For the Sake of All: Civic Education on the Social Determinants of Health and Health Disparities in St. Louis

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Abstract

Civic education translates research evidence about topics of social importance for broad public audiences, with increased understanding and meaningful action of the desired outcomes. For the Sake of All is an example of civic education on the social determinants of health and health disparities situated in the local context of St. Louis, Missouri. This article describes the research translation, community engagement, strategic communication, and approach to policy that characterized this project. It presents data highlighting racial disparities in health, educational, and economic outcomes, along with policy and programmatic recommendations. Engagement and

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implementation strategies are described within the context of the events in Ferguson.

**Keywords**
youth development, urban education, African American students, desegregation, diversity, social, housing, poverty, racism, race, identity

Although never far from the national consciousness, issues of racial inequality have become central to our discourse again, with incidents such as the acquittal of George Zimmerman in the shooting death of Trayvon Martin in Sanford, Florida, and the fatal police shooting of Michael Brown in Ferguson, Missouri. Indeed, more than 60 years after the landmark *Brown v. Board of Education* decision ended legal segregation in public schools and more than 50 years after the Civil Rights Act of 1964 ushered in additional sweeping changes in the law, race remains a crucial dividing line, and the United States continues to struggle with providing equal access to opportunity for all of its citizens.

It is within this context that an ongoing project, *For the Sake of All*, has sought to lay bare the stark realities of health inequity in St. Louis, Missouri, by drawing connections to a broader set of disparities in education, economic status, employment, housing, and other social factors known as social determinants of health (Braveman, Egerter, & Williams, 2011). An increasingly sophisticated body of evidence demonstrates that access to social and economic resources has a significant impact on the health of populations and helps to explain disparities in health outcomes (i.e., disease, disability, and death) for subpopulations defined by race/ethnicity and socioeconomic status (Adler & Stewart, 2010; Braveman et al., 2011; Kawachi, Adler, & Dow, 2010). Indeed, socioeconomic status and related social conditions have been described as “fundamental causes” of disparate health outcomes (Link & Phelan, 1995).

In this case study, we describe the process of developing *For the Sake of All* as an example of what we call civic education (defined below), with examples of community engagement, strategic communication, and policy engagement presented. We share examples of research translation and message delivery from the first (March 2013-June 2014) and second phase of the project (June 2014-June 2016), describe engagement of community members and key stakeholders, and present evidence of the impact of these efforts. Finally, we discuss the implications, lessons learned, and limitations of the project, whose approach may be applicable to urban, metropolitan areas in
the United States that face similar challenges with respect to racial equity and health disparities. Our goal is to demonstrate the importance of civic education as a strategy for improving developmental and health outcomes in an urban context. Moreover, as education is one of the prime social determinants of health (see the article by Zimmerman et al., in press), we seek to contribute to the education literature by describing how this approach supports a focus on health as both a crucial pre-requisite and an ultimate by-product of educational attainment.

**Civic Education: Communication, Engagement, and Action Across Communities**

There has been growing attention to the social determinants of health and health disparities by academic researchers in public health, education, medicine, and other disciplines, as well as governmental agencies and national and international non-governmental organizations such as the Robert Wood Johnson Foundation (RWJF), ASCD (formerly the Association for Supervision and Curriculum Development), the MacArthur Foundation, and the World Health Organization (Braveman et al., 2011; Harris, Jones, & Tate, 2015). However, public and policy maker opinions do not reflect this emphasis.

Public opinion in the United States continues to support the notion that access to health care and individual health-related behaviors have the strongest effects on health outcomes, while neglecting the role of social and economic factors (Robert & Booske, 2011). Without broad public knowledge and discussion of the social determinants of health, it is unlikely that policy remedies will be enacted to address inequalities that jeopardize population health. Even when attempts are made to alert the public to these contextual determinants of health, political ideology can undermine support for policy remedies (Gollust, Lantz, & Ubel, 2009). The lack of public understanding regarding social determinants of health and the danger that messages about social determinants may be counterproductive to policy action suggest that an opportunity exists for what we call **civic education**.

