Communities of Health

A Prospectus

www.communitiesofhealth.org

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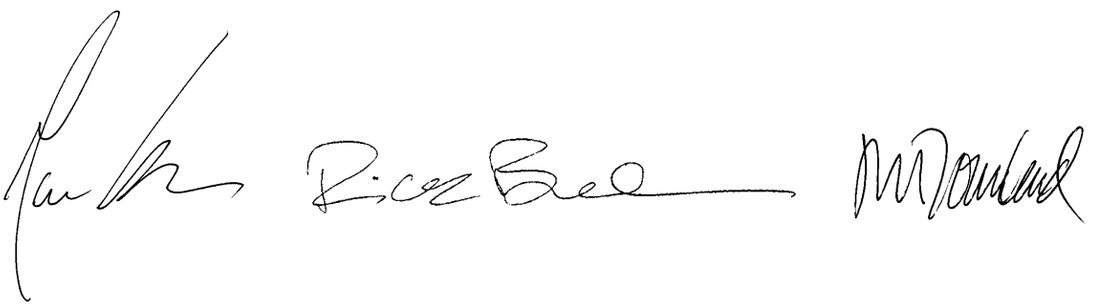
Preface

Today the U.S. accounts for nearly half of the world's health care expenditures, yet ranks near the bottom of all economically developed nations in life expectancy and infant mortality. Despite increased investment in the health of the nation, year after year we are less, not more, healthy.

At the same time vast sums are spent on medical care, researchers are discovering the fundamental determinants of health. Their discoveries have inspired a movement to rethink our understanding of health: what threatens it and how best to protect it. This movement is the best hope for a real solution to the global crisis in health.

We, the undersigned, believe that by examining, understanding and innovating to address these fundamental determinants of health, a profound force for good will be unleashed in the world. This booklet is a call and plan for action for those who wish to lend their energies to this force.



Called to Action

Called to Action

Considering the health of the

The Case for Change

With all the work to make treatments more effective and costs more manageable, we continue to face deteriorating health in America. As U.S. annual total health care spending exceeds $2 trillion, the time is right to change the national dialogue on health, to explore the deep causes of illness and disease that drive people into the care system in the first place.

Health Is More than Health *Care*

Conventional wisdom says that good health is the result of individual behavior, lifestyle, genetics and good medical care. However, research is now showing the limitations of focusing *solely* on these factors,[1,2,3] because they fail to address broader social and environmental conditions that cause poor health.

Significant Untapped Opportunity

Evidence is mounting that social dimensions – such as economic opportunity, food and transport systems, and the workplace – account for **at least 50%** of morbidity and mortality,[3,4,5] a number that looks to be growing year after year.

While healthy lifestyles and access to quality care will always be important, we are proposing an *integrated approach* that simultaneously addresses both individual and social dimensions of health.

"Interventions to improve access to medical care and reduce behavioral risk have only limited potential for success if the larger societal and economic context in which people live is not improved."

– Institute of Medicine

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community: does it matter?

Acute Symptoms

- By 2015 more than 75% of all U.S. adults and 51% of children and adolescents will be overweight or obese.[6]
- While the global population grows at a rate of 1.2% per year, diabetes is increasing at a rate of nearly 4%.[7]
- Chronic conditions in children and teens continue to rise (e.g., asthma rate was 5% in 1971, 18% in 2006).[8]
- Stress in the workplace has increased 25.5% and related costs have more than tripled over the past decade.[9]
- U.S. employers' health benefit costs continue to rise at twice the rate of inflation.[10]
- In the past year nearly 7% of American adults did not receive needed medical care, an increase of 57% over the past 7 years.[11]
- The overall percentage of the U.S. population living in poverty has risen by 11.4% in the past 5 years.[12]
- 64% of high school students do not meet the currently recommended levels of physical activity.[13]

UNDERLYING CAUSES

SOCIAL COHESION: Nine-year study in Alameda County, CA, found that people with few social ties were two to three times more likely to die of all causes than were those with more extensive contacts.[14]

NEIGHBORHOODS: In predominantly white neighborhoods with high playground safety scores, the prevalence of obesity is half that of non-white neighborhoods with low playground safety scores.[15]

Availability of supermarkets is more than three times greater in high income neighborhoods than in low income neighborhoods.[16]

CULTURE: Although England has a higher prevalence of smokers and heavy drinkers than America and spends 50% less per capita on health care, they have lower rates of diabetes (6.1% vs. 12.5%), hypertension (33.8% vs. 42.4%), heart attack (4% vs. 5.4%), and stroke (2.3% vs. 3.8%).[17]

WORKPLACE: Those who say they have low or intermediate control over how they meet the demands of their jobs had over twice the incidence of coronary heart disease as those who reported having a high level of control at work.[18]

SOCIOECONOMIC STATUS: Life expectancy is highest in societies with the smallest income differences between rich and poor, such as Sweden and Japan (80.5 and 82.3 years respectively). The United States, by comparison, in spite of having one of the highest standards of living, has greater income disparities and a lower life expectancy (77.9 years).[19]

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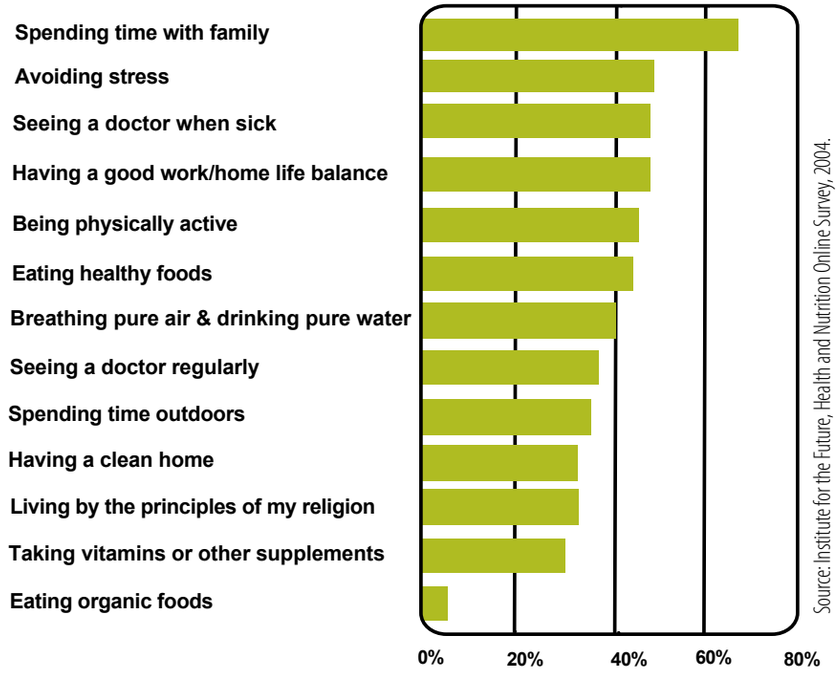
Rethinking Health

In addition to the research uncovering the social determinants of health, separate studies are revealing the attitudes of consumers of health care. It is clear from the findings that people define health in very personal and expansive ways. For most, health is much more than an absence of disease (see chart below).

