

How Cultural Alignment and the Use of Incentives Can Promote a Culture of Health

STAKEHOLDER PERSPECTIVES

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For more information on this publication, visit www.rand.org/t/RR1889

Library of Congress Cataloging-in-Publication Data is available for this publication.

ISBN: 978-0-8330-9788-0

Published by the RAND Corporation, Santa Monica, Calif.

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Preface

IN 2013, THE Robert Wood Johnson Foundation (RWJF) embarked on a pioneering effort to advance a Culture of Health. The Culture of Health Action Framework is founded on a vision “that enables all members of our diverse society to lead healthy lives, now and for generations to come” (Plough, 2014). This report is one of a series examining aspects and implications of building a Culture of Health in the United States. Over the course of the development of the Culture of Health Action Framework and the subsequent rollout of the framework and measures, two questions emerged as central to understanding how individuals and sectors think about health and are motivated to promote it:

- How can the commonly understood concepts of cultural identity (e.g., ethnic or religious; lesbian, gay, bisexual, transgender plus [LGBT+]; military) and organizational culture be harnessed to develop a Culture of Health?
- How can incentives be used to promote individual health and engage investors and leaders within organizations or governments to promote health and well-being broadly?

These two questions were identified as central to deepening the Culture of Health effort because recognizing and addressing unique identities and experiences of people bound together by culture (at organizational or community levels) is often viewed as the first step in social movement and cultural change. Incentives are critical first steps in catalyzing interest and action before that change is sustained or institutionalized as part of daily practice and policy. Taken together, culture and incentives are necessary first elements in embedding a Culture of Health within and across sectors. This report draws on a series of interviews that RAND researchers conducted with stakeholders whose work focused on culture, incentives, or both and follows from an initial report on stakeholder perspectives, *Stakeholder Perspectives on a Culture of Health: Key Findings* (Acosta et al., 2016). RWJF asked RAND to examine these two topics to help it understand how organizations are addressing and leveraging culture and incentives to promote health and well-being, as well as to identify facilitators, barriers, potential best practices, and lessons learned that may inform future work in these areas.

This report should be of interest to RWJF and to individuals and organizations interested in advancing the Culture of Health Action Framework. Given that RWJF is focused on using the Culture of Health Action Framework and measures to catalyze national dialogue about content and investments to improve population health and well-being, the report should be beneficial to a range of national, state, and local leaders across a variety of sectors that contribute to health, as described by the Culture of Health Action Framework.

This research was sponsored by the Robert Wood Johnson Foundation and conducted within RAND Health. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health. Anita Chandra leads the Culture of Health work at RAND and is assisted by a large, diverse team of RAND researchers. Questions about this report or the Culture of Health work at RAND may be directed to Chandra@rand.org.

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Summary

SINCE 2013, THE Robert Wood Johnson Foundation (RWJF) has led efforts to build a “Culture of Health that enables all members of our diverse society to lead healthy lives, now and for generations to come” (Plough, 2014). The Culture of Health Action Framework, published by RWJF in 2015, consists of four action areas and a fifth area focused on outcomes (as shown in Figure 1.1). Additionally, equity is an overarching theme of the Culture of Health Action Framework (Plough and Chandra, 2015). Health equity broadly refers to the opportunity of all to reach their full health potential, considering just and fair inclusion as a fundamental aspect of that opportunity (Braveman, 2014; National Academies of Sciences, Engineering, and Medicine, 2016; PolicyLink, 2014). Health equity, along with population health and well-being, is an intended outcome of a Culture of Health, and all three outcomes are embedded in the action areas, drivers, and measures that compose the Culture of Health Action Framework (Chandra, Acosta, et al., 2016).

This framework is intended to catalyze national dialogue about action and investments to improve population health and well-being. Building a Culture of Health is a bold vision that relies on traditional health promotion actors (e.g., public health and health care systems) and new and innovative partners (e.g., economic development investors, city planning commissioners) to make the changes to systems and communities that are required to sustain it. To understand how this framework is being used to advance action at the local, state, and national levels, RWJF has commissioned ongoing stakeholder engagement and other tracking and monitoring efforts from RAND and other organizations. Two questions emerged from an earlier literature review (Chandra, Acosta, et al., 2016) and stakeholder analysis (Acosta et al., 2016) as central to understanding how individuals and sectors think about health and well-being and how they are motivated to promote it:

- How can the commonly understood concepts of cultural identity (e.g., ethnic or religious; lesbian, gay, bisexual, transgender plus [LGBT+]; military) and organizational culture be harnessed to develop a Culture of Health?
- How can incentives be used to promote individual health and engage investors and leaders within organizations or governments to promote health and well-being broadly?

These two questions were identified as central to the Culture of Health effort because recognizing and addressing unique identities and experiences of people bound together by culture (at organizational or community levels) is often viewed as the first step in social movement and cultural change (Chandra, Miller, et al., 2016). Incentives are critical first steps in catalyzing interest and action to change, long before that change is sustained or institutionalized as part of daily practice and policy. Taken together, culture and incentives are necessary first elements in embedding a Culture of Health within and across sectors (Towe et al., 2016).

RWJF asked RAND to examine these two topics to gain insights into how organizations are addressing and leveraging culture and incentives to promote health and well-being, as well as to identify facilitators, barriers, potential best practices, and lessons learned that may inform future work in these areas. This report draws on the findings of interviews that RAND researchers conducted with stake-

holders whose work focused on culture, incentives, or both and follows from an initial report on stakeholder perspectives, *Stakeholder Perspectives on a Culture of Health: Key Findings* (Acosta et al., 2016).

Data Collection and Analysis

We conducted 43 one-hour semistructured interviews with representatives of organizations doing work related to culture and/or incentives. Potential respondents were identified via existing RAND and RWJF contact lists and related conference proceedings, literature reviews, targeted Internet searches, and snowball sampling. They were invited to participate in the study via email, and interviews were conducted by phone.

We developed a semistructured interview protocol (see Appendix B) for these interviews. The general structure of the protocol was based on the objectives of the research as described previously: (1) to understand how the commonly understood concept of culture relates to attaining a Culture of Health and (2) to understand how incentives are being used to engage individuals, employers, and organizations in health promotion activities. We were interested in hearing about efforts in these two areas that align with the Culture of Health Action Framework, as well as barriers, facilitators, and lessons learned coming out of that work. Specific interview questions were developed based on topics for future research identified by an initial stakeholder report (Acosta et al., 2016) and literature related to how culture and incentives are being used to promote health and well-being.

With regard to culture, the protocol included questions about how health and well-being differ across cultures and whether there are any specific cultural barriers or facilitators to building a Culture of Health within communities in the United States or to using the Culture of Health Action Framework to inform the promotion of health and well-being. With regard to incentives, questions explored barriers, facilitators, and lessons learned about incentivizing organizations, employers, and individuals to promote health and well-being. Though interviews generally followed the established protocol, the goal of this effort was to obtain a diverse array of perspectives on factors related to culture and incentives. As such, questions were not consistently asked across interviews, and interviewers often tailored questions to interviewees' areas of expertise. Interviews were not recorded, but interviewers took detailed notes.

Three staff who conducted the interviews used notes to identify emergent themes across respondents, following a general inductive approach to analyzing qualitative data. We summarized emergent themes in three categories: (1) themes relevant for understanding how culture and addressing cultural differences in programs and policies promote health and well-being, (2) themes relevant for understanding how incentives are being used to promote a Culture of Health, and (3) cross-cutting or foundational themes raised by both sets of stakeholders as particularly relevant for their work promoting a Culture of Health. After themes were coded, the same staff responsible for interviewing and coding consulted the literature and previous stakeholder engagement work to determine the extent to which emergent themes added to what was already known about health promotion in a cultural context and using incentives for health.

This report was ultimately constructed around emerging themes within and across the culture and incentives domains and within RWJF's priorities of applying the Culture of Health principles to achieving health equity.

Findings

Cross-Cutting Themes

Although this project set out to capture perspectives from two sets of stakeholders (those working on issues of culture and those using incentives to motivate health and well-being), several themes emerged as cross-cutting and foundational to promoting health and well-being at multiple levels, including a number related to health equity:

- **Establishing health as a shared value is an important but challenging step in promoting health and well-being.** Stakeholders described an array of opportunities for creating a shared value of health that is rooted in traditional cultural beliefs, including leveraging deeply held beliefs about family, religion or spirituality, and holistic well-being of one's self and one's community. Stakeholders noted that it is often challenging, however, to establish shared values or shared definitions of health when cultural beliefs do not align with Western beliefs (e.g., fatalistic views of disease), when working with multiple cultural groups, or when there are varied levels of acculturation within a single group. The concept of shared values was also cited as very important for incentivizing health, and stakeholders shared strategies for motivating diverse partners to view a desired health outcome as relevant to them. This is particularly true for large-scale models, such as Pay for Success, which requires a very clear and agreed-upon shared health outcome and objective that all parties are working toward (see Appendix A).
- **There is a need to acknowledge the importance of both individual and community health and well-being.** Related to the notion of shared values, stakeholders reported a need for better acknowledgment of and balance between individual and community health and well-being. While community health can be challenging to define, broadly speaking, it refers to the "health status of a defined group of people and the actions and conditions, both private and public (governmental), to promote, protect, and preserve their health" (McKenzie, Pinger, and Kotecki, 2011). Participants noted that in the United States, there is more emphasis placed on individual health and far less attention given to public health. One participant described this phenomenon as the "culture of me," noting that this focus on the individual is perhaps a bigger impediment to achieving a Culture of Health than any multicultural issue. Stakeholders felt that this was a particularly important issue for organizational and government leaders, who control how funds and resources are spent.
- **Data can support the development of shared values.** Data, and in particular the sharing of data, were cited as an important facilitator for building a Culture of Health in the community. Stakeholders noted, for example, that data on health and well-being, population characteristics, the utilization of health and social services, and the financial impact or burden of that utilization can help align diverse stakeholders around a priority concern and a shared definition of health. Additionally, data, along with storytelling to contextualize the data, were described as particularly influential tools for stakeholders to raise awareness of issues in their communities and make the case for funding.
- **Stakeholders spoke of equity as requiring integration, collaboration, and thinking about health equity from a broader perspective than just health or resolving health disparities.** Stakeholders noted that addressing health inequities will not be fully solved by one organization, or even by one sector alone, and requires more than targeting or adapting inter-

ventions to disadvantaged groups or cultural contexts. Participants pointed to the importance of having policymakers as a partner in efforts to address health equity. Stakeholders also felt that addressing equity requires keen attention to the historical causes of health inequities and cited the importance of taking a social activism and community resilience approach when addressing root causes of health inequity, including variable access to important social services and such basic needs as affordable food, stable housing, and safe neighborhoods.

- **Equity is often addressed in silos, which impedes progress toward a unified goal of health equity for all.** One challenge noted by stakeholders is that equity is often addressed, and funding is often distributed, in silos by racial, ethnic, or gender divisions, which impedes progress toward a unified goal of health equity for all. Stakeholders noted, for example, that collaboration between organizations serving different racial or ethnic groups is often hindered by funding mechanisms that divide or place limitations on how funds can be spent by racial or ethnic groups.
- **Structural inequity among organizations serving different communities can pose a barrier to progress.** One challenge raised by stakeholders is that smaller organizations working to support disadvantaged and marginalized populations are often at a significant disadvantage relative to larger organizations or systems with respect to access, data, and resources. They noted that such structural inequities, in turn, can pose a barrier to addressing issues of health equity because the organizations that need to be at the table and be part of the solution have a relatively smaller voice.
- **Addressing equity takes time and effort.** Beyond the time and effort required to ensure equitable access to programs and services, stakeholders shared that they and their colleagues are often involved in significant work outside of their day-to-day service provision to educate those in other systems (e.g., universities, health care systems, governments) on issues related to equity and approaches to addressing health inequity.

Themes Related to Addressing Culture and Cultural Differences to Promote Health and Well-Being

Building a Culture of Health necessitates recognizing and addressing the diversity of cultures in the United States. For the purposes of this work, we defined *culture* broadly to include groups based on ethnicity, tribal affiliation, or religion and groups of people with unique experiences, perspectives, and beliefs, including military-connected individuals, LGBT+ populations, and economically or geographically defined groups (e.g., residents in government-subsidized housing). Several themes emerged as particularly important for addressing culture and cultural differences in efforts to promote health and well-being:

- **Addressing culture presents opportunities and challenges.** Stakeholders noted that they adapted programs and messaging to fit the language and cultural context of the populations they serve. Stakeholders also emphasized the importance of having a strong connection to the cultures within their communities of interest, through either staff representation or connections with trusted leaders in the community. Stakeholders noted, however, that having the time and financial capacity to properly engage the community and accommodate multiple cultures can pose a challenge. Another challenge is that “diversity initiatives” are often targeted to a particular racial or ethnic group and do not account for all of the cultural groups served by the organization. Stake-

holders also pointed to possible unintended consequences of health campaigns tailored to specific cultural groups that inadvertently portray the groups in a negative light.

- **Members of specific cultural groups need to be given a voice in health-related activities to reach the outcomes they desire.** Stakeholders we interviewed pointed out that community engagement is very important, and discussions with communities should include a diverse mix of people, particularly representatives of marginalized populations for whom the effort is being developed. Stakeholders highlighted the importance of regular engagement with the community, rather than one-time engagement. Stakeholders cautioned, however, that while advocacy organizations can provide a powerful voice to traditionally marginalized populations, these organizations can supplement but should not replace the voices of the populations of interest. Stakeholders also noted that it is important to consider steps to ensure sustainable inclusion in ongoing discussions about health.
- **Meaningful community engagement takes time and money.** Although this theme was raised with stakeholders in the context of equity, it was also discussed at length in the context of community engagement. Trust-building was highlighted as a particularly important but very time-consuming process. This trust-building step, while critically important, is often not adequately funded for the amount of time and resources needed to do this well, and essential costs, such as the purchase of food and beverages, are often nonreimbursable expenses. Another challenge is that current grants or awards are often looking for results within a relatively short time frame (e.g., six to 12 months) and do not allow adequate time for trust-building to take place.
- **Systems are built around prevailing cultural norms, making it challenging for those working with specific cultures to make cultural adaptations.** Stakeholders reported that many systems suffer from a strong degree of inertia, operating via “business as usual” unless powerful catalysts force a change. Consequently, when constituents or clients require culturally informed adaptations to be made to policies or ways of working, they often confront challenges. However, stakeholders shared ways in which some health systems are adapting through the availability of translation services and the relaxation of policies, particularly around birth and the end of life. Stakeholders noted that such adaptations take ongoing communication and personal connections with system leaders, which enable them to advocate for the needs of their clients, without undermining health system policies. Respondents who advocated for systems change often did so on their own time, working outside of their organizational missions to provide direct health services or programming to educate others in their communities about the customs and needs of the cultures they represent.
- **Organizational culture plays an important role in how well organizations address cultural differences.** Stakeholders spoke to the importance of organizational culture for appropriately addressing cultural differences in health and well-being efforts. In this report, *organizational culture* is broadly defined and extends beyond wellness programs to include organizational commitments to diversity and inclusion among employees; efforts to improve job satisfaction; managerial processes; approaches to mentorship and performance reviews; and leadership and decisionmaking processes around mission, vision, and ways of working toward them. Several aspects of organizational culture were noted as important facilitators, including modeling health to the community (e.g., through food choices at meetings or policies that promote work-life balance) and ensuring that program staff at all levels reflect the diversity of the individuals they are working to serve. Stakeholders noted that it is even better when members of the community or clients

are brought on as staff or advisors. Stakeholders described ways in which these points apply equally well to local-, state-, and national-level leadership, in addition to local organizations.

Themes Related to the Use of Incentives to Promote Health and Well-Being

Stakeholders described ways that incentives are being used to motivate health and well-being at an individual level (e.g., to get individuals to adopt healthier behaviors, such as exercise) and ways that incentives are being used to motivate organizations or other investors to promote health and well-being. Several themes emerged as particularly important for how incentives may be used to promote health and well-being.

