BUILDING A CULTURE OF HEALTH IN TEXAS

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ACKNOWLEDGEMENTS

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(Available for download at www.itstimetexas.org/publications**)**

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> There needs to be a fundamental shift in the culture of health that influences all of us on a day-to-day basis.

EXECUTIVE SUMMARY

Massive shifts in consumption and activity patterns over the past three decades have led to increased rates of obesity and related chronic diseases. These changes have significant ramifications at the individual, community and state levels. As part of an effort to understand what leaders across Texas believe can and should be done to turn this trend around, input was gathered from 50 individuals in the government, healthcare, insurance, K-12 education, academic, business and community sectors. The underlying premise behind this project was that there needs to be a fundamental shift in the culture of health that influences all of us on a day-to-day basis. The result, this paper, is a consolidation of key themes and strategies that arose during the interviews.

A host of barriers exist at the individual level including that: a) health behaviors are complex, making it difficult to turn them into habits; b) while health information proliferates, many today lack knowledge about what is healthy and do not have basic skills, like food purchasing and preparation, that enable healthy consumption; c) our current culture works against those who want to be healthy in myriad ways; d) individuals are rarely motivated to be healthy for health's sake, but that is the way the public health field, historically, has promoted healthy behavior changes; and e) Texas' sizable low-income population faces added barriers to healthy lifestyles. In addition, system-level issues create population-wide barriers: a) a lack of financial incentives for investing in health promoting infrastructure, b) policy decisions that are driven by ideology and lack of information, c) food deserts, and d) missed opportunities to prevent chronic disease in health care. But the news is not all bad. Interviewees pointed to a host of opportunities that can address and, ultimately, remove these barriers. These included opportunities to: a) be more targeted and thoughtful in health promotion messaging, b) connect community / population health to non-health issues, c) develop cross-sector partnerships, d) build upon existing community resources, e) support the work of community catalysts, f) build measurement in from the beginning of initiatives and use data to make decisions, and g) build and communicate the (local) evidence base.

> We will consider this project successful if it fosters conversations and action on this issue around the state.

PURPOSE

The project underlying this white paper was inspired by the conversation recently started by the Robert Wood Johnson Foundation around how to create a "culture of health" across the United States. While the founders of IT'S TIME TEXAS have advocated the community-based, holistic approach being espoused in these discussions for over a decade, leadership wanted to know how other Texas stakeholders reacted to the phrase, and what they felt needs to happen in order to create a culture of health in Texas.

The specific objectives of this project were to gather and consolidate diverse perspectives on the following questions:

1) Why is preventable chronic disease on the rise in Texas?

2) What barriers exist to making a culture shift to one where healthy behaviors are the norm?

3) Conversely, what opportunities exist to make desired culture changes a reality?

The following paper is organized around these three questions, but includes first a description of the problem (Background section) and a brief explanation of the methods used to gather and organize input.

In addition, six case studies have been compiled as standalone documents to provide local and real world examples of themes that emerged from the interviews. Five of the case studies highlight work being done to create cultures of health within organizations and communities; and a final case study on breastfeeding provides a tangible example of the many influences on health behaviors and the need to address them at multiple levels.

Our hope is that these examples will be updated and more will be added over time via their electronic home on the IT'S TIME TEXAS website at: www.itstimetexas.org/publications. We will consider this project successful if it fosters conversations and action on this issue around the state.

BACKGROUND

The phrase Everything's Bigger in Texas can be applied not just figuratively, but literally. Currently, more than 1 out of 3 Texas adults aged 45-64 is obese (38.9%); almost one in five children between the ages of 10 and 17 are as well (19.1%). The rate of adult obesity has doubled in the past two decades, and these rates are projected to dramatically increase (see Fig 1-2). The rate of child obesity has **tripled** since 1980. **The vast majority of people who are obese as children (80%) will remain that way for the rest of their lives.** Why does this matter? Those who are obese are more likely to have heart disease, diabetes, breathing problems (including sleep apnea), osteoarthritis, gout, high blood pressure and stroke, and some cancers. When all is said and done, being overweight and obese lowers quality of life and longevity.

Closely related to trends in obesity are increasing rates of chronic diseases such as diabetes (see Figure 2).

These increasing rates of chronic disease and obesity create a huge economic burden. It has been estimated that an obese child who remains obese through adulthood will, on average, cost the system over $500,000 in obesity-related expenses over the course of his/her lifetime. Obesity currently costs Texas employers more than $9.5 billion annually with this number projected to grow to $32.5 billion by 2030. In addition to the direct costs attributable to obesity and chronic disease, there are also indirect costs including the impact on public safety and educational outcomes. A recent study by the U.S. Department of Defense found that 27% of young adults (17-24 year olds) are too fat to serve in the military today; in a related study, researchers found that a gain of just 1 percent body fat on average would disqualify over 850,000 additional men and 1.3 million women from Army service.

As to the connection to educational outcomes, a well-documented link also exists between students' obesity or physical fitness and academic achievement, although the relationship is not yet understood. What is known is that, as early as kindergarten, obesity is linked to poorer academic performance.