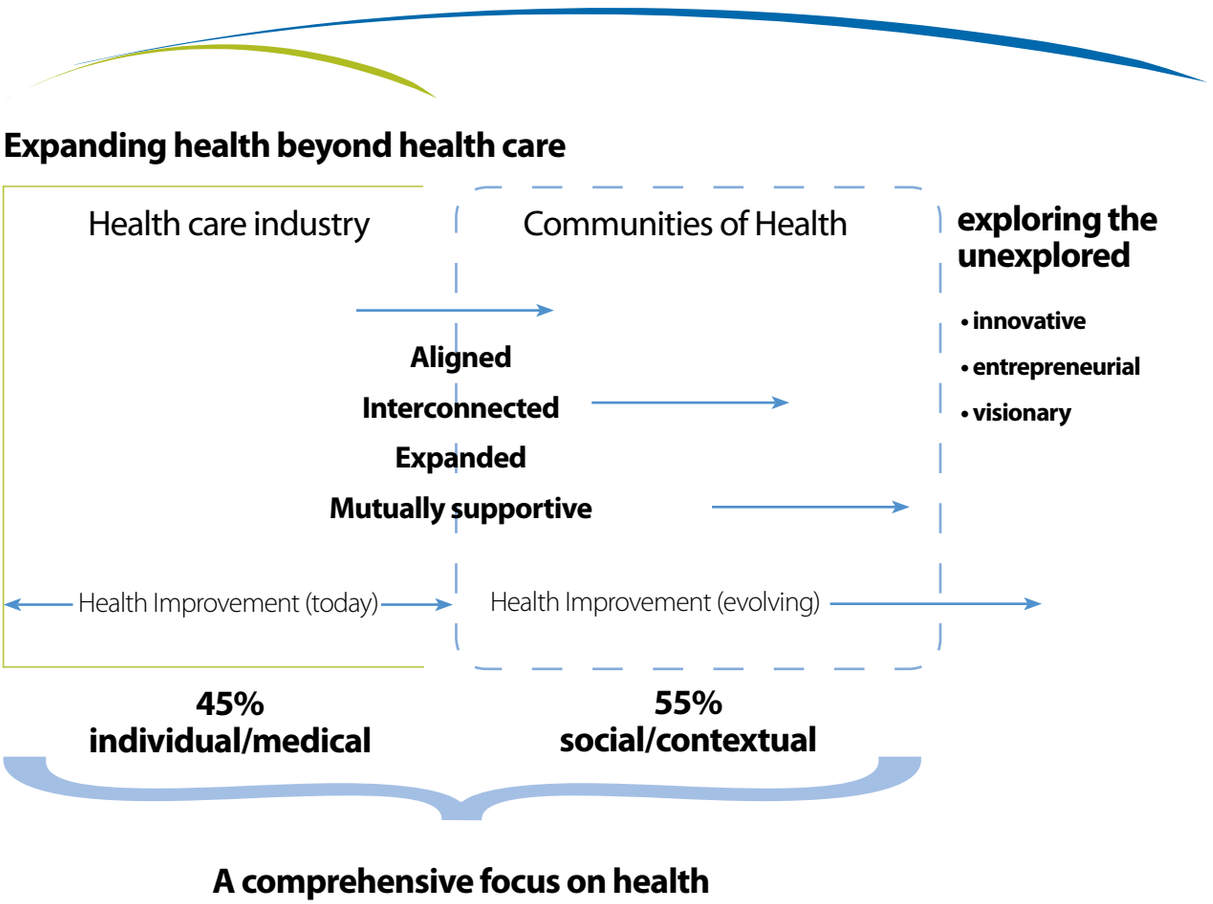
The deeply personal character of health is further reason that improving it requires more than medical interventions targeting conditions. This is an important consideration as we explore and design programs to address the social determinants of health.

A health care system that provides high quality care is critical to addressing the immediate medical needs of the individual. A supplementary focus on the broader social and environmental determinants of health represents a proactive move toward a more comprehensive approach that accounts for expansive, interconnected and deeply personal expressions of health.

Percent of consumers who report . . . "very important to my health."



community: does it matter?



"... approaches to the study of disease which look at individuals in isolation from their social environments are likely to miss this underlying process [which causes disease]."

– Morris L. Barer, Ph.D., Health Policy Institute, University of Texas at Houston

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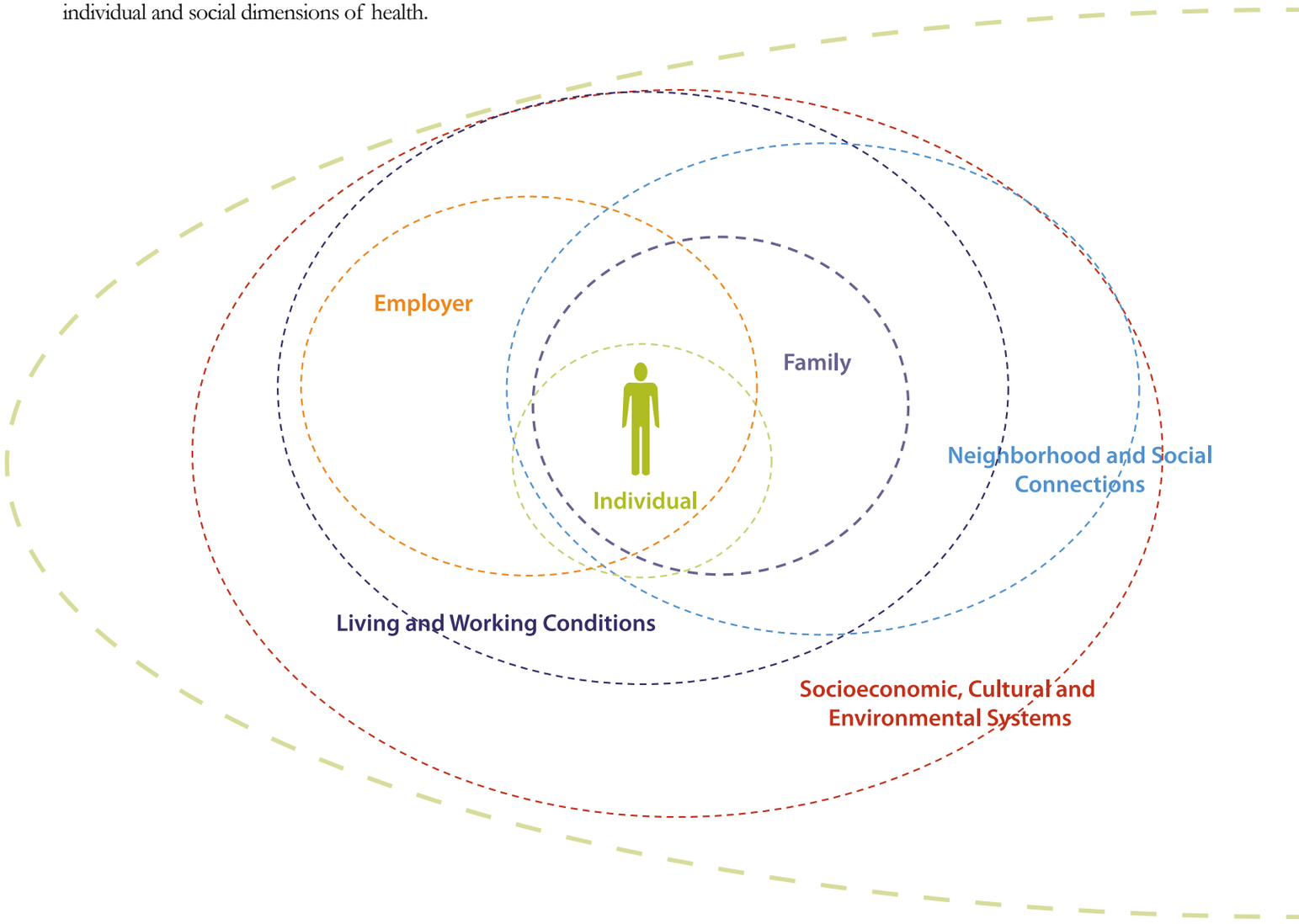
What We Are Proposing

An integrated approach that simultaneously addresses both individual and social dimensions of health.



ommunity: does it matter?

