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EXPLORING EQUITY IN MULTISECTOR COMMUNITY HEALTH PARTNERSHIPS

Proceedings of a Workshop

Darla Thompson and Joe Alper, *Rapporteurs*

Roundtable on Population Health Improvement

Board on Population Health and Public Health Practice

Health and Medicine Division

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This Proceedings of a Workshop has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published Proceedings of a Workshop as sound as possible and to ensure that the Proceedings of a Workshop meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the process. We wish to thank the following individuals for their review of this Proceedings of a Workshop:

Rebecca S. Etz, Department of Family Medicine and Population Health, Virginia Commonwealth University
Rachel A. Hogg, College of Health Sciences, University of Kentucky
Daniel Lau, Build Healthy Places Network
Wylie Liu, University of San Francisco, School of Medicine

Although the reviewers listed above have provided many constructive comments and suggestions, they did not see the final draft of the Proceedings of a Workshop before its release. The review of this Proceedings of a Workshop was overseen by **Ned Calonge,** The Colorado Trust. He was responsible for making certain that an independent examination of this Proceedings of a Workshop was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this Proceedings of a Workshop rests entirely with the rapporteurs and the institution.

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Acronyms and Abbreviations

BARHII	Bay Area Regional Health Inequities Initiative
BHC	Building Healthy Communities
SCALE	Spreading Community Accelerators Through Learning and Evaluation
SCARF	status, constancy, autonomy, relationships, and fairness
TLHIP	Tenderloin Health Improvement Partnership

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Introduction[1]

Building on previous National Academies of Sciences, Engineering, and Medicine workshops that explored how safe and healthy communities are a necessary component of health equity and efforts to improve population health (IOM, 2014, 2015), the Roundtable on Population Health Improvement wanted to explore how a variety of community-based organizations came together to achieve population health. To do so, the roundtable hosted a workshop in Oakland, California, on December 8, 2016, to explore multisector health partnerships that engage residents, reduce health disparities, and improve health and well-being. Sanne Magnan, co-chair of the roundtable, opened the workshop by emphasizing that understanding how local stakeholders from all sectors at the community level build partnerships to improve health is an issue that transcends politics. "In framing these partnerships," she said, "some might be interested in how they involve disadvantaged populations to achieve health equity, while others might be interested in how it decreases the size of government and gives power back to citizens to determine next steps." From her perspective, "all persuasions are interested in these goals that create life, liberty, and the pursuit of happiness for our families, neighborhoods, towns, and the states in which we live, and finding common ground will require us to listen deeply to the wisdom in communities and the multiple perspectives from which it comes."

In providing an overview of the workshop, George Flores of The California Endowment explained that the topic of community health partnerships encompasses such a broad array of initiatives that it would be impossible to cover all of these types in 1 day. He emphasized that this workshop would provide a sample of the depth and range of the individuals and institutions that come to these partnerships to work together to improve health and well-being in communities with the aim of understanding the following:

- Common elements, including measurements, evaluation tools, methods, and strategies, that these partnerships use and that can be shared with others.
- Models or strategies that engage residents on a continuum from the initial engagement through leadership development and sustained participation in community health improvement over time.

[1] The planning committee's role was limited to planning the workshop, and the workshop proceedings has been prepared by the workshop rapporteurs as a factual summary of what occurred at the workshop. Statements, recommendations, and opinions expressed are those of individual presenters and participants and are not necessarily endorsed or verified by the National Academies of Sciences, Engineering, and Medicine, and they should not be construed as reflecting any group consensus.

- Strategies or infrastructure that contribute to overcoming health disparities and improving overall community health and well-being, particularly for the most vulnerable residents.
- Potential co-benefits that accrue to communities and institutions that participate in multisector partnerships.

To gain this understanding, the roundtable appointed an ad hoc committee to plan and convene a workshop to explore the infrastructure of multisector community health partnerships. The committee's charge is described in Box 1-1. Flores, who served as the chair of the planning committee, explained that he and the other members of the planning committee (Anne De Biasi, Mary Lou Goeke, David Kindig, Marcie Parkhurst, Soma Stout, and Jomella Watson-Thompson) intended the workshop to serve as a way to explore how community health partnerships participate in the creation of health and in improving the health of populations.[2]

The workshop participants heard from speakers from a range of multisector partnerships with the goal of learning about what makes those partnerships and initiatives effective and of understanding the challenges that these partnerships have had to overcome in order to create change in their communities. The workshop also engaged the participants in a structured discussion to develop strategies for sharing power and engaging with different partners in developing and sustaining multisector collaborative relationships.

To set the context for the day's discussions, Flores reviewed some of the key terms used in talking about multisector community partnerships (see Box 1-2). The issue of equal opportunity, he said, is fundamental to health and to how communities perceive health, and it is important to ask how it is that a nation legally committed to equal opportunity for all, regardless of race, religion, national origin, or gender, produces and supports inequities. Equity, he explained, equals fairness in terms of everyone having access to the same opportunities, while equality is providing everyone the same thing. "We must ensure equity before we can enjoy equality because equality only works if everyone starts from the same place," Flores said.

BOX 1-1
Statement of Task

An ad hoc committee will plan and convene a 1-day public workshop that will explore the key elements needed to create and maintain innovative and sustainable approaches to multisector community health partnerships (e.g., community residents as well as staff from government, nonprofit, and business sectors). The workshop may include presentations on and discussion of how to create and support partnerships

[2] The choice of communities and speakers featured in this workshop proceedings was the result of a combination of factors. Once the planning committee discussed the scope of the workshop, individual members noted that communities involved in the Building Healthy Communities initiatives, SCALE communities, and Robert Wood Johnson Foundation Culture of Health prize communities might serve as good examples of what communities can accomplish in effective multisector community health partnerships. There are many other communities involved in each of these initiatives, and, in part, the individual speakers and communities featured were based on availability and also a desire to feature different-sized communities that reflect urban, rural, and suburban communities from different parts of the United States. Since the workshop was held in California—and, in particular, the Bay Area—there was a deliberate attempt to reach out to speakers in that area in order to highlight local initiatives in the vicinity of the meeting location.

that genuinely and equitably engage residents; the role of independent coordinating organizations and partners; sources of financing for building and maintaining partnerships and improved health and well-being; the skills necessary for authentic and effective organizational leadership; the role of local, state, and federal governments in supporting these collaborations; examples of the different approaches to improving health outcomes in rural and urban settings; and the ways such partnerships influence change in community health outcomes over time. A proceedings of the presentations and discussion at the workshop will be prepared by a designated rapporteur in accordance with institutional guidelines.

Racism, sexism, or any other kind of ism, he continued, is tolerance of an unequal relationship between social groups and is based on the privileged access to power and resources by one group at the expense of another. Flores explained that structural racism is a system for allocating social privilege and that historically in the United States, white males and wealth are the default settings for power. He added that in the current pyramid-shaped power structure, a few elites in the society hold most of the power and are able to use laws, myths, norms, and institutions for their benefit, with diluted power flowing down to the people who form the majority of the population in a society (Moyer, 2001).

People power, on the other hand, turns the pyramid upside down, puts people at the top of the power structure, and allows power to flow to the power elites from the will of the people (Moyer, 2001). Agency, Flores explained, is a sense of control over one's life and having the requisite capacities, opportunities, and connections to things that make one feel healthy. It is what makes people feel healthy, and it goes beyond biomedical health and encompasses concepts such as safety, financial security, and relationships. Community agency is collective control, connections, capacities, and opportunities, including partnerships with shared decision-making and mutual accountability. This notion of agency and of including the population and people in making decisions and setting priorities for action, rather than just relying on institutions and government, is often left out of the paradigms and models of how to improve health, Flores said (Bridging Health and Community, 2016)

Ending the culture of privilege and the consolidation of power in the hands of a few, Flores said, will require positioning people so that they can solve their own problems. Ending the culture of privilege would multiply opportunities for people to engage in genuine relationships without fear or prejudice, to expand personal and professional networks, and to enrich the human experience. "Ending a culture of privilege would allow each of us to stand unwaveringly on our hard-earned accomplishments, knowing that without the benefits of privilege we will be more resilient when faced with adversity," Flores said. "This is an end goal for community partnerships" (Burke, 2016).

With regard to activism, Flores outlined a number of effective and ineffective roles (see Table 1-1) and defined social movements as collective actions in which the populace is alerted, educated, and mobilized to challenge the power holders and the whole society and to redress social problems or grievances and restore critical social values (Moyer, 2001). "Community-building partnerships, therefore, engage authentic community residents and focus on capacity building among change agents," Flores said. "They identify key policies and practices that need reform and develop alliances that have the power to change [those policies and practices] and counter popular assumptions that work to reproduce the status quo" (Aspen Institute Roundtable

on Community Change, 2004). In participatory democracy, he concluded, social movements and the general public influence power and power holders by alerting, educating, inspiring, and involving the population at large (Moyer, 2001).

BOX 1-2
Terms That Are Used in Multisector Community Health Partnerships (as defined by Flores during his introductory comments)[a]

- Agency—is a sense of control over one's life and having requisite connections, capacities, and opportunities to things that make one feel healthy beyond the biomedical sense to include being safe, financially secure, and in healthy relationships.
- Community agency—collective control, connections, capacities, and opportunities, including partnerships with shared decision making and mutual accountability.
- Elite power/pyramid power—held by few people in the society, who are able to use laws, myths, norms, and institutions for their benefit. Power flows downhill to the people who form the majority of the population in a society.
- Ending the culture of privilege—creating the conditions in which a broader range of people, instead of a just a few, have opportunities to engage in genuine relationships without fear or prejudice, to expand personal and professional networks, and enrich the human experience.
- Equal opportunity—before equality of opportunity can be achieved in a society, we need to first have equity, which equals fairness in terms of everyone having access to the same opportunities.
- Equality—providing everyone the same thing; we can only enjoy equality in a society if everyone starts from the same place.
- Isms—racism, sexism, ism of any kind is the tolerance of an unequal relationship between social groups based on the privileged access to power and resources by one group at the expense of another.
- Participatory democracy—the conditions in which social movements and the general public influence power and power holders by alerting, educating, inspiring, and involving the population at large.
- People power—turns the pyramid upside down, puts people at the top of the power structure, and allows power to flow to the power elites from the will of the people.
- Structural racism—a system for allocating social privilege; historically in the United States, white males and wealth are the default settings for power.

[a]This list is the rapporteurs' summary of terms defined by Flores, and the comments have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

TABLE 1-1 Effective Roles versus Ineffective Roles in Activism

Effective Roles	Ineffective Roles
Empowered and hopeful	Disempowered and hopeless
Positive attitude and energy	Negative attitude and energy
People power: Participatory democracy	Elitist: Self-identified leaders or vanguard

Coordinated strategy and tactics	Tactics in isolation from strategy
Nonviolence; means equals ends	Any means necessary
Promote realistic vision and social change	Unrealistic utopianism or minor reform
Assertive/cooperative (win/win)	Passive or overly aggressive/competitive
Feminist/relative truth/nurture/adaptive	Patriarchal/absolute truth/rigid ideology
Faith in people	Put the "masses" down
Peace paradigm	Dominator paradigm

SOURCE: Flores presentation, December 8, 2016.

Organization of the Proceedings

This proceedings summarizes the presentations and discussions that occurred during the workshop (see Appendix B for the agenda) about community-driven and community-centered partnership initiatives and approaches to improving health and well-being. Chapter 2 describes the theory and practices of community-driven partnerships supported by The California Endowment through its Building Healthy Communities Initiatives. Chapter 3 explores approaches used in SCALE (Spreading Community Accelerators Through Learning and Evaluation) communities to shift power to residents so that they can participate in creating solutions to community problems. Chapter 4 highlights some of the community engagement concepts and strategies used by the communities that won the Robert Wood Johnson Culture of Health Prize. Chapter 5 summarizes the small-group discussions that were held during the workshop with the aim of brainstorming collectively about strategies for sharing power and engaging with different partners in developing and sustaining multisector collaborative relationships, and Chapter 6 provides the roundtable members' and workshops participants' reflections on the day's discussions. Highlights from the day's presentations are provided in Box 1-3.

In accordance with the policies of the National Academies of Sciences, Engineering, and Medicine, workshop participants did not attempt to establish any conclusions or recommendations about needs and future directions, focusing instead on issues identified by the speakers and workshop participants. In addition, the planning committee's role was limited to planning the workshop. The Proceedings of a Workshop has been prepared by workshop rapporteurs Darla Thompson and Joe Alper as a factual summary of what occurred at the workshop.

BOX 1-3
Highlights from the Presentations at the December 9, 2016, Workshop on Exploring the Infrastructure of Multisector Community Health Partnerships
Community-Driven Approaches to Building Healthy Communities[a]

1. It is important to recognize and acknowledge the impact of historical systemic and structural racism (Iton).
2. Overcoming an exclusionary narrative requires reweaving a social compact that creates real social, political, and economic power—rather than social vulnerability—in a critical mass of people living in disadvantaged communities (Iton).

3. Conversations about a community need to shift from a focus on community factors such as gang violence to one that emphasizes the strengths and resiliency of community members (Dhaliwal, Manzo).
4. Youth should be valued as assets and leaders and not as liabilities in the community (Dhaliwal, Manzo).
5. It is important to meet youth where they are; change the policies, practices, and systems to be mutually supportive and accountable (Dhaliwal).
6. A strength-based narrative can change an "us versus them" mentality to one that brings governments and community members together to collaborate on approaches that address systemic inequities (Manzo).
7. Resources are necessary for supporting capacity building and enabling investment in and taking a chance with those who have the lived experiences and good ideas on how to address problems that affect their communities. Part of capacity building is helping nascent organizations understand what they need to do to secure additional funding once the initial pot of money is gone (Manzo).
8. Relationships with other institutions based on trust and mutual benefit are a valuable resource in themselves (Dhaliwal).
9. Data can be used to change structures and systems (Dhaliwal).
10. It is necessary to strive for more than what is offered by logic models and theories of change; the aim should be changing the systems and conditions that dehumanize people and produce inequities by instead promoting justice to achieve liberation (Dhaliwal).

Improving Health Through Equitable Transformative Community Change

1. Achieving healthier communities requires unprecedented collaboration, the courage to ask questions about what is happening, and the courage to fail forward, learn, and understand that in coming together communities might create solutions and intentionally transform the systems that are creating inequity (Stout).
2. Community transformation requires understanding how the stories of community residents with lived experiences and their insights about how the system works can be combined with the capacities of those who have more formal positions of power in these communities (Stout).
3. Positively disrupting organizational silos involves co-creating with residents, using the framework of collective impact, convening stakeholders and residents to build consensus around issues and to identify new ones, and developing solutions that resonate with the residents on the ground (Varano).
4. One approach to making progress is to switch the narrative from one focusing on issues and needs to one that looks for the bright spots and positive spaces in a community to nurture (Douglas).
5. As the community partners continue to work and learn together, they are seeing that grants can be a helpful mechanism for seeding and activating collaboration in the community space (Douglas).
6. The challenge as a backbone organization and provider is integrating the voices of residents into the work that is done. This means letting the community tell its own story (Douglas).
7. Creating authentic community requires leading from within, leading together, and leading for outcomes (Douglas, Stout, VanLanen).
8. Everyone in a community can draw from the community's common resources, but they

also need to contribute to those resources to create sustainable change (Knox, VanLanen).

9. Provided with tools and resources to improve their community, children can be powerful and effective agents of change and social movements (Knox, VanLanen).
10. When thinking about the infrastructure that is needed to build and support the spread and scale of successful projects; it is necessary to think about what the system will look like a year or two in the future, not what it looks like today (Knox).

Engaging Communities in Building a Culture of Health

1. It is important to listen to and learn from the community. When given the tools, language, and opportunities, community residents can and will shape the direction of what community organizers and coordinators are doing to support the initiatives that are most meaningful to the community (Castro).
2. When developing collaborations, stories of the lived experiences of community members are important for bringing the powerful to the table (Castro).
3. It is important to recognize historical trauma before launching into discussions and talking about solutions (Castro).
4. Today, community decision makers look to the area's community-based organizations to ask important questions and actively engage community members in the decision-making and policy-change processes (Castro).
5. Typically the language used by the people doing the serving is different from the language used by the populations that they serve. Service providers often think of themselves in action-oriented, strength-based, positive frames, as opposed to the residents whom they work with in communities, who are typically depicted in language that emphasizes their liabilities (McElroy).
6. Asset framing rejects narratives that denigrate people by focusing instead on portraying people as assets who are capable of working with others to change their community for the better (McElroy).
7. Building trust in underserved communities with a history of inequity creates stronger partnerships. The actions that partnerships and coalitions take must be community informed (Co).
8. It is important to have a backbone agency with a dedicated staff to keep the partners accountable. It is also important to create a common agenda that supersedes individual interests and the agendas of specific organizations (Co).
9. It is important to develop strategies and activities to share power and humanize each other, whether through popular education, developing a shared language, or sharing a meal and a conversation with people who have different institutional or resident affiliations or backgrounds (Castro, Co, McElroy).
10. Grants come and go, and funding sources can change regularly. It is important to have good grant writers because work can come to a halt with lack of funding but also be slowed by the different metrics and deliverables expected by different funders. More long-term funding would contribute to the sustainability of successful programs (Castro)

[a] This list is the rapporteurs' summary of the main points made by individual speakers, and the comments have not been endorsed or verified by the National Academies of Sciences, Engineering and Medicine.

2

Community-Driven Approaches to Building Healthy Communities

The workshop's first panel session featured presentations on two community-level programs that are building healthy communities in California. Prior to the presentations, Anthony Iton, the senior vice president for Building Healthy Communities (BHC)[1] at The California Endowment, provided his views on how the nation got to where it is with regard to health inequities and how The California Endowment is addressing these inequities. Andrea Manzo, a hub manager for BHC in East Salinas, California, and Kanwarpal Dhaliwal, the co-founder and community health director at RYSE[2] in Richmond, California, then described programs that are translating theory into practice in two California communities. Following the presentations (highlights provided in Box 2-1), Iton moderated an open discussion among the workshop participants.

BOX 2-1
Highlights from Presentations on Community-Driven Approaches to Building Healthy Communities[a]

1. It is important to recognize and acknowledge the impact of historical systemic and structural racism (Iton).
2. Overcoming an exclusionary narrative requires reweaving a social compact that creates real social, political, and economic power—rather than social vulnerability—in a critical mass of people living in disadvantaged communities (Iton).
3. Conversations about a community need to shift from a focus on community factors such as gang violence to one that emphasizes the strengths and resiliency of community members (Dhaliwal, Manzo).
4. Youth should be valued as assets and leaders and not as liabilities in the community (Dhaliwal, Manzo).
5. It is important to meet youth where they are; change the policies, practices, and systems to be mutually supportive and accountable (Dhaliwal).
6. A strength-based narrative can change an "us versus them" mentality to one that brings governments and community members together to collaborate on

[1] For more information, go to http://www.calendow.org/building-healthy-communities (accessed March 21, 2017).
[2] For more information, go to http://rysecenter.org (accessed March 21, 2017).

approaches that address systemic inequities (Manzo).

7. Resources are necessary for supporting capacity building and enabling investment in and taking a chance with those who have the lived experiences and good ideas on how to address problems that affect their communities. Part of capacity building is helping nascent organizations understand what they need to do to secure additional funding once the initial pot of money is gone (Manzo).
8. Relationships with other institutions based on trust and mutual benefit are a valuable resource in themselves (Dhaliwal).
9. Data can be used to change structures and systems (Dhaliwal).
10. We have to strive for more than what is offered by logic models and theories of change; our aim is changing the systems and conditions that dehumanize people and produce inequities by instead promoting justice to achieve liberation (Dhaliwal).

[a]This list is the rapporteurs' summary of the main points made by individual speakers, and the comments have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

CONTEXT SETTING[3]

Launched by The California Endowment in 2010, the goal of BHC, is to improve community health status by addressing determinants of health rather than spending on health care. Anthony Iton, senior vice-president for healthy communities at The California Endowment, described how the foundation is investing $1 billion in 14 low-income communities in California over 10 years. BHC's strategy involves capacity building, narrative change, partnerships, and policy advocacy to produce health equity and measurable results. While he and his colleagues at The California Endowment created the specifications of this program, people such as Andrea Manzo and Kanwarpal Dhaliwal are responsible for translating these notions into practice.

