RECLAIMING AMERICA'S HEALTH AND WELLBEING

A Dialogue on the Power of Community and the Courage to Build a Well Nation

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ABSTRACT

Over the course of 2016, the authors engaged in extended conversation about health and healthcare, human flourishing, and the power of community. This article presents key themes and invites readers to join the dialogue.

Section I presents a few of the most salient fiscal, policy, and leadership challenges facing the nation's health. This includes an analysis of health outcomes in terms of cost and return on investment; consideration of equity and social justice matters; and an examination of chronic disease in the context of perverse market incentives.

Section II presents three promising opportunities for creating measurable improvement in population health status, while reducing expenditures and contributing to affordability:

(a) Fostering **behavioral pharmacies and experiential prescriptions** — cost-effective, place-based behavioral/experiential health interventions powered by connection and community — that can prevent and reduce chronic disease, and improve mental and emotional wellbeing;

(b) Advancing **clinic-to-community integration** — health strategies which link high quality medical care services with referrals to organizations that can meet basic human/social needs (e.g. food, transportation, housing, etc.) to improve overall health outcomes and reduce total cost of care;

(c) Leveraging the massive resources of **hospitals and health systems as anchor institutions** — applying all assets and activities (e.g. care delivery, hiring, purchasing, facilities design, grant making, impact investing, policy advocacy…) to benefit the economic, social, and environmental drivers of health.

Together, these approaches deliver on the triple aim of *best quality, at lowest cost, while increasing population health* – reducing preventable utilization and contributing to making care more affordable for all.

Section III summarizes leadership opportunities before the nation, and invites readers to join the authors in the questions, the possibilities, and shared action. The authors invite your engagement in this conversation on how as a nation, we can evolve a system of health and healthcare that works for all.

Please join us in dialogue, on the power of community and the courage to build a well nation.

Section I

THE CHALLENGE: As a nation, we are not getting an adequate return on our healthcare investments in terms of health outcomes. And we know better!

The United States is a nation increasingly at risk from our health and healthcare challenges. At nearly 18% of the U.S. GDP, we spend 50% more than any other developed nation per capita on care delivery[1], and yet our population health outcomes are middling at best[2]. As a measure of return on investment from our spending, we are at or near the top of global lists on chronic disease rates, rank in the mid-40s on such key measures as life expectancy at birth, and in the mid 20's on Disability Adjusted Life Years (DALY's)[3]. The U.S. ranks 11th among comparable western democracies on metrics of health equity[4]. Twenty-seven percent of adults in the U.S. will experience a mental health challenge in a given 12-month period, making the U.S. the country with the highest prevalence among countries studied by the World Health Organization.[5] This is an economic, social, and national security problem.[6] Increasingly, it is also an ethical problem, both because of profound and persistent health disparities by race and income, and because there is a significant and growing body of evidence on the practices, policies, and investments that measurably improve health outcomes. Put frankly, ***we know better***.

Unfortunately, many of the most promising health improvement strategies — rooted in the evidence-base of health promotion and disease prevention and in the economic, social, and environmental determinants of health[7] — are not profitable for the traditional business models in the medical care sector. The business models of most care providers and the array of their suppliers (e.g., finance, pharmaceuticals, devices etc.) are geared towards marketplace reward for diagnostics and treatment, but are not effectively incentivized to prevent disease in the first place.

Further, the political dynamics and rancor around providing equitable access to clinical care and a medical home for all Americans has, to date, thwarted meaningful discourse that could concurrently lead to increased fairness and systemic solutions for better managing access to care, and containing costs. Similarly, despite increasingly clear research on the impact of social and economic factors on health status[8], as a nation, we have failed to intervene on these determinants with enough "dose" (e.g. reach, intensity, and duration) in the form of policies, practices, and investments, to do justice to our understanding[9].