- **Incentivizing individuals requires a mix of short-term and long-term incentives that align with individual preferences.** Stakeholders who use incentives to promote health and well-being noted that there is not a one-size-fits-all approach to motivating individuals to take action. Those interviewed also noted the importance of time preference in structuring an effective incentive program, as people and businesses tend to act in their short-term interests, even though they may reap more benefit from a longer-term investment in health.
- **Closed-loop systems promote investment in individual-level incentives and facilitate sustainability.** While discussing issues of investment in and sustainability of incentives, stakeholders referred to *closed-loop* systems or settings, in which those paying for the incentives up front are the same organizations or entities that see the cost savings or, in some cases, increased revenue resulting from the incentivized behavior change. Stakeholders pointed out, however, that there are opportunities to close the loop within organizations that may help to advance workplace wellness. In many cases, the part of the company responsible for health insurance coverage (viewed as a corporate expense) is not aligned with health benefits and wellness programs (viewed as a benefit).
- **Not all incentives are monetary.** Stakeholders acknowledged that while monetary incentives play a role, personal goals may be an even stronger driving force for many individuals. Stakeholders noted that the key is to find the underlying motivation or reason why people are interested in making a change. Incentives can then be aligned to match each motivation. Identifying this underlying motivation is also critical for long-term sustainability of the activities because even if the incentive goes away, the underlying motivation remains. With respect to organizational or systems change, stakeholders noted that most impact investors (e.g., philanthropic individuals, banks) are also driven by health as a shared value and the opportunity to positively contribute to the development of community well-being.
- **Some incentive models, like Pay for Success (PFS), have the potential to act as a catalyst for systems change, but they require government buy-in.** Stakeholders commented that while the incentives structure embedded in PFS is a catalyst for change, the incentives themselves do not ensure that the change will be sustainable. In fact, the incentives currently in play in PFS models, usually private investment, are not seen as scalable without a broader belief on the part of the government that it can and should pay for successful outcomes resulting from services, as opposed to the amount of services provided regardless of their impact. Other stakeholders described the ways in which PFS models have encouraged public-private-philanthropic partnerships where they did not exist before.

Implications and Next Steps

Collectively, these findings point to a number of implications and potential next steps for thinking about fostering a Culture of Health in the United States. These implications are relevant not only for RWJF but also for others interested in supporting movement toward greater, equitable health for all.

- **Identify best practices for developing a shared definition of health within communities.** Health as a shared value was seen as critical to promoting a Culture of Health. Yet stakeholders reported that there is a need to balance a very broad definition of health that may be understood better by a more diverse set of stakeholders with a definition that is more narrow and thus more actionable. In the context of PFS, establishing shared definitions of target issues and outcomes across partners is a critical first step in the process. This suggests a need for best practices in developing a shared value of health at a local level that resonates across key stakeholders and community members but remains actionable. Literature related to stakeholder engagement and consensus-building identifies best practices for creating structures that allow for co-development of definitions and goals related to health and well-being. These include assembling diverse workshops with attendees from sectors including public health, city government, education, community-based organizations, and residents. Such best practices should be compiled into a toolkit for communities looking to build consensus around a definition of health.
- **Remove restrictions around diversity and equity efforts.** Diversity-related initiatives often have a narrow lens (e.g., they are targeted to a particular racial or ethnic group). While this is often by design and reinforced by funding that is earmarked for vulnerable populations, stakeholders noted that this can inadvertently cause inequities if such efforts and funds cannot be more broadly applied. Such findings point to the need to design funding opportunities that have diversity and equity as a focus but are not overly prescriptive regarding how funds can be used. Initiatives focused on addressing disparities or health equity should be crafted in a way that enables prioritization of priority populations but does not prohibit the opportunity for other community members to utilize or leverage the programs or resources that have been developed.
- **Institutionalize practices that ensure ongoing input from marginalized populations.** Community engagement, and particularly engagement of marginalized populations, is important to the success of any effort to promote health and well-being, as it helps to ensure that the programs, supports, and efforts developed align with the priorities and needs of that population. Stakeholders or other program staff should look to institutionalize best practices that ensure ongoing input from diverse and marginalized populations so that they have a continued voice at the table. Empirically based practices for empowerment, such as storytelling, and other identity narratives should also be spread and more widely adopted. Funders can encourage sustained community engagement by building it in as a requirement for funding or a marker of program success.
- **Create flexibility in funding structures for well-justified efforts to build trust among disadvantaged populations.** Funding is often tied to a budget cycle or specific short-term grant period, even though laying the groundwork to build trust often takes months or years. Flexibility should be built into funding structures for well-justified efforts to engage communities in dialogue, trust-building, and health promotion efforts. For stakeholders, this may mean adjusting expectations related to when the program may see a return on this investment. Funders may want to consider grants in smaller dollar amounts with minimal restrictions and longer time frames to support this very important but time-consuming effort. Such support can encourage thoughtful

and, as a result, sustainable engagement that can be leveraged to build a Culture of Health in the community.

- **Strengthen research around the role of organizational culture in promoting population health and well-being.** Building a Culture of Health requires a better understanding of how organizational culture directly and indirectly affects population health and well-being. While there is ample research on organizational commitments to employees' health and wellness through mainstream workplace wellness programs, examples of promising organizational practices related to building and maintaining a functional multicultural workforce and mechanisms by which employers are able to promote a holistic sense of well-being among their employees outside of workplace wellness programs are not well-studied. Moreover, more work is needed to understand the influence of the organizational culture of health-related organizations on the impact of their efforts to improve community health. Understanding these factors can point to potential organizational policies or practices that may improve the health and well-being not only of employees but also of their families and the broader community.
- **Identify ways to help smaller organizations overcome structural inequalities.** Local organizations committed to addressing health inequity or promoting the health and well-being of vulnerable populations often have fewer resources, reduced capacity to take on such efforts as data collection and sharing, and a smaller and already overstretched staff. These limitations create an often-insurmountable barrier to meaningful engagement in efforts to promote health and well-being in the community. These barriers also preclude such organizations from participating in some of the new PFS incentive models that require substantial up-front resources. Communities looking to address issues of equity should ensure that these smaller organizations are included in the dialogue. Funders and other stakeholders in a position to drive change should identify ways to help smaller organizations overcome structural and resource inequalities so that they can work as equal partners to address issues of health equity and promote the health and well-being of the populations they serve.
- **Institutionalize health promotion efforts in sectors other than public health or health care to sustain collaborative efforts.** Incentives, either monetary or nonmonetary, may attract initial collaborators or investors but are fundamentally only catalysts of collaboration. Research supports the idea that cross-sector collaborators should be engaged to take a sustained lead on efforts for health and well-being to create the system changes necessary to build a Culture of Health. Successful examples of these efforts have engaged the school system and other non-health sectors to implement health programming and collect health data.
- **Develop strategic approaches and tools for use by those who are interested in pursuing work in the Culture of Health framework.** The diversity of interests and needs across communities will mean equal diversity in readiness to pick up the Culture of Health framework and do something with it. Stakeholders may benefit from a set of strategic approaches and tools developed by RWJF to help them apply the Culture of Health framework in their own work to promote health and well-being in their communities. Such approaches and tools should reflect the key needs identified in this report—in particular, best practices for the development of shared values and long-term community engagement.

Acknowledgments

The study team is grateful for the support, oversight, and guidance of our colleagues at the Robert Wood Johnson Foundation—in particular, Carolyn Miller and Alonzo Plough. This report also benefited greatly from the assistance of David Adamson, who provided helpful feedback on its structure and writing. We also extend our thanks to our reviewers for their feedback: Jennifer Cerully, Donna Farley, and Paul Koegel.

In addition, we extend appreciation to the wide variety of stakeholders who shared their important work and perspectives about how culture and incentives can promote a Culture of Health.

Abbreviations

LGBT+	lesbian, gay, bisexual, transgender plus
NFP	Nurse Family Partnership
PFS	Pay for Success
RWJF	Robert Wood Johnson Foundation

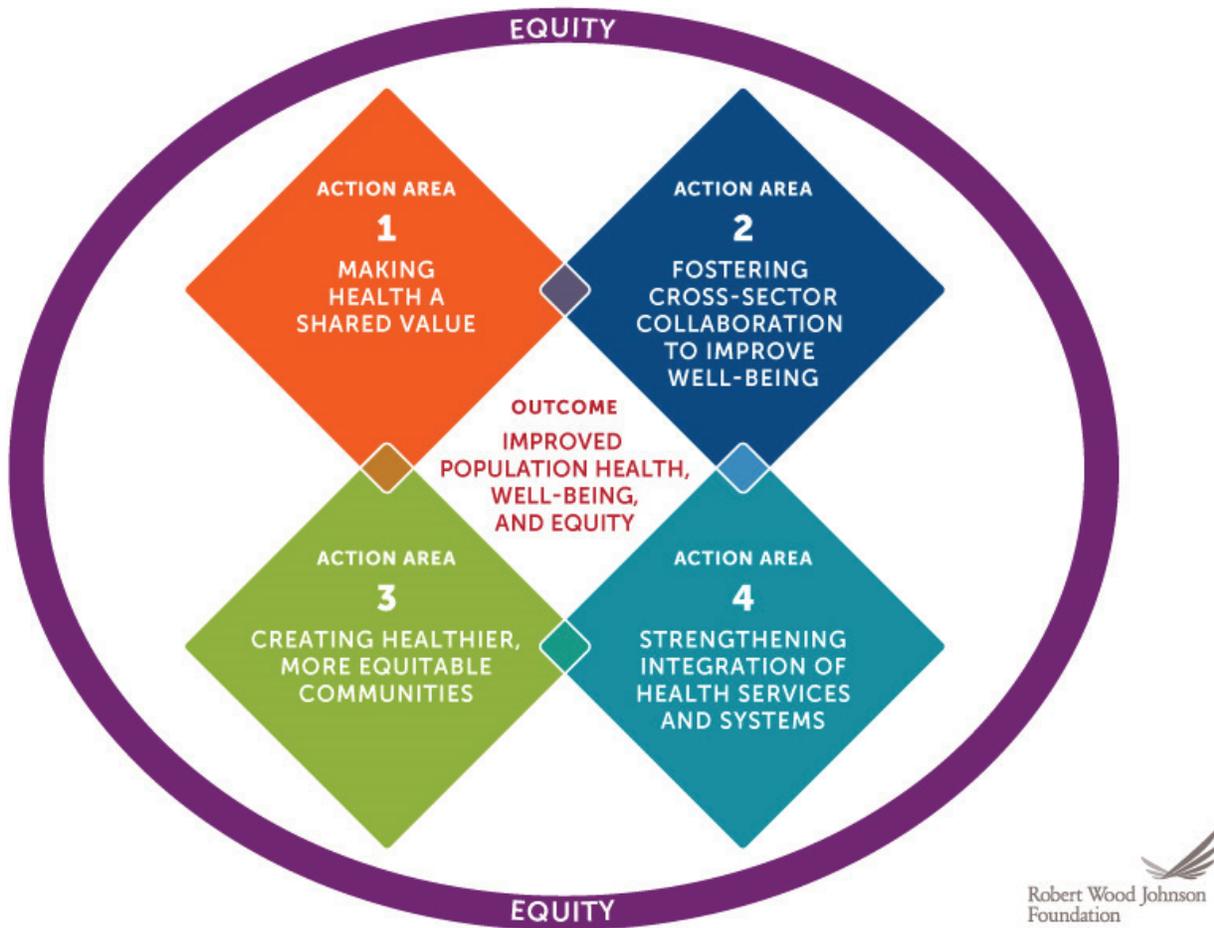
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Introduction

SINCE 2013, THE Robert Wood Johnson Foundation (RWJF) has led the development of a pioneering national action framework to advance a “Culture of Health that enables all members of our diverse society to lead healthy lives, now and for generations to come” (Plough, 2014). This Culture of Health Action Framework, published by RWJF in 2015, consists of four action areas and a fifth area focused on outcomes (Figure 1.1). Additional detail on the development of the framework and metrics can be found on the Culture of Health website (www.cultureofhealth.org) and in the RAND report *Building a National Culture of Health: Background, Action Model, Measures, and Next Steps* (Chandra, Acosta, et al., 2016).

Equity is an overarching theme of the Culture of Health action framework, both as it relates to health disparities and toward achieving health equity in the United States (Plough and Chandra, 2015). *Health equity* broadly refers to the opportunity of all to reach their full health potential, considering just and fair inclusion as a fundamental aspect of that opportunity (Braveman, 2014; National Academies of Sciences, Engineering, and Medicine, 2016; PolicyLink, 2014). Health equity is often conflated with eliminating health disparities, or differences between populations in terms of prevalence, incidence, or mortality as a result of health conditions (PolicyLink, 2014). However, health equity broadens the thinking about health disparities to consider the fundamental causes of differences: the social, structural, physical, and economic determinants of whether people can live their healthiest lives (Davis, 2015). Hence, health equity, along with population health and well-being, is an intended outcome of the Culture of Health Framework, but it is also embedded in the action areas, drivers, and measures that compose the framework (Chandra, Acosta, et al., 2016).

This framework is intended to catalyze national dialogue about action and investments to improve population health and well-being. This is a bold vision that relies on traditional health promotion actors (e.g., public health and health care systems) and new and innovative partners (e.g., economic development investors, city planning commissioners) to help create the changes in systems and communities required to improve health and well-being. In developing the Culture of Health framework,

Figure 1.1. Culture of Health Action Framework

SOURCE: RWJF.

we have learned more about the factors that play a role in driving systems change while understanding that the strategies for achieving a Culture of Health may not be the same in different systems or communities (Chandra, Acosta, et al., 2016). We need to consider the factors that drive larger systems change, such as resource investment across sectors and policy supports aimed at improving health (Chandra, Acosta, et al., 2016). But we also need to understand the factors that play into organizational systems change, such as alignment of vision and action, distributed leadership, promotion of staff engagement, creation of collaborative relationships, and the need to assess and learn from change with sensitivity to existing contextual values and beliefs within an organization (Willis et al., 2016).

RWJF was interested in understanding whether and how the Culture of Health framework has been used to advance action at the local, state, and national levels in the year since its launch. More specifically, the foundation identified two questions as central to deepening the Culture of Health effort:

- How can the commonly understood concepts of cultural identity (e.g., ethnic or religious; lesbian, gay, bisexual, transgender plus [LGBT+]; military) and organizational culture be harnessed to develop a Culture of Health?
- How can incentives be used to promote individual health and engage investors and leaders within organizations or governments to promote health and well-being broadly?

These questions were prioritized because recognizing and addressing unique identities and experiences of people bound together by culture (at organizational or community levels) is often viewed as the first step in social movement and cultural change (Chandra, Miller, et al., 2016). Incentives are critical first steps in catalyzing interest and action to change, long before that change is sustained or institutionalized as part of daily practice and policy. Taken together, culture and incentives are necessary first elements in embedding a Culture of Health within and across sectors (Towe et al., 2016).

This report draws on a series of interviews that RAND researchers conducted with stakeholders whose work focused on culture, incentives, or both and follows from an initial report on stakeholder perspectives, *Stakeholder Perspectives on a Culture of Health: Key Findings* (Acosta et al., 2016). The report summarizes the findings of 43 stakeholder interviews conducted by RAND to gain insights on these two areas of investigation.

Understanding How Culture Can Promote Health and Well-Being

Culture plays a role in beliefs and practices at all levels of societies, from individuals to organizations to nation-states. In developing the Culture of Health Action Framework, we paid extensive attention to how we were defining *culture* and how cultural factors influence implementation of the Action Framework and Culture of Health as a social movement. Drawing from a sizable body of research in anthropology, sociology, and other social science disciplines, we defined *culture* as the sharing and alignment of beliefs, attitudes, values, and actions across a set of individuals, organizations, and decision environments (e.g., where policies or laws are made) (Benedict, 1934; White, 1949; Kroeber and Kluckhohn, 1952; Geertz, 1973; Chandra, Acosta, et al., 2016). For the purpose of the Culture of Health, culture was considered to be a set of social ideas and practices that promote healthy individuals, households, neighborhoods, communities, states, and nations (Chandra, Acosta, et al., 2016). Despite being made up of individuals with diverse individual culture affiliations, communities with a strong Culture of Health can expect to share values related to the importance of health and well-being and can expect multiple sectors, including both governmental and nongovernmental institutions, to value and prioritize the health of their constituents and stakeholders. These communities also enable people to make healthy choices and maintain environments that favor healthy choices over unhealthy ones.

Notwithstanding efforts to acknowledge the diversity that can exist within a Culture of Health, stakeholders interviewed during the development of the framework expressed concerns that the phrase may not be seen as inclusive of all populations, particularly traditionally marginalized populations (Acosta et al., 2016). Specifically, stakeholders expressed concerns that culture can be interpreted as very personal and ingrained and not something that is mutable, as envisioned by the Culture of Health Action Framework (Acosta et al., 2016).

The impetus for conducting the current interviews on culture, therefore, was to help understand how people “of different cultural backgrounds encounter each other, seek avenues of mutual understanding, negotiate and compromise on their initial positions, and achieve some degree of harmonious engagement” with respect to health and well-being (Berry, 2005) and to understand how culture plays a role in health promotion (Chandra, Acosta, et al., 2016). Participants were asked questions about how health and well-being differ across different cultures and whether there are any specific cultural barriers or facilitators to building a Culture of Health or to using the Culture of Health Action Framework. Previous research also suggested that understanding variation in cultural values around health would be a way to adapt Culture of Health strategies to the needs and priorities of different groups

(Acosta et al., 2016). The research summarized in this report delves more deeply into these issues and identifies ways that such adaptation is already happening in communities.