Before turning the podium over to Manzo and Dhaliwal, Iton said he wanted to remind everyone how health disparities and inequities became so widespread in this country. "These communities did not arise spontaneously—they were created—and until we understand the forces and ideologies that created them, it is hard to undo them," he said. As a way to help the participants understand his own perspective on the pernicious history and legacy of structural racism, Iton started by reading a quote by Abraham Lincoln in which he stated that he did not favor "bringing about in any way the social and political equality of the white and black races," nor did he believe that blacks should have the right to vote or marry whites (*The New York Times*, 1860). Lincoln also claimed that there was "a physical difference between the white and black races" that forbade "living together on terms of social and political equality." Instead, Lincoln believed that while the two races could not live together, there "must be the position of superior and inferior" and Lincoln was in favor of whites being assigned the superior position (*The New York Times*, 1860).

Iton went on to cite the U.S. Supreme Court's Dred Scott decision in which the justices opined that in the language used in the Declaration of Independence, it was shown that "neither

[3] This section is the rapporteurs' synopsis of the presentation made by Anthony Iton, the senior vice president for Building Healthy Communities at The California Endowment, and the statements are not endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

the class of persons who had been imported as slaves, nor their descendants, whether they had become free or not, were then acknowledged as a part of the people, nor intended to be included in the general words used in that memorable instrument." Again emphasizing the "inferiority" of blacks, the Court's decision claimed that blacks were "unfit" to "associate with the white race, either in social or political relations and so far inferior that they had no rights which the white man was bound to respect and that the negro might justly and lawfully be reduced to slavery for his benefit" (U.S. Supreme Court, 1859). Iton also quoted the late Supreme Court Justice Antonin Scalia, who during oral arguments in a case involving affirmative action at The University of Texas cited claims that some African Americans are harmed academically by attending elite universities such as The University of Texas, and that they may be better served by attending "lesser schools."[4]

As a final example of the historical context for his work, Iton recited the third stanza of the Star Spangled Banner. It says in part that during the "havoc of war and the battle's confusion" that "No refuge could save the hireling and slave from the terror of flight or the gloom of the grave: And the star-spangled banner in triumph doth wave, o'er the land of the free and the home of the brave" (National Museum of American History, n.d.).

Iton explained that he shared the quotes not only to be a provocateur, but also to help people to think about the legacies that inform where the country is today. When he considered strategies to explain communities, he examined many socioecological frameworks and concluded they were not adequate at describing social factors and the drivers of inequity. While a framework may describe broad social, economic, cultural, health, and environmental conditions and policies at the school, national, state, and local levels, racism is often excluded from the list of relevant factors (IOM, 2011). "I think this is a problem when we talk about race and not racism," Iton said. "I put it to you that you cannot do this work and you will not be taken seriously by your partners if you do not talk about racism, if you do not talk about classism, if you do not talk about sexism, and do not talk about strategies to develop a practice that is anti-racist."

Out of this frustration, which Iton shared with other local health practitioners in the Bay Area Regional Health Inequities Initiative, emerged the Bay Area Regional Health Inequities Initiative (BARHII) framework (see Figure 2-1). "This is a framework, not a model, and it does not try to explain how all of these things interact," Iton said. "It just tries to pull apart the spectrum of opportunity for intervention and allow us to see where there may be meaningful opportunities to intervene." The framework, he explained, recognizes that the traditional medical model talks about individual behavior producing disease, which produces premature mortality, and that the medical model then offers health education, clinical care, and emergency departments to try to contend with these challenges.

Iton and his colleagues recognized that to get upstream, they had to determine where they could intervene in order to have an effect on health. These intervention points, he explained, are where social vulnerability manifests in a community—the places where hosts of people are exposed to community-level risks, such as foreclosure, or HIV/AIDS, or a hurricane. "We have created social vulnerability in a group of people and situated them geographically in close proximity to one another," he said.

[4] For more information, go to https://www.washingtonpost.com/news/post-nation/wp/2015/12/10/read-the-most-controversial-statement-by-justice-scalia-on-admissions-and-race (accessed March 21, 2017).

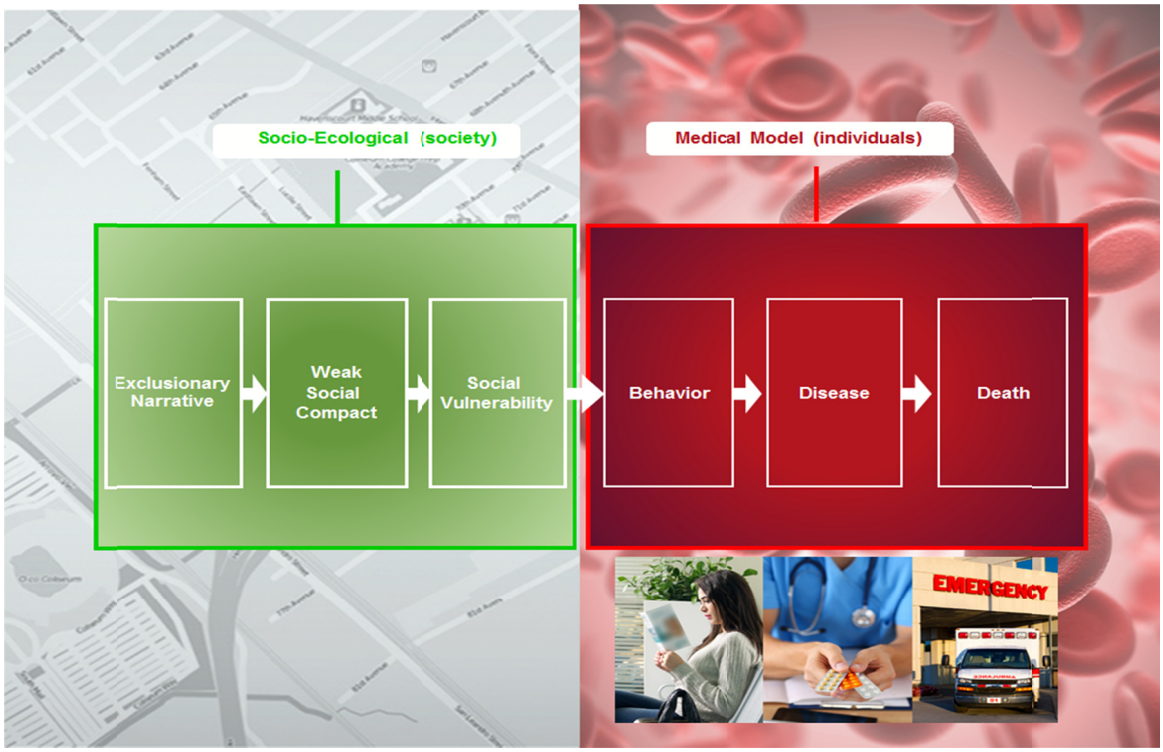

FIGURE 2-1 The BARHII framework for reducing health inequities.
NOTE: For more information on this framework, go to http://www.calendow.org/building-healthy-communities (accessed on June 7, 2017).
SOURCE: Iton presentation, December 8, 2016.

From the perspective of Iton and his colleagues, a weak social compact and a set of policies and practices that do not anticipate inevitable human needs and that steer resources away from people categorized as less deserving of the full benefits of society are what creates this situation. "We think that ultimately it is an exclusionary narrative, a way of thinking about who we are as Americans and who matters," he said. An exclusionary narrative, Iton explained, depends on "targeting a population that is deemed to be unworthy and then dehumanizing that population." An exclusionary narrative includes an argument that "we are in a zero sum competition, that there is scarcity, and if those others get what we need, we will suffer, so we need to be able to exclude them from fair competition for those resources." The exclusionary narrative, he added, argues for a rosy, nostalgic past and a future full of fear and anxiety.

Overcoming the exclusionary narrative, Iton said, requires reweaving a social compact to create real social, political, and economic power—rather than social vulnerability—in a critical mass of people living in disadvantaged communities. That, in fact, is what BHC is trying to do by creating a powerful, inclusive narrative.

HEALING-INFORMED COMMUNITY POWER BUILDING[5]

Salinas, California, is a community of approximately 160,000 plus a large undocumented population, located in the heart of an $8–$10 billion agricultural industry that supplies 70 percent of the nation's lettuce, Manzo explained. She noted how the legacy of institutional and structural racism that Iton discussed has negatively affected communities of color such as Salinas. As Iton noted, structural racism did not come from nature. "It was not designed by people of color, nor does it reflect their experiences, their cultures, their languages," Manzo said. Given that "power concedes nothing without a demand," (Douglass, 1857, p. 22) the only way to change such a system is to acquire the power necessary to have equal or greater power than those who designed that system and use that newfound power to change the system, Manzo said.

Manzo and her colleagues' project, Healing Informed Governing for Racial Equity (Dieng et al., 2016), is a power-building and healing-informed approach grounded in a set of core shared values and principles, and it emphasizes capacity building in the struggle to dismantle structural racism in Salinas. These core shared values help ensure that the preservation and the dignity of the value of the people in the community is the paramount concern, not saving money or minimizing resources. This healing-informed approach, Manzo explained, is different in that it uses a relational rather than a transactional approach. "Often, we think with our minds but not with our hearts, and I think power is really in the connection of the two," she said. Taking a relational approach creates an opportunity to acknowledge the historical trauma the community has experienced and to use that as a strength to transform the community.

One important piece of this work, Manzo said, is that it gives a name to the experiences the community's residents have lived so that they can have a common language with which to talk to system leaders. Having a shared language enables community members to build relationships both with those in government who have power and among themselves. "We are building the power and capacity of residents to analyze the structural problems and helping them realize they have the right to push our system leaders to change their policies that are affecting all areas of our lives," she said. The program includes multiple trainings on racial equity and historical traumas that allow community members to connect with one another, to build power and strength, and to exercise the emotional fortitude to deal with those traumas and move to action.

Another important programmatic emphasis has been to shift the narrative about Salinas away from one that stresses gang violence. Manzo said that Salinas has been labeled the nation's youth murder capital on several occasions. Rather than focusing solely on gang violence as a problem, there is a need to focus the conversation on violence as a symptom of a broader problem to solve, she said. The conversation needs to focus on the strengths of the community, the resiliency of the hard-working people that live in Salinas, and on the value of the community's youth as assets and leaders rather than liabilities, Manzo said. Instead of solely blaming residents for negative health outcomes, there is a need to shift some responsibility to the local government, Manzo said. The government needs to do its part to invest in residents, while residents need to constantly organize and exert their collective power to ensure that the government meets its own responsibilities concerning issues that affect their well-being and their overall health, Manzo added.

[5] This section is the rapporteurs' synopsis of the presentation made by Andrea Manzo, a hub manager for Building Healthy Communities in East Salinas, California, and the statements are not endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

Manzo recounted the first time she was bothered by the idea of centering the community's problems around gang violence. "I had gone to a community meeting, a collaborative made up of service-based organizations, community-based organizations, and, most importantly, law enforcement and elected officials and staff. Their presentation was on their violence prevention strategy, and I was automatically turned off because there was an introductory slide with a big red circle that said, 'The Problem: Gang Violence.'" Gang violence is a symptom of the lack of affordable housing, greenspaces, educational and vocational opportunities, and good-paying jobs in a region with a multi-billion-dollar agricultural industry, not something that just appeared with no context, Manzo said.

Manzo's response was to invite the presenter, who happened to work at the county health department, into the BHC world. The result was that this person has now become the individual who keeps her colleagues and peers accountable as far as taking a strength-based approach when talking about the community and who pushes them to look for solutions that address the root causes of these social problems that influence the community's health. "That would not have happened," Manzo said, "if I had not opened my arms" and invited the presenter to "hang out with us" and "hear what we say."

The power of owning a strength-based narrative is that it moves the discussion beyond one of "us versus them" with regard to government. "We cannot do this alone," Manzo said. "It requires collaboration that stretches across sectors and, more often than not, reaches out to entities that are not traditionally seen as allies or partners." The turning point, she said, was after four fatal officer-involved shootings occurred in 2014. Through that tragedy, her program was able to get buy-in from local government—not just the police department—to change the relationship between government and the community. Her team hosted a Healing-Informed Governing for Racial Equity training with city staff and community leaders which allowed them to name the inequities in the community and build the capacity of systems leaders to change the way they look at problems and find solutions. "It allowed us an opportunity to create that trust and to hold each other accountable and to really strip each other from our titles and be vulnerable and see our true selves," Manzo said. "System leaders often do not humanize residents, and they see them as numbers, they see them as data, and it also allowed the opportunity for residents themselves to see that these folks that are making those decisions are also human."

After achieving a shared language and a shared understanding of the complexities of structural racism in Salinas, Manzo and her team began looking at the system as a whole and building the capacity of system leaders through a community engagement spectrum that is about empowering, not just checking a box that community leaders have connected in some way with the people. Today, partners in this effort are working with the county health department and the local government to improve the built environment for the community's youth. "This would not have happened had BHC not opened the door for this type of collaboration," Manzo said. The same individual from the public health department with whom Manzo had connected approached the city's department of public works to invest in bathrooms, water fountains, and lights for parks in the city's neighborhoods with the most need instead of focusing resources on wealthier parts of the city. This, of course, took some organizing by BHC through their inside (health department)/outside (community organizing) strategy. "It has become less about who screams loudest and more about who could and should benefit more and who has been left out of the equation historically," Manzo said.

To illustrate the BHC approach in Salinas, Manzo used the upstream story often used in public health of the man fishing who rescues one person after another who is drowning in a

stream. Realizing he does not have the strength to keep rescuing people from the fast-moving water, he goes upstream and finds that people are falling in the river because the bridge needs repairing. Her community, she said, has evolved in its thinking to not only fix the bridge that leads to health inequities, but to look at who is building the bridge, how it is built, who has access to the bridge, and whether the bridge is actually saving people and improving health outcomes.

Concluding her presentation, Manzo asked the workshop participants to think about a policy- and systems-change approach using a racial equity lens. "We need healing to be embedded in our work" and connect our thinking to our hearts, Manzo said. "We need to explore creative ways to be transparent and inclusive in the decision-making process," she added. Manzo emphasized the importance of continuing to talk about structural racism because a consistent focus and conversation reduces anxiety and can lead to an approach in which racial equity become systemic. "The goal is to liberate us from this legacy of racism and oppression" and to give people the opportunity to have a chance to be healthier, she said. "In order to do this, we need to continue organizing and building power to keep our systems accountable to combating structural racism."

SOCIAL JUSTICE AND BUILDING YOUTH POWER[6]

Kanwarpal Dhaliwal described Richmond, California, as a community of immense fortitude, beauty, and resilience. Simultaneously, she said, Richmond is also a community that is over-surveilled, under-resourced, and governed by leadership that is challenged to address the needs and priorities of young members of the community. Richmond is composed of diverse communities of color traumatized by violence—historical, structural, and chronic—yet with residents who continue to show up every day with love, hope, and rage. The RYSE Center[7] is a youth-centered organization that works with young people ages 13 to approximately 21 years old. It runs some 30 to 40 programs related to community health, education, youth justice, media, arts, and culture. Above all, Dhaliwal said, the RYSE Center is a safe space that was born out of young people organizing to change the conditions of violence in their community, to get adults to do the work necessary "to be in service and be responsible to young people." She noted that the young people who first had the idea for the center in 2000 knew it would take years to establish—the center opened in 2008—and that they would never directly benefit from the services and programs they envisioned the center offering. "They were thinking about legacy, and it is in this spirit that I honor and offer what I have to share," she said.

Before describing RYSE, Dhaliwal asked the workshop participants to consider one idea: If the population health field continues to look at the issues of equity and social determinants of health from a white, middle-class, overeducated perspective, it will continue to be culpable for the inequities these communities face.

As a public health organization, RYSE is grounded in the ecological model of health, meaning that its members understand that "health is about where we live, who we are around, and what schools we go to," Dhaliwal said. Even in their direct services, RYSE staff focus their efforts "on changing systems, changing culture, and changing the narrative," so when therapists,

[6] This section is the rapporteurs' synopsis of the presentation by Kanwarpal Dhaliwal, co-founder and community health director at RYSE in Richmond, California, and the statements are not endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

[7] For more information, go to http://rysecenter.org (accessed March 30, 2017).

case managers, or studio manager are engaging with young people, their relationships are based on the validation of the young people's experiences, "the fortitude of these young people, and the harm that systems are causing," Dhaliwal said. RYSE is a trauma-informed organization that seeks to make it easier for young people to come through the doors by meeting them where they are. "We do not ask what is wrong with you or even what happened to you," she said. "We appreciate that you are here and that you trust us enough to be here."

The dominant media narrative of Richmond, Dhaliwal said, is that the young people are violent and harmful to one another. RYSE is working to change that narrative and challenge the systems that create and perpetuate it and also to talk about violence as a symptom of the level of the dehumanization and subjugation in which the residents live, Dhaliwal said. RYSE is grounded in addressing the social determinants of health. Staff members approach their work with an understanding of the relationships and structural conditions that have led to disease in the community by shifting the focus to producing instead a community of health, healing, justice, equity, and liberation, Dhaliwal said. If equity and optimal health are based on a model that presumes that people have racial and class power and privilege, it may do harm. Dhaliwal said that her perspective is grounded in lived experience and the process of understanding the structural forces at work in the community.

Dhaliwal shared an illustrative story about a hospital-linked violence intervention program run under a contract with the regional trauma center, which is located 24 miles from Richmond in an affluent white community. When a young person is shot, stabbed, or assaulted, he or she is transported to the trauma center, where the police immediately begin questioning that individual, often while he or she is still in shock. Many, if not most, of the victims are later denied victim-of-crime compensation services, to which they are rightfully entitled, because the police reports state they are non-compliant and do not acknowledge the trauma they just suffered. Dhaliwal's program's work is to share such lived experiences as examples of how systems perpetrate harm. "So while we understand behavior and outcomes and individual health indicators are important," she said, "our focus is on changing the systems and conditions because if we solely focus on behaviors and only behaviors, we continue to replicate the systems of oppression, inequity, and dehumanization." By grounding their work in intersectionality and an understanding that there are multiple, intersecting movements for liberation, RYSE operates as an anti-oppression organization that promotes racial, queer, and gender justice. The end goal, she said, is liberation.

Dhaliwal said that her program received strong support from The California Endowment even before the BHC initiative started. Nonetheless, RYSE engages in what Dhaliwal characterized as "healthy struggles" with its partners and stakeholders. "We have to be bigger and bolder than our logic models, than our theories of change," by striving for liberation, she said. If we define success only as meeting our grant deliverables, she said, we are culpable of continued harm.

However, RYSE is a learning organization that has used data to guide its decision making and planning. Dhaliwal credits the young people in the community with driving the organization to think about data and learning in a different way. As a result, the organization's members are looking at the idea of developing a syndemics framework of research and data to enable them to conflate factors in a way that would help them understand the synergy and relationship among those social factors instead of doing regression analysis.

In closing, Dhaliwal suggested that workshop participants visit the RYSE website[8] and watch some of the videos that illustrate what the young people in the Richmond community are doing to address the social determinants of health and create a system of racial justice and anti-oppression. "I do my best to speak truth to the power of young people, but I also know that there is just nothing that can replace [their own stories]," she said. "So I would really ask that you take a look at the work the young people have done, because that is really where the stories are and where the opportunity for transformation is."

DISCUSSION

Iton began the discussion by asking the panelists to list the critical resources they need from academia, philanthropy, health care organizations, advocacy organizations, and other potential partners to do the kind of work they see as most important in their communities. Dhaliwal answered with a story of a partnership that RYSE has with the School of Public Health at the University of California, Berkeley. After 5 years serving as first responders for multiple kinds of violence and trauma affecting young people in Richmond, she and her colleagues went to the city government for help dealing with this but were told that they needed data to support their claims. RYSE partnered with the School of Public Health to design a data collection program, called the Listening Campaign, that allowed more than 500 young people in Richmond to share their experiences of violence, trauma, coping, and healing in way that was rigorous and allowed for the sort of data analysis that would influence city officials. As partners, the School of Public Health did not send privileged graduate students into Richmond to interview the young people of color in Richmond but rather helped her program with coding and establishing the rigorous analytic process. Dhaliwal stressed that this partnership was not built on money—her program did not have funds to support this effort—but rather on the relationships that her staff formed with researchers and students in the School of Public Health. The key to success in this relationship, Dhaliwal said, was that the teams from the two partners were willing and able to step into a partnership grounded in "trust and healthy struggle."