INDIVIDUAL DIMENSIONS OF HEALTH

Engaging individuals

- locus of health and illness is the individual
- views health and illness as the result of individual biology and behavior
- intervention and prevention at the individual level
- treats symptoms of illness through improved health care access and lifestyle choices (e.g., biomedical testing and intervention, health literacy, clinical/condition management, behavior change)
- medicalization of health and illness through rapid growth and adoption of medical technology (approx. 95% of U.S. health spending goes to direct medical services; approx. 5% goes to population or community approaches)

SOCIAL DIMENSIONS OF HEALTH

Engaging communities

- locus of health and illness is the social contexts within which people live and work
- views health and illness as fundamentally a social phenomenon
- intervention and prevention require public/collective action
- addresses causes of illness within social, economic, cultural and environmental contexts (e.g., blighted neighborhoods, inadequate schools, unsafe public spaces)
- social dimensions were prevailing focus for health improvement at turn of 20th century (public water supply, sanitation, food security, housing and working conditions); still fundamental, though hidden by recent individualization-medicalization of health

"Whether people are healthy or not, is determined by their circumstances and environment. Factors such as where we live, the state of our environment ... our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact."

– World Health Organization

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A Broad Base of Support

Indicators that the time is right for an integrated approach to the individual and social dimensions of health:

Research Evidence Coming to the Forefront

The notion of social determinants of health is hardly new. However, the vast research evidence on the topic that has accumulated in recent decades is now being brought to the forefront by leading health authorities, policy makers and advocacy groups. For example, recent activities include:

World Health Organization

- The World Health Organization (WHO) Commission on Social Determinants of Health is developing a comprehensive review of the latest evidence. Its final report will include global recommendations for action. (www.who.int/social_determinants/en/)

ROBERT WOOD JOHNSON FOUNDATION
Commission to Build a Healthier America

- In February 2008, the Robert Wood Johnson Foundation launched a two-year non-partisan Commission to Build a Healthier America, co-chaired by Mark McClellan, MD, PhD, and Alice Rivlin, PhD, of the Brookings Institution. Through a series of public hearings, data analysis and reports, the commission is highlighting social factors that affect health, promoting policy change and encouraging public and private-sector initiatives to reduce health inequities. It is the first national, consensus-seeking organization to explore solutions outside the medical care system. (www.commissiononhealth.org)

- "Unnatural Causes," a PBS 4-hour documentary series detailing social determinants and inequalities in health, premiered nationwide March 27, 2008. Public screenings and community forums are ongoing, sponsored by government, schools, medical institutions, business and civic organizations at the local, state and national level. (www.unnaturalcauses.org)

Public Awareness to Accelerate

Acceleration of public interest in social determinants – and responses by business, civic, government and policy groups – is being fueled by a surge in:

- News coverage in consumer media and industry trades – from *USA Today* to *The Wall Street Journal* to *Health Affairs,* which dedicated an entire issue to the topic.

- Public relations, including several large contracts to Washington DC firms (Burness Communications, McKinney & Associates) to engage opinion leaders, constituency groups, legislators and media on the issue. For instance, the Robert Wood Johnson Foundation granted $6 million to promote the findings of its Commission to Build a Healthier America.

- Community-based forums, coalitions, grass-roots efforts, blogs and websites. (www.healthjustice.us; http://depts.washington.edu/eqhlth/; www.socialmedicine.org; www.spiritof1848.org; www.preventioninstitute.org; www.commonhealthaction.org; www.macses.ucsf.edu; www.hesperian.org; www.bettertogether.org)

Growing Community Interest

Communities of Health efforts and conversations are under way in a growing number of cities around the U.S. and globally.

In Las Vegas, an expanding circle of participants have come together to consider the health of the community. Since May 2008 (see timeline on pages 42-43) people from 40 organizations, agencies and neighborhoods have participated in an ongoing and collaborative exploration that is generating greater collective awareness of the fundamental determinants of health and opportunities for community-driven action.

In Detroit, the Communities of Health team has been part of a whole-system community transformation effort with local leaders, residents, business and civic groups, and an extended network of supporters across health, education, employment, housing, justice, urban farming and other disciplines. By engaging all stakeholders in a process that generates *change from within*, this work is producing a profound and sustainable shift in social, economic and ecological well-being.

In the San Francisco/Bay Area, an employer coalition on workplace influences of health and productivity is being launched in collaboration with the UC Berkeley schools of business and public health.

A partial list of additional Communities of Health gatherings, activities, requests and collaborative learning opportunities includes: Chicago, IL; Dallas, TX; Denver, CO; Hartford, CT; Houston, TX; Kansas; London, UK; Louisiana; Los Angeles, CA; Maine; Maryland; Michigan; Minnesota; Nashville, TN; New Mexico; New Orleans, LA; New York; North Carolina; Ohio; Orlando, FL; Richmond, VA; San Antonio, TX; San Jose, CA; South Africa; and Washington, DC.

Taking Action

What's Different About this Approach

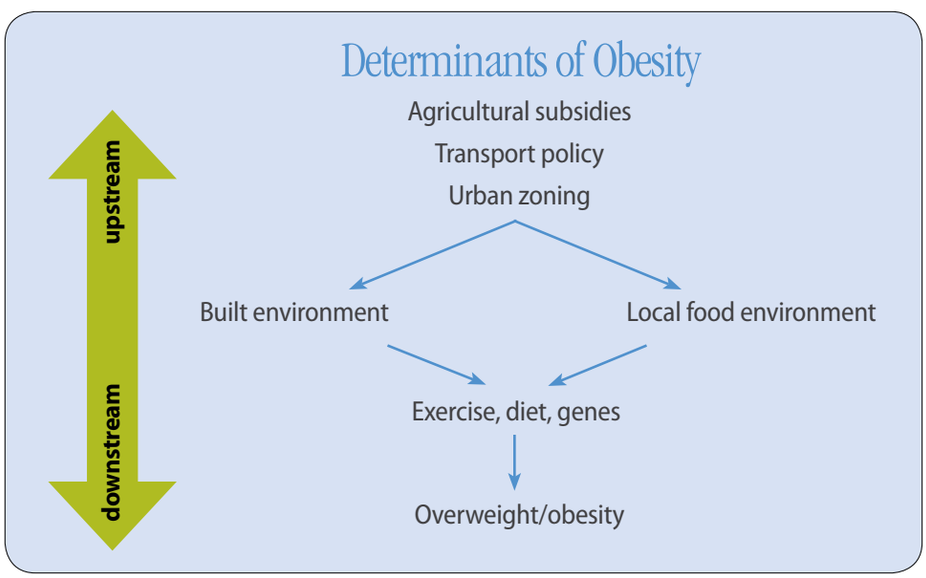
Medical interventions and lifestyle behaviors occur within social and environmental contexts that our current system of care is powerless to address. Here are three distinctions of an integrated approach that simultaneously addresses both individual and social dimensions of health, well-being and security.

1. *Place Matters:* The Choices We Make Are Shaped by the Choices We Have

EXAMPLE: Las Vegas was recently named by *Men's Fitness* magazine as the "fattest city in America" – not because it has the highest proportion of overweight or obese citizens, but because of prevailing social and environmental conditions such as crushing commutes, lack of open space, excessive TV viewing and extreme temperature. These "upstream" influences have been linked to lack of physical activity, poor diet and other "downstream" risk factors.

"It's very difficult for people to change their behaviors if they don't have an environment in which to make that change."
– Ana Diez-Roux, MD, PhD, MPH, University of Michigan School of Public Health

IMPLICATIONS: In addition to promoting healthy behavior change, an integrated approach considers the availability, condition and underlying causes of physical space, economic vitality and local services that can support or compromise individual health.