**Civic education** (which should be distinguished from education in civics, or the forms and functions of civil society) translates research evidence about topics of social importance for broad public audiences, including policy makers, media, members of the general public, and other decision makers. Both increased understanding and meaningful action (particularly, but not exclusively, policy action) are the desired outcomes of civic education. While civic education is conceptually and practically distinct, the For the Sake of All project’s approach does share principles and strategies with the community-based
participatory research (CBPR) paradigm, which has been described as “systematic investigation with the participation of those affected by an issue for purposes of education and action or affecting social change” (Green et al., 1995, p. 12). These include recognition of the community as a unit of identity, building upon community strengths and assets, facilitating collaboration with community, integrating knowledge and action for mutual benefit to partners, promoting co-learning and empowerment, addressing health from a positive and ecological perspective, and disseminating findings and knowledge broadly (Israel, Eng, Schulz, & Parker, 2005; Israel, Schulz, Parker, & Becker, 1998).

Increasingly, CBPR partnerships have been formed with policy action as their ultimate aim. Several have led to meaningful policy change and provided lessons for additional work in this area (Cacari-Stone, Wallerstein, Garcia, & Minkler, 2014; Minkler, 2010; Minkler et al., 2008). This is also relevant to the civic education approach. Common success factors for CBPR projects focused on policy are respect and trust among partners, appreciation for rigorous science, ability to build broad and diverse alliances that include key stakeholders such as policy makers or policy influencers, and the ability to attend to the policy process and context (Minkler, 2010; Minkler et al., 2008).

Cacari-Stone and colleagues (2014) provide a conceptual model that links CBPR to the policy-making process. Scholars in public policy and political science have characterized the policy process as involving (a) problem definition, (b) increased awareness and agenda setting with policy makers, (c) development of policy alternatives, (d) selection of specific policies, (e) implementation of policies, and (f) evaluation (Bardach, 2000; Kingdon, 2003). The CBPR for policy model suggests that an initial consideration of the historical, economic, social, and political context within a community should occur alongside a careful assessment of levels of trust, capacity, and readiness to take on a policy-focused CBPR partnership. Next, partners must attend to the dynamic interplay between the uses of evidence and civic engagement, which may take on both political and non-political forms of advocacy for policy change. Partners then engage in the policy-making process. Crucially, these efforts must also rely on the opening of what Kingdon (2003) calls “policy windows of opportunity” that focus the attention of the public and policy makers on a particular set of issues because of an external event (e.g., a media exposé or sudden crisis). The final phase of the model considers both policy change and, ultimately, health outcomes that result from policy-focused CBPR. Because the policy-making process is multiply determined and happens over long periods of time, it can be difficult to attribute policy change to the actions of a single CBPR partnership. Therefore, more appropriate outcomes to consider may be whether the partnership
resulted in a change in the policy environment or contributed to necessary steps in the policy process being taken (Guthrie, Louise, & Foster, 2006; Minkler, 2010).

Despite considerable overlap in principles and strategies, there are nonetheless critical distinctions between civic education in the instance of For the Sake of All and traditional CBPR. For example, the project did not originate with a community organization or group of residents seeking to answer a specific research question, but had its origins in academic institutions and among scholars interested in informing and engaging the public on the social determinants of health and health disparities and recommending a set of programmatic and policy solutions. Also, whereas the primary focus of CBPR is on partnership among academic and other institutional partners and affected communities, civic education focuses more broadly on changing public opinion and encouraging action even among members of the community who may not perceive themselves to be affected by social and health inequities. Indeed, because the multiple factors that influence health disparities will require resources and responses from influential actors across various sectors and segments of communities, one of the central principles of civic education is that appeals must be made to what de Tocqueville called “self-interest properly understood” (Tocqueville & Bender, 1981), or what has come to be known as “enlightened self-interest.” This orientation is as important in engaging individuals along the ideological spectrum as it is for organizations and institutions (e.g., schools, community and economic development organizations, non-health governmental agencies, etc.) that may not readily see their connection to health disparities or health more broadly.