Understanding the Role of Incentives to Promote Health and Well-Being

Incentives have been understood to play a critical role in motivating behavior since the 1940s. The complex changes required to advance a Culture of Health require us to understand how to motivate individuals, organizations, and sectors to participate in this process (Hockenbury and Hockenbury, 2003; Towe et al., 2016). Given the need for a multisectoral public and private collaborative effort to advance a Culture of Health, early stakeholder engagement efforts emphasized the importance of finding ways to make building a Culture of Health “good for business.” Several stakeholders working in health care talked about market-based solutions to encouraging a Culture of Health, including promoting businesses that are “triple bottom-line” sustainable, in which value is assigned to solutions based on their financial, social, and ecological benefits, and working with existing mainstream businesses to make the “business case” for fostering health (Acosta et al., 2016).

Incentives are also important for creating shared values of health within a community and engaging cross-sector collaborators, two critical components to building a Culture of Health (Chandra, Acosta, et al., 2016). To engage diverse and unexpected partners in health promotion work, incentives, including reputational benefits accrued from working on alleviating a recognized social issue or the advantage of a network of new partners that could be leveraged for future efforts, can be used to encourage sustained action toward prioritizing health and well-being (Towe et al., 2016).

Given the importance of incentives in promoting a Culture of Health on multiple levels, RWJF asked RAND to further explore stakeholder views on three types of incentives for health:

- incentives for investors to finance health and well-being
- incentives for companies to provide workplace wellness programs and invest in employee health
- incentives for individuals to make behavior changes that lead to better health.

Incentives for Investors to Finance Health and Well-Being

One innovative way that private investors are being incentivized to underwrite health and well-being is through Pay for Success (PFS) initiatives, also known as social impact bonds. These efforts are partnerships between (usually) private investors, such as philanthropies or banks; service providers; and public payers in which “impact investors” provide the initial funds to implement or expand evidence-based programs that provide social benefit (see Appendix A for more detail on PFS). Non-profit service providers manage the programs, and a payer, usually a government entity, repays the initial investor and provides an extra financial return if an impartial evaluation shows that the program has been successful. Investors’ incentives are twofold: First, they receive a financial return, paid for using a portion of taxpayer money that was saved by achieving the desired results, and the second, more altruistic incentive is knowing that their investment led to achieving a more cost-effective, value-based community benefit that would not have been possible without their support (Galloway, 2014). In addition, other kinds of social impact investing, in which investments are intended to generate a measurable social impact along with a financial return, are being undertaken by banks and community development financial institutions. Community development financial institutions are

mission-driven financial institutions focused on community development (e.g., Chicago's ShoreBank located in its South Shore neighborhood) that look to achieve social benefits but are also attracted by tax credits and other subsidies. Stakeholders interviewed for this research discussed their perspectives on these models as a means of promoting community health.

Incentives for Companies to Provide Workplace Wellness and Invest in Employee Health

Workplace wellness offerings and other preventive health programs for employees are widespread among major employers in the United States (Mattke et al., 2015). Programs offered by vendors and chosen by employers vary greatly in scope and intended outcome for their employees.

Evidence shows a return on investment for some forms of workplace wellness programs. Goetzel and co-authors (2014) note that programs that are effective in changing behavior can include strong management support, grassroots champions, and offering meaningful incentives to workers, but they note that additional research is needed to understand which program elements are best for different populations. While results of overall effectiveness and cost-effectiveness are mixed (Mattke et al., 2015; Goetzel et al., 2014), some studies have found there are other benefits to wellness programs, including better employee morale, reduced turnover, business profitability, health risk reduction, reduced sick or disability days, higher productivity at work, and increased quality of life (Ozminkowski et al., 2016).

Incentives for Individuals to Make Behavior Changes That Would Lead to Better Health

Many workplace wellness programs, health plans, and even some communities via "city wellness challenges" offer incentives to motivate healthy behaviors among individuals (Ozminkowski et al., 2016). Though the incentive theory (or reward theory) of motivation clearly supports the use of incentives for behavior change (Hockenbury and Hockenbury, 2003), evidence is mixed regarding the effectiveness of incentives for motivating changes to health behaviors, such as smoking, healthy eating, physical activity, and sustaining those changes (Strohacker, Galarraga, and Williams, 2014). More research is needed to understand the effectiveness of some widely implemented and currently inconsistently evaluated individual incentives programs (Blumenthal et al., 2013). Even so, Giles and colleagues (2014) find in a meta-analysis of more than 15 U.S.-based studies that financial incentive interventions encourage health behavior change more than usual care methods or no intervention.

To better empirically understand the roles incentives play, this report explores the various ways individuals and organizations are incentivized to work toward building a Culture of Health and lessons learned from those experiences.

How This Report Is Organized

In the remainder of this report, we present the study approach and findings from our stakeholder interviews. In Chapter Two, we discuss the study methodology and analytic approach. In Chapter Three, we discuss cross-cutting themes from our findings related to the importance of shared values, individual and community health, and data. Given the importance of equity to the Culture of Health work and to RWJF priorities overall, key equity themes emerging from this effort are also summarized in this chapter. Chapter Four examines themes related to culture in programs and policies as well as how

this work can be influenced by prevailing cultural norms in systems and communities. Chapter Five describes themes related to incentives to promote health and well-being. Chapter Six provides a summary discussion of findings, with implications and potential next steps for continued progress toward building a Culture of Health. Finally, there are three appendixes. Appendix A provides a detailed description of one incentives-based model we examined (Pay for Success). Appendixes B and C include interview and recruitment materials.

2

Methods

THIS CHAPTER SUMMARIZES our methodological approach to the identification and recruitment of stakeholders with expertise in how culture or incentives can be used to improve health and well-being at an individual, organizational, or community level. We conducted 43 phone-based interviews with organizational leaders whose work focused on addressing culture or using incentives to promote health and well-being. Interviews lasted about an hour and were conducted between mid-September 2016 and January 2017. Analysis began after the first ten interviews were conducted and was an ongoing and iterative process.

Identifying Respondents

We set out to conduct about 40 interviews, with an even balance between culture and incentives. For our interviews on culture, we sought to identify organizations that support the health or well-being of a specific cultural group. Here, *cultural group* was broadly defined to include cultures based on ethnicity or tribal affiliation and groups with unique perspectives or needs, including those in the military, LGBT+ populations, and geographically defined groups, such as those living in government-subsidized housing. We also included organizations that considered themselves to be multicultural by virtue of serving diverse populations. For our interviews on incentives, we sought to identify organizations that utilize incentives to motivate healthy behaviors or do work related to incentives or models, such as PFS, to motivate change at an organizational or community level. Potential organizations were identified through a variety of methods:

- contact lists from previous Culture of Health stakeholder engagement activities
- presenter lists from RWJF Culture of Health events, including the March 2016 event “Sharing Knowledge to Build a Culture of Health” and the April 2016 event “Building a Culture of Health: A New Imperative for Business”

- a review of published and gray literature, including an examination of a larger Culture of Health literature review effort to identify thought leaders in this space or programs or organizations identified in published case studies. Select keywords, used in different combinations, included “health” combined with “traditional culture,” “culture,” “social justice,” “neighborhood,” “shared identity,” “shared value,” “equity,” “community identity,” “incentives,” “return on investment,” and “workplace wellness.”
- Internet searches using similar keywords to identify organizations meeting criteria
- a “snowball” strategy (asking for recommendations for other individuals or organizations at the conclusion of each interview).

After assembling a list of potential organizations, we applied criteria to determine which to contact and in what order. We prioritized potential respondents in leadership positions, such as executive directors, or high-ranking employees with titles specific to our culture or incentives topics of interest (e.g., director of PFS initiatives) from organizations that met the following criteria:

- The language on the organization’s website or documents either explicitly referenced “Culture of Health” or could be directly related to one or more action areas to maximize contact with potential interviewees familiar with the Culture of Health.
- For culture interviews: The organization’s work addressed the health and well-being of one or more cultures (e.g., by race/ethnicity, religion, nationality, tribal affiliation, specific local culture) or had a program area or areas focused on specific culture(s).
- For incentives interviews: We prioritized organizations employing incentives for individuals to improve health and organizations potentially using the “business case” for a Culture of Health to drive change in communities.
- We aimed for a mix of geographic locations, organization types, and organization sizes, as well as a diverse mix of cultures served or incentive approaches.

Interview Protocol

We developed a semistructured interview protocol (see Appendix B) for culture and incentives interviews. The protocol was built from the objectives of the research as described previously: (1) to understand how the commonly understood concept of culture relates to attaining a Culture of Health and (2) to understand how incentives are being used to engage individuals, employers, and organizations in health promotion activities. We were interested in hearing about examples of work by stakeholders that align with the Culture of Health Action Framework and barriers, facilitators, and lessons learned from that work that relate to culture and incentives. Specific interview questions were developed based on recommendations for future research posed by an initial report on stakeholder perspectives on a Culture of Health (Acosta et al., 2016) and literature on culture, incentives, and health. For culture, for example, we consulted literature on cultural competency (Butler et al., 2016), acculturation (Miyawaki, 2015), ethnic identity (Brown et al., 2016), and health. For incentives, we consulted the literature on workplace wellness (Mattke et al., 2015), individual incentives for health (Lynagh, Sanson-Fisher, and Bonevski, 2013), and well-being-related PFS (Galloway, 2014) to develop the questions.

The three project staff conducting interviews reviewed the protocol and iterated on the ques-

tion set, adding probes and notes to further direct the interviews. In the final interview protocol, culture questions addressed the unique cultural context in which the interviewee worked, barriers and challenges to doing health work in a cultural context, and facilitators and barriers of adapting programming to achieve successful outcomes. Incentive questions delved into the ways in which the interviewee's organization used incentives to promote health and well-being, including what the incentives were, to whom they were targeted, how they were framed, and any assessment of their impact and ability to sustain changes.

The goal of the interviews was largely to explore diverse stakeholder perspectives on facilitators, barriers, and lessons learned. In keeping with this, the protocol and probes were designed to draw out details and explore the unique perspectives of each stakeholder. Interviewers met regularly to discuss progress, any misunderstandings that arose with the interview protocol, and gaps to probe in upcoming interviews.

Outreach and Scheduling

Potential participants were sent an email (Appendix C) that included information about the study, including specific references to the respondent's work, as well as a request to schedule the interview. We also included a summary of the Culture of Health Action Framework metrics, which is also included in Appendix C. If respondents agreed to participate, interviews were scheduled with one of three interviewers, according to availability. If respondents did not reply, a follow-up email was sent, followed by a phone call as necessary. If respondents declined to be interviewed, the response was recorded as such. Because identification of organizations was iterative, we invited participants in batches. We contacted a total of 87 individuals for interviews. Thirty-seven requests for interviews were not responded to; we received a notice that our email was not received (bounced back), or we received a notice that the interviewee no longer worked at the organization. Seven individuals declined to participate in an interview.

Conducting Interviews

Semistructured interviews were conducted via phone by one of three project staff. Conversations began with a general discussion about their organization, the types of activities currently under way that align with the Culture of Health Framework, and key barriers and facilitators to this work. Participants were then asked a series of questions about culture, incentives, or both, depending on their expertise.

Though interviews were structured around the established interview protocol, the goal of this effort was to obtain a diverse array of perspectives on factors related to culture and incentives. As such, interview questions were not consistent across interviews, and interviewers often tailored questioning to interviewees' areas of expertise or to fill an identified gap in our understanding of a given topic according to the way we conceptualized *cultures* and *incentives*, as described above.

Interviews were not recorded, but interviewers took detailed notes. Stakeholders who provided information on the PFS example included in Appendix A were given the opportunity to review the summary and gave RAND permission to include it in this report.

Overview of Interviewees

Table 2.1 summarizes the characteristics of the organizations included. In general, we were able to obtain an even distribution of interviewees discussing issues related to cultures and incentives, with a small group touching on both topics. Organizations that focused on culture served diverse racial/ethnic groups (e.g., African-Americans, Asian/Pacific Islanders, Latinos), Native populations, LGBT+ populations, military populations, and highly disadvantaged individuals in urban and rural settings. Organizations that focused on incentives represented perspectives related to community or organizational incentives to improve health, such as PFS models; employer incentives to improve employee health; and individual incentives via workplace wellness programs and the like that motivate healthy behavior change.

Collectively, the organizations represented were fairly well distributed on other characteristics, including type of organization (although the majority were nonprofit), geographic reach, size, and location (although slightly more respondents were from the northeast relative to other areas of the country).

Table 2.1. Characteristics of the Organizations Represented by Interviewees

Category	Characteristic	<i>n</i> (full sample) ^a	<i>n</i> (cultures) ^b	<i>n</i> (incentives) ^b
Topic of interest	Culture	20	20	—
	Incentives	17	—	17
	Both	4	4	4
Type	For-profit	6	2	5
	Nonprofit	24	13	13
	Academic	5	4	1
	Government	6	4	2
Geographic reach	Local	13	10	4
	State/regional	6	6	1
	National	15	3	12
	International	6	3	3
	N/A ^c	1	1	—
Size	Fewer than 20 employees	19	11	9
	20–50 employees	12	7	6
	More than 50 employees	10	5	6
Location	Northeastern United States	15	7	8
	Southeastern United States	2	2	1
	Midwest United States	5	3	3
	Southwest United States	9	6	3
	West coast United States	8	4	5
	Outside United States	2	1	1

^a 43 interviews were conducted with 41 organizations (two larger organizations included two interviews each).

^b The count of organizations by the culture and incentives categories includes those organizations focused on both, so these columns are not mutually exclusive and thus do not sum to the full sample count.

^c Academic organizations without a clear geographic focus to their work were assigned “N/A.”

Limitations

We recognize that there are many organizations or individuals not included in this study who work in areas of culture or incentives and who could provide additional insight into these important topics. However, due to the timing and scope of the project, we sought to identify a limited but diverse mix of perspectives that could help inform this work. Despite a fairly good distribution of organizations in the sample, nonprofits and organizations in the northeastern United States were overrepresented. However, this research was exploratory, and we did not set out to obtain a sample representative of the entire United States or of all organizations working on issues related to cultures and incentives. As a result, we do not believe that these limitations present a significant threat to the value of these findings. We also recognize that all data in this report reflect stakeholder perceptions of their barriers, successes, and lessons learned rather than a review of the effectiveness of initiatives described or a systematic scan of extant barriers and facilitators related to culture and incentives.

Analysis and Write-Up

The three team members who conducted the interviews collectively analyzed their notes to identify emergent themes across respondents following a general inductive approach to analyzing qualitative data (Thomas, 2006). All three read each set of interview notes and collaborated on a working document to summarize emergent themes into three categories: (1) themes relevant to understanding how culture, and addressing cultural differences in programs and policies, promotes health and well-being; (2) themes relevant for understanding how incentives are being used to promote a Culture of Health; and (3) cross-cutting or foundational themes raised by both sets of stakeholders as particularly relevant for their work promoting a Culture of Health. They consulted the literature and previous stakeholder engagement work (Acosta et al., 2016) to determine the extent to which emergent themes reflected what was already known about health promotion in a cultural context and the use of incentives for health and prioritized nuanced descriptions of themes and subthemes in the analysis and write-up, rather than looking for consensus across interviews.

This report is organized around emerging themes within the culture and incentives domains and within RWJF's priorities of applying the principles of Culture of Health to equity.

3

Cross-Cutting Themes: Shared Values, Community Health, Data, and Equity

ALTHOUGH THIS PROJECT set out to capture perspectives from two sets of stakeholders, those working on issues of culture and those using incentives to motivate health and well-being, several themes emerged as cross-cutting and foundational to promoting health and well-being at multiple levels. We present these themes first, as they provide helpful context for themes specific to culture or incentives presented in Chapters Four and Five, respectively. These cross-cutting themes include the importance of establishing health as a shared value, highlighting community health as well as individual health, and the importance of data and data sharing for transparency and accountability. Also included in this chapter are several themes that emerged related to addressing equity.

Establishing Health as a Shared Value Is an Important but Challenging Step in Promoting Health and Well-Being

Valuing health and well-being is foundational in building a Culture of Health. Achieving a shared understanding of health as a cultural value is enhanced by a stronger sense of community, civic engagement, and a shift in community members' mindset and expectations about health and well-being and who is responsible for them (Chandra, Acosta, et al., 2016). Stakeholders consistently raised the notion of these shared values as an important consideration when describing their work, regardless of whether they were addressing culture or using incentives. However, many stakeholders noted that developing these shared values is challenging.

Culture

Stakeholders whose work involved supporting specific cultures and addressing cultural considerations for promoting health and well-being described an array of opportunities for creating a shared value of health that is rooted in cultural beliefs. Some stakeholders described ways they were able

to capitalize on prevailing cultural factors within the community to advance their mission to promote health, such as the value of well-being and family. One respondent explained, for example, that she was fortunate to work in a community that naturally understood the value of good health for all, “where a lot of people are on board and are aware of the evidence of how health behaviors impact well-being and quality of life.” As a result, this city-sponsored health and well-being program was able to rely on cross-sectoral partners like the public school system to help with information dissemination, data collection (e.g., on student body mass index), and other health promotion activities.

Another leveraged the deep religious beliefs of the cultures she was trying to support and was able to use her connections with leaders in the local churches who had an interest in promoting the health and well-being of their respective congregations as a means of entry into the community. By partnering with local churches, this respondent was able to build trust, utilize natural opportunities to talk with residents about health priorities, and understand the ways in which health promotion could build upon existing shared values.

