

This will require developing new indicators of health—“vital signs” that identify barriers to achieving positive health outcomes—as well as incentives to address all factors that affect health. Health professionals, institutions, and payors must start with a clear understanding of how other factors in a patient's life affect his or her ability to be healthy or succeed with treatment. Health professionals should

assess their patients holistically, considering all factors that may be aiding or preventing health. For example, for years, health professionals did not assess patient behavior when diagnosing illness, but they now routinely ask patients whether they smoke, drink, or exercise.

In addition, health professionals must recognize nonmedical needs that affect a patient's ability to achieve health. For example, a patient may not take insulin as prescribed because he or she has no transportation to get to a pharmacy, or no way to refrigerate it. Other patients may be unable to follow recommendations to eat more fruit and vegetables because they can't get to a supermarket or afford the food.

Some health care institutions are leading the way to this broader approach to health. The University of Michigan recently established its **Complex Care Management Program**, where teams of doctors, nurses and case managers spend much of their time trying to bridge the chasm between inpatient and outpatient treatment systems. Case managers follow patients, sometimes for several years, accompanying them to doctor appointments, helping them obtain food or furniture and connecting them with community resources. The program is generating savings and better health. For example, one 42-year-old severely obese patient was able to dramatically change his health. In 2011, that patient spent 327 days in the hospital due to health conditions, but was able to avoid hospitalization in 2013.⁶⁴

Likewise, **Kaiser Permanente** has adopted a “Total Health” approach using clinical, educational, environmental and social actions to improve health. In its medical offices, medical assistants measure exercise as a “vital sign” and write prescriptions for walking or other physical activity. In its own offices, employees are urged to participate in “Instant Recess.” Kaiser Permanente also invests in the communities it serves. For example, it provided a grant to George Washington University Medical school to teach students about social determinants of health. In Portland, Ore., a Kaiser Permanente site has partnered with the local parks and recreation department to allow physicians to write “prescriptions” for swimming and other exercise. Patients who receive such scrips are contacted directly by department staff.

Health care institutions and professionals have a critical role to play in connecting patients to resources and supports

that can help maintain health. Questions that address what may be affecting a patient’s life outside the doctor’s office may lead to a broader “prescription” that in turn yields better health and reduced costs. Questions might include:

- How can we identify patients’ nonmedical health needs as part of their overall care?
- How can we connect patients to community services and resources that help people avoid getting sick in the first place or better manage illness, including physical, behavioral, and mental health needs?
- How can we provide strong leadership in collaboration with other sectors to ensure that where patients live, learn, work, and play improves, rather than compromises, their health outcomes?

- How can we connect people from the community to jobs in the health care sector—which typically is one of a community’s largest employers? And is there a role for community health workers in providing community-based services or linking them to needed supports?

Approaches to answering these questions are discussed below, along with recommendations for spreading new “vital signs” to address patients’ social needs; spreading models that connect health care, public health, and social services; and strengthening the role of health professionals and institutions in improving community health. Achieving this new model of integrated care will require innovation, incentives to change, and new measures of performance and accountability.

Sample Questions from Health Leads Patient Family Questionnaire

Please check any box below that applies:

	Sometimes I don’t have enough food for my family	<input type="checkbox"/>
	I worry that my home is unhealthy , or that my family may become homeless	<input type="checkbox"/>
	I want to find child care or activities for my children to do after school or during the summer	<input type="checkbox"/>
	I want help with transportation to clinic appointments, the pharmacy and other services	<input type="checkbox"/>

Source: Courtesy of Health Leads Co-Founder and CEO Rebecca Onie, July 5, 2013.

Recommendation

Adopt new vital signs to assess nonmedical indicators for health.

Health professionals use vital signs to gain a picture of a patient's physical health. Essential clinical vital signs include heart rate, blood pressure, temperature, weight, and height. But other, nonmedical vital signs such as employment, education, health literacy, safe housing, and exposure to discrimination or violence can also significantly impact health. For low-income patients in particular, nonmedical vital signs can both help clinicians make better-informed decisions regarding treatment and care, and clarify additional elements of care delivery necessary to health. These may include:

- Employment status
- Financial resources
- Access to healthy food
- Access to adult education classes
- Educational attainment
- ZIP code (which can be a strong predictor of health and longevity)
- Family structure
- Access to social supports
- Transportation
- Safe housing

To gain a broader picture of a patient's health, health professionals and institutions should incorporate nonmedical vital signs into their health assessment process. New vital signs for health should be objective, readily comparable to population-level data, and actionable. New vital signs checklists can be broad, assessing a variety of factors, or can be more focused, such as a poverty assessment tool focused on income level, one factor that is known to greatly affect health.

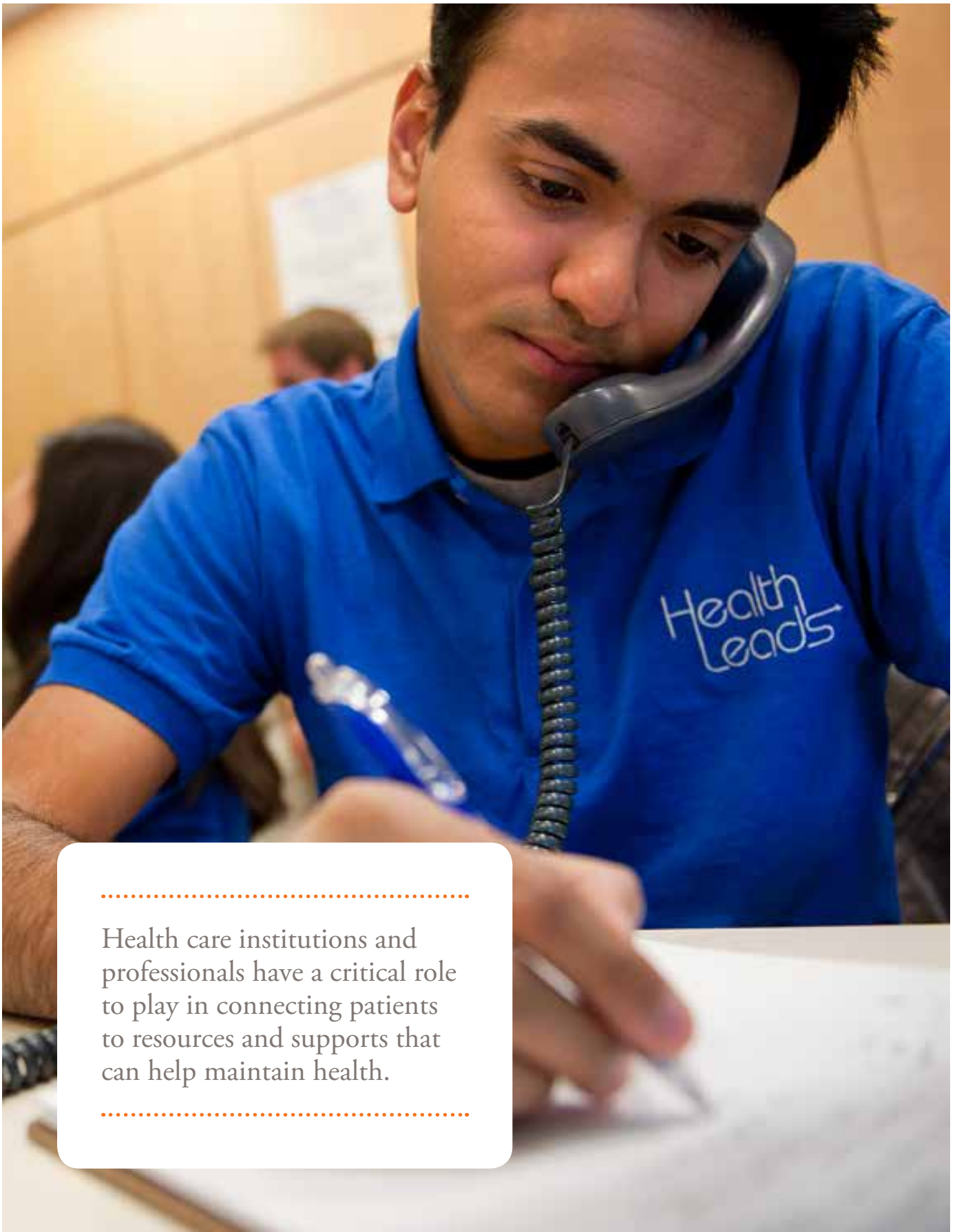
Another toolkit, developed by University of Toronto's Dr. Gary Bloch, provide primary care clinicians with guidance on how to assess whether poverty is affecting a patient's health, including the following questions:

- Do you have trouble making ends meet?
- Do you have trouble feeding your family?
- Do you have trouble paying for medications?
- Do you receive the child tax benefit?
- Do you have legal or immigration challenges?
- Do you have a safe and clean place to live?

The goal of adding nonmedical vital signs is to expand the country's approach to health beyond providing health care to also prescribe ways to enhance overall health. Adding nonmedical vital signs to the health assessment process will yield better-informed clinical decisions; trigger patient referrals to appropriate community resources and public benefits; improve health professionals' understanding of their patients; and forge greater connections between health care and public health and community supports. Collaboration between health professionals and other sectors in the community will be vital to forming a much-needed bridge between health care and health.

Commissioners reviewed different models and initiatives aimed at connecting patients with nonmedical services that will help improve their health. Some hospitals train social workers or lay health workers to reach out to patients, conduct health screenings, and link them with needed services. As an example, Kaiser Permanente's Colorado region has implemented hunger screening as part of its well-child visits. For positive screens, clinicians provide brief counseling and refer patients to a statewide hunger-free website and hotline that provides information on where to find food assistance and information on applying for federal nutrition programs.

Creation of a national, online clearinghouse of evidence-based models and best practices for linking patients with community resources to help maintain or improve health would help speed greater adoption of best practices. A clearinghouse could be modeled after the federal Center for Medicare & Medicaid Innovation, which supports the development and testing of innovative health care financing and service delivery models.



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Health care institutions and professionals have a critical role to play in connecting patients to resources and supports that can help maintain health.

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Photo: Matthew Moyer

Promising Approaches

Health Leads, a national health care organization, enables physicians and other health professionals to systematically screen patients for food, heat, and other basic resources that patients need to be healthy and “prescribe” these resources for patients. Patients then take the prescriptions to a Health Leads desk in the clinic, where a corps of well-trained and well-supervised college student advocates “fill” the prescriptions, working side by side with patients to access existing community resources. Health Leads advocates also provide real-time updates to the clinical team on whether a patient received a needed resource, resulting in better-informed clinical decisions. Health Leads currently operates in 23 clinics—pediatric and prenatal, newborn nurseries, adult primary care, and community health centers—across six geographic areas, all with significant Medicaid patient populations.

Inspired by Health Leads, **Basics for Health** in Vancouver has developed a poverty screening tool for primary care clinicians, with questions such as, “Do you ever have difficulty making ends meet at the end of the month?” The goal is to encourage health providers to consider poverty as a major health risk, noting: “The evidence shows poverty to be a risk to health equivalent to hypertension, high cholesterol, and smoking. We devote significant energy and resources to treating these health issues. Should we treat poverty like any equivalent health condition? Of course.” Funded by ImpactBC, Basics for Health trains recent graduates to be volunteers who connect low-income patients with community resources (food, shelter, and job training, for example) to improve their health.

The **Medical-Legal Partnership** program removes legal barriers that impede health for low-income populations. Legal professionals—legal aides, law school students, and private-sector attorneys—are integrated into the care team, where they partner with health professionals, case managers, and others to provide direct legal assistance to patients. Currently working in 38 states and 235 care settings, Medical-Legal Partnership volunteers intervene with landlords, social service agencies, and others to address health-harming conditions ranging from lack of utilities to bedbugs to mold in rental properties to accessing school support services for children with severe medical needs. Research shows that patients who receive Medical-Legal Partnership services have fewer emergency room visits, shortened hospital stays, decreased stress, and better coping mechanisms.

Community colleges and other local education leaders can also implement or expand training programs for lay health workers (e.g., community health workers, patient navigators, and peer health coaches) who can connect patients with health care and other services they need in their communities. Such programs improve the economic security and stability of people in low-income communities, providing them with jobs while addressing a growing need for new kinds of health care workers. For example, **Jobs For The Future**⁶⁵ trained more than 800 frontline health and health care workers, the majority of whom increased their pay, earned college credits or professional credentials, or achieved other positive outcomes. Seed funding from local businesses should be considered a potential source of support for these types of programs. Also, community organizations (e.g., YMCAs, faith-based organizations) could train their employees, members, and volunteers to help match patients to social services and community resources.

Nearly one in five Medicare patients discharged from a hospital is re-admitted within 30 days, at a cost of over \$26 billion every year. In an effort to improve care and keep high-risk patients from being re-admitted to the hospital, the Centers for Medicare & Medicaid Services’ **Community-Based Care Transitions Program (CCTP)** is connecting patients to local organizations such as social service providers, nursing homes, home health agencies, pharmacies, primary care practices, and other types of health and social service providers in the community. There are currently 102 organizations participating in the CCTP and working to prevent hospital re-admissions.

The University of Michigan Health System’s CCTP program assigns specialized case managers to patients who frequently visit the ER to assist them with finding resources once they leave the hospital. **Geisinger Health System’s Proven Health Navigator** program calls patients after they leave the hospital and provides heart failure patients with digital scales that transmit data back to their nurses. The Washington, D.C.-based **Medical Mail Health Services** provides home visits and makes sure that prescriptions are picked up and that patients have transportation to their next doctor visit.

Launched in April 2011, CCTP has made up to \$500 million in total funding available through 2015 for acute care hospitals partnering with community-based organizations in an effort to reduce readmissions.⁶⁶

Recommendation

Create incentives tied to reimbursement for health professionals and health care institutions to address nonmedical factors that affect health.

The ACA and other initiatives undertaken by employers, health insurers, and states are accelerating the use of new physician payment mechanisms and incentives, including paying more to health professionals who deliver better outcomes at a lower cost. Some public and private insurers already are moving in this direction. Government and private insurers should further expand payment reforms to include incentives and measures that relate to identifying and addressing social factors that affect patients, in keeping with the goal of using health care resources to have the greatest impact on the health of patients. Such incentives and measures should also address rewards for health professionals, hospitals, or other provider organizations that screen patients for social needs and work with community partners to link patients with appropriate services and resources in the community.