Because of its emphasis on inclusive messaging, civic education is informed by research in communication science on raising awareness about social determinants of health and health disparities. Niederdeppe, Bu, Borah, Kindig, and Robert (2008) suggest that population health researchers and advocates should consider messages that acknowledge a role for . . . individual decisions about [health-related] behavior but refute the idea that individual behavior or medical care are the sole causes of poor health and instead emphasize the influence of SDH [social determinants of health]. These messages might use narratives to provide examples of individuals or families that face structural barriers . . . in their efforts to avoid poverty, unemployment, racial discrimination, and other SDH. Evocative visual images that invite generalizations, suggest causal interpretations, highlight contrasts, and create analogies could accompany these narratives. (pp. 505-506)
Work by RWJF also explores the need to deliver messages about the social determinants of health both broadly and strategically to build public support. The foundation relied on extensive message testing research with Democrats and Republicans to develop *A New Way to Talk About the Social Determinants of Health* (RWJF, 2010). Among the recommendations of this report are to (a) use terminology that is broadly relatable, (b) prime audiences with messages they already believe rather than immediately challenging their beliefs, (c) use messages that convey one compelling fact, (d) identify problems but also point to solutions, (e) acknowledge the role of personal responsibility, (f) use a mix of traditionally conservative and progressive values, and (g) discuss how social determinants of health affect all Americans.

While acknowledging the critical importance of situating activities directed at social change within affected communities, civic education is equally concerned with the broader political contexts in which policy decisions touching on the social determinants of health and health disparities will be made. It combines meaningful community engagement with a communication strategy designed to appeal to multiple audiences and thereby increase the potential for broad public support for policy recommendations that result from community-informed research translation. The resulting approach is best summarized in a framework developed in parallel with colleagues at Virginia Commonwealth University for translating evidence into action that includes (a) research translation for use by decision makers in the lay (i.e., non-academic and non-health professionals) public, (b) community engagement that involves community members and other key stakeholders in the development and dissemination of information for action, (c) strategic communication that matches effective messages with audience characteristics and appropriate channels, and (d) policy engagement that is attentive to the special features of environments in which policies are made (Woolf et al., 2015).

**Method**

**Phase I**

Funded by the Missouri Foundation for Health, the first phase of work had four major goals, including to

1. inform the public about the social determinants of health as they affect African Americans;
2. present the regional economic and health consequences of intervening (or failing to intervene) on the social determinants of health;
3. provide evidence of the impact of persistent disparities on all members of the region, regardless of race or socioeconomic status; and
4. influence policy discussions on health disparities by broadening the conversation beyond personal responsibility and the delivery of medical care alone.

To accomplish these goals, an academic–community partnership for civic education was formed. The original academic team consisted of seven scholars from Washington University in St. Louis and Saint Louis University in the disciplines of public health and education.

**Community engagement.** Throughout the first phase, the project team engaged in extensive community engagement. The team partnered with a Community Partner Group (CPG) with representatives from the following:

- The health departments of the City of St. Louis and St. Louis County
- The Integrated Health Network, an organization composed of the region’s federally qualified health centers
- Washington University’s medical school and affiliated medical center
- Education Plus, an organization that supports the region’s school districts
- The Community Investment Division of the Federal Reserve Bank of St. Louis
- Urban Strategies, Inc., a national community development organization based in St. Louis
- The St. Louis Area Business Health Coalition, an organization of executives responsible for health benefits for the region’s major employers
- The Black Leadership Roundtable, an organization of African American civic and community leaders
- The *St. Louis American*, an African American weekly print newspaper in St. Louis
- The *St. Louis Beacon*, an independent online journal focused on topics of importance for the St. Louis region (now merged with the local National Public Radio [NPR] affiliate, St. Louis Public Radio)
- The St. Louis Regional Chamber, representing regional businesses.