Manzo agreed that partnerships are not always about financial resources. She added, however, that financial resources do play an important role by enabling capacity building. "Many organizations in East Salinas are emerging organizations, organizations that did not exist before BHC," she said, "but we have seen tremendous wins with these folks in these organizations because they are grounded in lived experience." The key here, Manzo added, is having the resources to invest in and take a chance with those who have lived experiences and have good ideas on how to address the problems that affect their communities. Part of that capacity building, she added, is helping these nascent organizations understand what they need to do in order to secure additional funding once the initial pot of money is gone.

Gloria Escobar, the founder of a new initiative called the Coaction Institute, asked about the sustainability of resources, particularly of the people involved in these programs. The California Endowment, she said, is a unique external partner in that it understands the need for long-term external investments in these types of programs, but even those investments are designed to end after 10 years. Given that, she asked the panelists how their programs were getting local investors to build on what BHC has started. Manzo said that her organization in East Salinas has taken the approach of demonstrating the value of their programs and showing

[8] For more information, go to http://rysecenter.org (accessed March 30, 2017).

the local health department, for example, that the organization is irreplaceable. So far, BHC has received small amounts of funding from the health department and the Centers for Disease Control and Prevention to demonstrate the value of its work. BHC has also secured a grant from the City of Salinas to do community engagement. Manzo said that it is important to be intentional about applying for grants from sources that can understand and appreciate the value of the work these programs do in the community. She added that The California Endowment program manager for the BHC hub is having conversations with local funders to convince them that if their goal is to achieve true community transformation, they need to invest in programs that have lasting value as opposed to those that merely put band-aids on local problems.

Judi Nightingale from the 1-year-old Riverside County Population Health Department asked how she as a white, middle-class, over-privileged individual could contribute to building a better community for the disenfranchised, largely Hispanic population in her county. She asked the panelists for their ideas on whom she should consider as outreach partners. Dhaliwal responded that she appreciated Nightingale's understanding of what her position might be with respect to her community. What is important in finding partners, she said, is having the ability to see what a healthy struggle looks like, to be able to see each other's humanity, and to understand that the work that needs to be done will not be at each other's cost. She admitted that having that attitude can be hard, and she said that success will come from dealing with the uncomfortable and sometimes angry emotions that will arise at times and remaining committed to the struggle and getting through those moments. It is important for white people in this work to develop their capacity for discomfort, for holding each other accountable, and "develop a thick skin." At the same time, it is important for people of color and structurally vulnerable communities to commit to and contend with prioritizing their humanity and not accommodating white privilege/fragility at their own expense.

Phyllis Meadows of The Kresge Foundation asked the panelists if there has been an opportunity for the 14 BHC communities to come together strategically on some health issue that could be addressed at the state level in addition to the local level. Iton said that the 14 communities funded by BHC are working on local issues in an environmental change framework with three primary components: schools, neighborhoods, and prevention or human services systems such as criminal justice, health care, and social services. That framework, he said, is consistent across the 14 communities, and it feeds into the part of the BHC program that he did not discuss, which is a statewide and regional policy change infrastructure that intersects with what is happening on the ground in these communities. "There is a bidirectional flow of learning, knowledge, and then implementation of statewide policy," he said.

Dhaliwal expanded on Iton's remarks by explaining how the Listening Campaign's approach was not to take the challenges identified from speaking with young people about their experiences and then tell them what behaviors they needed to change. "We were really committed to that [approach]," she said. Instead, she and her colleagues took the data and findings as they were getting them and held discussions about what these data and findings meant with stakeholders, community benefit organizations that are part of the Health Richmond Community, and public systems. For example, the main coping mechanism for young people was to smoke marijuana, and if her organization, which she said is the only harm reduction agency in Richmond, took a behavioral intervention approach, it would have started funding marijuana cessation classes. The responsibility of her program, however, is to meet young people where they are, and if that means they show up having smoked marijuana, then her program supports and works with them from that place. At the same time, the program pushes the local

systems to lift zero-tolerance and abstinence-only clauses from their contracts and make funding contingent on using harm-reduction approaches. It then also creates spaces for mutual support and accountability among the community of providers to make the necessary shifts in approach and practice. "This is an example of using data to lift conditions, and change structures and systems," Dhaliwal said. This is public health, she added.

David Kindig from the University of Wisconsin Population Health Institute asked Manzo if she could describe the leaders in her community and if any of those leaders come from the wealthy agricultural business sector in the Salinas area. Manzo replied that her program has yet to get representatives of the agricultural sector involved, calling that a long-term goal. Currently, system leaders come mostly from city and county government, with some involvement of local health care institutions, including the public hospital. She explained that she has not worked as much with service-based providers.

Marthe Gold from The New York Academy of Medicine asked the panelists if they had started thinking about how they were going to hold governments accountable, given that the signals from the most recent election cycle suggests that local governments may be spending less money on these types of programs. This is the best time to push local government to act in the best interest of local communities, Manzo said. She added that she believes that there is money for these programs, though perhaps from nontraditional sources such as health care and prisons, and she said that she has begun having conversations with local officials, categorizing them as amicable but slightly contentious. What is enabling these conversations, she added, is the set of core values that they all share, such as the importance of meeting the needs of the community and of valuing the dignity of the individuals in that community. These discussions, she said, are about holding local governments accountable to those core shared values.

Dhaliwal agreed this is the right time to push local governments and said that her young staff members do not feel much different after the recent federal election in that they were experiencing danger and distress before the election and will probably continue to have a similar experience. RYSE's response to the election has been to figure out how to shore up the power, capacity, and fortitude the organization has built to deal with what might lie ahead. This includes making space for staff and stakeholders to reflect, share, listen, and learn how and to what degrees communities will be affected and how they can continue to show up for and support each other. She added that the public systems in Richmond are rising to the occasion and realizing the importance of sustaining the progress the community has made. The key, she said, will be figuring out how to make sure the community's lived experiences are visible and prioritized.

Iton said he is scared about what is coming down the pike, but is working with local communities to strike a balance with regard to funding. For example, when he met with the Salinas city manager, he learned that 70 percent of the city's budget went to the police and fire departments. At the county level, he learned, a disproportionate amount of resources go to incarceration. BHC's response has been to start a campaign, Our School is Not a Prison, that aims to shift the narrative about the investments the city and county are making in young people away from these punitive, downstream systems. That said, he acknowledged that it is frightening that California could lose $20 billion per year just from the Affordable Care Act—money that enabled the state to expand Medicaid services. Nonetheless, this prospect does not change the approach The California Endowment is taking to address these problems, which is to build power in the state's underserved communities.

As an example, Iton mentioned that there has been success in getting the California justice system to make 1 million people eligible for having felony convictions reclassified into

misdemeanors, which means that those individuals would no longer have to check a felony conviction box when applying for a job or housing. The state now has 250,000 undocumented children who are getting the full scope of Medicaid services because of the advocacy that humanized this population. Thanks to some policy changes, there are now 300,000 fewer school suspensions in communities such as Richmond and Salinas, a 40 percent drop in 3 years, Iton said. "There are profound changes that are happening here as a result of the work that is happening in these communities and how these communities are networking their power to change state policy," he said.

Concluding the discussion, Iton predicted that there is going to be a clash between the direction California is moving and the direction the federal government seems set to move. He added that he and his colleagues see this as a good opportunity for organizing communities—an opportunity that is bringing people together across discipline and geography around a common set of aims. "We are afraid," he said, "but we are doubling down on our strategy."

3

Improving Health through Equitable Transformative Community Change

The workshop's second panel featured two examples of what it looks like to create conditions that shift power to residents and improve the health and well-being of communities. Jennifer Lacson Varano, the manager of community benefit and emergency management at Dignity Health Saint Francis Memorial Hospital, and Will Douglas, the manager of community impact for the Saint Francis Memorial Hospital Foundation, described the work of the Tenderloin Health Improvement Partnership. Teal VanLanen, a community activator for the Algoma School District, and Pete Knox, the executive vice president and chief innovation and learning officer at Bellin Health, then spoke about the Live Algoma[1] project in northeastern Wisconsin. Following the presentations (highlights provided in Box 3-1), Soma Stout, the executive lead of the 100 Million Healthier Lives[2] program at the Institute for Healthcare Improvement, moderated an open discussion.

BOX 3-1
Highlights from Presentations on Improving Health through Equitable Transformative Community Change[a]

1. Achieving healthier communities requires unprecedented collaboration, the courage to ask questions about what is happening, and the courage to fail forward, learn, and understand that in coming together communities might create solutions and intentionally transform the systems that are creating inequity (Stout).
2. Community transformation requires understanding how the stories of community residents with lived experiences and their insights about how the system works can be combined with the capacities of those who have more formal positions of power in these communities (Stout).
3. Positively disrupting organizational silos involves co-creating with residents, using the framework of collective impact, convening stakeholders and residents to build consensus around issues and identify new ones, and developing solutions that resonate with the residents on the ground (Varano).
4. One approach to making progress is to switch the narrative from one focusing on

[1] For more information, go to http://livealgoma.org (accessed March 31, 2017).
[2] For more information, go to http://www.100mlives.org (accessed March 31, 2017).

issues and needs to one that looks for the bright spots and positive spaces in a community that can be nurtured (Douglas).

5. As the community partners continue to work and learn together, they are seeing that grants can be a helpful mechanism for seeding and activating collaboration in the community space (Douglas).
6. The challenge as a backbone organization and provider is integrating the voices of residents into the work that is done. This means letting the community tell its own story (Douglas).
7. Creating authentic community requires leading from within, leading together, and leading for outcomes (Douglas, Stout, VanLanen).
8. Everyone in a community can draw from the community's common resources, but they also need to contribute to those resources to create sustainable change (Knox, VanLanen).
9. Provided with tools and resources to improve their community, children can be powerful and effective agents of change and social movements (Knox, VanLanen).
10. When thinking about the infrastructure that is needed to build and support the spread and scale of successful projects, it is necessary to think about what the system will look like a year or two in the future, not what it looks like today (Knox).

[a]This list is the rapporteurs' summary of the main points made by individual speakers, and the comments have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

100 MILLION HEALTHIER LIVES

Before introducing the panelists, Stout noted that the speakers represent two of the 24 Spreading Community Adopters through Learning and Evaluation (SCALE)[3] communities that, along with many other partners are involved in the 100 Million Healthier Lives initiative.[4] Together these participants are learning to create a community of solutions by shifting the balance of power and equity. "We call 100 Million Healthier Lives an unprecedented collaboration of change agents who are pursuing an unprecedented result of 100 million people living healthier lives by 2020," Stout said. "The way we are going to do that is not to go out and change them, it is actually by changing us, by transforming the way we think and act as people who are in communities and in systems of power, to transform the way we think and act to create health, well-being, and equity."

Getting to that place, Stout said, will require unprecedented collaboration, the courage to ask questions about what is happening in a community, the courage to "fail forward",[5] and understanding that in coming together communities might create solutions and intentionally transform the systems that are creating inequity. Achieving this goal will require data and

[3] For more information, go to http://www.rwjf.org/en/library/articles-and-news/2015/04/communities-receive-funding-to-accelerate-and-deepen-efforts-to-improve-residents-health.html (accessed March 31, 2017).
[4] This section is the rapporteurs' synopsis of the introductory comments made by Soma Stout, executive lead of 100 Million Healthier Lives, Institute for Healthcare Improvement, and the statements are not endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.
[5] To "fail forward" means to turn failures into opportunities to learn and do better in the future.

science, she said. It will also require understanding how to combine the stories of people with lived experiences and their insights about how the system works with the capacities of those who have more formal positions of power in these communities. Critical to this effort will be getting two groups to see each other not as separate but as part of the same team and to understand that each other's piece of the puzzle is needed to create solutions that will benefit the health of everyone in their community.

The price of admission to 100 Million Healthier Lives and SCALE is equity [6], Stout said, and this program is asking what it looks like for a community to change in a way that enables everyone to thrive. Changing the way communities think, she said, requires everyone to develop their capacity to "lead from within." "This means learning how to be self-reflective about who we are, where we are, and how we are leading so that we can develop the skills to understand our story and understand the story of the people that are before us and the places that are before us," she said. It also requires understanding what it looks like to come together and lead together, to understand and appreciate where the differences among one another make an individual stronger and where they are mere relics of the past that need to be left behind, she said. It also means having the courage to lead for outcomes without knowing ahead of time what the paths to those outcomes will be, adopting a humble spirit of learning and improvement together.

The Robert Wood Johnson Foundation is funding this program, and Stout explained that rather than stating a desired outcome, the foundation is allowing these 24 communities to co-design the approaches needed to help accelerate themselves toward a culture of health. Stout said that as she and her colleagues have been figuring out what it looks like to create these communities of solution,[7] they have been discovering a number of important elements that need considering: that people relate to each other in these communities in different ways; that the way leaders come together to create abundance is different in each community; and that the way a community takes on the change process to grow equity differs. Respecting and valuing these differences, Stout said in conclusion, translates to ownership that enables everybody in the community to thrive, particularly those who are most affected by the structural racism and inequities of their local systems.

TENDERLOIN HEALTH IMPROVEMENT PARTNERSHIP[8]

The Tenderloin Health Improvement Partnership (TLHIP)[9] is a place-based initiative rooted in a collective impact model, Varano said. The Tenderloin neighborhood covers approximately 40 square blocks in the heart of downtown San Francisco (see Figure 3-1) and has a long history of complex issues similar to those seen in other urban centers, she added. It is an ethnically diverse neighborhood with more than 30,000 residents, including 3,000 children. The neighborhood's median income is $27,269, compared with a citywide median of $84,160, and an

[6] For more information on 100 Million Healthier Lives' treatment of equity as the price of admission, go to http://www.100mlives.org/approach-priorities/#equity (accessed May 25, 2017).
[7] For more readings on "communities of solution," see the resource list posted on the roundtable's activity page http://nationalacademies.org/hmd/~/media/Files/Activity%20Files/PublicHealth/PopulationHealthImprovementRT/16-DEC-08/Resource%20list%2012%205%202016.pdf (accessed May 1, 2017).
[8] This section is the rapporteurs' synopsis of the presentation by Jennifer Lacson Varano, the manager of community benefit and emergency management at Dignity Health Saint Francis Memorial Hospital, and Will Douglas, the manager of community impact for the Saint Francis Memorial Hospital Foundation, and the statements are not endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.
[9] For more information, go to http://www.saintfrancisfoundation.org/tenderloinhip (accessed March 31, 2017).

estimated 57 percent of San Francisco's homeless population lives in the Tenderloin. Access to open space in the neighborhood is low, and alcohol outlet density is over six times higher than in the city overall. The Tenderloin ranks second in the city for preventable emergency room visits, with a rate more than twice that compared to the rest of the city. At the same time, there are over 100 nonprofit agencies serving the neighborhood, offering health, housing, arts, youth, senior, and other social services.

FIGURE 3-1 The Tenderloin neighborhood in San Francisco.
SOURCE: Douglas and Varano presentation, December 8, 2016.

Located just north of the Tenderloin, Saint Francis Memorial Hospital is a mission-driven, nonprofit organization that has served the Tenderloin and San Francisco for more than 100 years. "We have one of the busiest emergency departments, and we have invested a lot of time and money in our Charity Care program, as well as in building and strengthening relationships in the community to inform and design our Community Benefit program," Varano said.

As TLHIP was starting its work, the San Francisco Health Improvement Partnership was spearheading an alignment effort among the many different community health assessments that the public health department, other private hospitals, and other individual organizations were conducting. She noted that at the same time, FSG, a mission-driven consulting firm for leaders in search of large-scale, lasting social change, published its first paper on collective impact (Kania and Kramer, 2011). In addition, city residents were pressuring government to "do something" about the Tenderloin in response to an uptick in residential development, rapidly changing demographics, and a growing concern from the community about gentrification. Building on these events and our long history in the neighborhood, our hospital formed the TLHIP with the

help and support of the Saint Francis Foundation, and convened a series of solutions-oriented dialogues with nonprofit executive leadership, city partners, private partners in philanthropy, as well as residents working in the Tenderloin, Varano said. "We acknowledged upfront that the impact of our collective efforts would take time and money and that failing forward quickly was okay. Our hospital and our foundation were prepared to provide that space to have those conversations and to bring others to the table where it could help."

Adapting the citywide health needs assessment to the unique nature of the Tenderloin and looking specifically at safety issues, community connections, and opportunities for healthy choices, TLHIP was launched in 2014 as the first neighborhood-based coalition to pilot the vision and values expressed in San Francisco Health Improvement Partnership, Varano said. While a focus on safety served as the entry point, over the past 3 years, "positively disrupting" organizational silos has been and continues to be TLHIP's mantra. "We continue to learn how to do this with our community by co-creating with residents, using the framework of collective impact, convening stakeholders and residents to build consensus around issues and identify new ones, as well as solutions that resonate with the residents that are on the ground," Varano said. Participating in the 100 Million Healthier Lives initiative, she said, has helped the program learn how to integrate improvement science[10] and the "Plan, Do, Study, Act" cycle into its everyday work to continue to stay focused and continuously adapt.

Given the density of the issues and assets the program and its community partners initially identified, Varano said, it quickly became clear that the 40 square blocks in the Tenderloin were too big to target as a whole. Varano and her colleagues thus looked at the data and the deficits and created four action zones. For each action zone, the community residents helped to identify "game changers," or key place-based interventions with the potential to enhance existing bright spots[11] in the neighborhood or create new ones where they did not yet exist.

The first of these game changers, Varano said, were two projects—Boeddeker Park and Tenderloin Safe Passage—and a place-based strategy that was integrated into the city's Tenderloin Central Market Strategy through the Mayor's Office of Economic and Workforce Development. She said that one result of this alignment has been that researchers from the planning department were deployed in the neighborhood, fostering what she characterized as "a great working relationship" between the people in the neighborhoods and the city agencies "that has helped to improve both trust and communications to and from the community and City Hall."

Douglas explained that this place-based strategy hinged on switching the narrative from one focusing on issues and needs to one that looked for bright spots and positive spaces in the community that the program could be nurtured. Boeddeker Park was just such a place, a space that historically had been one of the most dangerous areas in the neighborhood but that was also the largest open space in the neighborhood. TLHIP funded the local Boys and Girls Club to serve as the master tenant of Boeddeker Park and helped establish a partnership among the Boys and Girls Club, YMCA, San Francisco Police Department, and Tenderloin Safe Passage, another program that TLHIP helped create and fund. Today, Douglas said, Boeddeker Park is considered

[10] IHI's definition of improvement science is available at http://www.ihi.org/about/Pages/ScienceofImprovement.aspx (accessed May 25, 2017).

[11] For more on bright spots, see http://www.100mlives.org/approach-priorities/opioid-resources/?sw=%5C%22bright+spots%5C%22 (accessed May 1, 2017) and the resource list posted on the roundtable's activity page http://nationalacademies.org/hmd/~/media/Files/Activity%20Files/PublicHealth/PopulationHealthImprovementRT/16-DEC-08/Resource%20list%2012%205%202016.pdf (accessed May 1, 2017).

one of the brightest, safest, and most active spaces in the Tenderloin neighborhood. Over the past 2 years, Boeddeker Park has served 70,000 visitors and provided 3,400 hours of activities for the community.

Tenderloin Safe Passage works with community members to establish safe corridors for children and seniors that allow them to walk safely in the Tenderloin neighborhood. With a sustained investment over the past 2 years, Tenderloin Safe Passage has become a safety project adopted by the Tenderloin Community Benefit District that stations 20 corner captains, the majority of whom are residents of the community, for an hour and a half daily on seven of the highest-need corners, creating a safe corridor for an average of 650 schoolchildren per week.