2. *Context Matters:* Our External Environment Gets Under Our Skin

EXAMPLE: Tobacco use could kill one billion people worldwide this century, a ten-fold increase from the previous hundred years, according to the World Health Organization. Yet, the rate of death per smoker varies widely by country and socioeconomic class, since the context in which people smoke can make them more susceptible to its harmful effects. While the Japanese smoke twice as much as Americans, they live four years longer on average. And low-income smokers in the U.S. are more likely to become ill and die sooner than those at the top of the income ladder who smoke the same amount.

"We can now show the biological consequences of social experience. You have gene propensity, but it's the environment that changes the way genes get expressed and makes people vulnerable to a range of diseases. The environment is where the action is."

– S. Leonard Syme, PhD, Health Research for Action Center, University of California Berkeley

IMPLICATIONS: Addressing social and environmental contexts must reach beyond health literacy and resource access to uncover deep sources of psychosocial stressors that weaken resiliency.

3. *Participation Matters:* Coming Together Improves Health

EXAMPLE: The link between social cohesion and health is well documented. In the U.S., regional differences in mortality and morbidity are directly tied to levels of "social capital," the networks, norms and trust that enable groups to cooperate toward shared objectives. This dynamic is particularly important in community health interventions, which are significantly more successful when designed by the community itself.

"Our society won't work well if we don't have these social connections. Schools don't work as well; crime rates are higher where people don't know their neighbors; people are unhappier and unhealthier."

– Robert Putnam, Harvard social scientist and author of Bowling Alone: The Collapse and Revival of American Community

IMPLICATIONS: Community transformation must be a participative process that allows people to come together in ways that are mutually supportive and empowering – because research shows that social support and empowerment are fundamental determinants of health.

Framework for Communities of Health

DEFINITION
Communities of Health is an ongoing and collaborative exploration to uncover and address fundamental factors within the social and environmental structures of communities that impact both individual and collective health.

PURPOSE
Communities of Health will instigate a profound force for good in the world. This force will be unleashed by building awareness of and urgency to address the fundamental "upstream" determinants of health.

OBJECTIVES
Demonstrate the value of an *integrated approach* that simultaneously addresses both individual and social dimensions of health:

- **Measurably improve long-term health and productivity;**
- **Create a demand for thinking that challenges convention; and**
- **Explore new venues for meaningful collaboration.**

Guiding Principles

1. The individual and the environment are inseparable. The challenges we face are the direct result of the systems we've created. For change to last we must simultaneously address both individual and social/contextual dimensions of health, well-being and security.

"We shape our buildings, then our buildings shape us." – Winston Churchill

2. Change happens through us. More than 70% of change efforts fail, most often because they don't engage people in what they really care about. Transformation begins on the inside, so it must be driven by what members of the community most aspire to create – and sustained by local leaders who will continue to evolve and manifest desired changes over time.

"There is no power for change greater than that of a community discovering what it cares about." – Margaret Wheatley

3. Systemic change engages the whole system. Stakeholders representing the many pieces of the system must come together to address all facets of a community concurrently. As we come to see these "pieces" as interdependent, we free innovative thinking and action from the structural and relational impasses we traditionally get stuck in.

"The more we study the major problems of our time, the more we come to realize that they cannot be viewed in isolation. They are systemic problems, which means that they are interconnected and interdependent." – Fritjof Capra

4. Our best emerges in the "coming together." The solutions to even our most pressing problems are already within us; we simply need to shift from mechanistic approaches to more generative methods that allow collective strengths, wisdom and will to emerge. In coming together, people uncover the roots of disconnect and disease, and create "control of destiny" that is essential to health.

"We shift from paying attention to the individual or the group, to what happens between *people… the emerging ability to think together that only happens in communities." – Finn Voldtofte*

5. As awareness deepens, action becomes inevitable. When we are open to see beyond our current assumptions, we develop ideas that mean something to us and the distance between thinking and action dissolves.

"Once there is seeing, there must be acting. Otherwise what is the point of seeing?" – Buddhist proverb

Three Focus Areas

Strategy: *principles that inform all actions*

- Exploration of social and environmental determinants
- Examination of implications and opportunities for Communities of Health
- Expansion and partnership opportunities
- Thought leadership/promotion/stakeholder influence

EXAMPLES:

– Commission/unify the research on social dimensions and establish new standards for measuring community health, interventions and return on investment

– Health Sustainability Consortium (network of companies committed to business practices and investment toward community health measures)

– Participation at policy level

Solutions: *the ingredients necessary for action*

- Capacity building
- Awareness development
- Participation and collaboration modeling

EXAMPLES:

– Formula for Communities of Health (see next section)

– Choice Points – business approach linking employee engagement/empowerment to quantifiable improvement in health and productivity (partnership with UC Berkeley)

– Community Participatory Action – assisting governments/municipalities in generating profound and sustainable change from within

– Social/environmental health risk assessment

Pilots: *test-and-learn environments*

- Community context
- Company context
- Cross-community/national/global context

EXAMPLES:

– Las Vegas (and others) long-term community transformation efforts

– Bay Area employers – Choice Points coalition co-sponsored with UC Berkeley schools of business and public health