CPG members helped to determine the overall project goals listed above and strongly influenced the structure of community engagement efforts supporting the project, including extending Phase I by 2 months to allow for greater community input. CPG members also approved the policy brief topics
and the initial outline of the final report. This group was instrumental in connecting the project team to community stakeholders consulted during the drafting of each policy brief. These topic-specific community stakeholders were asked to review the draft briefs for clarity and comprehensiveness as well as the appropriateness of recommendations made in their respective areas of expertise. For example, leaders of the St. Louis Regional Early Childhood Council and the Maternal, Child and Family Health Coalition were consulted during drafting of the first brief in which recommendations were made for improvements in policy related to early childhood programs.

**Strategic communication.** Multiple media channels were also crucial to increasing public awareness regarding the project. Represented on the CPG were the nationally recognized African American weekly newspaper, the *St. Louis American*, and an online source of regional news called the *St. Louis Beacon*. With the assistance of Washington University’s Office of Public Affairs and in coordination with University Marketing and Communications at Saint Louis University, press releases accompanied releases of the policy briefs and the report as well as other relevant project progress.

**Data analysis.** Policy briefs and the final report relied upon secondary descriptive analysis of locally relevant, publicly available data sources. In some cases, state and national comparisons were made as well. Data sources included the U.S. Census Bureau’s American Community Survey (ACS) and Decennial Census for demographic, social, and economic data; the Missouri Department of Elementary & Secondary Education (Missouri Assessment Program—MAP) for education data; and the Missouri Department of Health and Senior Services (Missouri Information for Community Assessment—MICA), Centers for Disease Control and Prevention (CDC), and previous reports on the St. Louis region (e.g., St. Louis Regional Health Commission) for health data. Additional health data were derived from the *2011 County-Level Study* for the State of Missouri.

Frequencies and age-adjusted population standardized rates were calculated for sociodemographic (e.g., population, poverty, educational attainment, unemployment) and health outcome (e.g., mortality, chronic and infectious disease, behavioral risk factors) data. Additional analyses included an estimation of life expectancy at birth for select zip codes representing locally meaningful geographies in the region; estimation of the number of deaths among African American adults in 2011 that were attributable to poverty and having less than high school education, using data from previous studies linking social factors to mortality (Galea, Tracy, Hoggatt, Dimaggio, & Karpati, 2011; see the appendix of Purnell, 2013, for detailed description...
of this analysis); and geographic information system (GIS)–generated maps of key frequencies and rates (e.g., African American population, poverty, African American enrollment, school dropout, and disease-specific mortality rates). Estimates of economic impact included calculation of the value of a statistical life, which quantifies the economic value of an additional year of life. The regional loss of life that was attributable to poverty and less than high school education among African Americans could therefore be assigned an economic value. Hospital charges for mental and physical health care and other direct medical expenditures and lost earnings, tax revenue, economic activity due to school dropout were also calculated or cited from previous reports (e.g., Alliance for Excellent Education, 2011). Finally, data or findings drawn from numerous peer-reviewed journals, reports, and books offered crucial context for the local data reported in the briefs and final report.

Data presentation. The approach to research translation and data presentation for the policy briefs prioritized several key features consistent with recommendations of Niederdeppe et al. (2008), the RWJF (2010), and research on textual analysis (Graesser, McNamara, & Kulikowich, 2011). First, it was important that the briefs be visually appealing. A professional graphic design firm was hired to develop the “look and feel” of all project materials, including consistent color palettes, fonts, and styles of data presentation to make the content more compelling (McGuire, 1991; Waddill & McDaniel, 1992). A consulting firm specializing in health literacy (i.e., individuals’ ability to
access, understand, appraise, and apply health information; Sørensen et al., 2012) also ensured that health-related data and text were accessible to a lay audience. A template was developed for the briefs so that they would consistently present information on social factors related to health (see Figure 1).

Briefs also included examples of local and national programs and links to additional resources. As the briefs were distributed through the project website, they were fully interactive documents.