Starting with Boeddeker Park and Tenderloin Safe Passages, TLHIP has been able to bring a variety of community organizations to the table, and the neighborhood is starting to see more positive changes occurring, Douglas said. As the community partners continue to work and learn together, they are seeing that grants can be a helpful mechanism for seeding and activating collaboration in the community space. In 2 years, he said, TLHIP has given out 65 different grants to 41 organizations totaling nearly $2 million, seeding activities such as Four-Corner Friday, a monthly activity for the community, and Boeddeker Trekkers, a walking group that brings residents living in single-room occupancy hotels in to Boeddeker Park so that they can get 45 minutes of walking exercise, engage in community building, and get a healthy lunch. With the help of its many partners in the community, TLHIP closed a liquor store and established 826 Valencia,[12] a nonprofit organization that supports students with their creative and expository writing skills. TLHIP also provided a grant to local artists to put up a mural in Boeddeker Park to make it an even more appealing place for community activities.

Working together, the backbone team of TLHIP—i.e., the Saint Francis Foundation, Saint Francis Memorial Hospital Community Benefit, and a multisector community advisory committee—defined a common agenda that enables those organizations that serve the community daily through direct service to focus on strategic areas of need. "We can help them think more strategically across the entire neighborhood so that we can all work together and align our efforts better," Douglas said. The backbone team also provides assistance with data collection, evaluation, consultations, and communicating and celebrating successes in the neighborhood. TLHIP has hosted and supported difficult conversations about community safety, community improvements, and intravenous drug use, even bringing intravenous drug users to a small stakeholder session to talk about their experiences in the community. "Bringing in residents, people with lived experiences, is the only way to identify solutions that are going to work for everyone," Douglas said. In September 2016 city officials asked TLHIP to convene a meeting for its health commissioners to help them learn what was going on in the community.

Going forward, Douglas said, the future of the Tenderloin neighborhood looks brighter than it ever has. San Francisco has allocated funding for two additional neighborhood parks, and TLHIP is now driving a strategy of thinking about these parks as part of a network of safe places connected using Tenderloin Safe Passage. He said he believes that the success of Tenderloin Safe Passages and Boeddeker Park is leading residents to believe that these could be game changers for the community.

As TLHIP has been doing this work, Douglas, Varano, and their colleagues have been evolving the program's framework which initially focused on broad-based safety and creating opportunities for making healthy choices. Today, TLHIP's framework includes six areas—community engagement and neighborhood voice; active, vibrant, safe, and clean shared spaces;

[12] For more information, go to http://826valencia.org (accessed March 31, 2017).

behavioral health; resident health; economic opportunity and affordable retail shopping; and housing access—that together are expected to reduce chronic disease and improve health outcomes for the residents of the Tenderloin. Through community-wide grants, positive community activation, and mutually reinforcing activities, we can see some clear outcomes and a quick return on those investments, but we are also trying to seed new ideas and things that take time to cultivate, Douglas said.

Douglas said that being part of the 100 Million Health Lives program and its SCALE program has taught him and his colleagues at TLHIP how to create authentic community by leading from within, leading together, and leading for outcomes. "For me," he said, "what that means is every time I bring myself to a meeting with a community, I am just going to bring who I am and recognize that and respect people's ability to do the same thing, and not just be who I am in work but who I am as a human." Leading together, he added, means acknowledging that none of these activities work alone and that being a funder and a backbone organization[13] is just supporting what is already taking place. To him, leading for outcomes involves looking at where TLHIP can use data and measurement in a manner that enables it to share results more widely. It also means acknowledging that this work will take time and that the benefits will accrue over the long term.

In closing, Douglas mentioned the 100 Million Healthier Lives Touchstones for Collaboration (see Box 3-2), a set of guiding principles that every member of the coalition has agreed to follow. The challenge as a backbone and provider, he said, is to "effectively integrate a resident voice and bring that into the work that we do. For me, the answer is not to tell the story of the community but actually let the community tell its own story."

BOX 3-2
100 Million Healthier Lives Touchstones for Collaboration
(as presented by Will Douglas, December 8, 2016)

- Be present as fully as possible. Speak our truth from our hearts and minds.
- Listen generously to each other's truths. Trust that we all hold a piece of the puzzle and we need each other's pieces to understand the whole picture.
- Embrace differences and be open to learning from each other.
- When the going gets rough, suspend judgment and get curious. Be quick to forgive and ask open questions to understand.
- Honor each other's learning and resourcefulness. Trust we each will learn and contribute in our own way, that there is no need to "fix" each other.
- Make space to pause and reflect to deepen our thinking.
- Be willing to have meaningful conflict to create unprecedented goals and solutions. When needed, seek counsel for help with conflicts.
- Allow our ideas to be developed further by others.
- Seek common ground. When we cannot fully agree, we commit to a unified decision and seeing what happens from a humble posture of learning. If we have made the

[13] For more information on backbone organizations, go to http://www.collaborationforimpact.com/collective-impact/the-backbone-organisation (accessed May 25, 2017).

wrong turn, we will discover it together and turn the right way together.
- Accept that we will sometimes fail, but will learn together and move forward.
- Help each other to have the confidence to spread our wings, be creative, and take on new roles.
- Balance our yearning for change with patience for the process of change and growth.
- Make the way we work together an example of what is possible.

LIVE ALGOMA[14]

Algoma, Wisconsin, is not a racially diverse community—95 percent of its residents are white—but 55 percent of its students live in poverty and 25 percent of the community's students have a cognitive or physical disability, VanLanen said. Her lived experience as a former fifth-grade teacher is that these demographics have created a great many obstacles in the classroom and that while there were many bright spots of individuals and organizations trying to address the community's problems, they were doing their work in silos and not coming together as a community.

Knox said that efforts to transform systems fail 70 percent of the time, and that much of his work over the past 30 years has been aimed at understanding why failure occurs so often when trying to execute transformative strategies. He has developed a nationally recognized framework for building community that he and his colleagues at Bellin Health have applied to inner-city schools and elsewhere and that serves as the basis of the Live Algoma program.[15] Knox's goal is to use this framework to build a common language to tell stories about building communities wherever that happens.

Knox has identified five "domains of transformation" that are important to understand and incorporate in thinking about building community and that he believes are universal: (1) understand the system, (2) social change, (3) critical conversations, (4) co-creation, and (5) spread and scale. The process of radically transforming the community starts with understanding it as a system of interdependent and dynamic parts, the building blocks that make up community, differ in every community. Next is building sustainable communities through social change, and having the critical conversations that further social change. Having critical conversations, Knox said, requires being vulnerable and inviting people in for conversation. "I am finding that around the world, people are desperate to have a conversation. They are waiting for the invitation, and that is up to us, but these are critical conversations. They are tough conversations." Co-creating involves creating a safe space for people to come have these conversations in order to co-create, develop, build, and innovate together. Knox said that the Tenderloin team created such a space as part of its effort. Finally, Knox said, it is important to understand the concept of spread and scale; failure to do so limits how far solutions will go and also limits their sustainability.

[14] This section is the rapporteurs' synopsis of the presentation by Teal VanLanen, a community activator for the Algoma School District, and Pete Knox, the executive vice president and chief innovation and learning officer at Bellin Health, and the statements are not endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

[15] For more information, go to http://livealgoma.org (accessed May 25, 2017).

Using Live Algoma as an exemplar of these domains, Knox then went into more detail of how they are applied in practice. In terms of the first domain, his team's understanding of Algoma as a community system was that it has five important interdependent parts (see Figure 3-2), the first of which is its children. "We needed to invite children in to be part of solving some of the big problems we have," Knox said. Healthy employers were the second dimension because there needed to be a strong economic base in Algoma if this effort was to be successful. "We needed Algoma to be a place where employers wanted to move their businesses and build that economic base," Knox said. As part of the effort to entice businesses to move to Algoma, Bellin Health created a new community collaborative insurance product in which one-third of any shared savings accruing from this product will go to support and sustain community work. Creating this new type of insurance represents an attempt to provide a long-term source of dollars to support community building that improves health and well-being.

The Algoma community's third component is the health of its individuals. "We needed to engage every individual in the importance of their own health and well-being," Knox said. A healthy community is the fourth part, and it requires the community to face the big social issues that exist in Algoma. The fifth component, at the intersection of the other four, is the commons, which are the assets of a community. The community needs to understand these assets, protect them, nurture them, and build them together, Knox said. People cannot just draw from the commons; they have to be willing to contribute to the commons. Knox noted that in this conceptualization, a community is not hierarchical, but a living organism made of connected and interdependent parts engaged in a dynamic and responsive interchange between groups and levels.

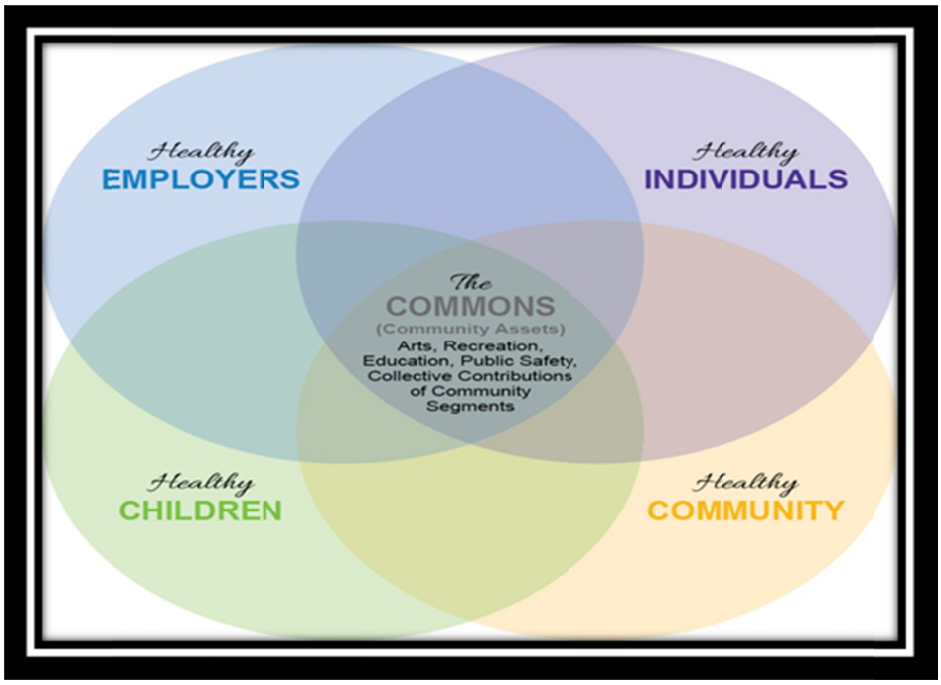

FIGURE 3-2 The building blocks of a community system.
SOURCE: Knox and VanLanen presentation, December 8, 2016.

VanLanen said that everybody in the community can find a place for himself or herself in this model of community and reiterated Knox's statement that everyone can take from the

commons, but they also have to contribute to it. "We educate our community members about the commons all of the time," she said. She also pointed out that the programs growing out of this model are composed of community members. "For example," she said, "in the healthy children team, we have someone from law enforcement, someone from social work, a private school teachers, a public school principal, a Hispanic mother, and two youths at the table." The team is made up of a variety of people, each with a different perspective, who can talk about what it is in the Algoma community that creates a healthy child. Having those perspectives at the same table can lead to an authentic shared vision, VanLanen said. Knox added that every dimension has an activation team such as the one VanLanen described for the healthy children domain.

With regard to the second domain, social change, Knox said the challenge is to use knowledge about the local system to create a social movement or revolution, and in Algoma's case it is the community's children who can create that revolution. From the studies Knox and his colleagues have done, he said, he believes there are six drivers to creating a successful social movement (see Figure 3-3), starting with developing transformational leadership that can create a unified, passionate vision and message that can rally the community and build a coalition for collective impact.

To build momentum capable of activating the community, Live Algoma staff gave activation team members invitations to a celebratory event that they could give to anyone in the community who they believed were bright spots in Algoma. "It was an incredible experience filled with tears," Knox said. "People who lived their entire lives in Algoma did not know who some of the bright spots were." With the community activated, it is then possible to build the comprehensive engine for community change using a variety of tools and resources that will produce the social revolution needed to create a healthy community.

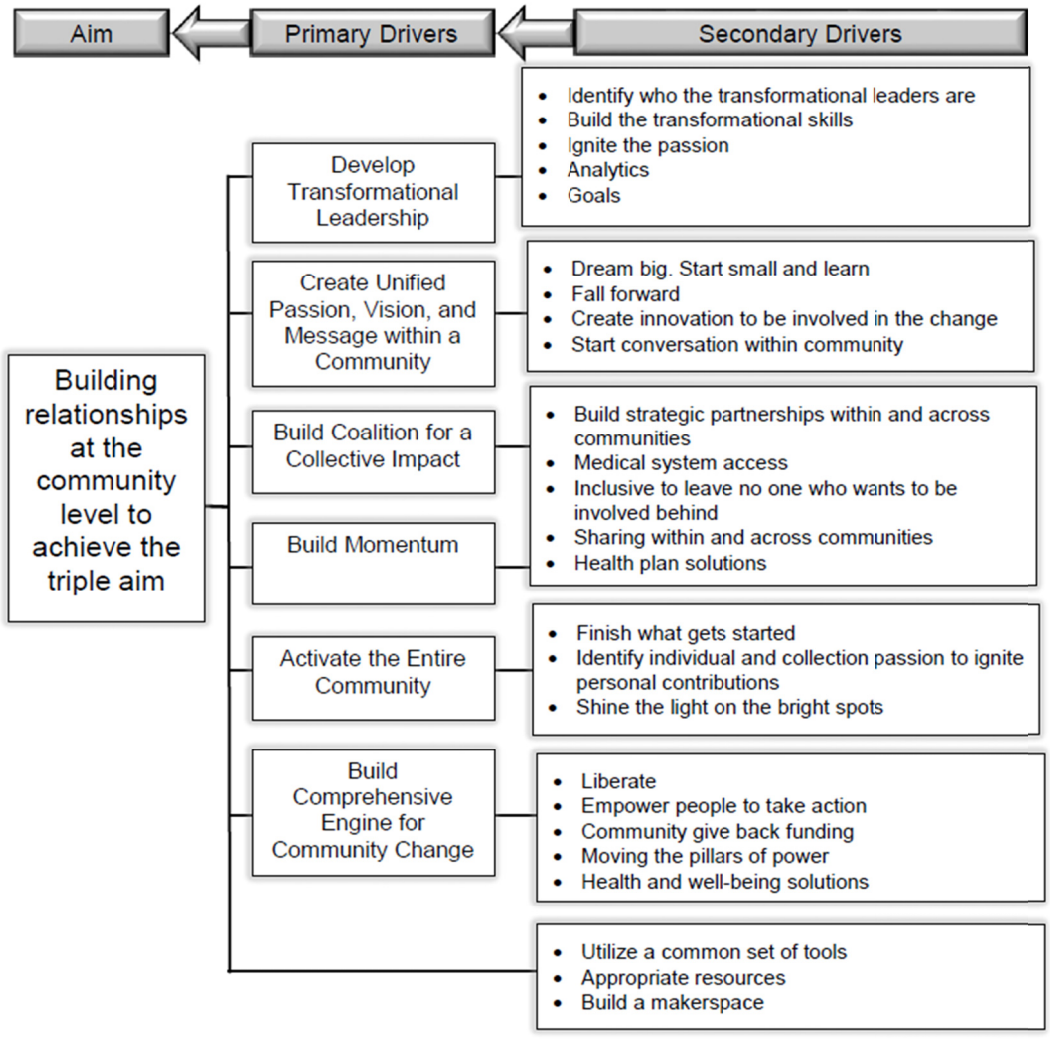

FIGURE 3-3 Building sustainable communities through social change.
SOURCE: Knox and VanLanen presentation, December 8, 2016.

VanLanen then discussed the third domain, which is having critical conversations. In Algoma, more than 50 percent of the population is age 55 and older, and this creates the challenge of including youth voices in community conversations. Live Algoma worked to build the capacity of the community's youth to develop the language needed to get their ideas heard in the community, and the result has been that adult community leaders, including the mayor and other key stakeholders, have had critical conversations with the youth about the challenges they face and possible solutions to those challenges. "When adults listen to the youth, it ignites them and activates them, and they become change agents in our community," VanLanen said. "Having critical conversations about what matters to them, and not us telling them what should matter to them or us not fixing a problem that we see, is very important in our community." To help build relationships between the youth and adults of the community, Algoma attached its community wellness center to the local high school.

To the same framework of leading from within, leading together, and leading for outcomes that the TLHIP team described, VanLanen and her colleagues added a fourth component, leading for equity. In the past. the community she works with typically did not hear or use the term "equity," she said, but equity is now a central theme in every decision the community makes, whether in terms of who is and is not thriving or in terms of whose voice is and is not heard at the table. As an example, VanLanen spoke of how the director of the school's technology department took equity into consideration when he established the Community Fab Labs. This community resource makes tools accessible to those who do not have them at home, with students teaching community members how to use these tools. This, VanLanen said, is one small example of equity in action.

VanLanen said that she sees her role as a capacity builder who can supply tools and resources and identify partners in the community who can help create and enact solutions. When her team brings different voices in the community to the table, they do not present data and tell the community members what needs to be fixed. Instead, they ask what the community members want to work on to create change that can improve health and well-being. Examples of change that have resulted from this process include

- More than 100 school-age volunteers showed up to clean the city's Crescent Beach, documenting collections of trash and increasing awareness of what waste can do to the area's ecology.
- More than 100 people have been educated on the nutritional principles of eating more fruits and vegetables, cutting out processed foods, eating healthy proteins and fats, and avoiding sugary beverages. In a pre- and post-survey of participants in the program, 100 percent of the individuals reported improvements in at least one nutritional principle.
- Adding a new salad bar in the school cafeteria resulted in a 450 percent increase in weekly average vegetable consumption and in 1 year contributed to an increase in baseline indicators from 35/100 to 51/100 on the Smarter Lunchroom assessment scorecard.[16]
- In 2016 the community built a new ice rink to take advantage of Algoma's cold weather climate and encourage locals to get out and move in winter. This project was so successful that the community is now working on building a walking and biking trail.
- A student who learned the "plan–do–study–act" process inspired teachers to learn it, too, and 33 school district staff are now using this improvement science process in their work.

VanLanen said that these success stories create momentum for change in the community, and program staff make a point of stressing that community members developed these projects. "We try hard not to talk solely about the problems but who are the people solving them and who the bright spots are in our community," she said. Identifying these bright spots and the things that community members are proud of pulls the community together, she explained, and turns challenges into opportunities for improvement. Live Algoma strives to keep community

[16] For more information, go to http://smarterlunchrooms.org/resource/lunchroom-self-assessment-score-card (accessed March 31, 2017).

engagement at the center of the change process. "We always say we have an open invitation," VanLanen said. "Some people are ready, some people are not, but there is always an open invitation."

For example, what began as an initiative to teach hands-only CPR at a high school basketball game soon became a community-wide effort that had students using improvement science to teach CPR to more than 800 individuals in the community, including at a Green Bay Packers football game and within the Hispanic community. A youth-generated idea on how to teach preventive methods to address the high rate of obesity in the community grew from training 45 people to training more than 1,000 individuals, one-third of the Algoma population. "I'm astonished at what community members can do, and it is not about what money we need," VanLanen said. "It is about who we need to partner with in order to make this happen." VanLanen emphasized the importance of including different voices at the table to drive community change. In Algoma, community members have benefited, for example from having a systems-level thinker such as Knox at the table, someone who can be a community engager and activator, and from having residents who can bring their lived experiences.

Knox briefly discussed the difference between problem solving and solution-based thinking. Solution-based thinking is about dreaming of a possible future situation and then working toward that dream rather than solving a particular problem. Knox explained that design thinking, a form of solution-based thinking, is a formal method of practical, creative resolution of problems and the creation of solutions, with the intention of obtaining an improved future result. The examples VanLanen gave show the power of working together to achieve a dream of creating a healthier, more equitable community.