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[1] http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective
[2] Shorter Lives, Poorer Health, http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2013/US-Health-International-Perspective/USHealth_Intl_PerspectiveRB.pdf
[3] https://www.ncbi.nlm.nih.gov/pubmed/23842577
[4] http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror
[5] http://www.who.int/mental_health/en/
[6] http://www.nbcnews.com/news/nbcblk/too-fat-fight-obesity-crisis-national-security-risk-n582331
[7] http://www.phac-aspc.gc.ca/ph-sp/pdf/perspect-eng.pdf
[8] McGinnis, Russo, Knickman, Health Affairs 2002 http://www.hdassoc.org/pdf/Active_Policy_Attention.pdf
[9] Schwartz, Rauzon, Cheadle et al, National Academy of Medicine, 2015 https://nam.edu/wp-content/uploads/2015/08/Perspective_DoseMatters.pdf

The result is a patchwork of efforts that while well-intended, do not add up to an effective system of delivering health and healthcare for all. By default, this non-system essentially rations access to medical care by wealth, employment, age and geography, and constrains equitable access to the very environments, experiences, and services that underlie health to begin with. In so doing, we fail to effectively reduce profound human suffering, in turn driving billions of dollars in preventable annual costs[10]. This is not only market failure, but a failure of courage and leadership.

These preventable costs are in turn borne by every taxpayer and, in effect, serve as a surcharge on the price tag of every U.S. product and service in the global marketplace. To those who would seek to deny selected Americans access to medical care in the name of short-term cost savings, we say: *if you think healthcare access is expensive, try the resultant poor health outcomes which lead to reduced productivity and will drive even higher care costs later*. As the old advertising quip states: "*you can pay me now, or pay me later*," and research on healthcare spending vs. social services spending supports this.[11] Such shortsightedness represents nothing short of a deliberately tattered social compact, a deferral of future costs to generations to come, and a threat to long term U.S. competitiveness in the global economy.

Health Inequity

Most vexing to the realization of the American Dream for all, are widespread health disparities by income, race, and ethnicity and geography, which remain a pervasive and persistent affront to social justice. As our technologies for treating illness improve, and an industry dedicated to boutique health and wellness care for those that can afford it flourishes, those of lower socioeconomic status (e.g. rural communities, communities of color, recent immigrants, and those in the declining middle class) are systematically excluded from reaping the benefits of these developments. Health food stores, exercise studios, mindfulness retreats, subscription-based web platforms, personal chefs, health coaches and concierge medicine are wildly popular among the privileged. Yet those without financial and sociocultural resources to access them face a double burden: their access to primary, secondary, and preventative care is rationed due to lack of infrastructure and funding, *and* the environments surrounding them (e.g. food deserts, unsafe streets, community violence, economic stagnation, and displacement) produce toxic stress and predispose individuals and families towards disease for generations to come[12].

Were this widening gap in health outcomes a mystery, an inexplicable and untouchable social phenomenon, as a society we might have a reasonable excuse. But the irrevocable fact again, is that *we know better*. Increasingly, across a field of fields (e.g. academia, healthcare, business, government . . .) we know how inequity is created and how disparities develop, are perpetuated, and maintained. Our failure is in part rooted in *not* having the necessary civic discourse, but also in not collectively acting at scale to accelerate and spread the things that work. Initiatives such as Harlem Children's Zone have created a systemic model for breaking the cycle of generational poverty.[13] But while we celebrate such outcomes, as a society, we fail to make needed longer-term commitments, too often reducing public health efforts to short term, small-scale grants and pilot initiatives. We have become stuck in the practice of "project-ism," perpetuated by self-congratulatory 'corporate social responsibility' at the margin, taking actions that might be directionally correct, but do not deliver sufficient "dose" to change lives.[14] This results in undercutting potential population-level impacts, especially for the most vulnerable among us.

The authors see the essential transformation as requiring a move from "*doing good things*" to "*taking accountability for outcomes*." This means owning the problems and solutions in partnership with the community: moving from pilots to scaled initiatives, and from sprinting towards the next shiny object or sexy technology to running the marathon of implementing the clinical, community, and systemic strategies that can work, if given time and resources. Anything short of this perpetuates a willful self-delusion about the impact of our interventions, and our commitment to those we are ostensibly serving.