Many of the same principles that guided development and dissemination of the policy briefs were used in preparation of the final report (Purnell, Camberos, & Fields, 2014). The same graphic design firm ensured that the presentation of information was consistent, easily accessible, and visually appealing. Economic impact and examples of promising or proven interventions were presented as well. The report also capitalized on the project’s partnership with the *St. Louis Beacon* by presenting summaries of their human interest reporting throughout the publication.

**Evaluation of Phase I impact.** The evaluative outcomes for Phase I were linked to the project goals. Key metrics for tracking outcomes included delivery of the main products (e.g., briefs and report); website traffic; media attention; number of presentations, briefings, and meetings with community groups, policy makers, and other key stakeholders; and attendance at community engagement events.

**Phase II**

With additional funding from the Missouri Foundation for Health, the second phase of *For the Sake of All* began in June of 2014, shortly after the May release of the report. It will extend until June 2016. Goals in the second phase are to

1. continue to inform and educate the public and policy makers regarding the social determinants of health and health disparities;
2. engage and mobilize the community around the recommendations;
3. activate key private and public sector stakeholders for implementation of recommendations; and
4. evaluate the impact of the project and determine its replicability.

The project team entered into a new partnership with a civic leadership development organization called FOCUS St. Louis to develop discussion guides and action toolkits in each of the six areas of recommendation. The purpose of the discussion guides is to distill key data points and background
information, provide examples of successful, evidence-informed strategies to address recommendations, and provide prompts to seed discussion within the social networks of community members. The action toolkits are designed to give community members multiple points of entry for taking action on the recommendations. Several examples of organizations currently working in the recommendation areas are also included along with a supplementary resource list. These materials are also developed with a professional graphic design firm as well as a dissemination coordinator added to the project team in Phase II. Writing is shared, with the academic research team providing an initial outline, updated data, and suggestions for graphical presentation, and the marketing director at FOCUS St. Louis drafting text that is accessible to a lay audience. All materials are available on the project website.

Discussion guides and action toolkits are released at Community Action Forums hosted throughout the St. Louis community. These events are designed to both educate and motivate action on the part of participants. The typical format for Community Action Forums has been a panel of community leaders and experts on the topic moderated by a professional facilitator, introduction to the Discussion Guide and Action Toolkit, and an opportunity for large and small group discussion.

Media partnerships with St. Louis Public Radio and the St. Louis American continue as well. St. Louis Public Radio received its own grant from the Missouri Foundation for Health to gauge the response of community members to For the Sake of All through an initiative called “The Listing Project.” St. Louis Public Radio staff members hold discussion sessions with community members from the northern and southern portions of the City of St. Louis and St. Louis County that have traditionally been divided along racial lines. They share highlights from the report and gather candid feedback from the groups.

In addition to the community listening sessions, St. Louis Public Radio also worked with the For the Sake of All team and a professional film producer to develop a brief video that presents the themes in the project in an accessible way. The Gateway Gauntlet (St. Louis is known as the “Gateway to the West”) dramatizes the life and health challenges faced by the protagonist in a narrative set against the backdrop of a video game and describes the social and economic resources necessary for the hero to be successful (Kaplan, 2015). The project team provided overviews of relevant academic literature to inform the film’s narrative. There was also consultation between the producer’s team and the project team on message development, graphic design, and other elements of the film. The Gateway Gauntlet continues in the vein of dramatization and narrative accomplished in the first phase and in keeping with the guidelines of Niederdeppe et al. (2008). The video is viewable on the project website.
The *St. Louis American* continues to devote coverage to the project and has been crucial to keeping the project in the consciousness of the African American community in St. Louis. Outreach to additional media outlets continues in the second phase as well.

Community and policy stakeholder engagement also continues in Phase II. Numerous presentations have been delivered to a broad range of community organizations, elected officials, and government bodies and agencies. Most of the presentations are by invitation, but targeted, proactive outreach has been directed at corporate leaders and policy makers as key influencers in the region.