A number of respondents also described family as a critical facilitator to the success of health promotion activities, noting that prevention efforts that emphasized maintaining health and quality of life in order to “be able to be there for one’s family” were particularly effective with some cultural groups. Stakeholders were able to utilize cultural beliefs about the importance of family to motivate their patients and constituents to engage in preventive behaviors or adhere to a chronic disease treatment plan.

Stakeholders who worked with Native American populations in a variety of settings noted that the holistic ways in which some Native populations think about spiritual, physical, and mental well-being facilitate health promotion. Integrated mental and physical health, complementary Western (i.e., health care providers, such as doctors and nurses, using medicines, surgeries, and devices to treat disease) and traditional (i.e., practices, theories, and beliefs rooted in cultural traditions and experiences) medicinal approaches, storytelling as a therapeutic approach to mental health, and cultural adaptations of health promotion (e.g., Native dance as an option for physical activity) are all ways in which stakeholders used culturally informed approaches to health that contribute to shared values. Additionally, stakeholders described building health and well-being around shared values and traditional connections to nature, water, and other natural resources.

While cultural beliefs can be leveraged to strengthen health and well-being efforts, other stakeholders noted that cultural beliefs related to how people think about health and disease, including causes of chronic disease, can also pose a barrier to achieving a shared value around health. One stakeholder described that some communities “have [a] more accepting approach to diseases like diabetes, hypertension, and cancer” and a more fatalistic set of philosophies around disease, which conflicts, at times, with health promotion messaging. Stakeholders observed that while it is critically important to acknowledge these perspectives, such perspectives can be a barrier to creating a shared approach to health.

While shared values can form a powerful foundation for promoting health and well-being within a cultural group, establishing shared values across different cultural groups is more challenging. Stakeholders who worked with populations new to the United States or to traditions of Western medicine, for example, described circumstances in which their efforts to connect people to health care or advance efforts to prevent chronic disease were inconsistent with the cultural beliefs of those with whom they were working. One stakeholder put it concisely: “Health is a shared value, but our definitions of health or values around health may not be others’ values.”

Another respondent working in a multicultural community with large immigrant populations raised an important point about the tension between shared values around health and real-world barriers to achieving health in the United States, particularly among disadvantaged or disenfranchised populations. This stakeholder noted that although there is often an interest in achieving or maintaining health and well-being among immigrant populations, some individuals may struggle with basic needs, such as securing income, housing, or food, when they come to the United States. These tensions are similar to those experienced by nonimmigrant populations but can be particularly challenging for individuals who may not be linked in to existing safety net programs:

A lot of the cultures we're trying to serve come from countries that value health, that have the same values we have in the U.S. about health, eating well, good food, and active living. But this [value] shifts a bit for many who immigrate over here due to jobs they get, economic challenges, housing access, etc. . . . It shifts their priorities.

A final challenge raised by stakeholders arises around terminology and how different cultural groups understand and use the term *health*. In one case, a stakeholder discussed gun-violence prevention efforts in a nearby community. The community held shared values and objectives related to reducing common occurrences of gun-related death and injuries but did not necessarily perceive this as a health issue:

Language matters . . . the word *health* doesn't resonate with every group. So if you are working with a community group worried about gun violence . . . "gun violence" is the term they use every day, and they have a committee looking at that [issue] in the community. As a public health person, I know the broader impact of gun violence as it relates to toxic stress, health issues, the far-reaching health effects. But when you are actually in the trenches, all [these community groups] want to do is figure out how to stop people from shooting each other.

Another stakeholder also mentioned that when working with diverse populations as a physician, the term *multicultural* can be seen as less inclusive than intended, which may create a barrier to identifying and building shared values, particularly if some cultural groups feel excluded:

The term *multicultural* was meant to be inclusive, not exclusive, but the perception is that most European-based groups in the U.S. typically see everyone but themselves in that term. So if you come along and start talking about terms like *race*, or *multicultural*, the [non-Hispanic white] majority sometimes feels excluded, but what it really means is everyone is welcome, and what we want is for you to respect everyone else by learning about others, and that's how you can treat them best, rather than just making judgments as a physician.

Incentives

Stakeholders whose work focused on using incentives to promote health and well-being also emphasized the importance of shared values. This was particularly true for participants working in the PFS field. These respondents noted almost universally that their work aligns with the Culture of Health action areas of making health a shared value and fostering cross-sector collaboration. Many were involved with projects outside of traditional health work, including community development, early

childhood education, and housing. The PFS approach, for example, is inherently cross-sectoral: It brings together investors (often from the business or philanthropic community), nonprofit service providers, payers (often public agencies), independent evaluators (often academics), and usually technical assistance contractors or intermediaries.

Many respondents asserted that establishing shared values and engaging cross-sector partners were foundational steps for the PFS process, as well as for other health promotion efforts involving incentives. Respondents described the PFS process as emerging out of a cross-sector understanding of a shared problem and agreeing on an effective solution. Some stakeholders noted that the collaboration and shared values often came ahead of the PFS process:

Projects usually come together around a shared disappointment in the status quo. Recognition by nonprofit provider, philanthropy, agency staffer not seeing anything change despite efforts. . . . Basically, [PFS projects] emerge as a response to the ineffectiveness of the current solution.

Others responsible for brokering PFS efforts described strategies for creating and maintaining this sense of shared purpose and commitment to working across sectors, one of which included efforts to get diverse partners to see the benefit of the proposed effort from multiple perspectives and to establish a shared, concrete objective. The various partners involved with the effort were motivated by the idea that their mission and organizational goals were also tied to the initiative's health outcomes of interest. Framing these mutual benefits is often a task for intermediaries or consultants offering technical assistance to a local PFS effort. As one stakeholder described:

Our entire existence is based on creating incentives to align diverse stakeholders around shared outcomes like child and maternal health. How can we [frame] low birth weight as a shared good? Not just for the baby, but the resident and taxpayer or governor? That is the way we design [these efforts]. We want government to put a price on that outcome and know [service providers] can do a good job [at achieving it].

Other stakeholders echoed the importance of strategic communications to make the case that a health outcome is relevant to nontraditional or previously unengaged partners and that the work aligns with efforts they are already engaging in.

It's almost like a translation role because different parties look for different [aspects] . . . how do you articulate [these benefits] to different clients?

A lot of what we do is storytelling. . . . A lot of people I meet in these other sectors don't always recognize [the connection of health to the work they do] and aren't trained in up- or down-stream efforts, but they learn quickly.

Because the process of designing, implementing, and fully executing a PFS project is very complicated, stakeholders were adamant that unless shared values were at the core of the process, the project would not succeed. Respondents noted that coming to a shared set of definitions was seen as critically important to the process of formulating shared values, which can be especially difficult when thinking about health:

We need more clarity around what we mean by "health." [We] talk about health as the absence

of disease, Culture of Health, well-being, personal agency and choice, nonmedical determinants of health (in that case, “everything is health”). Pay for Success requires you to be very specific about what you are trying to accomplish, how you’re going to measure it, counterfactuals. Clarity around those definitions and metrics would help. What do we mean by better health that would make these deals easier in a health context?

There Is a Need to Acknowledge the Importance of Both Individual and Community Health and Well-Being

Related to the notion of shared values, participants reported a need for better acknowledgment of and balance between individual and community health and well-being. Participants noted that in the United States, there is more emphasis placed on the former and far less attention given to the latter. This may be due, in part, to a lack of understanding or agreement about what community health is (Goodman, Bunnell, and Posner, 2014). While there is no single, agreed-upon definition, community health “refers to the health status of a defined group of people and the actions and conditions, both private and public (governmental), to promote, protect, and preserve their health” (McKenzie, Pinger, and Kotecki, 2011). The group, however, can be defined based on geographic location (e.g., city) or shared characteristic (e.g., youth or employees of a company). While the notion of community healing in many cultures can be leveraged to achieve more widespread community benefits, it was perceived by many stakeholders as a foreign concept in the United States.

In the Hispanic community, commitment to family and faith are assets and have an epigenetic effect, but as part of individualistic society in the U.S. it is very hard to maintain these priorities and consistently see their positive effects.

One participant described this phenomenon as the “culture of me,” noting that this focus on the individual is perhaps a bigger impediment to achieving a Culture of Health than any given multicultural issue.

You are never going to get to a shared value and to a collective and responsive allocation of resources until you get over the culture of me.

Participants noted that this tension between individual and community can be seen among organizations as well. Several stakeholders, for example, discussed coalitions or other collective efforts to address a community need but noted that not all organizations opted to participate, even if their work was quite relevant to the broader mission of the group. While organizations may have different reasons for refusing to participate, participants speculated that there may be concern about endangering their own funding or becoming less relevant in the larger solution over time. Because these are real and valid concerns, more work may need to be done to better understand how to help organizations, specifically, see the value of more collective and collaborative efforts.

Similarly, stakeholders pointed to the importance of ensuring that business and governmental leaders have a strong understanding of the value of community health and well-being, given that they are often responsible for priority-setting and resource allocation for the short and long term. When discussing the ability to successfully implement evidence-based community health programs using innovative incentives programs, stakeholders commonly expressed a lack of buy-in from government

leaders as a barrier. Stakeholders did note that some governmental leaders and agencies are actively promoting community health and well-being and could provide important best practices for others. Similarly, while there are many business leaders who value and prioritize the health and well-being of their employees, one stakeholder noted that “executive whim” is often the driving force behind the strength (or lack thereof) of workplace wellness programs or other health-related investments. Furthermore, there is often a disconnect between the leader’s perception of how easy it is to maintain health and well-being and the barriers that many of their employees or the broader community may face in trying to achieve these outcomes.

The kind of person who achieves executive status is well organized, driven, well educated, intrinsically motivated. They have no problem accomplishing. When it comes to taking care of themselves, there is this attitude of (and this is a direct quote from a CFO who eliminated an entire wellness department): “What do we need wellness for? I take care of myself and I work out and run, why can’t everyone do that for themselves? I can do it, why can’t you?”

These findings suggest that there is more work to be done across the board, in the context of both culture and incentives, to message the importance of *both* individual and community health and well-being. While the definition of community may vary for each person depending on his or her setting and role, stakeholders noted that there is inherent value in conceptualizing health and well-being as more than an individual outcome. Community health and well-being may be able to strengthen, buffer, or support individuals as they work to improve or maintain their health and contributes to thinking about health as a shared value.

Data Can Support the Development of Shared Values

Stakeholders cited data, and in particular the sharing of data, as an important facilitator for building a Culture of Health in the community. They noted, for example, that data on health and well-being, population characteristics, the utilization of health and social services, and the financial impact or burden of that utilization can be very useful to help align diverse stakeholders around a priority concern. Data, in the form of maps, can help stakeholders visualize the distribution of health and well-being (or lack thereof) and see potential overlap in populations served or where resources may be shared and leveraged. Data can help diverse coalitions come to an agreement around their shared priorities and also help traditionally non-health sectors (e.g., housing, transportation) see the impact of their work on the health and well-being of the community. This was particularly important for stakeholders working to involve cross-sector partners in efforts to address health and well-being, especially those working on PFS programs that require data collection and analysis to predict outcomes and then assess whether they were achieved.

The focus on data has been helpful—data is a common platform. It gets people to agree. With different housing departments, who don’t think about how they relate to pediatric asthma, we try to use data and outcomes to center everyone around a shared outcome, and as a result get the focus for everyone on preventing a negative outcome—for example, the number of ER visits [due to pediatric asthma as a result of poor housing].

Additionally, data, along with storytelling based on the data, such as the impact of programs on

real-life families to contextualize statistics, were described as particularly influential tools for stakeholders to raise awareness of issues in their communities and to make the case for funding. Particularly for respondents who represented minority populations, data were particularly valuable, if rare, tools to begin to address some of the priorities of their constituents. One stakeholder observed that the lack of data on the populations served by the group made it challenging to do their work, so a large part of the group's efforts was focused on collecting data "to develop reports, and for advocacy activities and grant writing."

Stakeholders noted, however, that more effort could be made to share this information with each other and with the community. Although pockets of data are being collected, they are not always being leveraged, connected, or disseminated in a way that enables an assessment of broader impact.

What worries me is that I see little efforts here and there to integrate [data], but these are important systems and records. So if you talk about how you improve outcomes and make cases across systems to make sure they are available collectively, you need robust data, which is not easy.

We don't do a good job of sharing that information with the community. . . . Even a year ago you would not have seen the types of data on our webpage as you do now, with different frequencies of data. We are better at FAQs [and] infographics of what we are collecting.

A final challenge noted by stakeholders is that robust data collection and sharing may be challenging for smaller organizations because the cost and resources required for data collection, data storage, and analysis may be a significant barrier. This may perpetuate inequities in the health system if data from marginalized populations are less likely to be available.

Equity

Given the importance of health equity to the Culture of Health Action Framework specifically, and the priorities of the RWJF more broadly, this section summarizes specific themes related to health equity. These include acknowledging that addressing health equity requires integration, collaboration, and a broad perspective; challenges with addressing health equity in silos; understanding how structural inequality can affect health equity; and the reality that addressing equity takes significant time and resources.

Stakeholders Spoke of Equity as Requiring Integration, Collaboration, and Thinking About Health Equity from a Broader Perspective Than Just Health or Resolving Health Disparities

Health equity is a complex and multifaceted issue that requires action at multiple levels. Perhaps the most straightforward approach, and one that can be implemented by individual organizations, is to consider issues of equity in the design and implementation of programs.

We have not necessarily made many adaptations for the different cultures in our community, but we have changed where we've prioritized the work to take an equity perspective. The [work on creating] complete streets, safe routes to school, infrastructure changes has been in more lower-income, Latino neighborhoods.

However, when discussing issues of equity, stakeholders noted that addressing health inequities will not be fully solved by one organization, or even by one sector, alone and requires more than targeting or adapting interventions to disadvantaged groups or cultural contexts. Stakeholders pointed to the importance of having policymakers (whether within an organization or community) as a partner in these efforts—for example, policymakers such as those who have influence on systems outside of public health.

The other thing with equity is that the policies related to environmental system change are important because that is [how we can] improve those issues.

Stakeholders noted that policies and data can be important tools for addressing health inequities, but one challenge is that current approaches to measuring equity are not well developed.

We at this time don't have equity measures but are working to try and develop those, but our city has developed an equity office.

Stakeholders also felt that addressing equity requires keen attention to the historical causes of health inequities (e.g., historical traumas, processes of marginalization). One stakeholder working in mental health described the value of this approach, especially when considered within the context of health and healing. While there is a perception that marginalization of members of certain cultural groups and vulnerable populations may be increasing in the United States, respondents reinforced that there has always been a need to address historical trauma as part of any health promotion activity with these populations.

Research shows that in Native communities, structural inequality, oppression, and historical trauma play a role in the ability of people to heal. In order to heal, you have to heal the path and change inequality through empowerment and understanding how the world works.

Stakeholders also cited the importance of taking a social activism and community resilience approach when addressing root causes of health inequity, including variable access to important social services and basic needs, such as affordable food, stable housing, and safe neighborhoods. Stakeholders raised concerns that while steps are being taken to address these issues, many interventions that operate at the individual level, and even some within specific communities, may be considered quicker fixes without a commitment to facing and collectively solving the deeper root causes of health inequity.

We're getting roses that come out of the concrete, but we're not working to change the concrete. Their schools, families, communities have it so hard. How do we build interventions that change the concrete?

You have to value people and value comes from experience. The huge barrier is the separation from a race and class perspective. We are more segregated than we were 60 years ago; it is a system, class, economic issue. I don't have the answer, but we have to figure out how to be more comfortable with each other. If we stay isolated, we will [be the same] five years from now.

Equity Is Often Addressed in Silos, Which Impedes Progress Toward a Unified Goal of Health Equity for All

While the majority of stakeholders we interviewed were working toward a goal of health equity and the best health outcomes for all, most were leaders of organizations working with specific populations or on certain health-related topics, including LGBT+ rights, Hispanic health, and Native American mental health. However, stakeholders acknowledged a key barrier: Equity is often addressed, and funding is often distributed, in silos by racial, ethnic, gender, or military identity or status, which impedes progress toward a unified goal of health equity for all. Stakeholders noted, for example, that collaboration between organizations serving different racial or ethnic groups is often hindered by funding mechanisms that divide or place limitations on how funds can be spent by racial or ethnic groups.

Initiatives around men of color are missing or not really embracing a gender justice framework that transforms all of that. Gender justice is not just a side issue, but a core issue that is embedded in the colonization of indigenous communities and impacts communities of color across the board (and really everybody). I don't think the conversation about racial justice can happen without the conversation of gender justice, and vice versa. For all of these efforts working in equity: The cultural piece is so critical. Those leading the work for racial justice don't really have an understanding of gender justice.

Structural Inequity Among Organizations Serving Different Communities Can Pose a Barrier to Progress

One challenge raised by stakeholders is that smaller organizations working to support disadvantaged and marginalized populations are often at a significant disadvantage relative to larger organizations or systems with respect to access, data, and resources. Such structural inequities, in turn, can pose a barrier to addressing issues of health equity because the organizations that need to be at the table and be part of the solution have a relatively smaller voice.