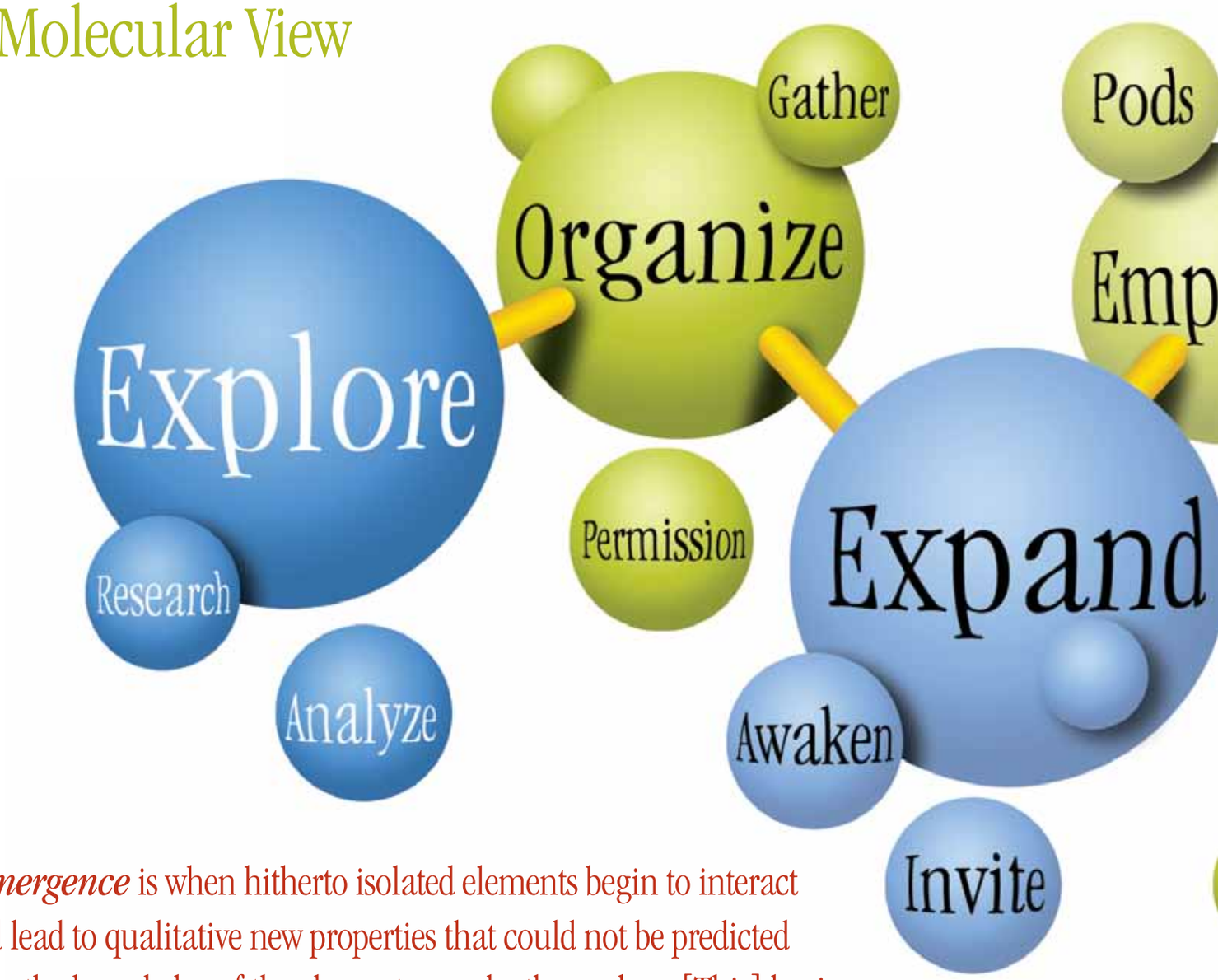
– Communities of Health grant

The Formula for Communities of Health

The Formula

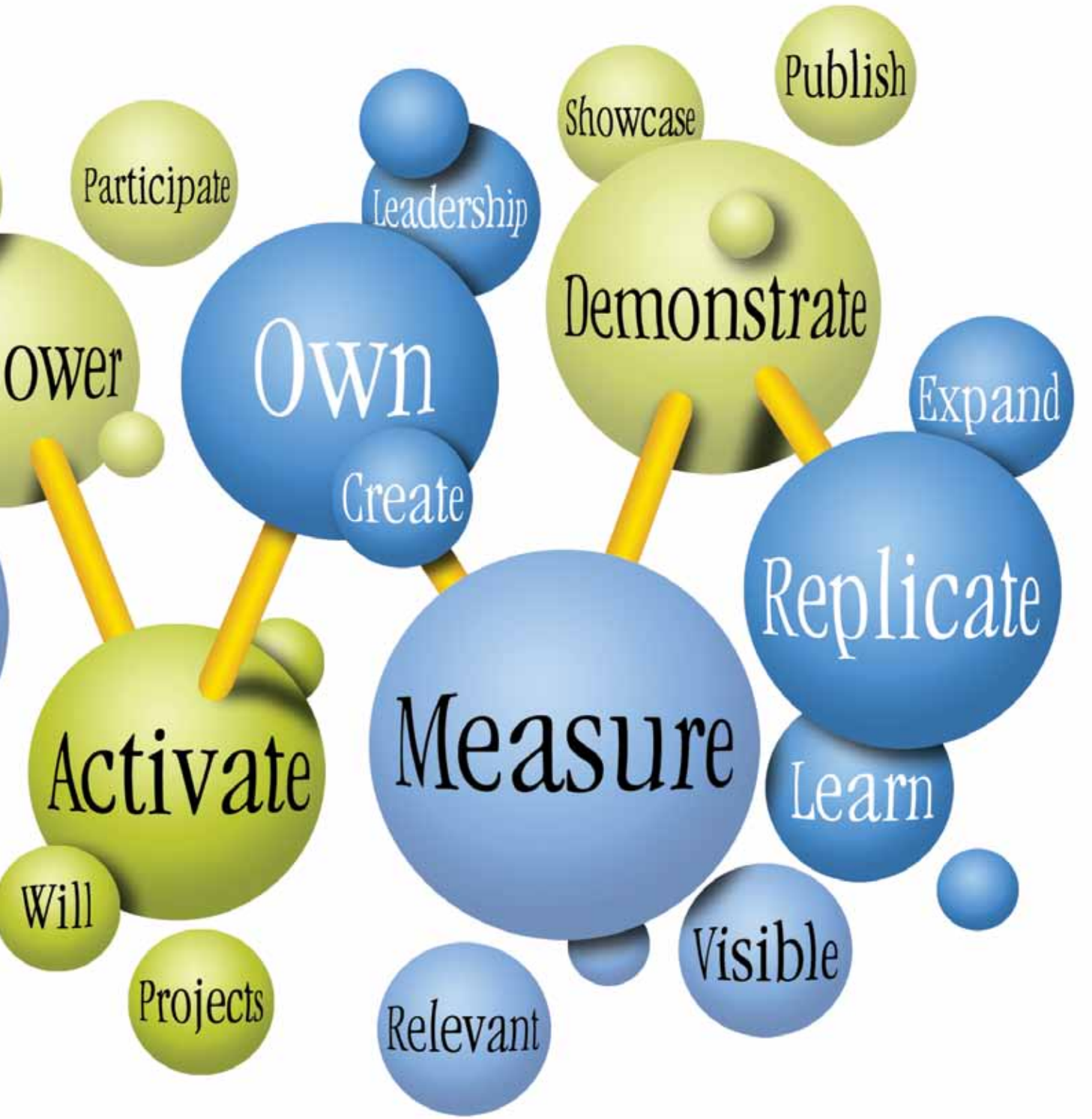
Communities of Health

A Molecular View



"***Emergence*** is when hitherto isolated elements begin to interact and lead to qualitative new properties that could not be predicted from the knowledge of the elements seen by themselves. [This] begins with a shift in awareness, from parts to relations between parts. Example: Oxygen and hydrogen together form water. The wetness of water is a new property that cannot be predicted by knowledge of oxygen and hydrogen. We are not necessarily able to explain how the emergent emerges, but... we can ascertain that it happens."

– Excerpted from *Introduction to Magic in the Middle*, Finn Voldtofte, March 2005


Publish
Showcase
Participate
Leadership
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Own
Demonstrate
Expand
Create
Replicate
Measure
Activate
Learn
Will
Visible
Projects
Relevant

1. EXPLORE

Research and Analysis: *getting to know the community*

Actions:

1a.
Identify and outreach:

Local research resources

- Local colleges and universities
- Local professional societies and organizations

1b.
Assess specific environments according to:

- Demographics
- Geographics
- Health status
- Social factors

1c.
Develop list of initial participants:

- Permission grantors
- Influencers
- Investors

"The voyage of discovery is not in seeking new landscapes but in having new eyes."

– Marcel Proust, novelist

1d.
Identify and outreach:

Local activity resources

- Existing agencies
- Existing resources/ capacity

1e.
Ongoing research and analysis:

- Community involvement
- Relevance to mission
- Expansion

Resources:

- CoH Group and CoH Leadership
- Local colleges and universities
- Local chapters of national advocacy groups
- Community-based research facilitators (e.g., from community-based participatory research [CBPR] projects)

Deliverables:

- Baseline assessment of local health status, key indicators and determinants
- Targeted participants (influencers, investors)
- Network of local support resources

2. ORGANIZE

Engage the Influencers: *community members with the best opportunity to mobilize core participants*

Actions:

2a. One-on-one dialogues:

- Relational
- Research presentation
- "Does it matter" (invitation to gathering)

2b. Initial gathering of influencers:

Awareness to Action

- Action-intended dialogue
- Collaborative inquiry

2c. Community forums:

- Participants with a stake (e.g., employees)
- Organization reps (e.g., school superintendents)

"The starting point for a better world is the belief that it is possible."

– Norman Cousins, political journalist

2d.