Projected Obesity Prevalence Rates

2010 RATES
- 23.8 - 28.0
- 28.1 - 32.0
- 32.1 - 36.0
- 36.1 - 40.0
- 40.1 - 44.0
- 44.1 - 48.0

2040 RATES
- 23.8 - 28.0
- 28.1 - 32.0
- 32.1 - 36.0
- 36.1 - 40.0
- 40.1 - 44.0
- 44.1 - 48.0

Figure 1

Diabetes Prevalence Projections

2010 RATES
- 8.20 - 12.0
- 12.1 - 16.0
- 16.1 - 20.0
- 20.1 - 24.0
- 28.1 - 32.0
- 32.1 - 37.4

2040 RATES
- 8.20 - 12.0
- 12.1 - 16.0
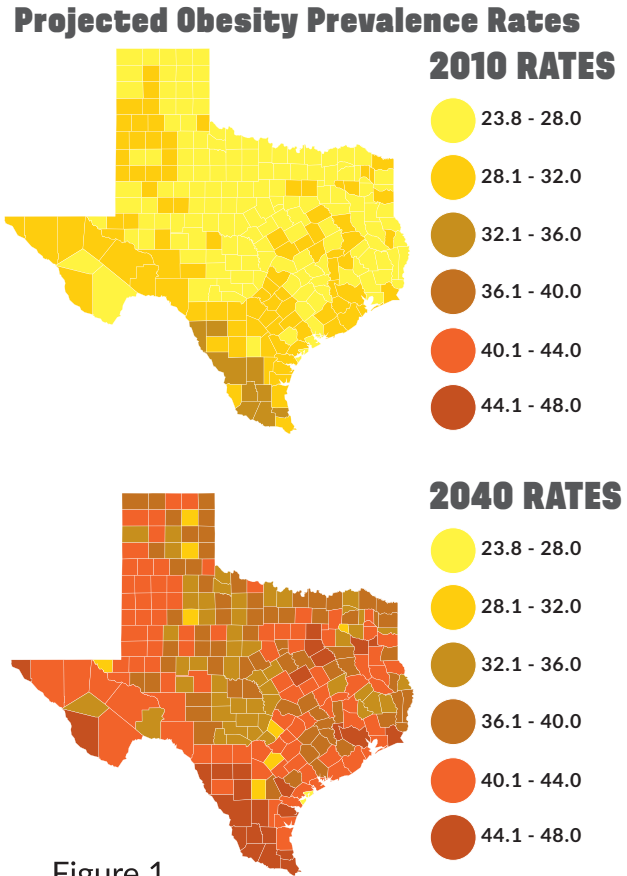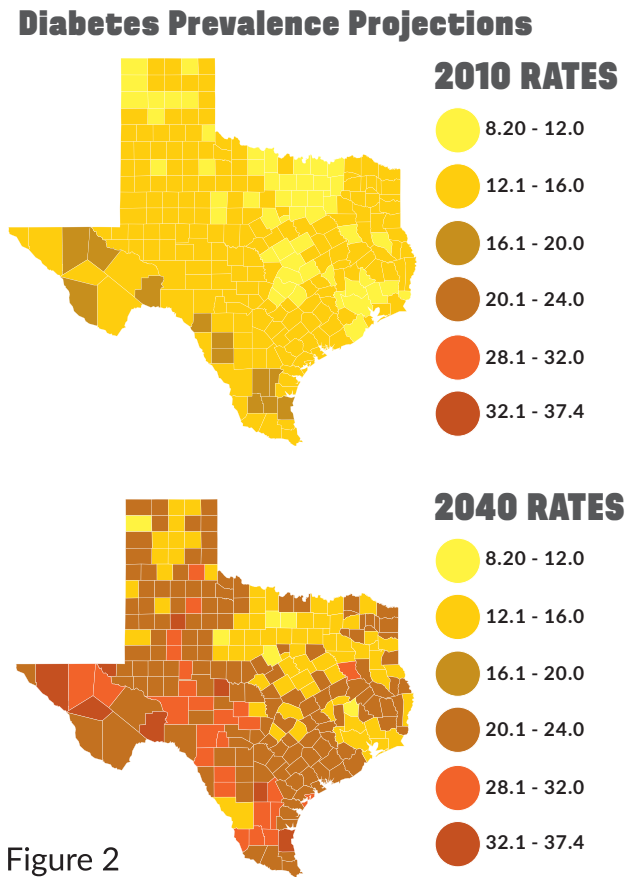- 16.1 - 20.0
- 20.1 - 24.0
- 28.1 - 32.0
- 32.1 - 37.4

Figure 2

Source: Texas Demographic Center (TDC).
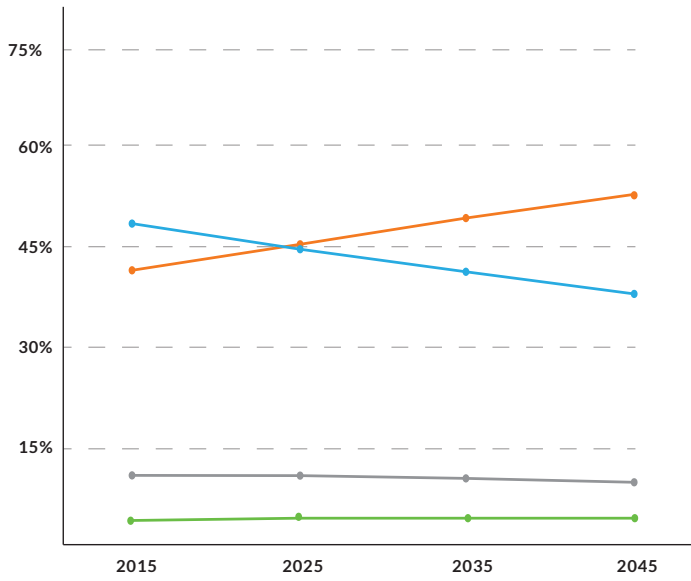
Projected Changes in Race/Ethnicity: Texas

Figure 3 — Anglo · Hispanic · Black · Other

Source: Texas Demographic Center (TDC)