New financial incentives are needed to re-align health care delivery so that it is more effective in achieving and maintaining health. New kinds of payment mechanisms and incentives are already taking shape, moving away from traditional “fee-for-service” models that reward the quantity of medical services to those that reward better quality care and better health outcomes at a lower cost.

For example, patient-centered medical home payment reforms give primary care providers a “per-member” rather than fee-for-service payment to help physicians coordinate and provide services that each patient may need to get better outcomes. Some accountable care organizations (ACOs) pay health care professionals at least partly based on performance. Bundled or episode-based payment models provide a lump payment to one or more health care providers that reimburses the cost of all services a patient may need over a period of time and across a continuum. Under these

types of health care financing reforms, health professionals have more flexibility in how they spend resources on behalf of their patients. But they must also demonstrate greater accountability for their results. In many cases, performance measures in accountable care payment reforms already address important health outcomes, such as reducing hospitalizations for preventable complications and achieving better control of common chronic diseases like diabetes and coronary artery disease. Health care organizations with accountability for better health outcomes recognize that these outcomes may be achieved by removing obstacles to healthy behaviors that include housing insecurity, food insecurity, lack of cooking facilities, or lack of safe places for exercise.

Health care payment reforms must go beyond incorporating measures that address individual patient health. Such measures might include the results of health risk assessments for adult patients, incorporating such elements as body mass index, smoking status, and cholesterol levels, but also factors such as employment, financial resources, and ZIP code.

Traditionally, adoption of such measures has been limited because they are difficult to influence through traditional approaches to health care. Health care institutions and payers are recognizing the need to change.

In addition, it is important to recognize that having the right measures is not sufficient. We must invest in the technology and infrastructure needed to systematically screen and refer patients to needed services. In other words, our measures must be actionable.

Promising Approaches

The **Oregon Medicaid program** has implemented community care organizations, which are similar to ACOs and which facilitate collaboration between health care and social services providers, with the goal of improving community health. In Minnesota, the **Hennepin Health Accountable Care Organization**, created as part of an early Medicaid expansion, is linking Medicaid health

services and county-provided social services such as housing and employment counseling.⁶⁷ The Center for Medicare & Medicaid Innovation recently issued a request for proposals for innovative payment systems at the regional or community level that may spur new, more cost-effective ways of paying for and improving population health.

We Must Act Now

Greater flexibility in using Medicaid or other health care funds for community-based approaches to improving health should also be tied to accountability for both improving health results and reducing overall health care costs. Strategies to spur greater integration could include:

- Patient-centered medical home payments tied to improvements in nutrition and health outcomes related to nutrition that support referrals to community-based services such as vouchers for healthy food.
- Patient-centered medical home payments for pediatricians that track and aim for improvements on attendance at school and preschool.
- Bundled payments that address social needs as part of prevention of complications in treating common health problems.
- Pathways for reimbursement for community health workers and other nonmedical community supports through Medicaid managed care organizations and other Medicaid providers that are reimbursed on the basis of improving outcomes without increasing costs.
- Differential payments for providing augmented services to patients requiring help with nonmedical factors that affect their health, in conjunction with more integrated funding between health programs and social services programs affecting such patients.
- Providers including screening for social factors known to impact health as a routine part of electronic medical records to get meaningful use credits.
- Financial disincentives, such as penalties for re-admissions, that can be wielded to support connecting patients to nonmedical services that support health.
- Philanthropy—with its ability to take risks and invest in innovation—should support evaluations of new “vital signs” initiatives that deploy lay health workers to connect patients with community resources and services. Evaluations should determine the effectiveness of these initiatives, including whether they achieve cost savings and improve health outcomes.
- The federal government, through the Center for Medicare & Medicaid Innovation, and states should support further development and piloting of payment reforms that recognize linkages to community-based services.

Recommendation

Incorporate nonmedical health measures into community health needs assessments.

In order for a nonprofit hospital to maintain its tax-exempt status, it must provide community benefit services that support the health and well-being of the community it serves. Historically, a majority of community benefit funds were used to help pay for clinical care for the uninsured or underinsured.

Under the ACA, every nonprofit hospital is now required to conduct a community health needs assessment every three years, with input from public health and community members, and adopt an implementation strategy to address community needs identified through the assessment. This requirement, along with reforms in health care financing, and greater evidence on how a broader approach to health care can improve health, presents an opportunity for nonprofit hospitals and health systems to have a greater impact on health improvement efforts in their communities.

To date, the percentage of investment that hospitals have put toward this requirement has averaged 7.5 percent, but it varies widely by state. An assessment of 2009 data shows that hospitals applied 45 percent of community benefit spending to offset Medicaid losses; dedicated 1.9 percent to true charity care; and put 20 percent of all community benefit expenditures toward community health improvement. This translated into approximately 2.2 percent of total hospital spending.⁶⁸

Hospital and health system leaders should engage and collaborate with the community, governmental partners, social services professionals, foundations, and others to determine the most effective ways to direct resources to improve community health, and link community support to measurable impacts on community health. In addition, the community health needs assessment process should require that residents and stakeholders be engaged in the assessment and priority-setting process.

This may require establishing measures that look at access to early childhood programs, wellness centers, job creation strategies, mental health services, or environmental factors. Assessment alone will not be sufficient to produce health improvements at the community level. Hospitals must prioritize investment in improvements identified through the health needs assessment. The assessments must include collection of information on social determinants of health. Special attention should be paid to quality early childhood and family support programs and initiatives to foster healthy community development, building a bridge between personal health and community health.

Ideally, community health assessments would identify the most pressing priorities for community benefits dollars, facilitating efforts at the health system level to improve population health improvement. Hospitals or health systems would screen patients for unmet resource needs and connect patients to community resources, including those that have come to light through the community health assessment. At the same time, community benefit dollars would be deployed to address priorities flagged in the needs assessment, improving population and community health.

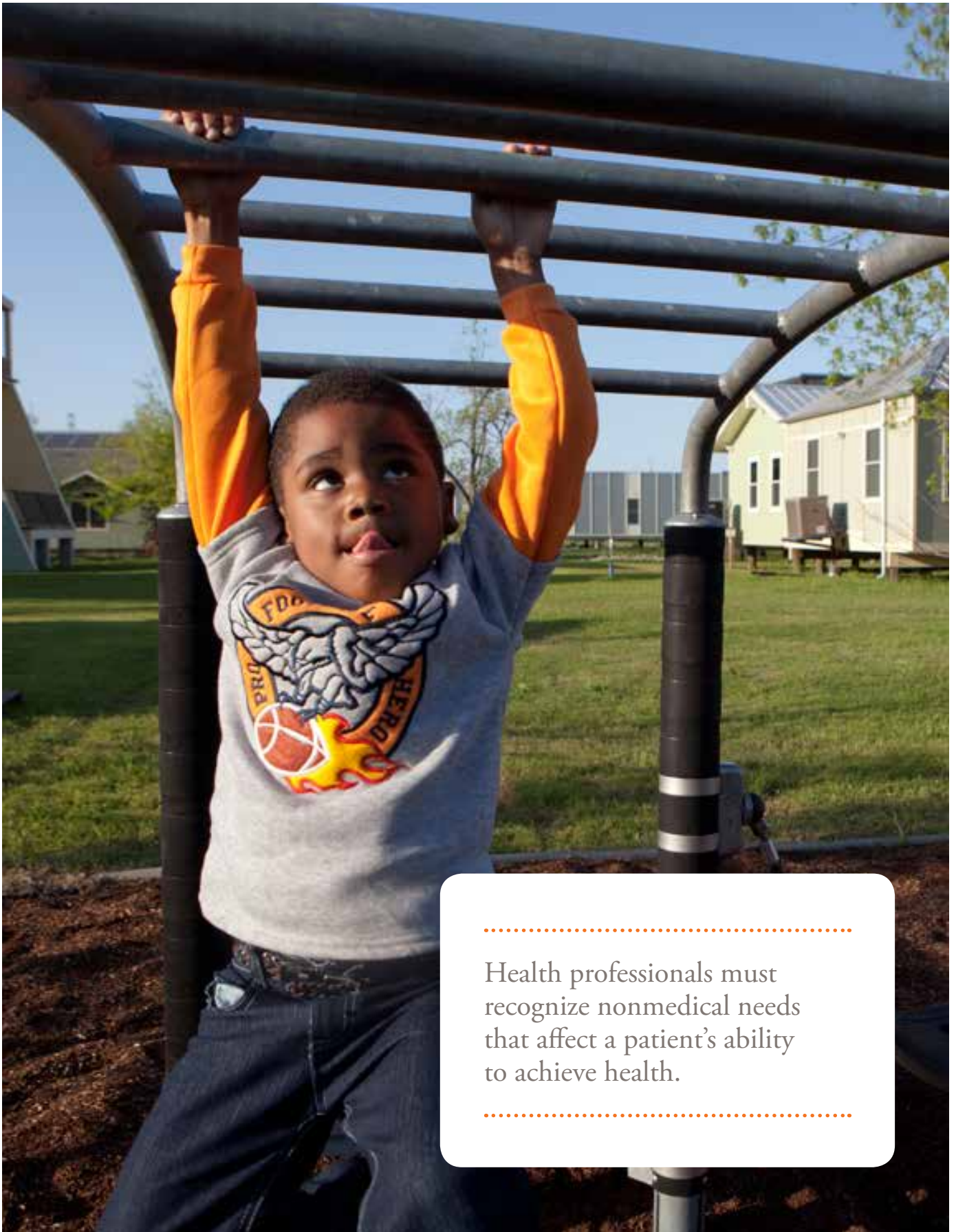


Photo: Tyrone Turner

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Health professionals must recognize nonmedical needs that affect a patient's ability to achieve health.

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Promising Approaches

To engage local residents in its planning process, **Bon Secours Health System** in Richmond, Va., initiated a series of “public visioning sessions” to ensure that community needs were being met during city planning. As a result, Bon Secours has created partnerships between the community and multiple private, philanthropic, civic and governmental organizations and established relationships for future city planning. From hiring a “healthy neighborhood liaison” to engaging multiple partners and local philanthropies, the public forums that Bon Secours convened have already led to new housing, new sidewalks and a wellness center in one of Richmond’s housing projects. The next project: a new supermarket that will provide fresh, healthy foods for local residents.

Boston Children’s Hospital approached its community benefit compliance by working to identify and understand which local and health-related issues were most important to its community. By analyzing health data, reviewing best-practice literature, conducting focus groups with residents, and interviewing key stakeholders, Boston Children’s Hospital aimed to understand what was most pressing. Over time, Boston Children’s Hospital determined that it could produce the most measurable results if it focused its efforts on a select few health issues that were identified by the community and were an existing specialization for the hospital and could be addressed by leveraging community partners. Ultimately, four were selected for this new portfolio: asthma, child development, mental health,

and obesity. The hospital’s asthma initiative, for example, has provided home environment assessments and asthma management education to families with a child who visited the emergency department or was hospitalized because of an asthma exacerbation. Such children are most likely to have poorly controlled asthma.

Program results have shown that participants have experienced fewer asthma-related hospitalizations, emergency department visits, and missed school days. The initiative has reached more than 900 families and has also shown some economic benefits—for every \$1 spent on the program, \$1.46 is returned to insurers and \$1.73 to society.⁶⁹

Nationwide Children’s Hospital in Columbus, Ohio, launched **Healthy Neighborhoods, Healthy Families** in response to community benefit requirements to improve neighborhood conditions that affect health. The public–private partnership between the hospital and local community-based organizations has targeted affordable housing, education, safe and accessible neighborhoods, and workforce and economic development. To date, HNHF has:

- Renovated neighborhood homes and provided grants to homeowners to increase the availability of quality affordable housing.
- Created farmers’ markets to improve access to fresh foods.
- Facilitated the mentoring of local elementary school students by hospital volunteers.

The **Community Health Initiative (CHI)**, a program of the Children’s Hospital Medical Center in Cincinnati, partnered with community groups to address asthma, accidental injuries, and poor nutrition in the community. For example, the hospital used geocoding technology to identify clusters of re-admitted asthma patients who lived in substandard housing units owned by the same landlord. The hospital then partnered with the Legal Aid Society of Greater Cincinnati to encourage the property owner to make repairs and improve living conditions. CHI also made referrals to Legal Aid for patients who needed help with Medicaid benefits or required other legal assistance.

To improve air quality, reduce greenhouse gas emissions, and shrink Seattle’s pollution levels, **Seattle Children’s** partnered with hundreds of community residents and over a dozen community organizations and advocacy groups to develop the **Livable Streets Initiative**. The citywide program included a walking audit, resident surveys, and a town hall event to help the hospital create bike boulevards and institute road safety improvements to encourage community residents to bike and walk to work. To overcome challenges in public transportation connections, Seattle Children’s developed its own transit program using 22 minivans (all with bike racks) to take passengers between transit hubs and workplaces.

It reports that alternative commuting efforts have taken 630,000 cars off the roads and freeways; reduced vehicle miles travelled by 6.5 million (the equivalent of 13 round trips to the moon); and saved 235,000 gallons of gas. This has resulted in the elimination of approximately 2,100 metric tons of CO₂ emissions.⁷⁰

Promoting healthy eating and active living are two core components of **Kaiser Permanente’s “Total Health” approach**. Working in 40 low-income communities across the country, Kaiser Permanente works with community collaboratives to identify and address barriers to health and combat the socioeconomic factors that contribute to obesity and related chronic diseases. Through partnerships with schools, Kaiser Permanente is working to make the school environment healthier for students, staff, and teachers. Programs include efforts to create safer routes to school and ensuring that healthy food options are provided.

We Must Act Now

According to the Hilltop Institute at the University of Maryland, financial benefits to nonprofit hospitals from federal, state, and local tax preferences totaled an estimated \$12.6 billion annually in 2002.⁷¹ This represents a significant opportunity that must be leveraged now.