With regard to the final domain, scale and spread, Knox said it is important to identify the human, organization, financial, policy, information, and communication resources in a community. The issue with scale, Knox said, is that the community needs to think about the infrastructure that needs to be built and to support the work that the community members are trying to do. Leaders need to be thinking about the future and to build the necessary infrastructure ahead of time. If that is not accomplished, the community-building process will hit a wall because the infrastructure is not in place to support it, he said.

VanLanen closed the Live Algoma presentation by discussing what a group of sixth-grade students who were taught improvement science by the graduating seniors mentioned in the CPR story accomplished in the community. Three of these sixth-graders decided they wanted to eliminate food insecurity. By using what their older peers had taught them, they convened a meeting with 23 key stakeholders in the community. The result of this meeting was that the two local grocery stores now donate all of their bruised apples and other "ugly produce" to the school to serve as healthy snacks. "It is just such an empowering story because it was not the adults spreading these tools," VanLanen said. It was the high school seniors saying, "'We cannot keep these things to ourselves. We have to spread it to the younger generation.'"

Stout added that Live Algoma is now sharing its work and successes with five other nearby communities in order to reduce poverty and increase equity. She noted that one lesson 100 Million Healthier Lives has learned is to "think about collective impact as not simply a group of formal leaders coming together in a room, setting some ideas and priorities, and moving them forward" but instead as a much more generative, living, and dynamic process of transforming the lives of people and communities together. Through its work, 100 Million Healthier Lives has identified three important characteristics for success in communities of solution: how people in a community relate to each other, how the community creates

abundance, and how the community approaches the change process. Participants briefly discussed at their tables the handout on communities of solution (see Appendix C) and provided written comments and questions that were generated during their discussions.

DISCUSSION

Stout began the discussion with the comment that one thing that 100 Million Healthier Lives is learning is that unleashing the power of communities requires unleashing the power of change makers at every level to create change together. "We often tend to think of change across sectors, but it is really change across levels along with everyone who is a piece of the solution," Stout said.

Sanne Magnan asked Douglas and Varano if their initial focus on safety brought different partners into the conversation about improving community health outcomes. Douglas replied that the Community Benefit District, which is a body funded through a small tax on businesses in and around the Tenderloin, as well as some of the technology firms that have moved into the area are now partners and have even taken over the Tenderloin Safe Passage Program. The Community Benefit District speaks for the business community and that, he said, has been an important voice to add to that of nonprofits and public health when speaking to various stakeholders in the community. He also noted the strong relationship that TLHIP has developed with the San Francisco Police Department around Boeddeker Park. There is now a police station diagonally across from the park, and a police officer spends time daily in the park. "That is critical because that officer gets to know the community in a different way," Douglas said. In addition, the focus on safety has brought groups like the YMCA, a local church, and the Golden Gate Safety Group into the conversation and has enabled them to play a role in community safety. Varano added that with safety serving as the common denominator, individual businesses owners have become more involved in the community.

Karen Ben-Moshe from the California Health in All Policies Task Force asked if TLHIP was thinking about gentrification and if it was doing anything to make sure the benefits accruing in the Tenderloin continue to benefit the residents of that area. Gentrification is a hot topic in San Francisco, Douglas said. TLHIP has funded a facilitator to work with a group called Development Without Displacement and craft a series of recommendations and approaches that the community can take to support the residents in the Tenderloin. He also said that a Tenderloin resident on TLHIP's steering committee has pointed out that the neighborhood's residents want a good neighborhood and opportunities to live and grow together with new residents.

Johnathan Heller of Oakland-based Human Impact Partners noted that the first panel spoke about the need to tackle power, oppression, and racism head on, and he asked how TLHIP was doing that. Varano replied that in September 2016 there were a number of violent acts in the community and for the first time in her experience, city officials approached them immediately to ask how they could help the Tenderloin. At the same time, community residents were turning to TLHIP with that same question. TLHIP convened a community gathering that included a room full of social service providers, concerned residents, and government officials who addressed head-on issues of race and power, in part because the term "safety" may operate euphemistically for racism in the community, Varano said. Douglas added that this is a difficult conversation and it requires being uncomfortable. Stout commented that structural racism is easy to name, but hard to dismantle. Doing so, she said, requires creating spaces where people can begin that conversation with one another, map out the system underlying structural racism, and

then think about how to work systematically to disrupt it. Much of the effort she and her colleagues have been involved in over the past 6 to 9 months has been focused on how to do justice to addressing inequity.

Ben-Moshe asked the panelists to comment on how they define community, whether geographically or demographically, and how large or small a community can be. Knox replied that community can be defined in different ways. One community he worked with was created around getting disabled individuals involved in athletic activities. An inner-city school or a company can be a community, and so can an entire city. Knox noted that he and VanLanen gave presentations with Sweden and Scotland, where those entire nations were the community. The defining characteristic, he said, is that a community is the population that needs to come together to accomplish a purpose and to create vision and passion around that purpose.

Douglas added that, for him, community is an organic thing that can change. "Sometimes, people identify with the community and sometimes that changes," he said. In the case of TLHIP, community was defined as a neighborhood for grant-funding purposes, and even that can be complicated because a neighborhood can be defined in various ways—for example, by zip code or specific streets. Douglas said that one difficult conversation that took place with residents of the Tenderloin was concerned with whether to include homeless individuals in the community, and the answer was yes. "That was a very important point to discuss as a community," he said. Stout said that 100 Million Healthier Lives thinks of two types of communities: network communities in which a group of people have something in common, and place-based communities that have a set of structures, systems, and functions and a group of people working in the context of a place.

Brian Russell asked the panelists if they could reconcile the two panels. The earlier panelists (see Chapter 2) pointed to the need to address the fact that people can come to the table feeling they are not fully recognized or that they are dehumanized or feeling that they are characterized as the problem that needs to change. The second panel, by contrast, seemed to be largely about how once people come together, it would be possible to facilitate a positive, solution-oriented collective impact conversation. VanLanen answered that an important factor is to lead from within before coming together with others and to question where one stands, what question one has, and what privileges one has. People need to build their capacities and language. "Language matters," she said. "People need a language to talk about what they are dealing with inside." Key stakeholders and community members with lived experiences need to build their capacity for having these conversations. Douglas agreed that language is important and said that "if we are not hearing discussions around structural racism and who has power in our community, then I do not think we have the right people at the table."

Stout said that her program teaches skills that help create conversations in safe spaces. This process starts by having people introduce themselves, telling the stories of their community, and listing their gifts and their habits of the heart—all of which is designed to start giving the various participants an appreciation of otherness and cohesiveness. Participants in this process take walks together and share their stories, their successes and failures, and where they have failed forward and had their hearts lifted. They learn how to build trust and talk about isms. "It is about beginning to create those conversations from a place of human interconnectedness," Stout said. When participants leave this training, their first task is to build a plan of engagement for the different people in their community who need to be on a problem-solving team, including system leaders, community connectors, and the community members with lived experiences. She

commented that this is not a static process, but one that keeps building on who is in the room and how their perspectives help create solutions.

Knox said that he thought there were many similarities between the presentations of the first and second panels. Listening to the morning panels, he said, he heard people understanding their communities and the dynamics that make the community what it is. He heard about creating and driving a social movement at a grassroots level, critical conversations, and co-creation.

An unidentified participant asked how to hold these conversations if the community has the prevalent belief that the best way to have long lives and safe lives is for everybody in that community to have an assault weapon or to get rid of government safety regulations. VanLanen replied that no matter where the community is, it is imperative to meet the community there and understand why it has those beliefs. Varano agreed that the power of listening and being present are critical and said it is important not to enter the conversation with assumptions and answers. She recounted one of TLHIP's fail forward experiences. The members would announce that TLHIP had money and invite others to join them in unearthing solutions. That process yielded a number of disparate ideas, she said, and it failed. Now, the approach is to come in as a co-creator, a supporter, and a cheerleader. Douglas said that there were strongly held beliefs in the Tenderloin neighborhood about injection drug use that needed to be heard and considered, which involved difficult conversations. However, by listening to one another, the community over the course of 2 years has come to agree on a common set of recommendations and agreements about potential solutions. "It is an evolution of the way that you think, but understanding the humanity in people and being able to find some common ground is critical." Stout added that stories from community members are crucial to creating a common vision.

Bridget Kelly from Bridging Health and Community said that two themes came out of discussions she had with other participants at her table (see Appendix C). The first was that it is not just community members who have lived experiences they can bring to the table; community leaders do as well. "It seems like that is not an us-and-them thing, but really a core to everyone who is participating," she said. The second theme was that perhaps the dynamic process and healthy struggle that develops from these relationships are outcomes, as opposed to metrics and indicators, in that they can demonstrate there has been a shift in the power dynamics of the community. Stout agreed with this second theme and said that 100 Million Healthier Lives has a metric for that. In fact, she said, the program does not define the outcomes by which it will judge a community a success. The program has a metrics database called Measure What Matters from which community members can choose the metrics they feel are important for measuring their successes, whether it is the percentage of ugly fruits and vegetables donated to schools or people feeling safe in the process of community engagement. Knox said he agreed wholeheartedly about the importance of letting the community define what is important and then helping the community set up the appropriate measurements. VanLanen said that when she first started her work with Live Algoma, her idea was that obesity was the problem that needed to be addressed, but after partnering with community members, it became clear that the community thought the biggest problem was a dream deficit regarding future possibilities, particularly among the community's youth.

With regard to Kelly's first theme, Stout acknowledged its importance and said that she would think about it more. She added that she thinks that part of what she and her colleagues want to convey is that community members need to be included in creating the solutions—and that the experiences of people who have lived with a particular condition the community is trying

to change (e.g., homelessness or joblessness) offer real insight into what the solutions might be. The intention, Stout said, is to recognize the experience that they have in creating solutions.

4

Engaging Communities in Building a Culture of Health

The workshop's final panel session explored how to bring groups of people together to support change in communities and develop systems that will create a culture of health. The panelists, representing three of the seven winners of the 2016 Robert Wood Johnson Foundation Culture of Health prize, were Yesenia Castro, the Mid-Columbia Health Equity Advocates coalition coordinator at Nuestra Comunidad Sana/The Next Door[1] in the Columbia Gorge region of Oregon and Washington; Shelton McElroy, a project manager at Metro United Way[2] and a Change Makers leadership instructor at Jefferson Community and Technical College in Louisville, Kentucky; and Stephanie Co, a special assistant to the president at Beyond Housing[3] in the 24:1 Community of North Saint Louis, Missouri. Following the presentations (highlights provided in Box 4-1), Jomella Watson-Thompson, an associate professor of applied behavioral science and an associate director of the Work Group for Community Health and Development[4] at the University of Kansas, moderated an open discussion.

BOX 4-1
Highlights from Engaging Communities in Building a Culture of Health[a]

1. It is important to listen to and learn from the community. When given the tools, language, and opportunities, community residents can and will shape the direction of what community organizers and coordinators are doing to support the initiatives that are most meaningful to the community (Castro).
2. When developing collaborations, stories of the lived experiences of community members are important for bringing the powerful to the table (Castro).
3. It is important to recognize historical trauma before launching into discussions and talking about solutions (Castro).
4. Today, community decision makers look to the area's community-based organizations to ask important questions and actively engage community members in the decision-making and policy-change processes (Castro).
5. Typically the language used by the people doing the serving is different from the language

[1] For more information, go to http://nextdoorinc.org/nuestra-comunidad-sana (accessed March 31, 2017) and http://nextdoorinc.org (accessed March 31, 2017).
[2] For more information, go to https://metrounitedway.org/servlet/eAndar.article/342/Metro-United-Way-Online (accessed March 31, 2017).
[3] For more information, go to http://www.beyondhousing.org/what-we-do (accessed March 31, 2017).
[4] For more information, go to https://communityhealth.ku.edu (accessed March 31, 2017).

used by the populations they serve. Service providers often think of themselves in action-oriented, strength-based, positive frames, as opposed to the residents whom they work with in communities, who are typically depicted in language that emphasizes their liabilities (McElroy).

6. Asset framing rejects narratives that denigrate people by focusing instead on portraying people as assets who are capable of working with others to change their community for the better. (McElroy).
7. Building trust in underserved communities with a history of inequity creates stronger partnerships. The actions that partnerships and coalitions take must be community informed (Co).
8. It is important to have a backbone agency with dedicated staff to keep the partners accountable. It is also important to create a common agenda that supersedes individual interests and the agendas of specific organizations (Co).
9. It is important to develop strategies and activities to share power and humanize each other, whether through popular education, developing a shared language, or sharing a meal and a conversation with people who have different institutional or resident affiliations or backgrounds (Castro, Co, McElroy).
10. Grants come and go, and funding sources can change regularly. It is important to have good grant writers because work can come to a halt with lack of funding but also be slowed by the different metrics and deliverables expected by different funders. More long-term funding would contribute to the sustainability of successful programs (Castro).

[a]This list is the rapporteurs' summary of the main points made by individual speakers, and the comments have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

MID-COLUMBIA[5]

In the region of Mid-Columbia where Castro works, the demographics are majority white, with roughly 30 to 40 percent Latino, and the schools are about 65 percent Latino. Castro explained that her job is to work in the Latino community to find out what the members of that community think about the community needs assessment that was developed from the perspective of powerful leaders in the community—county officials, doctors, school administrators, and others. For example, the community assessment stated the need for more housing, so she asked her community members what more housing would look like to them. With this information in hand, the coalition that she coordinates has been able to go the decision makers and develop a plan for working collaboratively to change policies that would facilitate the development of housing to meet her community's needs. The stories she gathered about lived experiences from community members were critical to getting the decision makers to take the time to work with the coalition.

One outcome of this process, Castro said, was that members of the community became activated to be more involved in the decision-making process, to learn how to run for the school board or an elected position in city and county government, and to explore how to take decision-

[5] This section is the rapporteurs' synopsis of the presentation by Yesenia Castro, the Mid-Columbia Health Equity Advocates coalition coordinator at Nuestra Comunidad Sana/The Next Door, Inc., and the statements are not endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

making positions in the community. Finding that there was no curriculum in Spanish designed to help community members learn how to get more involved in decision making, Castro and her community health worker colleagues built a curriculum, starting with translating Robert's Rules of Order into Spanish. Soon, she and her colleagues began hearing community members say they were part of a committee or that they ran for city counselor. As a result of those anecdotal reports, Castro shifted the focus of her work to help Latinos be part of the region's decision-making groups. She remarked that making these type of connections and doing this kind of educational outreach outside of the traditional realm of health is an important role for community health workers, promotoras,[6] and health navigators. She noted, too, that Oregon's Community Health Workers Association now offers training to certify community health workers.

Castro said that her community was proud to be recognized as a Culture of Health prizewinner, particularly being a rural community where the needs are great and program staff is always thinking about what needs to be done next. However, she said that what she is most proud of is the true collaboration between the decision makers and the community that she and her colleagues have helped foster. Today, she said, community decision makers look to the area's community-based organizations to ask important questions and actively engage community members in the decision-making and policy-change processes. One recent example of what happens when there is true collaboration has been the development of plain language trainings so that documents given to community members, including applications for programs and letters, are now understandable by everyone.

The rural community in which Yesenia Castro works is fortunate to have a newly hired individual whose title is collective impact specialist and whose job is to write grants for the community, Castro said. This is important, she explained, because he will only write grants when there are collaborating organizations participating in a proposed project, which has helped eliminate inter-organizational competition in the community.

In discussing some of the principles of engagement for recruiting members of the community to participate in group discussions and focus groups, Castro said that she gets popular disk jockeys (DJs) or radio hosts at a local nonprofit community radio station to announce meetings. She also schedules these meetings to include dinner and to be after work hours so that people have time to go home, shower or change clothes, and come to a meeting with dignity. She arranges for childcare and even provides a small stipend, particularly for focus group participation. Also important, Castro said, is always reporting back to the community. "Whatever we are asking the community to inform us on or to share stories, we always explain what the project is, what the community is doing, and then offer a space to report back on the results or whatever happened," she said. Having clear goals for a meeting and talking about mutual benefits is an important part of the recruitment process, too. It is also important to remember, she added, to not take too much advantage of people's time and to not expect so much from community members that they get exhausted. She said that transportation, particularly in rural areas, can be a barrier to participation and that acknowledging and discussing historical traumas is also important before starting any conversations about solutions. "Recognizing that and allow[ing] a space to heal is very important," she said.

Castro then said that she and her fellow community health workers are also important recruiters because they are trusted members of the community. "Using community health workers that most of the time are born and raised in the community and are part of the

[6] A promotora is a community health worker. For more information, go to https://www.cdc.gov/minorityhealth/promotores (accessed May 25, 2017).

community is such a key for community engagement of people that live there," she said. One technique that community health workers in her program use in meetings is known as popular education. "When we hold meetings with our community members, instead of sitting down and lecturing like you would typically do in a normal school setting in the United States, we gather in a circle where we can all see each other," she explained. Popular education also involves asking people what they already know about the topic at hand before launching into a discussion. Doing so enables the group to address misguided ideas and information and enables conversation to build on knowledge already in the room.

Popular learning can be fun, Castro said—even for chief executive officers and doctors—and it allows people to retain more information and respect the different learning styles of individuals in a group. As an example of a popular learning exercise, Castro had the workshop participants stand and she then turned on music and threw around a "cabbage" made of green paper layered to form a ball.[7] Each piece of paper had a barrier or challenge to effective community partnerships, and when the music stopped, whoever had the cabbage would peel off a "leaf" and read aloud what was on that piece of paper.

When thinking about how to invert the pyramid of power that George Flores discussed in his opening remarks to the workshop, Castro said that one question to ask is how the process is meaningfully including or excluding people who are affected. For example, a discussion about underage drinking should include teens in the community. When it comes to building relationships, she said, it is important to define clear roles and for everyone at the table to understand why they are there and what they are trying to accomplish. Humanizing the conversation with personal details is another key to relationship building, she said.

LOUISVILLE[8]

McElroy framed his presentation in terms of childhood development work that he does through the Metro United Way. He works with a lot of families in Parkway Place, one of the last two housing projects in Louisville. There, McElroy and his colleagues have been focused on trying to prepare children for kindergarten using the Ages and Stages Questionnaire.[9] This questionnaire, he explained, is a development tool that follows children from birth to age 66 months. Parent administer the questionnaire, which in the process of doing so teaches them about and engages them in their child's early developmental needs. The benefits from using this tool, McElroy said, have been that developmental issues, such as balance problems requiring a relatively simple solution such as inserting tubes into the children's ears, are recognized before they reach kindergarten, where such problems are normally identified.

Part of the process that his program goes through with parents is to have them play with their children in defined spaces, which helps parents better understand the developmental level of their small children. "We are working with parents to connect them with actual activities that are relevant to developmental milestones," McElroy explained. Currently, 250 families are

[7] The video of Castro's activity (starting at the 30:35 minute mark) may be found at the roundtable's website. http://nationalacademies.org/hmd/Activities/PublicHealth/PopulationHealthImprovementRT/2016-DEC-08/Videos/Panel%203/15-Activities-Video.aspx (Accessed March 2, 2017).

[8] This section contains the rapporteurs' synopsis of the presentation by Shelton McElroy, a project manager at Metro United Way and a Change Makers leadership instructor at Jefferson Community and Technical College, and the statements are not endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

[9] For more information, go to http://agesandstages.com (accessed March 31, 2017).

participating in the Ages and Stages project, one result which is that 54.7 percent of children living in Parkway Place are deemed ready for kindergarten, up from 49.3 percent prior to the start of the program. He said that when the program began, there was no penetration in the community. "We thought everybody is going to want to do this with their kids, but we had to build trust in the community first," McElroy said. To do that, he engaged advocates who live and reside in the community to knock on doors and get parents involved and remain engaged in using the questionnaire and working with their children.

Another project in the community, called Heart of Trees, has involved the community's children in planting trees around the housing project. One 11-year-old now thinks of himself as a forester because he learned not only how to plant trees but also how to lead others to plant trees. This project came out of the community deciding to plant trees and beautify the housing project. Each tree planted, McElroy said, represents something, such as resiliency, legacy, and the future hopes and dreams of the community's families.