Go/No go decision:

- Move from control to empowerment

Resources:

- CoH Leadership
- Business and community leaders (i.e. influencers)
- Community citizens

Deliverables:

- Awareness on part of key influencers and investors of local health stats and determinants
- Alignment on answer to "Does it matter?"
- Go/No go decision

3. EXPAND

Initiate Awareness: *awaken the community*

Actions:

AWARENESS CAMPAIGN (contingent on "Organize")

COMMUNITY COMMITMENT

3a. Media analysis:

- Local opportunities
- Existing resources and initiatives

3b. Campaign development:

- Creative
- Media
  - Traditional (e.g., print, radio, TV)
  - Interactive
  - Innovative (viral, etc.)
- Funding

3c. Community dialogue planning:

- Identification and evaluation of high impact targets
  - Neighborhoods
  - School systems
  - Employers
- Program development

"If you want to build a ship, don't drum up the men to gather wood, divide the work and give orders. Instead, teach them to yearn for the vast and endless sea."

– Antoine de Saint Exupéry, writer and aviator

3d.

Facilitate community dialogue events:

- Community (citizen), neighborhood (resident), workplace (employee) roundtables, forums and town halls
  - Surface truths, concerns, interests and capacities
  - Articulate (participative inquiry) and activate purpose/mission: "What we hope to address and possibilities for doing so"
  - Memorialize findings (for future dissemination)

Resources:

- CoH Leadership
- Marketing agency
- Local research and facilitation (CBPR)
- Community citizens (i.e., residents and employees)
- Local influencers

Deliverables:

- Community members awakened to action
- Community empowered to expand dialogue and action
- Emerging social networks/increased social capital
- Investment/engagement in social support – e.g., community Health Awareness Tour (HAT)

4. EMPOWER

Emergent Participation: *participative planning that flows from the community*

Actions:

4a.
Facilitate community sub-gatherings (pods):

- Diverse stakeholders/ shared interests
- Open forum: listen/ learn/consider

4b.
Establish "safe" environments:

- Post-gathering
- Gather information in "public" display (web, bulletin boards, mass media, etc.)
- Promote action orientation

4c.
Organize the leaders (influencers and authorities):

- Collect aspirations (theirs and the community's)
- Create shared and comprehensive vision
- Unify purpose/mission

"Control of destiny – the ability of people to deal with the forces that affect their lives, even if they decide not to deal with them – is one of the most important factors in the cause of disease at the community level. It is also something for which we can develop meaningful interventions."

– S. Leonard Syme, PhD, Health Research for Action Center, University of California Berkeley

4d.

Identify talents and desires:

- Special experience and interests

4e.

Formalize process:

- Community identifies teams (members)
- Pods are "commissioned"
- Integrate focus areas
- Remain open

Resources:

- CoH Leadership
- Local research and facilitation (CBPR)
- Community citizens (i.e., residents and employees)
- Local influencers and authorities

Deliverables:

- Planning and actions that emerge from cross-sector cooperation
- Vision, purpose and mission that represent the aspirations of the community

5. ACTIVATE

Engaged Implementation: *action in and by the community*

Actions:

5a. Facilitate gatherings:

- "Retail" dialogue: "expand the circle"
- Community-hosted open forums: listen/ learn/consider
- Does it matter?

5b. Establish means and goals:

- Identify issues
- Define outcomes (systems approach)

5c. Map the community (CBPR):

- Influencers and influenced
- Cross-reference issues

"One learns, I would hope, to discover what is right, what needs to be righted – through work, through action."

– Daniel Berrigan, peace activist and Roman Catholic priest

5d.
Design demonstration projects:

- Local facilitation of design

5e.
Move to action:

- Community identifies teams (members)
- Create
- Implement
- Coordination and reporting

Resources:

- CoH Leadership
- Local research and facilitation (CBPR)
- Pod leaders
- Community citizens (i.e., residents and employees)
- Local influencers and authorities

Deliverables:

- Dialogue events hosted by pods
- Demonstration projects conceived, designed and executed by community
- Preliminary road map for ongoing action by, for, and in the community

6. OWN

Claim the Mission: *guiding the community (pods, people) to a "point of no return"*

Actions:

6a.
Help community establish a foundation for action:

- Create a formal organizational structure

6b.
Connect existing and new resources/solutions:

- Indigenous expertise
- Identified gaps and available resources

6c.
Organize/integrate action (projects):

- Coordination of emerging and ongoing work
- Consideration of gaps and resources

"Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness, that most frightens us. And as we let our own light shine, we unconsciously give other people permission to do the same. As we are liberated from our own fear, our presence automatically liberates others."

– Marianne Williamson, activist and author

6d.
Expansion:

- Events that inspire aspirational thinking

6e.
Rationalize activity (community-driven):

- Group
- Prioritize
- Create
- Track

Resources:

- CoH Leadership
- Local research and facilitation (CBPR)
- Pod leaders
- Community citizens (i.e., residents and employees)
- Local influencers and authorities

Deliverables:

- Viable capacity to move forward with action
- Health-directed projects conceived, backed, funded and sustained by the community

7. MEASURE

Validate the Mission: *gauge progress toward the goal the community has defined*

Actions:

7a.
Help participants establish measurement criteria:

- What is meaningful to the community (participants)

7b.
Create collection ports:

- Aligned with project fields
- Data gathering and analysis

7c.
Aggregate/ substantiate:

- Comprehensive view
- CBPR: Follow-up

"A healthy social life is found only, when in the mirror of each soul the whole community finds its reflection, and when in the whole community the virtue of each one is living."

– Rudolf Steiner, philosopher and educator

7d.
Energizing:

- Indicates future action
- Opportunity for participation

7e.
Modifiable and expandable:

- Builds capacity

Resources:

- CoH Leadership
- Local research and facilitation (CBPR)
- Community citizens (i.e., residents and employees)
- Local influencers and authorities

Deliverables:

- Community-defined return metrics that reflect the social determinants of health
- Local process for data collection and evaluation
- Local capacity for CBPR
- Media coverage

8. DEMONSTRATE

Showcasing the Work: *wide-reaching public description of CoH activities*

Actions:

8a.

Demonstration:

- Public exposure of successes and failures to community
- Public exposure of successes and failures to other communities (future CoHs)
- Learning apparatus

8b.

Publication:

- Academic journals
  - Medical
  - Business
- Mainstream media

"At first people refuse to believe that a strange new thing can be done, then they see it can be done – then it is done and all the world wonders why it was not done centuries ago."

–Frances Hodgson Burnett, author of *The Secret Garden*

INITIATION PHASE
EMERGENCE PHASE
➤ **FLOURISH PHASE:** ***Self-sustaining, expanding, cross-pollinating***
6. Own
7. Measure
8. Demonstrate
9. Replicate

Resources:

- CoH Group and CoH Leadership
- National academic partners
- Local media outlets
- Local research and facilitation (CBPR)
- Community citizens (i.e., residents and employees)
- Local influencers and authorities

Deliverables:

- Widespread awareness of social determinants
- Media coverage
- Improved capacity to perform CoH activities
- Demand for CoH work in other communities

9. REPLICATE

Extending the Formula: *variability is built into the formula*

Actions:

9a.
Expand to next community:

- Application of the formula

9b.
Apply learnings:

- Broaden community involvement/ resources (e.g., more sophisticated local involvement of national organizations)
- Local customization of core practices (e.g., participatory action)

"Traveler, there is no path. Paths are made by walking."

