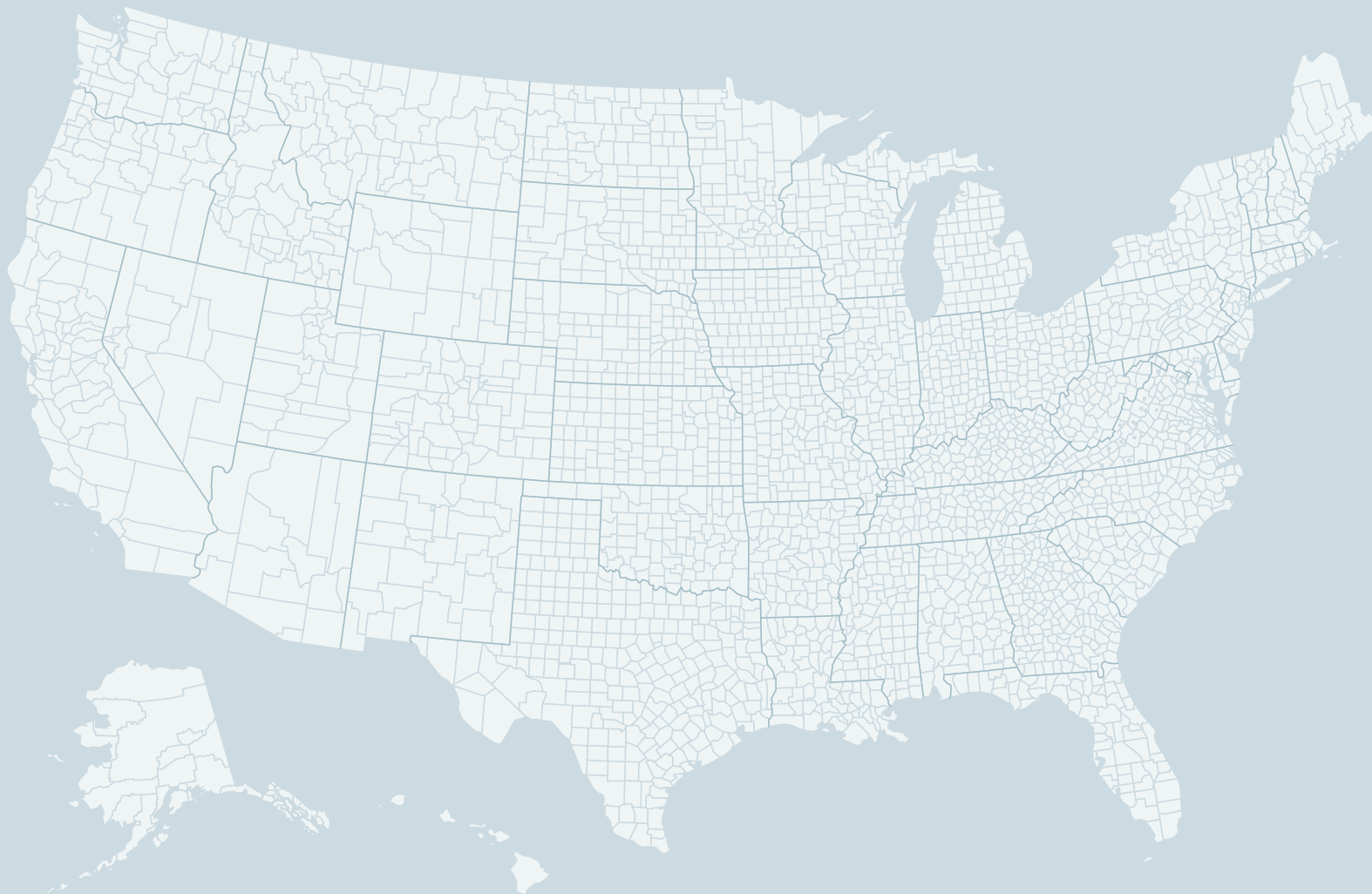


County Health Rankings & Roadmaps

Building a Culture of Health, County by County

A Robert Wood Johnson Foundation program



Ten-Year Reflections on the County Health Rankings & Roadmaps

A collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.



Support provided by

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Introduction

The University of Wisconsin Population Health Institute (UWPHI) has collaborated with the Robert Wood Johnson Foundation (RWJF) since 2008 to develop what is now known as the County Health Rankings & Roadmaps (CHR&R) program and the RWJF Culture of Health Prize (Prize). We (UWPHI) first conceived of the program—originally called Mobilizing Action Toward Community Health (MATCH)—with the preparation of County Health Rankings based on the model we had used in Wisconsin since 2003. Our initial plan was to create Rankings for five additional states in the first year, with the addition of five more states in years two and three. However, with input from Jim Marks, M.D., then senior vice president for the health group at RWJF, we were persuaded to “go national” with the preparation and release of County Rankings for all 50 states at the end of our first year.

The first County Health Rankings were released on February 17, 2010. With assistance from key public health organizations such as the Association of State and Territorial Health Officers (ASTHO), the National Association of County and City Health Officers (NACCHO), and the National

Network of Public Health Institutes (NNPHI), and a team of communication professionals led by RWJF, including Burness and Subject Matter, the media coverage for this first release exceeded all expectations, with broadcast coverage alone reaching over 24 million households in the first 24 hours post-release. Print coverage was also very high with over 400 national, state, and local stories in the first 48 hours. Activity on the associated website (www.countyhealthrankings.org) was also much higher than expected, temporarily grinding the site to a halt during the release event held in the District of Columbia. During the first six weeks following the release, there were over 325,000 visitors to the web site, with about 120,000 unique visitors in the first 24 hours alone.

In terms of audience reach and media impact, the 2010 Rankings release was one of the most successful events in RWJF’s history—RWJF was equally excited as we were at UWPHI and, together, we began to think about how we could build upon this initial success in increasing awareness of the determinants of population health by engaging multiple sectors in population health improvement

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efforts. In 2011, RWJF's expanded funding support enabled the program to add action resources including an online Action Center, What Works for Health (WWFH), community coaching, national partners, community grants, community learning labs, and the Prize. This package of data, evidence, guidance, and community exemplars became known as the County Health Rankings & Roadmaps. For a high-level overview of the evolution of each of these program components, please see the County Health Rankings & Roadmaps Timeline (Appendix A). The History of County Health Rankings & Roadmaps Funding, 2008-2020 (Appendix B) provides a description of our funding from RWJF.

To develop and implement these additional activities, our team grew rapidly over the years. In our first year, the team primarily consisted of faculty, scientists, researchers, and graduate students with training or expertise in population health and health data. Drs. Patrick Remington and David Kindig served as the principal investigators

with Dr. Bridget Booske Catlin serving as the project director. Dr. Catlin had a long history of leading large research programs, focusing on translating research findings for the public. Along with hiring researchers and graduate students, another critical hire was Dr. Julie Willems Van Dijk, who came on board to lead our community engagement efforts, bringing with her over 20 years of experience in community health. Over the years, Drs. Remington and Kindig stepped back into primarily advisory roles and the program was led by us, Drs. Catlin and Willems Van Dijk. This paper provides a summary of our collective reflections on the first ten years of CHR&R (January 2009-January 2019). Since both of us have now moved on to other pursuits, our thoughts in this paper are based not only on our recollection of the past 10 years and key documents but also on a larger perspective about how data, evidence, guidance, and examples can help communities improve the conditions in which their residents live, learn, work, and play.





Our Models and Theory of Change

a. The Rankings model

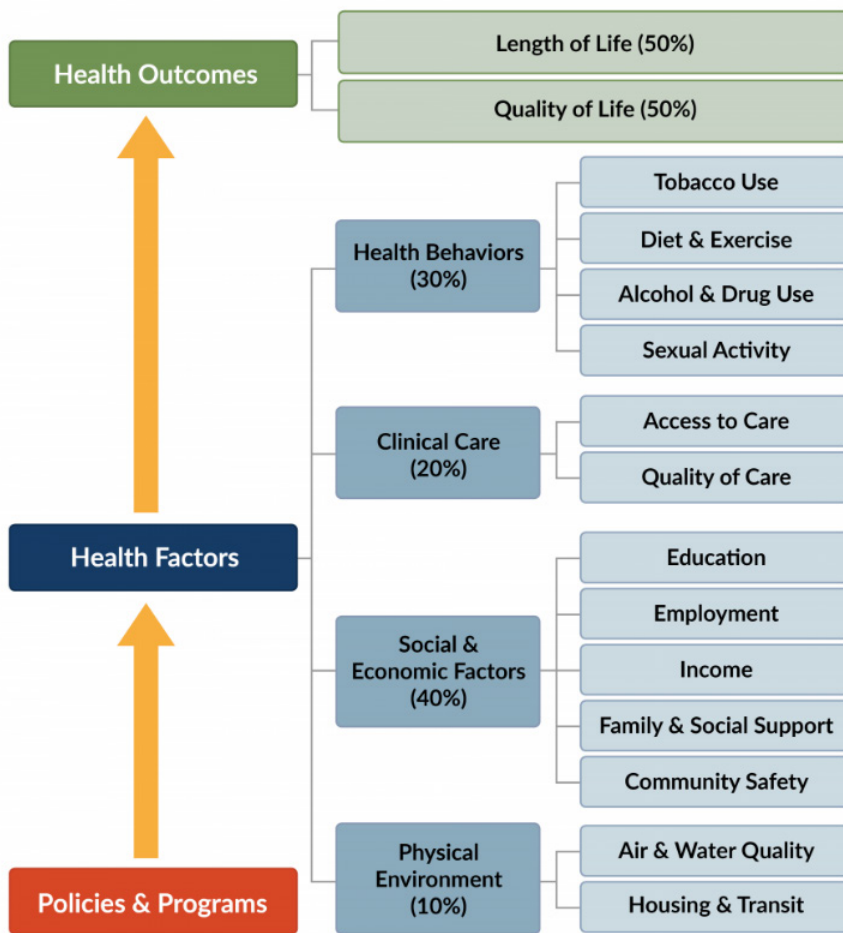
Perhaps one of the most recognized outputs of CHR&R is the County Health Rankings (CHR) measurement model (Figure 1) that drives the development of the rankings each year.

Six versions of the County Health Rankings model are included in Appendix C, beginning with the earliest models from the Wisconsin County Health Rankings where we released rankings annually from 2003 until 2008. These models are a depiction of how the Rankings are compiled. All but the first model (from 2003) have the same three components: Health Outcomes, i.e., how healthy a community is; Health Factors (previously Determinants), i.e., the modifiable factors that shape future community health; and Policies and Programs (previously Health Policies and Interventions), i.e., the tools that can be used to improve health. With the help of our communications colleagues, early on we began referring to outcomes as “today’s health” with factors representing “tomorrow’s health.” This was helpful in explaining why we ranked outcomes and

factors separately (in contrast to our forerunner, America’s Health Rankings, that provides one overall rank for states that captures both outcomes and factors).

The early Wisconsin models included the specific measures used whereas in later years we chose to list “focus areas” within the Health Outcomes and Factor components (there is no formal measurement of Policies and Programs to-date) rather than including detailed listings of measures. Moving to this summary form of the model allowed us to make minor changes to measures without having to change the overall model. In fact, over the past 10 years, we only changed the CHR model twice: the first time was a minor change in 2012 when we changed one of the Health Behavior focus areas from “unsafe sex” to “sexual activity.” The second change was more significant when we moved the “built environment” measures into their respective Health Behaviors category (i.e., diet and exercise), combined air and water quality, and added a focus area on housing and transportation.

FIGURE 1
County Health Rankings (CHR) Measurement Model



County Health Rankings model © 2014 UWPHI

These changes may seem minor but, not only did they require recoding the Rankings calculations, they also necessitated changes in the placement of strategies in our evidence tool, What Works for Health (WWFH). Along with these changes in our operational procedures, we were also cognizant there would be a rollover effect for those who had adopted our model for their own community work. Consequently, as noted above, we made few changes to the CHR model over the years. We explain more about our thinking regarding changes to the model and measures in the next few paragraphs.

Also, of note in these models are the weights that are assigned to each of the model components in order to construct the Rankings. The allocation of weights within the Health Outcomes component of the model has stayed constant over the years (at least through 2020). We received minimal feedback about these weights—the allocation of half of the Outcomes rank to mortality (Length of Life) and half to morbidity (Quality of Life) seems to have resonated with our users. Including both length of life and weighting them equally was a hallmark of our program since many community data efforts at that time relied only on mortality data (i.e., length of life).

We applied a lot of thought and analysis to how to distribute weights among the four Health Factor areas: Health Behaviors (30%), Clinical Care (20%), Social and Economic Factors (40%), and Physical Environment (10%). These weights represented a change from the weights we had used in the Wisconsin model where we gave a weight of 40 percent to Health Behaviors and only 10 percent to Health Care. [An in-depth examination](#) of how we derived the weights for the national rollout remains one of the most frequently downloaded documents from our website and is widely cited. We have also conducted several follow-up analyses, including two published in peer-reviewed journals,^{1,2} that confirm that these weights are a *reasonable approximation* of how these factors contribute to the health outcomes reported in the Rankings. We purposefully say *reasonable approximation* since the Rankings model uses round numbers (i.e., 30%, 20%, 40%, and 10%) rather than the more precise estimates that detailed statistical analysis provides. We believe the ability to contribute to community discussions about the relative contribution of different factors that can improve health is better supported by round numbers such as these rather than more precise estimates. We remain convinced that social and economic factors are the most important contributors to community health and have seen a growing recognition over the past 10 years of their importance in determining how healthy places are and can be.

1 Park, H., Roubal, A.M., Jovaag, A., Gennuso, K.P., & Catlin, B. (2015). [Relative Contributions of a Set of Health Factors to Selected Health Outcomes](#). *Am J Prev Med*, 2015, 49(6): 961-9.
2 Hood, C.M., Gennuso, K.P., Swain, G.R., & Catlin, B.B. [County Health Rankings: Relationships Between Determinant Factors and Health Outcomes](#). *Am J Prev Med*, 2016, 50(2):129-135..

FIGURE 2
County Health Rankings Logic Model

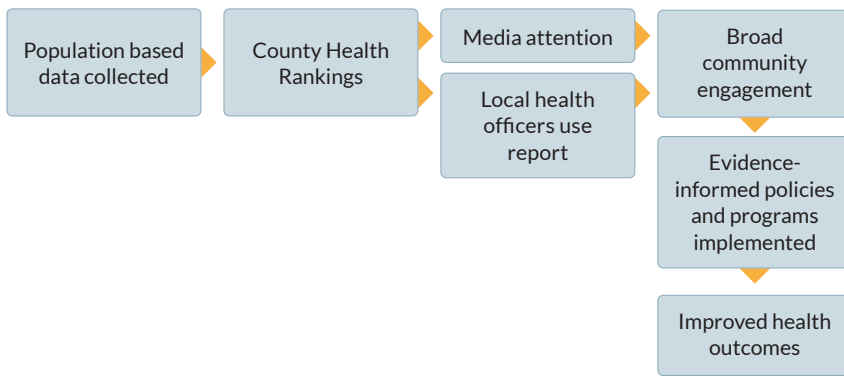


FIGURE 3
County Health Rankings Logic Model

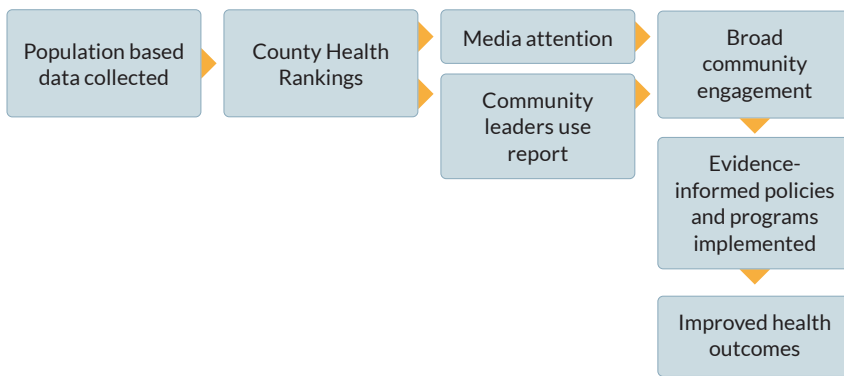
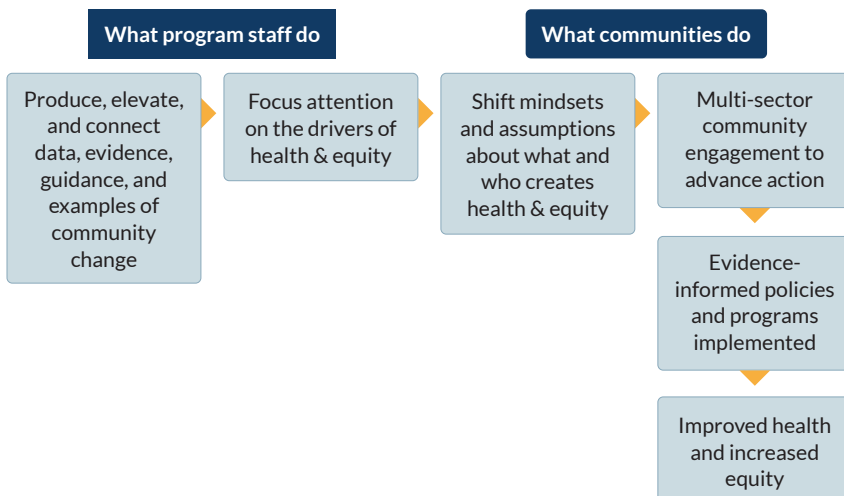


FIGURE 4
CHR&R/Prize Theory of Change



As we will discuss later in this paper, some academics have criticized the weights in the CHR model and at the same time many organizations have adopted a version of the CHR model as a *guide* to their own community health improvement work. While it is encouraging to see the reach of the CHR model, it is important to remember that the CHR model **is not** a perfect representation of the relative contribution of different factors that influence community health, but that **it is** an accurate representation of how the Rankings are compiled.³

b. Theory of change model

To put the County Health Rankings in context and explain how we saw them fitting into community health efforts, we developed our first logic model for the Rankings which looked like this (Figure 2):

After the first year, we realized we wanted to broaden the reach of our work beyond traditional public health and so we changed “local health officers use report” to “community leaders use report” and continued talking about this model (Figure 3) for several years.

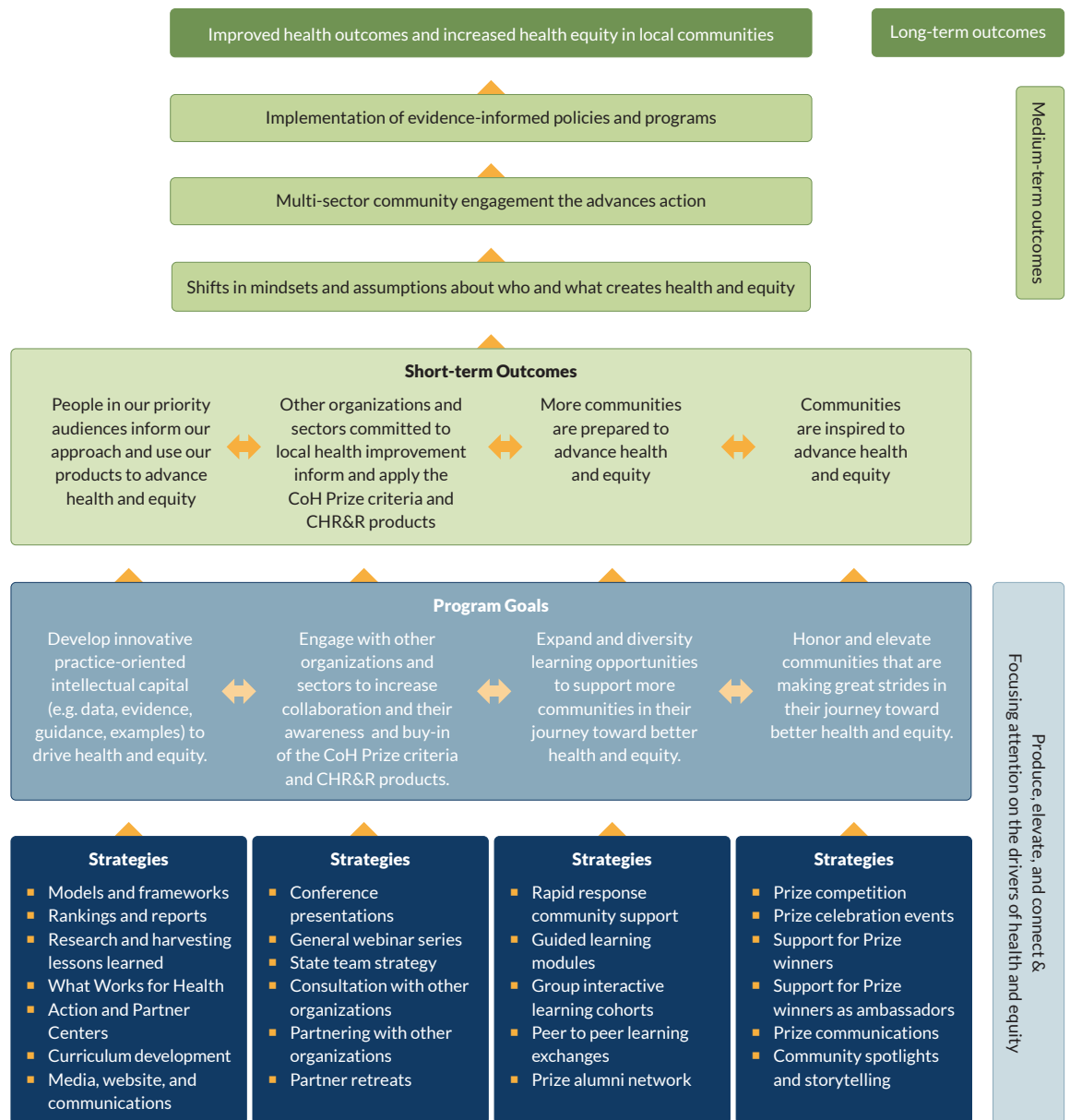
As the program grew with significantly more time spent on providing guidance to communities and identifying community exemplars, we realized we needed a more comprehensive logic model that highlights the four major CHR&R/Prize activities: data, evidence, guidance, and examples. The logic model on the left was our first attempt to broaden the model (Figure 4). This version also adds the concept of “shifting mindsets” to illustrate a critical step in moving community members from awareness to action.

A more recent and comprehensive version follows (Figure 5). This version articulates programmatic goals (in blue) and short-term community outcomes (in green) to connect program activities with intended outcomes.

In addition to adding mindset shifts, recognizing the broad range of our work, and providing more detail, perhaps of greatest importance is the fact that both newer logic models include the word “equity.” Calling out equity as an ultimate program outcome acknowledges that we not only want our

work to contribute to improved health outcomes in local communities but want it to further the elimination of disparities among population groups, the creation of opportunities, and removal of obstacles in the community, so that all members have a fair chance to be as healthy as possible.

FIGURE 5
CHR&R/Prize Program
Theory of Change/
Logic Model



c. Take Action Model

From the beginning, the purpose of the County Health Rankings was not simply to measure the health of communities, but to use this information to inspire action to improve health. Our Take Action Model (Figure 6) became a complement to the Rankings model to illustrate **who** was necessary to make change (priority audiences) and **how** that change transpires (action steps). The various Take Action Models used over the years are included in Appendix D and are summarized in Table 1.

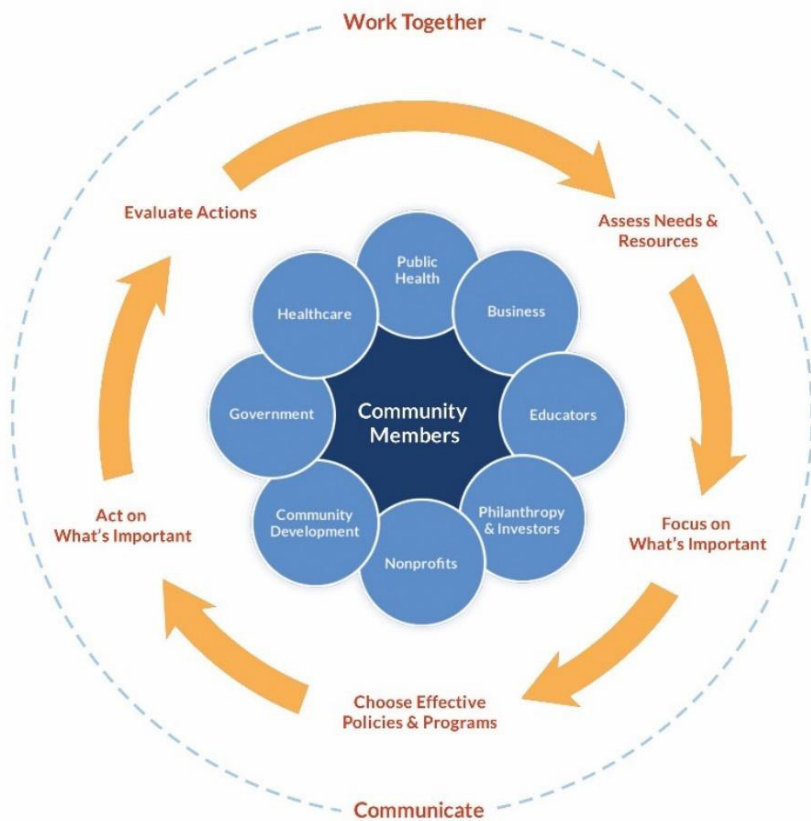
As previously noted, although we started off with public health professionals as our primary audience in our original logic model, we soon realized that to catalyze change we needed to get the attention and buy-in of other community leaders. Consequently, we also changed the audiences included in our

Take Action model several times, increasing the scope of our outreach. The action steps for how to make community change remained relatively stable over the years, however, the relationship among them evolved.

One of the issues identified in the latest theory of change/logic model (Figure 5) is the notion of “priority audiences.” This is a particularly challenging area since, as is apparent from Table 1, the number of “priority” audience types for CHR&R’s work expanded significantly over the first six years of the program. Various external entities (such as the Strategic Assessment Group commissioned by RWJF in 2016) weighed in on our multiple audiences but, as is so often true in public health work, no one wants to be excluded from our “priority audiences.” And, as we learned over the years, audiences that are poised to catalyze change at the community level may represent different groups from place to place, making it hard to classify “priority audiences” other than in broad categories.

With an increasing focus on health equity and improving health **for all**, we realized not only are community members central to health improvement efforts, but certain community members are more likely to experience poorer health outcomes due to historical and current circumstances beyond their control. In all our community activities, we now stress the importance of inclusion of marginalized community members as decision-makers and implementers of community health improvement.

FIGURE 6
Take Action Model



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TABLE 1
Evolution of the
Take Action Model

Year	WHO—Audiences	HOW—Action Steps
2010	Public health professionals Health care professionals Government officials Employers and businesses Community leaders	Assess needs & resources Pick priorities Find programs & policies that work Implement strategies Evaluate efforts Work together (<i>beneath Take Action title</i>)
2011	<i>Community (moved to center of model)</i> Public health Health care Government Business <i>Education</i> <i>Grantmakers</i>	No change
2012	Community <i>members (remains in center of model)</i> Public health Health care Government Business Education <i>Philanthropy & investors</i>	Assess needs & resources <i>Focus on what's important</i> <i>Choose effective policies & programs</i> <i>Act on what's important</i> <i>Evaluate actions</i>
2013	No change	<i>Added Communicate</i>
2014	Public health Health care Government Business Community members Education Philanthropy & investors <i>Community development</i> <i>Nonprofits</i>	<i>Added circle around audiences connecting Work Together and Communicate to indicate their interaction with other Action Steps</i>
2015	No change	<i>Moved Work Together and Communicate circle to the outer ring, encompassing entire model</i>

Note: Changes are indicated in orange.



Measuring the Health of Communities

a. How measures progressed over the years to reflect our evolving understanding

For the first 10 years of the County Health Rankings, the five ranked Health Outcomes measures (premature death, poor or fair health, poor physical health days, poor mental health days, and low birthweight) have remained essentially unchanged (with the exception of a change in data collection and analytic methods for the second through fourth measures which come from the Behavioral Risk Factor Surveillance System). This was a conscious decision so that communities would have consistent measures for tracking changes in health outcomes.

In addition to the five ranked Health Outcomes measures, we also started reporting on diabetes and HIV prevalence as “additional” measures in 2011. Over time, we added many additional measures for counties to further explore health in their communities. These measures did not qualify as ranked measures but are listed along with ranked measures in each county’s online snapshot.⁴ Other

additional health outcome measures added over the years include infant mortality, child mortality, age-adjusted mortality under age 75 (premature), frequent physical distress, frequent mental distress, and, most recently in 2019, life expectancy.

The measure we call premature death—years of potential life lost (YPLL) prior to age 75 per 100,000 population—has been the primary outcome measure over the years. We chose this measure among other mortality measures because YPLL focuses attention on deaths that could have been prevented, gives more weight to deaths at earlier ages, captures changes in death rates, and can be decomposed into years lost due to specific conditions. We thought these benefits outweighed the challenges that often arose when trying to explain the measure. (One of us still recalls the difficulty in explaining this measure simply to a New York Times health reporter 2011 in as few words as possible.) Alternative measures such as

life expectancy or even healthy life expectancy have more intuitive appeal because they are positively framed and, on the surface, seem easier to explain. However, life expectancy has only recently become available at the county and the subcounty level. In addition, the underlying calculations are quite complicated and can take years to capture changes in underlying mortality rates. This is a brief example of the thought that goes into selecting measures.

When it came to selecting measures for the four major Health Factors (health behaviors, clinical care, social & economic factors, and the physical environment), we did not commit ourselves to the same stability in measures because we wanted to make the most useful and up-to-date data available to communities. And, as a wise colleague once said, when schools report on their students' grade point averages (GPA) in a single numeric score, that GPA reflects a different combination of classes taken by each student—including both traditional and new courses of study. So, each year we set out to find the "best" measures available to reflect the different components of the CHR model. As noted previously, this even meant making a few changes to the CHR model to reflect new understanding of the root causes of poor health and newly available data measuring these causes.

The specific changes made to each year's measures⁵ can reflect:

- Modifications in data availability or calculation of existing measures,
- The identification of measures that are new to the Rankings, or
- Adjustments made in response to user feedback.

Over the years, we added key new measures such as:

- The food environment index and access to exercise opportunities (both developed by our own research team),

- Access to dentists and mental health practitioners (to expand our measure of access beyond just primary care physicians),
- Income inequality (included in the initial 2010 release and then re-added in 2015 with a measure that was easier to explain),
- Social associations (introduced in 2015 to replace a measure of inadequate social support that was no longer available), and
- Housing and transit measures (an entire new category added in 2014).

In addition, several measures that figured prominently in our annual Key Findings Report were not included in our Rankings calculations but were added as additional measures, e.g., drug overdose deaths (added in 2014), residential segregation and insufficient sleep (2016), disconnected youth (2017), and life expectancy (2019).

Over the years, the addition of new measures gave us the flexibility to highlight measures most relevant to what was happening in the external environment related to health and what community decision-makers were facing while maintaining fidelity to the CHR model and continuing to advance the narrative about who and what creates health.