Concerning the principles of engagement, McElroy discussed the importance of using language that is inclusive, not exclusive when asset framing. Too often, he said, mission statements and requests for proposals use language similar to the following:

- The Center's mission is to transform lives, schools, and **troubled neighborhoods,** from the inside out.
- By using a national model of a **youth violence** reduction and **high-risk student** mentoring program. Designed to operate in **the most trouble-plagued schools** in urban centers with **high levels of crime and violence.**

This kind of language, McElroy said, frames people as being served by a project from a deficit angle, making it harder to see people as assets. One thing that he said he likes about the Live Algoma project is that it did not talk about the community members in this manner, though he said he wondered if that was because the population of Algoma, Wisconsin, is 97 percent white. In other places, he said, it is common for programs to refer to the community members being served using terms such as "minority" and "underserved."

McElroy said that typically there is different language used by the people doing the serving and the populations that they are serving. For example, people who are doing the serving tend to characterize themselves with labels such as:

- Trainer
- Provider
- Mentor
- Stabilizer
- Promoter
- Educator
- Change Agent

Furthermore, the work that they do may be characterized as:

- Value-generating
- Faith-based

- Research-based

In contrast, the communities in which residents live whom the service providers are engaging may be framed in the following manner:

- Troubled neighborhood
- Target neighborhood
- Priority zip code
- Problems of poverty
- Youth violence
- Underserved

Furthermore, the residents in the communities may be labeled:

- Low-income individuals
- [Poor] behavior and life choices
- At risk
- High risk

McElroy stressed that he was not talking about wordsmithing. Rather, he said, it is about recognizing the value that individuals have and who they are at their core. "If I keep framing the conversation around 'high risk' and 'underserved,' I keep anchoring folks' thoughts to actually underserving, and I create a workspace in which there is no sustainability" he said.

McElroy shared a brief example of a very provocative interactive activity that he has used at community meetings to help people to understand asset framing. He asked everyone in the room to stand and find another person who was sitting close to them, then stand in front of the person and look at them and "please tell that neighbor what's wrong with them." People in the room were quite unsettled by this provocative exercise.[10]

In closing, McElroy pointed out that asset framing is about shifting the language and rejecting narratives that denigrate people and instead using language that gets people to work together to build a better society. Instead of saying "at-risk children," reframing one's language could instead identify "children of promise." McElroy said that asset framing is a struggle in the "nonprofit-industrial complex" because it is the language of requests for proposals and annual reports. "How do you release your annual report without sounding like Superman?" McElroy asked. "Nobody needs Superman. We need community. We need collaboration. That is sustainability."

[10] To see McElroy's presentation on asset framing and the group exercise (starting at the 15:31 mark), please go to the roundtable's activity page at http://nationalacademies.org/hmd/Activities/PublicHealth/PopulationHealthImprovementRT/2016-DEC-08/Videos/Panel%203/13-McElroy-Video.aspx (accessed June 6, 2017).

24:1 COMMUNITY[11]

The 24:1 Community comprises 24 small municipalities totaling approximately 40,000 people that make up the Normandy School District in North Saint Louis County. Initially these small municipalities grew out of the "white flight" phenomenon, Co said. They had restrictive covenants and were almost 100 percent white, but over time people migrated out of the dense public housing projects in St. Louis to these communities. In 2008, the foreclosure crisis and other factors led the Normandy school district to the brink of losing its accreditation. As a result, Co said, the mayors and other elected officials of these municipalities started meeting with one another for the first time to strategize on how to work together on problems that were too large for any one of the municipalities to address on its own.

This group of decision makers invited Beyond Housing to work with them on housing issues and soon came to realize collectively that *home* is much more than the house in which people live—that it is about everything that makes up a thriving community. Beyond Housing and its partners developed a robust community engagement process that resulted in the 24:1 Community Plan. This plan calls for the 24 communities to have a unified vision for creating a strong community, successful children, and engaged families. This plan includes a broad definition of health that recognizes that health outcomes are affected by where people live and by factors such as the availability of affordable housing, access to healthy food and affordable retail outlets, and access to good schools that provide quality education and wraparound services such as early childhood development and kindergarten-readiness programs. Responding to community input, the program has already facilitated getting a grocery store and health clinic for the 24:1 community, Co said.

The 24:1 Community's approach to addressing the problems, issues, and ideas identified as the partners created the community plan has been to act on them through collective impact and collaboration. For example, the Five By Age Five coalition includes advocates, community-based organizations, and daycare providers working together to ensure that all children in the 24:1 Community have access to opportunities at an early age that prepare them for kindergarten by age 5. Another coalition is involved in what Co called wraparound services and basic needs, both to address trauma and mental and behavioral health and to ensure that people have clothing and food that make a difference in a child's success in school.

The 24:1 Community has created a few coalitions focused on more traditional health outcomes as well. The Healthy Community Coalition is a cross-sector group of youth and health organizations working to improve child wellness in the community. Initially this coalition focused specifically on childhood obesity, but it has since taken a more holistic view of health. Based on a community health needs assessment that it conducted, the coalition is now starting to expand to deal with health care access and various wellness activities.

One issue that the municipalities in the 24:1 Community face, Co said, is that Saint Louis County, where these communities reside, has not provided them with the same level of support that it has provided for wealthier areas of the county. As an example, during the time when the county had an African-American led administration, the county agreed to fund a health clinic in the area, but after a change in administration the county closed the clinic. "Fortunately, our organization was able to fund another health care provider to come in, but that was a few years

[11] This section is the rapporteurs' synopsis the presentation by Stephanie Co, a special assistant to the president at Beyond Housing's 24:1 Community of North Saint Louis, and the statements are not endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

later," Co said. "That is one example of the importance of focusing on community empowerment within the local community." This is particularly true, she said, in a "super-majority red state" and with a county government that is not interested in making these types of investments in the community. "It is important to do as much as we can individually while continuing to advocate on a larger level," Co said.

Concerning the issue of additional resources and capacities that have been helpful for her program to sustain its community health partnerships, Co said that one resource is having a backbone agency with dedicated staff that keeps the partners accountable. It is also important, she said, to create a common agenda that supersedes individual interests and the agendas of specific organizations. Having funding attached to a specific agenda, which is the case for the Healthy Community Coalition, is helpful, though everyone from the time the coalition was formed was onboard with the larger vision of creating a healthier community even without the availability of grant funding. Trust among the partner organizations and with the larger community has been an essential ingredient for success, Co added, because in the past organizations would come and go and had no permanent status in the community. Recently, Beyond Housing and the 24:1 Community have made a big investment in the community by consolidating all of their offices, which had previously been in more informal spaces such as churches, into a single headquarters in an old school building in one of the municipalities. "Even though it is a symbolic shift, it shows we are committed to this community and are not going to leave," Co said. "We make sure the partners who come around the table are aware of this as well and make sure they are not here for a year to get some grant dollars but are really there for this larger vision."

Co noted, as other speakers had, that every action plan must be based on community engagement and community feedback and not on some projection of what program officers think the community needs. Co added that having both short-term and long-term wins within a coalition is important for maintaining momentum. "We know we have these larger challenges on policy and build environments that we continue to work on, but we also know that having these shorter wins gets the coalitions and partners to continue to be engaged because they see some progress," she said. One of those shorter wins was having the school district score in the provisional accreditation range, which was a major step toward the goal of regaining accreditation. This accomplishment will have a huge impact not only on better educational outcomes for the children in the school district, Co said, but also on both staff morale and pride among community members who have stuck with the school district and worked to regain accreditation.

Co's interactive activity for the session was an example of how to stimulate discussion on coalition forming and power sharing. Co had the workshop participants at each table discuss one of two questions. The first question asked participants to consider whom they would invite to participate in a coalition on child health and wellness in your community. Answers included hospitals, including pediatrics and gynecology; public health and behavioral health departments; health advocates; housing department and homeless shelters; school districts and community college; child care providers and Head Start; community members, including youth and grandparents; the faith-based community; fire and police departments; policy makers; social services; community organizers and connectors; city planners; executive office leaders; Justice system; tenant organizations; business associations; neighborhood associations; libraries; and senior citizen centers.

Co remarked how important it is to invite participation from a broad range of grassroots and community perspectives—which the list reflects—and not just health professional who decide what is best for the community. Her program's coalitions, for example, include youth football coaches, local food pantry volunteers, and a local boxing gym instructor. Getting a range of perspectives is helpful, she said, both for learning what might work and also for turning some ideas into actions.

The second question asked the audience to indicate three key ways and approaches to sharing power and ownership within the group. Answers included

- Ensure that language accessibility for non-English speakers and hearing-impaired individuals is common across all activities
- Develop group principles and a decision-making process
- Develop a situational analysis at the beginning to ensure that everyone participates and contributes equally
- Do not assume that all participants have equal power; reflect on individual positional power
- Engage in group decision making
- Invite individuals who are not like-minded to participate
- Acknowledge the historical context to issues
- Lead from within by defining where group members are coming from and what are their implicit biases
- Use facilitation strategies that enable a democratic process
- Grow a change process that redefines the roles and values of the people in power
- Engage in processes that engender trust and participation
- Ensure transparency in the decision-making process
- Rotate meeting sites and hosts, and use a neutral convener

To this list, Co added that her organization tries to share power, which at coalition meetings is accomplished by having many voices on a meeting agenda so that there is not just one organization reporting on the coalition's activities. Subcommittees can be an important facilitator of power sharing because they can enable members from different constituencies to serve as chairs. So, too, can having one-on-one meetings so that individuals who are uncomfortable speaking in front of groups can provide input. The best meetings also have an interactive social component and food, both to get people to want to come to meetings but also to provide an opportunity for people to engage with one another and get to know people outside of their own social circles. Finally, Co said, it is important to have celebrations.

DISCUSSION

Andrea Manzo opened the general discussion by asking Castro who develops the challenges used as part of the popular education process and whether it is done collectively or by the facilitator. Castro replied that the exercises are developed through a combination of input from everyone in the room and data that may exist about challenges in the community. She noted that it is important to look at these exercises through the lens of equity and empowerment.

Anne De Biasi of Trust for America's Health asked the panelists how they know when they have succeeded in engaging the community. The clearest measure of success, Co said, is trust. "When you feel like you can be invited to the table to work on specific initiatives from the community, that is one form of success," she said. Echoing what Co said, Castro added that creating spaces in which community members feel safe to be and to speak up and not be afraid to ask questions or say "I do not know" is another measure of successful engagement. McElroy said that he sees success in his community when he sees leadership within the community developed and people who were previously excluded now at the table.

Shauneequa Owusu of ChangeLab Solutions asked the panelists how they mitigate or address community fatigue, given that many solutions can take a long time to develop. "How do you keep folks engaged and then pull in those who tend to fall through the cracks or are not engaged at all?" she asked. Co said that her community definitely suffered from fatigue and that this is why she tries to avoid always holding meetings. When seeking community input, she and other program staff may go to grocery stores and ask questions there or form community street teams that go door-to-door and ask people what they think about an issue. Still, she acknowledged, fatigue is a reality when there is so much to do in a community and she has no great answer to that problem.

Castro said that having the members of the community set the agenda is another way to mitigate fatigue because then the conversations are addressing the problems that are most important to them. When people are not showing up at meetings or other events, it is time, she said, to step back and ask if the project is not respecting the community. On the other hand, when meetings are well attended and people continue talking after the meeting is over, that to her is a sign of success. Recently, for example, her program received an additional year of funding, and when she announced that to community, one community member said that the program was so valued that community members would have pitched in five dollars each to keep it going.

Jomella Watson-Thomson added that having early wins and celebrating them can forestall fatigue, though she noted that getting input from the community on how it wants to celebrate those wins is important. Making the work meaningful and framing it as a way to protect the best interests of the community is another key to mitigating fatigue. McElroy said that being realistic about the pace of progress and letting the people who are putting in the effort know that they might not see the end result can help them push through the moments of fatigue.

Teal VanLanen asked the panelists if they had trouble getting system leaders to the table and, if so, if that is a problem of them not feeling comfortable. McElroy said that his approach is to create spaces where community members and system leaders come together to share a meal at round tables. He calls them network nights and said that these have changed the power dynamics of the community. These evening get-togethers have been so well received that he holds them monthly and system leaders regularly attend them.

Mary Pittman from the Public Health Institute asked the panelists how they keep their communities going when their efforts hit a major roadblock and they have to regroup and perhaps go in a different direction or invite additional voices to the table. Castro said that the result of the recent presidential election was just such an event. She had scheduled a meeting for the Thursday after the election that was going to provide a robust training on how to connect with their newly elected legislators. Instead, the community had its usual gathering with food and had the opportunity to talk about what had happened and what the community needed going forward. "Nobody knew, but we all got together and had space to talk about how we felt on the happiest day of our lives, how they felt after the elections, and how they felt today," Castro said.

The meeting also featured several facilitators who had been involved in Oregon politics and who were able to share some of the big wins for the state. She said that while the discussion did not shy away from negative feelings about the election's outcomes, it also raised a number of positive points, such as people registering to vote and voting for the first time.

McElroy said that he is in the middle of just such an event. His employer, Metro United Way, is a funder, not a direct contact organization, but it started Ages and Stages because nobody else was doing it and it needed to be done. Now, however, the program is in what he called a "redesign phase" in which Metro United Way is looking to hand the program off to a local nonprofit organization. For McElroy, this will mean telling the advocates he has worked closely with that they will no longer work for Metro United Way, and it may be that the nonprofit has its own people who will carry on this work. In that case, all of the relationships these advocates have built with the community will vanish. He added that he appreciated Pittman's question because that is the nature of this work. What keeps momentum going at these times is leadership, he said. "Leadership development creates sustainability, so however it pans out, these folks are leaders. They have built their own capacity, and they can go and speak up and advocate for their community without us," McElroy said. "That is sustainability. They do not need us."

Phyllis Meadows from The Kresge Foundation asked a related question about the impact of turnover and what can be done besides leadership development to support communities so that they do not give up in the face of turnover. Castro replied that this is the nature of the nonprofit world, where grants come and go and funding sources can change regularly. While this is the reality and points to the importance of having good grant writers available, a program's hard-earned momentum can be halted by the fact that different granting organizations and requests for proposals can have different deliverables and metrics. In her opinion, she said, it is the responsibility of funders to offer funding that is more long-term and more sustainable for successful programs. Castro recounted how she heard a story at a recent conference about a company that had 10 years of funding to plan for developing its next big product. "If we could do that with our communities," she said, "I can guarantee you there would be a lot of cost savings in health care."

One trend that Co said she saw in the wake of the troubles in nearby Ferguson, Missouri, following the police shooting of Michael Brown was that funding organizations came in with huge short-term grants and expected programs to be sustainable over too short a time. "Sometimes you have to say no even though it looks like an amazing opportunity," she said, because in the long run it will not move the community any closer to its goals.

With regard to staff turnover, Castro said there is often high turnover among paid program leaders who usually have Ph.D.s and master's degrees and who are looking for new opportunities that pay better. Co pointed to the importance of recognizing long-time volunteers and residents in these communities who often have more knowledge about a program than the paid staff and charging these people with being leaders.

In response to a question from Marthe Gold of The New York Academy of Medicine about whether the idea of improving the health of a community serves as a draw to bring people to the table, Castro replied that she recruits people by asking them if they want their community to be a better place, not specifically a healthier place. Co agreed with that approach, particularly when trying to get a community's youth to the table. Once a program has some momentum, she said, then the conversation can be broadened to include health and health care. In his response to the question, McElroy noted how the Robert Wood Johnson Foundation and other funders are

framing health in the broadest possible terms—something that he said he believes the community perhaps has a better grasp on than many practitioners, academics, and health system executives. The members of his community understand that health is housing and economics, and while they may not use the term "health" explicitly, they know that wanting something better for their families and their neighbors is about being healthier.

When asked if any of the panelists' advocacy work had addressed policy change within institutions that can help sustain the positive changes their programs have achieved, McElroy discussed a specific example of doing just that. At one point, a disproportionate number of children in his community were going into the foster care system. Using a strategy developed by a mother in New York who had worked through the system to be reunited with her children and who had begun working to help other families reunite with their children, Metro United Way piloted the same approach and demonstrated that it worked. The Department of Community-Based Services eventually hired this mother and some of the other mothers and fathers who had had engagement with child protective services. These department employees now walk hand-in-hand with families with whom they have a shared experience and help them navigate a case plan developed by their child protective services officers. Nearly a decade later, that program is still heavily embedded in the Department of Community-Based Services.

5

Building and Sustaining Equitable Community Partnerships

To further explore ideas on how to build strong and effective community partnerships, the workshop participants were asked to work at their tables to answer one question that the workshop planning committee had developed per table (see Appendix B for the entire list). After 30 minutes, individual workshop participants shared the discussion highlights they viewed as being relevant, which are described below. These comments should not be construed as reflecting consensus or endorsement by the individuals at a table, the members of the roundtable, workshop participants, or the National Academies of Sciences, Engineering, and Medicine.

The first group discussed the question, What are the principle and practices of engagement and power sharing? Individual workshop participants in the first group shared various ideas, including respect, human connection, and trust; welcoming diverse participants; designing inclusive logistics; acknowledging the history of racism and other isms; acknowledging the power imbalance; having a good reason to partner; establishing balanced group dynamics; replenishing the commons to create a safe space; and building capacity for all partners.

The second group discussed the question, How do you build the relationships and bridges that enable you to work with people who have different viewpoints and personal and institutional positions of power, particularly at moments of community pain and polarization? Individual workshop participants in this group shared various ideas, including asking about aims and pain points; extending an olive branch; leveraging personal relationships, including those of spouses and children; finding a broker or go-between, someone less polarized than the individual in question; identifying and using points of affinity outside of any contentious viewpoints; showing interest in the individual as a person and finding out what his or her favorite things are that are not part of the topic of disagreement; meeting people in non-tense situations; meeting for coffee, for example, before anything is on the agenda; taking baby steps and celebrating small wins; compromising; finding a few powerful leaders to support the cause at hand; and finding a solid reason to convene a meeting.

The third group discussed the question, What are the other barriers and challenges to building and sustaining community partnerships? Individual workshop participants in this group shared various ideas, including distractors; the shifting priorities of funders that move them in different directions; an unfair allocation of resources, such as when an academic group writes a grant but distributes little of it to the community; the lack of funded backbone or core factors that keep programs moving; the lack of a skill base needed to procure needed resources; a lack of team members with the technical expertise to bring programs to fruition; leadership turnover; a

lack of business community engagement; "truthiness in a post-truth world" negatively affecting community perceptions; and a lack of evidence to support commonsense solutions.

The fourth group discussed the question, What is your proudest accomplishment? What has been most meaningful to you in doing this work? Individual workshop participants in this group shared various ideas, including changing a hospital's governance approach to include population and community engagement; getting city officials to put the Live Algoma logo on all city department letterheads, which changed the program from being an initiative to a movement; getting city officials to recognize the importance of the community's voice; the San Francisco Board of Supervisors passing a resolution on what it stands for; getting local officials to be willing to innovate, think differently about problem solving, and learn from outsiders; creating the menu of measures within Measure What Matters; getting state departments to think more creatively about how they can promote equity; and getting state departments outside of the health area to be health allies.

The fifth group discussed the question, Have you made mistakes? Individual workshop participants in this group shared various ideas and noted that although its members were from very different organizations, such as small and large local nonprofits and national foundations, similar mistakes were common. For example, several participants noted that taking a strong advocacy position, meeting only with people who share that position but not taking the time to meet with opponents, demonstrates a lack of respect for others and misses possible opportunities to come together. Other mistakes individual participants noted included failing to be transparent about who is included in a conversation and why, leaving some members of a coalition feeling disrespected and left out of the process; failing to be transparent about what does not work; not having simultaneous strategies for community work and for engaging elected officials; failing to establish checks and balances to prevent the misuse of resources, particularly when increasing staff responsibilities and authority; celebrating a policy win without having a plan for implementing that new policy or policy change; not doing the best job finding the right balance between providing too much structure and stifling creativity, particularly when talking about ideas generated by the young members of a community, and not having enough structure to make meaningful progress on addressing a problem; not trusting the process and coming into a meeting with a savior mentality; getting so involved in organizational branding that the program loses trust and the partners lose agency; failing to recognize the time and work needed to build connections and relationships and having a false sense that connections and relationships will just happen organically; and ignoring the historic trauma that communities face.