– Antonio Machado, poet

9c.
Interconnect communities:

- Cross-pollination
- Leverage shared resources

Resources:

- CoH Group and CoH Leadership
- Local colleges and universities
- Local chapters of national advocacy groups
- Community-based research facilitators

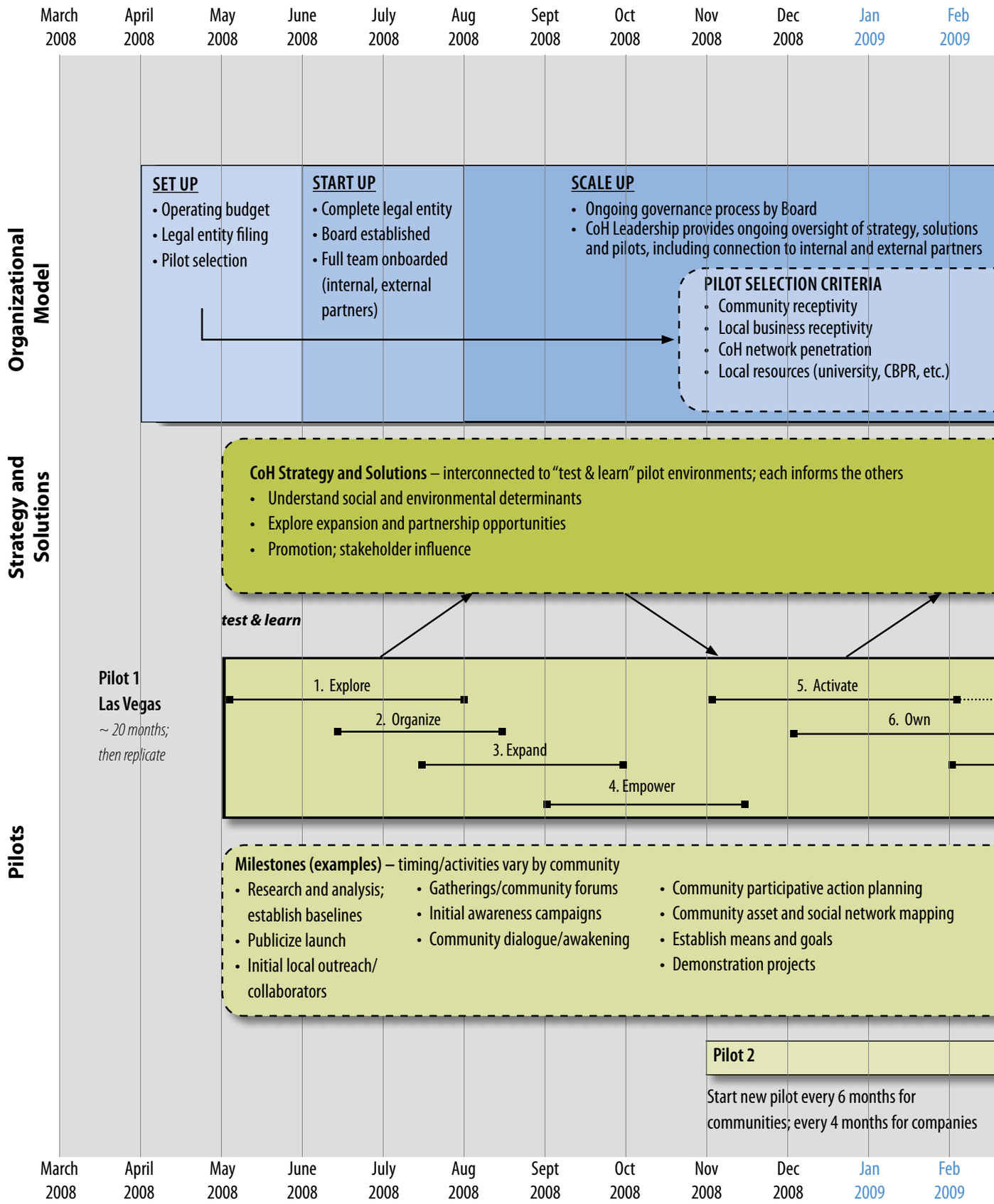
Deliverables:

- Expanding/increasingly involved group of participants and resources
- Expanding network of CoH communities

Activating the Formula

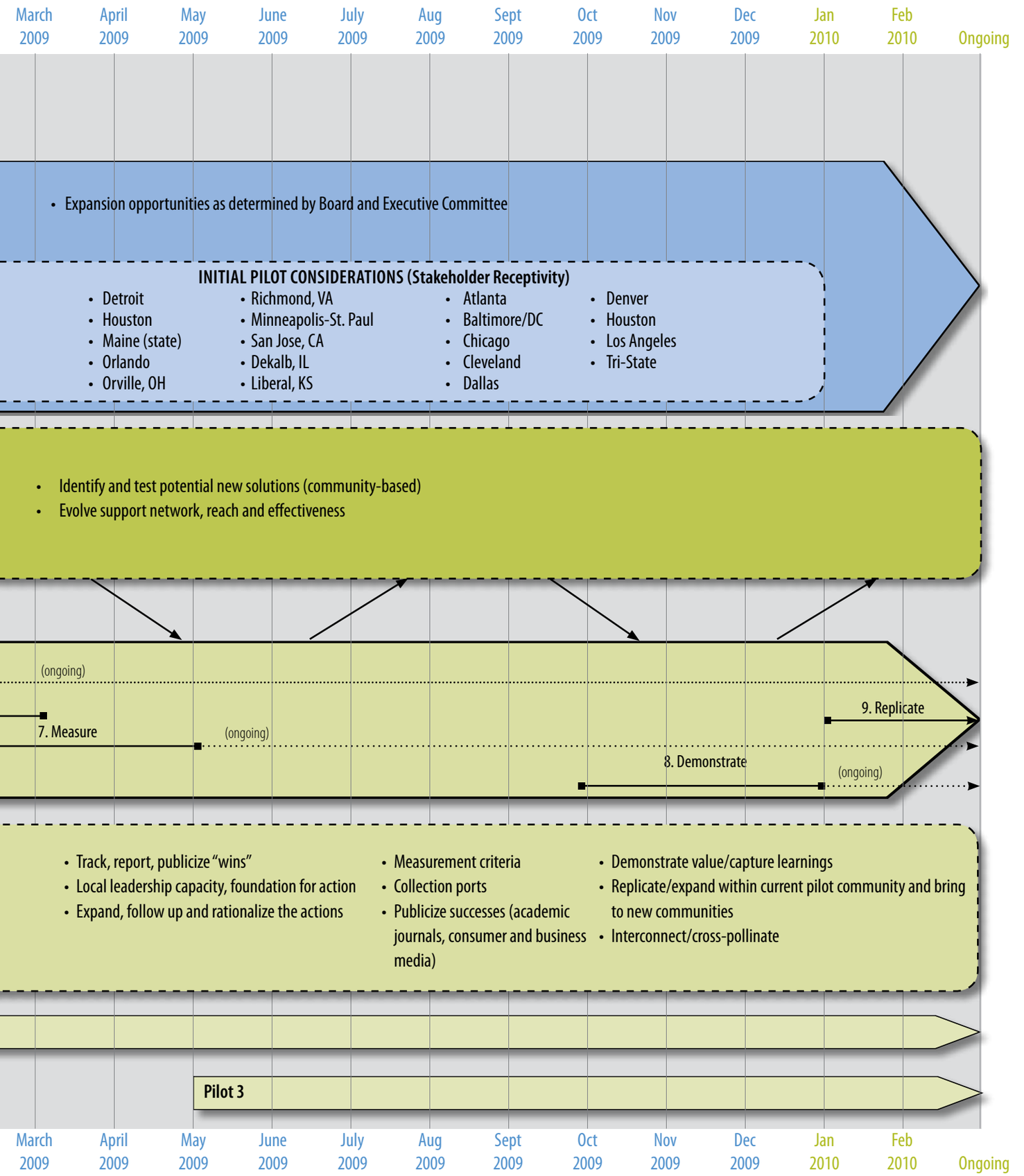
Activating the Formula

Building Communities of Health



"Wisdom is knowing what to do next; virtue is doing it."