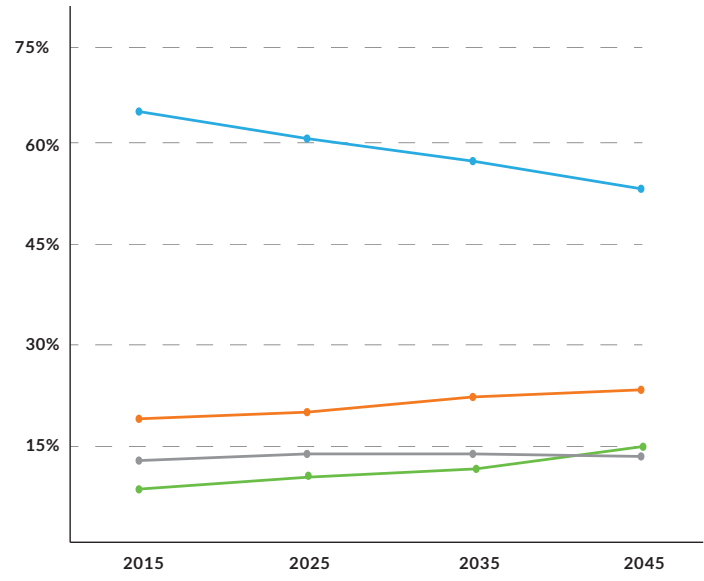## Projected Changes in Race/Ethnicity: U.S.

Figure 4 — Anglo · Hispanic · Black · Other

In Texas, we are used to operating on a large scale. We are the second largest state in terms of population size and one of the fastest growing. Since 2010, Texas has had the largest net increase in population among the 50 states - adding 2.3 million people, **exceeding the net population increase in all of the states in the Northeast and Midwest combined (1.9 million)**. Many factors drive this growth including favorable cost of living, plenty of jobs and natural increase (i.e. more births than deaths) due to having a younger population than most other states in the U.S. We are home to three of the 10 largest cities in the U.S. – Houston, Dallas and San Antonio. We have the second highest gross state product in 2014, behind California, and are home to six of the top 50 Fortune 500 companies in the U.S., and to 51 overall. **If Texas was its own country, it would have the 12th largest economy in the world**, just behind the GDP of Canada and ahead of Australia, Korea and Spain – and, 1.3 times that of our neighbor to the south, Mexico.

However, this wealth is not distributed evenly across Texas residents. While we rank third behind California and New York in the number of residents worth over $30 million (n=6,475), **1 in 4 Texas children lives in poverty, and 43% of Texans live in areas of concentrated poverty**. A wealth of research shows that those who live in areas with high levels of poverty, even if they are not impoverished themselves, lack access to good schools, health

care, good jobs, and a host of other resources fundamental to health and well-being. In addition, we lead the nation in portion of residents (20%) who are uninsured.

Our economic strength and ability to attract folks from around the country, and globe, is a source of pride. When we talk about "Texas pride," it is built upon this foundation of growth, independence and self-sufficiency. We are a state that takes pride in being different. And we are, in fact, different. Where Texas is today, the rest of the national will follow. We are a state that is evolving demographically to be younger, more diverse ethnically, and, unfortunately, to have greater inequality in income and education.

> **If you were to walk into a break room at your worksite and instead of cakes, cupcakes and candy bars, there were healthy choices... That is a game changer.**
>
> *Jeremy Lyon, PhD,*
> *Superintendent, Frisco Independent School District*

METHODS

Semi-structured interviews were carried out in two phases. The goal of Phase 1 interviews was to gather broad perspectives from leaders from the academic, government, health care, insurance, business, philanthropic and community sectors about what it would look like to have a culture of health throughout Texas, and what barriers and opportunities exist to creating it. Interviewees were also asked for their thoughts on what roles individual sectors could be playing; specific challenges their organizations, and the sectors in which they operate, face in playing these roles; and resources needed to overcome these challenges. Also discussed was the broader topic of framing, format and content of the paper. Twenty-six individuals were interviewed between August 2015 and January 2016.

Interviewees were also asked for suggestions on others who should be included in the interview process. Suggestions were discussed by internal team members and added as appropriate. As we neared the end of the first phase of interviews, suggestions began to significantly overlap with the list already developed (and people already interviewed) indicating we had a fairly complete list of possible interviewees. Of this list, six individuals were not available or did not respond to interview requests.

Phase 1 interview results were grouped into key themes and a set of recommendations was developed on overarching strategies that should be considered as part of a broader planning process. These results were vetted with internal team members as well as through two additional interviews with stakeholders who had statewide reach (one from the public sector and one from academia). Feedback was incorporated into the analysis, gaps identified, and from these gaps and prior suggestions about who else should be interviewed, a set of Phase 2 and case study interviewees identified. Phase 2 interviews (n=15) took place between March 7 and May 5, 2016. Finally, six additional interviews were carried out in order to develop case studies highlighting themes and recommendations included in the paper.

WHY PREVENTABLE CHRONIC DISEASE IS ON THE RISE IN TEXAS

As an antecedent to summarizing the themes that emerged around this question, we must acknowledge that "poor health behaviors" is a broad term with different meanings depending upon who defines it. Those working in public health and chronic disease prevention tend to connect it with eating, physical activity, and sometimes, tobacco use. Those in health care tend to add behaviors such as medication adherence, getting recommended screenings, and scheduling interactions with the health care setting as warranted by one's health status and age. Plenty of data exists to demonstrate we have poor adherence to recommendations for both types of behaviors in Texas. However, the focus of this paper is on the former set (primarily on dietary and physical activity behaviors). With that said, the answers to this question are both varied and interrelated.