A Case in Point: Chronic Disease

[10] Centers for Disease Control and Prevention www.cdc.gov/obesity/adult/causes.html
[11] Bradley EH and Taylor LA. The American Health Care Paradox. Why Spending More is Getting us Less. Public Affairs Press: NYC, 2013.
[12] http://www.pbs.org/newshour/bb/study-finds-ptsd-lingers-body-chemistry-next-generation/
[13] www.hcz.org
[14] Schwartz, Rauzon, Cheadle et al, National Academy of Medicine, 2015 https://nam.edu/wp-content/uploads/2015/08/Perspective_DoseMatters.pdf

Despite the miracles of medicine, the U.S. healthcare system has been notably ineffective in the prevention and reversal of chronic diseases such as obesity, diabetes, hypertension, and cardiac disease. The costs of this ineffectiveness are astronomical, and can be measured in dollars of medical spending, (preventable chronic disease contributes more than 86% of the $3.2 trillion spent on healthcare) productivity loss, and quality of life.[15]

It is not for lack of knowledge that we are ineffective: researchers have spent decades studying the causes of (and cures for) these chronic health problems.[16] Rather, we are in great part ineffective because the essential element for the prevention, treatment, and even reversal of these chronic diseases is *behavioral*. This most proximate cause of (and solution to) chronic disease is in turn, profoundly shaped by the environmental contexts and settings (at home, work, school, neighborhood) where behavior takes place and life choices are made.

Unfortunately, in most care settings, the best that a physician can do while assessing, diagnosing, and treating any number of chronic conditions (given reimbursement realities and increasingly tight schedules) is to offer behavioral instructions: *"exercise more," "eat healthier," and "reduce your stress"* are the most common admonitions, and in practice are too-often followed by (even if unspoken) *"…and good luck with that, I'll see you in six months!"* Unsurprisingly, for many patients, this verbal intervention by itself is profoundly ineffective in changing behavior.

While all of us struggle with making behavior changes of one sort or another, our most vulnerable individuals and families are most systemically set up for failure in this exchange. They are told to make radical changes to their daily health behaviors (e.g. shop for fresh produce, prepare it, eat together, clean up; and then go to the gym, meditate, connect with friends, and read to the kids), all while navigating food deserts, unsafe communities, inadequate public transportation, and the necessity of holding down multiple low-paying jobs to make ends meet. These Americans are predictably unable to enact needed lifestyle changes in a sustained way. In the process, their preventable, chronic, progressive conditions worsen, and their acute and specialty care utilization increases.

Practitioners become jaded and despairing about supporting behavior change over time and default to pharmaceutical interventions, which are easily accessible (and well reimbursed), but in many cases are not supported by evidence (such as anti-depressants for mild-moderate depression). Health expenditures, and therefore health premiums, continue to rise, further entrenching a system of "sick care" and perpetuating persistent inequities in health outcomes, while paying lip service to any understanding of the upstream determinants of health.

Countervailing Forces

We would be remiss in this dialogue on the status of our nation's aspiration for better health outcomes for all if we failed to mention powerful countervailing economic and political interests that thwart progress on a few fronts. Higher rates of disease can be wildly profitable for companies and investors in treatment-related businesses, such as the massive pharmaceutical industry, as well as those in the processed food and beverage and agro-chemical industries (increasingly the same global companies) that purvey cheap empty calories, and the organizations that back their interests. Many of those firms whose profits flow from products and services that either contribute to, are associated with, or treat disease, have a powerful hold on the marketplace as well as on public and lawmaker opinion. This is seen in everything from price-gouging on needed medications, to allowing unhealthy foods and beverages (and their related agricultural and processing methods) to avoid paying for the health externalities they create. It is also seen in resistance to accelerated investment and spread of integrated approaches that can improve health, such as the Prevention and Public Health Fund.[17] The forces for better health outcomes are simply not working unopposed or unimpeded in this quest.

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[15] Centers for Disease Control and Prevention http://www.cdc.gov/chronicdisease/

[16] Dr. Dean Ornish in particular has made immeasurable contributions to the understanding of the physical and psychological processes underlying health and disease, and has demonstrated that disease reversal is possible with intensive lifestyle change. https://www.ornish.com/

[17] http://www.hhs.gov/open/prevention/

Section II

THREE PROMISING SOLUTIONS: Opportunities for innovation and investment to drive health improvement impact at scale.

Far from hopeless, we have seen the power of leveraging existing human, organizational, and community assets to effect the kinds of changes we need to see in healthcare. In the face of the challenges outlined above, we propose three opportunity areas that with courageous innovation and application can become a sustainable power-source for population-level impact.