**Evaluation of Phase II impact.** The four primary evaluation questions in Phase II are as follows: (a) What legislation has been introduced or passed related to the *For the Sake of All* recommendation areas? (b) To what extent did project events and products reach a diverse audience throughout the St. Louis region, and how were products used? (c) To what extent do participants in project events report changes over time in awareness of, and action around, recommendation areas? (d) What are examples of current efforts that address the recommendation areas?

Several methods are used to answer these evaluation questions. The introduction, progress, and passage of legislation is tracked using legislative updates from the Missouri Foundation for Health and the Center for Family Policy and Research at the University of Missouri, and details are extracted from the Missouri House of Representatives and Missouri Senate websites. Bills are categorized by their relationship to the six areas of recommendation through a systematic policy review process. Reach is measured via website analytics, Twitter analytics, and a database to track meetings and presentations by the project team. Ongoing activities related to the recommendation areas are ascertained through informal environmental scans and the collective knowledge of the project team in their engagement with the community. Often these scans are part of the preparation of discussion guides and action toolkits.

Attendance at events like Community Action Forums are measured through a combination of online Eventbrite event registration website and a project database, including basic demographics (e.g., gender, zip code, organizational affiliation) on attendees through a web-based pre-event survey that is completed during the process of registration. Also as part of this survey, registrants answer questions about whether they have read project materials or used them in their advocacy activities. To determine awareness of the impact of social determinants, items were modified from an instrument that has been used in previous research to assess the extent to which the public
perceives various factors (e.g., income, personal health behaviors, level of education, genetics, etc.) to influence health outcomes (Robert & Booske, 2011). Responses are on a 10-point Likert-type scale from 1 = no effect on health to 10 = very strong effect on health. A range of advocacy-related actions (e.g., donation, contact legislator, attend an event, encourage others to take action) is also assessed with a binary yes/no measurement format. These items are completed prior to Community Action Forum attendance and again 12 weeks post-event. Changes in awareness and action are analyzed to determine whether the event had an impact on either.

Results

Phase I

Products. Five policy briefs were released between August and December of 2013. Brief content and recommendations were vetted by community stakeholders with expertise in the various topics that were explored. The first brief described disparities in death rates, educational attainment, and poverty between Whites and African Americans in the City of St. Louis and St. Louis County and recommended investments in early childhood development and creation of economic opportunities for low- to moderate-income households in the region (Purnell, 2013). An infographic depicting the loss of life associated with poverty and low levels of education (see Figure 2) provides an illustration of the effort to display data in an accessible manner and inclusion of health and economic impact.

The second brief described the implications of the association between education and health, but in the opposite direction of the first brief. Specifically, it distilled research literature linking poor health to worse academic performance and failure to complete secondary education (Tate, 2013). It recommended investing in coordinated school health programs along the lines of the CDC guidelines in this area (now called the Whole School, Whole Community, Whole Child [WSCC] model; Lewallen, Hunt, Potts-Datema, Zaza, & Giles, 2015), and investing in counseling and psychological services for young people.

The third brief examined the social and economic factors associated with mental health and disparities affecting African Americans (Hudson, 2013). Recommendations included improving mental health screening and awareness, investing in community mental health centers, and improving the quality and availability of mental health data.

The health impacts of residential segregation by both race and socioeconomic status were covered in the fourth brief (Goodman & Gilbert, 2013). As
another example of data presentation, the association between residential segregation by race and income (i.e., poverty) and health outcomes at a geographic level was presented using a series of maps at the zip code level depicting (a) the percentage of African American population, (b) the percentage of residents living in poverty, (c) heart disease mortality rates, and (d) cancer mortality rates (see Figure 3).

Recommendations for addressing these conditions included investing in quality neighborhoods for all in St. Louis, promoting development and housing choice without displacement, and promoting the benefits of diverse neighborhoods while safeguarding fair housing.