This theme was also noted in the context of PFS. While stakeholders generally perceive that PFS encourages diverse partners to come together around shared values and that it has resulted in more diverse partnerships than have historically been assembled, others note that the complicated nature of PFS projects can reduce the diversity of participants and potentially further disadvantage those organizations with lower capacity, which are often those serving or representing more vulnerable populations. As a result, there may be more work to be done to better engage traditionally under-represented and underfunded organizations in conversations about equity and objectives related to health and well-being.

There is a structural inequity within the sector: Larger or better-capitalized organizations, they have greater access. Not that they aren't doing good work, but there are a lot of smaller community-based organizations who don't have the access to consultants for capacity-building and training, grants, technical assistance, etc., and they are at a structural disadvantage.

Addressing Equity Takes Time and Effort

Stakeholders reported that addressing equity takes significantly more time and effort than is often anticipated. Beyond the time and effort required to ensure equitable access to culturally and linguistically appropriate information, programs, and services, organizational leaders and other stakeholders are often involved in significant work outside of their day-to-day service provision to educate those in other systems (e.g., universities, health care systems, governments) on issues related to equity and approaches to addressing health inequity.

To do great health equity work requires interrupting business as usual and to take risks. It's one thing to be conceptually committed to the work, but the work—to change how you do things and turn a mirror on ourselves to be open to working in communities in a different way—it takes time.

Conclusion

Given the importance of shared values and equity to fostering a culture of health in America, themes raised by stakeholders provide important insights for RWJF and others working to promote a Culture of Health. Building a Culture of Health requires a broad perspective and approach. Stakeholders highlighted the importance of integration and collaboration across multiple stakeholders and systems and the need to identify ways to develop shared values and definitions of health, including using strategies to align individual organizational missions with health outcomes of interest that tend to motivate diverse partners to be involved. Without such integration and alignment, efforts to address health, well-being, and equity can occur in silos and impede progress. Structural inequities also pose a barrier, suggesting that concerted effort and attention is needed to ensure that smaller organizations with fewer resources have a voice and contribute to proposed solutions for promoting health and well-being in the community.

4

How Attention to Culture and Cultural Differences Can Promote Health and Well-Being

BUILDING A CULTURE of Health necessitates recognizing and addressing the diversity of cultures in the United States. As noted in earlier chapters, we defined culture broadly to include not only groups of individuals based on ethnicity or tribal affiliation, but also the experiences, perspectives, and beliefs of groups of people with unique needs, including military-connected individuals, LGBT+ populations, and economically or geographically defined groups (e.g., in government-subsidized housing). Stakeholders working to address the unique cultural needs of the population discussed the push and pull of adapting messaging and interventions for different cultural contexts, as well as the challenges with and benefits of conducting community-engaged multicultural work while recognizing that larger political factors and factors of marginalization are at play. This chapter delves into themes related to making culturally informed adaptations and incorporating the voice of specific cultural groups into programs and policies that promote health and well-being, as well as considerations of the resources required to do the community engagement and adaptation necessary. This chapter also explores emergent themes related to the influence of prevailing cultural norms on systems design and processes, as well as how norms in organizational culture can impact the ability of organizations to do culturally informed work.

Addressing Culture Presents Opportunities and Challenges

Stakeholders noted that they adapted programs and messaging about health and well-being to fit the cultural context of the populations they serve. Common best practices include ensuring that materials and messages are translated into appropriate languages and written at a suitable and accessible reading level. Stakeholders also reported the importance of reflecting cultural values, history, and practices on health and well-being efforts. Stakeholders provided examples of adaptations for nutrition-related programs based on ethnic cuisine and an emphasis on cultural dance or movement as a way to promote physical activity. One stakeholder group noted, for example, that it had engaged

Brazilian immigrant residents in local urban agricultural efforts, building on traditions of farming in their communities of origin, to facilitate wellness and access to a range of nutritious foods familiar to that population. Another stakeholder noted, for example, that lacrosse is a traditional healing game of the Iroquois, so in teaching it to the children in the community, the Iroquois promote not only physical activity, but also a deeper connection to their culture. Still another stakeholder noted:

Our teaching faculty do a lot of work on indigenous ways of knowing and indigenizing their curriculum; there is a lot of support around that.

Cultural adaptation, in some cases, may also include rectifying traditional health promotion messaging with cultural norms. For example, smoking has traditionally been an important part of cultural ceremonies and celebrations among Native populations. As a result, one stakeholder described an adjustment from the standard anti-tobacco messaging to anti-tobacco *company* messaging. Finally, stakeholders noted that many cultures have a more holistic mindset with respect to well-being, so it is not uncommon for programs to address spiritual well-being and healing in addition to physical and mental health.

Stakeholders also emphasized the importance of having a strong connection to the cultures within their communities of interest. Some reported that it is very important and helpful to have staff members who share the same cultures as the individuals the programs serve. Others mentioned that it is critical to understand who the trusted leaders are within a community. These individuals may not be in positions of official leadership or power within the community but can be instrumental to the success of health and well-being programs.

Always nice to have staff as role models who look and talk like you to understand you and your family. Don't have to do additional explaining, Native staff "get it."

It is also very important to understand who people listen to in the community. If you have a multicultural organization, it is not just a language issue; it is an issue of authority.

These connections can serve another important purpose as well, which is to help ensure that the design and topic of the program or health-related initiative truly relates to what that cultural group is seeking. As one respondent stated, "interest in initiatives differs by cultural group." Other stakeholders reported on the importance of allowing the cultural or community leaders to spearhead health and well-being efforts in ways that align with their customs and beliefs, with organizations and health professionals playing a more supporting or technical assistance role. They noted that projects are often less successful when cultural leaders are brought in to support efforts after they have been designed.

Although for many programs best practices include adapting health and well-being efforts to the various cultures served, not all stakeholders reported taking this approach. One program serving individuals separating from the military, for example, had as its objective to help veterans transition back into civilian life and *away from* the military culture that they had been experiencing for many years. Such efforts are intended to help service members assimilate back into their home, work, and community life, which is critical for overall health and well-being.

What we are trying to do here is to help them put down the rifle and become a civilian. What we try to do is expose them to as much nonmilitary life as possible; we teach them how to dress for

interviews and for work, how to change their language, and how to interact with others. We are helping them to assimilate. If they can hear and see how civilians are dressing and acting, then that will help.

Despite many reported successes, adapting health and well-being promotion to cultural contexts can be particularly challenging. One challenge is that translation and cultural adaptation take time and money. From a practitioner perspective, having the time and financial capacity to properly engage the community and address multiple cultures is a significant barrier to addressing the full range of cultures that may be served by the organization. Another challenge is that “diversity initiatives” often have a narrow lens (e.g., targeted to a particular racial or ethnic group) and do not account for all of the cultural groups served by the organization. Even within a defined “cultural group,” there may be significant diversity, which can be a barrier to approaches to promoting health and well-being.

Culture is a little complicated because we are working in an intertribal community with over 50 tribes represented. Some of those tribes are close (15 minutes away), some are in other states. Families have a broad array of assimilation. On one end, some families retain their traditional tribal language and customs; on the other end, they speak only English, [and have] little knowledge of traditional customs. We are mindful of that, we understand not everyone is going to have the same exposure or desire. How we’ve tried to address it is by addressing [health and well-being through] our organization’s core values.

A possible unintended consequence of public-facing health campaigns through various media platforms, such as billboards, that are targeted or tailored to specific cultural groups is that the campaigns may not portray the groups in a way that represents them accurately and positively. This can be challenging because campaigns need to speak to the target population and reflect their culture in words and imagery, but campaigns that associate certain groups with negative outcomes can reinforce stereotypes and have the opposite effect on target groups. One participant who works with African American women and their health needs emphasized that

What is important is how women see themselves, and if they see themselves in the way they get portrayed. . . . You need to be portrayed positively. If we don’t focus on that, and we only focus on the statistics . . . you don’t get any hope. We need to communicate [that] there is hope.

Some stakeholders described how the cultural groups they worked with, defined by race, ethnicity, nationality, religion, sexual orientation, etc., are often at risk for marginalization, which respondents described as having wide-ranging health and well-being impacts for individuals and communities. A final challenge noted by stakeholders was that “in this political climate, culture is viewed negatively.” Stakeholders noted that there is often a misunderstanding of traditional cultures in the United States, particularly with respect to immigrants, adding an additional layer of complexity to their ability to address health and well-being through a cultural lens.

Members of Specific Cultural Groups Need to Be Given a Voice in Health-Related Activities to Reach the Outcomes They Desire

To ensure that projects and activities implemented in communities reflect those communities’ needs

and desired outcomes, representatives from the community need to participate. Stakeholders pointed out that community participation and buy-in matters a lot for the success of the effort, and discussions with communities should include a diverse mix of people, particularly representatives of marginalized populations for whom the effort is being developed. Stakeholders pointed to a number of different approaches to ensuring this voice, including in-person meetings that allow and encourage presentations of individuals' particular experiences and the use of digital storytelling platforms (e.g., videos). Regardless of how individuals are engaged, stakeholders noted that by providing a space and platform for all individuals to communicate, they are helping to ensure that the most oppressed have a voice at the table, helping individuals see the value of participating in discussions about health and well-being, and helping them to see that they do have power to make change.

As a community, wellness and health starts at trying to address those issues that have the broadest impact—education, poverty, inequality. That speaks back to multicultural issues. Communities that are most successful are the ones that include people at the table.

We want to make sure authentic voices are a part of the process from beginning to end, not just at the end. It's important to engage community residents and create [a] safe place to be part of that process. Volunteer engagement is very different. Not just agencies. . . . the consumer themselves.

Our belief is that by giving power to and lifting up voices, the parts of community experiencing health inequity will lead to changes we seek, not doing to them but letting them lead and finding the solutions that will work for the community.

Given the importance of giving all individuals a voice and ensuring that the voice gets translated into actionable steps that align with need, stakeholders identified a number of key considerations for success. First, stakeholders said that it is important to be regularly engaged with the community and to have staff members present in communities, talking to individuals about their experiences, needs, and preferences. They noted that this is different from one-time focus groups and requires ongoing interaction that aligns with the availability of the individuals one is trying to engage, rather than the other way around.

With health care for the homeless . . . we take the time. We don't rush to get people in and out. People have multiple issues, and our team is fabulous, very committed to the work and go above and beyond. For example . . . our staff went at 5 a.m. to meet with some [homeless clients] to ensure they are connected to services. Because by early morning, 8 a.m., they are gone.

Stakeholders cautioned, however, that there is an important distinction between the voice of the people and the voice of advocacy organizations that may represent the disadvantaged populations. While advocacy organizations can provide a powerful voice for traditionally marginalized populations, having these types of organizations at the table can supplement, but should not replace, the direct voice of the populations of interest. Still, there was recognition that the voices of these organizations are very important, particularly for elevating concerns to public officials at state or national levels.

At the same time, I think there needs to be a dialogue, and that's what we promoted from the grassroots level. Not just community level, but people who represent the voices of the patients up to national policymakers. That has been a huge hallmark of our success in the U.S. and

internationally, including work with the World Health Organization, Institute of Medicine, and European Union, as well as universities and civil society organizations globally.

It is not only important to provide a forum for discussion, but it is also important to consider the next steps for sustainable inclusion. As one respondent highlighted for a specific Diné Navajo tribe, not only does giving voice to certain groups matter, but it is also important that they know what to do with that voice when the opportunity is given.

[The] Navajo word *Taa Hwo' Aji T'eeego* ["it's up to me to take action for myself"] is focused on love and hope, and without that there can't be sustainable economic education or health. That is a key facilitator for me and my colleagues. The family focus on *Taa Hwo' Aji T'eeego* is, what I would say, a mindful ethno-relative approach to everyone in life. It is intercultural communication and looking at the power dimension. . . . It's about people and giving a voice to them, and if they are invited . . . it is about the *Taa Hwo' Aji T'eeego*.

Finally, stakeholders mentioned that when some organizations attempt to address disparities, equity may still not be achieved if certain populations are overlooked. One stakeholder, speaking of her work with the LGBT+ population, noted that there has been a history of separation between LGBT+ and other diversity initiatives.

This has resulted in a lack of voice for LGBT concerns in spaces addressing the needs of communities of color and other marginalized populations. There is also a lack of voice for communities of color and marginalized communities in LGBT spaces.

Meaningful Community Engagement Takes Time and Money

While it is critically important to give a voice to members of cultural groups or communities, stakeholders used multiple examples to underscore that this engagement is not a quick or easy process. Trust-building was highlighted as a particularly important but very time-consuming process.

Stakeholders referred to the "old way" of improving health, where an organization or community completes a needs assessment or draws on existing data to identify a need and then develops an intervention to address that need.

I've seen this over and over—we assess health needs, design interventions based on the data, launch, and fail. No one engaged community, [we] didn't establish rapport or trust. There was no buy-in in setting up [the program. It came] but no one wanted it.

Even if such approaches are culturally and linguistically appropriate, more often than not, one stakeholder noted, they "fail miserably." This process, while relatively quick and seemingly logical, ignores the priorities and preferences of the community, and in many cases the community does not trust the organizations offering the program or services.

One significant challenge, however, is that establishing this trust takes a very long time, on the order of several months to several years. Stakeholders noted, in particular, the importance of building trust and establishing a long-term commitment when working with traditionally marginalized populations who have a deep mistrust of the government or outsiders who arrive, tell them what their

problem is, offer a way to fix it (without incorporating any input from the community), and then leave. This trust-building step, while critically important, is often not adequately funded for the amount of time and resources needed to do this well, and essential costs like the purchase of food and beverages for community events and meetings are often nonreimbursable expenses. Another challenge is that current grants or awards are often looking for results within a relatively short time frame (e.g., six to 12 months) and do not allow adequate time for trust-building to take place. One stakeholder speculated that this is, in part, why there is so much reliance on needs assessments, which can be done much faster.

There is no funding for relationship building, no funds allowed for food/beverages. I had to use my own money to buy food, and when they came into the building they could see it and smell it, and many were willing to stay and talk with us. But sitting down one time, you will get nothing of depth, and it took us two months of meeting every other week before we started getting a core group together every week. Once people buy in to the notion that you really do want to hear what they have to say, they are willing to come without incentives. They trust you and are willing to participate. This is really overlooked in grants for how long it takes. I am a year and a half in for one neighborhood, and we are just now talking about what health outcomes they are concerned about. This is a really lengthy and time-consuming process, and people get turned off so they turn back to needs assessment, which is viewed as the most efficient, although ineffective, way. There is no grant funding for building trust.

Another stakeholder working with several tribal populations reported that they spent the first year of their job in the field, meeting leaders and other trusted members of the tribal communities, and spent most of the time listening, rather than talking. This step enabled the development of trust. Even after trust was established, supports and services were offered more in the form of technical assistance, while control for decisionmaking and implementation was left to the tribal leaders.

For me it isn't implementing best practice at this point but it is developing trust so I can help. For the first year here I went out in the field and met folks, and that has been the most important piece, meeting the players, meeting the folks and listening to what the challenges are and not being judgmental.

Systems Are Built Around Prevailing Cultural Norms, Making It Challenging for Those Working with Specific Cultures to Make Cultural Adaptations

As noted, cultural groups often subscribe to shared values and practices around health and well-being. However, the relatively smaller size of many minority cultural groups, coupled with historical system biases, makes it difficult for them or their advocates to exert much influence on large or powerful systems. Moreover, these systems suffer from a sizable degree of inertia, operating via "business as usual" unless powerful catalysts force a change. Consequently, when constituents or clients require culturally informed adaptations to be made to policies or ways of working, they often confront challenges.

When you think about health systems, that is clearly a place that has provider bias. There are also other system barriers that we need to address to have a Culture of Health. We hope leaders

in health systems not only value [the unique health needs of] black women and women of color but use these values to help improve their approach to delivery of care and prevention.

However, stakeholders shared ways in which some health systems are adapting to growing immigrant communities or other groups whose cultures may not share dominant norms. Stakeholders shared, for example, that translation services are now available in most health care settings but cautioned that even this seemingly straightforward adaptation may not meet the needs of all patients, given the vast array of languages and cultural beliefs within a particular service area. Other stakeholders provided examples of hospitals changing or relaxing policies around birth (e.g., allowing the mother to take the placenta home) and end-of-life customs (e.g., allowing the use of a ceremonial pipe in a smoke-free facility). Still others pointed to the fact that some organizations are revisiting their missions to better reflect the needs of vulnerable populations.

Respondents described the ways in which they were able to advocate for cultural adaptations, which included both working within existing systems and advocating for policy changes. One stakeholder reported that she was able to address many of the unique cultural needs of her clients by maintaining communication and personal connections with hospital staff. This allowed her to support and advocate on behalf of her clients without undermining hospital policies. Another respondent who works in mental health described how he was able to obtain flexibility within existing structures to allow for culturally competent treatment approaches that he thought were needed to complement existing approaches to therapy:

[My organization] has been open and flexible with my time, and given me time to do things other than individual therapy and crisis counseling. . . . I get eight hours to do what I want to do to help the students I serve.