- Philanthropy, health care organizations, and the federal government should support development and testing of protocols (e.g., standard community health needs assessment templates and procedures) and collaborative models for community health needs assessment.
- Technical assistance should be provided to communities that lack the fundamental resources or infrastructure to support broad-based community engagement for community health needs assessment and follow-up improvements.
- The elements on the IRS Schedule H Form 990 regarding nonprofit hospitals and community health benefit improvement activities should be carefully monitored and assessed as the field continues to evolve. Health care organizations should look to initiatives that have changed the culture of health care for “lessons learned.”



Photo: Nathaniel Wilder

Opportunities to Advance a Culture of Health



Photo: Roger Tully

The United States has spent vast amounts of money on health care services, technology and treatment—more than any other country—to make people well. But the return on investment isn't what it should be. Despite spending upward of \$2.7 trillion a year and 17.9 percent of our gross domestic product on health care, Americans live shorter, sicker lives than people in other developed nations.⁷² This hurts our international competitiveness and costs the U.S. economy \$576 billion a year, including \$227 billion in lost productivity due to illness.⁷³ We must put just as much energy into creating conditions that will keep people well in the first place as we do into providing treatment when it is needed.

The health care sector alone cannot bear sole responsibility for the country's health. Research demonstrates that there are important determinants of health beyond health care. For that reason, we need to break down conventional policy-making silos that separate health from education, transportation, community planning, and other areas of decision-making and engage in true cross-sector collaboration.

As a Commission, we are issuing a call to action for a broad range of players—from individuals and community organizers, to businesses, investors and community developers, to education leaders and policymakers—to integrate health into their work. We all have a stake in a healthy America, whether it's the need for a healthy and productive workforce, the need for children to be able to function and learn well in school, or the need for vibrant and self-sustaining communities. This chapter outlines the areas in which we see the greatest need, as well as opportunity, for collaboration, leadership, and on-the-ground action. It also provides specific examples of success and promise.

The 2009 Commission report called for creating "...a national culture infused with health and wellness—among individuals and families and in communities, schools and workplaces. Just as America has "greened" in response to global warming, we can and must integrate healthier decisions in all we do."⁷⁴

Since then, there has been movement toward a broader-based integration of health as a value, and in particular around work to foster communities that promote better health and to support early childhood development.

The Commission heard testimony from the Federal Reserve Bank of Minneapolis and Wilder Research about how cross-sector work between community development and health was launched by the Healthy Communities conferences begun by the Federal Reserve Bank of San Francisco. The U.S. Green Building Council has stated:

"As a leader in the green building movement, USGBC is committed to environmental sustainability and economic prosperity. Sharpening our focus on how green building can advance human health and well-being marks an important milestone in the history of our movement."⁷⁵

Reflecting the connection between community health and community design, the American Institute of Architects has recognized the important role that architects play in shaping communities. "Their design affects our safety, health, and the environment as well as the quality of life in our neighborhoods, towns, cities, and regions," the Institute notes. Its Center for Communities by Design promotes the design of "sustainable, healthy, safe, and livable communities."⁷⁶

The Low Income Investment Fund has also changed its investment strategy to better incorporate health metrics in its work. Its programs "work together to create a comprehensive approach to community development based on a vision for healthy communities—green, economically vibrant places, where people live, learn, and grow to their full potential."⁷⁷

At the same time, there is growing demand from multiple champions in business, science, finance, and the military, among others, to create opportunities for children to be healthy. In particular, the business community is seeing great value in investing in early childhood as a way to lay the foundation for an improved workforce. The U.S. Chamber of Commerce, CEOs across the country, and business roundtables are advocating for early childhood education as a critical investment in the country's future. It is easy to understand why: for every dollar spent on early childhood education, the return is \$7 in improved academics, health care savings, and other long-term societal benefits.⁷⁸ The Institute for a Competitive Workforce, a nonprofit affiliate of the U.S. Chamber of Commerce, has noted that "[a]chieving a world-class education system and creating a highly skilled workforce begins with high-quality early learning opportunities."⁷⁹

Steady movement toward a culture of health requires more than an investment of dollars. A culture of health that permeates neighborhoods, homes, schools, and workplaces demands different kinds of "investment," including leadership, collaboration, innovation, shared vision, and personal responsibility.

Some efforts can and should begin now, with the potential to dramatically improve opportunities for health in the near term. Other efforts will require time, and sustained investment, but have the potential to change the overall health and economic stability of generations to come.

Community Leaders Business Public Health Corporate Finance Health Care National Leadership Organizations and Advocacy Non-Profit

Early Childhood and K-12 Education

National Leadership Organizations and Advocacy Nonprofit Government (Local/State/Federal) Health Care Public Health Faith-Based Organizations Corporate Finance Business

Dramatically changing the nation’s approach to health, and the resulting outcomes, requires action on many fronts. This is a seismic shift, one that moves away from a targeted focus on individuals to a much broader emphasis on improving the health of all Americans, community by community.

Following are examples from around the country of opportunities for leadership and action, highlighting areas where change was needed and cross-sector collaboration made it happen. Cross-sector collaboration is a highly effective and efficient strategy for improving health. Opportunities may be pursued in the private, public, and nonprofit sectors and in academia.

It is also important to note that individuals from across generations have an important role to play in advocating and working for changes to improve health. Recognizing the necessity of good health for future generations, older Americans can take the lead in demanding that policy-makers invest in in health. Young people can also play a powerful role—using new advocacy and communications tools—in helping others understand how integral health is not only beneficial to their own futures, but also to those of their children. While everyone has a personal responsibility to make choices that support good health for themselves and their families, individuals can also catalyze others to do the same and spur action on the part of larger groups to remove barriers to good health.

Private Sector

A range of private-sector actors have resources and experience that may be used to help improve health. These include:

- **Businesses and employers** that recognize the long-term economic benefits of making their communities healthier places to live and work. In this capacity, they may have internal resources that can be targeted to provide financial services, elder care, or child care for employees; the ability to pull together coalitions and partnerships to meet community needs; and the capacity to offer educational materials or forums on healthy behaviors or resources.
- **Financial institutions**, which can incorporate health improvement into their investment strategies, recognizing the long-term return on investment for early childhood education and creating communities that promote health. Given the link between neighborhood vitality and health, financial institutions also have a role to play in lending and supporting small businesses and minority- and women-owned businesses.
- **Health professionals and institution providers**, which can adopt new vital signs for health and connect patients with services and resources. Perhaps most importantly, health professionals and institution providers can lead the way toward a new view of health that places as much emphasis on the factors that keep people well as on treating patients when they are sick. In addition, **health care payers** can restructure financial incentives to reward health promotion, not just disease management.

Examples

Accountable Care Community in Akron, Ohio

Accountable Care Communities (ACCs) work across a range of sectors, including business, housing, transportation, and education, in concert with health care professionals, provider organizations, and public health officials to improve health while achieving other critical goals. The Austen Bionnovation Institute in Akron, founded by Akron Children's Hospital, Akron General Health System, Northeast Ohio Medical University, Summa Health System, the University of Akron, and the John S. and James L. Knight Foundation, brought together leaders from 70 community groups to form Akron's ACC. While looking for ways to improve the community's economy, they identified high rates of chronic disease and related health care costs as a major concern. The ACC leveraged the resources and ideas of a wide range of organizations, including the major hospitals and health care providers; employers; the local chamber of commerce; universities; housing groups; transportation groups; economic developers; faith-based organizations; and many others.

Since its launch in 2011, success of Akron's ACC has been measured by the improved health of the whole community; cost effectiveness and cost savings in the health care system; improved patient experience for those using the health care system; and job creation. One example of success: a 10-percent decrease in the average cost per month of care for people with diabetes.

Bon Secours Health System

To engage local residents in community planning and service, Bon Secours Health System, Richmond, Va., held a series of "public visioning sessions" to guide city development planning to meet community needs. Each of its facilities throughout the Richmond area was required to participate in this "healthy community" effort to ensure that health-related issues were included.

Bon Secours' initiative increased engagement between the community and multiple private, philanthropic, civic, and governmental organizations, and established relationships for future city planning efforts. From hiring a "healthy neighborhood liaison" to engaging multiple partners and local philanthropies, the public forums have led to new housing, sidewalks, and a wellness center in one of Richmond's housing projects. The next big project: a new supermarket that will provide fresh, healthy foods for local residents.

Children's Hospital Medical Center

The Community Health Initiative (CHI), a program of the Children's Hospital Medical Center in Cincinnati, Ohio, partnered with community groups to address asthma, accidental injuries, and poor nutrition in the community. For example, the hospital used geocoding technology to identify clusters of re-admitted asthma patients who lived in substandard housing units owned by the same landlord. The hospital then partnered with the Legal Aid Society of Greater Cincinnati to encourage the property owner to make repairs and improve living conditions. CHI also made referrals to Legal Aid for patients who needed help with Medicaid benefits or required other legal assistance.

Goldman Sachs

Goldman Sachs, United Way of Salt Lake, and the J.B. and M.K. Pritzker Family Foundation have formed a partnership to create the first-ever social impact bond designed to expand access to early childhood education through the early Childhood Innovation Accelerator.

The investment supports a pre-school program intended to reduce the need for special education. Success will be measured by the level of cost savings when children do not need to use special education services financed by the state. Also known as pay-for-success bonds, social impact bonds help governments test innovative ideas for tackling social issues when they cannot afford the initial up-front costs.

The loan commitment of up to \$7 million will fund the expansion of a high-quality preschool program for at-risk children in Utah. The investors will only get an interest return on their loan if the preschool program is successful in preparing children to start kindergarten.

Health Leads

Health Leads is a national health care organization funded by the Robert Wood Johnson Foundation that seeks to build a health care system that addresses all patients' basic resource needs as a standard part of quality care. Founded in 1996, Health Leads was born of conversations with front-line physicians who described the frustration of prescribing antibiotics or asthma medication to patients, only to discover that these same patients had no food at home or were living out of a car. Such resource needs are far more critical drivers of patients' health than medication.

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As the notion that medical care is only part of a much greater web of factors determining health takes hold, hospitals are facing a growing need to understand how they can play a more substantial role in the health of their communities.

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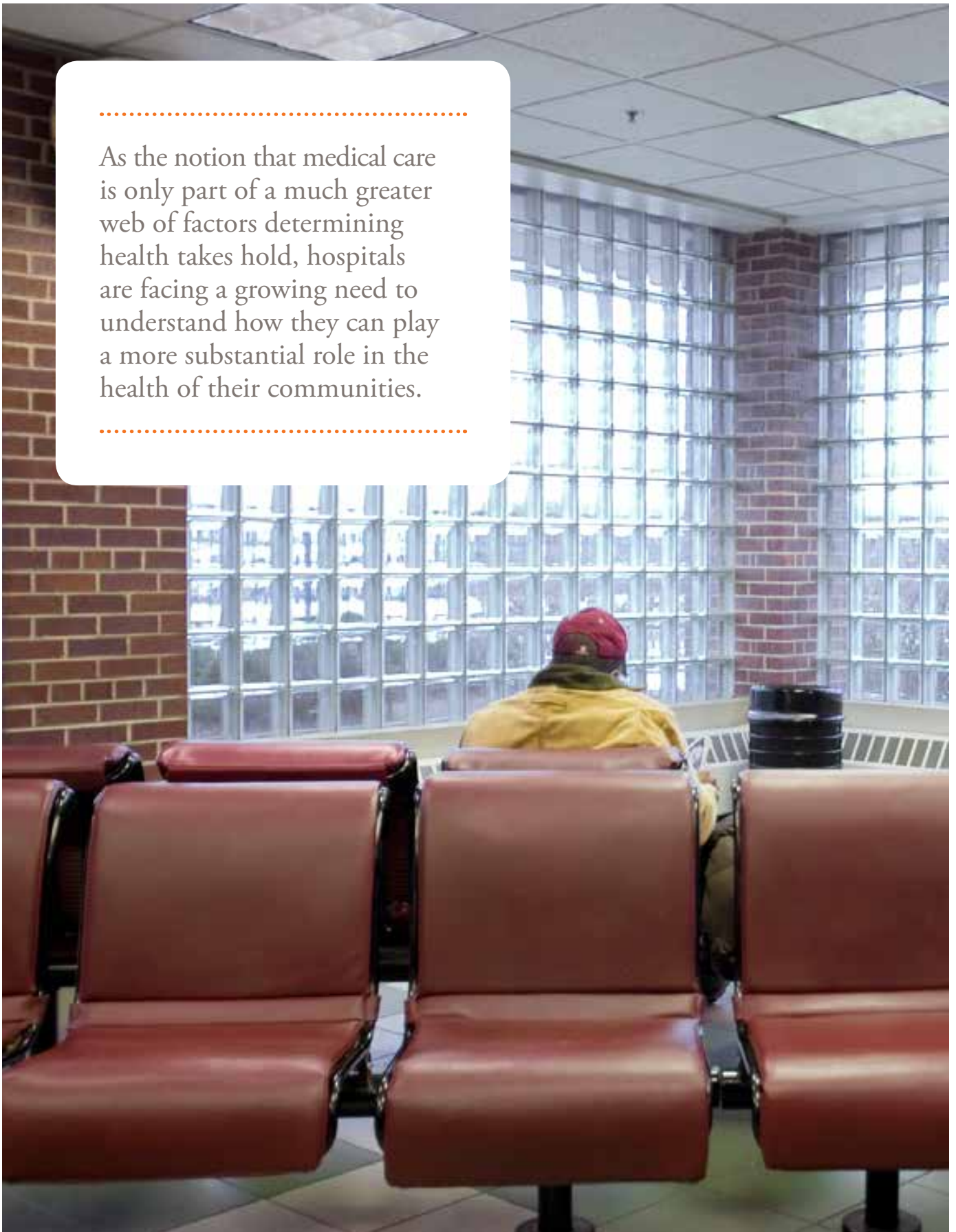


Photo: Roger Tully

Health Leads enables physicians and other health care providers to systematically screen patients for food, heat, and other basic resources they need to be healthy and “prescribe” those resources for patients. Patients then take the prescriptions to Health Leads’ desk in the clinic, where a corps of well-trained and well-supervised college student advocates “fill” the prescriptions, working side by side with patients to access existing community resources. The student advocates also provide real-time updates to the clinical team on whether a patient received a needed resource, resulting in better-informed clinical decisions. In 2012, Health Leads’ corps of 900 advocates served 11,500 patients in 23 clinics—pediatric and prenatal, newborn nurseries, adult primary care, and community health centers—across six geographic areas, all with significant Medicaid patient populations.

