Active Living by Design's Contributions to the Movement

Scott Bernstein, BA, Keith Laughlin, BA, Tyler Norris, MDiv

In the summer of 2002, we each agreed to serve as members of the first National Advisory Committee (NAC) for the Robert Wood Johnson Foundation's (RWJF's) Active Living by Design (ALbD) program. Two of us were serving as presidents of national nonprofits and one as president of a national consultancy. In diverse ways, we were each addressing elements of the ALbD mission in our day jobs. In this brief commentary reflecting on 9 years of activity, we note a few key successes, a few areas of challenge, and opportunity for further development and provide a summary pointing to the ever-progressing, but clearly unfinished, story of the national movement for healthy people in healthy places.

What attracted us to the invitation to serve on the NAC was our aspiration that ALbD would contribute to achieving three broad objectives:

1. Creating replicable models: showing that broad-based local partnerships could use public education, policy change, and improvements to physical infrastructure to create environments more conducive to routine physical activity;
2. Leveraging productive investment: demonstrating that relatively modest investments by one funder could leverage much larger public and private investments that would, in turn, ultimately result in reduced healthcare costs to society; and
3. Building an active living movement: serving as a crucial piece of a broader active living movement to spur change on a national scale that would result in creating active living environments in communities across America.

In February 2003, shortly after the deadline for proposal submissions, we were astounded to learn that almost 1000 applications had been received. This generated two responses: First, we were daunted by the task of narrowing this huge set of applicants to 25 grantees. Second, we were ecstatic with the response, because it represented an opportunity to catalyze a broad-based active living movement. Much discussion ensued on this second point because there was a strong consensus among all NAC members that the last thing we wanted was an outcome that crowned 25 "winners" while losing the opportunity to catalyze and support action in other locales that would be essential to creating a broader movement for change. The winnowing process was intense in the months that followed, leading to the announcement of the first 25 Active Living by Design communities in November 2003.

As a group, we helped oversee the initial steps of implementation and served in leadership positions. As such, our task in reviewing evaluation documents for this commentary is shaped by varied levels of involvement over the years.

In thinking about how good ideas get to scale, one helpful framework suggests that there are five prospective pathways: changing public policies, for example, the formal rules of the game; changing power relationships; changing marketplace practice; building professional and informal communities of practice; and building effective demand for change. ALbD was not specifically about changing power relationships. It did seek to change the rules of the game but did not address the marketplace per se (e.g., there was little connection to insurers, third-party payers, financial institutions, or municipal finance). However, ALbD was very much about building communities of practice and building effective demand for change—at the site, state, and national levels.

From direct observations of the broader healthy communities movement—as well as the actions of community sites, their funders, and program offices—we note the following contributions of ALbD to the field:

1. Leading the framing of healthy eating and active living as core to addressing the upstream drivers of chronic health conditions, while concurrently providing co-benefit to fields such as economic development, placemaking, active transportation, regional food systems, and health equity. ALbD has helped build demand for such change through a variety of policy venues, including activity in the fields of transportation reform, livability, sustainable communities, and food/nutrition policy. These are now widely viewed as alternatives

From the Center for Neighborhood Technology (Bernstein), Chicago, Illinois; Rails-to-Trails Conservancy (Laughlin), Washington DC; and Total Health Partnerships (Norris), Kaiser Permanente, San Francisco, California

Address correspondence to: Scott Bernstein, BA, President, Center for Neighborhood Technology, 2125 W. North Avenue, Chicago IL 60647. E-mail: scott@cnt.org.

0749-3797/$36.00
http://dx.doi.org/10.1016/j.amepre.2012.07.011

(and/or complements) to medical approaches to combat obesity, poor nutrition, and sedentary behavior.

2. Embedding a policy, systems, and environmental change operating system, or DNA, into the domain of place-based investments. This focus has become the new norm for local, regional, and state collaboratives. ALbD's multicommunity demonstration offered vital insights into implementation challenges and potential solutions. This field-building contribution is evidenced in overall congressional support (and protection) for an array of federal grant programs, and in the investments of national, state, and local funders. To wit, the very definition of what it means to be urban has been expanded and sharpened to return to the nature of the "walking city," which predated the motorized version of the recent past. This progress is due in no small part to a set of submovements that intersect the activities of ALbD's model.