For one, interviewees noted that at the individual level, **healthy behaviors can be complex**. This is especially true for healthy eating. At the individual level, people must regularly make decisions between multiple options, based on one's understanding of which option is "healthier". Compare eating healthfully to another behavior change that demonstrably impacts health outcomes, smoking cessation. With smoking, the behavior is a binary choice – to light the cigarette or not. With eating, the options are seemingly infinite. While we know that whole grains are preferred to processed grains, is a sandwich made with whole grain bread, turkey, mustard, lettuce and tomato or a salad made with lettuce, fruit, nuts and chicken the healthier lunch choice? The answer is, it depends – on one's caloric intake needs, and what else one is eating during the day. Multiply this over 4-5 eating instances per day, seven days per week, and 52 weeks per year, and one can see how the complexity can be daunting and increase the difficulty of forming healthy eating habits. (This is not meant to imply that smoking is an easier behavior to change as, of course, physical addiction is a strong barrier to cessation.

Rather the example is an attempt to highlight the complexity of dietary behaviors, and how this complexity can be a barrier to change).

Knowing what the healthier choice is between options and how much of it one needs to eat in order to meet dietary guidelines adds to this complexity. A number of interviewees pointed to the **need for education** – especially of kids – on this subject. However, they also noted that the proliferation of information on the Internet (and pendulum swings in what is deemed healthy by the "experts") actually hurts the cause. One individual who works in the retail food space admitted that even she gets confused about what healthy action on the dietary front looks like. While education is important, interviewees mostly agreed that it is not sufficient on its own. One can be motivated to be healthy and have the knowledge in hand to make the healthier choice, and yet encounter barriers at every turn.

Interviewees described the **current culture as being "toxic" to health,** giving many examples of why choosing to be healthy requires "swimming upstream" and "going against the grain" - from pervasive and highly-effective mass marketing of unhealthy foods (not just on TV and print, but through stealth marketing tactics such as product placement in stores), to cultural norms about what is served during group gatherings and how we reduce stress, to lack of sidewalks and public transportation in many Texas communities, down to the very basics of what we see others around us doing. These examples of the myriad ways the current culture works against healthy action highlight the importance of "multi-level" (eg. not just education or policy, but both and more) responses. (For an illustrative example of how a behavior with long-term health impact is influenced at many levels and how these influences can be mitigated, see the Breastfeeding case study).

> "Our culture has become accustomed to instant gratification, which makes sustained behavior change to reach a long-term goal very challenging. We are also bombarded with options that can derail good intentions. Think of the possibilities if all families knew how to purchase and prepare food, if breastfeeding was publicly supported in all places, if healthy affordable foods were available to all communities, and if our cities were built to make walking or bicycling as easy as driving. All too often making the healthy choice means going against the grain. We have to work toward a culture in which the easier default option is the healthy choice."
>
> *Lindsay Rodgers, MA, RD, LD, Director,*
> *Nutrition Services Section, Texas WIC*

> " **"It's about both the practice and proximity of health promoting resources. It is about dancing rather than watching Dancing with the Stars. It's about eating healthy rather than watching cooking shows. It's about having the ability to do those things where you mostly spend your time. From a culture perspective, it's not about consciously subscribing to a set of practices... but it is just how you live your life.** "
>
> *Eduardo Sanchez, MD, MPH,*
> *Chief Medical Officer for Prevention,*
> *American Heart Association*

Note that in no instance did interviewees point to specific ethnic cultures as being problematic. Rather, there was agreement that by "culture of health" we are referring to an overarching societal shift that will allow micro cultures to flourish in healthy ways.

Another barrier is that **health has a branding problem**, as U.S. Surgeon General Vivek Murthy noted at a recent lecture in Austin. When we think of "health" and "being healthier" there are usually negative connotations attached (as in, we are in poor health and are being urged to be healthier).

Few of us prioritize "good health" for its own sake and those in the public health space have done a poor job historically of marketing the positive side effects of healthy behaviors that people really care about – the heightened sense of well-being and happiness that comes with regular bouts of activity and consuming a balanced, nutrient-dense diet, and the ability to live a longer and more active life. As well, historically, public health campaigns are chronically under-dosed for their intended impact due to limited message exposure, intensity, and relevance, often resulting from underfunded campaign efforts.

> "Most public health campaigns conducted today have inadequate budgets to spend on message research, development, delivery, and evaluation. The result is that the campaigns have a miniscule dose of information that is dramatically insufficient to shift complex behaviors in the face of well-funded competitors promoting unhealthy products. "
>
> *Jay Bernhardt, PhD, MPH, Dean,*
> *Moody School of Communications,*
> *UT-Austin*

Many pointed to the need to **broaden our perspective on what it means to be healthy** beyond the purely physical (eg. weight status, blood pressure, cholesterol and disease state) to mental / emotional and spiritual health. Interviewees referred to these three components as a health triad with each aspect affecting the others. Notably, it was the feeling of good health that many interviewees honed in on when asked to define "health," describing it variously as **having energy, well-being, having peace** and **feeling good** rather than as an improvement in biometric data or reduction in disease states.

> "It is about being able to feel and perform at peak ability for a long, fulfilling life. If you are able to sustain it for a long period of time into your 70s and beyond, it means it is of value to you and to those close to you."
>
> *Joe Williams, Grocery Industry*
> *Consultant, Texas Retailers Association*

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They described how difficult it was for them, as members of households with resources and 'just' working one job, to consistently make healthy decisions.