Hospitals

Today’s hospitals employ more than 5.4 million people and spend more than \$340 billion a year on goods and services.⁸⁰ Nonprofit hospitals alone generate over \$650 billion in revenue, and are increasingly becoming the economic engines of the communities they serve.⁸¹ As the new “anchor institutions” in many communities across the country, hospitals are well situated to lead community revitalization strategies. The Mayo Clinic in Rochester, Minn., for example, buys many of its supplies from local and diverse suppliers to stimulate the local economy, and is also a principal funder for a land trust that has developed 875 units of affordable housing for its residents. Gundersen Lutheran Health System in La Crosse, Wis., is spearheading a renewable energy, waste management, and recycling program, and Bon Secours Health System in Baltimore, Md., is creating green spaces, offering youth employment opportunities, and expanding financial services to underserved populations.

Many other hospitals are embracing this anchor institution mission and forging partnerships throughout the communities in which they reside. From leading initiatives to expand public transportation to collaborating with local governments to spur employment opportunities, hospitals have the ability to build more prosperous and healthier communities.

Kaiser Permanente

Kaiser Permanente has adopted a “Total Health” approach—not only in the way it thinks about health care for its members, but also for its employees. The California-based company

is in the midst of implementing a new program to ensure its nearly 200,000 employees have the opportunity to make healthy choices at work. In 2013, the organization announced the Total Health Incentive Plan, which encourages and empowers employees to make their own health a priority, while building a culture of health in the workplace. Workers volunteer to become health care champions and set up programs such as walking meetings, walking clubs, healthy cooking programs and smoking cessation workshops for colleagues.

Living Cities, Inc.

For more than 20 years, Living Cities, Inc., has worked to improve the lives of low-income people and the cities where they live by bringing together 22 of the world’s largest foundations and financial institutions to invest in health and community development. From Morgan Stanley and the Kresge Foundation, to the Robert Wood Johnson Foundation and Prudential Financial, Inc., Living Cities has built a unique platform of partnerships to redirect public and private resources, and help communities build homes, stores, schools and community facilities. To date, members of the collaborative have shaped federal funding programs and collectively invested almost \$1 billion in dozens of communities across the country. Recent initiatives include bringing more green jobs to communities in need of workforce development and re-engineering public transportation.

Low Income Investment Fund

The Low Income Investment Fund (LIIF) is a community development financial institution that provides innovative capital solutions that support healthy families and communities. Serving the poorest of the poor, LIIF is a steward for capital invested in community-building initiatives. In doing so, LIIF provides a bridge between private capital markets and low-income neighborhoods. LIIF’s programs work together to create a comprehensive approach to community development based on a vision for healthy communities—green, economically vibrant places, where people live, learn, and grow to their full potential.

Nationwide Children’s Hospital

Nationwide Children’s Hospital in Columbus, Ohio, launched Healthy Neighborhoods, Healthy Families (HNHF)—per community benefit requirements—to improve neighborhood conditions that affect health. The partnership between

the hospital and local community-based organizations targeted affordable housing, education, safe and accessible neighborhoods, and workforce and economic development. To date, HNHF has:

- Renovated neighborhood homes and made grants to homeowners to increase the availability of quality affordable housing;
- Created farmers markets to improve access to fresh foods; and
- Facilitated the mentoring of local elementary school students by hospital volunteers.

Ready Nation

Ready Nation is a national coalition of business leaders that supports early childhood policies that strengthen the U.S. economy and workforce. Specifically, they believe that early education, home visiting, and parent mentoring will help close the achievement gap and reduce social costs—and that investing in disadvantaged children pays for itself.

For the past seven years, Ready Nation has built a business case for investing in early childhood and engaging business leaders nationwide to make such investment a reality. Following an initial research phase identifying the economic benefits of early childhood programs, Ready Nation has begun to mobilize business leaders to advocate for early childhood investment in their own communities, cities, and states. In-depth support from Ready Nation in the form of webinars, business leader summits, new economic evidence, profiles of business champions, training for advocates, sample op-eds, and presentation materials help business leaders and advocates engage executives to speak out successfully. Ready Nation has worked with business communities in 30 states. These efforts appear to be paying off: In 2010, AT&T California President Ken McNeely helped lead a successful effort to expand pre-kindergarten; and, in 2011, the Vermont Business Roundtable was essential in helping the General Assembly pass a bill expanding pre-kindergarten to all of the state's children.

Seattle Children's Hospital

To improve air quality, reduce greenhouse gas emissions, and shrink pollution levels, Seattle Children's Hospital partnered with hundreds of community residents, and more than a dozen community organizations and advocacy groups to develop the Livable Streets Initiative. The citywide program

included a walking audit, resident surveys, and a town hall event to help the hospital create bike boulevards and institute road safety improvements to encourage community residents to bike and walk to work. To overcome challenges in public transportation connections, Children's Hospital also developed its own transit program, using 22 minivans (all with bike racks) to take passengers between transit hubs and workplaces.

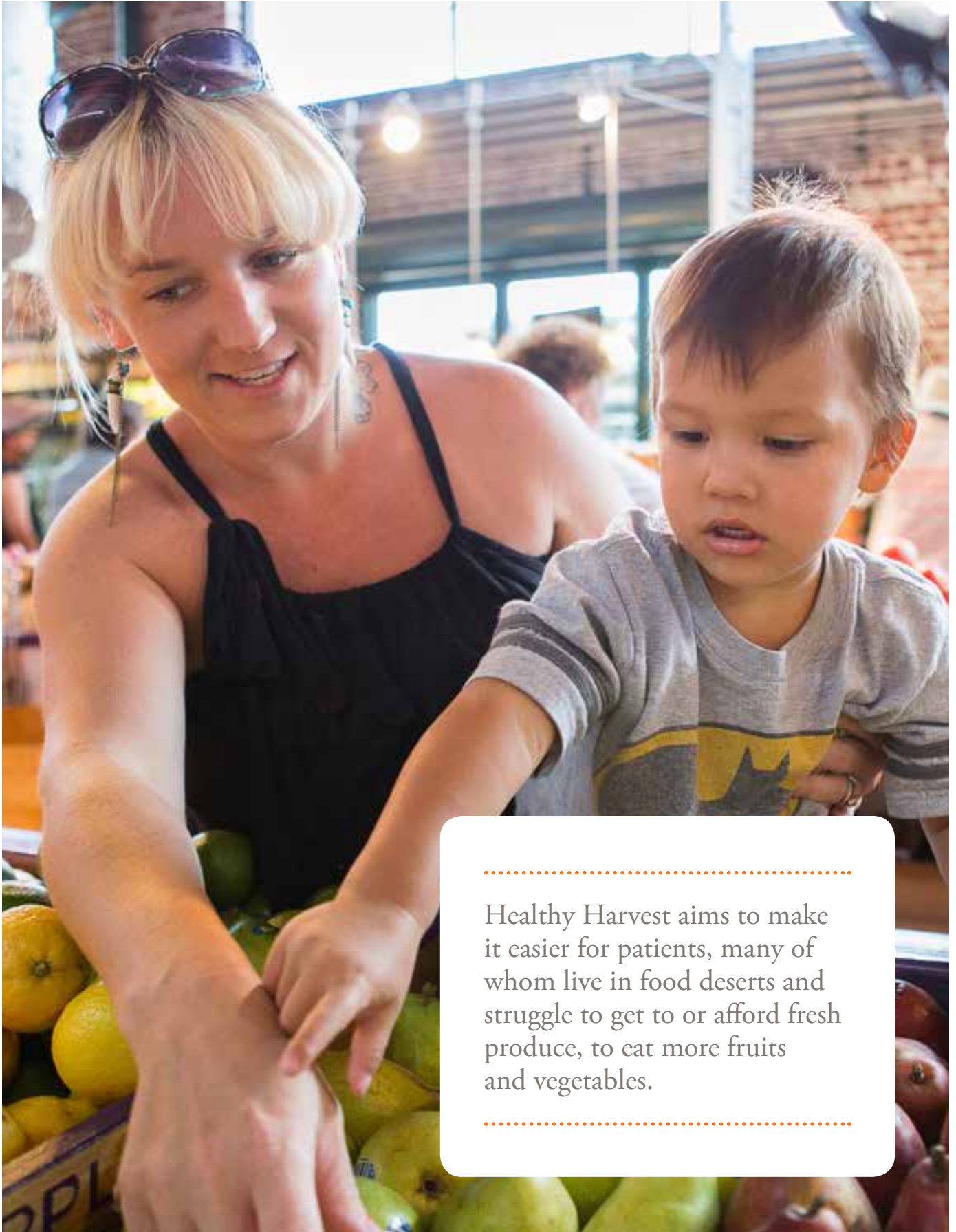
The hospital reports that its alternative commuting efforts have taken 630,000 cars off the roads, reduced vehicle miles travelled by 6.5 million (the equivalent of 13 round trips to the moon), and saved 235,000 gallons of gas. This has resulted in the elimination of approximately 2,100 metric tons of CO₂ emissions.

The Health Systems Learning Group

As the notion takes hold that medical care is only part of a much greater web of factors determining health, hospitals are facing a growing need to understand how they can play a more substantial role in the health of their communities. The Health Systems Learning Group (HSLG), made up of 43 organizations, including 36 nonprofit health systems, has met since September 2011 to share innovative ways health systems can do just that. In April 2013, HSLG released a call to action, making the case for health systems to engage in transformative community partnerships, allowing them to work deeply with others engaged in addressing community needs. Members also committed to innovative ideas like proactively investing a percentage of what they spend on charity care in communities with the hopes of reducing the need for preventable emergency room and inpatient care for the uninsured.

U.S. Chamber of Commerce

Recognizing the importance of early childhood education to economic development, the U.S. Chamber of Commerce Foundation has made early childhood investment one of its core focus areas. In July 2013, the Chamber gathered a bipartisan group of business leaders, policy-makers, and advocates from across the country to their "Oh the Places You'll Go," event at its Washington, D.C., headquarters. Noting the current challenges facing the country—growing income inequality, a shrinking middle class, increasing unemployment, a lack of skilled workers in many industries, and the long-lasting effects of growing up poor—attendees spoke directly about bringing the power and influence of business to bear



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Healthy Harvest aims to make it easier for patients, many of whom live in food deserts and struggle to get to or afford fresh produce, to eat more fruits and vegetables.

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Photo: Jordan Gantz

on creating policy changes needed so that all children have access to early childhood education. In addition to organizing this high-profile event, the Chamber has issued research on why and how business can support early childhood investment and is working at the state level to engage and support businesses around early childhood investment.

Public Sector

Clearly, the public sector is a significant driver of health improvement across all levels of government. Recently, public-sector agencies at the local, state, and federal levels have been increasing activities across policy silos—including early childhood and community development—to effect positive changes in health. More specifically:

- **State and local government** can make early childhood development a high priority and offer financial and policy incentives for investments in communities that create healthy choices. They can experiment with innovative financing mechanisms to fund priority programs and initiatives; partner with local businesses and philanthropy to fund and identify needed services; track health measures that also assess social factors to determine areas where investment is needed; offer incentives for unusual collaborations to share resources; and establish joint-use agreements to create more opportunities for people to pursue health.
- **Federal and state government** can maintain funding streams and continue to lead the way in cross-sector collaboration; streamline reporting requirements; and provide financial incentives for innovation; as well as guard against automatic health care spending while shifting focus to other areas that greatly impact health. They can also tie funding to performance; provide technical assistance, capacity-building, and training to low-performing initiatives; shift funding from nonperforming programs that fail to improve; require the creation of broader measures to be included as part of community health needs assessments; and create new funding streams for key initiatives.
- **Public health agencies**, organizations, and state health departments can share best practices and partner with other groups to integrate health into efforts outside of health care. Public health organizations can also begin to reflect on their own practice and move beyond the traditional disease-specific paradigm. There is a great deal that the public health sector can do to support neighborhood-level interventions that focus on systems-level change.
- **Public health payers** can use financial incentives to reward health promotion.

Examples

Affordable Care Act and Community Health Needs Assessments

Under the ACA, all nonprofit hospitals are required to conduct a community health needs assessment every three years and implement a strategy for addressing community needs identified through the assessment. This requirement presents an opportunity for nonprofit hospitals and health systems to contribute meaningfully—and strategically—to health improvement efforts in their communities. Hospital and health system leaders should engage and collaborate with the community, governmental partners, foundations, and others to improve the health of communities.

According to the Hilltop Institute at the University of Maryland, financial benefits to nonprofit hospitals from federal, state, and local tax preferences totaled an estimated \$12.6 billion annually in 2002.⁸² The federal government could ensure that these dollars are leveraged for community assessment and improvement. Actions could include:

- Supporting development and testing of protocols and collaborative models for community health needs assessment;
 - Establishing mechanisms to encourage philanthropies or local organizations to provide technical assistance to communities that lack the resources or infrastructure to support broad-based community engagement for community health needs assessment and follow-up improvements; and
 - Calling for careful monitoring and assessment of information regarding community health benefit activities listed by nonprofit hospitals on their federal tax returns.
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CDC-funded Community Transformation Grants

Funded by the U.S. Centers for Disease Control and Prevention (CDC), Community Transformation Grants (CTGs) support state and local groups that are trying to reduce chronic disease. These groups include government agencies, tribes and territories, nonprofit organizations, businesses, and communities across the country. In 2011, CDC awarded \$103 million to 61 state and local government agencies, tribes and territories, and nonprofit organizations, in addition to giving almost \$4 million to six national networks of community-based organizations. In 2012, the CTG program expanded to award approximately \$70 million to communities to implement broad, sustainable strategies. These programs will reduce health disparities and expand preventive services that will directly impact about 9.2 million Americans.

The CTG program is expected to improve the health of more than four out of 10 (130 million) Americans.

Community-Based Care Transitions Program

Nearly one in five Medicare patients discharged from a hospital is readmitted within 30 days, at a cost of over \$26 billion every year. In an effort to improve care and keep high-risk patients from being readmitted, the Centers for Medicare & Medicaid Services' Community-based Care Transitions Program (CCTP) connects patients to local organizations such as social service providers, nursing homes, home health agencies, pharmacies, primary care practices, and other types of health and social service providers. Currently, 102 organizations participate in the CCTP, working to prevent hospital re-admissions.