Our initial listing of measures was reviewed by our Metrics Advisory Group in 2009 and we began an annual process of checking and coordinating our choice of measures with other similar platforms such as America's Health Rankings and, more recently, the City Health Dashboard. Beginning in 2014, our Scientific Advisory Group⁶ and RWJF reviewed new measure proposals and helped us decide whether to include specific measures, and, if included, how to discuss the measures in written materials, presentations, and media interviews. Along with the invaluable advice provided by the members of these groups, we also received significant assistance over the years from staff at the Centers for Disease Control and Prevention who helped identify, provide, and interpret relevant data.

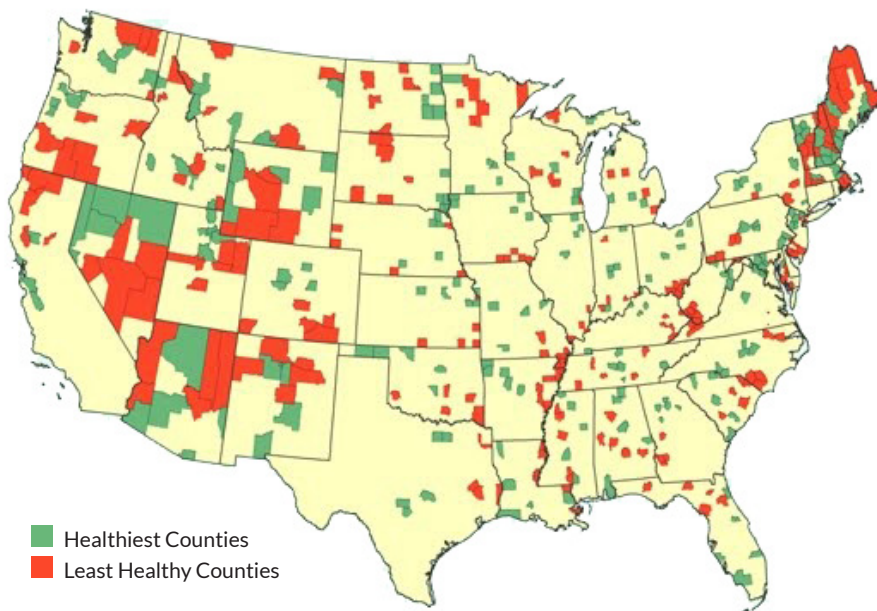
5 <https://www.countyhealthrankings.org/resources?keywords=CHR+Measure+Changes>

6 <https://www.countyhealthrankings.org/about-us/advisory-groups>

b. Review of results reported in press releases and Key Finding Reports

Each year we (UWPHI, RWJF, and Burness) produced 50 state press releases to announce the latest version of the CHR. State press releases are important because the CHR products are primarily directed towards states and local communities. However, to reach as many people as possible to shift the narrative about what creates health, national media coverage was also important. One of the challenges we faced every year when we released the Rankings was telling a “national” story for a project that focuses on within-state county rankings and community health outcomes and determinants. Each year, we were always short of time between when the last data became available and the planned release date and so there was often only time for more rudimentary analyses. In more recent years, with the addition of staff devoted to conducting research throughout the year, the challenge lessened but never completely went away: Encouraged by RWJF and our communications partners, we expanded our data view not just to the county-level Rankings data set but also to examine national data sets that focused on a wider array of more in-depth measures.

FIGURE 7
2010 County Health Rankings: 5 Healthiest and Least Healthy Counties by State, Continental U.S.



The press release in the first year (2010) not surprisingly highlighted the availability of the new CHR resource, available to all states and covering most counties in the United States. National outlets publishing stories on the 2010 release included the Washington Post, USA Today, and NPR. USA Today published a full-page story that included the map (Figure 7), reporting that premature death rates were 2.5 times higher in the least healthy counties than in the healthiest.

Other results included in the 2010 press release, focused on additional differences between the five healthiest and least healthy counties in each state, with the least healthy counties having:

- High smoking rates that lead to cancer, heart disease, bronchitis, and emphysema.
- High rates of obesity which can put people at risk for diabetes, disability, and heart disease.
- High unemployment and poverty rates.
- High numbers of liquor stores and fast-food outlets but few places to buy fresh fruits and vegetables.

Similar rudimentary analyses were conducted and reported in the press release the following year.

By 2012, we were able to expand our analyses to not only look at differences between counties in the top and bottom 10 percent but also to look at regional patterns across the nation, at that time:

- Excessive drinking rates are highest in the Northern states.
- Rates of teen births, sexually transmitted infections, and children in poverty are highest across the Southern states.
- Unemployment rates are lowest in the Northeastern, Midwest, and central Plains states.
- Motor vehicle crash deaths are lowest in the Northeastern and upper Midwest states.

By 2013 (our fourth release), our communication partners encouraged us to begin looking at national trends. While we did have four data points for most of our county-level measures, many of these data points were based on multiple years of data (rather than on single years) in order to have enough sample size across most counties. This meant that each data point had considerable overlap with data points from previous years. So, we began to turn to other national data sources to report trends in some of key measures, for example:

- *Child poverty rates have not improved since 2000, with more than 1 in 5 children living in poverty.*
- *Violent crime has decreased by almost 50 percent over the past two decades.*

In 2014, we added seven new measures: housing, transportation (two measures), food environment, mental health, injury-related deaths, and exercise opportunities. Our national press release not only highlighted trends from existing measures but also had brief profiles on each of the new measures, for example,

- *Housing: Almost 1 in 5 households are overcrowded, pose a severe cost burden, or lack adequate facilities to cook, clean, or bathe. These problems are greatest on the East and West Coasts, Alaska, and parts of the South.*
- *Food Environment: People in many parts of the country face food insecurity (or the threat of hunger) and limited access to healthy foods, especially in counties in the Southwest, across parts of the South, and the western United States.*

This was also the first year we published an official Key Findings Report, primarily to provide a national overview of health outcomes and the factors that lead to these outcomes.

Since we had decided to add a new measure of income inequality in 2015, we focused our national findings on social and economic factors. With our new measure of income inequality, we published

findings about children in poverty, income inequality, violent crime, and unemployment. Due to concerns that “income inequality” was either too wonky or too partisan, we did not actually refer to “income inequality” in our press release but instead talked about distribution of income as well as the links between income and health.

Later in 2015, we released 50 State Health Gaps Reports. Each report identified significant gaps in opportunities for good health among counties within every state. Each state report detailed how well the healthiest counties do; the difference that could be made if every county had the same chance to be healthy; and strategies to close the gaps between the healthiest and least healthy places. In other words, these reports represented a shift toward talking about equity, but without saying it.

In 2016, our Key Findings Report and national press release focused on comparisons between urban, suburban, and rural counties. For example:

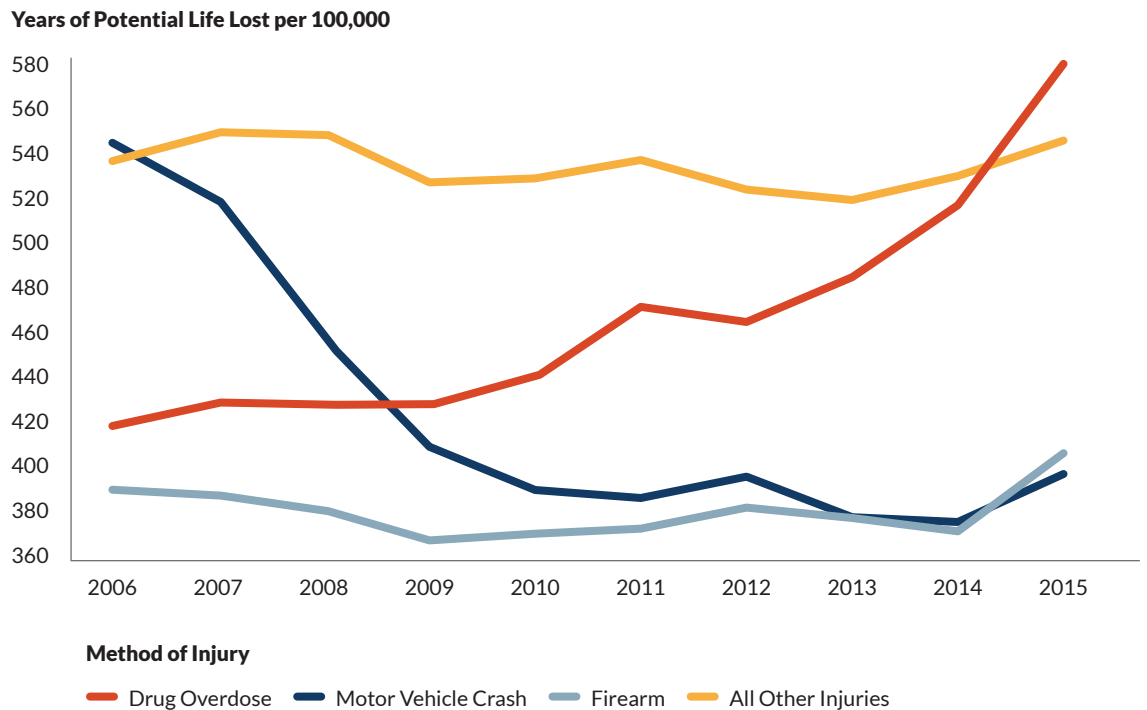
The report shows dramatic differences between rural and urban counties on a number of measures, most notably premature deaths rates. Rural counties not only have higher rates of premature death, but also nearly 1 in 5 rural counties saw rises in premature death rates over the past decade while most large urban counties experienced consistent improvement.

We also covered three new measures (additional not ranked): residential segregation, drug overdose deaths, and insufficient sleep.

In 2017, our Key Findings Report dug deeper into premature death rates, looking over time across age groups, race and ethnicity, and different causes of death by injury (drug overdose, motor vehicle crashes, firearms, and other types of injury).⁷ The report also introduced a new additional measure: disconnected youth (those who are aged 16 to 24 who are not in school or working). Figure 8 shows one of the key graphics featured in the report.

7 National and local data efforts were coordinated. Local end users were also able to unpack YPLL in the snapshot to understand leading causes of death in their community.

FIGURE 8
Premature Death
Trends by Method
of Injury from
2006 to 2015



By highlighting drug overdose deaths in two consecutive years, we were able to add to the growing national dialogue about loss of life (particularly among 15- to 44-year-olds) due to drug overdoses.

In 2018, the focus of the Key Findings Report was not only to continue to identify health gaps by place but also to highlight data by race and ethnicity.⁸ This was part of the program’s growing efforts to address not only health but also equity. We featured the “intersection of race, place, and health” with an examination of racial differences in low birthweight (one of the ranked five Health Outcome measures) and an extension of the discussion of residential segregation which we

began in 2016. Finally, the report addressed key trends among the nation’s children and youth, including teen births and children in poverty. (This year also marked a major revision to the annual state reports, incorporating data like that seen in the 2015 State Health Gap Reports and the 2018 Key Findings Report.)

2019 represented a change in strategy for the Key Findings report with its focus on a single topic: housing, and specifically, severe housing cost burden and residential segregation.

A detailed listing of the content of press releases and key findings is provided in Appendix E and Table 2 summarizes each year’s focus.

⁸ Explicit but not exclusive racial equity focus was strategically integrated into all products at the local, state, and national level. This was the first year we offered measures disaggregated by racial groups.

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TABLE 2
Summary of CHR
National Press
Releases and Key
Findings Reports,
2010-2019

Year	Focus of press releases/key findings	New measures highlighted	Important notes
2010	Top 5 healthiest vs unhealthiest counties by state	None	
2011	Top 5 healthiest vs unhealthiest counties by state	None	
2012	Top 10% healthiest vs unhealthiest counties by state Regional patterns	None	
2013	Trends in key measures: child poverty and violent crime	None	
2014	Trends in key measures: child poverty, college attendance, smoking, physical inactivity, and preventable hospital stays Listed healthiest and least healthy county by state Comparison of top 10% healthiest vs unhealthiest counties by state	Housing Transportation Food environment Mental health providers Injury-related deaths Exercise opportunities	First year publishing Key Findings Report
2015	Change in premature death between 2010 and 2015 Focus on social and economic factors (income and poverty, employment, and community safety) National results	Income inequality	Included “potential solutions” for the first time Released 50 State Health Gap reports
2016	Rural and urban differences over time: premature death and key health factors Health gaps: adult obesity, uninsured, and child poverty	Residential segregation Drug overdose deaths Insufficient sleep	Listed additional measures in Key Findings Report for the first time
2017	Premature death rates over time by age, race & ethnicity, and cause of injury deaths Focus on opportunities for youth and young adults	Disconnected youth	Featured Prize winners for the first time
2018	Health gaps by race and place: low birthweight, high school graduation rates, unemployment, and residential segregation Key trends among children and youth: children in poverty and teen births	None	
2019	Housing: severe housing cost burden, home ownership, residential segregation, and gentrification Compares large urban and smaller metro counties	Home ownership Severe housing cost burden	



The Evidence We Use to Guide Communities

a. The genesis and structure of What Works For Health

Our entry into compiling evidence to guide communities originated at UWPHI under the auspices of the Wisconsin Partnership Program-funded Making Wisconsin the Healthiest State project. This project had three analytic aims:

1. Characterize the population health of Wisconsin and Wisconsin communities.
2. Compare the population health of Wisconsin with that of other U.S. states and other states' communities, as well as relative trends across states.
3. Attempt to determine relationships between health determinants and outcomes across states and identify programs and policies that may be effective in altering determinants that yield intended outcomes to guide policy and investment for Wisconsin improvement.

In working towards completing the latter part of the third aim, the project leaders (Kindig, Remington, and Catlin) originally hoped to identify a "short list" of effective programs and policies. However, it became apparent that with so many health determinants and so many different strategies for addressing each determinant, identifying a "short list" was not going to be possible. Instead we changed course to develop a database containing summaries from our team's reviews of literature regarding the evidence in support of policies and programs that might influence key health determinants. This evidence was entered into a database, *Policies and Programs to Improve Wisconsin's Health*.

For each policy or program, the database contained the following information:

- A brief description of the policy or program,
- The decision-maker(s) who could enact the policy or program,
- The level of implementation in Wisconsin,
- The expected beneficial outcomes of the policy or program, and
- The sources of evidence on the effectiveness of the policy or program.

In addition, we rated each policy and program based on:

- Strength of evidence of policy or program effectiveness,
- Potential impact of the policy or program on health disparities, and
- Potential population reach, i.e., the number of Wisconsin residents potentially affected.

We launched this database on a publicly accessible web site, What Works for Health: Policies and Programs to Improve Wisconsin's Health, in 2009 (while also starting work on the County Health Rankings and related activities). Since its Wisconsin launch in 2009, What Works for Health has offered a searchable database of policies and programs with evidence ratings, summaries of research findings, and implementation resources.

When we expanded the CHR program in 2011 with funds from RWJF, we converted What Works for Health (WWFH) into a national platform.

To populate WWFH, strategies are identified that address one of the factors in the CHR model. Evidence analysts begin with a broad orientation search to define each strategy and identify appropriate search terms and then conduct targeted literature searches. They focus first on systematic reviews and peer reviewed studies, then on selected sources of grey literature and the findings of relevant, reputable organizations that assess policy and program effectiveness (rating organizations). All searches are conducted electronically. Due to the broad nature of the factors in the County Health Rankings model, the sources searched vary by health factor and strategy. Retrieved articles are screened by date, relevance to the topic of interest, applicability of findings, study type, and impartiality of author(s). Analysts retain the most relevant, recent, rigorous reviews and studies for consideration in evidence rating. Ratings are assigned based on two analysts' assessments of the strength of the overall body of evidence (type, quality, number of studies, consistency of findings, etc.) as it pertains to specified outcomes. They place the most weight on the findings of studies with designs that demonstrate causality; we consider study quality in conjunction with design. External content experts also review ratings.

b. How What Works for Health has been used over the decade

With its national launch in 2012, WWFH has now grown from 200 to over 400 strategies. WWFH is designed to make it easier for public health practitioners and community members to find evidence as they think about which strategies (policies, programs, systems, or environmental changes) will best meet their priorities and fit their culture and context.

WWFH has also been used by several other national organizations working to improve health. They direct people to WWFH via specific feeds of its content. In addition, America's Health Rankings used it to help populate the "Take Action" component of their website. WWFH is also one of several databases that was used to populate CDC's Health Improvement Navigator⁹ and was also recently added to the Pew-McArthur Results First database (Pew-McArthur, 2018).¹⁰

9 Roy B, Stanojevich J, Stange P, Jiwani N, King R, Koo D. (2012). Development of the Community Health Improvement Navigator Database of Interventions. *MMWR Suppl*; 65(2):1-9. doi:10.15585/mmwr.su6502a1

10 The Pew Charitable Trusts. Results First clearinghouse database. 2018.

<https://www.pewtrusts.org/en/research-and-analysis/articles/2018/06/27/results-first-improves-clearinghouse-database>.

While there are many other tools that offer evidence summaries,¹¹ WWFH is unique in its comprehensive coverage of the many factors that drive health, and with its emphasis on strategies to address social and economic factors, where evidence summaries and assessment are less common than in the medical or public health fields. Since the Wisconsin launch of the database in 2009, in addition to its evidence ratings, WWFH has also offered an assessment of the likely impact of strategies on disparities¹² among socioeconomic groups, racial/ethnic groups, and geographic areas. In addition, two reports were created to provide assistance in identifying effective strategies for rural areas¹³ and for those seeking to address socioeconomic factors.¹⁴

WWFH can be used to get a sense of the types of potential strategies that can be used to address a health factor or issue or to find out how effective a known strategy has been found to be. However, just because a strategy is found using a specific search term, this does not necessarily mean that CHR&R recommends that strategy to address that issue. The strategy may be only tangentially related to the search term or the strategy may not have adequate evidence: WWFH not only includes strategies that have been shown to be effective but also includes those where there is insufficient evidence of effectiveness or evidence of ineffectiveness.

11 Bergum A, Grigg L, Givens ML, Catlin BB, Willems Van Dijk, JA (2019). How to Be an Informed Consumer of Evidence Ratings: It's in the Details. *Prev Chronic Disease* 2019;16:190067. DOI: https://www.cdc.gov/pcd/issues/2019/19_0067.htm

12 <https://www.countyhealthrankings.org/take-action-improve-health/what-works-health/our-ratings>

13 <https://www.countyhealthrankings.org/what-works-strategies-improve-rural-health>

14 <https://www.countyhealthrankings.org/reports/what-works-social-and-economic-opportunities-to-improve-health-for-all>



Perspectives on the Who, What, and How Community Change is Led

It was clear from the first release of the County Health Rankings in 2010 that the Rankings were an effective approach to gaining media attention. What was less clear was how that attention translated into community action to improve health. In 2011, UWPHI and RWJF embarked on a new approach to building healthy communities across the nation by providing a cadre of tools to support communities moving from data to action; engaging leaders from sectors outside

of the public health sector; and creating a competitive award to honor and elevate communities working at the forefront of advancing health, opportunity, and equity. Over the decade, the program provided an evolving continuum of support to communities in conjunction with a network of partners, alliances and technical assistance providers, and a rich online resource of data,¹⁵ evidence,¹⁶ guidance,¹⁷ and examples¹⁸ of positive community change.

a. Who creates community change?

Core to every iteration of CHR&R's theory of change/logic models (see section II.b.) has been two primary audiences—the media and those who create community change. Both groups have been essential CHR&R audiences—each with a unique role. The media has been a critical audience for disseminating the Rankings and, through the program's messaging, contributing to shifts in the

public narrative about health and equity and the assumptions about what and who creates health and equity. This media coverage, along with the program's assets, have worked to enlarge the circle of sectors and people who engage together to implement evidence-informed policies and programs to improve health and increase equity.

15 <https://www.countyhealthrankings.org/explore-health-rankings>

16 <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health>

17 <https://www.countyhealthrankings.org/take-action-to-improve-health>

18 <https://www.countyhealthrankings.org/learn-from-others>

i. Media

As noted in multiple evaluations of the program, the strong communications investment in CHR&R has been a key element of the program's success to widely engage the media in disseminating the program's key messages. Each year, the County Health Rankings and its accompanying Key Findings Report generates thousands of print, broadcast, and online stories, reaching millions of people. With the communication team's focus on achieving a combination of national, state, and local coverage, the program has been able to sustain a high level of interest in the Rankings over the entire first decade of the program.

Key messages about the Rankings that were drafted for the first release still serve as core messages for the program:

- Where we live matters to our health.
- There are great disparities in health based on where we live.
- Many factors contribute to health.
- Health is more than health care.
- Health is everyone's business.
- We all need to work together to improve the health of our communities.

Over the years, key messages were expanded to include analyses from the Key Findings Reports, often accompanied by suggested policies and/or examples of action. See Appendix F for a comprehensive collection of key messages. Beginning in 2015, the core messages began to include messages that expanded the focus from simply improving health to increasing equity. Initially we focused on differences between the most and least healthy counties, and later added new equity-oriented measures (e.g., income inequality, residential segregation) and analyses that compared data by geographic type (urban, suburban, rural), age groups, and race and ethnicity to illustrate disparities in status and opportunities both within and across counties.

ii. Community changemakers

Three key messages prevailed throughout every release of the County Health Rankings:

1. Health is influenced by many factors,
2. Where we live matters to our health, and
3. Health is everyone's business.

A fourth message, emerging in later years, emphasized that **not everyone has the same opportunity to be healthy**. The program's focus on local data to drive local action compelled us to think strategically about who was most likely to lead and implement efforts to improve their community's health.

As illustrated in the evolution of the Take Action Model, our initial approach to identifying key audiences for action was to focus on sectors of community leaders. In 2010, we largely connected with public health leaders in state and local health departments and public health institutes, encouraging them to build partnerships with leaders in other sectors including health care, government, business, and community organizations. At that time, building multisector partnerships was a new practice for many public health professionals. They suggested that their approach would be strengthened if RWJF and the CHR&R program conducted initial outreach to other sectors—such as hospitals, county officials, and employers—that would open the door for public health practitioners to follow up with them. This suggestion became the foundation of the CHR&R partner strategy. In 2016, the approach of public health leaders as strategists convening and facilitating multisector partnerships became a core component and expectation of the profession as outlined in the Public Health 3.0 approach.¹⁹

Building on the counsel from public health partners, the CHR&R partner strategy aimed to stimulate other sectors to engage in local health building efforts. Through formal funded relationships with national organizations—including United Way Worldwide, National Association of Counties, National Business Coalition on Health,

NeighborWorks, and Local Initiatives Support Corporation (LISC)—that also had local presence, we expanded our reach to multiple sectors including local elected officials, employers, United Ways, and community development organizations. Less formal partnerships emerged with other sectors including philanthropy, hospitals, advocacy organizations, and education. Initially, we raised awareness about CHR&R, its key messages, and its data, evidence, guidance, and examples to support their constituents' local action. As awareness led to buy-in by local leaders, the program's efforts shifted to providing customized support for local initiatives led by multisector leaders from these organizations.

An approach that simply focused on each sector, however, turned out to be far too limiting. During a 2012 visit with former New Orleans Health Officer Karen DeSalvo, she shared that “community members do not live in sectors,” challenging us all to think about an integrated approach. The program's emerging focus on equity led us to think about how community members, especially those most affected by poor health, must be included in all aspects of health improvement efforts in meaningful ways that include shifting and sharing power. And population health leaders opined about who does, could, or should serve as the “super integrator” for multisector efforts.²⁰ What we have seen, largely in Culture of Health Prize-winning communities, is that there is not one recipe that works for all; however, successful efforts that are sustainable and outcome-oriented generally require people serving in a combination of the following roles:

- **Conveners:** People who see the need for change; who know they can't achieve change alone; who have fire in their bellies for change; who can influence people, policy, and power in their communities; and/or who can mobilize partners to turn recommendations from required reports—such as hospitals' Community Health Needs Assessments (CHNA) or public health's Community Health Assessment and Improvement Plans (CHA/CHIP)—into meaningful action. Conveners come from a variety of sectors including public health, health care, local government, community development, nonprofits, school districts, philanthropy, and more.

- **Investors:** People who hold the power and purse strings to allocate resources for meaningful change. Investors include local and regional philanthropy; local elected and government officials; anchor institutions, such as hospitals or universities, community development financial institutions (CDFI) and other local lending institutions; and more.
- **Community Voice:** People who represent the need for and the assets to create change, including those who are experiencing poor health and/or the worst inequities. Community voice in changemaking can be heard through individual community members or may be represented through others in the community such as organizers, social/racial justice organizations, civil rights advocates, or faith-based organizations.

Throughout CHR&R's evolution, RWJF and UWPHI recognized that shifting the narrative about health and equity and supporting communities in taking action to implement evidence-informed policy, systems, and environmental (PSE) change required a broader skillset and more resources than the staff and other assets of CHR&R possessed. As we focused on supporting community changemakers, we built relationships with other organizations, many who were also funded by RWJF, to broaden the expertise available to communities. Early in the expansion of the Roadmaps component of the program, Community Catalyst was funded to provide policy and advocacy expertise primarily focused on the recipients of the Roadmaps to Health community grants. In 2014, Healthy Places by Design (formerly known as Active Living by Design) was funded to support smaller community grants, contributing their expertise in PSE change and working with communities most affected by poor health. Knowledge and skill building on boundary spanning leadership, coaching models, and networking strategy were provided by the Center for Creative Leadership. Collaborative relationships with numerous other partners provided coordination of data, evidence, and guidance focused on community change and many opportunities to learn together.

b. The what and how of community change: The Prize criteria

In 2011, under the leadership of Dr. David Kindig, we began to conceptualize an award to honor communities who were leading efforts to improve health in their communities. This initiative acknowledged the reality that many communities were already engaged in multisector action focusing on the many factors that influenced health and that finding places who were already deep into this work would enhance our and other communities' learning. This effort, originally known as the Roadmaps to Health Prize, was later retitled the RWJF Culture of Health Prize to reflect the Foundation's investment in its strategic vision of a Culture of Health.

In retrospect, the most important element of creating the Prize was establishing the criteria used to select the winning communities. From the first Prize winner selection in 2013 to the most recent announcement in 2019, these communities have served as inspirational and instructional examples for how to move action forward to improve health across the many factors that influence outcomes. The Prize criteria have come to serve as the central explanation and guidance for how communities can weave together an integrated health and equity improvement strategy.

The criteria emerged through an iterative process. Because we wanted to learn how multiple sectors are working together to create a comprehensive response to the needs and assets of the community, the Prize applicant was determined to be whole communities rather than individual leaders or organizations. It appeared that this was a unique approach and thus finding similar criteria in other programs was challenging. Our approach focused on the collective wisdom and life experience of program staff, expert advisors, and RWJF staff coupled with emerging models of collective action²¹ and standards for community health improvement in specific sectors such as public health and hospitals.^{22,23}

The original Prize Advisory Group (PAG) held a strong position that the Prize should be awarded based on criteria with a heavy emphasis on improvement in health outcomes and reduction in health disparities. The issue of quantitative metrics versus qualitative elements was hotly debated among staff and PAG members. In the end, RWJF weighed in as noted in this letter describing the Foundation's reaction to the PAG's initial recommendations:

Our RWJF partners are very excited about the award and pleased with our direction, expressing strong support for the key themes and purpose elements that you helped craft. However, they did express concern about the feasibility of measuring improvement, achievement, and inequity reduction—which I know is a concern shared to some degree among PAG members. The Foundation team sees the award as a vehicle for engagement and cautioned that setting too high a bar with respect to metrics could have the unintended consequence of discouraging participation. The consensus from our call was that quantitative data should play a supporting rather than a driving role in the application process, particularly early on, as the award is developing and building momentum.

Seven years into the Prize, a quantitative approach to measure population health outcomes and inequity reduction in cities, towns, counties, or tribal communities remains a challenge; however, the criteria and methods for qualitative review have continued to develop over the life of the Prize program. The Prize criteria address the following six themes:

- Defining health in the broadest possible terms;
- Committing to sustainable systems changes and policy-oriented long-term solutions;
- Creating conditions that give everyone a fair and just opportunity to reach their best possible health;

21 Kania J, Kramer M. Collective Impact. *Stanford Social Innovation Review*. 2011:36-41.

22 Public Health Accreditation Board. Standards and measures, Version 1.5, 2014. <http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-20141.pdf>

23 Rosenbaum, S. Principles to consider for a community health needs assessment process, George Washington University, 2013. https://nnphi.org/wp-content/uploads/2015/08/PrinciplesToConsiderForTheImplementationOfACHNAProcess_GWU_20130604.pdf

- Maximizing the collective power of leaders, partners, and community members;
- Securing and making the most of available resources; and
- Measuring and sharing progress and results.

Appendix G includes a year-by-year description of the Prize criteria that have evolved based on what CHR&R/Prize team members, RWJF staff, and PAG members have learned from communities. Notable changes over the course of the Prize include:

- Encouraging communities to prioritize both the identified needs of their communities and those areas that have the greatest contribution to health outcomes, with an emphasis on social and economic factors when addressing the multiple factors that contribute to health;
- Encouraging a balance between innovation and evidence-informed approaches;
- Emphasizing upstream investments and a focus on value with resource decisions;
- Challenging communities to measure both process and outcomes with clearly defined definitions of success, goals, metrics, systems for process improvement, and opportunities to celebrate progress;

- Threading the elements of equity, collective impact, and RWJF's Culture of Health key messages across the criteria; and
- Making the most significant changes to the third criterion including:
 - Shifting from simply a focus on disparity reduction to cultivating a shared commitment to equity across the community;
 - Creating a welcoming, safe, and inclusive environment where people who are most affected by inequities have full voice to identify, prioritize, implement, and evaluate solutions;
 - Expecting a community-wide commitment to increasing opportunity and reducing obstacles to poor health; and
 - Emphasizing that the concepts of equity are not only contained within this criterion, but throughout all the criteria.

The ongoing evaluation of the Prize criteria, largely based on the practice-based evidence provided by the experience of Prize-winning communities, led to the full incorporation of the criteria into the tools and guidance provided by the Roadmaps to Health Action Center (described below).

c. The what and how of community change: Roadmaps to Health Action Center

With the inaugural release of the County Health Rankings in 2010, community leaders began calling UWPHI and RWJF to ask what they should do next to address their rankings. Program staff directed them to the data and the Take Action Model and encouraged them to “dig deeper” to understand more about their community’s needs, but clearly this was not a comprehensive or sufficient response. In 2011, the addition of Roadmaps to the program included a focus on community support to provide more complete resources to meet the needs of community leaders, described in the grant proposal as “real time, personalized training and consultation ... for all who request it via e-mail and/or telephone.”

Based on the initial response to the Rankings release, the expansion was grounded in a “Field of Dreams” philosophy of “if we build it, they will come.”

Originally, the Roadmaps to Health Action Center²⁴ was intended to be completely virtual—an online space that aggregated tools and guidance for communities—coupled with an ongoing webinar series to guide people to resources and examples of ways communities were advancing health. These online resources would also include light-touch technical support for those website visitors who had additional questions. In 2010-2011, when lower-ranking counties requested assistance,

we felt an obligation to respond and so staff would conduct follow-up phone contact and, in some cases, face-to-face site visits to consult with community leaders on how to advance action. Based on these early site visits and key informant interviews, we heard a need for human support to supplement virtual support in a more comprehensive way than simply responding to questions. Our local partners made the following recommendations:

- Build an empowering, supportive, strength-based model that begins with listening to the community's unique needs;
- Anticipate some communities will need more support than others to be ready for action, so it will be important to build a tiered model;
- Make it easy for a community to get support;
- Develop an outreach strategy (because if you build it, target audiences will not necessarily be able to find it), and
- Use a continuous improvement approach—i.e., learn from each situation, adapt, and move on.