Respondents who advocated for systems change often did so on their own time, working outside of their organizational missions to provide direct health services or programming to educate others in their communities about the customs and needs of various cultures. Stakeholders noted that they used a variety of strategies to communicate these needs, including conducting continuing education sessions with health care providers, offering presentations to university staff, attending community meetings, and offering trainings to organizations in their communities. In preparation for these conversations, stakeholders explicitly considered the ways in which broader culture shaped the systems they were working to change. One stakeholder working in health care alluded to the importance of understanding the culture of medicine:

Be aware of cultures of insurance and doctors and cardiologists. They have their own cultures. We ask ourselves: What is their agenda? How do we help representatives of the communities we are trying to work with frame their needs?

Another stakeholder working with military-connected individuals described the ways in which prevailing military culture, with its focus on fitness, can run counter to health promotion and health care-seeking. He noted that many service members do not want to speak up if they are sick or injured, as this is often seen as a sign of weakness:

When you are in the military there is a culture . . . if you are injured and you are not pulling your own weight, or if you couldn't perform, they would have you fall out and walk behind everyone else, and that was seen as a weakness. . . . you don't want to be considered weak, lame, and lazy.

This respondent observed that returning veterans attempting to reintegrate into civilian systems still confront the “pervasive attitude to not get hurt or sick,” even if it is not as discouraged outside of the military. Additionally, this respondent described ways in which former service members have to adapt their perceptions of health systems moving from military to civilian systems:

[In the military] you feel that you don't have a lot of say in anything. When you see a care provider, you are not trained or feel like you have choices. [You] expect to be seen and you will do what they tell you. Doctors in the military are officers, so you do what they say.

Similar perceptions around health, medicine, and physicians or other health care providers are seen in other cultures as well. This example shows the complexity of adapting an effort (in this case, patient-centered care) to a cultural context in which the default expectation runs counter to the effort's goals (that is, the patient does not feel empowered to be at the center of care). This underscores the importance of considering how different cultures interact with the culture of broader systems to produce health and well-being of individuals and communities.

Organizational Culture Plays an Important Role in How Well Organizations Can Address Culture

Stakeholders spoke to the importance of organizational culture for appropriately addressing culture in health and well-being efforts. Organizational culture can be a barrier if it does not adequately reflect the communities it serves. Stakeholders, for example, reflected on the fact that those in roles of power in many communities are frequently white males. As a result, our governments, systems, and businesses often primarily reflect—intentionally or not—the perspectives of those in power.

Stakeholders noted that organizational culture can serve as a facilitator to such efforts when organizations work to enhance diversity and inclusion and build and integrate multicultural values into everyday practices as well as in the work they do as an organization. Several aspects of organizational culture were noted as important facilitators to addressing culture in the workplace, including “practicing what we preach” by modeling health to the community, which could involve more careful selections of food options at meetings, development of policies that value personal cultures and beliefs to promote work-life balance, and offering professional development opportunities for staff. Other stakeholders noted the importance of ensuring that program staff at all levels reflect the diversity of the individuals they are working to serve and added that it is even better when members of the community or clients are brought on as staff or advisors.

Cultural competence is easier to achieve when the organization itself has integrated multicultural values into their everyday business practices, staffing models, etc. The organization can then reflect that mindset out into the communities they work with and it doesn't feel like an afterthought or retrofitted solution.

Starting with our board of directors, we have a very diverse board, and this was purposeful in terms of age, gender, and race; you can see diversity in our board because we wanted to have a

very forward-thinking notion that wellness was important for all. We wanted to foster that nature of diversity and inclusion.

It is helpful when organization staff is part of the community and are often clients as well. This helps to make sure that they are sharing in the process of making clients whole and well.

Stakeholders described ways in which the points raised above related to organizational culture apply equally well to our local-, state-, and national-level leadership.

We have lots of cultures in our community, and I think one of the things we need to continue to do is to make sure people [who] are working in City Hall are reflecting the cultures of people we're trying to serve. This is currently not the case. This is a huge gap in understanding. It's hard to know if our intentions are getting translated or interpreted as we intend them.

Stakeholders also noted that while organizational culture can affect the extent to which governments and organizations can address cultural differences in their communities, understanding organizational culture is also important for partnership-building. Respondents described that it is important to understand cultural differences when looking to engage other sectors or systems.

Different sectors have different ways in which they approach work and language used and what resonates with them and what doesn't. If we really want to have an impact, there [have] to be really open conversations when you bring people together to understand organizational cultures. If you don't understand, that could be a barrier to progress.

Conclusion

Numerous stakeholders reported making use of cultural contexts in the effort to improve community health in traditional and nontraditional settings. In particular, it was important for them to consider when and how populations want certain aspects of their cultures brought to the forefront. Doing so requires developing an understanding of cultural contexts and requires significant time and funds to build trust. However, stakeholders noted that some of the challenges related to this work are driven by artificial bounds set around the use of funds, as well as unrealistic timelines for building lasting, meaningful partnerships with the community and other stakeholders. This suggests a need to relax restrictions around how funds can be spent so that they are maximally beneficial to the effort and can facilitate the development of efforts that are not only beneficial for one marginalized population but may also be beneficial for others, helping to achieve true health equity rather than health equity for one specific group. Findings also suggest that stakeholders would benefit from a compilation of best practices to help encourage and sustain the voice of marginalized populations and smaller organizations that serve disadvantaged populations.

5

Incentives to Promote Health and Well-Being

INTERVIEWS EXAMINING THE use of incentives to promote a Culture of Health explored ways individuals and organizations are motivated to promote health and well-being. These interviews considered ways in which wellness programs could incentivize individuals to improve their health behaviors; ways that employers could be incentivized to offer interventions that improve the health of their employees; and ways that diverse stakeholders could be incentivized to work together to implement and fund proven, effective programs that improve health on the community level. Stakeholders also described factors that impacted the effectiveness and sustainability of these incentives at motivating participation in health promotion. While external or grant funding can help to advance action through specific health initiatives or programs, stakeholders reported that efforts often dwindled once the funding ended. One stakeholder emphasized that outcomes of long-term health initiatives were somewhat determined by grant funds they received for a short period of time. These funds were not sufficient. After a two-year grant period, they knew that efforts needed to be sustained, but there was no continued financial support. They tried to maintain the initiative with other financial support, but it was not with the same degree of funding they had in previous years.

Themes that emerged include utilizing a mix of short- and long-term incentives, lessons from closed-loop systems (in which those who invest in the incentive reap the returns from improvements), and the ways in which PFS and other organizational incentive models can catalyze longer-term systems change.

Incentivizing Individuals Requires a Mix of Short- and Long-Term Incentives That Align with Individual Preferences

Organizations and individual stakeholders that use incentives to promote health and well-being noted that there is not a one-size-fits-all approach to motivating individuals to take action. Individuals differ in the type and amount of incentive needed to incite action. While some individuals respond well to

financial incentives, others may be driven more by personal goals, such as being able to play outside with their children or grandchildren for an extended period of time. Stakeholders noted that while these differences can be leveraged when working with individuals, such differences can be challenging at the community level, as not everyone may be as motivated by the incentive being offered. To help address this challenge, some stakeholders have developed more personalized incentive programs for their communities, in which participants earn points for achieving personal goals or participating in community events, and those points are then redeemed for the participants' choice of rewards.

Those interviewed also noted the importance of time preference in structuring an effective incentive program. People tend to act in their short-term interests, even though they may reap more benefit from a longer-term investment in their health. Stakeholders were quick to point out that this mindset is not limited to the general population, as we see this in many different sectors. Business leaders, for example, often make investment or programmatic decisions that will result in short-term gains for their shareholders rather than longer-term benefits that may result in a healthier workforce, higher productivity, and lower turnover. Given that so many of the benefits of healthy behaviors, such as eating well, being physically active, and smoking cessation, are longer rather than shorter term, stakeholders noted a need to figure out how to align short-term with long-term incentives.

We tend to act in short- versus long-term interest. "Today is easiest/most comfortable so I will do what I like now." Fifteen percent of the population would take \$100 today, instead of waiting a month for \$200. This sounds completely irrational to most, but these individuals are more likely to be obese, have substance use problems, etc., and we need to have better incentives that address this mindset.

Stakeholders highlighted that the design of incentives has to be meaningful and easy but also connected to our understanding of what drives behavior change. One stakeholder pointed to research showing that a small reduction in food prices does not change behavior substantially, but a larger reduction (15 percent or more) causes significantly more individuals to start to change their behavior, noting that this information can be helpful in designing an effective incentive program (French, 2003). One approach to incentivizing health offered by one stakeholder leveraged an understanding of human behavior by reversing the way incentives are typically administered. Instead of offering a reward for achieving a goal, the reward, in this case an expensive device to assist with health and fitness goals, was offered to the individuals from the outset. As long as their activity remained high, they were able to keep it for free, but if their activity dropped, they had to pay to keep the device. As such, they were using loss aversion as motivation, the use of which for weight loss is supported by a theoretical and empirical evidence base (Volpp et al., 2008). This was viewed as a very successful incentive for motivating change.

People respond to losing something they feel they are entitled to, so this type of incentive has worked very well. Even those who could afford to buy [the device] themselves—they want it for free, so they keep their activity levels high.

Some stakeholders also described that while there is value in using incentives to achieve a short-term health outcome, there is a concern that offering incentives as an extrinsic motivator might perhaps drive out intrinsic motivation. While more research is needed to understand whether this is the case, there is some evidence to support the idea that success on a smaller scale may help to

build self-efficacy, or a person's belief in his or her own ability to accomplish tasks and complete goals (Bandura, 1997). Small successes, for example, may allow individuals to achieve better health or well-being, which may, in turn, create the intrinsic motivation to sustain the changes and perhaps address another health goal, even without an incentive. However, stakeholders noted that more research is needed to better understand how to help individuals make this transition to continue to improve health and well-being in other areas of their lives. One stakeholder questioned, for example, whether offering healthy snacks after a community exercise class would help individuals see the connection between health, exercise, and food and to perhaps help them set a new health goal around nutrition.

Closed-Loop Systems Promote Investment in Individual-Level Incentives and Facilitate Sustainability

While discussing issues of investment in and sustainability of incentives, stakeholders referred to closed-loop systems or settings, in which those paying for the incentives up front are the same organizations or entities that see the cost savings or, in some cases, increased revenue resulting from the incentivized behavior change. As an example, one stakeholder reported on a unique partnership between a life insurance company and a grocery store, which collectively reduced the price of healthy food by 25 percent for individuals with life insurance policies. This financial incentive not only promoted healthier food choices but also benefited the grocery store in terms of increased traffic and benefited the life insurance company in terms of longevity gained and reduced payouts to policy holders. This drop in pricing was successful in increasing the consumption of healthy foods. Some stakeholders noted that offering incentives, such as reductions in health insurance premiums, made financial sense, and what the incentives added to the expense was a small price to pay relative to the cost savings resulting from healthier members. As one stakeholder noted, "We have to make sure the balance sheet works out correctly or we go bankrupt."

Interestingly, stakeholders pointed out that in many cases, the loop is not closed, even within a given organization. Many companies disconnect the section of the company looking at the health care insurance they have to cover (viewed as a corporate expense) from health benefits and wellness programs (viewed as a benefit). In other words, they are not linked financially or otherwise. Closing the financial loop within organizations with respect to health and well-being may help to advance workplace wellness.

Given that the vast majority of costs are spent on treatment and hospitalization, even a 0.5-percent improvement could be a substantial saving for the company. But so many companies opt for the cheapest, as opposed to the most effective wellness program.

Stakeholders also speculated that this alignment of investment and return on investment may be why most social impact investing is focused on real estate, where investments are recaptured through rent and resale of property. Challenges arise when there is not a clear link or loop between the entity making the investment and the return on investment. One stakeholder described this as "the wrong pocket problem," meaning that the returns from a successful program are not going back into the "pocket" of the initial investors or returns are diffuse among a wide swath of beneficiaries. This stakeholder speculated that this is why it is more difficult to invest in human capital, particularly when the

gains to be realized may be years out. This points to the need to find and generate longer-term views and conceptualization around investment.

Right now incentives are largely there to invest in real estate development—mechanisms exist for incentivizing banks to invest in low-income neighborhoods. I would like to see it shift toward human capital development. Investment tools don't exist to incentive this. Rent pays off investment, but early childhood [education]: What pays off that investment?

Other stakeholders described this closed loop in geographic terms. One stakeholder noted that the work that Kaiser has done in Hawaii on the island of Maui is a good example of this closed-loop system (Kaiser Permanente, 2017). This stakeholder noted that Kaiser is investing in upstream factors in the community to build health and well-being at an early age, given that Kaiser is a leading health insurer of individuals residing on the island. The stakeholder noted that these same principles could apply to closed-loop systems in rural or isolated locations, where the cost burden of a fairly discrete population may be borne by a single payer. In these cases, the upfront investment in incentives to promote health and well-being may positively impact their bottom line. Interestingly enough, other stakeholders noted that this closed-loop system may be a disadvantage when thinking about hospital systems or providers in small, isolated areas who may gain more revenue from more visits. In these cases, such entities may be much less inclined to invest in incentive programs that will likely result in a net loss in revenue.

Not All Incentives Are Monetary

Stakeholders acknowledged that while many incentives have some monetary value, the decision to participate in a health-promoting activity or effort is not typically driven by monetary gains. Rather, it is driven by other factors, such as wanting to lose weight, to be around for children or grandchildren, or to reduce stress. One stakeholder noted that, in practice, this means that wellness programs have to be designed so that they can be used in many different ways. Everyone has a different reason for participating in health-promoting behaviors, and the key is to find that underlying motivation or reason why they are interested in making a change. Incentives can then be aligned to match each motivation. Identifying this underlying motivation is also critical for long-term sustainability of the activities, the idea being that even if the incentive goes away, the underlying motivation remains. Alignment of individual motivations with larger shared values of health in the community will also help to promote sustainability because positive changes can also be viewed as contributing to a larger whole.

Another stakeholder posited that the incentive itself is not the motivator, but the prompt that gets people to initiate change. The transtheoretical model posits that intentions to change health behaviors and actual behavior changes progress through multiple stages of readiness (Prochaska and Velicer, 1997). Thus, stakeholders perceive that some incentives are more effective at motivating changes among individuals at stages where they are more ready to make changes.

I don't think the prizes motivated people. We got them right at the stage of change where they wanted to make a change. I don't think our work is changing people on that spectrum, but when they are in that readiness stage it is pushing them to do it.

With respect to organizational or systems change, stakeholders noted that while some people are drawn exclusively to the potential financial gains, most impact investors (e.g., philanthropic individuals, banks) are also driven by the opportunity to positively contribute to the development of community well-being. As one stakeholder noted, “They are motivated by the mission, and not just the money.” Several stakeholders who are experts in the PFS model noted explicitly that the initial investors in PFS projects are not doing it for the money, as this is technically not a good investment in terms of risk and return on investment, and there are a number of better options for investors if their goal is simply to make money. However, they believe in health as a shared value, and, as a result, they support efforts that may result in higher-value health-related services for all. Other incentives for investors include an opportunity to shape how governments are making decisions related to programs.

With respect to wellness programs in the workplace or community, many stakeholders pointed to a more altruistic incentive and, again, the notion that health is a shared value. While stakeholders acknowledge that wellness programs cost money and understand that what drives employers to institute and utilize workplace wellness programs may be monetary (e.g., reducing health care costs of employees), some employers truly care about the health and well-being of their staff, and this drives their wellness programs.

Companies are motivated to do two things: improve employee health and activity and reduce employee-related expenses . . . to save money and to improve productivity and morale. They are interested if they [organizations] suffer from poor employee health. . . . You have to remember these organizations are spending money and they have skin in the game. So they want to see some kind of return on investment and benefit available to that. They won’t start if they don’t care about health outcomes. So, unless they are already interested, [they] are not going to start [a wellness program] in the first place.

[Employers] are motivated because at the end of the day they are changing people’s lives. . . . We change people’s lives for the better in preventing suffering and preventing death. So there is a sense of accomplishment and reward.

Other stakeholders raised similar points, but in the context of motivating individual behavior. One in particular suggested that while incentives can help with extrinsic motivation and may get employees to care about health and wellness, intrinsic motivators are critical to success and sustainability.

Instead of looking at it from the point of view that you “should” [work out], you should do it very selfishly—a workout is a gift, hate doing it, but it is a gift, rather than chore, I’m more likely to do it, and I will want to give myself that gift more, it makes me feel successful and it leads to my success.