– David Starr Jordan, biologist and activist


March 2009
April 2009
May 2009
June 2009
July 2009
Aug 2009
Sept 2009
Oct 2009
Nov 2009
Dec 2009
Jan 2010
Feb 2010
Ongoing
• Expansion opportunities as determined by Board and Executive Committee
INITIAL PILOT CONSIDERATIONS (Stakeholder Receptivity)
• Detroit
• Houston
• Maine (state)
• Orlando
• Orville, OH
• Richmond, VA
• Minneapolis-St. Paul
• San Jose, CA
• Dekalb, IL
• Liberal, KS
• Atlanta
• Baltimore/DC
• Chicago
• Cleveland
• Dallas
• Denver
• Houston
• Los Angeles
• Tri-State
• Identify and test potential new solutions (community-based)
• Evolve support network, reach and effectiveness
(ongoing)
7. Measure
(ongoing)
9. Replicate
8. Demonstrate
(ongoing)
• Track, report, publicize "wins"
• Local leadership capacity, foundation for action
• Expand, follow up and rationalize the actions
• Measurement criteria
• Collection ports
• Publicize successes (academic journals, consumer and business media)
• Demonstrate value/capture learnings
• Replicate/expand within current pilot community and bring to new communities
• Interconnect/cross-pollinate
Pilot 3
March 2009
April 2009
May 2009
June 2009
July 2009
Aug 2009
Sept 2009
Oct 2009
Nov 2009
Dec 2009
Jan 2010
Feb 2010
Ongoing

Organizational Model: Social Cooperative

SOCIAL COOPERATIVE – DEFINITION

- The primary objective of a social cooperative is: *the general benefit of the community and the social integration of people*.
- Cooperatives put people at the core of the business. They follow a broader set of values than those of traditional organizations.
- Decisions and direction balance the need for profitability with the need of the member *and* the wider interests of the community.
- Cooperatives are legal entities and traditionally provide health, social or educational services to a community.
- Cooperatives are owned, operated and democratically controlled by the members, be they individual, group, or capital enterprise.
- The guidelines of the operation are traditionally based on what is known as the Rochdale Principles (www.ncba.coop/abcoop.cfm).

"While focusing on member needs, cooperatives work for the sustainable development of their communities through policies accepted by their members."

– National Cooperative Business Association

SOCIAL COOPERATIVE – PRIMARY ADVANTAGES FOR COMMUNITY

- Business model reflects CoH mission (health is improved as a consequence of "coming together;" empowering community)
- Social purpose positions CoH for community collaboration, eliminates risk of conflict of interest
- Allows potential new partnerships and funding sources, in/outside of community
- Benefits of membership extended to community of citizens
- Helps to unify and integrate the community around compelling shared purpose

ENTITY DETAIL

GOVERNANCE:

- Board
- Executive Committee

STAKEHOLDERS:

- Interconnection to community resources

STRUCTURE:

- Shared partnership

Why a Social Cooperative?

Consideration was given to a number of potential organizational models to support this work. First, the model must be driven by the purpose and guiding principles outlined in this proposal. Second, the model should be positioned to openly pursue expansion opportunities, leveraging the widest possible means, partnerships and funding sources within and outside the community. Third, it is essential that the model be properly aligned and entrusted with the resources required to successfully initiate and sustain the work.

A social cooperative meets these criteria, while delivering on the significant advantages to the community described in previous pages.

Operational Flow

"The time is always right to do what is right."

– Martin Luther King, Jr.

Funding/Return Opportunities

Base Operating Budget: $2.3 million/year 1 – funded by investment

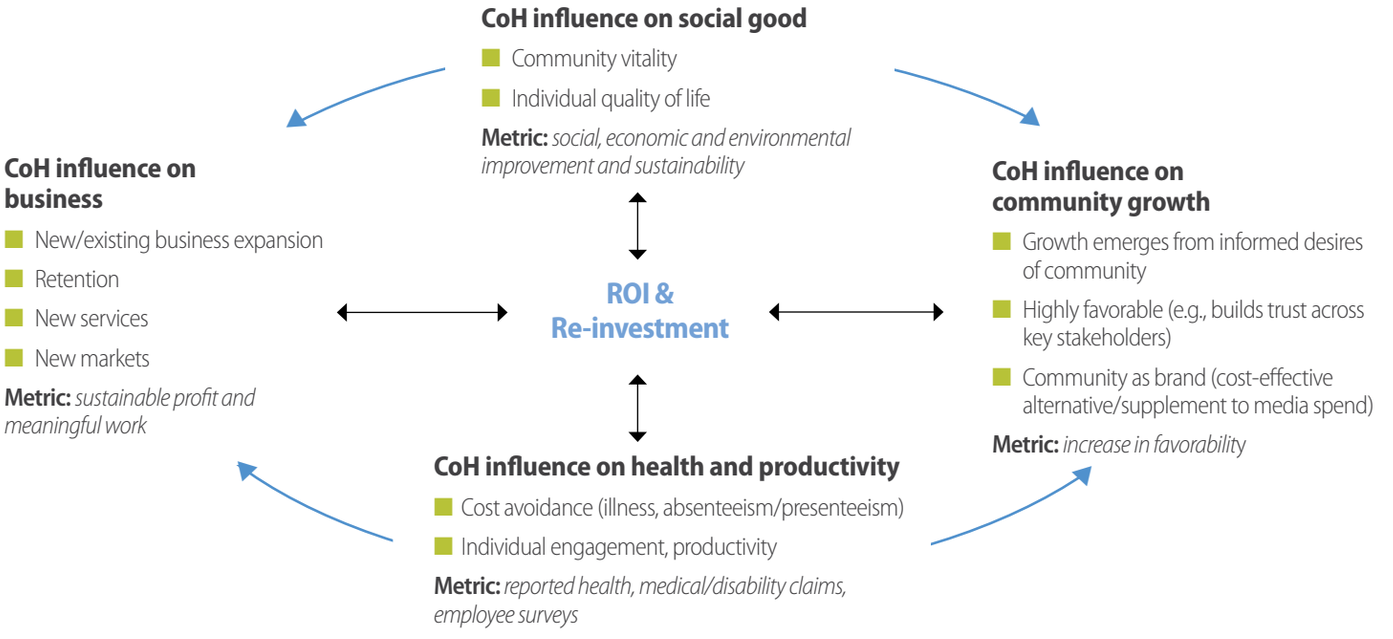
Strategic/Solutions Investment: Additional investment opportunities to benefit community are anticipated as an output of the pilots and through ongoing strategy and solutions work (e.g., commission research study to validate the CoH formula; develop Choice Points employer services; create a social/environmental health risk assessment). – funded by Coop members

Community-Generated Actions: The actions generated by the pilot community members (e.g., urban renewal, improved schools, targeted campaigns) will be funded through a variety of sources.

- A key objective of the pilots is to create empowered communities, which invest in their own success. This includes generating wide-scale participation and establishing sustainable sources of funding, such as:
  - Grants, foundations, government support, nonprofits/affiliates, fundraising and private investment;
  - Business/industry partnerships;
  - Coop/association fees;
  - Financial institution Community Reinvestment Act (CRA);
  - Microlenders and local entrepreneurship; and
  - Community member, stakeholder and employee giving, volunteering and designating contributions such as through the United Way.
- In addition, the CoH base operating budget includes "seed capital" ($50K per pilot) for small/visible demonstration projects that will establish momentum and encourage wider participation and support during initial phases of the pilots.

Return on (Community) Investment – "RCI"

Calculating the full benefit of Communities of Health requires new measures and return models. The return on investment is driven by four levers that are also connected to broader social impact, which might best be viewed as "return on community investment (RCI)." As a social cooperative, this return fuels our ability to expand the reach and impact of future efforts.



Notes

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Coming together in uncommon ways for a common purpose.

– thg