   Examples of this evolution can be found in the design of the American Recovery and Reinvestment Act of 2009 (ARRA) health stimulus funds in Communities Putting Prevention to Work; the Partnership for Sustainable Communities (Housing and Urban Development, Department of Transportation [DOT], and the Environmental Protection Agency); four rounds of DOT Transportation Investment Generating Economic Recovery (TIGER) grants and the DOT urban circulator program, as well as the Community Transformation Grants made possible via the 2010 Accountable Care Act. Progress can also be seen in the changes in program content over recent years of annual professional gatherings sponsored by such groups as the Transportation Research Board, Railvolution, New Partners for Smart Growth, and Food and Community. These gatherings point to a maturing movement for the health of people and place, not just community responsiveness to program-funding opportunities.

3. Catalyzing the development of a new generation of peer learning networks that engage local leaders and national experts in collaborative problem solving and innovation across the nation. In great part, this stems from modeling a programmatic leadership approach that is committed to deep and transparent learning as foundational to authentic performance improvement, rather than to public relations alone. This values-based quality has contributed greatly to the development of practice-based evidence and cross-sector, cross-discipline, and cross-site field building. Additionally, ALbD designed and implemented an effective technical assistance model that has informed, and to a great extent helped shape, the technical assistance approaches of many multisite cohorts funded since (e.g., W.K. Kellogg Foundation, CDC, YMCA of the USA, Kaiser Permanente, Blue Cross Blue Shield of Minnesota, and others).

4. Serving as the birthplace for the National Convergence Partnership, composed of a small set of leading health funders, integrated health systems, and the CDC. In the past 6 years, the Convergence Partners have helped guide tens of millions of dollars in community investments and grants and helped shape an array of national and state prevention, wellness, and health-related policies. We encourage the Convergence Partners to continue to embrace other partners in a spirit of valuable inclusion and collaboration that further democratizes the movement. More recently, *Advancing the Movement* has complemented this mission from its community-centric bias via The Community Commons: www.communitycommons.org.

These outcomes, combined with findings reflected in the articles of this supplement to the *American Journal of Preventive Medicine*,[1–16] affirm that ALbD has been highly successful in achieving site-level gains as well as movement/field-building. ALbD can demonstrate a solid return on the investment made by the RWJF. The ALbD program staff—serving in partnership with local site leaders— has done a tremendous job. That said, the evaluations do not fully reveal these successes, and left us with a shared sense of incompletion. To a great extent, they fail to bring to life the scores of inspirational stories that lay behind the program summaries. Further, the notion of building a broader movement beyond the 25 selected sites has been inadequately addressed.

We offer the following observations in the interest of exploring whether there are other means of showing site-level success, and whether the movement-building work has met initial expectations. At the heart of our concern are three fundamental—and related— questions about the paradigm that defines the work of the U.S. public health establishment.

First, those in the public health profession repeatedly emphasize that the field is built on the foundation of evidence-based science. The discipline assumes that trials can be run, data collected, and results evaluated on the basis of the evidence. This is clearly a valuable approach that protects both the public and the health field itself from the damages associated with quackery. But when the hypothesis being tested is something as complex as the connection between the design of our communities and the health of our people, traditional evidence-based evaluation processes falter. Evidence of this can be found in reading evaluation documents that struggle to apply a quantitative evidence-based approach to complex real-world situations that defy such evaluation, while ignoring the richer and more valuable qualitative stories that are hidden behind the clinical prose. Clearly an agreement is

essential on how to evaluate strategies that rely on traditional evidence and those that might require indicators of collective efficacy, an approach that has been used with success in fields such as community policing as a practice defined as coproduction of justice between the police and community-based organizations. We recommend a study session that can explore and effectively deploy such methods.

The second fundamental question concerning the public health establishment is the inherent tension created when a public enterprise adopts both the goals of a social change movement and the methods of an evidence-based academic institution. What results is an agenda that fully acknowledges that policy change is a prerequisite for creating active living environments, while giving the distinct impression that the actions essential to fostering policy change—namely lobbying—should be kept at arm's length. This disconnection between broad goals and specific methods contributes to confusion and ineffectiveness.

The third fundamental question concerning the public health establishment is its insularity. We have been attending public health conferences for more than a decade, and also attend numerous active transportation and food systems conferences where public health professionals have presented. Although the objectives of the public health professionals and the nonprofit activists align almost perfectly, there is still inadequate development of the systematic partnerships at the national, regional, and local levels to catalyze the change we seek. From the perspective of nonprofit advocates lacking in public health credentials, it appears that the two issues raised above create barriers to such collaboration, with the result that the public health profession is largely absent from the policy advocacy work of related cobenefit fields. This difficulty in forging ongoing collaborations that focus on collective impact—and not just meeting periodically at conferences—is a serious impediment to creating an effective active living movement in the context of the larger, distributed multifield movement for the health of people and place.