The sixth group discussed the question, If you could go back to the beginning and start from scratch, is there anything that you would do differently? Individual workshop participants in this group shared various ideas, including building in a process that reviews what works and does not work with the community's involvement; learning from failure to fail forward and from success; being transparent in every way with community members; and taking a healing approach to community engagement.

The seventh group discussed the question, How can partnerships better use data to inform learning, strategy, decision making, and future actions? Several participants in this group suggested finding frameworks for data use and evaluation that are credible in academic and health sector circles, meaningful for communities, and appropriate for this kind of work, which differs from the type of work that experts in the health sector and academia are trained to conduct. The current data and evaluation industry that the health sector defaults to does not work in the service of community partnerships in that it places too much value on counting and does

not approach evaluation in a deeply participatory manner. There is, however, a data and evaluation industry that works to use methods appropriate to these community partnerships. Many participants in the group also suggested that evaluations may be more democratic if they are participatory in the same way that priority setting and problem solving are in the best partnerships and that actions based on evaluations may be more democratic if the evaluations are participatory.

Many workshop participants in the seventh group also suggested exercising caution in using initiative-wide or national menus of metrics, which are necessary for aggregating successful examples, to the exclusion of community-generated metrics and community-developed approaches to measurement that may better match community concerns. Individual participants suggested that funders incentivize the use of both types of metrics and aggregate both types of metrics as a means of identifying new tools that programs can use. One way of measuring change in partnerships is to ask how people perceive the partnership to be working. Several participants in this group also suggested that social media can provide insights into what community members think about a program and about changes in policies and in the local environment as well as insights into the impacts of programs on social norms, the balance of power, the development of relationships, and the sustainability of relationships and partnerships beyond what gets measured for grant assessment.

The eighth group discussed the question, How can community health partnerships use communications and social media to advance health improvement agendas? Individual workshop participants in this group shared various ideas, including that the first step in communication is listening and trying to define who the audience is and what the issue is, followed by defining a shared vision to ensure that all communications are relevant to the intended audience and have a common language. Several participants noted that it is important to ensure that the vehicles used for communication are both trusted sources and important sources of information in the community. For example, the *Federal Register* is a trusted source of information, but few people read it. Actions as well as language can be used to communicate with the community, that is, making sure the program's presence and accomplishments are visible in the community. Social media, particularly Twitter and texting, can be used as a means of establishing peer-to-peer communication in addition to program-to-community communication. Tweets and re-tweets can generate useful data to gauge message impact. Text messaging can be used as a means of rapid and immediate communication of urgent methods and even to create flash mob events or meetings.

6

Reflections on the Workshop

In the workshop's final session, George Flores of The California Endowment asked the roundtable members and the workshop's other participants to think about what they had heard over the course of the day and to consider the implications of those observations. Flores began the session by repeating an adage he uses in presentations—"Nothing about us without us"—to reiterate the point made throughout the day that communities are intent on making sure that if they are going to be studied or be involved in an initiative, their members should be at the table with shared power, respect, and the capacity and tools to be full participants in the partnership.

He also commented on an important lesson from the recent national elections, which is the importance of thinking more carefully about who has and has not been left out of the conversation, perhaps because it has not been convenient to bring them to the table because their point of view is so different and they come from a different part of the country. It is incredibly important to connect to all sectors in society and with people who have different belief systems, Flores said. It is not sufficient to associate merely with people who support one's point of view, he said.

Another lesson that Flores said he learned from the day was the need to be deliberate in forming partnerships while remembering that there is no one way to form a partnership, no one-size-fits-all approach to community building. Flores also said that he heard about how much hard work it takes to build successful partnerships in communities. "We cannot rush in and expect people to fall in line and for change to happen immediately," he said. "Even if you have the most wonderful idea in the world, you cannot expect that pushing it on others is going to result in change right away."

Flores said that the adage "Go slow to go fast" applies to working in communities. Sometimes, he said, it takes years to gain the trust, participation, and common understanding to build a common vision needed to get a particular task accomplished. He reflected on his work with Building Healthy Communities and how frustrating it can be to wait year after year for work focused on a disease prevention outcome to bear fruit. Going into a community with money and instructions does not produce results if the goal is building community to achieve community change, he said. "It is about giving up that right of making decisions for others and handing it over to the community members to decide for themselves once they have the capacity to do so," Flores said. "Once they have gone slow to build up that capacity and make decisions, they all want that change to happen. They all want a better life for themselves, and once they have the tools and the resources to do that, they will move quickly to make life better for themselves and make the necessary change for improved population health."

Matt Stiefel from the Kaiser Permanente Care Management Institute and 100 Million Healthier Lives said that the day's discussion pointed to the importance of making measurements to serve local communities and of making them meaningful to the people in those communities. While saying that he agrees completely with that idea, he noted it is also important to learn from other places. There is great power, he said, in not having to invent everything locally, and one way to do that is to have a common framework for measurements from which others can learn. "If everything is measured and invented locally, it makes it very hard to aggregate stories, and while stories are powerful, they need to be accompanied by measurement," he said.

His second observation referred to the question that Marthe Gold of The New York Academy of Medicine had asked earlier about whether health is the right way to frame these improvement efforts. He said that he has had discussions with people in the population health field about changing the slogan from "Health in all policies" to "Well-being in all policies," but after today, he said, he wondered if the goal should be to improve communities.

Karen Ben-Moshe of the California Health in All Policies Task Force remarked that Shelton McElroy's comments on the harm of labeling communities as disadvantaged communities are important to remember. "How do we do right by communities without retraumatizing them through the way that we talk about them?" she asked.

Thomas Kottke from Health Partners spoke about some relevant lessons learned from studies using functional magnetic resonance imaging to identify five qualities of social interaction that can enable the brain's reward response: status, constancy, autonomy, relationships, and fairness (SCARF). Going into a community and telling the community what to do to solve their problems lowers their status and their autonomy. Taking that approach does not foster relationships, and it leaves people feeling that they are being treated unfairly. It should be no surprise then, he said, that people's brains freeze up. "So if we use that acronym SCARF to think about how we approach people," Kottke said, "we give them status by asking them how they would like to approach a problem. We do not make too many changes. We give them autonomy. We create relationships, and we treat people fairly."

Mary Lou Goeke from United Way of Santa Cruz (California) County remarked how hopeful she was after hearing the inspirational stories from all types and sizes of communities from around the country. She also recounted something that Alexis de Tocqueville wrote in his book *Democracy in America* some 200 years ago, which was that Americans are really curious in that they love to help each other out, and not just in their village or among people of their own origin. Today, she said, she has witnessed that same phenomenon, with people sharing with each other a great deal of skill and commitment and knowledge, which fills her with hope about what community partnerships can achieve together.

Soma Stout of the Institute for Healthcare Improvement also said she was inspired by the stories from these communities and wondered how much more would be gained by letting go of privilege and not needing to be the saviors of communities and instead trusting communities to be able to create their own healing with the support of programs such as the ones discussed during the day. "I wonder what if, instead of funding communities to do the things that we think are needed to create change, if we funded communities to make progress on their journey of transformation for growing their own capacity, and for learning what it takes, wherever they are at, to be making progress on that journey," she said.

Stout then noted that she and her colleagues at the Institute for Health Improvement have been looking at data on organizations that are trying to make changes. The difference between the ones that are performing and achieving outcomes and savings and those that are not, she said,

is that the ones that are achieving outcomes chose to do it because they thought it was the right thing to do. "I think that there is an important lesson to be learned in that," she said. "I think there is enormous inefficiency to believing we know what is right and to let the money be the driver of sustainability. I wonder what it looks like to let our belief in community and the abundance that community has within it be the driver for doing what we do and what the implications would be for us as funders if we were to be able to invest in that."

Gold remarked that the day's discussions had inspired her at a time when she needed some inspiration. However, she said, the idea of bringing everyone into a room and finding common ground does not always work for her when thinking about engaging people who have points of view that are not just and not fair. She has seen tension in discussions about how broad a canvas one draws so that everybody comes under the umbrella versus having to argue, fight, and prevail when others think so differently. "I think there is great work do be done for people who want to work together to achieve good things with justice and fairness, but I think there are many people who do not think that way, and we have to be careful not to be too Pollyannaish about this issue," she said.

Dory Escobar of Escobar & Associates said that she was thinking the same thing as Gold but was leaning toward a different conclusion. "I believe that if we put more focus on shared values and the principles around which we are willing to work together, then that to me makes it clearer about who is going to be in the room and the sector they represent," she said. "If people do not want to work together, they are not going to show up." She recounted experiences in which there were significant disagreements about goals, strategies, or tactics and discussions had to stop to call out the disrespect being shown for someone's values before agreeing to disagree and moving on. "That requires first building human relationships and being explicitly in agreement that we have the will to do that," Escobar said. "If not, then people self-select or they are invited not to participate."

Pete Knox reflected on several things he heard during the day. "This is about empowering communities to dream and realize those dreams, and about empowering the many to have a stronger voice," he said. Too often in too many communities, he said, the voices of the few dominate the voices of the many, but as the stories shared over the course of the day showed, creating the collective voice of the community to speak about what the community wants to achieve can produce meaningful change that benefits all.

Knox also remarked that there are lessons to learn from why there are so many failures, and he said he believes that studying those failures could produce a roadmap or a set of common features that could provide guides to success in creating momentum going forward. "I think there is a common set of principles, concepts, and building blocks that can be put into that roadmap," he said. "I do not think as we move into the future that we can continue to tell our stories in all different languages. I think that at some point we have to develop common language and be able to tell common stories."

Bobby Milstein from ReThink Health took Knox's idea one step further. "I think the examples that we have seen here today are very inspiring, but they are not the norm," he said. "I am wondering whether the synthesis of the practice that we are seeing here ought not [to] develop into defining new standards for the field about what is expected when you are in a situation of trying to orchestrate change at this level with so many stakeholders and processes that need to get fulfilled." He said that he does not see any inconsistency in saying on the one hand that there is not a dogma and a formula for success but on the other hand that there are standards of excellence for doing this work. "I think we have seen some examples of that here,

and I do not think we are all that far away from being able to summarize some of those," he said. "I would love to see the field go in that direction."

Anne De Biasi wondered if agency, gained through community engagement as a strategy, can have a positive impact on the community by empowering it. "This could be a new way of thinking about community engagement for public health," she said, "and I am interested in working to develop policies on how to move that forward." She explained that this idea is something that came up when the Trust for America's Health held focus groups with the NAACP and Salud America! to explore why obesity prevention programs in African-American and Latino communities were not producing the expected results.

Gillian Holey, an independent consultant, said that one thing she has learned from managing complex change in Fortune 500 companies is that it is important to look at the world through someone else's eyes and to step into that person's shoes to build understanding as a starting point for change. Trying to push change through someone who is resisting will often lead to that person undermining the change process. Talking about why that person is resisting change and understanding those reasons can make the ultimate solution better and more successful, she said.

Mary Pittman commented that she also felt hopeful after hearing the workshop's presentations, but she cautioned that the room was full of shared values. "I am concerned that we are facing a big tsunami of change that is going to come that is not based on the shared values of the community work we talked about today." Pittman noted that the speakers presented some good ideas on how to frame this community's work in a way that can be open and accepting of others, but she said she is fearful that she does not have the tools to be able to address some of the challenges ahead to keep this great work in communities going forward. "I am hoping that we can continue this dialog in a learning mode and activist mode to make sure that we do not lose sight of these values that have really driven all of this wonderful work that we have talked about today."

Shelton McElroy reminded the workshop that the work this community does is often a matter of life and death. "We are talking about 9-year differences [in life expectancy] from one zip code to another zip code, so we have to have a sense of urgency and determination in spite of the obstacles we face."

José Montero from the Centers for Disease Control and Prevention commented that the only way to identify the real needs of the nation is through community work. "Community work is what will keep us on track and allow [us] to know toward what end we are moving," he said. It will be important going forward to figure out how to moderate the factors about which Pittman and Gold expressed concern, he said. "If we are unified and believe we are going in the right direction, we will get there, but we need to be systematic in the way that we define the goals, in the way that we assess them, in the way that we provide the results, and the way that we interact with organizations." Montero also agreed with Knox's earlier comment that there are important lessons to learn from what did not work if for no other reason than that it may prevent other groups from wasting time and resources and perhaps losing the opportunity to achieve meaningful change.

George Isham from HealthPartners reflected on the comments Flores made at the start of the workshop about power and racism and other isms and wondered how the events of the recent national election will affect how those issues play out at the community level. He also noted Gold's question about the role of health relative to other framing with regard to the work being

done in communities. "I think about education, economics, and race and wonder about those relationships and how they should be framed versus wellness," he said.

Another item he mentioned was the recent spate of news stories about falling life expectancy in the United States, and he noted that increasing life expectancy and quality of life, along with addressing disparities across the population, are central to the purpose of the roundtable. The challenge, Isham said, "is thinking about the complexity of the different levels at which these various questions arise and trying to get clear about what messages we should be thinking about in terms of that complexity so that we can convey messages to people that want to take action, whether they are in communities, organizations, or local, state or federal governments." He noted, too, that the tremendous examples of activism and inspiring leadership at the local level presented at the workshop seem to occur irrespective of what is going on at the national level, and that is something to tap into. "Quite frankly," he said, "it is a strength that we need to admire, be part of, and be inspired by."

Isham pointed to the importance of McElroy's statements about framing and language and the need to truly see one another, and he thanked him for bringing those ideas to the table. Isham then commented on the tension Stiefel discussed between the need for both national metrics and standards and those developed by the community, and he said that it is possible to do both. In his home state of Minnesota, for example, there is a strong commitment to measuring things by national standards but also a strong commitment to measuring things by Minnesota standards. "They are not in conflict with one another," he said.

Sanne Magnan said that the day's discussions brought to mind a paper she and a number of individuals at the workshop wrote nearly a decade ago in which they proposed a vision of a community-based reinforcing loop in which health care would save money, some of which could be reinvested into communities to make them stronger. The paper was rejected by one journal after another, and, as she recalled, one physician said, "Why would anyone ever give up their margins to put it back into the community?" Given that experience, she said it was almost unbelievable to hear that Algoma and Bellin Health are actually making that vision a reality. "It just reminded me," she said, "about the importance of vision and of having an idea whose time is not quite right, yet you hold on to that idea and keep working at it, thinking about it, and promoting it."

Concluding her comments, Magnan said that the roundtable's vision of building a strong, healthful, and productive society that cultivates human capital and equal opportunity was evident in all of the stories recounted over the course of the day. To her, the common theme among these stories was deep listening and the importance of being heard in the midst of conflict. "That is the first step toward any resolution, and that resolution is possible if we believe it." On that note, Isham thanked all of the speakers for their outstanding presentations and adjourned the workshop.

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References

Aspen Institute Roundtable on Community Change. 2004. *Structural racism and community building.* Washington, DC: The Aspen Institute. http://www.racialequitytools.org/resourcefiles/aspeninst3.pdf (accessed May 24, 2017).

Bridging Health and Community. 2016. *Our inaugural symposium: Bridging health and community*. October 6. https://www.healthandcommunity.org/updates/2016/11/18/our-inaugural-symposium-bridging-health-and-community (accessed May 1, 2017).

Burke, Natalie S. 2016. Losing your privilege: 5 stages of grief + 1. *Medium.* https://medium.com/@natalie4health/5-stages-of-grief-1-f90137b756 (accessed May 1, 2017).

Dieng, J. B., J. Valenzuela, and T. Ortiz. 2016. *Building the we: Healing-informed governing for racial equity in Salinas.* Oakland, CA: Race Forward: The Center for Racial Justice Innovation.

Douglass, F. 1857. Two speeches by Frederick Douglass: One on West India emancipation, delivered at Canandaigua, Aug. 4th, and the other on the Dred Scott decision, delivered in New York, on the occasion of the anniversary of the American Abolition Society, May 1857. https://archive.org/details/ASPC0001937700 (accessed May 24, 2017).

IOM (Institute of Medicine). 2011. *For the public's health: Revitalizing law and policy to meet new challenges*. Washington, DC: The National Academies Press.

———. 2014. *Supporting a movement for health and health equity: Lessons from social movements: Workshop summary*. Washington, DC: The National Academies Press.

———. 2015. *The role and potential of communities in population health improvement: Workshop summary*. Washington, DC: The National Academies Press.

Kania, J., and M. Kramer. 2011. Collective impact. *Stanford Social Innovation Review*, Winter. https://ssir.org/articles/entry/collective_impact (accessed May 20, 2017).

Moyer, Bill, J. McAllister, M. L. Finley, and S. Soifer. 2001. *Doing democracy: The MAP model for organization social movements.* Gabriola Island, British Columbia, Canada: New Society Publishers.

National Museum of American History. n.d. *The Star-Spangled Banner*. Smithsonian Institution. http://amhistory.si.edu/starspangledbanner/the-lyrics.aspx (accessed March 21, 2017).

The New York Times. 1860. Mr. Lincoln and Negro equality. December 28. *The New York Times.* http://www.nytimes.com/1860/12/28/news/mr-lincoln-and-negro-equality.html?pagewanted=all (accessed March 30, 2017).

U.S. Supreme Court. 1859. *Dred Scott vs. John F. A. Sanford*. The Dred Scott decision: Opinion of Chief Justice Taney. https://www.loc.gov/resource/llst.022/?sp=10 (accessed March 21, 2017).

B

Workshop Agenda

Roundtable on Population Health Improvement
Exploring the Infrastructure of Multisector Community Health Partnerships: A Workshop
December 8, 2016

James Irvine Conference Center
Kaiser East Bay Community Foundation, Oakland, California

WORKSHOP OBJECTIVES

1. Explore multisector community health partnerships that engage residents, reduce health disparities, and improve health and well-being with the aim of understanding the following:
   a. Common elements (including measurements, evaluation tools, methods, strategies) used by partnerships that can be shared with others.
   b. Models or strategies that engage residents on a continuum from initial engagement through leadership development and sustained participation in community health improvement over time.
   c. Strategies or infrastructure that contribute to overcoming health disparities and improving overall community health and well-being, particularly for the most vulnerable residents.
   d. Potential co-benefits that accrue to communities and institutions that participate in multisector partnerships.
2. Engage speakers from a range of multisector partnerships in a structured way about what they have learned makes their partnerships and initiatives effective and the challenges that they have had to overcome in order to create change in their community.
3. Engage workshop participants in a structured discussion with the goal of developing a list to be included with the proceedings that lists strategies for sharing power and engaging with different partners in developing and sustaining multisector collaborative relationships.