Interviewees were quick to note that poor health behaviors proliferate across all segments of the population. That said, they also acknowledged that for many Texans – those who are poor or living in poverty – the barriers described above are harder to overcome. Consistently they described how difficult it was for them, as members of households with resources and 'just' working one job, to consistently make healthy decisions. The poor are more likely to live in communities that lack access to safe, accessible places to be active and not to live near a store that sells fresh fruits and vegetables. However, the barriers go beyond the environmental. Choosing to be healthy requires an investment of time –to be active, to shop and prepare healthy meals, to sleep 7-8 hours per night. Lack of time is a frequently used reason for not being active. For those who are struggling to make ends meet, free time by all accounts is scarce. The picture was most frequently painted as that of a single mother, working two jobs, trying to raise three children on her own. While this certainly tugs at the heart strings, any rational person who is working two (or more) jobs to make ends meet is going to prioritize sleep and eating whatever fills the belly over getting 150 minutes of physical activity

and cooking meals at home. **The underlying issue for this segment of the population (38% of working families) is NOT poor choice of health behaviors but the inability to earn a wage that is sufficient to cover household expenses**. Does earning a living wage guarantee healthy choices will be made? Certainly not. If it did then the poor would be the only ones not eating healthfully and not engaging in recommended levels of physical activity. Clearly that is not the case. However, the combined lack of financial resources and time create barriers that have ramifications at a population level (i.e. some individuals will find ways to overcome them, but by and large, the majority will not be able to do so).

Finally, in addition to the multi-level complex nature of how health behaviors are initiated and sustained, **motivations vary** at the individual level; moreover, Texas is a big, diverse state. What works for one person might not work for another. And what works in a community like San Antonio (see case study) likely won't be a perfect fit for Texarkana or Carthage. Thus, there is no magic bullet that will work for everyone or everywhere.

SYSTEMIC BARRIERS TO MAKING CULTURE CHANGE A REALITY

To a person, those interviewed acknowledged the existence of a host of daunting challenges impeding our progress toward developing a culture of health in Texas. Beyond the individual barriers described above, a number of systemic barriers exist as well. For one, at the policy level, the **benefits of health promoting policies frequently do not directly accrue to the entity that foots the bill**. As one example, the costs of infrastructure modifications to promote active transportation (eg. sidewalks, bike lanes) are paid by municipal agencies; however, the health benefits – in terms of improved health and reduced health care costs – accrue to insurance companies and employers.

In addition, **public policy decisions are often driven by lack of information and ideology, especially in the current environment of political polarization**. As one interviewee who works in the policy arena pointed out, policymakers, at the most basic level, frequently do not understand the basic functions of traditional public health programs (eg. mosquito control programs) and their impact on population health. Add to that the role that political ideology plays in policymaking, and it becomes paramount that constituents provide hard evidence as well as personal stories supporting desired policy change. Interviewees pointed out that data is more likely to have the desired effect if it comes from local communities and initiatives and trusted sources. As importantly, constituents must be prepared to deliver personal stories of how proposed initiatives have impacted their lives, in organized fashion. This is especially true when proposed legislation is viewed as mandating behaviors and reducing personal freedom.

The issue of **food deserts** was also raised as an impediment to healthy eating for those living in low-income communities. However it was also acknowledged that, like education, improving access to healthy foods is one piece of the puzzle, not a panacea. Eating patterns develop over time and are heavily influenced by cultural and social norms. Providing access to new, healthier inputs is important but won't, on its own, change dietary patterns at the population level.

Current culture is toxic to health

BARRIER	OPPORTUNITY
"Being healthier" is complex / Health has a branding problem	Keep messaging simple / Focus on what people care about
There is a need for education (esp. for kids)	Build and communicate local successes
Policy makers need clear evidence and personal stories	Build measurements in from the beginning / Communicate evidence base once available
Low income Texans face the largest barriers	Seek Unlikely Partners / Build upon local resources / Support local catalysts and solutions
Health benefits don't accrue to entities bearing the costs	Connect population health to other issues / Seek unlikely partners
Food deserts and healthcare gaps	Build upon local resources / Seek unlikely partners / Support local catalysts and solutions

Finally, while it is recognized that only 10-20% of health outcomes are driven by clinical care, the **health care system** was frequently raised as an area where missed opportunities exist to influence health behaviors by those both in health-care and not. Currently the system, as it works in the U.S., prioritizes sick care over keeping patients healthy.

> "In primary care there is limited time to deal with health promotion and disease prevention. There is no ICD-9 code for 'preventive care.' The main focus is on treating diseases—things that make people sick—rather than things they could do to stay well."
>
> *Bill Tierney, MD,*
> *Chair of Population Health,*
> *UT-Austin Dell Medical School*

That is changing with the move toward value-based care – where health care entities are compensated based on patient outcomes rather than per service provided. However, those in the field noted this will require a fundamental re-orienting of the health care system and that the paradigm shift will be a generational one. Systems will need to be in place to effectively share patient information across providers and coordinate patient care across teams that will include not just physicians and nurses, but possibly nutritionists, health educators and community health workers. The good news is that this work has begun. Across the nation, insurers and health care providers are collaborating to create value-based care delivery models. Models are also being piloted through the Centers for Medicare & Medicaid Services (CMS) and it is assumed many valuable lessons will be learned from these early initiatives.

EXISTING OPPORTUNITIES TO CHANGE OUR CULTURE OF HEALTH

While many seemingly insurmountable challenges exist, not the least of which is that no one action or actor can turn the clock back behaviorally to previous decades where kids spent time outdoors playing rather than inside on video games, families ate home-cooked meals almost everyday, and time spent in cars was minimal compared to today, Texas is a state built on innovation and overcoming challenges. Many are already working in this area to improve the health behaviors and health of communities in Texas. Building off this work, as well as the experience and expertise of those interviewed, following is a list of opportunities to build a culture of health in Texas, many of which directly address the barriers noted above.