For example, the University of Michigan Health System's CCTP program assigns specialized case managers to patients who frequently visit the ER to assist them with finding resources once they leave the hospital. Geisinger Health System's Proven Health Navigator program calls patients after they leave the hospital and even provides heart failure patients with digital scales that transmit data back to their nurses. The Washington, D.C.-based Medical Mall Health Services provides home visits and makes sure that prescriptions are picked up and that patients have transportation to their next doctor visit.

Launched in April 2011, CCTP has made up to \$500 million in total funding available through 2015 for acute care hospitals partnering with community-based organizations.

County Health Rankings & Roadmaps

By ranking the health of every county in the nation, the *County Health Rankings & Roadmaps* program aims to educate the public and policy-makers on the multiple factors that influence community health—such as education, economic conditions, and the physical environment—and provide solutions that will improve community health. Grantees of the *Roadmap* project are working to improve health outcomes through community partnerships and cross-sector collaboration.

For example, San Bernardino County in California launched a "Healthy Communities" initiative aimed at getting every community involved in improving the area's health. To date, 17 of the county's jurisdictions are at some stage of implementing a strategic health initiative that include changing policies to allow for more community gardens and farmers markets, improving safe routes for children to walk to school, and establishing after school programs, walking clubs

and cooking classes for local residents. To lower obesity rates in Mississippi's Hernando County and encourage wellness overall, local officials there have revamped city parks, built more athletic facilities and community gardens, and started a local bike club. Hernando County has also taken on initiatives to widen roads, expand sidewalks, and encourage residents to lead more active lives.

Denver Preschool Funding

In 2006, Denver voters approved a ballot measure that sets aside a percentage of city sales tax revenue to fund the Denver Preschool Program. Since January 2007, the city has collected approximately \$10 million per year for the program, the vast majority of which goes directly to students' education through tuition credits and quality improvement funding for preschools.

The typical Denver Preschool Program family receives \$254 to \$283 per month to help pay for preschool. Two-thirds of Denver Preschool Program families report annual family incomes of less than \$30,000. The Denver Preschool Program has quickly grown to become one of the most highly enrolled programs of its kind anywhere in the country, with 70 percent of Denver's 4-year-olds participating each year.

Georgia's Pre-K Program

Georgia was the first state to offer pre-kindergarten, free of charge, beginning in 1993 under Governor Zell Miller. Financed through lottery funds, the program initially provided pre-kindergarten programs for at-risk 4-year-olds. In 1995, the program was expanded beyond at-risk children to include all eligible 4-year-olds in the state. In March 1996, the Georgia General Assembly created the Office of School Readiness, a one-stop children's department that administered the pre-K program, federal nutrition programs, and other early intervention services. This department became Bright from the Start: Georgia Department of Early Care and Learning in 2004. Currently, the program serves 84,000 children.

Harris County Hospital District

Stopping by the farmers market for Dollar Store-priced produce while leaving a medical appointment is a healthy, convenient reality for patients in Houston. Since November 2011, Harris County Hospital District, Houston's largest public health care system, has partnered with Veggie Pals,

Inc., a private produce distributor, to hold weekly farmers markets at 11 of the District's health centers. The program, called Healthy Harvest, aims to make it easier for patients, many of whom live in food deserts and struggle to get to or afford fresh produce, to eat more fruits and vegetables. The program's founders were inspired to take action to get healthier foods into their community as a means of combatting the obesity crisis, which they estimate is costing their health care system about \$109 million every year. So far, the program has been successful selling an average of 30 tons of produce each month, with individual farmers' markets often selling out their stock by mid-afternoon.

Joint-Use Agreements: Sharing Community Space to Improve Health

Sharing community spaces like school athletic facilities and fields, city recreational centers, playgrounds, and gyms can keep costs down and communities healthy. A common manner of creating this kind of shared space is a joint-use agreement—a legal arrangement between a city or county and a school district stipulating that facilities can be shared. According to a 2012 Bridging the Gap report, nearly 93 percent of schools had some type of joint-use agreements in place with their community; however, many were vague. The report's authors recommended that for joint-use agreements to work most effectively and give people better access to physical activity in their communities, they should specify how the agreement will be managed on an ongoing basis.

Hernando, Miss.

In Mississippi's DeSoto County, the city of Hernando worked with the local school district to provide more recreational space without increasing taxes. The 2011 County Health Rankings classified DeSoto County as the healthiest county in Mississippi for health outcomes and the fifth-healthiest county for health factors, with lower unemployment rates, higher education rates, and greater access to healthy food, compared to the rest of the state.

Redwood City, Calif.

In Redwood City, Calif., a joint-use agreement between city and school officials stipulates not only which facilities may be shared but also who is responsible for maintenance, scheduling, and training new employees on the rules of the agreement. In addition, the agreement includes twice-yearly meetings for all parties to evaluate the agreement and discuss challenges and potential improvements, creating a living agreement that will allow city and school leaders to make adjustments as needed.

Tucson, Ariz.

Tucson, Ariz., averages 6.2 acres of park per 1,000 residents—about half the national average. Meanwhile, the city's population is rapidly increasing. In 2007, Councilman Rodney Glassman made schoolyard access a central campaign issue. After his election, his staff identified neighborhood schools as “low-hanging fruit” and used joint-use agreements between the city and Tucson Unified School District to open these spaces to the community after school hours. The goal was to have a park or play space within a half-mile of every resident.

National Prevention Council

At the federal level, the National Prevention Council, created under the ACA, has modeled how to integrate health improvements across sectors. Twenty federal departments and agencies with representation on the Council have committed to supporting tobacco-free environments; expanding access to healthy, affordable foods; and identifying additional opportunities for considering prevention and health. An action plan released by the Council in 2012 detailed some 200 prevention and wellness actions underway at federal departments and agencies aimed at improving quality of life, eliminating health disparities, promoting healthy behaviors, and creating health-promoting social and physical environments. Some states and counties have launched similar multi-agency initiatives that incorporate health-related factors into a more holistic approach to decision-making.

Oklahoma's Universal Pre-K Program

Oklahoma's Universal Pre-K program, created in 1998, enrolls 74 percent of the state's 4-year-olds. The program is funded by the state's school finance formula; public school districts may subcontract with other classroom providers, allowing the program to operate in a variety of settings, including private child care centers and Head Start programs. All Oklahoma pre-K teachers must hold at least a bachelor's degree and be certified specifically in early childhood education, in addition to following research-based curricula in the classroom. While the state does not provide specific funding for 3-year-olds, some Oklahoma school districts offer classroom programs for these younger students through a combination of funding sources, including Title I, Head Start, special education, and general district funds. Multiple studies have shown that Oklahoma's effort has improved children's

academic, cognitive, social, and emotional development, which researchers attribute to a strongly supported early learning program with higher standards. According to a 2008 study, children who attended a Tulsa pre-K program entered kindergarten nine months ahead of their peers in reading, seven months ahead in writing, and five months ahead in math.

Partnership for Sustainable Communities

Three federal agencies—the Department of Housing and Urban Development (HUD), the Department of Transportation (DOT), and the Environmental Protection Agency (EPA)—created the Partnership for Sustainable Communities in 2009 to help neighborhoods around the country develop in more environmentally and economically sustainable ways. Through this collaboration, the Partnership focuses on areas such as increasing transportation options, promoting affordable housing, and leveraging federal policies and investment, while protecting the environment. In addition, the Partnership coordinates infrastructure investments across these sectors. In June 2013, the Partnership released the Sustainable Communities Census HotReport, a data analysis tool that allows community leaders and residents to determine their community’s sustainability performance. The Partnership has also convened regional roundtable discussions and supports the Governor’s Institute on Community Design.

Pennsylvania Pre-K Counts

Pre-K Counts, established by the Pennsylvania Department of Education, makes quality pre-kindergarten opportunities available to children and families across the state, with priority given to those in at-risk communities. It provides families with a choice of quality options in Head Start, a school, or child care center.

The program builds on the work of the Pre-K Counts Public-Private Partnership for Educational Success, a three-year, public-private project funded by leading Pennsylvania foundations and supported by the Commonwealth of Pennsylvania. Early results from the Pre-K Counts public-private initiative found that children’s early learning improved across every measure. At the beginning of the 2010-2011 school year, fewer than one in four of the 11,500 children in Pennsylvania Pre-K Counts classrooms had age-appropriate skills. By the end of the year, approximately three in four Pre-K Counts children showed age-appropriate language, math, and social skills.

Pre-K 4 San Antonio

San Antonio voters approved a sales tax increase of one-eighth of one cent to offer high-quality, full-day preschool to 4-year-olds in the city. The plan, “Pre-K 4 SA” (prekindergarten for San Antonio), is a partnership between the city of San Antonio and seven San Antonio Independent School Districts, representing 90 percent of the preschool-age population in the city. The city’s sales tax increase, which took effect April 1, 2013, is expected to generate about \$32 million annually and will pay for four new full-day pre-kindergarten centers, workforce training for early childhood educators, and grants for schools to expand preschool programs in San Antonio. The tax increase is estimated to cost less than \$8 per year for median-income San Antonio households. During the next eight years of the sales tax increase, the program is expected to reach about 22,400 4-year-olds, with the goal of closing achievement gaps and decreasing the number of students requiring special education as they enter public schools.

Strengthening Head Start

In November 2011, the U.S. Department of Health and Human Services enhanced the nation’s Head Start program by implementing tougher rules for low-performing grantees. The new rules require grantees that fail to meet benchmarks to re-compete for continued federal funding if onsite reviews reveal deficiencies, if they fail to establish and use school-readiness goals for children, or if they perform poorly in the classroom. Grantees also are required to re-compete if their state and local licensing has been revoked, a Head Start grant has been suspended, or if fiscal or management issues prevent them from properly managing federal funds.

Currently, Head Start programs are permitted to provide and/or broker health services. Such services may include helping families find a medical home; locating funding for health services; working with local Medicaid and State Child Health Insurance Program agencies to determine a child’s eligibility for medical assistance; or tracking health services.

Nonprofit Sector

- **Advocacy organizations at local, state, and national levels** can demand quality early childhood programs and opportunities, promote opportunities for improving health, and mobilize cross-sector collaboration for achieving common goals. They are in a good position to identify needs, marshal the resources at hand, and engage effective partners. They can also participate in public meetings; lead or join coalitions; and promote personal responsibility for pursuing healthy options whenever possible, including buying healthy food when it is available, taking advantage of parenting or job training programs if needed, and providing nurturing environments for families.
- **Community leaders** are particularly critical in advocating for local residents. They operate from a place of trust and can spur people to action. They uniquely understand local needs, challenges, and potential solutions.
- **Philanthropic institutions** can identify and support innovative models of cross-sector collaboration that integrate health, community building and design, joining with new partners in supporting demonstrations, and recognizing the need for risk-taking in new ventures. They also may fund research on the best ways to improve health over the life course; convene groups and initiate exchanges of best practices and ideas among unconventional stakeholders; fund innovative, untested solutions, moving ideas from theory to practice; incentivize states and communities to try new approaches; replicate successful local initiatives in other areas; and spur new movements, such as tackling childhood obesity, building healthy communities, and investing in early childhood. Finally, they may engage in or support advocacy to create policy and environmental change.
- **Faith leaders** can serve as respected voices in their communities, teaching community members about the value of health. They can also motivate a cadre of volunteers to push for initiatives such as early childhood learning or parent supports to improve health; lend real estate and space to programs, such as preschool classes, job training, health assessments, or informal discussions on the importance of nutrition; partner with community leaders and local officials to assess the needs of the local community and advise on where resources are most needed; and use moral authority to spur action.
- **Nonprofit hospitals** can use community benefit assessments to identify ways to improve the overall health of the community. Under the Affordable Care Act, nonprofit hospitals are already required to do this; however, they could be more strategic about how they do it.

- **Community development practitioners** can consider health improvement as one goal of their work, seeking out new partners and asking that every investment in a low-income community promote health. By partnering with community and health leaders to integrate health-specific objectives into their work, they can improve the overall health of communities. Community development practitioners can also encourage investors and local leaders to demand that any development in low-income communities is designed to promote health.
- **Education and early childhood development program leaders** can integrate the latest science into their trainings and curricula, help raise awareness of what constitutes “high quality” early childhood development, and demand high performance. They are also in a position to establish stronger program standards based on the latest science; recognize the value of ensuring that parental support programs are also available to help improve a child’s home environment; and advocate for making homes and communities safer so that children’s cognitive abilities are not harmed by the stress associated with chronic, harmful environmental conditions.

Examples

ADC YouthBuild

Abyssinian Development Corporation’s YouthBuild program serves the needs of Harlem youth ages 16 to 24 by helping them become community leaders. Although ADC is now a nonprofit community and economic development corporation dedicated to improving the Harlem community, it actually got started in 1987, when the Rev. Dr. Calvin O. Butts III urged Abyssinian Baptist Church parishioners to “rebuild this community brick by brick and block by block.”

The award-winning program model now integrates education, leadership development, counseling, construction, and other vocational training skills, and provides resources for graduates. Through YouthBuild, young people work toward acquiring their high school or general education diploma, learn job skills, and serve their communities by building affordable housing.

Advocacy in Nebraska

In Nebraska, several advocacy organizations—including First Five Nebraska, Nebraska Children and Families Foundation, Nebraska’s Early Childhood Business Roundtable, and others—partnered to galvanize public demand for quality early childhood programming. In the past five years, the local partners:

- Expanded funding for pre-kindergarten;
- Secured funding for at-risk 4-year-olds through state education funding;
- Established a \$60 million public-private endowment, called Sixpence Early Learning Fund, to support birth-to-3 services for children at risk;
- Fought to protect existing early childhood funding during the years of state budget cuts; and
- Helped pass legislation to expand the Sixpence Early Learning Fund, initiate a quality rating and improvement system for child care, and raise the eligibility standard for the child care subsidy.