A. Solution: Fostering behavioral pharmacies and experiential prescriptions.

As evidenced in our discussion of chronic disease, the absence of an effective and equitable delivery system for basic health behavior change represents a massive deficit in our national and community health strategies. We have a clear and present opportunity to change that. We suggest that a "behavioral prescription" without an accessible, known, and effective "behavioral pharmacy" is simply not an effective or viable solution for patients, providers, insurers, or communities.

Fortunately, despite intensely politicized debate and market competition over the ways in which healthcare will be financed and delivered, there is fundamental academic and practical agreement about some basics: four fundamental and essential nutrients for physical and psychological wellbeing:[18]

1. Physical movement.
2. Nutritious food.
3. Stress reduction.
4. Social support.

IMAGINE THIS

A doctor informs a patient that she has pre-diabetes. She needs to change her diet and start exercising. Instead of saying: "Make these changes, here's a handout, good luck, and I'll see you in 6 months," the physician says: "I've written you a prescription to our Integrated Behavioral Pharmacy, for eating healthier, moving more, and managing stress, where you can learn and experientially practice these lifestyle changes with others who are working on similar things. It's not a class or a lecture – they actually cook healthy food, do fun physical movement, and learn stress-reduction practices together. Once you've completed your 3-month formal prescription, which is covered by your insurance, they will help you connect with others in your neighborhood who gather to sustainably integrate these changes into their lives. Here, let me walk you down the hall and introduce you."

The scenario described above is one in which a patient from any socioeconomic or cultural background, with any one of a series of behaviorally-mediated physical or psychological challenges (e.g. diabetes, cardiac disease, obesity, even mild-moderate depression) has an opportunity, a fighting chance, at sustained adoption of a healthy path forward. This is the vision that underlies Open Source Wellness, one such "behavioral pharmacy"

[18] http://www.healthways.com/intensivecardiacrehab

dedicated to experientially facilitating and making enjoyable and sustainable the practices (behaviors) underlying wellbeing.[19] Whether one is struggling with chronic disease or is in generally good physical and psychological health, the basic behavioral/experiential prescription for wellbeing is fairly universal, fairly inexpensive, and not terribly complex. Whether clinically-integrated (affiliated with and proximate to healthcare delivery settings), community-based (e.g. in schools, housing facilities, faith settings, etc.) or widely dispersed (operating informally out of individuals' homes), the facilitation of these basic practices are at the heart of sustainable health and wellbeing.

Furthermore, this behavioral pharmacy model is an example of what is emerging as a broader category of intervention: the *experiential* prescription. We increasingly understand that what matters for health is not merely physical; rather, it is the deeply complex and interactive sum total of the experiences in our lives — early attachment relationships, traumas large and small, the richness or paucity of our learning environments, and countless other factors. As such, we are seeing progressive health practitioners and community organizations collaborate to both make and "fill" prescriptions for missing experiences or "nutrients." Medical providers are increasingly prescribing the purchase of healthy fresh foods from farmers markets, walking and physical activity, time in nature, mentorship, and peer support groups. These are promising signs that can go much further.

Finally, through qualitative and increasingly quantitative research, the power of human connection in particular is being shown to moderate stress, predict mental health and wellbeing, and drive physical health outcomes in powerful ways.[20] This is shifting the narrative around social connection from "*that's nice*" to "*that's essential*." The importance of social support characterized by authenticity and intimacy, along with practicing the skills of managing emotional distress, are now being understood as foundations of wellbeing and resilience. In fact, stepping outside the bounds of conventional medical terrain, we offer a fifth set of nutrients in addition to the above list of movement, nutrition, stress reduction, and social connection: purpose, meaning, and contribution — experiencing one's self as a beneficial contribution to another person, group, and/or cause.[21] [22]

While these foundations of mental and social wellbeing have been cultivated and delivered historically through membership in extended family, neighborhood, worship, and community –profound changes to the socioeconomic, demographic, and cultural climate have left large groups of individuals without reliable or sustainable sources of these fundamental nutrients/experiences. While we must absolutely do the ongoing work to rebuild communities that sustainably provide these nutrients, we can also circumvent these inequities and offer direct and targeted support to individuals and families. We anticipate and aspire to a reality in which physicians have at their disposal a full complement of social, behavioral, and experiential interventions with community based structures for fulfillment, just as reliable and accessible as a prescription for medication from the nearest pharmacy.