Our plan evolved to include both virtual and human touch elements within the Action Center with a focus on incorporating the recommendations listed above.

We began with two community engagement specialists who designed the online Action Center. Our intent was to make it easy for communities to find all the information they needed to advance health-building efforts. So, we created a one-stop shop including facilitation guides based on the Take Action Model and a variety of tools to support each action step. To build on what was already known, most of the content in the Action Center linked to resources developed by and available online through other organizations' websites. The online Action Center also included a robust webinar series to provide audience members with monthly opportunities to listen, learn, and interact on specific topics about community health improvement—featuring subject matter experts and community leaders who were deploying strategies.

The public announcement of the Action Center platform coincided with the third release of the County Health Rankings in 2012. Our belief was that coupling this action resource with the communications outreach associated with the Rankings data would drive community members to both resources. We now clearly had better answers and resources for community leaders who called us and asked what to do next than simply replying “dig deeper.” In response to the release, we did see both online traffic to the Action Center and requests for community support; however, the numbers in both categories never reached the level of visitors to the data component of the website.

As we were solidifying the online/virtual approach to supporting communities, our community engagement specialists were simultaneously determining methods for supporting community members who reached out to the program for more assistance. In 2011-2012, the approach was organic and responsive with each of the staff members striving to address community members' questions or issues with a customized approach. As they conducted this responsive approach, they were also learning from two related program activities:

- **Roadmaps to Health Community Grants:** This formal, competitive grant program provided \$200,000 in grant funds (coupled with a \$200,000 local matching component) and technical assistance (provided by Community Catalyst) to address policy and systems change in areas related to the social and economic factors. Thirty communities participated in this two-year grant program from 2011-2014.
- **Learning Labs:** Two communities—Clare County, Mich., and Wyandotte County, Kan.—who had been early adopters of the Rankings model and its approach to community change were contracted to serve as Learning Labs. CHR&R staff worked with these communities to learn how the virtual Action Center and human support could help them advance their goals.

Based on our experience with a responsive approach to community support and lessons learned from the above initiatives, our iterative approach to community support was informed by the following:

- Designing a tiered system of support made sense and we needed to describe the tiered system in a way that both potential consumers and our own staff understood what would be provided in each “tier” and what was expected from community members who participated.
- Breaking through the complexity of community change with guidance that broke down large goals into smaller steps and tools that were simple to use was important to community members.
- Assessing readiness of communities to move from activities on the right side of the Take Action Model (e.g., working together, assessing and prioritizing) to action-oriented strategies on the left side of the Take Action Model was important.
- Recognizing policy development and implementation did not happen unless foundational steps on the right side of the Take Action Model were well underway.

In 2012, the tiered system included three levels: Rapid Response (up to three contacts with a coach); Individual Coaching (several months to a year of one-on-one coaching), and Team Coaching (up to a year-long engagement between a coach and a team of community members). In later years, the system was reduced to two levels, with Individual Coaching becoming part of Rapid Response with the flexibility to add more than three contacts on an as-needed basis.

Within the tiered system of support, higher-intensity support was intended to be provided to communities who had a desire and commitment to health improvement; who were moving beyond assessment and into action; who had limited access to technical

assistance or coaching through other mechanisms; and who were from lower-ranking places. Even with higher intensity of time, nearly all the community support was provided via virtual methods (telephone or video conferencing). A variety of methods to refer communities to coaches evolved, including offering coaching to communities who did not proceed in the Prize competition, cohorts of communities identified through national partners, communities who received small community innovation grants, and open calls for coaching via the website.

Considering the breadth of information available within the Action Center, standardizing an approach to prioritizing our focus and intended results of coaching was important. As the Prize criteria (see Appendix G) developed and we learned what communities were seeking, we established the CHR&R Guiding Principles (Table 3). Over time, the principles with asterisks became the primary focus of our website and webinar content and our coaching engagements.

Program staff also developed a community readiness assessment, titled *Poised for Progress*,²⁵ in alignment with the Take Action Model and the Guiding Principles. This work was based on “Stages of Community Change Framework” that focused on four levels—*inquiry, initiation, implementation, and institutionalization*.²⁶ Community members could access the new tool on the CHR&R website and use it to self-assess their stage of change (not started, could do more, and doing well) for sub-elements within each of the guiding principles. It also directed users to resources within the Action Center. *Poised for Progress* was also used as a pre- and post-assessment for team members who worked with a community coach and as part of the formal system evaluating the coaching component of the program.

As our team defined the tiered system of support, understanding what was meant by “personalized consulting and training support” crystallized into a clear differentiation between a “technical assistance (TA) provider” and a “coach.” The *Field Guide to Community Coaching*²⁷ and the Center for

25 <https://www.countyhealthrankings.org/poised-progress-worksheet>

26 The Stages of Community Change Framework was based on Michael Fullan’s “stages of proficiency” theory and A.D. Kaluzny & S.R. Hernandez’s “Stage Theory of Organizational Change”: Emerging, Initiating, Implementing, Sustaining.

27 *A Field Guide to Community Coaching*. Developed by Mary Emery, PhD, Ken Hubbell and Becky Miles-Polka. Supported by W.K. Kellogg Foundation, Annie E. Casey Foundation, Kellogg Action Lab at Fieldstone Alliance, Northwest Area Foundation. 2011.

TABLE 3
CHR&R Guiding Principles

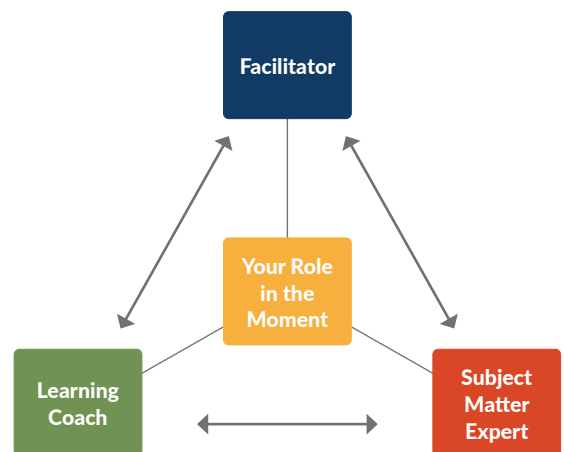
1. *Harnessing the collective power of leaders from multiple sectors and of community members;
2. *Putting health within everyone's reach by addressing gaps that disproportionately and negatively affect certain populations;
3. Using data, including the Rankings and additional local data, to identify needs, set priorities, and track progress;
4. Using evidence where it exists to guide the work and where evidence is lacking creating new and innovative solutions and evaluating these new efforts along the way;
5. *Focusing action on all the factors that influence health, especially those that contribute the most, such as social and economic factors;
6. *Committing to sustainable solutions that focus on systems, policies, and environmental changes;
7. Recognizing and building on existing and emerging assets to chart the community's unique course toward a shared vision of health;
8. Securing and making the most of resources, including fully leveraging human capital and the consideration of health impacts into public and private decision making;
9. Measuring and sharing progress and results widely and using these results to continuously improve progress towards health; and
10. Contributing to a national movement to create a Culture of Health by sharing stories and lessons learned and seeking out opportunities to learn from others.

* These principles became the primary focus of our website and webinar content and our coaching engagements.
 Orange text represents RWJF Culture of Health Prize criteria

Creative Learning (CCL)'s model (Figure 9) of the three roles a coach plays were helpful in shaping the distinction between technical assistance and coaching. In 2012, CHR&R coaches participated in RWJF's Community Coalition Leadership Program, led by CCL, which served as a rich learning opportunity for refining the concepts of coaching.

In a TA approach, the provider delivers subject matter expertise to the community, often on a particular topic. The TA provider may also act as a consultant or facilitator and perform functions such as leading strategic planning processes, facilitating community meetings, or producing reports for communities. While a coach may, from time to time, facilitate a meeting or provide technical content, the focus is on modeling facilitation skills and processes to build team capacity for self-facilitation. A coach assists community members to reflect on their effectiveness and to develop skills and perspective for their work.

FIGURE 9
Coaching Roles (Center for Creative Leadership)



A key distinction from the TA model is that a coach does not “produce for” communities. While coaches may at times serve in the subject matter expert mode, their focus is to help community members understand the data and tools provided through CHR&R, so community members can independently apply this content to their work. Coaches serve as thought partners, connectors, neutral, third-party observers, and skill builders.

While TA providers bring extremely valuable support to communities, there are many highly expert TA providers available to communities, and our discussions with communities and content experts revealed that communities want support for building their own capacity versus “being done to.” This was an important consideration in selecting a coaching versus technical assistance approach. Thus, “personalized consulting and training support” was reframed as “community coaching” and by early 2012, we replaced the term community engagement specialist with community coach.

In 2014, we recognized that our ability to fully support communities across the nation was limited if all the coaches came from a Midwestern community where the University of Wisconsin was located. To assure that the program would provide coaches that were more fully in tune to the unique geographic and cultural experience of people across the country, CHR&R’s coaching team was expanded from four coaches to 11 coaches, including seven who lived in other regions of the nation. Not only did this expansion provide geographic diversity, but it added racial/ethnic, gender, and professional diversity to our team.

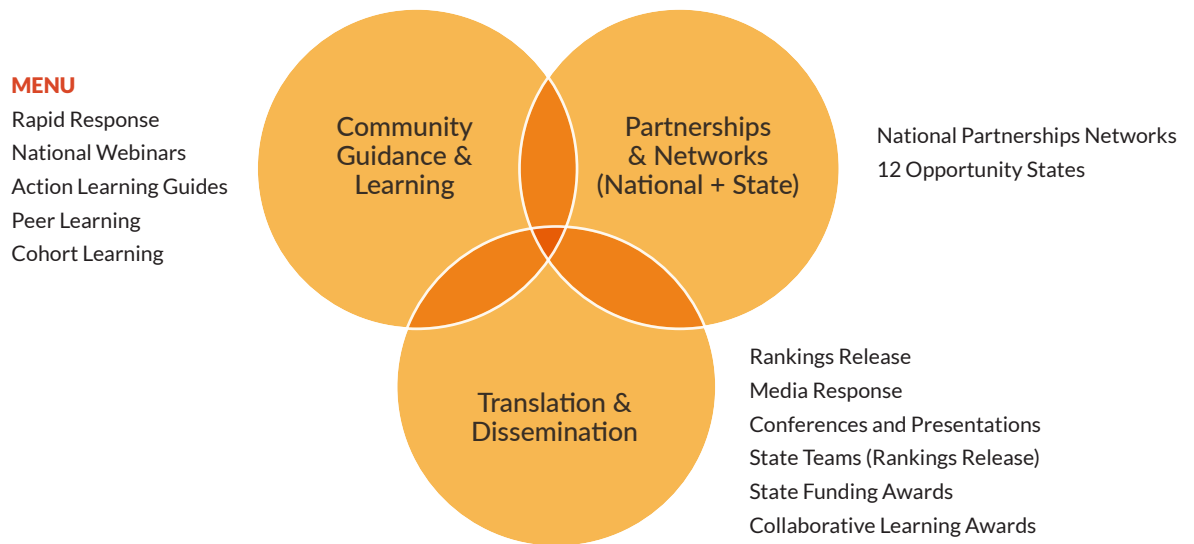
This combined virtual and human approach to community support was unique in 2011 (when the Roadmaps program began) for several reasons. First, the focus of CHR&R was very broad. Most programs that provided some level of community support were topically focused—on specific subject matter (e.g. tobacco, obesity, early childhood) or specific processes (e.g. community health needs assessments, policy advocacy, storytelling). CHR&R’s commitment to a broad definition of health, policy, systems and environmental approaches, equity, and multisector partnership made it one of the few programs at the time

to address health improvement from such a comprehensive posture. Second, its services were available to any community leader who was interested—at no charge to that person or their organization. Most of the TA or coaching resources available at this time were either fee-for-service or a benefit associated with a successful grant application. Third, our services were delivered primarily via virtual technology versus face to face meetings. CHR&R staff were early adopters of webinar technology—long before this became a common practice for organizations to deliver information. Early in our coaching encounters, we learned that telephone-only contact was very limiting and so coaches worked on developing methods for using video conferencing during team coaching sessions to both keep everyone’s focus and build personal connections.

In late 2016, RWJF engaged a panel of experts to conduct a strategic assessment that reviewed CHR&R’s work and provided outside expertise to inform the program’s future direction. Many of the panel’s recommendations, finalized in December 2016, focused on the program’s work to support communities. While acknowledging many positive aspects of the program, including the effectiveness of the coaching model, the panel expressed concern about the feasibility of scaling such a model to reach the many communities in need. They also noted that CHR&R web content, while comprehensive, could also be overwhelming. As a result, the panel made numerous recommendations about how to repurpose the coaching program as community managers, curate CHR&R’s data to provide more manageable pathways for users, and create network strategies to connect communities and peers who were working within the community health improvement space with each other.

Given the time, effort, and commitment that had been invested in creating the coaching model, it naturally took RWJF and CHR&R staff some time to collaboratively process the panel’s recommendations which happened throughout much of 2017. The program was also committed to completing coaching commitments with communities that were already underway which took much of the year. In 2018, the program ended team coaching and implemented a new menu

FIGURE 10
Menu of Community Transformation Services (2018)



of services. This menu focused in three areas—Community Guidance & Learning; Partnerships & Networks; and Translation & Dissemination—as noted in Figure 10.

Some of the activities were a continuation of existing activities, such as national webinars, conference presentations, and activities to support the annual Rankings release. Other activities were adaptations of past activities. One example of this is Rapid Response which continued to be an avenue to provide short-term community support, but now more focused on how to help recipients navigate the website resources for their own future use, rather than serve as a possible entrée to team coaching. Many of the new activities focused on ways to reach more communities and link them with each other with the intent of building peer support and networks for ongoing action. In 2018-2019, the program introduced peer learning opportunities where communities could learn and work together on common themes, such as the opioid crisis or youth engagement, and cohort learning where groups of communities with some level of affinity, such as rural communities or coalitions led by United Way organizations, could work and learn together as they advanced health and equity in their own communities.

The program also delved into ways to advance curation of the program’s vast resources. One of the most important ways CHR&R would eventually support communities is the work described in section VII.c. to define the developmental pathways communities travel through as they strive to improve community health. CHR&R team members, working with staff from 100 Million Healthier Lives and the Georgia Health Policy Center, created a developmental assessment tool titled Assessment for Advancing Community Transformation (AACT). This tool provided a framework for guiding development and organization of website materials to meet communities where they were at in their community improvement journey. Five Action Learning Guides were created in 2018 and deployed in 2019 to address the early stages of this journey in key areas such as equity, engaging with community members, and policy development.

Just as CHR&R has done throughout its history, these new approaches are both being evaluated via a developmental approach to learn and improve in real time and through process and outcome evaluation approaches.

Appendix H contains a more detailed history of CHR&R’s efforts to support communities.



What Have Others Discovered or Opined About the County Health Rankings?

Over the 10 years of the County Health Rankings & Roadmaps program, we have either directly captured people's observations and opinions about the program or we (UWPHI or RWJF) have contracted with others to evaluate different aspects of the program. In this section, we talk (in detail) about the opinions of the Rankings.

Even before we began publishing the first Rankings for all 50 states, public health practitioners and academics across the nation gave us feedback on the work we had done in Wisconsin. And, they have continued to provide feedback ever since! They have opined on the Rankings model (including the weights for the major components), the measures we chose, the methods we used for compiling the Rankings, comparisons from year to year, and whether rankings themselves are helpful or harmful.

a. Feedback on the Rankings model

On the positive side, we have heard people find the Rankings model:

- Is simple and easy to understand,
- Shows the difference between health outcomes (how healthy communities are now) and determinants (how healthy communities might be in the future),
- Shows there is more to health than health care and via the weights, shows health care is not necessarily the most important factor
- Shows there are factors beyond the control of individuals that influence health (i.e., health is not just about individual choice),
- Focuses on modifiable factors,
- Calls attention to the fact that there are actions (i.e., policies and programs) that can be implemented to impact determinants and thus outcomes,
- Implicitly suggests the need for multisector involvement, and
- Appeals to people across the political spectrum.

The model is widely recognized, cited, and used. While we thought its purpose was clearly as a county-level measurement framework showing what goes into the Rankings, some are using the model beyond that—as a definitive list of areas to address to improve health in a community. However, others have correctly noted that the model does not include items that are critical to community health but are difficult to measure, such as racism and power. Others have observed that the model:

- Is not asset-based, meaning that it is framed negatively (for all outcomes and most determinants) with its focus on premature death rather than well-being,
- Does not show any interactions between factors (i.e., the lack of arrows is helpful to some but not all),
- Does not reflect that not only do factors such as employment and income affect health outcomes, but these factors can also be affected by health outcomes,
- Does not mention equity or inequity in outcomes or determinants,
- Is not connected to specific actions, for example, it could be more action-oriented and does not explicitly promote policy, systems, or environmental change,
- Is not an aspirational model, i.e., it does not include any goals or targets,
- Does not address health across the life course, and specifically, does not include much specific to children or the elderly,

- Does not address specific diseases or conditions such as mental health, although over time some health system measures were added, such as availability of providers of mental health and dental care, and
- Does not include race or genetics.

This last observation and several others were the result of conscious design decisions made by the team in our early years, with advice from the Metrics Advisory Group (MAG) that we convened before the first release. Race and genetics were not included as they were not considered modifiable. Another example of the MAG input focused on the model flow. Although many other frameworks go from left to right, our model flows up from factors to outcomes. We tried out a version with the MAG where we reversed the model (so that factors lead down rather than up to outcomes) but this was not well received. Another early decision was to move away from the term “health care” and to use the term “clinical care” because the health care system can take action in areas beyond traditional provision of care. Whether this nuance was apparent to others is not clear. Later, we made the decision to move measures of the built environment, such as access to healthy foods and recreation opportunities, out of physical environment and into health behaviors. In our minds this change made sense because many actions on the built environment are intended to encourage and support healthy behaviors.

b. Feedback on the weights in the model

Before we published the first County Health Rankings for all 50 states, we had a fair number of questions about the origins of the weights in our model, focusing not on the 50:50 allocation we made between length and quality of life in Health Outcomes, but on the 40:30:20:10 allocation across the Health Factors: social and economic factors, health behaviors, clinical care, and the physical environment. A [working paper](#) that we published on the CHR&R website in 2010 helped explain the rationale behind the weights and

has been cited many times. However, discussion of the appropriateness of the weights continues among practitioners and academics, including:

- Whether the 20 percent allotted to clinical care is “too low,”
- Whether the weights should be different in different states because the context can differ,²⁸

28 Arndt S, Acion A, Caspers K, Blood P. (2013) How Reliable are County and Regional Health Rankings? *Prev Sci* (2013) 14:497-502. doi: 10.1007/s11121-012-0320-3

- Whether the weights should sum to 100 percent because the model does not capture everything that impacts health outcomes,²⁹ and
- Whether the weights should sum to more than 100 percent because of all the interactions between factors.³⁰

c. Feedback on what we ranked

The critical early decision to publish “county-based” rankings in each state, rather than across the nation, led to a variety of comments. Some public health agencies wanted the analysis to be done using either larger (e.g., public health regions) or smaller (e.g., ZIP code or city level) units. When we held our first release event in the District of Columbia, several people commented on the irony of releasing the Rankings in a place that we had not included. We subsequently added data for Washington, D.C., but without any rankings since there are no counties to rank. Others suggested the addition of Puerto Rico but we were unable to find enough data to allow this.

Counties or county equivalents are identified in federal and most other data sets using Federal Information Processing Standard (FIPS) county codes. The nuances behind the allocation of FIPS codes contributed to some inconsistencies across different states. For example, in Virginia, FIPS codes are assigned to counties and cities whereas Louisiana has parishes and Alaska has boroughs and census areas. Other states, including some in New England and the Plains, have legal boundaries for counties but do not administer many services on a county basis. This became apparent before the 2010 release when we tried to notify the county that would be named least healthy in South Dakota but had difficulty finding a county health officer or any other county official.

The most recent feedback on what we rank (i.e., counties within states rather than counties across the entire nation) came from our first research analyst who published a blog based on her work in the state of New York.³¹ She noted that:

In the Rankings, a county's performance is assessed relative to others in the same state, leaving stakeholders to ask the question: How are the counties in our state doing relative to counties nationwide? In the Rankings' current format, a county may rank as the healthiest within its own state, but if the state's health has worsened overall, the county's rank will not reflect the state decline.³²

She reports on her work with the New York State Health Foundation where she compared the health outcomes of counties in New York with counties across the nation, using the data publicly available on the CHR&R site. This desire to be able to not only rank counties within states but also across the nation has frustrated the media since our first release in 2010. While we could not prevent others from this (particularly with the high level of transparency about our methods), we wanted to honor the promise we had made to public health practitioners that we would not identify the healthiest or least healthy counties in the nation. In recent years, in collaboration with the Aetna Foundation, US News and World Report has begun to rank the health of counties across the nation, annually publishing ranks for the top 500 counties (or county equivalents). Their ranking approach includes different methods and measures and combines outcomes and determinants together to determine the “healthiest” communities.

29 Krieger, N. Health Equity and the Fallacy of Treating Causes of Population Health as if They Sum to 100% *Amer J Pub Health* April 2017 107(4): 541-548; doi: 10.2105/AJPH.2017.303655

30 Braveman P. (2019) Comment made during [Drivers of Health Meeting](#) in Princeton, NJ June 2019.

31 Athens J. (2019) Using The County Health Rankings To Assess County Performance At A National Scale. *Health Affairs Blog* November 14, 2019. 10.1377/hblog20191111.2684.

32 Athens J. (2019) Using The County Health Rankings To Assess County Performance At A National Scale. *Health Affairs Blog* November 14, 2019. 10.1377/hblog20191111.2684.

d. Feedback on specific measures

The indicators used in the County Health Rankings are selected because they are reliable, valid, available at the county level, modifiable, and contribute to population health. A more detailed list of criteria for selecting measures was published beginning in 2015.³³ Each year, we searched for new or improved measures of the many factors that influence health often responding to suggestions from users. For example, one early piece of feedback said, “Physical environment measures are not comprehensive enough. For example, what about measures of access to parks & recreation, bike paths, trails and sidewalks, community development, water quality or transportation?” Over the years, we were gradually able to either find new sources of measures (for example, the housing data released in 2019) or derive our own.³⁴

Perhaps the most controversial decision was one that was beyond our control: the CDC expanded their collection of Behavioral Risk Factor Surveillance System (BRFSS) data to include cellphones to better reflect the quality of life and health behaviors of the entire population (not just those with landlines), to provide more timely data (based on a single year rather than seven years), and to provide multi-level modeled estimates for all counties (rather than just providing estimates for counties with larger populations and sample sizes). To produce estimates for those counties where there was no or limited data, their modeling approach borrowed information from the entire BRFSS sample as well as census population estimates. These changes that we implemented with the release of the 2015 Rankings led to more changes in ranks than we normally saw and caused great consternation in several states. For example, the president of the local health officers’ association in North Carolina wrote to us to say that using this “synthesized data to then rank the ‘health’ of individual counties ... it is counterintuitive to use aggregate data from similar counties and then say one county is better than the other.” Her recommendation was that it is not appropriate to base counties’ ranks on data that is not entirely based on individual

counties and we should discontinue reporting county-specific ranks but report on rank quartiles. While we understood this concern, we felt that the benefit of continuing to produce the Rankings dataset and release the annual Rankings—despite the data limitations—outweighed the disadvantages.

Beyond BRFSS, users have expressed concerns about the adequacy of specific measures, including:

- Concerns that quality of care measures are limited to those available from data about fee-for-service Medicare beneficiaries: It would be better to have a broader set of quality of care measures but such measures are not currently available nationwide at the county level for populations other than Medicare.
- Concerns that our air quality measure is based on monitor data only when it is available, but for counties that do not have air quality monitors in place, it is based on modeled data, with a significant time lag.

The limitations of these and other measures are listed online in the description for each measure.

Other concerns reflect measures that are not included, such as:

- There is a measure for low birthweight but no measure for prenatal care: Due to changes in birth certificates, we were advised by the CDC not to include a measure of prenatal care.
- There are measures for adults but not for teens on smoking, diet/exercise and alcohol use. Adults are important, but it can be more effective to address teen behaviors and thereby improve the health of the geographic region in the long term by preventing fewer new adults engaging in those behaviors but, unfortunately, county-level data on teen activities was not available in enough states for us to incorporate these measures.

33 https://www.countyhealthrankings.org/sites/default/files/media/document/resources/CHR_measure_criteria_2015.pdf

34 Roubal, A. M., Jovaag, A., Park, H., & Gennuso, K. P. (2015). [Development of a Nationally Representative Built Environment Measure of Access to Exercise Opportunities](#). *Prev Chronic Dis*, 12, E09. doi: 10.5888/pcd12.140378.

Another concern is that the same measures are not always available because data sources and measures come and go. For example, BRFSS no longer includes a question about social and emotional support in its core survey and so, in 2015, we had to replace the measure about inadequate social support with a measure about social associations (the number of membership associations per 100,000 population). Early on, we made the decision not to change the measures in the Health Outcome ranking (although the underlying methodology did change for the BRFSS measures) so that the Health Outcome rankings are based on a relatively stable set of measures that communities can use to measure the health of their community over time.

As a curator of data from other sources, CHR&R is reliant on other organizations, such as the CDC, to provide us with data—when an organization makes a significant change in their methodology, the CHR&R team has to decide how to proceed. In general, there are five options:

- a. Do not update the measure(s) in question, i.e., keep using the same estimates from prior years—this means ranks will not change as much but does not provide new data to communities.
- b. Use the new estimates—this often means ranks will change more than usual but it also means communities have access to updated/improved data.
- c. Find an alternative measure from the same or other sources.
- d. Bypass national sources and use data from state-level sources (or a hybrid of the two).
- e. Drop the measure from the Rankings calculations—this would also cause changes in ranks and would mean communities will not have access to this data thus presenting a less comprehensive view of the health of communities.

Each year, we publish information about what measures changed and why we changed them.

e. Concerns about our methods

Our Rankings methodology has been reviewed and refined by colleagues at CDC and an additional panel of technical experts. It was also reviewed by the Wisconsin Legislative Audit Bureau and found to be sound. In addition, we solicited and incorporated feedback from Wisconsin public health practitioners over six years before beginning the preparation for all states. A peer-reviewed brief report on the Wisconsin County Health Rankings was published in the *American Journal of Public Health*.³⁵ A methods paper on the current Rankings was published in 2015.³⁶ While we felt strongly that our methods were sound, we also acknowledged there were limitations and we tried to be as transparent as possible about them. The Rankings are not intended to serve as a definitive evaluation tool but as a tool to raise awareness and stimulate action.

One specific area of concern, particularly in rural states such as Iowa, was the issue of whether to suppress data for counties with small populations. We spent a lot of time trying to determine the most appropriate ways to handle small numbers. As a result, we did not rank the smallest counties (in terms of population size) whose Health Outcomes data are not reliable due to small numbers. If any indicators are based on sample data, they are estimates and are subject to variation which can become very wide as the sample size decreases. This is especially true at smaller geographies, such as counties. Even use of statistical smoothing, weighting, or adjustment cannot render estimates based on small sample sizes reliable for analytical uses. In addition, the estimates based on small numbers can fluctuate dramatically each year,

35 Peppard et al. (2008). Ranking community health status to stimulate discussion of local public health issues: The Wisconsin County Health Rankings. *American Journal of Public Health*, 98, 209-212.

36 Remington, P.L., Catlin, B. B., & Gennuso K. P. (2015) [The County Health Ranking: rationale and methods](#). *Popul Health Metr*, 13(11). doi: 10.1186/s12963-015-0044-2.

thereby having a potentially significant impact on the final rankings from one year to the next. So, we established criteria to evaluate the reliability of data points for any measure, generally following the suppression criteria of national datasets. For example, if there were less than 50 occurrences (e.g., survey responses) for an individual county, a measure value is not used in calculating ranks. If any indicator for a county was not included due to unreliable numbers, the state mean was used instead to calculate the rankings. We realize that our use of the state mean may not be the “best” representation for a county, but we believe this is a better option than using an unreliable number specific to the county.

Another often cited concern is about the lack of timeliness for many of the measures. We have always tried to use the most current data possible but there is often a significant delay between when data are collected and when they become available to the Rankings team. We recognized this

concern early on and knew that some states had more comprehensive and up-to-date data than we could get from national data sources. We added the option of allowing states to provide their own state-specific sources of additional data but only two states provided their own data—and one of those states was our own home state of Wisconsin.

Since 2009 when we began preparing the first 50-state rankings, we realized that it was important that our state and local public health colleagues throughout the nation understand the ranking methodology and had ample opportunity to discuss not only the statistical soundness of the report, but also the rationale for using rankings and the opportunities to use this report to promote and expand community health improvement efforts. This is why we began our outreach six months prior to the first Rankings release and provided multiple methods (website, webinars, e-newsletters, and personal consultations) to learn, discuss, and consult about the project.

f. Cautions about comparing year to year

Every year after the first release we advised our users not to compare ranks from one year to the next. This can be very difficult for local health directors and boards of health and even for those on our UWPHI and RWJF team. In a 2016 radio interview, a new CHR&R media spokesperson was quoted saying, “Look at the data and compare from last year’s ranking to this year, but this is only part of the story ... recognize that there were improvements made as well, even if there was a slip in the rankings.” Clearly, it is human nature to compare progress and trends if the data are there so we advise our users to view the data as an annual checkup so that they can look for opportunities within their community where they may not be doing as well as others in the state. To get a sense of whether a community is making progress, we encourage users to look at individual measures where the data is comparable from year to year. Ranks do fluctuate from year to year, but it is only large changes (e.g., from one quartile to another) that are significant and worthy of further exploration.

The Rankings can be used as an indicator of improving health over the *long* term. We emphasize the long term because in addition to the overlapping years of data, it may take a long time to see changes in some indicators such as mortality rates. For example, if a county’s premature death rate (Years of Potential Life Lost) is primarily due to chronic diseases (such as cancer or heart disease), it will take much longer before you see the impact of interventions such as smoking cessation or decreased obesity. However, if it is primarily related to infant mortality, you may be able to see an improvement in a shorter period. Another cautionary note is that for some Rankings measures, multiple years of data are combined to calculate estimates so from year to year, several years of data may overlap.

We rank to get attention, start conversations, and bring others to the table so that local public health directors do not have to do this alone. Ranks are great for garnering attention, simplifying a lot of complex data, and making comparisons between

one community and another at a point in time—but they should not be used alone to measure a single community’s progress. Rather, we encourage our users to look at them as one tool among many. Because ranks are relative, they are not as helpful in isolation—a county’s rank depends not only on what

is happening in that county, but also on what happens in all the other counties in that state. In fact, if every county in a state improved its health equally, their ranks would all stay the same. In 2014, we developed the Measuring Progress guide to help communities determine how to track improvement.³⁷

g. Feedback on using a rankings system

Rankings are ubiquitous across the world, and particularly in the United States. We see the County Health Rankings as a tool to raise awareness about the multiple determinants of health and to provide an opportunity to engage more people in the discussion. They are also a tool to highlight that health varies from place to place. We always encourage communities to take a further look at local data and discuss their meaning to determine a plan of action. As one of the founders of the Wisconsin County Health Rankings noted: “Rankings are a Polaroid snapshot of the community and we encourage communities to develop their own high-resolution picture.”