Some Incentive Models, Like Pay for Success, Have the Potential to Act as a Catalyst for Systems Change

PFS models are an innovative way of financing effective interventions that improve health and well-being that were formally funded as line items in public budgets or via government contracts. To be successful (and in the vast majority of situations, even to be pursued as a PFS project), there must be evidence that the intervention works to improve outcomes. (See Appendix A for more detail on PFS models and an example from our interviews.) PFS contracts require data to prove that outcomes

were achieved. Payments to service providers and investors are only made when outcomes set forth in the contract are achieved. As a result, the PFS model has the potential to change the typical government decisionmaking process about which programs to use for certain services, how service providers are reimbursed (e.g., payments for achieving outcomes as opposed to payments based on quantity of services delivered), and the ways in which data are used by all parties involved. On the other hand, PFS also puts a spotlight on capacity constraints, challenges with government buy-in and leadership change, and problems with the ways in which nonprofit service providers typically do business. These internal factors impact the success of PFS projects but also have implications for the sustainability of the model within a community and the changes that it inspires.

Incentives Can Catalyze Systems Changes in Government, Philanthropy, and Nonprofits

Stakeholders commented that while the incentives structure embedded in PFS is the catalyst for the change, the incentives themselves do not ensure sustainable change. In fact, the incentives currently in play in PFS models, usually private investment, are not seen as scalable without a broader belief on the part of the government that they can and should pay for successful outcomes resulting from services, as opposed to the amount of services provided regardless of their impact. In other words, it requires a systems-level change in the way the government thinks about reimbursing for services, which goes against the status quo. One stakeholder put it this way:

Funding alone doesn't cause purpose, and getting from here to there requires risk capital, and looking to mainstream capital isn't where you get the funds. You need philanthropy or government, and Pay for Success is not the silver bullet. The silver bullet is in proving to government that they should pay for outcomes, getting them to take the risk.

This is something that stakeholders have observed at different levels of government, from the federal government offering funding to incentivize outcomes to local governments using lessons learned from PFS to change their processes. In addition to changing government decision processes to an outcomes-based orientation, innovative models like PFS can have an impact on other systems. Stakeholders acknowledged the challenges presented by traditional health care financing models, such as fee for service, that paid providers and systems for services rather than value or outcomes and noted that the shift toward new payment delivery models that focus on outcomes and value is a necessary driver for change:

In the health care system, the financial incentives (e.g., fee for service) have gotten the system to where it is today. In that way, changing incentives will mobilize change. If you have to measure outcomes to get government funding, everyone will measure outcomes. In this way, incentives act as a good system driver.

Other stakeholders described the ways in which PFS models have created “new markets” in jurisdictions where they are implemented, encouraging public-private-philanthropic partnerships where they did not exist before. One stakeholder described these changes as working toward a “tipping point” where there is a “transformation toward more outcome-based funding.” Finally, PFS had the potential to change how nonprofits make and raise money. Stakeholders provided examples of how PFS projects have shifted from writing grants to receiving reimbursement from the government (e.g., Med-

icaid), which stands to benefit from positive outcomes. And by focusing on program outcomes rather than typical markers of nonprofit success (e.g., “How do we keep administration costs low relative to program costs?”), PFS projects help to shift the way that nonprofits work:

[We] have held nonprofits to an unfair standard where they need to be constantly bootstrapping, starving the organization, working in cost-reimbursement-based contracts, not value-creation-based [contracts].

From the investment perspective, respondents described that the model is typically attractive to a particular type of philanthropic investor, one interested in motivating systems change by developing “not just a grant-by-grant funding stream, but a sustainable way to keep money growing” and one that is interested in taking risks:

They are interested in applying an approach to an intractable problem. They are people who may want to climb a mountain just because the mountain is there. They are the risk-takers we try to get in front of, and your tolerance for risk can have impact on change.

Lack of Government Buy-In Presents Challenges to Widespread Implementation and Sustainability, Though Institutionalizing Changes to Process May Help

As the payer that ultimately recoups the investments made by impact investors into a PFS model, government agencies play a critical role in a functional and sustainable PFS system. As one respondent put it, “until you have the government promise to pay for an outcome, you can’t get impact investors to invest in something.” And one of the reasons large systems, including local governments, health systems, and education systems, continue to do things the way they always have is that innovating is risky: “There is so much inertia built into systems, and the systems get bigger, and to consolidate the inertia is part of the challenge.” Thus, depending on their leadership structure, their experience of working across sectors, the characteristics of the leaders themselves, the relationship between government and philanthropy, and their willingness to take risks, governments are more or less likely to want to participate. According to one respondent who has worked with different jurisdictions on PFS:

We hear different things and different priorities. . . . Some really want to integrate the different data systems, break down silos, and push forward: How do you think about health with broad lenses? . . . But we have others who are not as much interested in that. I don’t think we interact with people who are negative but who are more passive, who are jaded about the level of change—some eyes wide open who think you can drive a lot of change and others maybe think about the level of change as minor.

To maintain the changes catalyzed by PFS models, internal champions require the motivation and capacity to continue pushing for outcomes-driven decisionmaking. One stakeholder pointed out a number of factors that influence the ability of changes to be institutionalized beyond an initial PFS program:

You . . . need to task leadership to . . . drive [data-driven decisionmaking] forward. You need to make [data and outcomes] something that is relevant to government leadership so they think it’s important, and they care about it.

Respondents offered examples of the ways in which funding structures can produce incentives for cross-sector partners to be champions for health promotion. One interviewee observed that long-term grants enabled community-wide wellness program leaders to “promote the work and connect the people” that would do the work, including the public school system and city departments. In this example, even after the funding structure changed, roles were institutionalized within the city, schools, and nonprofits that kept partners committed to supporting health: “[This program] is our Culture of Health in the city.”

Pay for Success Is Enabled by Supports and Technical Assistance That May Not Be Sustained

Earlier themes described the challenges with widely implementing PFS, including the complicated nature of contract development, issues with government buy-in and capacity, and a mismatch between the risk to investors of investing in PFS and the return on that investment. To attempt to address these challenges, a number of mechanisms, including technical assistance provision and federal seed funding, have been established. Stakeholders noted that those who are new to the model, especially government partners, need a push to make a transformational change. One stakeholder pointed out that one role of the group’s PFS technical assistance organization is to “educate government partners about why this is good for them and worth participating in,” and another organization uses an embedded assistance model, “providing capacity to governments to do difficult projects . . . sending our fellows to work full time as members of the government team” to ensure dedicated personnel and capacity. However, these services are expensive. While interested jurisdictions can often obtain such services with the use of federal seed funding, some stakeholders felt that the future of that funding is uncertain. For example, the Social Impact Fund, which supports a large amount of PFS technical assistance, just announced its final round of funding. One stakeholder mentioned that the impact of that funding loss could be catastrophic: “The whole ecosystem supporting PFS is going to probably go away or be substantially reduced once the federal support is gone.” Finally, impact investing outside of the PFS field, including support by Federal Reserve Banks or other large banking institutions of projects with impact on community well-being, is largely supported by federal funds and tax credits. Community Reinvestment Act credits and the Community Development Financial Institutions Fund enable impact investors to do work that they do not anticipate will have a large financial benefit but will have a positive community benefit. As one stakeholder put it:

The way the world works is by subsidy—very few projects can be financed without subsidy. [Constructing] a building with the same expenses as another building but that houses low-income residents does not happen without subsidy.

Conclusion

There are various ways in which incentives can be used to motivate efforts to promote health and well-being, including via wellness programs that incentivize individuals to improve their health behaviors, incentives to employers to offer interventions that improve the health of their employees, and incentives for diverse stakeholders to work together to implement and fund proven, effective programs that improve health on the community level. Stakeholders pointed to the importance of a shared definition of health, particularly for PFS efforts, but there is a need to identify best practices

for how communities and diverse groups of stakeholders can take on this challenging task. More work is also needed to understand how to sustain the positive changes catalyzed by incentives. Stakeholders offered some insights, including balancing short- and longer-term incentives, as well as fostering intrinsic and extrinsic motivation; connecting organizations or parts of organizations together to develop closed-loop systems; capitalizing on the potential of nonmonetary incentives; and utilizing innovative models to engage nontraditional partners and catalyze systems change.

6

Key Findings, Implications, and Next Steps

FINDINGS FROM THESE interviews provide important insights into real-world considerations, challenges, and strategies for promoting health and well-being for all individuals. Several cross-cutting themes emerged from both culture- and incentives-focused stakeholders, despite their differences in focus, related to the importance of shared values around health and well-being, the value of data for building those shared values, and challenges related to elevating the health of groups (such as employees or community members) as a priority for those who are accustomed to thinking about health as an individual concern. Cross-cutting findings also point to the importance of equity for fostering a Culture of Health in America. Stakeholders acknowledged that equity requires a broader conceptualization than health disparities to consider the fundamental causes of differences: the social, structural, physical, and economic determinants of whether people can live their healthiest lives. Achieving equity requires not only significant time and resources but also integration and collaboration across sectors. Stakeholders, however, cautioned against efforts to address equity on one dimension (e.g., race) without a full understanding of other inequities that may also be at play (e.g., gender).

In addition to these shared perspectives, stakeholders provided details of their approaches to addressing health and well-being from the unique perspectives of cultural contexts and incentivizing health. When considering unique communities, stakeholders spoke in particular about the importance of developing trust and ensuring that important, trusted community voices are represented in programs or interventions, but they noted that current funding mechanisms often do not align with the real-world resources required for meaningful community engagement efforts. Stakeholders also noted that prevailing cultural norms and organizational environments provide important context for understanding barriers and facilitators to promoting health and well-being among diverse cultures. This broader context can serve as a facilitator to such efforts when systems and organizations already work to enhance diversity and inclusion and work to build and integrate multicultural values into everyday practices and into the work they do as an organization. However, prevailing norms of systems and

organizations can be a barrier to culturally informed health work if they do not adequately reflect the communities they serve.

For incentives, stakeholders pointed to the need to balance intrinsic and extrinsic motivation, as well as short- and long-term incentives, noting in particular that while monetary incentives are common, individuals also respond to other kinds of incentives, including those that are more altruistic. Stakeholders also noted that incentives, when structured well, have the potential to catalyze systems and noted that closed-loop systems in particular (where the person paying for the incentive is the benefactor of the positive change) can facilitate sustainability.

Collectively, these findings point to a number of implications and potential next steps for thinking about fostering a Culture of Health in the United States. Given that approaches to fostering a Culture of Health are incredibly varied and depend on the health needs of the community, populations served, community resources and potential partners, and the broader environmental and policy context, identifying best practices is outside the scope of this project. However, findings shed light on promising approaches and areas where progress has been made at a local level, as well as areas where additional investments may be made and best practices established. These implications may be relevant not only for RWJF but also for others interested in supporting movement toward greater, equitable health for all.

Implications and Next Steps

- **Identify best practices for developing a shared definition of health within communities.** Health as a shared value was seen as critical to promoting a Culture of Health. Yet stakeholders reported that there is a need to balance a very broad definition of health that may be understood better by some stakeholders with a definition that is more narrow and actionable, which may be better understood by other stakeholders. Coming to a shared definition of health issues to target with PFS initiatives and establishing a common understanding of desired outcomes of programs financed with PFS are crucial first steps in the process. This suggests a need for best practices in developing a shared value of health at a local level that resonates across key stakeholders and community members. Research on conceptualizing population health asserts that definitions of health should reference not only health outcomes and their distribution in populations but also the determinants of population health and upstream causes of those outcomes to broaden buy-in (Kindig and Stoddart, 2003; Stoto, 2013; Chandra, Acosta, et al., 2016). Additionally, literature related to stakeholder engagement and consensus-building points to best practices for creating structures that allow for codevelopment of definitions and goals related to health and well-being. These include assembling diverse workshops with attendees from sectors including public health, city government, education, community-based organizations, and residents. In communities where this has been done successfully (e.g., Richmond, California), workshops include a presentation of local health data and a facilitated discussion about community barriers and facilitators to health in various geographic areas of a community to create a community-informed definition of the conditions necessary to improve health for all (Corburn et al., 2014). Such best practices could be compiled into a toolkit for communities looking to build consensus around a definition of health.

- **Remove restrictions around diversity and equity efforts.** Diversity-related initiatives often have a narrow lens (e.g., targeted to a particular racial or ethnic group). While this is often by design and is reinforced by funding that is earmarked for vulnerable populations, stakeholders noted that this can inadvertently cause inequities if such efforts and funds cannot be more broadly applied. Such findings point to the need to design funding opportunities that have diversity and equity as a focus but are not overly prescriptive as to how funds can be used. Initiatives focused on addressing disparities or health equity should be crafted in a way that enables prioritization of priority populations but does not prohibit the opportunity for other community members to utilize or leverage the programs or resources that have been developed. Efforts that have taken this broader approach have been able to see not only a reduction in disparities and health inequities but also an improvement in the health of the community overall (Economos et al., 2013).
- **Institutionalize practices that ensure ongoing input from marginalized populations.** Community engagement, and particularly engagement of marginalized populations, is important to the success of any effort to promote health and well-being, as it helps to ensure that the programs, supports, and efforts developed align with the priorities and needs of that population. One challenge, however, is that community engagement is often obtained at the start of a project or initiative and is provided only when those in power ask for it. Despite literature to suggest that ongoing engagement results in improvements to program sustainability by developing local capacity (Wallerstein and Duran, 2010) and may be cost-effective (O'Mara-Eves et al., 2013), ongoing community engagement is still rare. Stakeholders or other program staff should look to institutionalize best practices that rely on ongoing input from diverse and marginalized populations, ensuring that they have a continued voice at the table. Empirically based practices for empowerment, such as storytelling and other identity narratives, should also be spread and more widely adopted. Funders can encourage sustained community engagement by building it in as a requirement for funding or a marker of program success.
- **Create flexibility in funding structures for well-justified efforts to build trust among disadvantaged populations.** Stakeholders noted that there is often a misalignment between allowable expenses on program and grant budgets and the costs incurred when looking to build trust and meaningful community engagement among traditionally marginalized populations. Funding is often tied to a budget cycle or specific short-term grant period, even though laying the groundwork to build trust often takes months or years to nurture and develop. Flexibility should be built into funding structures for well-justified efforts to engage communities in dialogue, trust-building, and health promotion efforts. For stakeholders, this may mean adjusting expectations related to when the program may see a return on this investment. There is also an opportunity for funders to consider grants in smaller dollar amounts with minimal restrictions and longer time frames that could support this very important but time-consuming effort. Such support can encourage thoughtful and, as a result, sustainable engagement that can be leveraged to build a Culture of Health in the community.
- **Strengthen research around the role of organizational culture in promoting population health and well-being.** Stakeholders with whom we spoke discussed how organizational culture and prevailing cultural norms within the organization were often a hindrance to implementation of new ideas, frameworks, and initiatives. Similarly, stakeholders discussed how the perspectives of those in power helped to shape organizational norms and priorities. Building a Culture of Health requires a better understanding of how organizational culture directly and indirectly

affects population health and well-being. Here, organizational culture is broadly defined and extends beyond wellness programs to include organizational commitments to diversity and inclusion among employees; efforts to improve job satisfaction; managerial processes; approaches to mentorship and performance reviews; and leadership and decisionmaking processes around mission, vision, and ways of working toward them. Research abounds related to organizational commitments to employees' health and wellness, as conceptualized by many mainstream workplace wellness programs that focus on, for example, healthy eating, physical activity, and stress management (Danna and Griffin, 1999), as well as on organizational culture and employee well-being and retention (Sparks, Faragher, and Cooper, 2001). However, examples of promising organizational practices related to building and maintaining a functional multicultural workforce and mechanisms by which employers are able to promote a holistic sense of well-being among their employees outside of workplace wellness programs are not well-studied. Moreover, more work is needed to understand the influence of the organizational culture of health-related organizations on the impact of their efforts to improve community health, beyond select case studies (Craigie and Hobbs, 2004). Understanding these factors can point to potential organizational policies or practices that may improve the health and well-being not only of employees but also of their families and the broader community.

- **Identify ways to help smaller organizations overcome structural inequalities.** Local organizations committed to addressing health inequity or promoting the health and well-being of vulnerable populations often have fewer resources, reduced capacity to take on such efforts as data collection and sharing, and smaller and already overstretched staffs (Hager, Galaskiewicz, and Larson, 2004; Guo and Acar, 2005). These and other limitations create an often-insurmountable barrier to meaningful engagement in efforts to promote health and well-being in the community. These barriers also preclude such organizations from participating in some of the new PFS incentive models that require substantial up-front resources. Communities looking to address issues of equity should ensure that these smaller organizations are included in the dialogue. Funders and other stakeholders in a position to drive change should identify and disseminate best practices to identify ways to help smaller organizations overcome structural and resource inequalities so that they can work as equal partners to address issues of health equity and promote the health and well-being of the populations they serve.
- **Institutionalize health promotion efforts in sectors other than public health or health care to sustain collaborative efforts.** Incentives, either monetary or nonmonetary, may attract initial collaborators or investors. However, enacting the systems changes necessary to build a Culture of Health must extend beyond these initial catalysts, especially in light of concerns about a lack of sustainability of funding structures that currently support PFS and other incentive models. Research supports the idea that cross-sector collaborators ought to be engaged to take a sustained lead on efforts for health and well-being (Towe et al., 2016). Communities that have taken this orientation have successfully embedded health promotion and measurement work in other sectors, including engaging school systems in promoting healthy behaviors in before-school, during-school, and after-school programming and collecting a broad swath of student health data in school settings (Economos et al., 2013).
- **Develop strategic approaches and tools for use by those who are interested in pursuing work in the Culture of Health framework.** The diversity of interests and needs across communities will mean equal diversity in readiness to pick up the Culture of Health framework

and do something with it. Stakeholders may benefit from a set of strategic approaches and tools developed by RWJF to help stakeholders apply the Culture of Health framework in their own work to promote health and well-being in their communities. Such approaches and tools should reflect the key needs identified in this report—in particular, best practices for the development of shared values and long-term community engagement.