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Basics for Health

Inspired by Health Leads, Basics for Health in Vancouver has developed a poverty screening tool for primary care clinicians, with questions such as, “Do you ever have difficulty making ends meet at the end of the month?” The goal is to encourage health providers to consider poverty as a major health risk, noting: “The evidence shows poverty to be a risk to health equivalent to hypertension, high cholesterol, and smoking. We devote significant energy and resources to treating these health issues. Should we treat poverty like any equivalent health condition? Of course.” Funded by ImpactBC, Basics for Health trains recent graduates to be volunteers who connect low-income patients with community resources (food, shelter, and job training, for example) to improve their health.

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California Endowment

The California Endowment’s Building Healthy Communities initiative is improving employment opportunities, education, housing, neighborhood safety, unhealthy environmental conditions, and access to healthy foods in 14 communities across the state. Over the next 10 years, the Endowment will work with schools, local governments, business leaders, neighborhood groups, and individuals to create healthy and safe environments for families. For example, in the Long Beach community, the Endowment is working with the local school district to prepare youth for higher education, and, in the Boyle Heights community, organizations are working with elected officials to help residents own homes.

The program will invest hundreds of millions of dollars to improve health throughout the chosen communities and

encourage those living there to think about health in a more comprehensive way. To measure success, the Endowment and its community partners will look at outcomes like childhood obesity, youth violence, and school attendance rates in the target communities.

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Calvert Foundation

Calvert Foundation, which empowers investors to empower communities, is a community development financial institution (CDFI) that provides a range of financing options for small businesses, child care centers, healthy food retailers, community health care clinics, charter schools, and affordable housing providers—the core elements of stable communities. CDFIs are well-positioned to offer financial resources to groups in need, primarily due to their ability to attract private capital. To date, CDFI investors and supporters have helped Calvert Foundation build or rehabilitate more than 17,000 homes, create 430,000 jobs in the U.S. and in developing countries, and finance over 25,000 cooperatives, social enterprises, and community facilities.

In October 2013, Calvert Foundation received a financial assistance award from the U.S. Treasury’s Community Development Financial Institutions Fund. With this \$1.35 million grant, Calvert Foundation will increase lending in underserved communities and connect investors to those communities.

Calvert Foundation has provided a total of more than \$567 million in financing to support organizations focused on improving the lives of low-income individuals, families, and their communities.

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Child First

Child First uses home visits and a network of community services to prevent and repair the devastating effects of early childhood adversity. The program targets vulnerable children, up to age 6, who exhibit developmental or emotional problems or who have parents facing multiple, serious challenges. The program model is based on the latest research on brain development, which shows that extremely high-stress environments, such as those marked by poverty, domestic violence, or substance abuse, can harm the developing brain of a young child. The program offers services and supports aimed at strengthening the parent-child relationship and protecting the child’s brain from the stressful environment.



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The impact of Play Streets goes beyond enabling physical activity in a safe environment. The initiative spurs interactive play, helps reduce rates of childhood obesity, and creates opportunities for cognitive development that can have a long-lasting effect on the lives of the children who participate.

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Photo: Matthew Moyer

Child First provides evidence-based, family-centered services, including screening, consultation, and home-based mental health interventions. Child First builds collaborative relationships among community service providers to ensure access to comprehensive and coordinated care, and connects families to well-integrated community-based resources to help them address sources of stress directly: from basic needs such as food and housing to issues like depression or domestic violence. The program, which began in Bridgeport, Conn., is unique among home-visiting models because it features a skilled mental health specialist as a leading part of the team.

The program helps vulnerable children overcome the effects of environmental stressors and facilitates healthy growth and cognitive development, which in turn put a child in a position to learn. A randomized controlled trial showed that Child First has a significant and lasting impact on both children and families. Stress and depression among Child First mothers decreased. Children behaved better, were more emotionally secure, and their language development improved vastly—a predictor of greater success later in school. In the randomized trial, for children with baseline language problems who had a Child First intervention, 80 percent demonstrated competent language, compared with 36.4 percent of the usual-care children.

Early Steps to School Success

Created by Save the Children, Early Steps to School Success (ESSS) builds a strong foundation for early learning in low-income, rural communities where there are few, if any, services for young children and their families. Built on public-private partnerships with local schools and states, ESSS aims to enhance school readiness for children up to age 5 and to mentor parents. During 2010–2011, the program served more than 5,000 children and 3,500 parents.

ESSS provides culturally relevant early childhood education services to children and their parents and ongoing staff training to community early childhood educators. It not only recognizes the essential role families have in preparing their children for school, but also reinforces parents’ roles as advocates for community-wide efforts that support school readiness. Key components of the program include:

- Providing home visits, which give parents age-appropriate activities for their children, help them monitor their children’s developmental progress, and offer them guidance on interacting with young children to promote early literacy and language learning.

- Helping parents develop skills and strategies that support child development, including healthy sleeping routines, interpreting and responding to babies’ efforts to communicate, and helping toddlers develop self-control and problem-solving skills.
- Fostering a positive connection between families and schools with parent education groups, toddler story-book hours, and play groups.
- Ongoing staff training to early childhood coordinators, who conduct home visits.

Educare

Educare is a growing network of full-day, year-round schools designed to serve at-risk children from birth to age 5. Educare schools are financed primarily through existing public dollars, but are grounded in partnerships involving local philanthropies, federal Head Start and Early Head Start providers, and school leaders. All are dedicated to narrowing the achievement gap for children in their communities. Through this pan-philanthropic strategy, Buffett Early Childhood Fund and seven other national funders (W.K. Kellogg Foundation, George Kaiser Family Foundation, Irving Harris Foundation, J.B. and M.K. Pritzker Foundation, Bill & Melinda Gates Foundation, David and Lucile Packard Foundation, and an anonymous foundation) co-invest in early childhood practice, policy, and knowledge in order to achieve better outcomes for vulnerable young children and their families.

Educare schools rely on mostly existing public funding streams—including Head Start and local child care and preschool dollars—to leverage existing assets. Operating budget gaps at Educare schools often reflect policy gaps that, once recognized, provide opportunities for advocacy and grassroots pressure to improve the resources available for children in need.

ISAIAH

ISAIAH, a faith-based community organization in Minnesota, formed the “Stops For Us Coalition” to ensure that a new light rail transit line included stops in two Twin Cities neighborhoods that would assist in expanding economic development. A coalition of neighborhood groups, bus riders, housing advocates, and faith-based institutions worked together through public meetings, planning commission hearings, and meetings with officials. ISAIAH was a key mobilizer in this project, serving as an intermediary between stakeholders and the community.

Magnolia Place Community Initiative

The Magnolia Place Community Initiative (MPCI) in Los Angeles is undertaking full-scale community change in order to assure that the 35,000 children within the community's five square miles break all records of success for health, education, family relationships, and economic well-being. In order to achieve this, MPCI has gathered a large and diverse network of more than 70 organizations, ranging from the Los Angeles school district and police department, to the University of California-Los Angeles, local food banks, and small grassroots organizations. This network will come together to strengthen individual, family, and neighborhood "protective factors" that are the buffers that help individuals find the resources and strategies to function effectively, even under stress. These include parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and children's social and emotional competence.

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Mercy Housing

Mercy Housing is an affordable housing organization that participates in the development, preservation, management, and financing of affordable, program-enriched housing across the country. In California, Mercy Housing recently collaborated with the San Francisco Redevelopment Agency, the San Francisco Department of Public Health, and the San Francisco Public Library to build the Mission Creek Senior Community, a mixed-use housing development that combines an adult day health center for low-income seniors with 140 apartments and the city's first new branch library in 40 years.

The adult day health center, which is visited by more than 50 seniors every day, provides medical care, occupational and physical therapy, social services, and even lunch to the building's residents and people in the neighborhood. The city of San Francisco reports that the Mission Creek Senior Community saves the city nearly \$1.5 million a year in avoided nursing home costs for its residents. Most importantly, residents enjoy a better quality of life.

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Neighborhood Centers, Inc.

Neighborhood Centers supports community development in and around the Houston region through partnerships with other nonprofits by bringing resources and education to low-income communities. Its initiatives have enhanced the lives of more than 400,000 people living in the Houston and

Texas Gulf Coast areas. The organization's work is centered on the premise that significant community development can only be achieved when local residents are involved: "Our approach recognizes that individuals and communities already possess skills, knowledge and resources that can produce powerful benefits when neighbors are linked with neighbors."

In the Gulfton/Sharpstown community, Neighborhood Centers worked with residents to create the Baker Ripley Community Center on four acres in the heart of the neighborhood. In its first year and a half of operation, the center served 23,000 people. It offers a wide range of services from family health and wellness programs to leadership classes to immigration workshops and courses in economic development.

The center integrates education, financial opportunity, health services, and performing and visual arts into one site. This has resulted in savings for the community, improved school graduation rates, a reduction in juvenile crime, and increased interest in living in Gulfton/Sharpstown.

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Oasis

In Southern Florida, Calvary Chapel of Fort Lauderdale started Oasis, a church ministry that helps provide free confidential testing and counseling for people living with HIV/AIDS. It also offers a monthly support group in a safe, confidential location off the church campus. Through the ministry's support groups, medical professionals offer information about HIV updates, insurance, and changes in medicine. Oasis also partners with the Florida Department of Health in a neighboring county for National HIV Testing Day in June, where more than 1,000 people are tested.

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Play Streets

In New York City, where streets and sidewalks make up 80 percent of public space, community residents from the Bronx to Manhattan are building momentum around the idea that children need safe places to play. A broad coalition of organizations are creating "Play Street" weekends by closing streets to cars and repurposing them for people in the community. Play Streets provide much-needed open space and opportunities for kids to stay physically active.

The impact of Play Streets goes beyond enabling physical activity in a safe environment. The initiative spurs interactive play, helps reduce rates of childhood obesity, and creates opportunities for cognitive development that can have a long-lasting effect on the lives of the children who



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Child First uses home visits and a network of community services to prevent and repair the devastating effects of early childhood adversity. The program targets vulnerable children, up to age 6, who exhibit developmental or emotional problems or who have parents facing multiple, serious challenges.

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Photo: Tyrone Turner

participate. In 2010, the New York Academy of Medicine (NYAM) evaluated the physical and social impacts of Play Streets. The evaluation found that more than 1,200 children and teenagers engaged in the two Play Streets, in neighborhoods where more than one-third of residents live below the poverty line and more than 40 percent of primary school children are overweight or obese.⁸³

Purpose Built Communities

Purpose Built Communities is modeled on the redevelopment of Atlanta's East Lake neighborhood, which was once known for its poverty and sky-high crime rates, but today is nationally recognized for community revitalization. In 1995, instead of attacking poverty, urban blight, and failing schools piecemeal, a group of community activists and philanthropists took on all of these issues at once. All of the distressed public housing units were demolished, and replaced with new apartments, half of which were market rate. The neighborhood, which once had 1,400 extremely low-income residents, is now home to 1,400 mixed-income residents. As a result, significant changes have occurred:

- The employment rate of low-income adults increased from 13 percent to 70 percent.
- The neighborhood's Drew Charter School moved from last to first place among 69 Atlanta public schools.
- Violent crime dropped by 90 percent.

The model is now being replicated in eight communities across the country. Each project is designed to address the needs of the community, but all share three key features:

- Quality mixed-income housing aimed at de-concentrating poverty;
- An independently run cradle-to-college educational approach for low-income children that also attracts middle-income families to schools; and
- Community facilities and services that not only support low-income families but also bring neighbors together and create a sense of community.

StriveTogether

StriveTogether brings together educators, nonprofit organizations, philanthropies, businesses, government agencies, political leaders, and others to pursue common goals for improving education from early childhood through early employment. It works with communities to develop

plans tailored to the needs and circumstances of children in each community, improve and build upon those efforts over time, and leverage resources for the greatest impact.

Since 2006, StriveTogether has helped communities in 34 states and the District of Columbia. In Cincinnati, the program has worked in partnership with the school department and a local United Way program to assess the readiness of every student entering kindergarten. Subsequent work led to a 9-percent increase in kindergarten readiness over four years in Cincinnati, where progress had been stagnant for years. Similar gains have been realized in Newport, Ky., and Covington, Ky. The kindergarten readiness rate in Newport has improved from 12 percent to 72 percent of students since 2005, and Covington has seen a 4 percent improvement since 2010 to 67 percent of students prepared.

The Kresge Foundation's Re-Imagining Detroit Initiative

Working with other philanthropic organizations, nonprofits, business, government, and other partners, the Kresge Foundation is investing in areas that leverage Detroit's strong assets and present opportunities for helping Detroit residents imagine and build a vibrant 21st-century version of their city. The Foundation believes that if it can make headway against the extreme social and economic challenges here, the lessons will have broader applicability to other communities.

In 2009, Kresge offered *Re-Imagining Detroit 2020* as a guide for more focused efforts between the public sector and business leaders to embrace foundations as more active partners in the decision-making processes around Detroit's future. This proactive approach required Kresge to move away from more traditional grantmaking guidelines and embrace higher levels of risk. In 2011, Kresge provided grants for the *Re-Imagining Detroit* framework for an investment of \$25.5 million.

The ReFresh Project, New Orleans

The Low Income Investment Fund's ReFresh Project, which launched in New Orleans in May 2013, is the first development in the nation to house healthy and fresh food retail options under the same roof with a broad range of organizations and programs designed to promote positive health outcomes and healthy behaviors. The new development, which has taken over an old grocery building in the city left vacant following Hurricane Katrina, combines direct services and goods with education, training, and outreach. The goal of ReFresh, created under a partnership

between Broad Community Connections (BCC), a local nonprofit, and L+M Developers, a New York-based firm that specializes in low-income and market-rate housing, is to build a healthier community in a historically underserved area of New Orleans.

Although a major goal is to offer better food options to residents, the partners recognized that what was needed was a transformative project that would engage the community and anchor economic and community development. BCC and L+M believed that simply placing a fresh food retailer in an underserved community with a preponderance of unhealthy food options would not change the community's health.

Instead, they launched ReFresh, which includes a Whole Foods Market, a culinary and life-skills training program for at-risk youth, a medical teaching kitchen, and other health and wellness-related businesses and programs. The idea is to provide educational programming and supportive services, new jobs, economic opportunities, and crucial resources that can help residents live healthier lives over the long term.