Rankings of overall health can change significantly based on what indicators are used and how they are weighted and calculated within the formula. In other words, no matter how much time and effort are put into determining what indicators and weights to use in the rankings, the decisions about what data to use and how to compute the rankings are subjective to some degree. Some public health professionals do not believe that any one set of indicators can adequately define the overall health of an area much less be used to rank different geographic areas. At best, a grade or composite indicator ranking is just one assessment of health. Communities may or may not be able to use grades or ranks based on multiple indicators to identify areas that needs further investigation. Such investigation is necessary to determine whether an underlying problem exists.

Rankings at both the top and the bottom can be particularly problematic for counties.³⁸ For example, those trying to improve community health in low-ranking counties may get discouraged while others

have used the low ranking to mobilize community health improvement resources and effort. For example, an analyst in Wyandotte County, Kan., dug into the data on the CHR web site. She looked at the underlying z-scores for each of the measures and noticed how much lower Wyandotte’s scores were than those of other counties for many of the measures. Consequently, she realized that even if Wyandotte improved across these measures, they would likely still be the least healthy county in the state. Fortunately, this did not discourage community leaders from moving forward with significant strategies to address social and economic conditions in the county and it did require the community to look at other measures of success for their work. Even high-ranking counties can struggle. For example, we heard that the county board in a high-ranking county in one state used the high rank as a reason to cut public health funding. The thought in this community was two-fold: (a) if we are doing so well in the Rankings there is no need to continue to invest in public health and (b) since we are a wealthy community people already know what they need to do in order to be healthy so there is no need to invest dollars in the public health system.

One communication strategy for moving the media and the public away from specific differences in rankings is to focus on quartiles. The mapping portion of the Rankings places counties within one of four quartiles for each state. One state even suggested we discontinue reporting individual rankings for each county and instead just report the county’s ranking quartile. The question remains as to whether such a change would reduce media attention and the potential for involvement of those in sectors beyond traditional public health.

³⁷ <http://www.countyhealthrankings.org/measuring-progress>

³⁸ Ranks in the middle quartiles can also be problematic – particularly for states with more counties of small populations that jump around in ranks from year to year.

Ten-Year Reflections on the County Health Rankings & Roadmaps

Any entity endorsing and using a specific set of rankings requires the organization to be well prepared to defend its choice and provide solid analytical proof that the rankings are statistically sound and appropriate. The indicators and statistical methods used will be closely scrutinized by the public, press, and other public health-related organizations (especially at the local levels) and they may not agree with the rankings and may even denounce the use of such rankings. The risk is that the ensuing discussion will then be focused on how the grades or rankings were calculated rather than on what they mean and how health status can be improved. This has not been the case for media reports on the Rankings: less than 1 percent of the media mentions over the program's duration have criticized the indicators or methods.

We believe that another requirement for publishing rankings should involve being as transparent as possible about the underlying data and the ranking methods. Although there continue

to be questions every year, we feel that by 2012, there were fewer complaints and more discussion about how communities were using the Rankings. Several users thanked us for making all the data available online so that they could reconstruct the Rankings or prepare their own. Others expressed interest in being able to compare data across state lines and by 2013 we were happy to be able to offer this option along with appropriate caveats about applicability for some measures. Beginning in 2017, at the request of the CDC, we also incorporated data on peer counties allowing counties to compare themselves to demographically similar counties from other states.

One additional concern that emerged early on was whether the reports would come out every year. With permission from RWJF, we were encouraged to be able to tell users that even though funding was provided to UWPHI in two to three year increments, the reports would come out every year—this has now held true for 10 years!



Improving Health Outcomes and Increasing Equity—An Emergent Approach

In this section, we present an emergent approach to learning about how our efforts to support communities have evolved.

a. Community health improvement is a complex problem

Based on its logical series of boxes with unidirectional arrows, the CHR&R Theory of Change (Figure 4 from earlier in this paper, shown again on the next page) suggests a simple approach to advancing health outcomes and increasing equity. In reality, the process of supporting communities in implementing health- and equity-improving changes is anything but simple. Instead, it represents a **complex problem**—one where the whole is much more than the sum of its parts and where community context and assumptions are in a constant state of flux.

The clear messages that “many factors influence how long and how well we live” and therefore “we need everyone working together to improve health” led us into this land of complexity. These messages assume communities need to implement multiple strategies across numerous community systems in an interactive way to achieve health and

equity improvement. For example, a community working on affordable housing strategies may not only be striving to decrease homelessness. It may also be striving to reduce emergency room utilization by stabilizing chronic disease management, support student achievement by assuring students can attend the same school for the full academic year, and increase the likelihood that adults can be successful in a job when they are not worrying about where they and their families will sleep each night. Solving homelessness is not simply in the purview of one agency, such as the local housing authority. This integrated approach creates complexity by including partners from housing, health care, education, business, and people who are experiencing homelessness to work together to select approaches and leverage resources from diverse funding streams to address solutions.

FIGURE 4
CHR&R/Prize Theory of Change

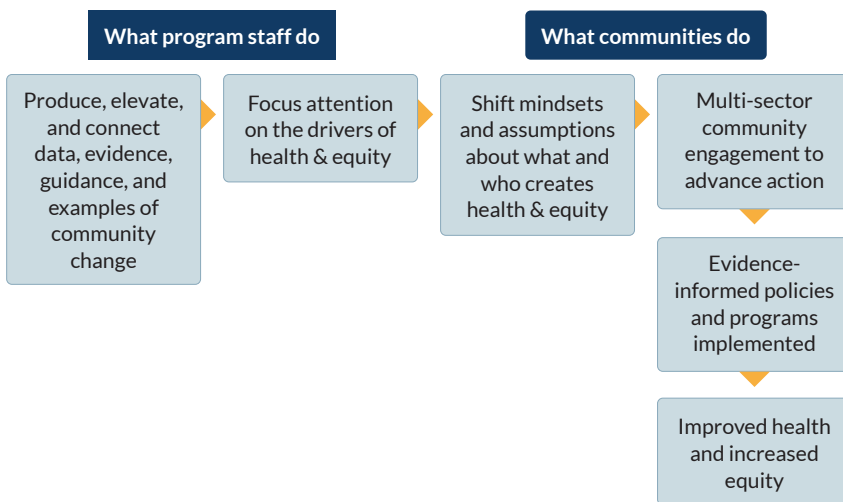


FIGURE 11
How Emergent Strategy Works

Emergent strategy accepts that a realized strategy emerges over time as the initial intentions collide with, and accommodate to, a changing reality.



Source: Henry Mintzberg, Sumantra Ghoshal, and James B. Quinn, *The Strategy Process*, Prentice Hall, 1998.

Complex problems are not easily evaluated with traditional, summative evaluation processes, particularly in early stages of assessing and responding to the complex problem. The first decade of CHR&R has been a learning journey for RWJF and UWPHI to probe and explore ways to understand community context and ways that the data, evidence, guidance, and examples from CHR&R could be valuable to communities as they strive to improve.³⁹

Emergent strategy is one framework for describing how to understand and evaluate approaches to complex problems, such as community members coming together to identify evidence-informed policies and programs to improve health outcomes and increase equity (the changes depicted in the right side of the CHR&R Theory of Change model, Figure 4). Figure 11, described in Kania, Kramer, & Russel's 2014 paper discussing strategic philanthropy, provides a framework for discussing the formal evaluations and informal assessments that have been conducted on and with CHR&R over the past decade.⁴⁰ This combination of intended, deliberate, and emergent strategy, coupled with real time decision-making to adapt the program, have been our approach to the complex problem of addressing how to pivot from the left side (what program staff do) to the right side (what communities do) of the CHR&R Theory of Change model (see section II.b. for more on this model).

We have used our real-time learning to guide the evolution of the program to support communities beyond simply providing data. The following sections describe strategies based on the authors' perception of how they progressed through this emergent model.

39 For more on the distinctions between simple, complicated and complex problems, see Snowden, D. J. & Boone, M. E. A leader's framework for Decision Making, *Harvard Business Review*, November 2007, 69-76.
40 Kania, J., Kramer, M., & Russell, P. (Summer, 2014). Strategic philanthropy for a complex world. *Stanford Social Innovation Review*, 26-37.

b. Intended strategy to deliberate strategy to realized strategy (What we thought would happen and did contribute to our aims)

The County Health Rankings raised awareness about the many factors that influence health.

One of the clearest realized strategies of the CHR&R program is that the investment in communications resources throughout the program's duration has resulted in extensive coverage of the program's annual County Health Rankings release. Although the estimated audience when the updated Rankings are released in early spring has fluctuated over the years, it continues to reach into the millions—indicating the sustainability of the Rankings and its associated analyses (i.e., Key Findings Reports) as a strategy to continue to build awareness around its key messages.

Since 2010, RWJF has invested in content analyses of media messages, conducted by Upstream Analysis. Mentions of the key message that “many factors contributed to health” more than tripled from 2010 to 2016. This message alone accounted for 29 percent of the mentions in media from 2010-2016.

A survey of randomly selected local health officers conducted in 2017–2018 by the American Institutes for Research (AIR) found that 94 percent of local public health officials were aware of the County Health Rankings and 81 percent of these local health officials reported awareness by other key leaders from various sectors in their communities. When queried further about the Rankings, 76 percent reported they increased awareness about the many factors that influence health. A 2016 Georgia Health Policy Center (GHPC) analysis of interviews with key informants who had used CHR&R resources cited that one of CHR&R's major influences was “reframing health from health care to population health and addressing the social determinants of health.”

CHR&R raised awareness about who needs to be involved in health improvement and shifted understanding about what they need to do. Just as the Rankings raised awareness about what creates health, the Rankings also contributed to

raising awareness about who needs to be involved in efforts to improve health. Upstream Analysis reported that the number of mentions of the key message that “organizations across the community must work together to improve health” doubled from 2010 to 2016.

In addition to the messages, the messengers diversified over time. In 2010–2011, the most common voice in media articles was that of the local public health practitioner. By 2012, the voices of non-public health sources were also captured with less than half the quotes attributed to public health leaders. Over time, the level of public health quotes remained about the same but, by 2016, the number of quotes from other sources was over 130 percent higher than those of public health sources. These other sources represented a wide variety of sectors—including hospital administrators, clinicians, elected officials, business leaders, education leaders, university professors, local businesses, foundations, religious organizations, YMCAs, United Ways, and many other non-profits. Over time, the percentage of these leaders who were not from traditional health settings increased from 13 percent of the total in 2012 to 42 percent of the total in 2016.

The 2017-2018 AIR survey also affirmed that CHR&R assisted them in reaching out and building or strengthening partnerships with people from different sectors. As noted in Figure 12 (on the next page), local health officials discussed all of the sectors in the Take Action Model, except philanthropy, community development, and community members who were not included as specific options in the survey. Local health officials noted that CHR&R was helpful for engaging these partners by raising awareness about the factors that drove health and identifying health issues within their communities, particularly those that needed improvement.

FIGURE 12
**American Institutes
for Research 2017-
2018 Survey of Local
Public Health Officials**

Community-based organizations:	63.1%
Hospitals:	53.4%
City or county government:	50.1%
Health care other than hospitals:	41.9%
Education (K-12):	38.6%
State government:	31.1%
Faith-based organizations:	29.5%
Parks and recreation:	29.1%
Businesses:	28.2%
Education (higher):	22.9%
National organizations/local affiliates:	18.5%
Transit:	9.5%

A 2018 internal program analysis of who was participating in CHR&R programs found that public health was the single largest user of our services, representing 42 percent of the total; however, this was largely dominated by webinar attendees and state team support for the annual CHR release. When looking at other program elements, such as rapid response contacts, coaching teams, or applications for the RWJF Culture of Health Prize, public health represented a much smaller share of the participants with nonprofits, health care, and other government agencies leading the participation rates.

When thinking about who is best poised to lead community health improvement efforts, there does not appear to be one answer. One could hypothesize that community organizations that led the efforts in Prize-winning communities might provide some insight into this question. An analysis of the winners in the first five years of the Prize reveals diverse organizations providing key leadership including public health (26%), other local government (17%), health care (14%), education (11%), community development (9%), nonprofit community-based organizations (9%), coalitions (8%), and philanthropy (6%).⁴¹

While the above data clearly illustrates CHR&R has been effective in engaging and raising awareness across many different sectors, the program also has evidence about how people's understanding and actions shifted in response to the message that many factors affected health. The CHR model and data have become the framework used by many communities as they conduct traditional, and often mandated, health assessments, including those led by public health agencies and not-for-profit community hospitals. Using this framing has compelled leaders to think beyond the traditional priorities related to health care access and health behaviors to consider priorities within the social and economic and physical environment factors. Key informants in the GHPC study also noted shifts in resources within their organizations based on the CHR model of health, including the weighting of the different factors. For example, one state-wide foundation reallocated their grant-making based on the CHR model moving away from health care access and health behaviors to a balanced portfolio that also addressed social and economic factors and the physical environment.

Providing online data and action resources inspired community members to take action.

When the County Health Rankings were first released in 2010, many local communities across the nation did not have readily available access to local data. The message from that first release that received the most mentions in media activity was "for the first time you can compare health from county to county." This was affirmed in numerous conversations with local health officials, particularly in rural communities or states with fewer resources. In one 2010 call to the lowest-ranked county in Michigan, the local health official indicated she had been waiting for the Rankings data so that she could lead her community in a health needs assessment with reliable quantitative data. Her community's ranking as the unhealthiest county in Michigan provided additional motivation for this work.

41 University of Wisconsin Population Health Institute. [Actions toward equity: Strategies Communities are using to ensure everyone has a fair and just opportunity for Health](#). Summer 2019.

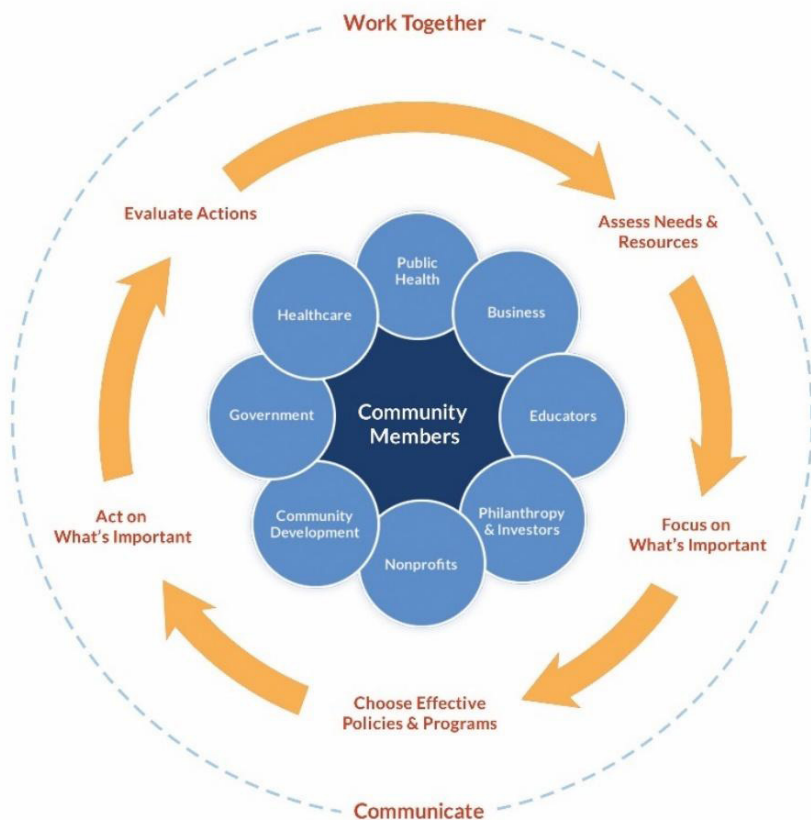
CHR&R’s website presence attracts thousands of visitors. Quarterly visitor counts range from 200,000 to 375,000 with peaks always coinciding with the annual Rankings release. Quarterly pageviews range from 1.25 to 2 million and are heavily dominated by a focus on data; however, after a December 2017 refresh of the CHR&R website, the program saw steady increases in pageviews of What Works for Health and the Action Center.

In 2012, when the full CHR&R website launched (with the addition of the Action Center and WWFH), it was unique in its approach to providing a one-stop shop for data, evidence, and guidance. Over the decade, a proliferation of other similar sites emerged and, in 2016, RWJF engaged the GHPC to conduct an assessment of online platforms supporting community action. Their review of 60 online platforms revealed that CHR&R was one of only two sites that provided a combination of data, tools, a structured framework, and customized technical assistance. The reviewers noted that:

The Roadmaps to Health Action Center maintains the edge in general usability and integration of tools and resources in a structured way that drives local action. Thus, out of an initial examination of 60 web-based platforms providing support, guidance, and tools to improve community health, none are as comprehensive and usable as the Roadmaps to Health Action Center.

Users of the CHR&R online resources reported how the elements were helpful to them in moving action forward. In a 2017-2018 survey conducted by American Institutes for Research, over half (54%) of the surveyed local health officials indicated they used the program’s resources, with less wealthy counties more likely to do so than more wealthy counties. The most frequently used tool reported by this group was CHR&R webinars. Key informants interviewed by GHPC indicated CHR&R’s online resources assisted them in conducting community health assessments, assessing and broadening which stakeholders participated in these processes, identifying and implementing best practices, and sharing the resource with others (such as grantees). These key informants also noted that CHR&R is seen as a highly credible resource.

FIGURE 6
Take Action Model



Providing human support, in addition to online resources, assists communities in advancing change. Throughout the evolution of technical assistance and coaching, the program conducted ongoing internal and external evaluation of this CHR&R service. The intended strategy was to support communities in taking action based on the Guiding Principles, so that they would implement evidence-informed policies and programs to ultimately improve health outcomes and increase equity.

Internal program evaluation conducted by the Evaluation unit of the University of Wisconsin Population Health Institute focused on the perceptions of 140 team members from 49 teams who received coaching between 2015 and 2017. Pre-coaching and post-coaching surveys were done to both evaluate how well coaching met the community’s needs and what progress the team made in increasing skills to take action. At the beginning of coaching, team members scored themselves highest in the steps of Work Together, Assess Needs & Resources, and Communicate—

indicating they were skilled in these areas. By the conclusion of coaching, these three areas remained the highest ranked; however, team members also indicated they were knowledgeable in the other four components of the Take Action Model (Figure 6).

Qualitative comments from coaching team members focused on their achievements including how they:

- Diversified and deepened their team relationships;
- Expanded their focus on the many factors that influence health;
- Narrowed the focus of their priorities to create actionable plans; and
- Created effective ways to communicate their work and achieve buy-in from policymakers.

An internal review of 74 summative team coaching reports from 2015-2017 provided insights from the coaches' perspectives on the intended strategy of advancing community health improvement efforts. The goals that communities selected and pursued reflect the following themes:

- Improve community engagement,
- Goal-setting and strategic planning,
- Evaluation,
- Advocacy and communication,
- Building partnerships and internal capacity,
- Finding or building a tool,
- Strengthening the team, and
- Policy and program identification and implementation.

These goals largely align with the areas of strength-building reported by the communities. Coaches also noted that coaching communities is a dynamic process where their work does not follow the orderly process noted in the Take Action Model. In real life, communities move back and forth among the steps in a more organic manner where progress in one area often leads to the realization that more work needs to be done in a step that might have been considered "finished." For example, narrowing the focus of a priority to create an action plan often reveals there are missing stakeholders who need to be part of the action planning and implementation process.

An external evaluation of 49 2015-2016 coached teams (conducted by Mathematica Policy Research) focused on how well the teams had achieved four intended outcomes of the coaching program. Table 4 captures the results of this evaluation.

TABLE 4
2015-2016 Coached Teams Progress Achieving Coaching Program Outcomes (Mathematica Policy Research)

Intended Outcomes	Results
Implementing policy, systems, and environmental (PSE) change	73 percent of the communities had implemented at least one type of PSE change and nearly half of those changes had focused in the arena of social and economic factors.
Using data and evidence-informed strategies	Almost all communities had discussed data and evidence with their coach and 79 percent had considered evidence as they selected strategies.
Focusing on health equity	86 percent of teams had discussed health equity with their coach, resulting in strong or moderate self-reported knowledge. Those that had not discussed this concept with their coach reported little or no understanding of health equity.
Including people with lived experience of health inequities in the community's work	15 percent of the community partnerships involved people with lived experience of health inequities and 38 percent of partnerships collected data from this population. 79 percent of partnerships indicated this was an area where they struggled.

c. Emergent strategy to realized strategy (What we learned, added, and contributed to our aims)

Strategies were developed and adapted in response to user feedback and co-created with CHR&R users and partners. The Wisconsin-based County Health Rankings program had always been diligent about seeking feedback from its users and incorporating appropriate changes into the program. While user feedback was always a foundation of the program, we consider it an emergent strategy due to the significant ways users and partners influenced the way programs were adapted and delivered. This is particularly significant since the program was led by an academic institution and funded by the largest national health philanthropy—two types of organizations that are often more grounded in their own expertise than the knowledge of practice-based experts.

Examples of this type of feedback and co-creation include:

- Implemented program changes based on 2010 survey feedback from state and local public health officials, conducted after the first Rankings release, including:
 - Diversified the state teams that support Rankings releases beyond state health department representatives to include local public health officials and public health institutes (accomplished in 2011 release);
 - Provided local health departments direct access to embargoed reports and communication resources (accomplished in 2011 release);
 - Found ways to support local communities in reaching out to other sectors (accomplished through the partner strategy begun in 2011 and beyond);
 - Expanded learning opportunities about the Rankings, methods, actions to improve community health, and examples of communities doing this work (accomplished in 2011 and beyond through webinars and the Roadmaps to Health Action Center);
 - Developed specific tools to assist communities including:
 - » Options for identifying funding and resources to support action initiatives (accomplished in 2012 with the publication of the Funding Guide);
 - » Menus of evidence-based policies and programs to respond to specific measures (accomplished in 2012 and beyond with What Works for Health);
 - » Guidance on how to drill down into more extensive data to better understand community needs (accomplished in 2011 and beyond with expanded web content).
- Made changes in CHR health factor measures throughout the duration of the program (as previously discussed).
- Used input from focus groups and listening sessions to drive the early design of the Roadmaps portion of the program including addressing challenges to working collaboratively with communities (“do with, not to”), including community members, attending to racism and equity, building community capacity—particularly in expanding and leading multi-sector partnerships, and being sure to include a customized, human guidance component of the program.
- Funded two low-ranked communities to serve as CHR&R Learning Labs to evaluate the early development and implementation of the Roadmaps to Health Action Center, What Works for Health, and the coaching model. Many of their suggestions were incorporated into the evolution of the web content and the approach to coaching.
- Elevated the stories of the Prize communities and, based on their progress in moving action forward, incorporated the Prize criteria into core content of the Action Center and the coaching program.

- Listened to feedback from program staff, partners, community members, conference attendees, and others to consider how to fully incorporate the principles of equity into CHR&R.

At the end of 2010, we decided to emphasize the social and economic factors in meaningful ways throughout CHR&R.

During media interviews in the first year of the program, one of the more common questions was “Why is there data about unemployment and poverty in a health report?” It became clear that the model’s emphasis on social and economic factors was a new frontier and to make it more than just a percentage in an academic model, we would have to do more than just message about this. Over the ensuing years, examples of how we did this include:

- When the Request for Proposals for the Community Grants was drafted in late 2010, we (RWJF and UWPHI) decided to make awards to communities that were focusing on policies in the social and economic factors. Both elements of this request were challenging to communities—a focus on *policy* and a focus on *social and economic factors*.
- The evolution of the Prize criteria and subsequent judging criteria emphasized the importance of winning communities making meaningful change in these factors.
- We began to focus webinars on topics such as early childhood education, policies around a living wage and paid sick leave, successful programs supporting reentry into the community for people who were formerly incarcerated, increasing high school graduation rates, and other social and economic factor approaches.
- The County Health Rankings annual messaging focused on social and economic factors and examples of what communities could do in these areas.

- The Key Findings Reports focused on analyses of these factors.
- Our coaches challenged communities to look at their social and economic data and consider it actionable—not simply descriptive—by considering priorities in social and economic areas.

In 2015, we recognized that a focus on social and economic factors alone would not get us to improved health outcomes for all and so we began to explicitly focus on incorporating an equity lens across our work.

The first five years of the program had seen incredible progress in advancing the concept that social and economic factors contributed to health. By 2015, few reporters asked why these data were included in the Rankings and many communities were beginning to acknowledge the contribution of these factors and seeking ways to improve them.

However, as we and others conducted further analyses, it became clear that many times the worst social and economic factors were in communities that had been disadvantaged in other ways such as racial segregation or geographic isolation. Simply focusing on the factors themselves, without any attention to the root causes and institutionalized policies that led to disadvantage, would not result in meaningful change moving forward.

In 2015, the program produced Health Gaps reports to begin the discussion of these disparities. Dr. James Marks, the RWJF executive vice president that had originally insisted on a 50-state approach to the County Health Rankings, was an insistent voice in driving the program toward equity with this initial data analysis. During this same time frame, we added measures that focused on inequities including income inequality and residential segregation. One of the challenges during this period of the program was coming to consensus on how to talk about these issues in ways that resonated across many different audiences from many different political perspectives. At times,

our collective attention to this concern may have masked our intent to highlight inequity, e.g., talking about gaps does not explicitly address whether these gaps are fair and just or whether these gaps are caused by structural inequities.

2015 also marked the year that our staff diversified with the addition of seven coaches from different racial and ethnic backgrounds and regions of the nation. They helped us see some of our blind spots in how the program was delivered. Our coaching team began to re-shape the content of the Action Center and coaching program to explicitly focus on how communities could measure and address inequities and expand their efforts to be inclusive of community members who had experienced many of those inequities.

We also honed this enhanced focus on equity in the Prize program. A review of the Prize criteria evolution (see Appendix G) indicates how the language of one of the criteria (#3) evolved to more fully focus on equity and how equity principles were incorporated across the criteria. This focus on equity also affected how the judges viewed community work and as a result, equity became one of three elements (along with a broad focus on health and policy-oriented strategies) that were fundamental to naming Prize winners. In 2019, the Prize program published an analysis of the first five years of the program describing Prize winners' approaches to increasing equity.⁴²

The program's Key Findings Reports began to conduct analyses that illustrated the intersections between place and health;⁴³ age, place, and health;⁴⁴ and race, place, and health.⁴⁵ Each of these reports highlighted inequities and evolved in the way they explicitly called out historical and structural policies that contributed to those inequities. In 2017, the program also added the disaggregated display of several measures to illustrate differences between White, Black, and

Hispanic populations. At this time, we also started to translate portions of the website into Spanish, including the data pages and Prize application materials. The CHR&R team also added staff who could regularly conduct media interviews in Spanish. (In prior years, a couple of RWJF staff members conducted some day-of-release interviews in Spanish.)

In 2017, we moved from a focus on community readiness to a community developmental assessment.

The discussion of “community readiness” for change is often heard between funders and technical assistance/coaching providers. In CHR&R's own experience, along with many others, we often identify communities for a policy-change grant or coaching assistance to advance policy change only to find the community is not “ready” to take on such work in the near future.

As previously discussed, CHR&R used the CHR&R principles and Prize criteria to develop a tool called Poised for Progress to assist communities in identifying where they were doing well, where they could do more, and where they had not yet started.⁴⁶ Coaches used this tool with team members at the beginning of coaching assignments and, while it functioned as a good conversation starter, they found the topics we asked people to rank were too broad for communities to clearly identify where they were proficient and where they needed to make further change.

This challenge of granularity coupled with the concept of readiness led CHR&R to join forces with colleagues from two other organizations who were grappling with similar issues—100 Million Healthier Lives at the Institute for Healthcare Improvement and the Georgia Health Policy Center. A work team consisting of program leaders and staff who worked in the field with communities studied the

42 University of Wisconsin Population Health Institute. *Actions Toward Equity: Strategies Communities are Using to Ensure Everyone Has a Fair and Just Opportunity for Health*. Summer 2019.

43 <https://www.countyhealthrankings.org/reports/2016-county-health-rankings-key-findings-report>

44 <https://www.countyhealthrankings.org/reports/2017-county-health-rankings-key-findings-report>

45 <https://www.countyhealthrankings.org/reports/2018-county-health-rankings-key-findings-report>

46 <https://www.countyhealthrankings.org/poised-progress-worksheet>

variety of tools that our programs were using to support communities and shared their experiences in doing so. Our analysis resulted in the following conclusions and action steps moving forward:

- The team recognized readiness is *not* a dichotomous choice—ready or not. The ability to make change is a complex interaction of multiple factors that are often at different stages of development within the same team or community system.
- The team moved away from a “readiness” mindset and moved into a “developmental” framework. This was consistent with earlier thinking by the CHR&R team who had originally wanted to design the Action Center around a series of developmental steps based on four stages of community change—inquiry, initiation, implementation, and institutionalization.⁴⁷
- The group identified four stages of community development—not yet started, starting, gaining skill, or sustaining—in six main topics (Collaboration, Communication, Advancing Equity, Planning, Measuring, and

Sustainability). Within each topic there were two to four sub-items. A tool was created that described each developmental stage for each item in the six key areas, resulting in 23 scores for each team or community who completed the tool.

- The team will disseminate the tool to communities once it is fully validated and then provide a resource directory for where communities can go to seek more skill building in each area. For example, if a community was starting in the Focus on and Advocate for Policy section of the Sustainability topic, they would be able to find organizations and/or online resources to help them advance their work in this area at their stage of development.

As with many elements of CHR&R, this work to assist communities with furthering their development in community change is not seen as something that would be solely owned and operated by the CHR&R program. Instead, the development of this tool with sister organizations is intended to be open sourced and available to anyone who can use it to advance their efforts.

d. Intended strategy to unrealized strategy (What we intended, tried, and did not or has not yet contributed to our aims)

Providing carefully crafted summaries of evaluations of specific health improvement strategies did not always assist communities in identifying effective approaches. In 2016, the CHR&R Strategic Assessment panel, an independent group of advisors commissioned by RWJF to reflect and provide recommendations, noted “WWFH is one of the strongest examples of how CHR&R serves as a curator of the science, using its analytic capabilities to look at interventions through the equity lens and glean information from a broad set

of sources.” As one scientist interviewed by the panel said, “they are updating their database on interventions much faster than the government can.” However, the panel also heard concerns about the need to make What Works for Health nimbler, e.g., make it easier to search to find interventions that fit a given community.

In addition, in their environmental assessment of other organizations in the community health improvement space, the GHPC Team noted that:

47 The Stages of Community Change Framework was based on Michael Fullan’s “stages of proficiency” theory and A.D. Kaluzny & S.R. Hernandez’s “Stage Theory of Organizational Change”: Emerging, Initiating, Implementing, Sustaining.

WWFH is a lesser known component of CHR&R. Several Interviewed Organizations had never used WWFH and most who had, found it difficult to find evidence-informed practices that were practically applicable to their skill set, purpose, resources, or geographic location. WWFH was perceived by many as unwieldy and difficult to navigate. More specifically, representatives of many organizations that were interviewed commented that the formatting of WWFH is difficult to navigate. Specifically, there is a lot of text and little direction for nontraditional users, and a significant amount of time needed to sift through results. Often sectors did not find evidence-informed practices that related to their industry or expertise. Respondents also felt it would be possible to streamline the evidence-informed library. CHR&R information and tools could be categorized and presented to allow targeted sectors to be directed to specific information they are most likely to use. Users would be guided to a smaller list of more relevant interventions based on a filtering process. This would make it easier for sectors to navigate the site.