8:30 a.m. **Welcome and Overview of the Day**

Sanne Magnan, co-chair, Roundtable on Population Health Improvement

George Flores, senior program manager, Healthy California Prevention Team, The California Endowment; chair, planning committee; member, Roundtable on Population Health Improvement

9:00 a.m.	**Community-Driven Approaches and Perspectives on Building Healthy Communities** *Moderator: Anthony Iton, senior vice president for Healthy Communities, The California Endowment* *Speaker: Kanwarpal Dhaliwal, co-founder and community health director, RYSE, Richmond, California* *Speaker: Andrea Manzo, hub manager, Building Healthy Communities, East Salinas, California* *Speaker: Dawn Phillips, co-director of programs, Causa Justa: Just Cause, Oakland, California*
10:00 a.m.	**Q&A Discussion Facilitated by Tony Iton**
10:30 a.m.	**Break**
10:45 a.m.	**Approaches and Perspectives on Community Engagement in Partnerships to Improve Community Health** *Moderator: Soma Stout, executive lead, 100 Million Healthier Lives, Institute for Healthcare Improvement; member, planning committee* *Speaker: Will Douglas, manager, community impact, Tenderloin Health Improvement Partnership, San Francisco, California* *Speaker: Jennifer Lacson Varano, manager, Community Benefit and Emergency Management, Tenderloin Health Improvement Partnership, San Francisco, California* *Speaker: Teal VanLanen, community activator, Algoma School District and healthy children team lead, Live Algoma, Wisconsin* *Speaker: Pete Knox, executive vice president, Bellin Health, and chief learning and innovation officer, Live Algoma, Wisconsin*
11:45 a.m.	**Q&A Discussion Facilitated by Soma Stout**
12:15 p.m.	**Lunch**
1:00 p.m.	**Approaches and Perspectives on Community Engagement in Partnerships to Build a Culture of Health** *Moderator: Jomella Watson-Thompson, associate professor, Applied Behavioral Science; associate director, Work Group for Community Health and Development; University of Kansas; member, planning committee* *Speaker: Shelton McElroy, project manager, Metro United Way, and Change Makers leadership instructor, Jefferson Community and Technical College, Louisville, Kentucky* *Speaker: Yesenia Castro, Mid-Columbia health equity advocates coalition coordinator, Nuestra Comunidad Sana and The Next Door, Inc., Columbia Gorge Region, Oregon and Washington* *Speaker: Stephanie Co, special assistant to the president, Beyond Housing, 24:1*

	Community, North Saint Louis, Missouri
2:00 p.m.	**Q&A Discussion Facilitated by Jomella Watson-Thompson**
2:30 p.m.	**Break**
2:45 p.m.	**Table Discussion with Speakers and Community Members** *Each table should identify a facilitator/reporter and develop a list with examples that answer questions* (this is a draft list of questions that will be revised and modified before and during the workshop): 1. W*hat are the resources and capacities needed to initiate and sustain community health partnerships?* *a. Human resources (e.g., skills, abilities, specialized knowledge, expertise, experience, leadership development, relationships)* *b. Organizational resources (e. g., backbone, health integrator, dedicated staff)* *c. Financial resources (e.g., sources of startup and sustainable funding, foundations, corporations, government funding streams, braided funding streams)* *d. Informational resources (e.g., data collecting and sharing; technical support)* *e. Communication resources (e.g., in-person and online meetings or webinars, social media, listserv)* *f. Policy (e.g., local, state, federal)* *2. What are the principles and practices of engagement and power sharing in multisector community partnerships (e.g., language, roles, leadership development, individual residents, and institutional relationships)* *3. How do you build the relationships and bridges that enable you to work with people that have different viewpoints and personal and institutional positions of power, particularly at moments of community pain and polarization?* *4. What are the (other) barriers and challenges to building and sustaining community partnerships?* *5. What is your proudest accomplishment? What has been most meaningful to you in doing this work?* *6. Have you made mistakes? If you could go back to the beginning and start from scratch, is there anything that you would do differently?* *7. How do partnerships use data to inform learning, strategy, decision making, and future actions?* *8. How are partnerships evaluated and their impact measured?* *9. How can community health partnerships use communications and social media to advance health improvement a*gendas?

3:45 p.m.	**Report Out and Discussion in Plenary**
4:30 p.m.	**Closing Remarks and Reflections on the Day** *George Flores* *George Isham, co-chair, Roundtable on Population Health Improvement*
5:00 p.m.	**Adjourn**

URL: nas.edu/pophealthrt ● Email: pophealthrt@nas.edu ● follow the conversation #pophealthrt

C

Communities of Solution

A WORKING MODEL BASED ON SCALE AND COMMUNITY BRIGHT SPOTS DEVELOPED BY 100 MILLION HEALTHIER LIVES[1]

Provided By Soma Stout, 100 Million Healthier Lives, Institute for Healthcare Improvement, December 8, 2016

How people related to each other	How the community creates abundance
• They have gone from treating a community like a hierarchical organization and see it instead as a living organism made up of connected, interdependent parts—dynamic and responsive interchange between groups and levels • People with lived experience work together with community connectors and formal leaders to co-design and drive the change • A critical mass of people see themselves as stewards of the community's well-being, with the agency and capacity to create change • Leaders across the community work together strategically to create the systems and policies needed to sustain long-term change • They prioritize equity and create change process that grows equity (ownership) of those with lived experience	• Leaders across sectors in a community coordinate and leverage their assets in usual and unusual ways to address the priority needs of the community, using an anchor institution approach • They have the trust and governance processes in place to share resources and accountability • They prioritize the unlocking of trapped and untapped potential in people and organizations as a pathway to abundance • They see the development of leaders and their ability to contribute to the solutions at every level of the community as a key part of creating abundance • They invest in a change process which is dynamic and grows engagement, relationship, capacity, and the will for change

[1] For more information, see http://www.100mlives.org (accessed May 1, 2017).

Individual Participant Questions and Comments about the 100 Million Healthier Lives Communities of Solution Framework

Many workshop participants discussed the Communities of Solution handout at their tables and generated written questions and comments that were collected by staff at the end of the panel session.

Individual participants had the following questions and comments about how the framework characterizes how individual people and communities relate to each other: How is community defined? Who is in the community? Are leaders part of the community or separate from the community? If people work in the place but do not live there, are their commitments to the community? How do we bring different groups together in a way that builds trust? How do we ensure that we aren't simply responding to the group with the loudest voice? How do you address privilege in relationships and at the community level? How do you elevate the understanding of privilege? How do we change our language to move beyond "us" and "them"? How does a heterogeneous community relate in terms of a critical mass of people who see themselves as the stewards of the community's well-being? How small do you get in order to make change? How are you/your community acknowledging how the system became inequitable, the history? What are we trying to change in the community? How do we ensure that we're not simply changing who the dominant group is in a community? At the outset, are some people inhibited from full open conversation because they feel (a) dehumanized, (b) blamed for bad behavior? Does productive conversation require "naming" of systemic barriers like systemic racism or root causes at the structural level? Do you value acknowledging past inequities, isms, etc., to promote healing?

Some individual participants commented that there were missing elements from the framework, such as a vision of a healthy community that accounts for communities with significant multi-dimensional challenges, i.e., defining success at the earliest stages (e.g., simply having a young person walk through the door of a community center can be a success but is missing from this framework). Also missing is how to create abundance as you work with the community, ensure opportunities for not just sector leaders at the table, but look for opportunities for community members—e.g., employee wellness programs that benefit the community of employees (but if employees don't live in geographical area, look at impact for the geographical community).

Individual workshop participants also had a few questions about the nature of institutions in this framework, such as: Ultimately, the important decisions about resource allocation and policy are made by our democratic institutions in our representative democracy. How far can we go without them? How do we engage them if they aren't already engaged? How do you develop the will and ability of institutions to shift the way they do business so that they are more inter-connected with others and more likely to exchange resources beyond their narrow lines of work?

Individual participants also asked about challenges to the change process, such as: What is the resistance? Should name so can address barriers. How do you gauge the level of resistance or pitfalls that might stand in the way or otherwise defeat a proposed process? What is the ignition? Leadership? What are the rules of evidence that we are actually changing? Could you create a succession plan to develop residents as the future leaders? Is it necessary to think about a longer time horizon when doing this work? How do you overcome the temptation for short-termism to eclipse long-term investments? How do you plan from the start for spread and scale? How do you sustain this work over time? What have we learned about sufficient activation energy to sustain improvement? What are the feedback processes or input processes to learn

from previous work? How does the health care delivery system engage—hospitals, doctors, clinics, others? What kinds of metrics are used?

D

Speaker and Moderator Biographical Sketches

Yesenia Castro is the Mid-Columbia Health Equity Advocates Coalition Coordinator with Nuestra Comunidad Sana and The Next Door Inc. Ms. Castro was born and raised in Hood River, Oregon. She studied public health and merchandising management at Oregon State University and proceeded to work in the Mid-Columbia Region to ensure Latino inclusion and voice in community initiatives related to education, housing, transportation, immigration, access to healthy food, and access to free or reduced physical activities (the social determinants of health). Ms. Castro is the oldest child of Mexican immigrant parents and has four other siblings. As soon as she could speak, she was advocating for her parents; now she advocates for her community as a certified community health worker. Passionate about social justice and equity, this was a natural fit at her current job with The Next Door Inc.

Stephanie Co has worked in community development in St. Louis for the past 7 years and has a passion for working to advance racial equity in cities. Ms. Co currently serves as the manager of public policy and special projects at Beyond Housing, a community development organization based in North St. Louis County, where she leads public policy efforts, neighborhood marketing, and strategic projects. Previously, Ms. Co served as the special assistant to the president of Beyond Housing, and she continues in her current role to support the organizational leadership. Ms. Co has volunteered with a range of affordable housing, education, food access, and transportation projects, boards, and committees and currently serves as a board member of Citizens for Modern Transit. Ms. Co earned her B.A. at Washington University in St. Louis and is an M.P.P.A. candidate at the University of Missouri–St. Louis.

Kanwarpal Dhaliwal is one of the co-founders of RYSE and currently serves as its community health director. Prior to her time with RYSE, Ms. Dhaliwal worked as an independent consultant and has more than 15 years of experience in facilitating and developing cross-sector collaborations, organizational development and strategic planning, and community-based and community-driven planning, organizing, and advocacy. Her work spans the fields of supportive housing, intergroup relations, violence prevention, youth leadership, Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) advocacy, and immigrant rights. Ms. Dhaliwal holds a master's in public health degree and is an instructor at San Francisco State University.

Will Douglas is a public health professional with project, team and departmental management experience both in for-profit and nonprofit settings. His expertise is in public health, evaluation, data collection and analysis, software-as-a-service technology, and community engagement. Mr. Douglas has broad experience with community health needs assessments, implementation strategy design, evaluation data collection and analysis, community health and health care, project facilitation, and group collaboration. He has worked in a variety of sectors, including public health, information technology, regional planning, and emergency management. Mr. Douglas holds a bachelor of arts degree in international relations from the University of California, Davis. He also studied at Lund University in Sweden and the University of Barcelona in Spain.

George Flores, M.D., M.P.H., is a senior program manager for The California Endowment's Healthy California Prevention team. He manages grants and oversees programs that strengthen primary prevention and the practice of health equity; link health care, public health, and community-based prevention; get the public involved in improving conditions for health; and increase the number of diverse health professionals practicing in underserved places. Previously Dr. Flores was a public health officer in San Diego and Sonoma Counties; a clinical assistant professor for the University of California, San Francisco Family Practice Residency Program; the director of Project HOPE in Guatemala; and a deputy health officer in Santa Barbara County. His M.D. is from the University of Utah and his M.P.H. from Harvard University. Early in his career he served in the National Health Service Corps and practiced family medicine in the Santa Maria, California, area. He is a member of two Institute of Medicine committees that published the milestone reports *Preventing Childhood Obesity: Health in the Balance* and *The Future of the Public's Health in the 21st Century*. He is a member of the National Academiesof Sciences, Engineering, and Medicine's Health and Medicine Division Roundtable on Population Health Improvement, which recently published his Perspective, Democratizing Health: The Power of Community. Dr. Flores is a founder of the Latino Coalition for a Healthy California. Over his career, Dr. Flores's work has addressed primary care, health policy, international health, obesity and chronic disease prevention, community prevention, health disparities, health workforce, and environmental policy. Dr. Flores's work has been published in the *Journal of the American Public Health Association*, *American Journal of Preventive Medicine*, and *Preventing Chronic Disease*, among others. He is co-author of Latino Children's Health and the Environment in *At Risk! Latino Children's Health*. Dr. Flores was recognized by the National Hispanic Medical Association as 2011 Physician of the Year and is the American Public Health Association's 2016 Helen Rodriguez-Trias Social Justice Award recipient in recognition of his careers' work to improve health and equity for the underserved and for Latino communities in particular.

Anthony Iton, M.D., J.D., M.P.H., is a senior vice president for healthy communities at The California Endowment, a private, statewide health foundation whose mission is to expand access to affordable, quality health care for underserved individuals and communities and to promote fundamental improvements in the health status of all Californians. Prior to that Dr. Iton served for 7 years as the Alameda County Public Health Department director and health officer, overseeing an agency with a budget of $112 million with a focus on preventing communicable disease outbreaks, reducing the burden of chronic disease and obesity, and managing the county's preparedness for biological terrorism. Dr. Iton's primary interest is the health of disadvantaged populations and the contributions of race, class, wealth, education, geography, and employment to health status. He has asserted that in every public health area of endeavor, be it immunizations, chronic disease, HIV/AIDS, sexually transmitted diseases, obesity, or even disaster preparedness, public health practitioners must recognize that they are confronted with the enduring consequences of structural poverty, institutional racism, and other forms of systemic injustice. He further asserts that the only sustainable approach to eliminating health inequities is through the design of intensive, multisectoral, place-based interventions that are specifically designed to identify existing assets and build social, political, and economic power among a critical mass of community residents in historically under-resourced communities. In the fall of 2009 Dr. Iton moved to The California Endowment to help oversee the organization's 10-Year, Multimillion-Dollar Statewide Commitment to Advance Policies and Forge Partnerships to Build Healthy Communities and a Healthy California. Dr. Iton received his medical degree at Johns Hopkins Medical School and subsequently trained in internal medicine

and preventive medicine at New York Hospital, Yale University, and the University of California, Berkeley, and is board certified in both specialties. Dr. Iton has also received a law degree and a master's of public health from the University of California, Berkeley, and is a member of the California Bar. He has worked as an HIV disability rights attorney at the Berkeley Community Law Center, a health care policy analyst with Consumers Union West Coast Regional Office, and as a physician and advocate for the homeless at the San Francisco Public Health Department. His experience practicing both medicine and law independently has enabled him to blend both disciplines in the day-to-day practice of public health and in responding to recent public health emergencies such as SARS and anthrax. His awards include the Champion of Children Award from the United Way, the National Association of City and County Health Officials Award of Excellence for the use of information technology in public health, the 2009 Clean Air Award from Breathe California, and the HeartSaver Award from the American Heart Association. In 2006 he was awarded the prestigious Milton and Ruth Roemer Prize for Creative Public Health Work, awarded by the American Public Health Association to a U.S. local health official in recognition of outstanding creative and innovative public health work. In February 2010 Dr. Iton was recognized by the California Legislative Black Caucus with the Black History Month Legends Award and presented on the floor of the California State Assembly with a resolution memorializing his life's work and achievements. He serves on the board of directors of the Public Health Institute, the Public Health Trust, the Prevention Institute, and Jobs For The Future, and he formerly served in various leadership roles at the Health Officers Association of California, the California Conference of Local Health Officers, and the National Association of County and City Health Officials.

Pete Knox has been associated with Bellin Health System in Green Bay, Wisconsin, in a variety of leadership roles for the past 34 years. Bellin has been on the leading edge of quality for many years and is recognized nationally for superior results. Currently, Mr. Knox is the executive vice president and chief learning and innovation officer. In this role he is responsible for population health strategies, physician networks, employer strategies, learning and innovation, and the execution of strategy. In addition, he is a consultant for health care and non-health-care organizations and is a senior fellow at the Institute for Healthcare Improvement. His book *The Business of Healthcare* is used by a number of universities and organizations across the country, and he is currently working on a second book, *The Strategy Execution Playbook.*

Andrea Manzo is a hub manager for the East Salinas Building Healthy Communities (BHC), a 10-year initiative funded by The California Endowment. Her role is to support the BHC initiative, including its grantees, by forging relationships with community and government to ensure meaningful collaboration. She is an advocate for authentic community engagement and is passionate about supporting youth to be agents of change and opportunity in their community. In partnership with the City of Salinas, she co-leads the Salinas Governing for Racial Equity (GRE) Steering Committee and leads the BHC GRE Action Team, which focuses on implementing racial equity policies and practices within local government. As the daughter of immigrant parents, she is deeply rooted in her culture. She grew up in Salinas and received her bachelor of arts degree in Chicana/o studies and French studies from the University of California, Santa Barbara. In 2015 she was honored as one of the Women of the Year by the Monterey County Commission on the Status of Women, which commended her work with youth on the only nationally youth-led open streets event, Ciclovía Salinas.

Shelton McElroy, M.S., is the Change Makers Leadership Instructor at Jefferson Community and Technical College (JCTC), where he teaches classes and helps students with personal and career development. Mr. McElroy is also a recruiter for the school's Samuel Plato Academy, which teaches historical preservation skills to students. In addition to his work at JCTC, Mr. McElroy is part of the Metro United Way's Ages and Stages program, which helps new parents monitor their children's development, and he works as a parent advocate helping foster children reunite with their families. Mr. McElroy was raised in the Cotter Homes housing project by a single mother of three, who lost custody due to substance abuse and mental health issues. Between the ages of 3 and 18, he lived in 25 different foster homes, usually in rural Kentucky away from any relatives. Mr. McElroy was sent to prison at 18 for trafficking in marijuana and burglary. At 25, Mr. McElroy got out of prison and returned to Louisville for the first time since he was a child. That is when his life began its upward trajectory. Through the Change Makers Program, where he teaches today, Mr. McElroy found his niche in human services. He earned an associates of arts from JCTC and 12 months later received a B.A. in human services and counseling from Lindsay Wilson College. He also has a master's degree in education and human development from the same school and may pursue a Ph.D. "I'm trying to use my own experience to guide other disadvantaged youth," Mr. McElroy said. "I went from the walls of prison to the halls of academia. If I can make that journey then anything is possible."

Soma Stout, M.D., M.S., has worked as a primary care doctor and health system transformation leader in the safety net for more than 15 years and in global community and population health for over 20 years, working with health care systems and communities which have made remarkable strides to improve individual, community, and population health, well-being, and equity. She currently serves as the executive lead of 100 Million Healthier Lives, convened by the Institute for Healthcare Improvement, to support 100 million people globally to live healthier lives by 2020. Previously, she served as the vice president for patient-centered medical home development at Cambridge Health Alliance (CHA), where she led a whole-system transformation that aligned large-scale payment reform with delivery system redesign to meet the needs of populations. The CHA transformation garnered numerous national awards for achieving breakthrough results in the triple aim of better health, better experience, and lower cost while improving joy and meaning of work for providers and staff. In 2012 she was awarded the Robert Wood Johnson Foundation Young Leader Award for her contributions to improving the health of the nation. She has consulted with health system leaders from across the world in Australia, Brazil, Guyana, Singapore, Sweden, and the United Kingdom. She also directs the Innovation Fellows Program at Harvard Medical School Center for Primary Care, where she is helping to grow a generation of change leaders who can create the needed changes in health and health care, and she continues as the lead transformation advisor at CHA.

Teal VanLanen is a community activator with the School District of Algoma, Wisconsin, and the Healthy Children team lead for Live Algoma, a community coalition. Ms. VanLanen focuses on using Institute for Healthcare Improvement science and ways of being to drive wellness within the community of Algoma, located a little south of Green Bay, Wisconin. Ms. VanLanen's journey within the community started as a fifth-grade teacher, teaching the kids of Algoma for 8 years, and she was also the wellness coordinator for the school staff. Her two worlds joined together about 1 year ago as she moved into a leadership role in directing the wellness center for the community. Today she focuses on empowering individuals, young and old alike, to share their passions and lived experience in order to improve health and well-being within the community.

Jennifer Lacson Varano, M.P.H., is a health care professional with experience in nonprofit and private health care settings. In her role as the director of community health, volunteer services, and emergency management at Saint Francis Memorial Hospital (SFMH), Ms. Varano oversees the development and implementation of the community benefit plan, social accountability reporting, and grants administration. She also provides planning, backbone, and community health outreach support to the hospital's community advisory committee and Tenderloin Health Improvement Partnership initiative. Ms. Varano holds a bachelors of arts in public health policy from the University of California (UC), Irvine, and a masters of public health from UC Berkeley

Jomella Watson-Thompson, Ph.D., is an associate professor of applied behavioral science and an associate director with the Work Group for Community Health and Development at the University of Kansas. As an applied scientist, her mission is to cultivate healthy, safe, and prosperous communities through the integration of research, teaching, and service that fosters meaningful improvements in people's lives. Through engaged scholarship, her teaching, research, and service activities support a reciprocal process of knowledge discovery and application among students, community, and academic partners. Dr. Watson-Thompson is interested in the use and promotion of behavioral community approaches to support social problem solving. She facilitates courses to train students in community leadership and community health and development competencies. Her research team, the Kansas University Work Group Team for Community Youth Development and Prevention, conducts research in affiliation with the Work Group for Community Health and Development, a center in the Schiefelbusch Institute for Life Span Studies. Her particular interests focus on neighborhood development, positive youth development, and prevention, including substance abuse and violence prevention. Using community-based participatory research methods, her research has focused on the application of behavioral science approaches to improve how communities address issues related to community health and development.