B. Solution: Advancing clinic-to-community integration.

Community Health Needs Assessments (CHNA's) are increasingly revealing that economic insecurity, food insecurity, housing insecurity, and non-emergency transportation are ranking highly as the most pressing social needs, alongside issues such as obesity, mental/behavioral health, and community violence.

A deceptively powerful, cost-effective, evidence-informed practice beginning to spread across the nation is the integrated assessment of and referral to basic human needs as a standard of clinical care. Many such referrals are related to affordable housing, transportation, healthy foods, legal and financial services, and home care. Such referrals, (in the future, facilitated by data exchange for outcomes tracking and reimbursement when warranted) sit in between: (a) behavioral prescriptions with warm handoffs to evidence-informed settings such as behavioral/experiential pharmacies, and (b) place-based healthy community strategies that employ practice,

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[19] http://www.opensourcewellness.org/

[20] Ornish, D. (1999). *Love and survival: The scientific basis for the healing power of intimacy.* New York: Perennial Currents

[21] http://www.nytimes.com/2016/11/04/opinion/dalai-lama-behind-our-anxiety-the-fear-of-being-unneeded.html

[22] http://greatergood.berkeley.edu/ To highlight one group of researchers who are lending legitimacy to that which we have known all along, the Greater Good Science Center explicates four essential elements that drive wellbeing and create protective resilience against life's inevitable slings and arrows: having purpose and meaning in life; a sense of belonging; the experience of awe and wonder, and opportunity for generosity ––to give back through service.

policy, and investment approaches to impact the upstream economic, socio-cultural and environmental determinants of health.

Increasingly, as healthcare providers are prompted to ask their most vulnerable patients about the economic, social, and behavioral realities that impact outcomes, they can reduce preventable and costly over-utilization of the care delivery system. As revealed in a recent study of Kaiser Permanente members in Southern California applying predictive analytics to inform future demand, 1% of patients drive 29% of costs, requiring custom-designed care and active referral to community organizations that are equipped to meet non-medical needs.[23] By using an integrated system of medical assistants, health navigators, coaches, case managers, and even highly-trained students, such as modeled by Health Leads – linked via web-based (and smartphone enabled) *resource locators* [24] – providers and their community partners can directly connect patients to community-based resources. In the Los Angeles area, Latino Health Access is an example of employing '*promotores*' (trusted, local, culturally appropriate, lay community health workers), and is leading the way in creating cost-effective models that can be integrated with quality clinical care as a seamless continuum for health and wellbeing.

In this, community is revealed as our most abundant renewable resource. Rather than impossibly heavy (and expensive) clinical service "lifts," a focus on tapping community assets serves as an intentional social design resource that deftly turns people towards each other in mutually beneficial ways. As Soma Stout, MD, Director of the 100 Million Healthier Lives initiative says: "We must find ways to liberate the 'trapped and untapped' resources that lie dormant within our communities."[25]

Instead of hiring ever more highly trained (and expensive) clinical health professionals, we need to develop scalable ways to leverage existing skills, resources, and aptitudes already resident in our communities to sustainably nourish our population. Peer and paraprofessional service structures (such as support hotlines), intentional communities (such as cohousing), and well-designed patient navigator programs (such as Health Leads) all represent successful innovations that can draw out previously untapped social abundance. We are only at the beginning of an era in which we thoughtfully and more intentionally design social structures, engaging community contribution to collectively meet population-level needs for living well. We predict revolutionary progress in this area over the coming years.

C. Solution: Leveraging the massive resources of hospitals and health systems as anchor institutions.

One of the most promising strategies for significantly boosting the "supply side" of health production is through health systems (as well as universities, governments and large employers rooted in place) serving as "anchor institutions" in their communities.