Online resources and relatively small doses of human support have not led to policy change across the health factors. As we contemplate the complex change necessary to achieve improved health outcomes and increased equity in communities, we have not seen the type of support CHR&R offers result in the interwoven and enduring type of action necessary to achieve improved length and quality of life for all members of the community. Even among the Prize winners (many of whom were unaware and did not use any CHR&R resources prior to their selection), the communities are on the journey toward these outcomes and have not fully arrived.

When we started the program 10 years ago, we did not know what dose of support would produce what level of change. While we have clearly seen that the online and human resources provided to date have raised awareness, inspired people to convene, and, in some cases, moved targeted action forward, it is still unknown what it would take to fully deliver desired outcomes.

Coupled with the uncertainty of appropriate levels of support, we have faced the challenge of scalability which has led to abandoning promising strategies. From 2011-2014, RWJF supported 30 communities as part of the Roadmaps to Health Community Grants program. These communities were awarded \$200,000 (paired with a requirement for raising \$200,000 in local matching funds) to implement policy and systems change to address social and economic factors. The project was a learning experience for all—RWJF, the communities, Community Catalyst who provided technical assistance, and CHR&R who provided ancillary support. Some communities were quite effective in implementing changes such as the passage of paid sick leave in New York City and the design of systems to support reduced absenteeism and increases in high school graduation rates in Spokane, Washington. However, the high per community cost to continue the program was not feasible to scale it to the many more communities who may have benefited from the approach.

Instead, the program pivoted to expanding the coaching program and providing much smaller activation grants (\$10,000-20,000 per community). While this approach also resulted in positive changes and at much smaller cost per community, it was still deemed to fail as a scalable option. The 2016 CHR&R Strategic Assessment panel found the CHR&R coaching model to be high quality and affirmed communities supported by coaches had shown gains in building multisector partnerships, focusing on a wide variety of health factors, and taking steps toward increasing their focus on equity and their movement toward PSE change. However, the model itself was highly labor intensive, serving approximately 100-125 communities per year with the more intensive team-based coaching. The panel challenged the program to consider ways to scale up to meet the needs of larger populations of communities. They suggested that a better way to reach communities across the nation was by further curating the web content and designing networking approaches that connected community members in ways to learn from each other. The program is currently embarking on a variety of

initiatives to reach more people and maintain the opportunity for person-to-person interaction including self-learning modules, virtual convenings, and in-person opportunities to network and learn together. An emphasis on network theory and peer-to-peer learning are important elements of this new approach. This work continues in 2019-2020, so it is too soon to tell if this intended strategy will become a realized strategy or not.

We have not yet solved for how to help communities measure progress and meaningful change toward improved health outcomes and increased equity. Since the first survey of CHR&R users in 2010, the topic of how to measure change has been at the forefront of peoples' requests. While we have taken incremental steps, such as pointing out that the Rankings themselves are not an appropriate singular measure of change and directing people to individual measures that can be compared from year to year, we have not yet designed an approach that fully embraces the complexity of community change.

While there are beacons of progress, there is not yet an enduring culture shift where the CHR&R principles are regular parts of decision-making for the majority of communities. The best data, the best evidence, the best tools, the best coaching, and even the best grantmaking process will not advance health and equity without sustainable buy-in and resource investment from local communities. CHR&R began in the shadow of the 2008 recession and while the country has made significant progress in the economic recovery, it has also faced an opioid epidemic that has robbed thousands of people of years of productive life, ongoing and deepening disparities in many health factors (such as income inequality) and outcomes (such as life expectancy), and political climates that threaten policies that have improved health factors for many. The 44 Prize-winning communities—that span 26 states and include 5 federally recognized tribes—provide us with hope, yet that still leaves many states and the majority of counties without such beacons of progress. We continue to be challenged by the best way to use finite resources to connect communities and build the social and political will to advance nation-wide progress towards improved health and increased equity, particularly in times of prosperity when resources should not be the barrier.



VIII.

Conclusions

a. What did we learn?

Over the years since we first set out to transfer our broad model of population health measurement from a single state to all 50 states, we have learned many lessons—both individually and collectively as a team. Our initial focus was very much on the left side of our first logic models (i.e., on assembling population health data, creating reports, and garnering media attention). It turns out that despite the complexities and nuances of population health data, this was the easy part!

For example, we learned that an important part of moving from data to action includes shifting mindsets and assumptions about who and what creates health and equity. One of our most important messages from the first release of the Rankings for all 50 states on February 17, 2010 was that there is more to health than health care. In 2010, this message was quite unique but over time we have observed that many others have taken on this change in mindset.

Another shifting mindset had to do with the importance of moving beyond health behaviors to look at the underlying social and economic factors that shape community health. With the first set of community grants released as part of the addition of “Roadmaps” to the program, we (RWJF and UWPHI) decided to focus these grants on social and economic factors. We also sought out communities that were working on social and economic factors as finalists for the RWJF Culture of Health Prize. We noticed increasing uptake of this mindset shift among our partners across the nation. And, then more recently, an additional shift is occurring as more and more communities address both social and economic factors and the role they have in determining the level of equity within communities.

We also learned important lessons about moving those folks whose mindsets have shifted into action. We learned that it takes leadership

and collective action. To affect many different health factors requires community members, organizational leaders, and staff from many different areas to come together with a shared commitment. And to work together in a system without traditional structure and hierarchy requires different approaches to leadership—such as those informed by the principles of collective impact or boundary-spanning leadership.

As communities move from gathering people to implementing action, we know it is important for them to assess their own development and

where they may need more skills, structure, or resources to effectively advance community health improvement. We also learned that our Take Action Model is not as orderly as it seems. True community action often involves customized approaches that may jump back and forth from step to step as the team learns more and addresses obstacles for action. And we've learned that successful communities stage their approach to community health improvement, recognizing it is a long journey and that they can build on earlier successes to create momentum for taking on new challenges.

b. What's next?

As CHR&R embarks on a brand-new decade with a brand-new leader, Dr. Lawrence Brown, we are excited for the future of the program and humbly offer a few high-level recommendations, structured around CHR&R's major strategies: data, evidence, guidance, and examples:

i. Data

We recommend CHR&R consider revising or expanding the CHR model. The County Health Rankings model appears widely across the internet and in state and local publications with a simple and clear explanation of how things in our communities influence how healthy we are. However, the model is a depiction of how we measure health and only covers the drivers of health that are measurable at the county level. It does not cover many of the characteristics of communities that have developed over time due to biased and discriminatory practices nor does it include important concepts such as power and culture that influence the opportunities residents have to lead healthy lives. And, specifically, the model only addresses overall health but does not include health equity in either health outcomes or the factors that drive health outcomes.

We recommend revamping the CHR&R website to better facilitate access to data within and across counties, with clear and accessible linkages to

other reliable sources of sub-county data. While the term “county” defines the measurement focus for CHR, it is important to remember that the county is not necessarily the most appropriate boundary for local or state community health improvement methods. By upgrading the mapping technology upon which the CHR website is built, it should be possible to continue to provide the ease of use to which CHR users are accustomed while also improving functionality.

Since rankings are not particularly helpful in measuring progress, we recommend CHR&R and RWJF give additional thought to the pros and cons of rankings and determine whether the need to garner attention necessitates their use. We realize that rankings represent the foundation of the CHR&R program, but we are also fully aware of the confusion and difficulties communities face each year when their new ranks are published. Despite CHR&R's best intentions, it does not seem possible to stop people from focusing their attention on their ranks rather than on underlying measures that can be used to measure progress. Alternatives to ranking could include reporting by deciles or quartiles, assigning grades, or simply just publishing the data. Whatever approach is taken, it is important to note that the current ranks only capture health *not* equity and so any alternatives considered should seek ways to raise awareness of both dimensions.

ii. Evidence

We recommend work continue to improve the What Works for Health interface to make it easier for users to find relevant strategies that might work in their community. One of the challenges of providing a one-stop shop for data, evidence, guidance, and examples is that each of these components of CHR&R result in different user needs. We have long heard that potential users are either not aware of What Works for Health or are not able to use it as easily as they would like. The search tool that makes it easy for users to find their county does not work nearly as well for finding evidence about potential strategies. One possibility is to add further curation by investigating the feasibility of tiering or developing one or more short lists of strategies (taking reach, depth, impact on equity, amount of change, and/or cost into consideration) that would counteract the possibility that communities see a generic “top ten” list of strategies and feel that if they have implemented those strategies, their work is done. Examples of this type of focus or tiering can be found in CDC’s work in the top strategies to improve health for children under age 6⁴⁸ or its work to advance evidence to improve six high-burden health conditions.⁴⁹

We recommend CHR&R and RWJF work together to determine how to maintain the feasibility of continued growth of the number of strategies within What Works for Health. As noted earlier, the database has more than doubled in size since its inception, such that there is a significant tradeoff between the demand for identifying new strategies versus updating the evidence about existing strategies. With the same small number of staff since its inception and the desire to continually add new strategies that are attracting interest, the frequency with which updates are made to existing strategies has declined significantly. Consideration might be given to revising WWFH to link to other evidence bases that address some of the core health factors and then focus its own work on the types of strategies that are not included in other evidence databases. In addition, as a funder,

RWJF might want to invest more resources into evaluating the effectiveness of more complex strategies since it is normally the more simple and straightforward strategies that are studied.

The Policies and Programs box in the CHR model is not currently “measured” and so we recommend consideration of how to learn from communities about the strategies they are finding effective. While there are databases of state laws and policies, it is much more challenging to find out what strategies are in place and working to improve health factors in local communities. Looking beyond its current source of funding, CHR&R could explore partnerships with other organizations that are measuring state policies to see how CHR&R could provide communities with insights into the work others have underway.

iii. Guidance

We recommend CHR&R and RWJF consider expanding the local lens that CHR&R primarily applies. CHR&R’s primary focus has been on supporting local communities to move with data to action. Local communities can truly be innovation hubs; however, without connecting these innovations, they will simply exist as isolated beacons of success. When local communities connect and market their innovations, they can influence state or federal policy that will have much wider ranging population health effects. This requires a focus on connecting local communities and building relationships with state and federal partners. Examples of how local action has stimulated state or federal policy include the passage of local smoke-free air laws that led to state-wide clean indoor air policies and the piloting and testing of home visitation programs to support children’s and families’ well-being that has resulted in federal support for such programs. Building CHR&R’s partner portfolio to enhance connections with state legislators and governors’ offices, training local practitioners in skills to advocate with their state elected officials (such as through a state-focused Connect program), and

48 <https://www.cdc.gov/policy/hst/hi5/interventions/index.html>

49 <https://www.cdc.gov/sixteen/index.html>

featuring more success stories of local innovation transforming state-wide policy in webinars and on the CHR&R website could be first steps to strengthening these connections.

We recommend CHR&R participate more actively in discussions around the medicalization of the social determinants of health.

While health care organizations across the nation are recognizing the importance of social determinants of health, in general their response has been to look primarily at individual social needs rather than also looking at the conditions within communities that drive these needs. This conflating of language where social determinant of health means the same as an individual patient's social need results in actions that are not effective. CHR&R can use its strong communication prowess to help reinforce the differences between social determinant of health, social risk factors, and social needs.⁵⁰ This work is time critical. Recently published research that focused on identifying people who use emergency rooms frequently and providing them with additional support to meet their social needs found that this approach did not significantly reduce ER utilization when compared with a control group of similar patients who did not receive the additional services.⁵¹ With dozens of health systems and states investing in similar programs, it is critical to delve into this work and understand what was done (or not done) to improve the social and economic conditions in the communities where the studies were conducted. For example, if no affordable housing exists, no level of social service support is going to be able to connect at-risk people with housing. This distinction between social needs and social determinants is critical in both program planning and research to evaluate the effectiveness of interventions.

We recommend CHR&R connect with investors to help guide communities to sustainable funding approaches.

The American Institutes for Research

survey of local health officials identified “lack of resources to address issues” as the most common reason officials said they could not move action forward. This is a message that has been heard repeatedly over the past decade. At the same time, more and more foundations are reluctant to invest in short-term projects that are not sustainable in communities post-grant funding. Three strategies that could enhance resource portfolios for moving health improvement change forward include:

- Working with local and state legislators and agency leadership to identify initiatives or enhancements to programs such as Medicaid to support health improvement efforts;
- Working with major locally based employers (e.g., hospitals, universities, local government) to promote the concept of their role as anchor institutions and the opportunity to invest via local purchasing, workforce development, and investment portfolio options;⁵² and
- Working with community development professionals who possess expertise in both the needs of low-income populations and the mechanics of financing to make infrastructure and programmatic improvements that will benefit neighborhood revitalization and health.

A current example of the first approach is a new initiative in the state of Wisconsin. Medicaid funds are now available to pay for lead abatement in homes with lead hazards where children or pregnant women who receive Medicaid live. By protecting the current and future residents of that home from the consequences of lead poisoning, the state will see children who are more likely to achieve in school, and thus are more likely to get family-wage supporting jobs in adulthood. Because lead poisoning often results in more violent behavior in children who are

50 Green, K. & Zook, M. When talking about social determinants, precision matters. Health Affairs Blog, October 29, 2019. <https://www.healthaffairs.org/doi/10.1377/hblog20191025.776011/full/>

51 Finkelstein, A., Zhou, A., Taubman, S., & Doyle, J. (2020) Health care hotspotting: A randomized control trial. *New England Journal of Medicine*, 382: 152-162, doi: 10.1056/NEJMsa1906848.

52 Norris, T. & Howard, T. (2015) Can hospitals heal America? The Democracy Collaborative. <https://democracycollaborative.org/content/can-hospitals-heal-americas-communities>

poisoned, fewer lead-poisoned children means fewer criminal charges and incarcerations. And because the funding is a sustainable source of revenue, this will encourage more construction companies to hire lead-certified workers—thus creating good-paying jobs in the community.

We recommend CHR&R creates a roadmap of resources based on the developmental assessment tool framework (currently under validation).

Throughout its 45-year history, RWJF has invested millions of dollars in how to support communities in successful interventions. The developmental tool allows communities to self-assess what they need to do to advance health improvement. When coupled with a roadmap of the resources that will help them advance their work, this approach holds great promise for breakthroughs in actions to improve health and increase equity. Once the tool is completed, adequate resources to fully populate the roadmap of action and then study the experience of communities who use the tool will be critical to understanding this approach's value in solving the complex issue of improving health.

iv. Exemplars/Examples

We recommend CHR&R refine and deliver a robust set of activities to provide opportunities for communities to learn from each other and to support community networks in scaling successful initiatives.

Over the past decade, CHR&R has touched hundreds, if not thousands, of communities with its webinars, coaching, online resources, and RWJF Culture of Health Prize application and award process. We hypothesize that communities are well poised to advance action together and future investments could provide both staff support to convene communities and seed money to support communities willing to build networks to advance strategies through affinity groups.

We recommend the communications team help communities at different stages in their journey toward health improvement describe their work to help others.

The RWJF Culture of Health Prize winner story content, including videos, is amazing. But for a community who is early in their work, the Prize stories may seem unachievable. Stories of places that are just starting their work in equity, collaborative leadership, or policy initiatives would add value to the storytelling library to support other communities.

Acknowledgements

To say that everything we have written about in the paper was based on a team effort is a massive understatement. We would likely fill another 40 pages if we tried to list everyone who has been a part of this decade-long journey. However, we would like to acknowledge the key groups who have been at our side throughout:

1. The leadership and staff of the Robert Wood Johnson Foundation who had the faith to invest in our program and strategies.
2. Our colleagues, both current and former, at the University of Wisconsin Population Health Institute and in the Department of Population Health Sciences who helped us chart new territories and implement innovative but challenging strategies.
3. Our many formal advisors and reviewers who have served on our early and current advisory and review groups and who generously give of their time and insights to help us steer the CHR&R program in an everchanging environment.
4. Our data partners who not only provided us with data within challenging timeframes but gladly gave us advice along the way.
5. Our national partners in community health improvement who saw the necessity of not only sharing data but also providing guidance and support to local communities.
6. Our evidence reviewers who ensure that our evidence database is based on the best science possible.
7. Our communications and technical colleagues who helped take our ideas and turn them into meaningful messages and accessible information (we both still proudly wear blue and orange garb!).
8. And, last but by no means least, our state and local community health partners and all those who have used and given us feedback on our data, evidence, guidance, and examples on their road toward health for all.

Finally, we would like to acknowledge the feedback and assistance we received on this report from Abbey Cofsky, Joe Marx, and Kathryn Wehr of the Robert Wood Johnson Foundation; Sheri Johnson, Carrie Carroll, Marjory Givens, Kate Kingery, and Kim Linsenmayer of the University of Wisconsin; and Chuck Alexander and staff at Burness.

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APPENDIX A

County Health Rankings & Roadmaps Timeline

2007

- Presented Wisconsin work on County Health Rankings and Wisconsin Report Card at a pre-session for the National Network for Public Health Institutes (NNPHI) annual meeting, with RWJF associates in attendance (May).

2008

- David Kindig began discussions with RWJF about supporting work around metrics, partnerships, and incentives for Population Health Improvement; original plan was to collect data for 5 states per year for 3 years.
- Patrick Remington and Bridget Booske had telephone discussion with Jim Marks where Dr. Marks indicated he would like us to rank all 50 states at the end of the first year.
- Submitted our original proposal, Mobilizing Action Towards Community Health (MATCH), including three types of work: metrics (which became CHR), partnerships (a series of case studies were completed), and incentives (expert panel and papers).
- Bridget Booske attended CDC Community Level Health Index Workshop (September), announcing that discussions were underway with RWJF about producing national County Health Rankings; established key contacts for data acquisition.

2009

- Hired first Mobilizing Action Towards Community Health (MATCH) staff and graduate students.
- Stakeholder engagement meeting in Washington, D.C. (May 1).
- Community engagement calls with all 50 states via state health department representatives.
- Presented Rankings concept at national meetings with primary focus on public health (e.g., APHA, NACCHO).
- Data collection/ranking for all 50 states using national data sources.
- Developed strategy for imputing missing values for individual measures (use state average).
- Developed strategy for determining which counties had sufficient data for ranking.
- Attend RWJF Strategic Communications training and during the training made the strategic decision to rank *within* states.
- Decision to provide separate ranks for health outcomes and factors.
- Participated in RFP process with RWJF and Burness to select Forum One as web vendor.
- Began ongoing coordination/consultation with America's Health Rankings, National Center for Health Statistics/CDC.
- Initial branding as County Health Rankings: Mobilizing Action Toward Community Health.
- Began delivering webinars as a primary mechanism for communicating with our stakeholders.

2010

- Released 1st Rankings for all 50 states (February 17).
- Robust communications support (key messages, state press releases, messaging documents, pitching in all 50 states) for RWJF/UWPHI spokespeople and state teams.
- Expanded presentations at national meetings to include other sectors—United Way, National Education Association, National Association of Counties.
- Began use of video to tell our story with Rankings release video (featuring Juneau County, Wis. Public Health Director Barbara Theis).
- Provided embargoed data to state teams at the state report level.
- Worked with Burness to prepare first communications toolkit.
- Turned down requests from national media to name the healthiest and least healthy counties in nation.
- Prepared national results comparing healthiest counties in each state with least healthy counties.
- Added a county snapshot for Washington, D.C.
- Began consulting with local communities upon request (e.g., Central Michigan, Empire Foundation).
- CDC funding via NNPHI to support public health institutes (PHI) in supporting state teams in Rankings release rollout.
- Cohosted post-Rankings event with CDC to solicit feedback about the Rankings release from national leaders, RWJF, community members, and UWPHI (April).
- Launched Improvingpopulationhealth.org blog (David Kindig and Kirstin Siemering).
- Bridget Booske and Julie Willems Van Dijk met with RWJF representatives in Princeton to scope out a MATCH expansion grant, jointly deciding that planned grants to communities should focus on social and economic factors.

2011

- Released 2nd Rankings (March 30).
- Added “additional” measures to the web site as well as measures used to calculate rankings.
- Added PHI and State Association of County and City Health Officials (SACCHO) representatives to state teams.
- Rankings release video featuring Wyandotte County, Kan., and Mayor Joe Reardon (move beyond public health).
- Hired first community coaches and team lead for What Works for Health (WWFH) and began development of Action Center and WWFH.
- Began informal coaching model.
- Selected Policy Advocacy Lead Organization (Community Catalyst).
- Launched *Roadmaps to Health* Community Grants, with Community Catalyst.
- United Way Worldwide became first national partner.
- Established and met with Roadmaps to Health Advisory Group.
- Provided full set of embargoed data to state and local leaders at the community level via an embargoed preview website.
- RWJF/UWPHI provided funding to state teams to support Rankings rollout and pivot into action.
- Aligning Forces for Quality issued population health grants based on the CHR model and in consultation with CHR&R staff.
- In consultation with RWJF, rebranded as County Health Rankings & Roadmaps, Building a healthier nation, county by county.

2012

- Released 3rd Rankings (April 3).
- Rankings release video featured Hernando, Miss., Mayor Chip Johnson (broadened the story to action without explicit use of Rankings).
- Launched Roadmaps to Health Action Center (April 3).
- RWJF Culture of Health Prize (Prize) competition launched (April 3).
- Launched CHR&R WWFH evidence database (September).
- Began inviting external WWFH reviewers.
- Mathematica began their evaluation of the Roadmaps portion of CHR&R.
- National Business Coalition on Health became a national partner (December).
- Added first trend graphs (premature death) to website.
- Decision to hold an in-person Prize Event.
- Community Health Learning Labs (Clare County, Mich., and Wyandotte County, Kan.) funded to test Action Center resources.
- Community Coalition Leadership Program launched, using communities who were part of the CHR&R network as their applicant pool (community grants, learning labs, coached communities, national partner communities).
- Partnership with Kate B. Reynolds Charitable Trust for Healthy Places North Carolina began.
- First CHR&R retreat with team leadership, RWJF, and partners held (September).

2013

- Released 4th Rankings (March 20).
- First Prize winners awarded in February.
- Second Prize competition launched.
- Prize videos contribute to the storytelling movement.
- Awarded first three research grants to support the Rankings.
- National Association of Counties (NACo) becomes a national partner (January).
- Second CHR&R partner retreat held with team leadership, RWJF, and partners (May).
- Launched team coaching application process.
- Website enhancements:
 - Added Areas to Explore to county snapshots.
 - Add links to WWFH policies and programs from Rankings data.
 - First mobile responsive version of website (automatically adjusting to size of screen whether on desktop, tablet, or mobile).
- Worked with US News and World Report on special feature on healthiest places for children, in conjunction with the release of their Children's Hospitals Rankings.

2014

- Released 5th Rankings (March 26).
- Third Prize competition launched.
- First cohort of teams entered coaching.
- Prize Alumni Network launched with quarterly calls, e-UPDATE newsletter, password protected site.
- Held three regional Rankings release events (Kentucky, western New York, North Carolina).
- Change in tagline: County Health Rankings & Roadmaps, Building a Culture of Health, County by County.
- First Key Findings Report published.

- Website enhancements:
 - Added state landing pages to website.
 - Added Measuring Progress section to website.
 - Introduced Community in Action writeups (spotlights).
- Third CHR&R retreat held with expanded group of partners including other RWJF grantees in the community health improvement space (December).
- Shifted WWFH focus to include strategy updates and greater emphasis on implementation.
- 2014 Prize winners announced at Aspen Ideas Festival.
- Selected Active Living By Design to lead Action Award work.
- Selected Center for Creative Leadership (CCL) to lead Network Discovery Work.
- Contracted with NNPHI to hire six additional community coaches across the nation.
- New Jersey Health Initiative adopts CHR&R models and coaching as part of the Culture of Health Grant program.

2015

- Released 6th Rankings (March 25).
- First scholarly article published on Rankings approach and methods (Population Health Metrics).
- First Prize round that provided feedback/Action Awards/coaching to communities not advancing.
- Health Gap Reports released (November).
- Awarded five research grants focused on the use of community data.
- Fourth Prize competition announced.
- Action Awards released.
- 2015 Prize winners announced at RWJF.
- Infrastructure for Prize Alumni Network expanded: listserv; innovation fund.
- Prize community as host site for NACo Learning Lab.
- Changed from measure quartile maps to measure heat maps to better visualize gaps in health.
- First publication featuring research from Prize communities (Health Affairs).
- Learning exchanges between Prize winners and coaching communities initiated.
- LISC and NeighborWorks added as national partners.
- Network Discovery Report (prepared by Center for Creative Leadership) issued.

2016

- Released 7th Rankings (March 16).
- Fourth CHR&R retreat with team leadership, RWJF, and partners held (January).
- Website enhancements:
 - Added Areas of Strength to county snapshots.
 - Added Compare Counties Across States feature.
 - Expanded Our Approach section to include measure details.
- Fifth Prize competition announced.
- Bridget Booske Catlin, CHR&R co-director, retired; Julie Willems Van Dijk served as sole director of CHR&R and RWJF Culture of Health Prize; Carrie Carroll serves as Prize deputy director; three additional deputy directors were hired: Marjory Givens (Data and Science), Kate Kingery (Community Transformation), and Kim Linsenmayer (Operations).
- 2016 Prize winners announced at RWJF (September).

2017

- Released 8th Rankings (March 29).
- 2017 Prize winners announced at RWJF (September).
- Sixth Prize competition announced.
- Awarded four research grants focused on strengthening Rankings methods.
- Website/data enhancements for Rankings release:
 - Added leading cause of death for premature death.
- Website sitewide design refresh include redesign of the Action Center and Partner Center (December).

2018

- Released 9th Rankings (March 14).
- 2018 Prize winners announced at RWJF (September).
- Seventh Prize competition announced.
- Began shift from coaching individual communities to programmatic offerings designed to reach multiple communities across the country.
- Began working with Visible Network Labs to provide network analysis and state profiles in support of CHR&R networking strategies.
- Website/data enhancements:
 - Revised State CHR reports significantly, discussing health equity and race and place.
 - Added demographic breakdowns for selected measures within the snapshots.
 - Made county snapshots available in Spanish.
 - Added peer county comparison (transferred from CDC).

2019

- Released 10th Rankings (March 19).
- Julie Willems Van Dijk takes position as Wisconsin Deputy Secretary of Health Services (February); Sheri Johnson (UWPHI director) takes over as acting director, CHR&R and RWJF Culture of Health Prize.
- Awarded four research grants to support the evolution of Rankings.
- Produced our first online Action Learning Guides (three at Rankings release and two in November).
- Launched two Active Group Learning Cohorts, an evolution of the previous cohort model (July and September).
- Launched Collaborative Learning Awards in collaboration with Healthy Places by Design.
- Website/data enhancements (for Rankings release) including redesigned and updated content for all measure detail pages.
- Published first peer-reviewed paper on What Works for Health and other evidence clearinghouse (Preventing Chronic Disease).
- 2019 Prize winners announced at RWJF (November).
- Eighth Prize competition announced.
- New director of CHR&R selected: Lawrence Brown.

APPENDIX B

History of County Health Rankings & Roadmaps Funding, 2008-2020

History of Funding by Robert Wood Johnson Foundation to the University of Wisconsin-Madison School of Medicine and Public Health, Population Health Institute for The County Health Rankings and Roadmaps Program*

Grant Title	Description	Funding and Leadership	Year
Shifting mind-sets and catalyzing action on health and equity in communities through the County Health Rankings & Roadmaps and RWJF Culture of Health Prize	<p>This effort will enhance the County Health Rankings & Roadmaps program and the RWJF Culture of Health Prize to accelerate national and local momentum on addressing the multiple factors that affect health and equity. This project will evolve the County Health Rankings & Roadmaps (CHR&R) program and RWJF Culture of Health Prize (Prize) in ways that build national and local momentum in addressing the multiple factors that affect health and equity. Deliverables will include:</p> <ol style="list-style-type: none"> (1) the annual CHR&R release, annual Prize competition and celebration event, expanded learning opportunities for communities and partners, and synthesis of insights across the two programs; (2) collaboration with national, regional, state, and local organizations to catalyze and equip communities to create healthier, more equitable communities; (3) rapid-cycle improvements to strengthen the movement from data to action, including a renewed focus on health equity and on the influence of key audiences and users of the two programs; and (4) a business assessment to inform the two programs' structure and sustainability. 	<p>Amount awarded: \$14,681,381</p> <p>Awarded on: 9/30/2018</p> <p>Timeframe: 9/30/2018 - 9/29/2020</p> <p>Grant number: 75425</p> <p>Project Director: Julie Willems Van Dijk (9/18-2/19) Sheri Johnson (2/19 -) Lawrence Brown (1/20 -)</p>	2018
Accelerating improvements in health and equity in communities through County Health Rankings & Roadmaps and the RWJF Culture of Health Prize	<p>The County Health Rankings & Roadmaps program was designed to help communities translate the County Health Rankings into multisector action that addresses the social, economic, environmental, and behavioral factors that affect health. This grant supports the University of Wisconsin Population Health Institute (Wisconsin) in continuing as a strategic partner on the County Health Rankings and Roadmaps (CHR&R) program, including County Health Rankings (Rankings), Roadmaps to Health Action Center (Roadmaps), and the Culture of Health Prize (Prize). CHR&R and the Prize are platforms and drivers for the Robert Wood Johnson Foundation (RWJF) goals of increasing awareness of the multiple factors that influence health and igniting action to improve health; making health a shared value among all living in the United States; and fostering collaboration and solutions focused on healthier, more-equitable communities. Deliverables will include:</p> <ol style="list-style-type: none"> (1) annual data collection for and development and release of the Rankings; (2) website updates; (3) research grants and progress on developing subcounty data; (4) innovations for and increased promotion of the Roadmaps, including the What Works for Health online tool, coaching, support for virtual learnings, peer-to-peer learning, and webinars; (5) expanded engagement with partners and network support; (6) management of and support for the Prize selection process, celebrations, and alumni network; (7) implementation of the 2016 recommendations from the strategic assessment of CHR&R and the Prize; (8) steady release of publications, blog posts, and reports, including an equity-related report; (9) implementation of real-time learning and quarterly reports; and (10) managing three advisory bodies. 	<p>Amount awarded: \$12,842,339</p> <p>Awarded on: 7/26/2016</p> <p>Timeframe: 9/30/2016 - 9/29/2018</p> <p>Grant number: 73634</p> <p>Project Director: Julie Willems Van Dijk</p>	2016

*This does not include funding provided directly to other contractors (such as Community Catalyst or Healthy Places by Design) that complemented the work of UWPHI nor prizes or grants to communities or grants to partners that augmented UWPHI's reach and implementation. In addition, other than a small subcontract with Burness and a subcontract with Forum One (after 2010), the majority of communications support for CHR&R was funded separately and directed by RWJF.