Messaging: Keep It Simple & Targeted

Few people's primary motivation to change behavior is because "it is good for" them. In addition, motivations and readiness to change vary from person to person. Knowing that behavior change is going to make us feel better, have more energy, live longer and be more active while doing it, are bigger motivators than being told it will lower our blood pressure, lower our cholesterol or lower our risk of diabetes or heart disease. And yet, many public health campaigns communicate the benefits of exercise and dietary changes in the latter way.

> "Humans make most decisions based on values and emotions rather than logic and rationality. When we make bad ones, it's often for immediate satisfaction without considering the longer-term consequences. We should be taking a lesson from food companies that effectively connect their unhealthy products to happiness because healthy products and behaviors, unlike food, can actually produce long-term positive emotions and outcomes."
>
> *Jay Bernhardt, PhD, MPH, Dean,*
> *Moody School of Communications, UT-Austin*

Humans make most decisions based on values and emotions rather than logic and rationality.

In addition to playing to what people care about, campaigns (educational and otherwise) need to be kept simple. For example, rather than telling people they need to reduce the amount of sugar in their diets and trying to educate them on all the places where sugar lurks, a simpler campaign like *Don't Drink Your Sugar* that targets one behavior – replacing sugar-sweetened beverages with non-sugar-sweetened options – is likely to be more effective.

Finally, in recognizing that motivations and readiness vary, one interviewee noted that the "mass marketing is a waste" especially in light of the tendency of public health campaigns to be under-funded. Targeted messaging and methods (eg. text messaging) are a better use of resources and can be designed to meet people where they are. For example, for those who are committed, ready to take action and just needing a nudge, a campaign promoting 30 minutes of walking per

day might be successful. However, for those who are sedentary and not ready to commit to regular exercise, a more appropriate campaign might be around parking farther from the grocery store (something several of those interviewed mentioned doing and encouraging their children to do) or other small steps, literally.

Connect Population Health to Other Issues

Just as we don't prioritize "good health" (or reducing bad health) in individual decision-making, the good health of employees and citizens is not a priority for policy-makers for its own sake. For employers a connection can be made to lowering costs in terms of lower health care costs and insurance premiums (a motivation noted in both the H-E-B and City of Houston case studies), improved employee morale and retention, and reduced absenteeism.

For community health advocates, ample opportunity exists to connect resident health to other issues. As one example, public safety is impacted by the ability of the military, police and firefighting organizations to recruit from a sufficient pool of able-bodied prospects (something the military, for one, has struggled to do in recent years).

Synergies also exist with education advocates. Education influences health in a variety of ways including: a) through better critical thinking, information processing and communication skills; b) better living and work conditions; c) socialization to health promoting behavior; d) greater psychological resources; e) access to human capital; and f) lifetime earnings. Conversely, healthy students are more likely to absorb what they are being taught (see the LiiNK Project case study for more on this). Thus, community health can be improved through reducing education disparities, and education gains can be made via investments in student health and fitness.

Similarly community health and poverty / social justice advocates have shared priorities. Many would say the two issues are inextricably linked. Core to social justice is the idea that all residents should have the right and ability to live their lives to the fullest. Those who are poor are more likely to live in areas lacking public amenities (such as parks, sidewalks, public transportation, high quality schools), good-paying jobs, and health care facilities; and in sub-standard, overcrowded housing. All of these issues are directly connected to health.

Seek Unlikely Partners

Larger, more diverse coalitions can more effectively influence policy decisions and resource recruitment. Once the connections to other priority issues have been identified, those in the community health space should seek out "unlikely partners." In addition to engaging partners who are not traditionally health-focused in community health initiatives, those from community health should look for opportunities to engage in conversations that are not ostensibly about health. As one example, members of Brownsville's Community Advisory Board (CAB) have engaged in conversations about city planning, taxation policy, and zoning. In these conversations, discussions center around the impact of policies on property values, resident quality of life, population retention, and tax revenues. While health is not a focus, CAB members have learned to advocate for policies that improve the walkability of communities alongside those who are concerned with recruitment of the best and brightest young people, who are known to prioritize walkability. (For more on this subject, see the Brownsville case study).

In evaluating the potential of cross-sector collaborations, it is important to identify shared priorities, develop and implement strategies to achieve them, and employ measures by which interim and long-term progress can be assessed. These cross-sector collaborations will require upfront investment of time in building trust, learning each other's priorities (and sensitivities), identifying where shared priorities exist and agreeing on roles and responsibilities. However, the investments can pay off in the long-run in terms of more powerful partnerships and innovative, holistic solutions.

> "At Frisco ISD, between 9:00am and 3:00pm non-teaching staff members can take a 30-minute walk on district time. We have seen not just physically healthier employees, but increased productivity and morale. What if enabling employees to leave work healthier than they were when they arrived was the norm in all workplaces across the nation?"
> Jeremy Lyon, PhD,
> Superintendent, Frisco Independent School District

A host of local resources are often available but are un- or underutilized.

Build Upon Existing Local Resources

Several interviewees noted that a host of local resources are often available but are un- or underutilized. In an environment where financial resources always fall short of optimal, interviewees urged building upon what already exists. These may be parks, unused buildings, empty lots, school facilities, and more. One interviewee cited research indicating that residents are frequently unaware of parks within one-half mile of their homes even when those parks include significant features – such as trails, playgrounds, ball fields, or water areas. Approximately 80% of those surveyed were unaware of parks near their homes. These findings have been confirmed in other studies, which together indicate that lack of knowledge of parks and their facilities is common.