The fifth and final brief examined local data on mortality from cardiovascular disease, cancer, and diabetes using the Healthy People 2010 goals.
(U.S. Department of Health & Human Services, 2010) established by the U.S. Department of Health & Human Services (Drake & Elder, 2013). While decline in cardiovascular death rates for both African Americans and Whites in the City of St. Louis and St. Louis County between 2000 and 2010 exceeded the Healthy People 2010 goal of a 20% reduction, similar reductions were not realized for cancer or diabetes. Recommendations were to

Figure 3. Maps of African American population, poverty, cardiovascular disease mortality, and cancer mortality in St. Louis.
Note. Mortality rates were age-adjusted using the U.S. standard population. Rates were not included for zip codes with less than 20 deaths due to heart disease or cancer. MICA = Missouri Information for Community Assessment.
formally consider the health impact of even non-health policies, and invest in chronic disease prevention and management through expanded community partnerships supporting positive health behaviors.

Following release of the five policy briefs, a Community Feedback Forum was held in March 2014 to elicit community response to draft elements of the final report. Poster boards with professionally designed charts, graphs, figures, and text were arrayed in a centrally located meeting space in St. Louis’s Forest Park. Over the course of the 4-hr open house-style event, 91 community members provided feedback directly onto the poster boards using adhesive notepads. This feedback was analyzed by the project team to determine the most prevalent themes. They included (a) a need to address social determinants of health for all racial and ethnic groups; (b) a desire to see lesbian, gay, bisexual, and transgender (LGBT) issues covered; (c) a need for clarification of specific data sources and limitations as well as more detailed accounts of the methodology for analyzing and reporting data; (d) a desire to see more information on HIV/AIDS presented; (e) attention to the clarity of data presentation and the definitions of potentially unfamiliar terms; (f) expanded coverage of youth violence; and (g) more examples of positive activities in the community and sources of hope. The project team responded to each of these concerns either by clarifying the scope and intent of the project or by including or enlarging areas of coverage in the final report. For example, readers were referred to a report on LGBT health disparities prepared by the Missouri Foundation for Health in response to feedback regarding coverage of these issues, and report sections on violence and HIV/AIDS were expanded.

The culmination of Phase I was the release of the final report at a Community Conference held on May 30, 2014, at the Missouri History Museum. A total of 267 people were in attendance to hear highlights of the findings, a keynote from the senior vice president of the National Urban League and editor of its annual *State of Black America* report and panels of experts and community leaders on (a) early childhood education and health, (b) social and economic factors in mental and physical health, and (c) multi-sector approaches to healthy neighborhoods. The event ended with a call to action to implement the recommendations in the report to secure a more equitable future for the region.

After an executive summary and brief description of the project’s goals and process, the report was divided into six major sections: (a) an introduction providing the rationale for considering economics, education, and health alongside one another; (b) an historical overview of select socioeconomic and health indicators using the landmark anniversaries of the 1950s and 1960s as the point of reference; (c) an examination of the critical role of neighborhoods and other features of place in determining health outcomes; (d) an examination of the
bi-directional relationship between education and health; (e) a health profile of African Americans in St. Louis; and (f) updated and revised recommendations based upon the feedback received during the Community Feedback Forum and consultation with the CPG and other stakeholders.

The final list of recommendations includes both policy and programmatic strategies specific to the regional context in St. Louis, and in several instances, at the state level.

**Recommendation 1: Invest in quality early childhood development for all children.** Targeted investments and strategies include the following:

- Expanding all children’s access to well-designed early childhood programs with (a) small class sizes, (b) qualified teachers, (c) significant time spent on instruction, (d) school–family partnerships and programs, and (e) an emphasis on social and emotional development in addition to academic preparation
- Fully funding early childhood programs at the state level
- Implementing a quality improvement process with accountability measures
- Improving the level of child care subsidies for low-income families
- Expanding home visitation services and other supports to parents that cover the prenatal through early childhood period.

**Recommendation 2: Help low- to moderate-income families create economic opportunities.** Targeted investments and strategies include the following:

- Making college savings accounts universally available for children at birth or school entry, and providing additional savings as incentives for educational success and parental engagement throughout K-12 schooling
- Making financial advice and services easily accessible and affordable to families at all income levels.