Rachel Diller, vice president of the Urban Investment Group with Goldman Sachs, said the investment banking firm provided \$6 million in loans and equity to ReFresh because it will revitalize a struggling neighborhood: "It's classic public investment in areas that need a kick start."

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Transit-Oriented Development in Oakland, Calif.

In response to community advocates who used data to illustrate how public transit, affordable housing, and job creation affect health, city officials, residents, and health advocates in Oakland, Calif., embarked on a project to create a transit-oriented development (TOD) around the Lake Merritt Bay Area Rapid Transit (BART) station. In 2010, six local community organizations collaborated to ensure the planned revitalization effort addressed concerns around pedestrian safety and affordable housing. The collaborators, which include transit and environmental justice organizations, health services, and housing and economic development agencies, will use a health impact assessment to evaluate the health effects of the proposed project. The TOD will offer residents an environmentally friendly community by creating developments within short walking distances of public transportation (BART).

Academia

Research institutions and universities can train leaders in developing healthy communities, help create new data and metrics for cross-sector collaboration, and serve as clearing houses for data. They can also train health professionals how to recognize and address the social factors that affect health as part of overall patient care. Although still not common, an increasing number of medical schools are incorporating information about social factors into their curriculums. Finally, they can inform the development and implementation of new service models and programs that address social factors that influence health.

Examples

Association of American Medical Colleges

In January 2012, the American Association of Medical Colleges released a report, "Behavioral and Social Science Foundations for Future Physicians," calling on medical educators to expand education of future physicians to include knowledge of social determinants of health and behavioral factors that impact health. Examples include the University of California San Francisco, the University of Massachusetts Medical School, and a required "Health Care Disparities in America" course at the University of Chicago Pritzker School of Medicine.

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Cincinnati Children's Hospital Medical Center

There is reason to believe that incorporating social determinants into medical education curricula would improve health in communities. A 2010 study conducted at Cincinnati Children's Hospital Medical Center found that new social determinants of health curricula increased pediatric interns' comfort and knowledge of social determinants of health and community resources.

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Medical-Legal Partnership

The National Center for Medical-Legal Partnership is a project of the George Washington University School of Public Health and Public Health Services' Department of Health Policy that improves the health and well-being of low-income and other vulnerable populations by addressing unmet legal needs and removing legal barriers that impede health. Legal professionals—from the legal aid, law school, and private sector *pro bono* communities—are integrated into the health care team, where they partner with physicians, nurses, case managers, and others to provide direct legal assistance to patients and change policies to ensure that vulnerable people get and stay healthy.

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Dramatically changing the nation's approach to health, and resulting outcomes, requires actions on many fronts. This is a seismic shift, one that moves away from a targeted focus on individuals to a much broader focus on improving the health of all Americans, community by community.

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Photo: Jordan Gantz

Glossary of Terms

Accountable Care Organization: Accountable care organizations (ACOs) are groups of doctors, hospitals, and other health care providers that work together to give coordinated, high-quality care to the patients they serve. Some ACOs pay health professionals at least partly based on performance. Bundled or episode-based payment models provide a lump payment to one or more health care providers to reimburse the cost of all services a patient may need over a period of time and across a continuum. Under these types of health care financing reforms, health professionals have more flexibility in how they spend resources on behalf of their patients. But they must also demonstrate greater accountability for their results.

Community Development: The community development sector—made up of a network of nonprofit service providers, real estate developers, financial institutions, foundations, and government—leverages public and private dollars to transform impoverished neighborhoods into economically viable and healthy communities. Community development works locally to meet the needs of residents by planning and building roads, child care centers, schools, grocery stores, community health clinics, and affordable housing.

Community Development Financial Institution: A community development financial institution provides financial services to communities in economically distressed markets, such as mortgage financing for low-income and first-time homebuyers and nonprofit developers, and commercial loans and investments to small start-up or expanding businesses in low-income areas.

Community Health Needs Assessments: The Patient Protection and Affordable Care Act (ACA) creates an opportunity for hospital organizations, public health agencies, and other stakeholders to promote community health improvement by conducting community health needs assessments and adopting related implementation strategies that address priority health needs. Under the ACA, hospital organizations satisfy their annual community benefit obligations by meeting those new requirements, which are described in section 501(r)(3).

Community Reinvestment Act: Passed by Congress in 1977, the Community Reinvestment Act laid the foundation for the community development finance system by requiring banks to help meet the credit needs of the low- and moderate-income communities where they operate. Although it is difficult to measure the exact amount of financing generated by this law, estimates range in the tens of billions of dollars per year. Taken together, the government, philanthropic, and market capital that is contributed to the community development industry represents over \$100 billion invested into low-income communities annually.

Community Transformation Grants: Community Transformation Grants (CTGs) support state and local groups that are trying to reduce chronic disease. These groups include government agencies, tribes and territories, nonprofit organizations, businesses and communities across the country. CTG funding is provided by the U.S. Centers for Disease Control and Prevention.

Health Impact Assessment: A health impact assessment (HIA) is a process that helps evaluate the potential health effects of a plan, project, or policy before it is built or implemented. An HIA can provide recommendations to increase positive health outcomes and minimize adverse health outcomes.

Joint-Use Agreement: A joint-use agreement is a formal agreement between two government entities—often a school district and a city or county—setting forth the terms and conditions for the shared use of public property. Joint-use agreements allow school districts to share with local government the costs and responsibilities incurred by opening their facilities.

Nonmedical Vital Signs: Health professionals use vital signs to get a picture of a patient's physical health. Essential clinical vital signs include heart rate, blood pressure, temperature, weight, and height. But other, nonmedical vital signs such as employment, education, health literacy, safe housing, and exposure to discrimination or violence can also significantly impact health. For low-income patients in particular, nonmedical vital signs can both help clinicians make better-informed decisions regarding treatment and care and clarify additional elements of care delivery necessary to health.

Public Health: Preventing disease and promoting improved health where we live, work and play is the job of public health. Where medicine focuses on individual patients, public health takes a broader view, targeting population groups and communities. Its work is often invisible, yet it is credited with adding 25 years to the life of the average American.

Social Determinants of Health: The social determinants of health are conditions in the environments in which people are born, live, learn, work, play, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social Impact Bonds: Also known as pay-for-success bonds, social impact bonds help governments test innovative ideas for tackling social issues when they cannot come up with the money up front.

Toxic Stress: The American Academy of Pediatrics has described toxic stress as “severe, chronic stress that becomes toxic to developing brains and biological systems when a child suffers significant adversity, such as poverty, abuse, neglect, neighborhood violence, or the substance abuse or mental illness of a caregiver.”

Resources

Adverse Childhood Experiences Study

www.cdc.gov/ace/ind

American Academy of Pediatrics: A Public Health Approach to Toxic Stress

www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/EBCD/Pages/Public-Health-Approach.aspx

Basics for Health

<http://basicsforhealth.ca/>

Bon Secours Health System

www.eastendvision.org/home.html?

Boston Children's Hospital

www.childrenshospital.org

Bright From the Start:

Georgia Department of Early Care and Learning

<http://dec.al.ga.gov/>

The California Endowment: Building Healthy Communities

www.calendow.org/healthycommunities

Calvert Foundation

www.calvertfoundation.org

Child First

www.childfirst.com

Center on the Developing Child at Harvard University: National Scientific Council on the Developing Child

<http://developingchild.harvard.edu/activities/council/>

County Health Rankings and Roadmaps

www.countyhealthrankings.org

Crittenton Women's Union

www.liveworkthrive.org

Denver Preschool Program

www.dpp.org

Educare Schools

www.educareschools.org/home/index.php

Head Start Performance Standards

<http://eclkc.ohs.acf.hhs.gov/hslc/standards/Head%20Start%20Requirements/1304/1304.20%20Child%20health%20and%20developmental%20services..htm>

Healthy Futures Fund

<http://kresge.org/news/100-million-investment-fund-integrate-health-care-affordable-housing-low-income-communities>

Health in All Policies: Seizing Opportunities, Implementing Policies

www.hiap2013.com

Health Leads

<https://healthleadsusa.org/>

Hennepin Health Accountable Care Organization

www.hennepin.us/healthcare

ISAIAH

<http://isaiahmn.org/>

Jobs for the Future

www.jff.org

Joint Center Place Matters

www.jointcenter.org/hpi/pages/place-matters

Kaiser Permanente

<https://healthy.kaiserpermanente.org/html/kaiser/index.shtml>

Kresge Foundation

<http://kresge.org/programs/community-development>

Living Cities

www.livingcities.org

Local Initiatives Support Corporation

www.lisc.org

Low Income Investment Fund

www.liifund.org

Magnolia Place

www.magnoliaplacela.org

Medical-Legal Partnership

www.medical-legalpartnership.org

Medicare Care Transitions

<http://innovation.cms.gov>

Mercy Housing

www.mercyhousing.org

**Minnesota Early Learning Foundation:
Saint Paul Early Childhood Scholarship Program**
[www.melf.nonprofitoffice.com/index.asp?
Type=B_BASIC&SEC=%7B8868E9AD-3850-4506-9D5A-
6E230A5C6A73%7D](http://www.melf.nonprofitoffice.com/index.asp?Type=B_BASIC&SEC=%7B8868E9AD-3850-4506-9D5A-6E230A5C6A73%7D)

**National Association for the Education of
Young Children: A Call for Excellence in
Early Childhood Education**
www.naeyc.org/policy/excellence

**National Institute for Early Education Research:
Abbott Preschool Program Longitudinal Effects Study**
[http://nieer.org/publications/latest-research/abbott-
preschool-program-longitudinal-effects-study-fifth-
grade-follow](http://nieer.org/publications/latest-research/abbott-preschool-program-longitudinal-effects-study-fifth-grade-follow)

**National Institute for Early Education Research:
The State of Preschool 2011 – Oklahoma**
<http://nieer.org/sites/nieer/files/Oklahoma.pdf>

National Prevention Council
[www.surgeongeneral.gov/initiatives/prevention/
about/index.html](http://www.surgeongeneral.gov/initiatives/prevention/about/index.html)

**Nationwide Children's Hospital:
Healthy Neighborhoods, Healthy Families**
[www.nationwidechildrens.org/healthy-neighborhoods-
healthy-families](http://www.nationwidechildrens.org/healthy-neighborhoods-healthy-families)

Neighborhood Centers, Inc.
www.neighborhood-centers.org/en-us/default.aspx

Partnership for a Healthier America: Play Streets
<http://ahealthieramerica.org/play-streets/>

Partnership for Sustainable Communities
[http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/
EPA2/EPA_HomePage2.html](http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/EPA2/EPA_HomePage2.html)

Pennsylvania Pre-K Counts
[www.pakeys.org/pages/get.aspx?page=Programs_
PreKCounts](http://www.pakeys.org/pages/get.aspx?page=Programs_PreKCounts)

Purpose Built Communities
<http://purposebuiltcommunities.org/>

Save the Children: Early Steps to School Success
www.savethechildren.org/siteec.8rKLIXMGlpI4E/b.8193011

Seattle Children's
[http://construction.seattlechildrens.org/2011/03/livable-
streets-initiative-gathers-momentum/](http://construction.seattlechildrens.org/2011/03/livable-streets-initiative-gathers-momentum/)

StriveTogether
www.strivetogether.org

United Way of Salt Lake: Innovation Accelerator
[www.uw.org/news-events/news/pritzker-goldman-
sachs.html](http://www.uw.org/news-events/news/pritzker-goldman-sachs.html)

U.S. Green Building Council
www.usgbc.org

YouthBuild USA
<https://youthbuild.org/>

References

1. Braveman P and Egerter S. *Overcoming Obstacles to Health in 2013 and Beyond*. Princeton, NJ: Robert Wood Johnson Foundation, 2013.
2. Centers for Medicare & Medicaid Services, www.cms.gov/Research-StatisticsData-and-Systems/Statistics-Trends-andReports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Accessed November 11, 2013.
3. Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of obesity and trends in body mass index among U.S. children and adolescents, 1999-2010. *Journal of the American Medical Association*. 2012;307(5):483-490.
4. *Ready, Willing, and Unable to Serve, Mission Readiness*. www.missionreadiness.org/2009/ready_willing/. Accessed November 15, 2013.
5. *Poor Health Costs U.S. Economy \$576 Billion According to the Integrated Benefits Institute*. PR Newswire; September 12, 2012. www.prnewswire.com/news-releases/poor-health-costs-us-economy-576-billion-according-to-the-integrated-benefits-institute-169460116.html. Accessed October 30, 2013.
6. Radley D, et al. *Rising to the Challenge: Results from a Scorecard on Local Health System Performance*, 2012. The Commonwealth Fund. March 14, 2012. www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Local-Scorecard.aspx. Accessed October 30, 2013.
7. *KIDSCOUNT Data Snapshot on High Poverty Communities*. Baltimore: Annie E. Casey Foundation; 2012. www.aecf.org/~media/Pubs/Initiatives/KIDS%20COUNT/D/DataSnapshotonHighPovertyCommunities/KIDSCOUNTDataSnapshotHighPovertyCommunities.pdf. Accessed October 30, 2013.
8. *Where We Live Matters for Our Health: Neighborhoods and Health*. Princeton: Robert Wood Johnson Foundation; September 2008. Accessed October 30, 2013.
9. Frey, W. *America's Diverse Future: Initial Glimpses at the U.S. Child Population From the 2010 Census*. Washington: Brookings; April 2011. www.brookings.edu/~media/research/files/papers/2011/4/06%20census%20diversity%20frey/0406_census_diversity_frey.pdf. Accessed November 19, 2013.
10. *U.S. Census Bureau Projections Show a Slower Growing, Older, More Diverse Nation Half a Century From Now*. U.S. Census Bureau; December 12, 2012. www.census.gov/newsroom/releases/archives/population/cb12-243.html. Accessed November 19, 2013.
11. Oliff, P. *States Continue to Feel Recession's Impact*. Center on Budget and Policy Priorities, June 27, 2012. www.cbpp.org/cms/index.cfm?fa=view&id=711. Accessed November 1, 2013.
12. www.hhs.gov/secretary/about/blogs/head-start-numbers.html. Accessed November 1, 2013.
13. Frey, supra.
14. Frey, supra.
15. Frey, supra.
16. U.S. Department of Education, www.ed.gov/early-learning.
17. McLanahan S, Sandefur G. *Growing Up With a Single Parent: What Hurts, What Helps*. Cambridge, Mass; Harvard University Press; 1994.
18. Livingston G. *The Rise of Single Fathers*. Pew Research; July 2013. www.pewsocialtrends.org/2013/07/02/the-rise-of-single-fathers/. Accessed December 23, 2013.
The Marriage Gap: The Impact of Economic and Technological Change on Marriage Rates. The Hamilton Project; 2012. www.hamiltonproject.org/papers/the_marriage_gap_the_impact_of_economic_and_technological_change_on_ma/. Accessed December 23, 2013.
19. KIDSCOUNT, supra.
20. Testa M, Astone N, Krogh M, et al. Employment and marriage among inner-city fathers. In: Wilson, William J., ed. *The Ghetto Underclass*. Newberry Park, CA: Sage; 1993. pp. 96-108.
Wilson W, Neckerman K. Poverty and family structure: The widening gap between evidence and public policy issues. In: Danziger, SH.; Weinberg, DH., eds. *Fighting Poverty*. Cambridge, MA: Harvard University Press; 1986. pp. 232-259.
21. *Status, Food Stamp Receipt, and Public Assistance for Children Under 18 Years by Selected Characteristics: 2012*, www.census.gov/hhes/families/data/cps2012.html