Anchor institutions[26] wield significant power as engines of local economic growth and revitalization and have a massive opportunity to deliver on community wellbeing and prosperity objectives. Typically the largest employers in their locales, the sizeable human resource needs of anchor institutions can help fuel local workforce pipelines and training and career development opportunities for disadvantaged populations and workers across fields at multiple skill levels. The expansive size of their footprints create building and development demands that can lead to creative "place making,"[27] and fuel local construction trades. Their purchasing power in combination with the demands of their operations, when procurement is localized, can drive powerful wealth-multiplier effects across regions. Investing pension funds and capital reserves for direct impact on the economic, environmental, and social determinants of health — from housing as a platform for health[28], to healthy food and clean energy enterprises — can bring much-needed resources to places and communities that have experienced the disinvestment which drives poor health.

At Kaiser Permanente, Community Benefit, aspirations initially led to Healthy Eating and Active Living (HEAL) initiatives with an expanded emphasis on policies, systems, environmental changes that support behavior change. As Kaiser Permanente and partners immersed themselves more deeply in this work, they came to recognize the

[23] Shaw et al, NEJM http://catalyst.nejm.org/predictive-analytics-determine-next-years-highest-cost-patients/
[24] https://healthleadsusa.org/
[25] http://www.100mlives.org/
[26] http://community-wealth.org/strategies/panel/anchors/index.html
[27] www.pps.org
[28] http://www.enterprisecommunity.org/

imperative of increasing the "dose" of investments (beyond grant-making) so as to harness the full power of hospitals as community anchor institutions.[29] By targeting these multiple assets and activities towards bolstering the capacity of communities and the organizations that would receive non-medical referrals from healthcare, as well as into the economic, social, and environmental drivers of community health, KP is doubling-down with an 'all-in' approach to increase impact for health and wellness. Combined with engaged philanthropy and patient capital, multi-sector initiatives that apply anchor institution strategies are raising the bar for total health impact.[30]

AN INVITATION FOR LEADERSHIP, COMMUNITY, AND COURAGE

Section III

"A healthy community, is a garden for the growing of people."
James Rouse, place-maker and founder of Enterprise Community Partners, 1963

"We must regain the conviction that we need one another; that we have a shared responsibility for others and the world; and that being good and decent are worth it."
Pope Francis, 2016

In order to deliver on the promising solutions described above, (e.g. behavioral pharmacies, addressing basic human/social needs, and anchor institution strategies) we, as nation, need to understand and leverage the following:

A. There is an emerging market for health that can complement the market for healthcare.

While the market for healthcare services is well understood, it is only a partial solution, in that it primarily incentivizes volume (of treatment and care services provided) rather than value (production of health outcomes.) In effect, while the provision of medical services is financially rewarded, health promotion and reduction in disease rates may create benefit to the nation overall while *not* necessarily accruing benefit to the healthcare sector as structured. In essence, the financial reward for improving our nation's health does not directly accrue to those who are responsible for driving the impact. Fortunately, shifts in the economic context of healthcare, in part via "at-risk payments" in the Affordable Care Act (ACA), represent an opening for aligned action across the healthcare, finance, and community development sectors to improve health, not just deliver more reimbursed care.

As integrated delivery systems increase in market share and fee-for service providers increasingly go "at-risk" via offering health plans, providers become incentivized to drive health outcomes rather than deliver more care. In such at-risk arrangements, providers take on the financial risk for health outcomes, but as they directly control only 10-20% of the drivers of total health via clinical care[31], they are stepping increasingly into the role of "*purchasers of health*." That is, instead of hiring ever-more highly trained and expensive specialists and expanding services for downstream consequences of chronic disease, healthcare organizations are increasingly dedicating their resources to addressing the upstream determinants of health in the communities they serve.

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[29] Norris et al, Trust for America's Health Annual Report, 2015
[30] Howard and Norris, *Can Hospitals Heal Americas Communities* 2016 http://democracycollaborative.org/content/can-hospitals-heal-americas-communities-0
[31] Howard and Norris, *Can Hospitals Heal Americas Communities* 2016 http://democracycollaborative.org/content/can-hospitals-heal-americas-communities-0
[31] http://www.countyhealthrankings.org/

By contracting with and investing in a wide variety of local community organizations as "*producers of health,*" healthcare providers are increasingly entering partnerships with Community Based Organizations (CBO's), Community Development Corporations (CDC's), and Community Development Finance Institutions (CDFI's). This is the emerging *market for health.*[32]

Pay-for-success initiatives such as those seeking to reduce prison recidivism in New York State, investments in early childhood development in Salt Lake City, and financing green and healthy homes for housing stability in San Jose, CA are exemplars of this formative market for health that can complement the well-established market for healthcare treatment and services.