In conclusion, we are proud to have been participants in an initiative that has improved the lives of millions of Americans. A rich set of windows of opportunity around active livability has emerged nationally, which have advanced the movement and built the field. That said, the learning from ALbD can be further mined for lessons and approaches that can be taken to scale, and inform future policy change and investments in place-based strategies. As we look to the future, particularly in a time of partisan toxicity and greater financial austerity, we suggest that we move beyond lessons gleaned from traditional evaluation processes, to embrace the broader dialogue of how the movement has been growing, and what it needs in order to go to the next level. To that end, we see the value of a more inclusive national dialogue on how the many partners and sites that constitute this movement can more effectively work together as a learning community, investment advisors, and a policy constituency to create healthier places that improve the lives of all Americans.

Publication of this article was supported by a grant (57649) from the Robert Wood Johnson Foundation.

No financial disclosures were reported by the authors of this commentary.

References

1. Brownson RC, Brennan LK, Evenson KR, Leviton LC. Lessons from a mixed-methods approach to evaluating Active Living by Design. Am J Prev Med 2012;43(5S4):S271–S280.
2. Bors PA. Capturing community change: Active Living by Design's progress reporting system. Am J Prev Med 2012; 43(5S4):S281–S289.
3. Baker EA, Wilkerson R, Brennan LK. Identifying the role of community partnerships in creating change to support active living. Am J Prev Med 2012;43(5S4):S290–S299.
4. Bors PA, Brownson RC, Brennan LK. Assessment for active living: harnessing the power of data-driven planning and action. Am J Prev Med 2012;43(5S4):S300–S308.
5. Evenson KR, Sallis JF, Handy SL, Bell R, Brennan LK. Evaluation of physical projects and policies from the Active Living by Design partnerships. Am J Prev Med 2012; 43(5S4):S309–S319.
6. Claus JM, Dessauer M, Brennan LK. Programs and promotions: approaches by 25 Active Living by Design partnerships. Am J Prev Med 2012;43(5S4):S320–S328.
7. Kraft MK, Lee JJ, Brennan LK. Active Living by Design sustainability strategies. Am J Prev Med 2012;43(5S4): S329–S336.
8. Brennan LK, Brownson RC, Kelly C, Ivey MK, Leviton LC. Concept mapping: priority community strategies to create changes to support active living. Am J Prev Med 2012; 43(5S4):S337–S350.
9. Brennan LK, Brownson RC, Hovmand P. Evaluation of Active Living by Design: implementation patterns across communities. Am J Prev Med 2012;43(5S4):S351–S366.
10. Kinney AM, Hutton L, Carlson B, Perlick LM, Minkler KK, Kimber C. Isanti County active living: measuring change in perception and behavior. Am J Prev Med 2012;43(5S4): S392–S394.
11. Chomitz VR, McDonald JC, Aske AB, et al. Evaluation results from an active living intervention in Somerville, Massachusetts. Am J Prev Med 2012;43(5S4):S367–S378.
12. Huberty J, Dodge T, Peterson KR, Balluf M. Creating a movement for active living via a media campaign. Am J Prev Med 2012;43(5S4):S390–S391.
13. McCreary LL, Park CG, Gomez L, Peterson S, Pino D, McElmurry BJ. A mixed-methods evaluation of school-based active living programs. Am J Prev Med 2012;43(5S4): S395–S398.

14. Sayers SP, LeMaster JW, Thomas IM, Petroski GF, Ge B. Bike, Walk and Wheel: a way of life in Columbia, Missouri, revisited. Am J Prev Med 2012;43(5S4):S379–S383.
15. Sayers SP, LeMaster JW, Thomas IM, Petroski GF, Ge B. A Walking School Bus program: impact on physical activity in elementary school children in Columbia, Missouri. Am J Prev Med 2012;43(5S4):S384–S389.
16. Schasberger MG, Raczkowski J, Newman L, Polgar MF. Using a bicycle–pedestrian count to assess active living in downtown Wilkes-Barre. Am J Prev Med 2012;43(5S4):S399–S402.