> "One of the things we are doing in Cameron County is mapping our assets. What is going to allow us to propel our agenda of improving community health? Well, we have great weather and can be outside year-round. We also have the prettiest beaches, the best birding and parks that our residents don't even know are here. We are designing initiatives around creating demand for using these."
>
> *Judy Quisenberry*
> *Grants Director, Valley Baptist Legacy Foundation*

Support Community and Organizational Catalysts

Multiple interviewees cautioned against a state-wide approach to changing the culture of health, noting that the diversity of the Texas landscape calls for local solutions. At the end of the day, the success of initiatives geared at changing the culture of health in communities depends on there being one or more local champions who will rally resources and ensure that implementation occurs and is sustained over time. These catalysts are also in a better position than external players to identify community assets that can be marshaled.

That said, interviewees suggested a number of ways that external parties concerned with seeing the culture of health improve across our state can support local catalysts. One is through the provision of technical assistance and training geared toward building the ability of local catalysts to effectively build and facilitate collaborations, map assets, carry out action planning, and develop systems for monitoring progress and measuring impact. Another potentially impactful role involves connecting catalysts directly with one another for peer support and shared learning.

Build Measurement in from the Beginning

For all initiatives, whether it be a local community effort, a cross-sector initiative designed for a very specific purpose, or coalition efforts aimed at impacting policy, over and over interviewees noted the need to measure progress – and the complexities of doing so. While all agreed that the ultimate goal is to see chronic disease rates and levels of obesity fall, they also acknowledged that this is a goal that will take one or two generations to achieve. Many noted that it is critical interim measures of progress be developed. Suggestions varied, highlighting the complicated nature of how culture change is presumed to transpire. Suggestions included measuring changes in attitudes and behaviors related to nutrition and physical activity, measures for which are available through the Behavioral Risk Factor Surveillance System (BRFSS); measuring environmental change such as the number of communities with public transportation systems, sidewalks or other active transportation facilities; and measuring change in resident awareness about access issues in their communities.

Other interviewees noted the importance of measuring progress toward sustainability. Is there evidence that the initiative will continue to recruit funding from diverse sources, that community leadership capacity is growing, and that the initiative has grown beyond being dependent upon one person for its success to being truly owned by the community? (See Brownsville and San Antonio case studies for more on this topic).

Discussions about measurement need to take place during intervention planning, not once initiatives are launched. This keeps parties aligned on goals and what the initiative is being designed to impact. In addition, it ensures that measurement is included in design and implementation plans.

Build and Communicate the Evidence Base

Lastly, a recommendation that rose to the top was the need to communicate what works, when, and why. It has two distinct components. The first is to build the evidence base through well-designed, local initiatives so that policymakers and stakeholders understand which initiatives work and why. This speaks to the importance of building measurement into the design of projects from the beginning to ensure needed data is gathered. Both the City of Houston and H-E-B (see case studies) have implemented evaluations of their employee wellness initiatives using a mix of participation and health metric data.

The other step is to communicate the existing evidence in a way that is easily digestible. Several interviewees noted the proliferation of initiatives taking place across Texas and felt that a centralized compilation of initiatives describing activities, results, lessons learned, keys to success and points of contact would be useful to local community and organization-level catalysts. In addition, an overwhelming number of systematic reviews and community guides have been published on the impact of different health promotion initiatives that are variously digestible by lay audiences. The potential exists to organize and better communicate the results of these reviews so that local initiatives are built using evidence-based best practices.

> "An early point of measurement for us in the communities with which we partner in South Austin is to assess whether residents recognize that barriers to healthy food access exist in their communities. We found that initially they did not but that as we engaged residents in the process, they became more aware of and concerned with these barriers. Other related measures of progress for these initiatives are: a) do we see teams forming and substantively engaging in the process, b) are we changing access and quality in terms of number of safe places to be active and to buy healthy foods, and c) do we see increased utilization as awareness and access improve? We won't begin to measure health outcomes until years 4 or 5."
>
> *Aliya Hussaini, MD,*
> *Health Portfolio Director, Michael & Susan Dell Foundation*

IT'S TIME TEXAS RECOMMENDATIONS

IT'S TIME TEXAS commissioned this project in order to learn what other stakeholders with varying perspectives had to say about this topic and where there were synergies. What we learned is informing our efforts, and will continue to do so. As such, the following recommendations will drive our work, and we hope, the work of other community health stakeholders.

1. Identify, build and nurture committed leadership in communities and at the state level.

2. Prioritize creating unifying visions and supporting action plans in community work.

3. In all community health efforts, seek opportunities to partner and align efforts cross-sector. This requires being willing to step out of our health promotion shoes; to listen, learn and respect the priorities of those in other sectors.

4. Specifically, engage the business sector. Its members have both the need and the potential to have great impact on both employee and community health.

5. While it is oft-stated that all health is local, this doesn't mean neighborhoods working in isolation. It is important to develop and support robust backbone entities to identify synergies and coordinate across individual efforts.

6. Disparities in health outcomes and health promoting resources exist. To reduce them, we must engage those we are trying to serve in our efforts. We can bring data and knowledge of what works; community members, however, have an understanding of practical realities and priorities that are fundamental to the success of any translation efforts.

7. Collect data and use it to drive decisions. In recognition that those involved may not be experienced statisticians, we must be thoughtful about how data is presented.

8. Leverage technology. In an era when cell phones are ubiquitous, and smartphone technology becoming ever more so, we must look for opportunities to use technology to collect data and to promote access to resources, information and support.

CONCLUSIONS & WHAT'S NEXT

Much like the rest of the country, poor health exists in Texas and has reached crisis-level status. Contributing to this complex issue are a host of barriers, including income inequalities which make health behaviors difficult to sustain for a sizable portion of Texas residents. Nonetheless, action is being taken, and impact is being demonstrated, in communities across the state. Opportunities exist to build upon these successes and the experience of those who have led them – by learning from them, by more broadly promoting their impact, and by supporting catalysts in other settings who have a strong desire to improve the health of their communities.