Ten-Year Reflections on the County Health Rankings & Roadmaps

Grant Title	Description	Funding and Leadership	Year
<p>Implementing and expanding the County Health Rankings & Roadmaps to improve health outcomes in communities, 2014-2016</p>	<p>The County Health Rankings & Roadmaps program was designed to help communities translate the County Health Rankings into multisector action that addresses the social, economic, environmental, and behavioral factors that affect health. This renewal grant includes support for the County Health Rankings (Rankings), Roadmaps to Health (Roadmaps), and RWJF Culture of Health Prize (Prize). The University of Wisconsin Population Health Institute (UWPHI) will continue to serve as a strategic partner and leader with the Robert Wood Johnson Foundation (RWJF) on all aspects of the County Health Rankings & Roadmaps (CHR&R) program and will work collaboratively with CHR&R national partners and a to-be-named network lead on new activities for community connections and network-building. Deliverables will include:</p> <ol style="list-style-type: none"> (1) annual Rankings reports, website updates, and Rankings roll-out activities in 2015 and 2016; (2) creation of the new Health Gap Index, based on the Rankings, to be issued annually starting in 2015; (3) exploration of sub-county measures with up to five pilot sites; (4) expansion of the Roadmaps to Health Action Center, including coaching for approximately 400 communities, regular updates to the virtual Action Center and What Works for Health database, and a robust webinar series; (5) management of and support for the 2015 and 2016 cycles of the Prize and development of a Prize alumni network; and (6) a quarterly updated dashboard to track progress of all aspects of the CHR&R program. <p>UWPHI will, in collaboration with RWJF, convene and staff two advisory bodies to guide this work. The newly formed Scientific Advisory Group will provide guidance for the Rankings and related products and research; and the established Roadmaps Advisory Group will continue to provide guidance on Roadmaps and Prize activities.</p>	<p>Amount awarded: \$12,204,832</p> <p>Awarded on: 6/30/2014</p> <p>Timeframe: 6/30/2014 - 9/29/2016</p> <p>Grant number: 71865</p> <p>Co-Project Directors: Bridget Catlin and Julie Willems Van Dijk</p>	<p>2014</p>
<p>Continuing the work of the County Health Rankings to improve community health</p>	<p>This grant support will continue the production, dissemination, and promotion of the County Health Rankings, which score the health of every county in the nation and show that much of what affects health occurs outside of the doctor's office, for the next two years. Published annually by the University of Wisconsin Population Health Institute (UWPHI) and the Robert Wood Johnson Foundation (RWJF) since 2010, the Rankings help counties understand what influences how healthy residents are and how long they will live. Deliverables will include:</p> <ul style="list-style-type: none"> ■ annual releases of the Rankings in 2013 and 2014; ■ updated web content and functionality; and ongoing outreach, training, and technical assistance to promote the use of the Rankings. <p>New in this grant period will be the:</p> <ul style="list-style-type: none"> ■ development and launch of a tool to allow Rankings users to track community-level progress in health improvement; ■ development of web and mobile-device applications to connect Rankings data to new users; ■ collaboration with up to six external research teams to increase the utility of the Rankings; and ■ submission of at least six articles to peer-reviewed journals. <p>UWPHI will continue to collaborate with RWJF and its communications partners on the dissemination and promotion of the Rankings and will contract with a communications strategist to serve as the communications director for the entire County Health Rankings & Roadmaps initiative.</p>	<p>Amount awarded: \$4,607,353</p> <p>Awarded on: 9/3/2012</p> <p>Timeframe: 8/31/2012 - 8/30/2014</p> <p>Grant number: 69835</p> <p>Co-Project Directors: Bridget Catlin and Patrick Remington</p>	<p>2012</p>

Ten-Year Reflections on the County Health Rankings & Roadmaps

Grant Title	Description	Funding and Leadership	Year
Implementing the County Health Roadmaps initiative to improve health outcomes in communities, 2011-2014	<p>Mobilizing Action Toward Community Health (MATCH), was designed to help communities translate the County Health Rankings into multisector action that addresses the social, economic, environmental, and behavioral factors that affect health. This grant supports the University of Wisconsin Population Health Institute (UWPHI) in implementing MATCH. MATCH comprises the MATCH Center, the Community Grants Program, and grants to partnering agencies. As the lead organization for this initiative, UWPHI will employ the following strategies to support action in local communities:</p> <ol style="list-style-type: none"> (1) development of online solutions that support peer-to-peer networking; (2) implementation of tailored training and technical assistance to support community-health-improvement projects; (3) development of partnerships with key member organizations outside traditional public health; (4) creation of a national award in population health to recognize communities that have made great strides in creating health improvement through multisector partnerships; and (5) establishment of a MATCH advisory group. <p>UWPHI will also work with the Foundation to identify an advocacy organization to serve as the MATCH Center’s policy-advocacy lead, manage the Community Grants Program and lead all of the MATCH Center’s advocacy-related training and technical assistance. UWPHI will help develop the call for proposals for the Community Grants Program and will coordinate with the Foundation on communications and outreach in the launch of the center and the grants program.</p>	<p>Amount awarded: \$3,774,224</p> <p>Awarded on: 3/31/2011</p> <p>Timeframe: 4/14/2011 - 6/29/2014</p> <p>Grant number: 68735</p> <p>Project Director: Bridget Catlin</p> <p>Deputy Director: Julie Willems Van Dijk</p>	2011
Planning for the County Health Roadmaps initiative to improve health outcomes in communities, 2010-2011	<p>The County Health Rankings & Roadmaps initiative was designed to help communities translate the County Health Rankings into multisector action that addresses the social, economic, environmental, and behavioral factors that affect health. This grant supports the University of Wisconsin Population Health Institute (UWPHI) in developing a detailed plan and laying the groundwork for full implementation of the MATCH initiative. The initiative comprises the MATCH Center, the Community Grants Program and grants to partnering agencies. As the lead organization of the MATCH Center, UWPHI will use this planning grant to:</p> <ol style="list-style-type: none"> (1) develop and finalize a strategic plan, timeline, and staffing infrastructure for the center; (2) develop a long-term training and technical assistance (TA) plan to support community action and roll out short-term training and TA opportunities with the release of the 2011 County Health Rankings; (3) develop a national award for population health improvement to recognize best practices and innovation in community efforts to improve health outcomes; and (4) identify, recruit and convene a MATCH advisory group. <p>UWPHI will also work with the Foundation to identify an advocacy organization to serve as the MATCH Center’s policy-advocacy lead, manage the Community Grants Program, and lead all of the MATCH Center’s advocacy-related training and TA. UWPHI will help develop the call for proposals for the Community Grants Program and will coordinate with the Foundation on communications and outreach in the launch of the center and the grants program.</p>	<p>Amount awarded: \$196,159</p> <p>Awarded on: 12/19/2010</p> <p>Timeframe: 12/14/2010 - 6/29/2012</p> <p>Grant number: 68588</p> <p>Project Director: Bridget Catlin</p> <p>Deputy Director: Julie Willems Van Dijk</p>	2010

Ten-Year Reflections on the County Health Rankings & Roadmaps

Grant Title	Description	Funding and Leadership	Year
Support for Mobilizing Action Toward Community Health (MATCH)	<p>One goal of Project MATCH (Mobilizing Action Toward Community Health) is to release three annual report cards, based on population health metrics, in all 50 states as catalysts to improve health and reduce health disparities. The Robert Wood Johnson Foundation believes that the reports for all 3,000 U.S. counties will spur community leaders to improve health rankings for their communities. Deliverables will include:</p> <ul style="list-style-type: none"> ■ health rankings for the years 2009, 2010, and 2011; ■ web-based technical assistance to all states each year in preparing the release of the county reports; ■ a report describing multisector partnership models for population health improvement; a report assessing financial and governance models that might be tested in multisector demonstration programs designed to improve health outcomes and reduce health costs; and ■ a website devoted to providing tools and resources for population health improvement. 	<p>Amount awarded: \$4,934,201</p> <p>Awarded on: 10/27/2008</p> <p>Timeframe: 12/31/2008 - 8/30/2012</p> <p>Grant number: 65017</p> <p>Co-Project Directors: David Kindig and Patrick Remington</p> <p>Deputy Director: Bridget Catlin</p>	2008
Using summary measures of health outcomes to guide multisectoral planning to improve community health (Phase 1)	<p>This project is the first phase of an initiative to improve population health outcomes in America's communities by using county health scorecards to mobilize action across different sectors of the community. The project will produce a white paper on summary health outcome measures that can be used to compare overall health between counties and between states. In addition, a feasibility study and workplan will be produced for annual National County Health Rankings based on the Wisconsin County Rankings model. White papers on the use of summary metrics, demonstrating the impact of major determinants of health on summary metrics to communities, bringing together health and non-health sectors to commit to improving public health, and policy levers that can provide incentives for population health improvement will be summarized in a final report. A website on population health designed for communities and policymakers will be available to provide information and evidence on population health outcomes, determinants, and interventions. These products will form the basis for the anticipated second phase.</p>	<p>Amount awarded: \$181,141</p> <p>Awarded on: 8/26/2008</p> <p>Timeframe: 8/31/2008 - 8/30/2009</p> <p>Grant number: 65020</p> <p>Co-Project Directors: David Kindig and Patrick Remington</p> <p>Deputy Director: Bridget Catlin</p>	2008
		Total: \$53,421,630	

APPENDIX C

County Health Rankings Models, 2003-Present

FIGURE C.1
Wisconsin County Health Rankings, 2003

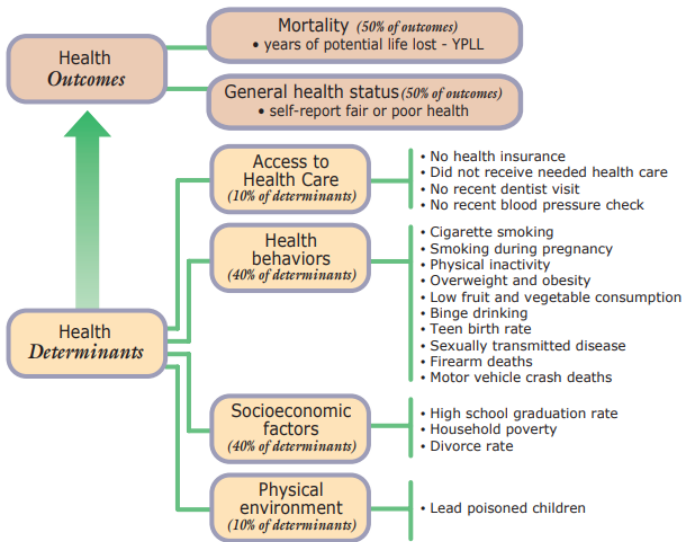


FIGURE C.2
Wisconsin County Health Rankings, 2006

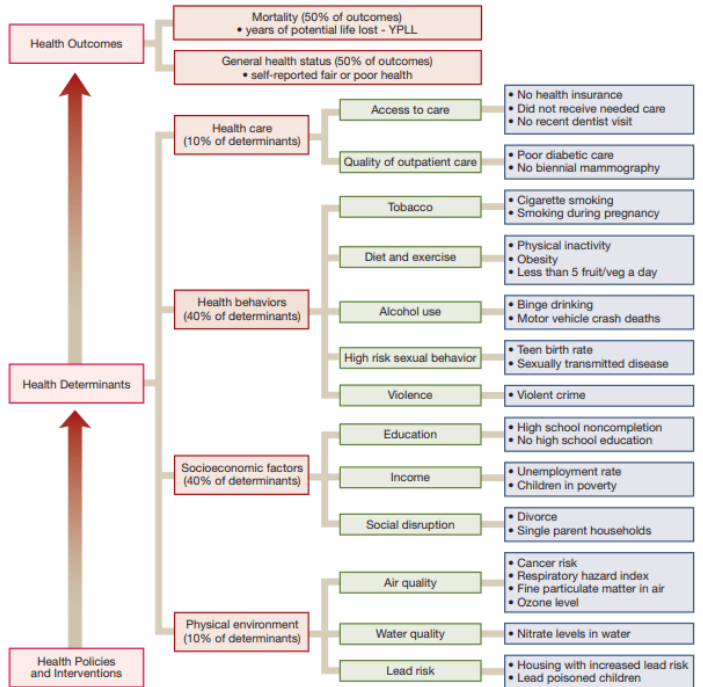


FIGURE C.3
Wisconsin County Health Rankings, 2008

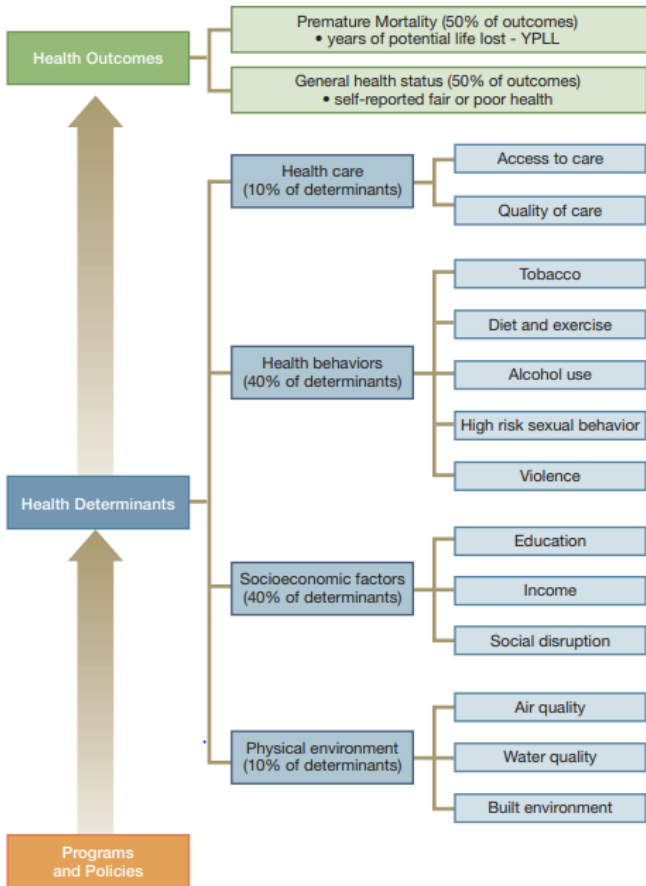
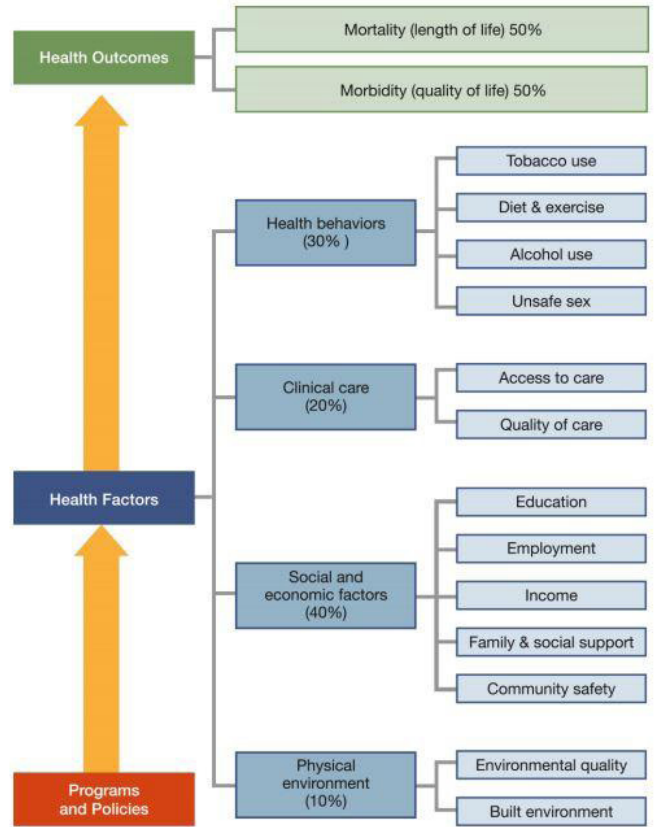
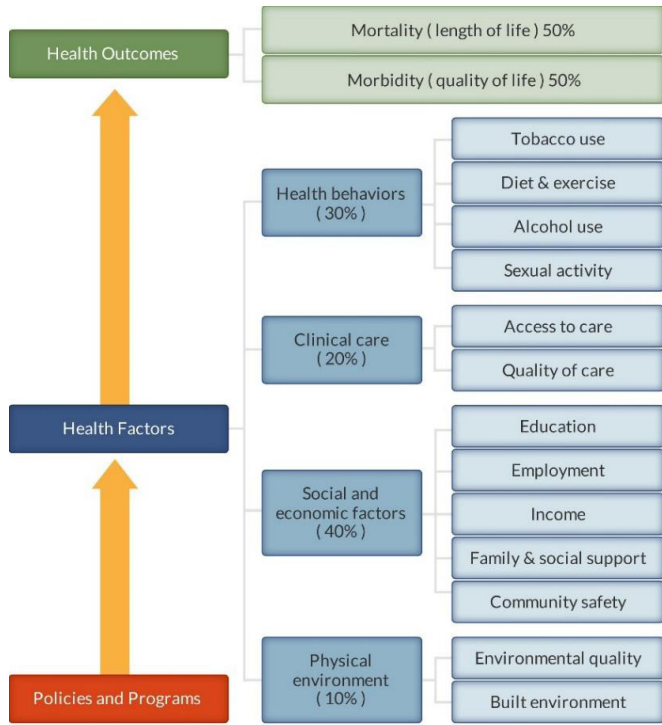


FIGURE C.4
County Health Rankings, 2010



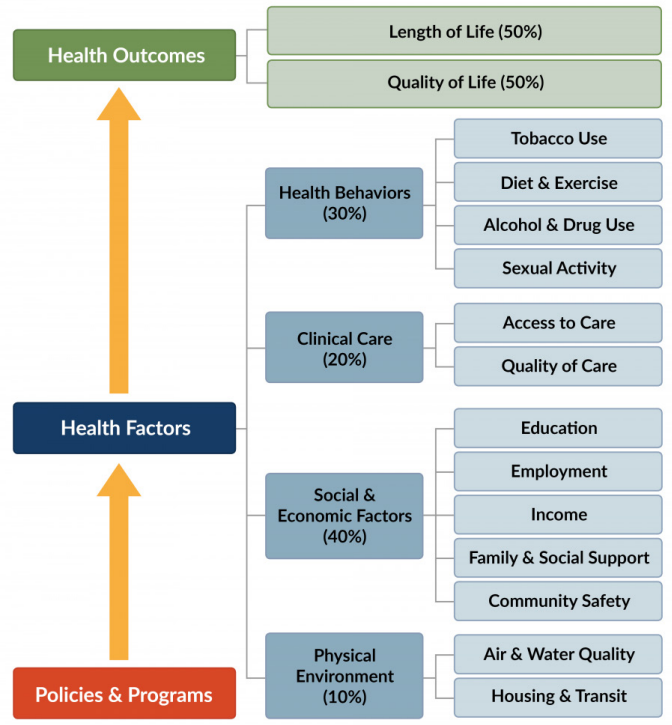
County Health Rankings model ©2010 UWPHI

FIGURE C.5
County Health Rankings, 2012



County Health Rankings model ©2012 UWPHI

FIGURE C.6
County Health Rankings, 2014-Present



County Health Rankings model © 2014 UWPHI

APPENDIX D

Take Action Models, 2010-Present

FIGURE D.1
Take Action Model, 2010



FIGURE D.2
Take Action Model, 2011



FIGURE D.3
Take Action Model, 2012



FIGURE D.4
Take Action Model, 2013



FIGURE D.5
Take Action Model, 2014

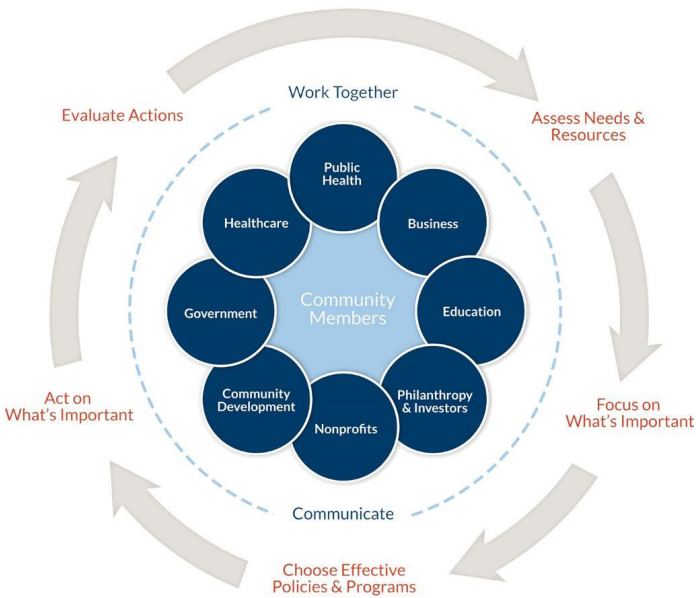
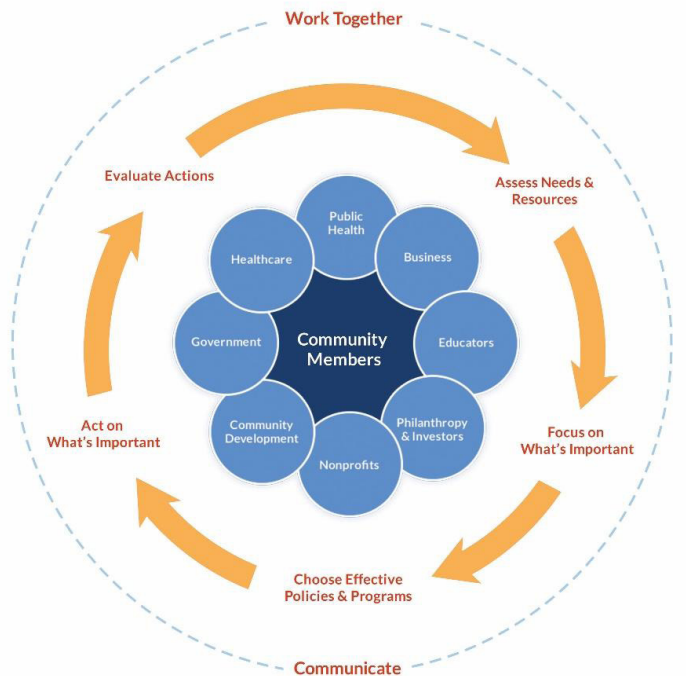


FIGURE D.6
Take Action Model, 2015-Present



APPENDIX E

National Findings as Reported in County Health Rankings Press Releases, 2010-2019

2010

Poorly ranked counties often had multiple challenges to overcome, including:

- Two- and three-fold higher rates of premature death, often from preventable conditions.
- High smoking rates that lead to cancer, heart disease, bronchitis, and emphysema.
- High rates of obesity which can put people at risk for diabetes, disability, and heart disease.
- High unemployment and poverty rates.
- High numbers of liquor stores and fast-food outlets but few places to buy fresh fruits and vegetables.

2011

Each county's rank reveals a pattern of strengths and weaknesses. And, the Rankings reveal that all counties have areas where they can improve, even those that are the healthiest. Some highlights of what counties look like nationally:

- People are nearly twice as likely to be in fair or poor health in the unhealthiest counties.
- Unhealthy counties have significantly lower high school graduation rates.
- Unhealthy counties have more than twice as many children in poverty.
- Unhealthy counties have much fewer grocery stores or farmer's markets.
- Unhealthy counties have much higher rates of unemployment.

2012

Within each state, even the healthiest counties have areas where they can improve. Healthier counties (those where people live longer and have a better quality of life) have lower rates of smoking, physical inactivity, teen births, preventable hospital stays, unemployment, children in poverty, and violent crime and higher levels of education, social support, and access to primary care physicians. But healthier counties are no more likely than unhealthy counties to have lower rates of excessive drinking or better access to healthy food options.

Across the nation, some factors that influence health, such as smoking, availability of primary care physicians, and social support, show highs and lows across all regions. Meanwhile other factors reflect some distinct regional patterns, such as:

- Excessive drinking rates are highest in the Northern states.
- Rates of teen births, sexually transmitted infections, and children in poverty are highest across the Southern states.
- Unemployment rates are lowest in the Northeastern, Midwest, and central Plains states.
- Motor vehicle crash deaths are lowest in the Northeastern and upper Midwest states.

2013

Although the Rankings only allow for county-to-county comparisons within a state, this year's Rankings showed significant new national trends:

- Child poverty rates have not improved since 2000, with more than 1 in 5 children living in poverty.
- Violent crime has decreased by almost 50 percent over the past two decades.
- The counties where people don't live as long and don't feel as well mentally or physically have the highest rates of smoking, teen births, and physical inactivity, as well as more preventable hospital stays.
- Teen birth rates are more than twice as high in the least healthy counties than in the healthiest counties.
- Access to health care remains an important factor and this year, the Rankings include residents' access to dentists, as well as primary care doctors. Residents living in healthier counties are 1.4 times more likely to have access to a doctor and dentist than those in the least healthy counties.

2014

National Trends

The Rankings provide county-to-county comparisons within a state; this year's Rankings also showed important national trends:

- Teen birth rates have decreased about 25 percent since 2007.
- The rate of preventable hospital stays decreased about 20 percent from 2003 to 2011.
- Smoking rates dropped from 21 percent in 2005 to 18 percent in 2012.
- Completion of at least some college increased slightly from 59 percent in 2005 to 64 percent in 2012.

New Measures in 2014

This year's report featured the following new measures:

- **Housing:** Almost 1 in 5 households are overcrowded, pose a severe cost burden, or lack adequate facilities to cook, clean, or bathe. These problems are greatest on the East and West Coasts, Alaska, and parts of the South.
- **Transportation:** More than three-quarters of workers drive to work alone and among them 33 percent drive longer than a half hour each way. Driving contributes to physical inactivity, obesity, and air pollution.
- **Food Environment:** People in many parts of the country face food insecurity (or the threat of hunger) and limited access to healthy foods, especially in counties in the Southwest, across parts of the South, and the western United States.
- **Mental Health:** Amid growing attention to mental health care, the availability of mental health providers in the healthiest counties in each state is 1.3 times higher than in the least healthy counties. The West and Northeast regions of the country have the best access to mental health providers.
- **Injury Related Deaths:** The third leading cause of death in the United States., injury death rates are 1.7 times higher in the least healthy counties than in the healthiest counties. These rates are particularly high in the Southwest, part of the Northwest (including Alaska), and the East, South, Central, and Appalachian regions.
- **Exercise Opportunities:** Access to parks or recreational facilities in the healthiest counties is 1.4 times higher than in the least healthy counties.

2015

This year's Rankings showed that almost 1 out of 4 children in the United States lives in poverty. Child poverty rates are more than twice as high in the unhealthiest counties in each state than in the healthiest counties. The report also looks at distribution in income and the links between income levels and health.

Beyond poverty and income, the 2015 County Health Rankings Key Findings Report highlighted two other key social and economic factors that drive health: violent crime and employment. These findings showed that:

- **Violent crime rates are highest in the South:** Violent crime rates, which affect health, well-being, and stress levels, are highest in the Southwest, Southeast, and Mississippi Delta regions.
- **Having a job influences health:** Unemployment rates are 1.5 times higher in the least healthy counties in each state as they are in the healthiest counties. During the recession, counties in the West, Southeast, and Rust Belt region of the United States were hit hardest by growing unemployment. Many, but not all, of these counties have seen their unemployment rates drop since the recession ended in 2010.

This year's Rankings data also shined a light on the characteristics of healthy and unhealthy counties. The healthiest counties in each state have higher college attendance, fewer preventable hospital stays, and better access to parks and gyms. The least healthy counties in each state have more smokers, more teen births, and more alcohol-related car crashes.

2016

The 2016 County Health Rankings compared health differences on a broad range of measures among almost every county throughout the country. The report shows dramatic differences between rural and urban counties on a number of measures, most notably premature deaths rates. Rural counties not only have higher rates of premature death, but also nearly 1 in 5 rural counties saw rises in premature death rates over the past decade while most large urban counties experienced consistent improvement.

Rural counties have higher rates of smoking, obesity, child poverty, and teen births, and higher numbers of uninsured adults than their urban counterparts. Large urban counties have lower smoking and obesity rates, fewer injury deaths, and more residents who attended some college.

The 2016 Rankings Key Findings Report included several new health-related measures: residential segregation, drug overdose deaths, and insufficient sleep.

- Residential segregation between Blacks and Whites, a fundamental cause of health disparities, is highest in counties in the Northeast and Great Lakes regions and lowest along the Southeastern seaboard. In areas where Black and White residential segregation is highest, there are typically vast differences in health, well-being, opportunity, and quality of life.
- Drug overdose deaths have increased 79 percent nationwide since 2002 and are reaching epidemic proportions in parts of the United States. The highest death rates are in counties in northern Appalachia and parts of the West and Southwest.
- One out of three adults don't get enough sleep—less than seven hours a night—with implications for health and productivity. Lack of sleep is tied to higher levels of stress and depression, hypertension, heart and kidney disease, motor vehicle accidents, and suicide. The highest rates of insufficient sleep are found in counties in the southeastern United States, while the lowest rates are in the Plains states.

The 2016 Rankings data also took a closer look at health gaps in each state, comparing how the top performing counties stack up against the bottom performing counties on key measures. Enormous difference in health outcomes can exist within a state.

2017

The 2017 County Health Rankings showed premature death rates are rising nationally because of an increase in deaths among 15- to 44-year-olds. From 2014 to 2015, 85 percent of the increase in premature deaths can be attributed to a swift increase in deaths among these younger Americans. The Rankings Key Findings Report reveals that while a myriad of issues contributed to the rise, the drug overdose epidemic is the leading cause of death among 25- to 44-year-olds and is a clear driver of this trend. Drug deaths are also accelerating among 15- to 24-year-olds, but nearly three times as many people in this age group die by homicide, suicide or in motor vehicle crashes.

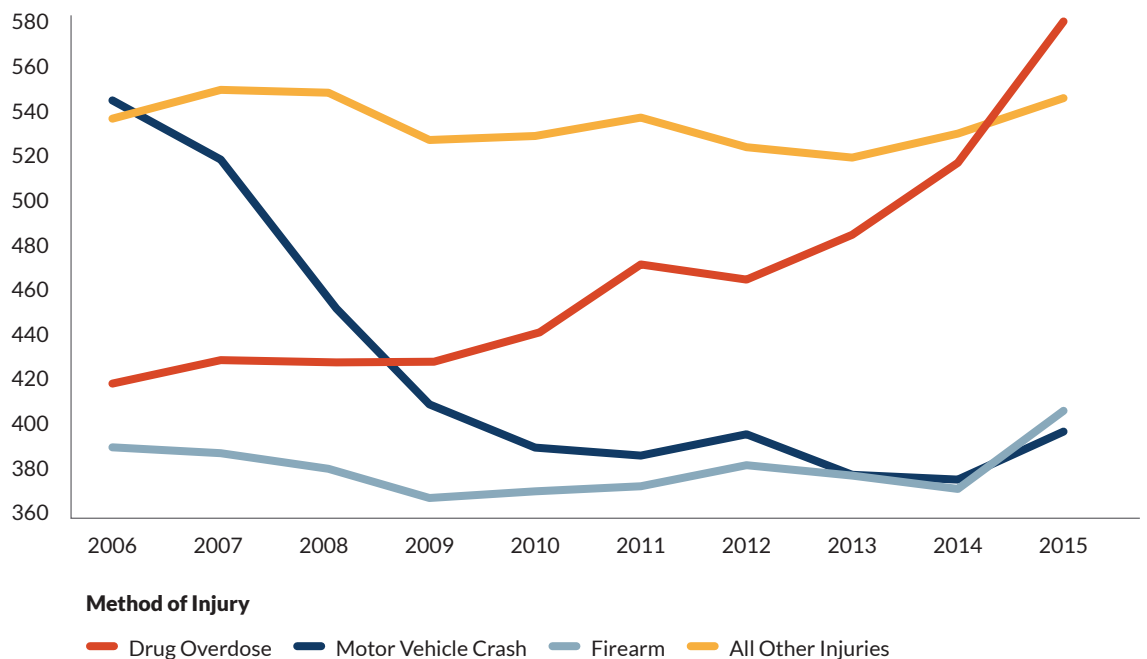
With this year’s exploration of rising premature death and drug overdose rates, stark disparities became apparent from community to community and among racial/ethnic groups:

- **A tragic turn in suburbs:** Drug overdose deaths are climbing in communities of all shapes and sizes, but a significant shift occurred in the suburbs, which a decade ago had the lowest rates of premature death due to drug overdoses but now have the highest. (The rate increased 5.4%.) Smaller metro and rural counties also have higher rates of premature death due to drug overdoses.
- **Differences among racial and ethnic groups:** Premature deaths due to drug overdoses were highest among Whites and Native Americans in 2015. Premature deaths have consistently been highest among American Indians/Alaska Natives and Blacks. Suicide and homicide rates in 2015 are highest among Asian/Pacific Islanders and Blacks, respectively, among those ages 15 to 24.