B. Thirty years of initiatives that create healthier communities provide much to build on.

Nearly three decades of place-based, local initiatives to build healthier cities and communities via multi-sector collaboration have resulted in a set of promising practices, policies, and investments.[33] Thousands of local communities have articulated shared visions, identified assets and needs/gaps, established action plans and implementation strategies, and developed metrics and indicators for accountability. The nation has done and learned a lot through this non-partisan and trans-partisan work that can be replicated and spread in red and blue states. [34]

A notable national example of what this kind of long-term systemic work can produce is the halving of tobacco use over the past 50 years. This is the result of proven clinical strategies integrated with a coherent array of policy, practice, pricing, communications strategies, systemically applied locally and nationally over two generations. With perseverance and meaningful cross-sector investment, the U.S. has demonstrated the efficacy of combined clinical, policy, systems, and environmental change approaches that make the healthier choice the easier and more affordable choice. Change is possible, and with trans-sector, trans-issue, trans-jurisdiction, trans-cultural leadership, we can apply lessons to issues ranging from chronic disease to mental and emotional health.

C. A call for leadership: There is much to be done.

Returning to the genesis of this article, an ongoing conversation between a health psychologist and a community health entrepreneur, we offer some final reflections, a call to action, and most importantly, an invitation.

First, ensuring access to primary, specialty, and preventive care via a medical home, ideally via community-centered health homes[35], is necessary, even as it is not sufficient. Given our cumulative knowledge of the profound impact that the environmental context (e.g., social, built, human, economic, cultural) has in determining the behaviors that mediate health outcomes, it is increasingly an ethical imperative that we turn our attention to the community forces that comprise the upstream drivers of health. Our leadership and our investments must reflect this shift.

Secondly, as we embrace the role of community as the primary "producer" of health, we must seamlessly and courageously bridge the clinical-community divide not only with assessment and referral to essential non-medical resources, but also make targeted investments into the capacity of and accessibility to those environments. In the case of chronic disease, if we wish for our patients to successfully learn and sustain needed lifestyle changes, our behavioral prescription must be met with a community-based behavioral pharmacy ready to receive and supply patients with the supports they need to make these changes.

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[32] Community Development and Public Health http://www.rwjf.org/en/culture-of-health/2011/06/community-development-and-public-health-a-qa-with-david-erickson.html

[33] Norris et al, National Civic League; 2014 http://onlinelibrary.wiley.com/doi/10.1002/ncr.v102.4/issuetoc

[34] The Community Guide, CDC https://www.thecommunityguide.org/

[35] www.preventioninstitute.org

Finally, we see a clear and pressing need for courageous and visionary leadership. Perhaps more relevant than ever given the current political climate, we will need courage to disproportionately invest in our most vulnerable, to claim and reclaim collective responsibility for our national health and wellbeing, and to "vote with our feet," driving innovation and movement in the direction of what we know is possible. This is not a call to individual heroism, although bold movement from individuals is certainly required. Rather, we suggest that in working together – community is perhaps the only power-source potent enough to make these shifts possible.

As context for the opportunity before us, and in light of the blessing of our democracy, a perspective from history. In 1834, Alexis DeTocqueville wrote *Democracy in America*, chronicling the rich form of civic engagement that defined localism and community-based participatory democracy in the new nation. He wrote of town hall community engagement, whereby residents identified challenges and then set about finding and implementing local solutions.[36] By informing (rather than waiting for) Washington, community-enabled strategies such as those proposed here are perhaps best poised to build leadership bridges across sector, status, and political persuasion. We have the opportunity to make bold moves and together embrace shared local responsibility for the health and wellbeing of the nation; nothing less than our future in our third century is riding on it.

Join us in a conversation worthy of our democracy, the potential of community, and the dignity of every human life. What do you think? What do you see? What have you learned? Who else needs to be part of this conversation?

Join us in this dialogue on the power of community and the courage to build a well nation.

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[36] http://www.tylernorris.com/pubs/perspjan02.html