22. Teachman, J; 2007. Race, military service, and marital timing: evidence from the NISY-79. *Demography*. 44:389-404.
- Teachman, JD and L Tedrow. 2008. Divorce, race, and military service: more than equal pay and equal opportunity. *Journal of Marriage and Family*. 70:1030-1044.
- Teachman, J. 2009. Military service, race, and the transition to marriage and cohabitation. *Journal of Family Issues*. 30:1433
23. *Where We Live Matters for Our Health*, supra.
24. Woolf S, Aron L. U.S. Health in International Perspective: Shorter Lives, Poorer Health. National Research Council and Institute of Medicine. Washington, DC: National Academies Press, 2013.
25. Chetty R, Hendren N, Kline P, Saez E. Economic Impacts of Tax Expenditures: Evidence from Spatial Variation Across the U.S. Equality of Opportunity Project, July 2013. http://obs.rc.fas.harvard.edu/chetty/tax_expenditure_soj_whitepaper.pdf. Accessed Aug 2, 2013.
26. Strong Families, Sustainable Societies. *Family Studies*. <http://ifstudies.org/strong-families-sustainable-societies/>. September 18, 2013. Accessed October 30, 2013.
27. Wilcox. BW. Marriage Makes Our Children Richer—Here's Why. *The Atlantic Monthly*, October 29, 2013. www.theatlantic.com/business/archive/2013/10/marriage-makes-our-children-richer-heres-why/280930/. Accessed October 30, 2013.
28. Urahn, S. K., Currier, E., Elliott, D., Wechsler, L., Wilson, D., and Colbert, D. (2012). Pursuing the American Dream: Economic mobility across generations Economic Mobility Project. Washington, DC: The Pew Charitable Trusts.
29. DeParle, J. Harder for Americans to Rise From Lower Rungs. *The New York Times*. January 4, 2012. www.nytimes.com/2012/01/05/us/harder-for-americans-to-rise-from-lower-rungs.html?pagewanted=all. Accessed October 30, 2013.
30. The Foundations of Lifelong Health are Built in Early Childhood. National Scientific Council on the Developing Child, National Forum on Early Childhood Policy and Programs, Center on the Developing Child at Harvard University, 2010. www.developingchild.harvard.edu
31. Garner A, Shonkoff J, et al. Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. *Pediatrics*. 2012; 129 (1):224-231.
32. Testimony Prepared for the Robert Wood Johnson Foundation Commission to Build a Healthier America, 2013. www.rwjf.org/content/rwjf/en/research-publications/find-rwjf-research/2013/06/real-economic-development.html. Accessed November 15, 2013.
33. Grunewald R, Rolnick A. *An Early Childhood Investment with a High Public Return*. Federal Reserve Bank of St. Louis, 2010. www.stlouisfed.org/publications/re/articles/?id=1987. Accessed November 8, 2013.
34. ReadyNation.org. www.readynation.org/uploads/20131008_ReadyNationCEOstatementinPOLITICO10.08.13.pdf. Accessed November 19, 2013.
35. Fiester L. *Early Warning Confirmed*. Annie E. Casey Foundation. 2013, www.aecf.org/~media/Pubs/Topics/Education/Other/EarlyWarningConfirmed/EarlyWarningConfirmed.pdf. Accessed November 8, 2013.
36. Hernandez D. Double Jeopardy: How Third-Grade Reading Skills and Poverty Influence High School Graduation. Annie E. Casey Foundation. 2011. www.aecf.org/~media/Pubs/Topics/Education/Other/DoubleJeopardyHowThirdGradeReadingSkillsandPoverty/DoubleJeopardyReport040511FINAL.pdf. Accessed December 16, 2013.
37. Testimony Prepared for the Robert Wood Johnson Foundation Commission to Build a Healthier America. 2013. www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf406410. Accessed December 23, 2013.
38. *A Call for Excellence in Early Childhood Education*. NAEYC. <http://oldweb.naeyc.org/policy/excellence.asp>. Accessed November 8, 2013.
39. *A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children*. Center on the Developing Child. http://developingchild.harvard.edu/resources/reports_and_working_papers/policy_framework/. Accessed December 23, 2013.
40. Child Health and Developmental Services. Head Start. <http://eclkc.ohs.acf.hhs.gov/hslc/standards/Head%20Start%20Requirements/1304/1304.20%20Child%20health%20and%20developmental%20services..htm>, Accessed November 8, 2013.
41. *Head Start Impact Study Final Report*. Office of Planning, Research and Evaluation, 2010. www.acf.hhs.gov/node/8375. Accessed November 8, 2013.
42. Gormley T, Phillips D, Gayer T. Preschool programs can boost school readiness. *Science*. 27 June 2008; Vol. 320 no. 5884 pp. 1723-1724.

43. Barnett W, Jung K. *Abbott Preschool Program Longitudinal Effects Study: Fifth Grade Follow-Up*. New Brunswick, NJ: National Institute for Early Education Research, Rutgers University; 2013. <http://nieer.org/sites/nieer/files/APPLES%205th%20Grade.pdf>. Accessed November 8, 2013.
44. *2012-2013 Partnership Report*. www.strivepartnership.org/sites/default/files/wp-content/2012-13%20Partnership%20Report.pdf. Accessed November 8, 2013.
45. Pennsylvania Pre-K Counts promotes children's school readiness and school success Pennsylvania Early Learning. 2011. www.pakeys.org/uploadedContent/Docs/outreach/PAPKC_Outcomes_6-10-11.pdf
46. Parents and the High Cost of Child Care. Child Care Aware of America, 2012. www.naccrra.org/sites/default/files/default_site_pages/2012/cost_report_2012_final_081012_0.pdf. Accessed December 16, 2013.
47. Hamm K. *Who's not Going Back to School? How Sequestration is Scaling Back Early Childhood Education Programs*. Center for American Progress; August 28, 2013. www.americanprogress.org/issues/education/report/2013/08/28/72911/whos-not-going-back-to-school. Accessed November 19, 2013.
48. Testimony, *supra*.
49. Denver Preschool Program Impact Report, 2011. www.dpp.org/_literature_124173/2011_Impact_Report. Accessed December 16, 2013.
50. Investing in Tomorrow's Leaders Today: San Antonio's Preschool Initiative. PolicyLink. 2013. www.policylink.org/site/c.1k1XLbMNJrE/b.8600515/k.E4BB/Americas_Tomorrow_March_13_2013.htm#.Uq-bMPRDtZg. Accessed December 16, 2013.
51. San Antonio Expands Preschool. Eye on Early Education. May 2013. <http://eyeonearlyeducation.com/2013/05/08/san-antonio-expands-preschool/>. Accessed December 16, 2013.
52. Haag M. *Dallas Morning News*. January 6, 2011. <http://educationblog.dallasnews.com/2011/01/former-disd-superintendent-lin.html>. Accessed November 19, 2013.
53. Research and Tools. Crittenton Women's Union. www.liveworkthrive.org/research_and_tools/data_and_outcomes. Accessed November 8, 2013.
54. Jerrett M, Almanza E, et al. Smart growth, community design and physical activity in children. *Amer Jour Prev Med*. 2013; 45(4)
55. *Sustainable Communities HotReport*. Partnership for Sustainable Communities. http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/EPA2/EPA_HomePage2.html. Accessed November 8, 2013.
56. Galloway I. *Funding Holistic Community Development with Pay for Success*. Nonprofit Finance Fund; October 21, 2013. <http://nonprofitfinancefund.org/blog/funding-holistic-community-development-pay-success>. Accessed November 19, 2013.
57. *Community Development Investment Review Pay for Success Financing*: Volume 9, Issue 1; April 2013.
58. Community Transformation Grants (CTG)/Centers for Disease Control and Prevention. <http://nonprofitfinancefund.org/blog/funding-holistic-community-development-pay-success>. Accessed November 19, 2013.
59. *Joint Use Agreements: Creating Opportunity for Physical Activity*. Bridging the Gap. February, 2012. www.bridgingthegapresearch.org/_asset/gl9776/btg_joint_use_agreements-2-10-12.pdf. Accessed November 20, 2013.
60. Baker-Ripley Neighborhood Center One Year Later. Neighborhood Centers. Inc. www.neighborhood-centers.org/en-us/news/310/One+Year+Later.aspx. Accessed November 20, 2013.
61. *Inside Atlanta/ East Lake: Achieving our Goals*. Purpose Built Communities. <http://purposebuiltcommunities.org/success-stories/east-lake-atlanta/planning-progress/>. Accessed November 20, 2013.
62. Centers for Medicare & Medicaid Services. www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Accessed November 11, 2013.
63. Cohen S, Uberoi N. *Differentials in the Concentration in the Level of Health Expenditures across Population Subgroups in the U.S., 2010*. Agency for Healthcare Research and Quality. http://meps.ahrq.gov/mepsweb/data_files/publications/st421/stat421.shtml. Accessed November 11, 2013.
64. Boodman S. *Costliest 1 Percent of Patients Account for 21 Percent of U.S. Health Spending*. Kaiser Health News; October 7, 2013. www.kaiserhealthnews.org/Stories/2013/October/08/one-percent-of-costliest-patients.aspx?p=1. Accessed November 20, 2013.
65. www.jff.org/. Accessed November 11, 2013.

66. *Community-Based Care Transitions Program*. Centers for Medicare & Medicaid Services. <http://innovation.cms.gov/initiatives/CCTP/>. Accessed November 20, 2013.
67. www.hennepin.us/healthcare. Accessed November 11, 2013.
68. Rosenbaum S, Rieke A, Byrnes M. *Hospital Community Benefit Expenditures: Looking Behind the Numbers*. Health Affairs Blog; June 11, 2013. <http://healthaffairs.org/blog/2013/06/11/hospital-community-benefit-expenditures-looking-behind-the-numbers/>. Accessed November 20, 2013.
69. Cammisa M, and Woods E. *Boston Children's Hospital's Approach to Community Health: Using Programs to Achieve Systemic Change*. Trust for America's Health. <http://healthyamericans.org/assets/files/TFAH2013HealthierAmericaXrpt07.pdf>. Accessed November 11, 2013.
70. http://masterplan.seattlechildrens.org/documents/FINAL_Livable%20Streets%20Report.pdf
71. Somerville M. *Community Benefit in Context: Origins and Evolution-ACA §9007*. The Hilltop Institute; June 2012. www.hilltopinstitute.org/publications/CommunityBenefitInContextOriginsAndEvolution-ACA9007-June2012.pdf. Accessed November 19, 2013.
72. Centers for Medicare & Medicaid Services, www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Accessed November 11, 2013.
73. *Poor health costs U.S. economy \$576 billion according to the integrated benefits institute*. PR Newswire. September 12, 2012. www.prnewswire.com/news-releases/poor-health-costs-us-economy-576-billion-according-to-the-integrated-benefits-institute-169460116.html. Accessed November 20, 2013.
74. Miller W, Simon P, Maleque S. *Beyond Health Care: New Directions to a Healthier America*. Washington: Robert Wood Johnson Foundation Commission to Build a Healthier America; 2009.
75. *Health is a Human Right. Green Building can Help*. Summit on Green Building & Human Health. January 2013. www.usgbc.org/sites/default/files/GBHH_Final_1.pdf. Accessed November 19, 2013.
76. Allison D, Battisto D, et al. *Liveability 101: What Makes a Community Liveable?* American Institute of Architects. 2005. www.aia.org/aiaucmp/groups/aia/documents/pdf/aia077944.pdf. Accessed November 19, 2013.
77. Low Income Investment Fund. www.liifund.org/about-liif/what-we-do/. Accessed November 19, 2013.
78. Landry S. *Childhood Programs: Turning Knowledge Into Action*. Children's Learning Institute; 2005. www.childrenslearninginstitute.org/library/publications/documents/Effective-Early_Childhood-Programs.pdf. Accessed November 19, 2013.
79. *Ready, Set, Go! Why Business Should Support Early Childhood Education*. Institute for a Competitive Workforce, U.S. Chamber of Commerce. http://education.uschamber.com/sites/default/files/ICW_EarlyChildhoodReport_2010.pdf. Accessed November 19, 2013.
80. American Hospital Association. www.aha.org/advocacy-issues/initiatives/econcontributors.shtml. Accessed November 19, 2013.
81. Zuckerman D. *Hospitals Building Healthier Communities: Embracing the Anchor Mission*. Community-Wealth.org; March 2013. <http://community-wealth.org/sites/clone.community-wealth.org/files/Zuckerman-HBHC-2013-summary-twopage.pdf>. Accessed November 19, 2013.
82. Somerville, supra.
83. *Evaluation of the Harvest Home Play Street: Summer 2010*. New York Academy of Medicine's Center for Evaluation. www.transalt.org/files/news/reports/2010/Evaluation_of_the_Harvest_Home_Play_Street.pdf. Accessed November 11, 2013

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