Conclusion

The Culture of Health Action Framework was developed by RWJF to catalyze action to improve population health and well-being. This report summarized the results of interviews exploring two necessary elements in embedding a Culture of Health within and across sectors: cultural identity and incentives. The key findings drawn from this research highlighted important topics, concerns, and considerations stated by various stakeholders, including some key foundational themes related to the importance of shared values and data; understanding the importance of both individual and community health; and the need to consider carefully our approaches to promoting health equity to ensure that they are inclusive, collaborative, and address structural inequalities. Taken collectively, this information can inform efforts of individuals and organizations at a local, state, or national level working to foster a Culture of Health in their community.

APPENDIX A:

Pay for Success Related to Health and Well-Being

Overview of Pay for Success

PFS (sometimes referred to as “social impact bonds”), a relatively new approach to financing programs that aim to solve social programs, originated in the United Kingdom in 2010. As of July 2016, 11 PFS projects are ongoing in the United States (Lantz et al., 2016). The goal of PFS is to utilize private funds to pay for proven programs that will eventually save the government money on health care or other social service costs, such as housing services for chronically homeless individuals that reduce their visits to the emergency department. Investors pay for the programs up front; they are reimbursed and receive an additional financial return when specified positive outcomes are achieved. The model transfers financial risk from the original payer (government) to the private sector and encourages the implementation of proven interventions.

Participants in Pay for Success

PFS involves a minimum of four participating parties, but the complex structure of the model typically results in additional partners:

- an impact investor that provides the funding to implement a social program or intervention, under the assumption that the program will produce positive outcomes and that the investment will be paid back with an additional (usually small) financial return. However, the investor bears the risk in the PFS model, and if outcomes are not achieved, the investor will not recover the investment.
- a government payer (state and local [e.g., a county department of human services]) that pays the investor for positive outcomes out of its cost savings
- a service provider to deliver the intervention
- beneficiaries who receive the intervention or services and participate in the evaluation (e.g., their outcomes are tracked to assess whether “success” was achieved).

- Common additional partners include
 - an independent evaluator to coordinate data and validate outcomes (i.e., was the program successful at meeting the established outcomes?)
 - an intermediary organization to support such activities as raising capital; designing contracts; launching services; providing oversight and ongoing performance management; and designing adaptations, if necessary.

Process of a Pay for Success Initiative

Pay for success projects begin with the development of a performance-based contract between a government payer, a nonprofit service provider, and an investor (or multiple investors). The contract sets out the terms by which payments will be disbursed from the payer to the investor, including the expected outcomes of the intervention to be implemented by the service provider that define success. Interventions are typically already being implemented in the community and have a good evidence base, which informs the expected outcomes included in the contract. The intervention is then implemented, and data are collected to determine whether outcomes are being achieved. If so, payment is disbursed to the investor from the government, and if not, payment is not disbursed and service providers can no longer claim to be implementing an effective intervention.

Health and Well-Being Outcomes Currently Addressed by Pay for Success

- juvenile detention recidivism
- special education utilization
- employment of formerly incarcerated individuals (juveniles and adults)
- housing status (stable tenancy) of formerly chronically homeless people
- foster care placement
- preterm births
- emergency department/hospital usage
- birth spacing
- out-of-home placements and social welfare referrals for parents with substance use disorders
- substance use disorders (Lantz et al., 2016).

Example from Interviews

Nurse-Family Partnership (NFP) is an evidence-based maternal and child nurse visitation program for vulnerable first-time parents that has been operating in the United States since 1977 (Nurse-Family Partnership, 2017). South Carolina's Nurse Family Partnership Pay for Success project, initiated in early 2016, has expanded the reach of NFP in South Carolina to an additional 3,200 first-time mothers. Approximately \$30 million to expand NFP was provided by a multifaceted public-private investment group, including a \$17 million investment from BlueCross BlueShield of South Carolina, Boeing Company, Duke Endowment, Arnold Foundation, and a consortium of smaller private funders, and \$13 million from the Department of Health and Human Services through a Medicaid waiver. NFP, the service provider, has used the funding to increase its capacity to deliver the intervention to more families, and the State of South Carolina will pay back up to \$7.5 million if posi-

tive outcomes are achieved, which will be invested back into the community to sustain NFP services. The Institute for Child Success conducted the original feasibility study leading to this project. Harvard Kennedy School's Government Performance Lab provided technical assistance to the state (e.g., design payment structure and PFS contract, implement pilot) to complete the PFS contract. Social Finance US is the intermediary for the entire project. Expected outcomes of the intervention include reducing preterm births, decreasing child hospitalization and emergency department usage due to injury, improving healthy spacing between births, and increasing the number of first-time mothers served in the lowest-income communities.

APPENDIX B:

Interview Protocol

Introduction

Thank you for taking the time to talk with us today about your work building healthy communities. In case you are not familiar with RAND, our organization is a nonprofit public policy research center. As part of a RAND project funded by the Robert Wood Johnson Foundation or RWJF, we would like to ask you questions about the priorities and key activities you think are needed to drive community health. We will also ask you about any measures you have in place to monitor or evaluate your community's path to health, and the processes that led you to those measures.

Robert Wood Johnson Foundation (RWJF), the funder, wants to understand how to build a Culture of Health. In other words, they want to know how communities are creating healthy conditions that support individual, family, and overall community health and well-being. RWJF would like to offer communities tools to support greater action to improve health in the United States. Feedback from [TAILOR TO INTERVIEWEE, COULD BE community leaders, organization heads] like you is essential to this study and we greatly appreciate you speaking with us today.

Consent

Before we begin, I want to assure you that your responses to our questions are held in strict confidence and you will remain anonymous. Any research reports will include your feedback combined together with the feedback from several other organizations, and no specific organizations will be named. If we quote you, we will not identify you or your specific organization by name.

We would like to take notes during conversation to capture all of your important feedback. We will destroy the notes at the end of the project. Is this okay with you?

Your participation is voluntary and if you are uncomfortable with any questions that are asked, please feel free to not respond to the questions. We estimate that the interview will take about 45 minutes.

Do you have any questions before we begin?

If you have any questions following this discussion, you can contact the Principal Investigator [name, email address, and phone number].

Questions

Section A: Initial Questions

- A1. Can you briefly describe what your organization does and role within the organization?
- a. Size
 - i. Number of employees
 - ii. Size of network, number of constituents, and number of clients
 - iii. Annual budget
 - b. Target population
 - c. Geographic scope: National, state, local
 - d. For-profit/nonprofit
 - e. Year established
- A2. Prior to our interactions, were you familiar with the Robert Wood Johnson Foundation's Culture of Health vision and Action Framework?
- a. If so, how did you become familiar with it?
- A3. Given [your familiarity with the framework OR what you've read about the framework], we'd like to discuss activities, policies, protocols, or strategies your organization is using to build a Culture of Health. These could be activities that promote any of the specific action areas. As a reminder, those are
- health as a shared value—where people appreciate the importance of achieving, maintaining, and reclaiming health as a shared priority
 - supporting cross-sector collaboration so that health systems, businesses, local health departments, community organizations, individuals, and federal agencies all see opportunities for alignment and success
 - creating healthier and more equitable communities by addressing head-on the chronic environmental and policy conditions that hold back too many Americans from living in good health
 - transforming the health care system so it's driven by a focus on prevention; the integration of health services and the public health and social service systems; and the delivery of comprehensive, high-value care for all Americans
- a. Are you engaged in any activities that are **directly informed** by the RWJF Culture of Health framework?
 - i. If yes, please describe:
 1. Do/did you have an overarching conceptual or operational framework/plan that guides [this work]?
 2. How did you or others at your organization select this framework/plan?
 3. [Based on their answer] Do you have any materials you could share with us that reflect what you just described?

- ii. If no:
 1. After hearing about the framework and its action areas, could you describe any activities that you see as *relevant to or could be informed by* the Culture of Health framework?
 2. Do you have an overarching conceptual or operational framework/plan that guides [this work]?
 3. How did you select this framework/plan?
 4. [Based on their answer] Do you have any materials you could share with us that reflect what you just described?
- A4. What have been the key facilitators to the implementation of [this work]? These are the things that have made it easier for [your work] to be successful and can include intentional strategies you used (e.g., for recruiting or retaining patients), characteristics of your organization, or external factors to your organization or community (e.g., political support, board support).
 - a. What has helped you to secure the resources you've needed?
 - b. Any barriers in getting resources needed to do [this work]?
 - c. What has helped you reach your [external partners, patients, clients, or constituents]?
 - d. Could you imagine any additional facilitators that would potentially help with the implementation of [this work]?
- A5. What has the response been from [patients/clients/constituents/partners] when you began applying the framework (or implemented this Culture of Health-related work)? We are interested in hearing about the response from individuals both inside of and outside of your organization.
 - a. Who are the [patients/clients/constituents/partners/internal partners] you have attempted to engage to implement [this work]?
 - i. External partners: Which sectors do they represent? Are these traditionally sectors your organization works with?
 - b. Have they been supportive of the work? Engaged? Involved? If so, what are a few examples?
 - c. Have they been resistant to the work or put up any barriers? If so, what are a few examples?
 - i. Any barriers within your organization (mission alignment, board buy-in, etc.)?
 - ii. Who do you wish you were working with to implement [this work]?
 - d. Are you tracking satisfaction or response in any formal ways?
 - e. Are you tracking, monitoring, or measuring anything else related to this work?

Section B: Cultures Questions

We are interested in how the implementation of Culture of Health activities like [your work] are similar across cultural settings or may differ based on the type of organization or community in which they are implemented. We are also interested in how these efforts work toward achieving health equity, which is an overarching theme of the Culture of Health Action Framework. We understand that there are many unique cultures and shared values within and across communities that can exist and evolve at many levels within organizations, sectors, and larger communities.

We would like to understand how a set of shared health values can be fostered across populations with diverse and distinct cultures through targeted health and wellness interventions such as yours. Shared health values refer to individual beliefs that health is a priority and a right and the organizational policies and culture that support these individual beliefs.

- B1. What are the unique/important aspects or characteristics of the culture of the populations you work with?
- B2. How do you facilitate/adapt [your work in fostering a Culture of Health] to make it fit better with your organization or community as a result of the unique social, cultural, linguistic, or political landscape?
 - a. Can you provide a few examples? [Prompt: Are the changes structural or cultural? Or related to language, gender, ethnicity, or traditions?]
 - b. How do you think these adaptations lead to successful outcomes of [your work]?
 - i. How have these adaptations contributed to addressing issues of equity (i.e., impacting differential access)?
 - c. How do you foster strong working relationships between or among those you work with when necessary, especially in light of cultural factors? What are the key factors to consider?
- B3. What are the barriers you face in [your work fostering a Culture of Health] as a result of the unique social, cultural, or political landscape of your organization or community? Were you able to overcome them? If so, how?
 - a. Have you experienced any conflict between the [Culture of Health values being promoted] and the unique values in your community?
 - b. Can you provide a few examples?

Section C: Incentives Questions

We are interested in whether (and how) Culture of Health activities like [your work] are incentivized. We learned during the development of the Culture of Health framework that incentives for individuals and organizations or “making a financial case” for activities that foster a Culture of Health was key to obtaining support from diverse or initially difficult-to-engage partners or constituents. Therefore, we are interested in **[both]** incentives to individuals as part of an effort to improve health behaviors or health outcomes [and/or] incentives to nontraditional partners or funders as a way to obtain support for interventions that improve health, such as investors in pay-for-success (PFS) models or social impact bonds. I’ll use the word *incentive*, but we are generally interested in efforts under way that offer financial motivation to work on improving health.

- C1. How is your organization involved—what roles does it play—in using incentives to motivate improvements in health, like those in the categories I just described (meaning incentives to individuals or organizations)? [Prompt if necessary.] (E.g., Is the role investor in PFS, partners’ investors with organizations needing funding in PFS, runs program that offers incentive?)
 - a. Who are you trying to incentivize/motivate to engage in Culture of Health activities?
 - b. What outcomes are you hoping to achieve by using incentives?
 - c. How are incentives framed to [partners/constituents] in order to motivate them?
 - d. *If appropriate/relevant*: In general terms, where does the [money or other benefit that acts as incentive] come from?
 - e. What is your perception of the sustainability and/or appropriateness of these incentives to achieve your desired outcomes? Do you anticipate any changes to participation or buy-in if or when incentives change? Why or why not?

- i. How does participation in [program] differ by group (i.e., are some groups “easier” to incentivize to participate)?
 - ii. What are some factors that would make folks more or less likely to participate if incentivized?
 - iii. What are the implications for equity, based on who is more or less likely to participate?
 - f. Are there any specific barriers or facilitators to incentivizing these activities? At the individual or organizational level?
- C2. What has been the response of [patients/clients/constituents/partners/partners] to these incentive offers? E.g., has participation changed, have diverse partners been engaged?
- C3. [If not addressed in tracking/monitoring/outcomes discussion earlier] What has been the impact on health outcomes, if any?

Section D: Wrap-Up Questions

- D1. Based on our discussion, do you have any suggestions for others doing similar work that we should speak with?

Thank you so much for your time! Don't hesitate to follow up with me if you have any questions or further thoughts.

APPENDIX C: Recruitment Materials

Invitation to Participate

Dear [Name],

The RAND Corporation, a nonprofit research institution is conducting phone interviews with organizations such as yours to understand your work in building healthy communities.* This is part of an effort to further inform the Robert Wood Johnson Foundation's Culture of Health Framework and metrics (attached). Building a Culture of Health is a national movement, driven by the belief that we will make true progress when we work together toward a shared goal. The vision of a Culture of Health is to see health become a national priority, valued and advanced by collaborators from all sectors.

This interview would focus on your work to [description here] as well as work contributing to a Culture of Health, more broadly.

Are you interested and available for an interview that would take *45 minutes to an hour* of your time? If so, what is your availability in the next week or two? What is the best number to reach you at?

We look forward to learning more about your important work. Please let us know if you have any questions.

Sincerely,
[SIGNATURE]

* Your participation in this effort is completely voluntary. Information gathered from this interview will not identify you in any way.

Figure C.1. Culture of Health Action Areas, Drivers, and Measures (included with invitation to participate)

ACTION AREAS	DRIVERS	MEASURES
<p>1</p> <p>MAKING HEALTH A SHARED VALUE</p>	MINDSET AND EXPECTATIONS	Value on health interdependence Value on well-being Public discussion on health promotion and well-being
	SENSE OF COMMUNITY	Sense of community Social support
	CIVIC ENGAGEMENT	Voter participation Volunteer engagement
<p>2</p> <p>FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING</p>	NUMBER AND QUALITY OF PARTNERSHIPS	Local health department collaboration Opportunities to improve health for youth at schools Business support for workplace health promotion and Culture of Health
	INVESTMENT IN CROSS-SECTOR COLLABORATION	U.S. corporate giving Federal allocations for health investments related to nutrition and indoor and outdoor physical activity
	POLICIES THAT SUPPORT COLLABORATION	Community relations and policing Youth exposure to advertising for healthy and unhealthy food and beverage products Climate adaptation and mitigation Health in all policies (support for working families)
<p>3</p> <p>CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES</p>	BUILT ENVIRONMENT/PHYSICAL CONDITIONS	Housing affordability Access to healthy foods Youth safety
	SOCIAL AND ECONOMIC ENVIRONMENT	Residential segregation Early childhood education Public libraries
	POLICY AND GOVERNANCE	Complete Streets policies Air quality
<p>4</p> <p>STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS</p>	ACCESS	Access to public health Access to stable health insurance Access to mental health services Routine dental care
	CONSUMER EXPERIENCE AND QUALITY	Consumer experience Population covered by an Accountable Care Organization
	BALANCE AND INTEGRATION	Electronic medical record linkages Hospital partnerships Practice laws for nurse practitioners Social spending relative to health expenditure
OUTCOME	OUTCOME AREAS	MEASURES
<p>IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY</p>	ENHANCED INDIVIDUAL AND COMMUNITY WELL-BEING	Well-being rating Caregiving burden
	MANAGED CHRONIC DISEASE AND REDUCED TOXIC STRESS	Adverse child experiences Disability associated with chronic conditions
	REDUCED HEALTH CARE COSTS	Family health care cost Potentially preventable hospitalization rates Annual end-of-life care expenditures

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