In addition, while there was resounding agreement that action and individualized effort needs to be supported at the community level, we also heard that the potential exists to define a shared purpose that connects and amplifies our individual actions. We should look for ways to leverage our pride for our state to create a unifying purpose.

So, what is next? This white paper is an initial step in determining what can be done to hasten the (re)building of a culture of health in our great state. Through sessions at the IT'S TIME TEXAS Summit in August 2016, we will be gathering additional input from attendees. The findings of both this white paper and conference attendee feedback will be used by IT'S TIME TEXAS in collaboration with the University of Texas System to develop a strategic plan for how the two organizations will work together, in conjunction with other statewide partners, to transform the health of Texas communities and residents.

About IT'S TIME TEXAS

The nonprofit IT'S TIME TEXAS is championing the fight for a healthier Texas. IT'S TIME TEXAS empowers Texans to lead healthier lives and build healthier communities through its portfolio of award-winning technology, programs, events, initiatives, training, and support services. Together with its allies and partners, IT'S TIME TEXAS will impact the health of more than 5 million Texans in over 500 communities across the state this year. Join the cause for a healthier Texas at: www.itstimetexas.org.

Interviewees

Tom Banning, CEO and Executive Vice President, Texas Academy of Family Physicians
Karen Batory, MPA, Vice President, Division of Public Health and Medical Education, Texas Medical Association
Julie Bedingfield, Public Affairs, Health & Wellness Manager, H-E-B
Jay Bernhardt, PhD, MBA, Dean, Moody School of Communications, University of Texas at Austin
Carrye Chen, Wellness Consultant, Northeast, Texas Association of Counties
Albert Cheung, Public Health Analyst, Healthy Living Matters, Harris County Public Health
Celia Cole, Chief Executive Officer, Feeding Texas
Susan Combs, Former State Comptroller
Adrianna Cuellar, Executive Director, United Ways of Texas
Ashley Cureton, Wellness Consultant, Northwest, Texas Association of Counties
Bob Deuell, MD, Family Practice Physician & Former Member, Texas State Senate, Primary Care Associates
Rosalinda DiTommaso, Wellness Consultant, Southeast, Texas Association of Counties
Diana Everett, Executive Director, Texas Association for Health, Physical Education, Recreation & Dance (TAHPERD)
Kristy Hansen, M.Ed., Program Coordinator & Team Lead, Community & Worksite Wellness , Texas Department of State Health Services
Ernie Hawk, MD, MPH, Vice President for Cancer Prevention & Population Sciences, MD Anderson Cancer Center
Denise Herrera, PhD, Program Officer, Robert Wood Johnson Foundation
Aliya Hussaini, MD, Health Portfolio Director, Michael & Susan Dell Foundation
Rand Jenkins, Child & Family Advocate, Texas Baptists
Kim Jones, Director of Test & Research, Jason's Deli
Steve Kelder, PhD, MPH, Co-Director, Michael & Susan Dell Center for Healthy Living, University of Texas Health Science Center School of Public Health - Austin Regional Campus
Carrie Kroll, Vice President Advocacy, Quality and Public Health, Texas Hospital Association
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Michael Lopez, MUP, Extension Program Specialist, Environmental Health, Texas A&M AgriLife Extension
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Jay Morrow, DVM, MPH, Program Director, Texas Health Improvement Network, Population Health, University of Texas System
Lexi Nolen, PhD, MPH, Vice President for Impact, Episcopal Health Foundation
Becky Pastner, MPA, Senior Capacity Building Officer, St. David's Foundation
Rocky Payne, MA, Statewide Wellness Coordinator, Texas Department of State Health Services
Stephen Pont, MD, MPH, Medical Director, Texas Center for the Prevention and Treatment of Childhood Obesity (TCPTCO) at Dell Children's Medical Center
David Porras, Business Office Manager, Student Health Center, University of Texas Health Science Center - El Paso
Judy Quisenberry, Grants Director, Valley Baptist Legacy Foundation
Lindsay Rodgers, MA, RD, LD, Director, Nutrition Services Section, Texas Women, Infants & Children (WIC)
Eduardo Sanchez, MD, MPH, Chief Medical Officer for Prevention, American Heart Association
Brett Spencer, Statewide Wellness Coordinator, Texas Department of State Health Services
William Tierney, MD, Chair of Population Health, University of Texas at Austin Dell Medical School
Clayton Travis, MSSW, Advocacy and Health Policy Coordinator, Texas Pediatric Society
Chris Traylor, Former Executive Commissioner, Texas Health and Human Services
Joe Williams, Grocery Industry Consultant, Texas Retailers Association
Carol Zernial, Executive Director, WellMed Charitable Foundation
Mark Zollitsch, Wellness Consultant, Southwest, Texas Association of Counties

Case Studies

Tracy Erickson, RD, IBCLC, Breastfeeding Coordinator, Texas Women, Infants & Children (WIC)
Nicole Hare-Everline, DHS, Employee Wellness and Employee Assistance Programs Director, City of Houston
Belinda Reininger, DrPH, Professor of Health Promotion and Behavioral Science, University of Texas, School of Public Health Regional Campus at Brownsville and Member of the Brownsville Community Advisory Board, University of Texas Health Science Center - Brownsville
Debbie Rhea, DEd, MEd, Project Creator & Director, LiiNK Project
Kate Rogers, Vice President, Communications & Health Promotion, H-E-B
Jeff Skelton, Chair, San Antonio Mayor's Fitness Council

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