The 2017 Rankings also introduced a new measure focused on young people, those 16- to 24-years-old, who are not in school or working. About 4.9 million young people in the United States—1 out of 8—fall into this category. Rates of youth disconnection are higher in rural counties (21.6%), particularly those in the South and West, than in urban ones (13.7%).

Premature Death Trends by Method of Injury from 2006 to 2015

Years of Potential Life Lost per 100,000



2018

For nearly a decade, the County Health Rankings have shown that where we live makes a difference in how well and how long we live. In 2018, our analyses showed that meaningful health gaps persist not only by place but also by race and ethnicity. These health gaps are largely influenced by differences in opportunities that disproportionately affect people of color, such as access to quality education, jobs, and safe, affordable housing. The 2018 report showed some troubling trends. For example, after nearly a decade of improvement, we saw more babies born at low birthweight (8.2% in 2016, a 2% increase from 2014)—low birthweight is a key indicator of quality of life for mothers and babies. A pattern of disparity by race in low birthweight can be seen across the nation, with poor birth outcomes more likely among Blacks. Compared to White babies, Black babies are twice as likely to be born at low birthweight and about twice as likely to die before their first birthday.

One of the connections this report illuminated between race and place is that segregated communities of color are more likely to be cut off from investments that promote good schools, affordable housing, and other opportunities for health. The United States has a long history of racism and discriminatory policies and practices that have limited the opportunities of people of color in choosing where to live, including practices like denying housing loans to people of color. Poor health exists in places segregated from opportunity. Decades of research show that residential segregation is a fundamental cause of health disparities in the United States. The 2018 report showed Blacks in more segregated counties fare worse in rates of child poverty, infant mortality, and high school graduation than those in less segregated counties.

The 2018 Rankings explored important trends happening among the nation's children and youth:

- **Teen births:** There are strong ties between poverty and births among teens. Teen birth rates have been declining across community types and racial groups for more than a decade, with most recent data showing a US rate of 27 per 1,000 females, ages 15-19. Hispanic teens have seen the most improvement in birth rates, falling from 77.7 to 31.9 births per 1,000 females—ages 15-19, from 2006 to 2016. Black and American Indian/Alaska Native teens have also seen notable improvements. Teen birth rates are highest among counties in the Southwest and Southeast as well as parts of Appalachia, the Mississippi Delta, and the Plains regions. These regions have seen little change over the last decade, while the East and West Coasts have seen improvements.
- **Children in poverty:** Poverty limits opportunities and increases the chance of poor health. Today, 1 in 5 children grow up in poverty. Available data show that, for most U.S. counties, child poverty rates for American Indian/Alaska Native, Black, or Hispanic children are higher than rates for White children, and these rates are often twice as high.

2019

Through this year's County Health Rankings, we saw how widespread the burden of severe housing cost is across the nation—facing hundreds and thousands of families and communities and this has important implications for our health. More than 1 in 10 households lives with the burden of severe housing costs, and across and within counties there are stark differences in affordability, depending on who you are, how much money you make, and where you live. While good health depends on jobs, education, transportation, health care, and more, all of these factors are linked to where we live—our home. In places where severe housing cost burden is high, there are more children in poverty, more people who are food insecure, and more people in poor health. As housing expenses have outpaced local incomes, many families experience the burden of severe housing cost—meaning they pay more than half their income on housing. While severe housing cost burden has decreased for homeowners in the past decade, this improvement does not hold true for renters with as many as 1 in 4 impacted. Low-income renters face steep hurdles to health with 1 in 2 households spending more than half their income on rent. When the vast majority of a family's paycheck goes to housing, it leaves little money left for other essentials that contribute to good health, such as healthy

food, medicine, or transportation to work and school. High housing costs can force some families to live in unsafe or overcrowded housing, to move away from neighborhoods where they have family connections and opportunities for good education and jobs. And too many households are just one unforeseen event—an illness, job loss, or financial crisis—away from losing their homes, and all the stability our homes provide.

Residential Segregation & Severe Housing Cost Burden

The 2019 County Health Rankings Key Findings Report examined housing affordability by place and by race. Its analysis looked at large urban and smaller metro counties—places with residential segregation of Black and White residents—and found counties that are more segregated have higher rates of severe housing cost burden, both for White and Black households. However, Black residents face greater barriers to opportunity and health than Whites in these counties. Nearly 1 in 4 Black households spends more than half their income on housing compared to 1 in 10 White households. And that burden is further increased for Black households due to differences in incomes. The median household income for White residents in these communities is \$56,000 compared to \$33,000 for Black residents. Segregation, and how it has shaped the social and economic conditions of neighborhoods over time, is fundamental in understanding the stark differences in health between Blacks and Whites. Compared to Whites, Blacks living in residentially segregated places are more likely to be cut off from well-resourced schools and good paying jobs. They also face higher rates of child poverty, infant mortality, and poor health. Many of the differences we see in more residentially segregated communities stem from the history of discriminatory policies and practices that limited the opportunities of Black people to choose where to live, such as redlining or denying housing loans to Black families. While most explicit policies and practices have been outlawed, racial discrimination persists in many forms, and this continues to have an impact on community and resident health and well-being.

APPENDIX F

Key Messages for County Health Rankings Releases, 2010-2019

<p>2010</p>	<ul style="list-style-type: none"> ■ Where we live matters to our health. ■ There are great disparities in health based on where we live. ■ Many factors contribute to health. Health is more than health care. ■ Health is everyone's business. ■ We all need to work together to improve the health of our communities ■ For the first time, we have a standard measure to compare health from community to community. ■ The County Health Rankings are a call to action.
<p>2011</p>	<ul style="list-style-type: none"> ■ Where we live, learn, work, and play matters to our health ■ The Rankings helps counties see where they are doing well and where they are not so they can make changes to improve health. ■ Health is everyone's business ■ You can see how your county compares to other counties in your state ■ Mobilize action to improve health
<p>2012</p>	<ul style="list-style-type: none"> ■ The County Health Rankings continue to reinforce that where we live matters to our health—and the County Health Roadmaps projects show how communities are taking action to improve health. ■ The Rankings help counties see how they compare to their neighbors so they can identify where they are doing well and where they need to improve. The Roadmaps help counties see what steps they need to take to remove barriers to good health. ■ Improving health is everyone's business. ■ You can see how your county compares to other counties in your state. ■ Mobilize action to improve health.
<p>2013</p>	<ul style="list-style-type: none"> ■ The County Health Rankings continue to show us that where we live matters to our health. ■ The Rankings serve as an easy-to-use health snapshot of the many factors that influence health and help community leaders identify areas where improvement is needed. ■ Roadmaps supports communities working together to make progress on those factors. ■ Improving health is everyone's business. ■ Communities are coming together to create a Culture of Health. ■ The Roadmaps to Health Action Center offers an expansive portfolio of information, tools, and guidance supporting action to improve the health of your community. ■ Communities investing in health will want to be sure they are focused on the most effective strategies. Information to guide leaders about what works to improve health can be found at www.countyhealthrankings.org/what-works-for-health.
<p>2014 (5th Rankings)</p>	<ul style="list-style-type: none"> ■ The County Health Rankings show us where we live matters to our health. ■ The Rankings motivate community leaders and citizens to work together in new and creative ways to build a Culture of Health. ■ Since their national debut in 2010, the Rankings have helped to expand the conversation about the broad range of factors that impact health. ■ This year's report features even more new factors that influence health, such as housing, transportation, and access to mental health providers. ■ For the fifth anniversary release of the County Health Rankings, several communities are hosting local events to highlight how they have used the Rankings to build their own path to better health. ■ The County Health Rankings show how we're doing and where we can improve our health. The Roadmaps offer communities resources to move from awareness to action. ■ The RWJF Culture of Health Prize honors communities whose efforts illustrate an enduring commitment toward creating a Culture of Health for all residents.

Ten-Year Reflections on the County Health Rankings & Roadmaps

2015	<ul style="list-style-type: none">■ The County Health Rankings show us where we live matters to our health.■ We know that income and poverty matter a lot to health.■ Income affects our choices in housing, education, childcare, food, and more.■ Our new measure, income inequality, allows each county to begin to see differences, even gaps, across their entire population.■ Using this data, communities can start a conversation about ways to address these gaps and reduce poverty.■ Income inequality is the first measure in the County Health Rankings that allows all counties—even the healthiest, to begin to see differences and even gaps across their entire population.■ This can help start a conversation about what these gaps mean. For example, the implications for disparities within counties in areas such as housing or access to fresh food.■ In addition, income inequality may make it difficult for community members to work together for the well-being of all—like when we rely on the personal connections and relationships within our communities. Or ensuring that everyone has a say in community decision making.■ Communities are using the Rankings to invite new partners to the table—leaders in education, business, and community development—to take action.■ In many cases, we know what works to improve health. Tools from our Roadmaps to Health Action Center can assist communities on their journey.■ For example, we have 11 Community Coaches, located across the nation, who provide hands-on customized assistance to local communities on how to accelerate their health improvement efforts. You can contact a coach by simply activating the Get Help button at countyhealthrankings.org.■ What Works For Health is an online data base which provides communities with information about evidence-informed policies, programs, and system changes that will improve the variety of factors we know affect health.■ Our Poised for Progress tools helps communities identify strengths and possible areas for growth to build a healthy community.■ The RWJF Culture of Health Prize honors trailblazing communities that are making health a priority in all their decisions and building a Culture of Health. Visit rwjf.org/prize to learn more.
2016	<ul style="list-style-type: none">■ The County Health Rankings show us where we live matters to our health.■ An easy-to-use snapshot that compares counties within states, the Rankings show that where you live influences how well and how long you live.■ Good health allows people to be their best, fulfill their potential, and thrive. The Rankings make it clear that good health includes many factors beyond medical care including housing, education, jobs, access to healthy foods, and more.■ We are ranking communities on factors that they can do something about. Community leaders can look closely at the Rankings for their county, find common ground, and pinpoint actions that can improve health.■ All counties can take action to improve, no matter where they rank. It's not a race to the top. It is about progress toward better health.■ Building a Culture of Health means creating a society that gives every person, no matter who they are or where they live, the opportunity to be as healthy as they can be.■ Every county is different and will chart its own course towards better health.
2017	<ul style="list-style-type: none">■ The County Health Rankings show us where we live matters to our health.■ An easy-to-use snapshot that compares counties within states, the Rankings show that where you live influences how well and how long you live.■ Good health allows people to fulfill their potential and thrive. The Rankings make it clear that good health is influenced by many factors beyond medical care including housing, education, jobs, access to healthy foods, and more.■ The Rankings show us not everyone has the same opportunity to be healthy.■ All counties can take action to improve, no matter where they rank. It's not a race to the top. It is about progress toward better health.■ Building a Culture of Health means creating a society where everyone has the opportunity to live a healthier life.■ Find out more about the health of your county at countyhealthrankings.org

Ten-Year Reflections on the County Health Rankings & Roadmaps

2018	<ul style="list-style-type: none">■ County Health Rankings are an easy-to-use snapshot of the health of nearly every county in the nation.■ The Rankings show us that where we live makes a difference in how well and how long we live.■ The Rankings show us not everyone has the same opportunity to be healthy where they live.■ This year, we explore differences in health by place and by race and ethnicity. Both of these are influenced by differences in opportunity.■ Visit countyhealthrankings.org to learn more.■ Possible solutions for low birthweight: Communities can look at their data and work with others to increase opportunities for mothers to be healthy like safe neighborhoods, quality housing, good education, and affordable health care coverage.■ Possible solutions for residential segregation: Community development and revitalization (without displacement), living wage jobs, and expanding public transit.■ Possible solutions for children in poverty: Invest in education starting in early childhood, expand earned income tax credits, paid leave, or unemployment insurance.■ Possible solutions for teen births: Increase opportunities for education and job training, cultivate youth leadership, and everyone has adequate, affordable health care coverage.■ Communities can look at their data to see what's happening and bring partners together to prioritize and tackle the barriers to health they see locally.■ What Works for Health offers evidence-informed strategies and our Take Action Center provides helpful guidance and tools for communities to explore.■ The RWJF Culture of Health Prize communities offer great examples of places creating powerful partnerships to develop solutions. Check out rwjf.org/prize.
2019	<ul style="list-style-type: none">■ The County Health Rankings show us that where we live makes a difference in how well and how long we live.■ But we know that not everyone has the same opportunities to be healthy where they live.■ This year, our report shows that people with low-incomes and people of color are disproportionately burdened by high housing costs, often spending more than 50 percent of their incomes on housing. We can do better.■ A safe, secure, and affordable place to call home is a foundation for good health.■ We can't thrive as a nation when whole communities are left behind. We need to fix the things that stand in the way of opportunity for everyone—such as residential segregation, discrimination, not enough good-paying jobs, and lack of access to quality health care.■ The good news is that we can fix this problem. Every community should look at its County Health Rankings data and work together to find solutions so that everyone—no matter how much money they make or the color of their skin—has the opportunity to live in a safe, secure, and affordable home.■ We encourage people to go to countyhealthrankings.org to take action.■ Housing costs remain unacceptably high and this is bad for our nation's health. The high cost of housing impacts all of us-in every county of the nation.■ Renters are disproportionately burdened by high housing costs—and low-income renters experience an even greater financial burden.■ Owning a home is an important vehicle for families to build wealth for their children and grandchildren, but not everyone has had a fair chance to pursue this valued American dream.■ The more segregated the community, the more Black and White families are burdened by severe housing costs.■ There is no single solution to high housing costs. Every community must look at the challenges in their neighborhoods and address the most pressing needs.■ Communities across the country are making strides and we are learning from them about innovations that work.

APPENDIX G

RWJF Culture of Health Prize Criteria, 2013-2019

Bolded text indicates new text that year. Unbolded text represents text that remained the same from the prior year.

Broad definition of health

2013	Recognizing the multiple factors that influence health (including health behaviors, clinical care, social and economic factors, and the physical environment) and prioritizing those factors having the greatest impact on overall health according to the County Health Rankings (CHR) model.
2014	IMPLEMENTING A STRATEGIC APPROACH TO IMPROVING HEALTH THAT FOCUSES ON THE MULTIPLE FACTORS THAT INFLUENCE HEALTH including health behaviors, clinical care, social and economic factors, and the physical environment as illustrated by the CHR model. Judges have a particular interest in communities that are addressing all four factors in the CHR model and communities that are prioritizing those factors that most influence health.
2015	DEFINING HEALTH IN THE BROADEST POSSIBLE TERMS. Building a Culture of Health (CoH) means using diverse strategies to address the multiple factors that influence health. This includes raising awareness and catalyzing action in a manner that aligns with the CHR model and its four health factor areas: clinical care, health behaviors, social and economic factors, and the physical environment. Applicant communities are encouraged to share how they are bringing this model to life in ways that demonstrate responsiveness to community needs, assets, and priorities. Given the relative weight of the social and economic factors that influence health, judges are particularly interested in how communities are addressing these barriers to better health.
2016	Defining health in the broadest possible terms. Building a CoH means using diverse strategies to address the multiple factors that influence health. This includes raising awareness and catalyzing action in a manner that aligns with the CHR model of health and its four health factor areas: access to and quality of clinical care, health behaviors, social and economic factors, and the physical environment. Applicant communities are encouraged to share how they are bringing this model to life in ways that demonstrate responsiveness to community needs, assets, and priorities, and that exemplify a balanced portfolio of activities across the health factors. Given the relative weight of the social and economic factors that influence health, judges are particularly interested in how communities are moving beyond merely targeting programs to populations in need to taking specific action to improve social and economic factors that lead to better health.
2017	Defining health in the broadest possible terms. Building a CoH means using diverse strategies to address the many things that influence health in our communities. This includes all of the factors in the CHR model of health: access to and quality of clinical care, health behaviors, social and economic factors, and the physical environment. Judges will look to see that applicant communities are taking action across these areas. Applicant communities are also encouraged to share how they respond to community needs, assets, and priorities. Given the importance of social and economic factors in influencing health, judges are particularly interested in seeing how communities are making changes in education, employment/ income, family and social support, and community safety.
2018	Defining health in the broadest possible terms. Building a CoH means using diverse strategies to address the many things that influence health in our communities. This includes taking action across all of the factors in the CHR model of health: access to and quality of clinical care, health behaviors, social and economic factors, and the physical environment. Judges will look to see that applicant communities are taking action across these areas. Communities are also encouraged to show how they respond to community needs and priorities. Given the importance of social and economic factors in influencing health outcomes, strategies addressing education, ... and community safety are considered crucial elements to achieving a CoH.
2019	Defining health in the broadest possible terms. Building a CoH means using comprehensive strategies to address the many things that contribute to health, opportunity, and equity in our communities. This includes acting across multiple areas that influence health, such as the factors in the CHR model: health behaviors, clinical care, social and economic factors, and the physical environment. Communities are also encouraged to show how they respond to key challenges and build on the strengths of their community. Given the importance of social and economic factors in influencing health outcomes, strategies addressing education, employment/ income, family and social support, and community safety are considered crucial elements to achieving a CoH.

Policy-oriented strategies

2013	Planning and implementing policy, systems, and environmental changes that target populations rather than individuals.
2014	DEVELOPING SUSTAINABLE, LONG-TERM SOLUTIONS TO SHARED COMMUNITY PRIORITIES including planning and implementing policy, systems, and environmental changes that target populations rather than individuals.
2015	COMMITTING TO SUSTAINABLE SYSTEMS CHANGES AND POLICY-ORIENTED LONG-TERM SOLUTIONS. Building a CoH means making thoughtful and deliberate policy, programmatic, environmental, and systems changes focused on identified community priorities with a goal of sustaining the impact of these changes over time. This includes having a strategic approach to problem-solving that recognizes both the value of evidence as well as the promise of innovation. Applicant communities are encouraged to share how leaders, organizations, and sectors throughout the community are making decisions with the goal of improving health.
2016	Committing to sustainable systems changes and policy-oriented solutions. Building a CoH means making thoughtful and deliberate policy, programmatic, environmental, and systems changes focused on identified community priorities with a goal of sustaining the impact of these changes over time. This includes having a strategic approach to problem-solving that recognizes both the value of evidence as well as the promise of innovation. Applicant communities are encouraged to demonstrate how community members, leaders, and organizations across sectors are creating a common agenda by collectively identifying priorities and taking coordinated action to solve the health challenges facing their communities.
2017	Committing to sustainable systems changes and policy-oriented solutions. Building a CoH means making thoughtful, data-informed, and sustainable policy, programmatic, and systems changes. This includes having a strategic approach to problem-solving that recognizes both the value of evidence as well as the promise of innovation. Applicants are encouraged to show how residents, leaders, and organizations across sectors are collectively identifying priorities and taking coordinated action to solve the health challenges facing their communities.
2018	Committing to sustainable systems changes and policy-oriented solutions. Building a CoH means making thoughtful, data-informed, policy, programmatic, and systems changes that are designed to last. This includes having a strategic approach to problem-solving that recognizes both the value of evidence as well as the promise of innovation. Communities are encouraged to demonstrate how residents, leaders, and organizations are collectively identifying priorities and taking coordinated action to implement sustainable solutions to the health challenges they face.
2019	Committing to sustainable systems changes and policy-oriented long-term solutions. Building a CoH means making thoughtful, data-informed, policy, programmatic, and systems changes that are designed to last. This includes having a strategic approach to problem-solving that recognizes both the value of evidence as well as the promise of innovation. Communities are encouraged to demonstrate how residents, leaders, and organizations are collectively identifying priorities and taking coordinated action to implement sustainable solutions to the health and equity challenges they face.

Fair and just conditions for all

2013	Addressing problems that disproportionately and unjustly affect vulnerable groups, such as ethnic minorities and those with limited income and education.
2014	ADDRESSING PROBLEMS THAT DISPROPORTIONATELY AFFECT VULNERABLE POPULATIONS such as ethnic minorities and those with limited English skills , income and/or education, and creating opportunities for all members of the community to make choices allowing them to live a long, healthy life.
2015	CULTIVATING A SHARED AND DEEPLY-HELD BELIEF IN THE IMPORTANCE OF EQUAL OPPORTUNITY FOR HEALTH. Building a Culture of Health (CoH) means working to identify and address gaps in opportunity that tend to disproportionately and negatively affect certain populations, such as ethnic minorities and those with limited English skills, lesser income, and/or limited education. This includes recognizing the power of collective problem-solving approaches that not only value the voices and perspectives of all community members, but engage all, especially those most impacted, in creating and implementing solutions. Applicant communities are encouraged to share how they are putting health within everyone's reach.
2016	Cultivating a shared and deeply held belief in the importance of equal opportunity for health ... Building a CoH means creating a sense of community where all individuals feel they have a voice and a role to play in improving health. This includes a shared commitment to identifying and addressing gaps in opportunity that tend to disproportionately and negatively affect certain populations, such as ethnic minorities and those with limited English skills, those with lesser income, populations who have been historically underrepresented, people with disabilities, and/or limited education. Applicant communities are encouraged to demonstrate how they are fostering a community where all people feel a sense of security, belonging, and trust; and recognizing the power of collective problem-solving approaches that not only value the perspectives of all community members, but engage all, especially those most affected by poor health outcomes, in creating and implementing solutions.
2017	Cultivating a shared and deeply held belief ... Building a CoH means creating a shared commitment to identifying and addressing gaps in health and creating conditions that give everyone the opportunity to achieve the best health possible. To do this, all individuals should have a voice and a role to play in creating more equitable communities. Applicant communities are encouraged to 1) demonstrate how their efforts are leading to a community where all people feel a sense of security, belonging, and trust, and 2) show how collective problem-solving and diverse perspectives, including full participation by those most affected by poor health outcomes, are driving solutions.
2018	Creating conditions that give everyone a fair and just opportunity to reach their best possible health. Building a CoH means intentionally working to identify, reduce, and ultimately eliminate disparities in health, in partnership with those most affected by poor health outcomes. This includes cultivating a shared commitment to equity across the community; valuing diverse perspectives; and fostering a sense of security, belonging, and trust among all residents. Communities are encouraged to demonstrate: 1) how they are engaging in collective problem solving, including full participation by excluded or marginalized groups and those most affected by poor health in making decisions and driving solutions; and 2) what actions they are taking to remove obstacles and increase opportunities for all to be healthy.
2019	Creating conditions that give everyone a fair and just opportunity to reach their best possible health. Building a CoH means intentionally working to identify, reduce, and ultimately eliminate disparities in health, in collaboration with those most affected by poor health outcomes. This includes cultivating a shared commitment to equity across the community; valuing diverse perspectives; and fostering a sense of security, belonging, and trust among all residents. Communities are encouraged to demonstrate: 1) how residents from excluded or marginalized populations and those most affected by poor health are involved as full participants in making decisions and driving solutions; and 2) what actions the community is taking to remove obstacles and increase opportunities for all to be healthy.

Multi-sector partnerships

2013	<p>Demonstrating the value of working together through action-oriented, multisector partnerships made up of employers, community advocates, health care and public health professionals, grantmakers, policymakers, educators, and others.</p> <p>Identifying and empowering people who have the commitment, passion, and skills to inspire and lead change (Note: this was a separate criterion in 2013).</p>
2014	<p>HARNESSING THE COLLECTIVE POWER OF LEADERS, PARTNERS, AND COMMUNITY MEMBERS by listening to diverse voices, inspiring each other, and developing strategies for buy-in, decision-making, and coordinated action among groups (including employers, community advocates, health care and public health professionals, government officials, grantmakers, policymakers, educators, and others).</p>
2015	<p>HARNESSING THE COLLECTIVE POWER OF LEADERS, PARTNERS, AND COMMUNITY MEMBERS. Building a Culture of Health (CoH) means recognizing we are all in this together and share a common vision for providing all with the opportunity of better health. This includes developing strategies for buy-in, decision-making, and coordinated action; finding and empowering champions (including those with and without positional power); and strengthening all people's voices and contributions through authentic civic engagement. Applicant communities are encouraged to share how business, government, individuals, and non-profit organizations are working together to improve health outcomes and how becoming healthy and staying healthy is valued by the entire community.</p>
2016	<p>Harnessing the collective power of leaders, partners, and community members. Building a CoH means that we are all working together to provide everyone with the opportunity for better health. This includes developing structures and strategies for buy-in, decision-making, and coordinated action; continuously communicating about health improvement efforts; and developing community leaders (including those with and without positional power) to foster collaboration, collective action, and authentic civic engagement. Applicant communities are encouraged to demonstrate how business, government, residents, and nonprofit organizations are working together and across sectors and disciplines to improve health outcomes and how becoming healthy and staying healthy is valued by the entire community.</p>
2017	<p>Harnessing the collective power of leaders, partners, and community members. Building a CoH means that individuals and organizations are all working together to provide everyone with the opportunity for better health. This includes developing methods for buy-in, decision-making, and coordinated action; building a shared sense of accountability; continuously communicating about health improvement efforts; and developing leadership skills and capacity among all community members. Applicant communities are encouraged to demonstrate how business, government, residents, and non-profit organizations are working together and across sectors and disciplines to improve health outcomes; and how becoming and staying healthy is valued by the entire community.</p>
2018	<p>Harnessing the collective power of leaders, partners, and community members. Building a CoH means that individuals and organizations are all working together to provide everyone with the opportunity for better health. This includes building diverse and robust partnerships across business, government, residents, and nonprofit organizations. Communities are encouraged to demonstrate how they are developing methods for buy-in, decision-making, and coordinated action; building a shared sense of accountability; continuously communicating about health improvement efforts; and developing leadership skills and capacity among all community members.</p>
2019	<p>Harnessing the collective power of leaders, partners, and community members. Building a CoH means that individuals and organizations are all working together to provide everyone with the opportunity for better health. This includes building diverse and robust partnerships across business, government, residents, and nonprofit organizations, and fostering leadership skills and capacity among all community members. Communities are encouraged to demonstrate how they are:</p> <ol style="list-style-type: none"> 1) inspiring people to take action to support change for better health; 2) developing methods for buy-in, decision-making, and coordinated action; 3) building a shared sense of accountability; and 4) continuously communicating about community improvement efforts.

Leveraging resources

2013	Working in strategic and innovative ways to gather and make the most of available resources, such as individual and organizational experience and expertise; federal, state, local, foundation, and charitable dollars; private investment; donated time and materials, etc.
2014	SECURING AND MAKING THE MOST OF AVAILABLE RESOURCES including innovative strategies to make the most of financial resources and individual and organizational experience and expertise dedicated to programs and policies that are improving the health of the community.
2015	SECURING AND MAKING THE MOST OF AVAILABLE RESOURCES. Building a Culture of Health (CoH) means adopting an enterprising spirit toward health improvement. This includes the critical examination of existing and potential health investments, with an eye toward minimizing waste and maximizing value. Applicant communities are encouraged to share how they are creatively approaching the generation, allocation, alignment, and mobilization of diverse financial and non-financial resources to sustain their health improvement efforts.
2016	Securing and making the most of available resources. Building a CoH means adopting an enterprising spirit toward health improvement. This includes: the critical examination of existing and potential health investments, with an eye toward maximizing value; a focus on leveraging existing assets; and a strong belief that everyone in the community can be a force in health improvement. Applicant communities are encouraged to demonstrate how they are creatively approaching the generation, allocation, alignment, and mobilization of diverse financial and non-financial resources to evolve and sustain their health improvement efforts.
2017	Securing and making the most of available resources. Building a CoH means adopting an enterprising spirit toward health improvement. This includes critically examining existing and potential resources, with an eye on value; a focus on leveraging existing assets; prioritization of upstream investments that address social and economic determinants of health; and a strong belief that everyone in the community can be a force in health improvement. Applicant communities are encouraged to demonstrate how they are creatively approaching the generation, allocation, and mobilization of diverse financial and non-financial resources to improve health.
2018	Securing and making the most of available resources. Building a CoH means adopting an enterprising spirit toward health improvement. This includes critically examining existing and potential resources to maximize value, with a focus on leveraging existing assets; prioritizing upstream investments that address social and economic factors that influence health; and cultivating a strong belief that everyone in the community can be a force to improve health. Communities are encouraged to demonstrate how they are creatively approaching the generation, allocation, and mobilization of diverse financial and non-financial resources to improve health.
2019	Securing and making the most of available resources. Building a CoH means adopting an enterprising spirit toward community improvement. This includes critically examining existing and potential resources to maximize value, with a focus on leveraging existing assets; prioritizing upstream investments that address social and economic factors that influence health; making equitable decisions about how to invest resources; and cultivating a strong belief that everyone in the community can be a force to improve the community so that all people can live their healthiest lives possible. Communities are encouraged to demonstrate how they are creatively approaching the generation, allocation, and alignment of diverse financial and non-financial resources to improve the community's health and well-being.

Progress and results

2013	Engaging in thoughtful, rigorous, and ongoing evaluation that assesses progress toward goals and informs efforts to sustain and build on successes.
2014	MEASURING AND SHARING RESULTS including setting achievable goals and engaging in thoughtful and regular monitoring and public reporting of strategies to improve health as well as the impact those strategies are having on health measures.
2015	MEASURING AND SHARING PROGRESS AND RESULTS. Building a Culture of Health (CoH) means beginning with the destination in mind. This includes having a commitment to quality and impact in both process and outcomes. Applicant communities are encouraged to share how they are agreeing upon definitions of success based upon shared priorities; identifying specific goals; and finding ways to track, communicate, and celebrate progress along the way and change course when progress is not evident.
2016	Measuring and sharing progress and results. Building a CoH means beginning with the destination in mind. This includes having a commitment to quality and impact in both how the work is done (process) and what impact is achieved (outcomes) . Applicant communities are encouraged to demonstrate: how they are agreeing upon definitions of success based upon shared priorities; how they identify specific goals, use data, and share measurement to track progress and change course when progress is not evident; and how they communicate and celebrate successes along the way toward achieving better health outcomes.
2017	Measuring and sharing progress and results. Building a CoH means beginning with the destination in mind. This includes a commitment to quality and impact in both process (how the work is done) and outcomes (what impact is achieved) . Applicant communities should show how they are: 1) establishing shared priorities; 2) agreeing upon definitions of success; 3) identifying specific goals; 4) using data to track progress; 5) changing course when progress is not evident; and 6) communicating and celebrating successes as they achieve better health outcomes.
2018	Measuring and sharing progress and results. Building a CoH means beginning with the destination in mind and a commitment to measuring the quality and impact of coordinated efforts. This includes: 1) establishing shared goals across sectors and partners; 2) agreeing on definitions of success, with attention to reducing disparities; 3) identifying measurable indicators of progress; and 4) continuously using data to improve processes, track outcomes, and change course when necessary. Communities are encouraged to demonstrate how they are developing systems for collecting and sharing information, determining impacts across efforts, and communicating and celebrating successes when goals are achieved.
2019	Measuring and sharing progress and results. Building a CoH means beginning with the destination in mind and a commitment to measuring the quality and impact of coordinated efforts. This includes: 1) establishing shared goals across sectors and partners; 2) agreeing on definitions of success, with attention to reducing disparities; 3) identifying measurable indicators of progress; and 4) continuously using data to improve processes, track outcomes, and change course when necessary. Communities are encouraged to demonstrate how they are developing systems for collecting and sharing information, determining impacts across efforts, and communicating and celebrating successes when goals are achieved.

APPENDIX H

History of CHR&R Community Transformation (Roadmaps) Efforts

Original Author: Jan O'Neill, Community Coach 2011-2017

In the Beginning: 2008-2011

The origins of County Health Rankings & Roadmaps (CHR&R) go back to a conference in New Orleans in 2007 where several RWJF staff attended a breakout session presented by Drs. Bridget Catlin, Patrick Remington, and David Kindig. The University of Wisconsin presenters told the audience about the changes happening in Wisconsin as a result of ranking the state's 72 counties' health every year since 2003, using a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work, and play. Intrigued, the RWJF staff approached the presenting team, beginning a dialogue that became the foundation for CHR&R.

In 2009, RWJF began funding the Mobilizing Action Toward Community Health (MATCH) project. The successful national release of the County Health Rankings in 2010 was the first step in MATCH, providing a vehicle for raising awareness, with the goal of mobilizing communities to take action to improve local health.

The project leadership knew that it would be important to get out in front of the media release and support local health officers by letting them know about the Rankings and how they could use them as a call to action. Toward that end, we established state teams, composed of state health officers, public information officers, and/or other SACCHO¹ members, for every state in advance of the national release. Based on the Wisconsin experience where each year the lowest-ranked county was provided additional support for addressing media and mobilizing action, a process was also put in place for contacting the lowest-ranked county in each state.

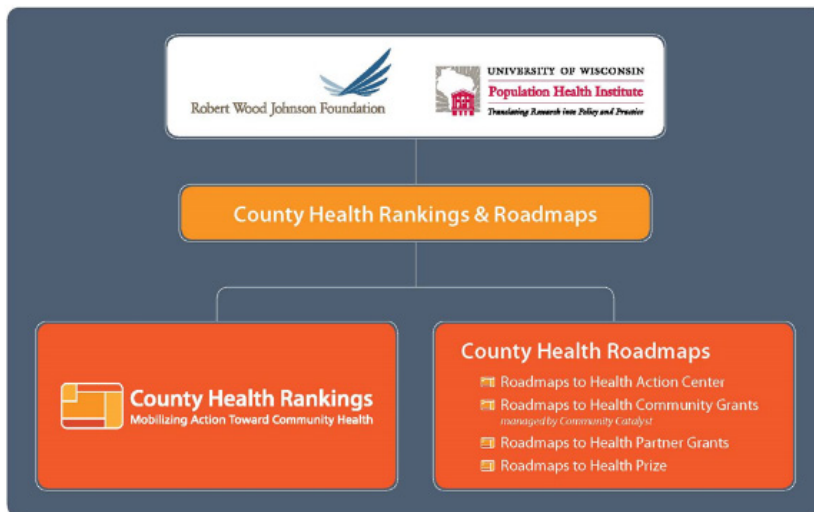
Calls for assistance and support immediately followed on the heels of the national release. While communities desired change, many local health officers and community leaders also expressed uncertainty about how to move forward. A graduate student triaged all calls and emails, and "all hands were on deck" to respond, from the director to graduate students.

In early 2011, RWJF provided funds to expand the MATCH project, the first step toward building the Roadmaps side of the program. The expanded MATCH project's purpose was to provide tools and resources to "incentivize and help communities translate the Rankings into the creation of multi-sector partnerships that implement evidenced-informed policies and systems change to address the multiple factors that influence health outcomes in their community."² The success of the effort, then as now, would be gauged by the expansion of multisector partnerships and implementation of evidence-informed policies and systems change, with the long-term goal being improvement in health outcomes in local communities throughout the nation.

1 State Associations of County and City Health Officials

2 Source: Internal document, MATCH Initiative Proposal revised, 2/6/11

Ten-Year Reflections on the County Health Rankings & Roadmaps



A County Health Roadmaps Advisory Group, comprised of RWJF, CHR&R, and other organizational partner leaders, began meeting to provide input and guidance on the four elements of the expanded effort: Roadmaps to Health Action Center, Roadmaps to Health Community Grants, Roadmaps to Health Partner Grants, and Roadmaps to Health Prize. MATCH was officially retitled County Health Rankings & Roadmaps to reflect the purpose of the effort, based on analysis by communications consultants and discussion with key staff. New messaging reflected this shift: The County Health Rankings illustrate **what we know** when it comes to what is making people sick or healthy. The County Health Roadmaps show **what we can do** to create healthier places to live, learn, work, and play.³

The four objectives of the expanded initiative were to:

- Increase community leaders' knowledge and commitment to addressing the multiple factors that influence health.
- Increase the diversity of community partnerships to improve community health by including members from all key determinants of health sectors (e.g. business, education, environment, health care, public health, government).
- Increase community leaders' knowledge and application of the action steps needed to address community health improvement.
- Increase the number of evidence-informed policies and systems changes implemented to address the multiple factors that influence health.

Development of Partnerships

Development of partnerships with key member organizations outside of traditional public health was a critical strategy to connect with and support local health improvement. This strategy would help increase community leaders' commitment to addressing the multiple factors that influence health, as well as diversify community partnerships to include all sectors. It was also a key outreach strategy for providing additional resources to local communities. As noted in the MATCH expansion grant proposal, "Through relationships with multisector partners, we will identify opportunities for personalized consultation that are likely to yield innovative strategies to address complex community health issues."

Criteria for consideration as a partner organization included the organization's experience and ability to engage local partners and leaders, their ability to deliver high quality training and technical assistance, and their commitment to the mission of MATCH. The first national partner, selected in 2011, was United Way Worldwide (UWW). UWW's mission, "to improve lives by mobilizing the caring power of communities," and their focus on education, income, and health as the building blocks for a good quality of life and a strong community made them a natural leader in addressing the factors that play a key role in determining how healthy people are and how long they live. The National Association of Counties (NACo) followed in 2013. NACo has played a crucial role in bridging from the university-based CHR&R program to counties, particularly rural ones, providing credibility and connections to county leaders.

As part of the expansion to support local communities, MATCH staff began working with Community Catalyst,⁴ that was initially responsible for managing and supporting twelve coalitions that were recipients of RWJF community grants of up to \$200,000 over two years, with an additional \$200,000 in matching funds, to work on policy adoption for social & economic factors. (Examples included prison reform, transportation, college readiness.)⁵

The MATCH expansion grant also included a role for Community Catalyst in providing materials and counsel on policy and advocacy for the training materials section of the site. The technical assistance providers who contracted with Community Catalyst to work with the 12 1st round communities brought important policy and advocacy knowledge and skills to the program and provided guidance and insights to the first coaches.

Real-time, Personalized Training and Consultation

At the time of the MATCH expansion, “real-time, personalized training and consultation” was envisioned as hands-on consultation to “all who request it via e-mail and/or telephone.” Based on specific questions and concerns, project staff would provide consultation and direct community members to appropriate resources on the County Health Rankings website or to other relevant resources. Limited on-site consultation would be provided to communities based on “their readiness and willingness to mobilize action, the absence of other state or local resources to assist them, and the availability of project staff.” These on-site communities would be identified in several ways: self-referrals, Rankings state contacts or national partner organizations, email and phone consultation requests, and outreach by staff to lower-ranking communities as identified by the County Health Rankings. On-site consultation was envisioned as some combination of one-on-one meetings with community leaders, small group meetings, and/or larger community meetings as determined by community needs. In other words, the vast majority of contacts with communities would happen virtually, by phone and email, with a very small percent receiving limited on-site support. At the time, this was understood to be the best way to reach the greatest number of communities given limited community engagement resources.

To better understand how “real-time, personalized training and consultation” could be beneficial to communities, in the spring of 2011, staff conducted a series of interviews and focus groups⁶ with community leaders and technical assistance providers. Sessions were held with dozens of individuals and organizations familiar to RWJF, inquiring into technical assistance, coaching methods and models of success. One of the biggest takeaways from these sessions was the critical importance of having a “human touch” (beyond online tools and resources). Key recommendations from the report included:

1. build an empowering, supportive, strength-based model, one that begins with listening to the community’s unique needs;
2. some communities will need more support than others to be ready for action, so it will be important to build a tiered model;
3. make it easy for a community to get support;
4. develop an outreach strategy (because if you build it, they will not necessarily be able to find you), and
5. use a continuous improvement approach—i.e., learn from each situation, adapt, and move on.

These themes informed the formation of early community support strategies and have remained guideposts throughout the coaching program’s development.

4 <https://www.communitycatalyst.org/>

5 See Community Catalyst projects here: <http://www.countyhealthrankings.org/about-project/community-grants>

6 Source: Internal document, MATCH Training and Technical Assistance Findings from Community Discussions, 2011.

The Groundwork: 2011-2012

In late summer of 2011, two community engagement specialists were added to the program. Their first tasks were 1) build the Roadmaps to Health Action Center by developing new content for each of the action steps, including facilitation guides with links to tools and resources, and 2) establish a “tiered support” model that would allow easy access to staff.

Take Action Model Guides

The reflection questions in the [Stages of Change Framework](#) informed development of the facilitation guides, tools, and resources in the Take Action Model. With a spring 2012 deadline for an updated website release (in conjunction with the third national Rankings release), the community engagement specialists inventoried existing tools and resources on the site, explored additional tools and resources, and developed robust facilitation guides for each of the action steps.

While the Action Center has undergone many changes over the past six years, the format of today’s guides remains reflective of the original design: an overview of the Take Action step, its purpose, whom to involve, and key activities that describe what to do along with links to suggested tools. The design was driven by an effort to “make the complex simple,” provide ways for people from all sectors to relate to every step as “typical phases in a variety of planning or problem-solving frameworks,” and provide selected activities and tools that community members can easily navigate through.⁷ Exemplars for early design of each guide included the business best-seller, *The Team Handbook*,⁸ and the public education best seller, *The Handbook for SMART School Teams*.⁹

Tiered Support

In the MATCH expansion, we thought that most communities would access support online via the Take Action Model guides, with on-demand, real-time e-mail and telephone consultation available to all community members requesting assistance, and only a small number—25 to 35 communities per year—receiving on-site consultation and facilitation. By the end of 2011, the concept of a “tiered support system” had evolved into three-tiered “coaching options packages” that included a formula for the number of coaching communities each community engagement specialist could support.¹⁰ Early thinking was that face-to-face engagements would be on an invitation-only basis, for the small number of communities that had “articulated a readiness to lead policy implementation strategies, especially if they include active engagement from multisectors, or those who have made steady progress in previous tiers and need additional support to get to the next level.”¹¹ (Later thinking evolved to more active outreach in order to more consistently fill the coaching “pipeline,” including a call-for-applications process, cohorts developed with partner organizations, and other models.)

The three-tiered approach was important for several reasons. First, as careful stewards of the resources and support being provided by RWJF, staff felt it was important to be able to identify which communities would be best suited for more intensive consultation and facilitation. Additionally, since one of the

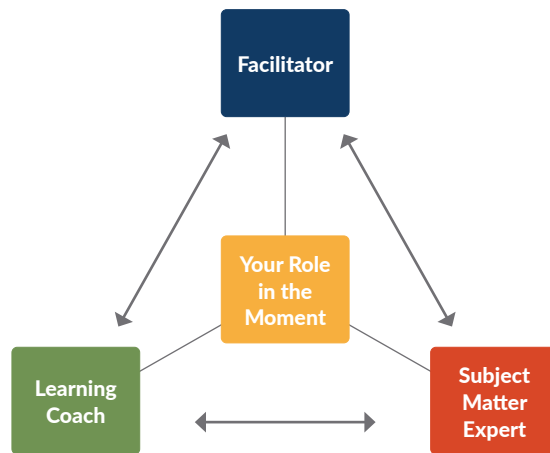
7 Source: Internal document, Roadmaps to Health Action Center Briefing Document, Advisory Group, 5/23/12

8 https://www.amazon.com/Team-Handbook-Teams-Improve-Quality/dp/0962226408/ref=pd_lpo_sbs_14_t_1?encoding=UTF8&pvc=1&refRID=4HHTCVFRN5B2VT5QM640

9 https://www.amazon.com/s/ref=nb_sb_noss?url=search-alias%3Dstripbooks&field-keywords=Handbook+for+SMART+School+Teams+

10 Source: Internal document, Coaching Package DRAFT plan 12/14/11

11 Source: Internal document, Honing in on audiences, 10/6/11



objectives of the Roadmaps expansion grant was to “increase the number of evidence-informed policies and systems changes implemented to address the multiple factors that influence health,” a community’s readiness for deeper policy/systems change work would, it was assumed, require more intensive support. Third, it was important to be able to communicate to those who visited the website the different levels of support available, from email and phone contact to face-to-face site visits, and have a rationale for how different levels of support would be provided. Finally, having an articulated leveled approach provided staff with guidance about whom to invite (or say “yes” to) to engage in more support.

Coaching or Technical Assistance (TA)

As staff sought to define a tiered system of support, understanding what was meant by “personalized consulting and training support” crystalized into a clear differentiation between a “technical assistance provider” and a “coach.” In 2012, CHR&R staff participated in RWJF’s Community Coalition Leadership Program, led by Center for Creative Learning (CCL), which served as a rich learning opportunity for refining the concepts of coaching. CCL’s model of the three roles a coach plays was helpful in shaping the distinction between technical assistance and coaching.

With technical assistance, the provider delivers subject matter expertise to the community, often on a particular topic. The TA provider may also act as a consultant or facilitator and perform functions such as leading strategic planning processes, facilitating community meetings, or producing reports for communities. While a coach may, from time to time, facilitate a meeting, the focus is on modeling facilitation skills and processes in order to build team capacity for self-facilitation. A coach assists community members to reflect on their effectiveness, to develop skills and perspective for their work. A key distinction from the TA model is that a coach does not “produce for” communities. While coaches may at times enter a subject matter expert mode, it is to help community members understand the data and tools provided through County Health Rankings & Roadmaps. In addition to the roles defined by CCL, CHR&R added several others including: a coach serves as a thought partner, connector, neutral, third-party observer, and skill builder.

While TA providers bring extremely valuable support to communities, there are many highly expert TA providers available to communities, and the MATCH discussions revealed that communities want support for building their own capacity vs. “being done to.” This was an important consideration in selecting a coaching vs. technical assistance approach. Thus, “personalized consulting and training support” was reframed as “community coaching.”

Staff developed core values. Coaching:

- is always permission-based—we do not impose coaching on communities;
- is goal-focused—the community establishes a clear purpose and objectives for what they want to get out of coaching;
- builds on a community’s assets and strengths—we do not tell communities what to do, but rather support them in discovering their strengths;
- does not “do to or for” communities—we build community capacity to achieve their own goals

By early 2012, the term community coach had replaced community engagement specialist.

Learning Labs

Once the tools and guidance in the Action Center had been compiled, it was important to test them in communities, to see if CHR&R could accomplish the portion of its original theory of change involving strategies for broad community engagement to the implementation of evidence-informed policies and programs to ultimately improve health outcomes. This work was especially true in lower-ranked and lower-resourced communities. In addition, one of the recommendations from the 2011 training and technical interviews was to pilot-test products and processes with communities that had been early adopters of action in response to the Rankings. Toward that end, RWJF funded Clare County, Mich., and Wyandotte County, Kan., both of whom had been early adopters of the Rankings model to drive change, to serve as practice-based, living laboratories. The funding was coupled with coaching support to “identify winning strategies that could be shared with other communities via the Roadmaps to Health Action Center.”¹² In alignment with the goal of testing the CHR&R theory of change, the Learning Labs provided feedback on Action Center tools and capacity building workshops that supported multi-sector policy/systems change work based in evidence (e.g., Policy Advocacy Choice Tool, 27-9-3 messaging, Collaboration Multiplier).

Several important lessons emerged from the Learning Labs that informed the design and structure of a more “formal” coaching process, including:

- the importance of clarifying parameters of coaching support;
- the need to create a more systematic accountability system between coaches and communities to ensure that goals were being met;
- the importance of working with a team so that “more people buy into using the tools;”
- scheduling face-to-face time to support momentum; and
- the most helpful tools were simple to use and had immediate practical use.

Coaching Expansion: 2013-2014

With the clarity gained through testing tools, processes, and approaches in the field, as well as numerous shorter-term coaching contacts by phone and email with individuals, it was decided that both individual and team coaching would be offered in packages combining virtual (phone, video conference) with “as needed” on-site, face-to-face time. Coaching was described as a “continuum:”

- Rapid Response—up to three contacts with a coach (in response to individual inquiries through the website, emails, or phone);
- Individual Coaching—several months to a year-long coaching engagement; and
- Team Coaching—up to a year-long coaching engagement.

Assessing readiness for policy/systems change work continued to be a focus, with individual and team applications becoming a critical review step before agreeing to longer-term engagements. Criteria for more intensive coaching support included:

- Desire and commitment for health improvement;
- Lower-ranking communities;
- Moving beyond assessment and into action;
- Limited technical assistance resources through other mechanisms; and
- Requesting assistance.

More intensive coaching was reserved for those communities that were “ready for action,” (i.e., action that focused on factors that influence health, especially those that contribute the most, such as social and economic factors).

The Inaugural Cohort

In 2013, CHR&R expanded its capacity, increasing to four full-time coaches and bringing in a director for the Action Center. With this expanded capacity, formal testing of team coaching began with an “inaugural” coaching cohort that included a call for applications. In alignment with CHR&R Guiding Principles, team coaching would be selectively offered to diverse, multisector teams, with preference for those applications that showed readiness to take action. Priority would be placed on those that were working on policy, systems, or environmental change, particularly those focused on social and economic factors, given their contribution to health outcomes.

Based on the coaching package options “formula” developed in 2011, the selected inaugural group was expected to number up to 12 community teams, with coaches each supporting four teams for up to a year. Outreach for the inaugural cohort included a public webinar, emails to previously coached individuals, and emails to organizational and TA partners. The assumption was that the program would receive many dozens if not hundreds of applications, so the selection process was based on the RWJF Culture of Health Prize approach, with a review team, a set of criteria, and a formal review process. Although only 15 communities applied, it was decided to accept them all to test the newly structured coaching system. Quite a few did not meet the criteria of working on policy, systems, or environmental change nor were they working on social or economic factors. Most were focused on changing health behaviors using programmatic approaches.

Reflecting on the outreach process, the staff decided that they had been unable to attract more applications because: 1) coaching was (and still is) a relatively new approach for communities, 2) coaching is difficult to describe in concrete terms, 3) there was no financial incentive attached, and 4) promotion was limited to the website, newsletter, and social media; a promotional webinar to existing CHRR users; and the network of national partners.

At the end of the inaugural coaching, CHR&R staff made a number of adjustments to coaching, based on the teams' and coaches' feedback, including the decision to move site visits to any time in the coaching engagement to accelerate momentum on coaching goals. Most importantly, the process for accepting applications to Team Coaching was significantly changed: Coaches moved to a "coaching conversation" process that would provide communities with support while allowing the coach to assess readiness for moving into action. Returning to the community readiness questions first developed in 2011, a Conversational Guide was developed to use with communities indicating an interest or readiness to 1) work on policy, systems, and/or environmental change using a multisector approach, and 2) readiness and willingness to be coached. In the course of these conversations, coaches discovered they were able to help communities get ready for longer-term coaching, (e.g., helping them expand their partnerships to include other sectors, introducing them to others in their community doing this work, showing them where to find key tools in the Action Center so they could do the assessing and focusing work needed to get ready for action). It was therefore decided to move to a "rolling application" process, where a team would submit an application when the coach felt it was ready versus an online application open to all.

Other Coaching Opportunities

In addition to launching the inaugural cohort of coaching communities, in 2013 each of the three coaches also worked with NACo to pilot test what NACo called "community dialogues." These dialogues brought together a diverse, multisector group of individuals to learn about the CHR&R principles, tools, and resources. While they were somewhat successful as awareness builders, they were less successful as momentum builders. Reflecting on these results, NACo later added more structure to their approach, becoming more focused on community teams and an application process.

Also, during this time coaches developed and tested a distance learning activity with University of Wisconsin Extension, to build capacity of community teams to learn how to navigate the rich tools and resources on the website. Delivered as a "case study," on-site University of Wisconsin Extension facilitators in different locations guided teams through the activities led by the CHR&R coaches back in Madison. The case study approach was a success in that capacity for better understanding of how to use CHR&R tools and resources was built both in the community teams and the University of Wisconsin Extension staff, and it was a scalable coaching approach.

Coaches Plus

All coaches were expected to respond to Rapid Response requests as well as provide coaching to individuals and teams. In addition, the coaches continued to be responsible for developing and leading bi-monthly webinars, writing and reviewing Action Center guides and tools (including making recommendations about their favorite tools which became "Top 5 Tools" in each key activity, part of the 2013 release), and communicating with state teams not just during Rankings release season but year-round. In addition, coaches participated in Prize reviews each year, presented, and exhibited at conferences, and participated in discussions with a growing number of TA providers who could provide communities with support and advice.

Partners

These were the years that CHR&R began to ramp up expansion of partners to expand coaching to local communities and to different sectors, as reflected by the sectors in the Take Action Model. NeighborWorks, Build Healthy Places Network, Local Initiatives Support Corporation (LISC), Active Living by Design (ALBD), Humana, and Tennessee Institute of Public Health joined NACo, UWW, and University of Wisconsin Extension. Partners began to play a key outreach role, bringing coaching to local communities through both funded and unfunded cohort applications.

Expanding Coaching

At the end of 2013, the Roadmaps to Health Advisory Team brought together a focus group of community leaders who had had early experience with coaching. This was a pivotal learning point in the program's history, as the leaders emphasized the importance of having local area/regional cultural and political understanding in order to effectively coach community teams. Accordingly, in order to both expand CHR&R's reach to more communities and to better understand the context of communities, seven regional coaches were hired to "work with a variety of communities including those who request assistance via the CHR&R website, recipients of the Community Activation Awards, and referrals from national partners. By locating coaches throughout the nation, the program will benefit from connecting with and learning from local communities."¹³ These coaches were onboarded in January 2015.

Rapid Growth Years: 2015-2016

With the addition of seven new regional coaches, each of whom was seasoned, skillful, and knowledgeable but new to CHR&R and the coaching system, there was an onboarding challenge. While staff did not want to stifle individual creativity, they did want to provide an infrastructure and tools coaches could use as they began to take on the task of coaching communities. Additionally, it would be important for program evaluation as well as careful stewardship of resources for CHR&R to maintain a standardized approach to coaching teams as Roadmaps Coaching expanded. To address these challenges, staff developed a "curriculum" in a four-stage Coaching Process that outlined coaching activities:

- **Connect**—Introductory calls where the coach gets to know the community and the community gets to know the coach, and the application, which defines the purpose of coaching for the community, and helps the community home in on its needs and hopes. At this stage, the team takes a "pre-coaching" survey that becomes part of the program evaluation.
- **Engage**—Coaching kick-off calls where the coach introduces the team to the coaching program expectations, the Action Center and website, and engages the team in formal goal setting.
- **Guide**—Monthly calls where the coach helps the team work toward its coaching goal using tools, key activities from the Action Center, and coaching questions. At this stage, the team takes an "interim" survey that helps the coach know what to adjust in the coaching process.
- **Transform**—Final coaching calls with the team where the team reflects on progress they made and develops next steps after the coaching. At this final stage, the team takes a "post-coaching" survey. As part of the "close out," the coach writes an internal "Summative Report" describing the team's accomplishments and challenges, what worked well, and what could have been improved in the coaching process.

A Coaching Guide aligned to these four stages included the tested forms, tools, activities, and questions coaches would need as they began to work with their own coaching communities. The four-stage team coaching process included up to twelve 90-minute calls and an optional site visit at any point during the coaching engagement.

Poised for Progress, an online CHR&R tool built for communities to self-assess their readiness to build a culture of health locally, became a key part of the coaching process.¹⁴ It was used in three key ways:

1. As a program evaluation tool, for the pre- and post-coaching survey.
2. As part of the coaching application.
3. As a goal-setting tool for teams to set their coaching goals with the help of their coaches.

The process of onboarding the new coaches provided an opportunity to document the coaching process and all the tools and resources that had been developed over four years. For their part, the coaches brought new skills, new perspectives, and fresh eyes to the coaching model. With the addition of coaches from each region of the country (with one coach focused exclusively in New Jersey), new insights were gained into local and regional cultures and politics. The new coaches also added gender, race, and sexual orientation diversity to the team, (later adding a bilingual coach), which broadened and deepened the program's equity perspective. Additionally, the program gained expertise in policy advocacy, bringing "in house" what before had been relied upon through TA partnerships.

The expectation for the regional coaches was that they would each coach up to 10 communities, based on the original "formula," in addition to making conference presentations. The "rolling application" approach served the program well in this regard, as Rapid Response inquiries would often develop into coaching engagements. Responding to inquiries was also a "low risk" way to begin coaching, as the coaches got up to speed on both the website and the coaching process, tools, and resources. In addition, there began a process of "shadow coaching" that continues to this day, enabling coaches to listen in to each other's coaching calls in order to learn different approaches and strategies and/or to consult with each other about coaching challenges. The network of national and TA partners also expanded, while building on existing relationships, to add cohorts of coaching communities who could be part of peer learning networks, something the communities had indicated was important. In this period, coaching cohorts launched through NeighborWorks, LISC, as well as NACo. ALBD took the lead for implementing funding awards focused on accelerating action and collaborative learning for coaching communities. In addition, the entire staff received training from the Center for Creative Leadership (CCL) on how to incorporate the principles of networking from CCL's Network Discovery Report (completed in 2015) into every aspect of our work.

Once the coaches got up to speed on the program and had a solid year of coaching and conference presentations under their belts, they began supporting state teams to better align regional knowledge with the states and provide another connection to local communities that might need coaching. Some of the coaches began developing and leading webinars in addition to their coaching responsibilities, while all coaches took responsibility on a rotating basis for planning and facilitating monthly Action Center large group meetings and off-sites. With the additional number of people, many of whom were virtual, the number of large group work meetings was reduced, moving to more frequent small group meetings for deeper learning, reflection, and innovation. In order to create a more cohesive team culture, a key technology improvement was changing to a completely virtual conferencing environment, where each Action Team member participated in meetings from their own computers in their own offices, mirroring the model being used for coaching communities virtually.

Increased Equity Focus

With the increase in staff diversity came deeper conversations about equity, one manifestation of which was the creation of an internal Healthy Equity Work Group, led by coaches, committed to “spend concentrated effort focused on equity to truly make improvements to the program internally and externally.” One of the first actions of the work group was writing a blog that called out “our own implicit bias” in the way we were reporting on health gaps, by shading the counties with the greatest share of avoidable deaths in darker colors compared to those with fewer deaths, “contributing to the “dark is bad, light is good” narrative.¹⁵ While these conversations were sometimes uncomfortable, they were also open, constructive, and transformative, leading to a more focused and intentional commitment to equity throughout the program.

Focusing Outreach on Least Healthy

Another benefit of bringing on new coaches was a new perspective for answering the question the program had been asking for several years: Where should we focus our coaching outreach? As an outgrowth of CHR&R’s increasing focus on equity, in 2016, another internal work group, led by the “new” coaches, developed and launched the “10 state outreach pilot” to focus on the 10 least healthy states identified in America’s Health Rankings. The goals of this pilot included:

- Increase state engagement with County Health Rankings & Roadmaps through active state teams in each of the 10 states.
- Develop opportunities to present (in person or virtually) in each state.
- Increase webinar participation from the 10 states.
- Increase short- and long-term coaching requests in the 10 states.
- Increase the number and depth of community teams working on addressing the vulnerable populations with specific attention to social and economic factors

With the program’s commitment to innovation and emergent learning, this initiative received full support from the leadership team, and each coach took responsibility for developing deeper relationships in their respective states.

Balancing Standardization with Individual Style

As the coaches became familiar with the CHR&R program and the coaching process, and as the internal program evaluation results were periodically discussed and reviewed (e.g., pre- and post-coaching feedback, interim survey feedback), the coaches began experimenting with different formats, structures and approaches. Some coaches met only with team leaders who then worked with their teams, others worked with teams with as many as nine participants; some used video conferencing technology exclusively without slides, others always prepared slides in advance; some used the call prep forms with their teams to prepare for calls, others developed agendas at the beginning of each coaching call; some played more of a back-seat observer role on the calls, while others took a more active facilitation role. Reflecting on what seemed to be essential about successful coaching, the coaches identified “essentials” for each stage of the coaching process:

- **Connect**—develop a relationship with the team lead and understand the community’s context; ensure the right team composition (multisector, diverse, motivated to learn).
- **Engage**—verify commitment from team members to engage in coaching; establish a specific focus for the coaching (goal/s); have agendas and documentation for each call.
- **Guide**—use the website (Rankings model, data, evidence, action tools, community examples); use coaching questions, including frequent reflection.
- **Transform**—use final call to review key takeaways and next steps; capture reflections on team’s progress and lessons learned (Summative Reports).

Left to coaches’ discretion was the use of many of the structures developed in the early years (prep call forms, follow-up notes, slides), but the intent of the structures remain intact: having a clear set of expectations about the coaching engagement, creating specific goals to be achieved, ensuring each call has a plan and there is accountability for follow up, building in time for reflection, and using the rich resources on the website.

Transition Years: 2017-2019

At the end of 2016, the Strategic Assessment Panel issued its analysis of the CHR&R program to RWJF and to UWPHI. The report had very specific recommendations for the coaching component of CHR&R, including this recommendation: “While the CHR&R Coaching Program has provided high quality support to a number of communities, its approach needs to evolve to reach a much larger, more diverse audience.” The report went on to discuss several approaches including the concept of an online “community manager” and network weavers. One might imagine how shocking this was to the CHR&R coaches. It took a period of time for the team to wrestle with how they would wind down the system they had built and focus on how to re-invent themselves to reach more communities through a different model.

Throughout 2017 and into early 2018, the team completed team coaching with communities who were already underway or had been on a waiting list as the Strategic Assessment recommendations were made. During this same period, a group of CHR&R leaders and staff worked with colleagues at the Georgia Health Policy Center and 100 Million Healthier Lives to design what was originally intended to be a “readiness” assessment and later evolved into a developmental assessment. Titled the Assessment for Advancing Community Transformation (AACT) tool, the product was intended to provide communities an opportunity to self-assess their own development around six themes (Collaboration, Communication, Advancing Equity, Planning, Measuring, and Sustainability) in four different developmental phases (not yet started, starting, gaining skill, or sustaining).

AACT became an organizing framework for the development of future steps. The staff began to design web content around the “not yet started” phases of AACT by designing self-directed learning modules for key themes. They also began to think about how this framework could structure content for other community activities including Rapid Response, Peer-to-Peer Learning Exchanges, and Cohort-Based Learning. The team also consulted with experts in networks to design ways they could enhance information and action acceleration via these routes. Next steps include validation of the AACT tool and based on the final results, identifying ways to assist communities with self-identifying their phase of development within each of the six themes. Online content, learning, and networking opportunities will be structured in ways to assist communities with maximizing their development to more fully deliver effective strategies to improve health and equity within their communities.

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