**Recommendation 3: Invest in coordinated school health programs for all students.** Targeted investments and strategies include the following:

- Expanding coordinated school health programs to all schools, particularly those in high-poverty communities
- Making positive child and youth development opportunities available through afterschool and other programming in partnership with the community
Implementing evaluation, technical assistance, and resource plans to support school districts in their efforts to create or expand coordinated school health programs
• Building private–public partnerships to support coordinated school health efforts.

**Recommendation 4: Invest in mental health awareness, screening, treatment, and surveillance.** Targeted investments and strategies include the following:

• Investing in counseling and psychological services for young people through private and public sources
• Improving mental health awareness using community-wide education to change community norms and increase screenings in medical and other settings
• Investing in more outpatient community mental health centers, particularly in areas of need, and coordinating screenings and referrals for high-risk populations
• Improving the quality and availability of mental health data by establishing regional systems for tracking and reporting on the prevalence of mental health conditions and their treatment.

**Recommendation 5: Invest in quality neighborhoods for all in St. Louis.** Targeted investments and strategies include the following:

• Promoting development and housing choice without displacement
• Investing in the viability, stabilization, and health promotion of neighborhoods through strategic community partnerships and regional economic integration
• Addressing violence as a public health problem that affects the quality of neighborhoods
• Using tax, zoning, and other housing policies to allow residents choice and voice in development
• Promoting the benefits of diverse neighborhoods through community partnerships that highlight model communities
• Safeguarding fair housing by enforcing existing laws.

**Recommendation 6: Coordinate and expand chronic and infectious disease prevention and management.** Targeted investments and strategies include the following:

• Expanding health promotion partnerships across sectors to address chronic disease in both clinical and community settings;
Addressing social and economic barriers to health in medical settings;
• Considering the health impacts of all policies at the state and local levels; and
• Investing in chronic and infection disease prevention and management by making healthy behavioral choices easy for residents.

Among the prominent features of the report were the use of graphics and narrative to educate a broad audience about health disparities and the social determinants of health. One of the most widely cited graphics was the life expectancy map by selected zip codes in the St. Louis region (see Figure 4). These areas were chosen to be representative of the common understanding, or cognitive map, of St. Louis, which typically divides the City of St. Louis between the north and the south, and St. Louis County by its northern, southern, western, and central sections.
The largest gap in life expectancy at birth is between children born in the predominantly African American, high-poverty zip code of 63106 in North St. Louis (67 years) and those born in the affluent, mostly White, central suburban zip code of 63105 (85 years). This is a geographic distance of less than 10 miles and a difference in life expectancy of 18 years.

Another graphic depiction used the narrative and visual image approach suggested by Niederdeppe et al. (2008) to distill the complex set of social and economic factors that drive health disparities. It was called “The Two Lives of Jasmine” (see Figure 5 for an excerpt).

Jasmine is a fictitious character whose simplified life course is charted along two paths. Along the first path, Jasmine starts life in a college-educated, two-parent family unit and has access to a range of social, economic, and environmental resources to support her success in life. Along the second path, Jasmine has a single mother struggling to make ends meet and lacks the resources that would support her native intelligence and drive to succeed. At each stage in her development along the second path, the report describes interventions in line with the six areas of recommendation that could bolster Jasmine’s chances of success. This simple graphic tied several aspects of the overall project together, making for an accessible and impactful discussion piece for readers. The graphic became an even more powerful teaching tool when it was animated by the Nine Network of Public Media as part of a program that aired in June of 2014 about the project (Berger, 2014). It is now on the project website and a regular part of presentations in the community.
Impact

Website traffic. The project website, forthesakeofall.org, was launched in August 2013. It is the primary means of accessing all the products, background information, and media coverage about the project. Although originally envisioned as an interactive space where community members could share comments and questions, the website has proved to be more unidirectional, with visitors accessing resources without much interaction. Despite this, interest has been substantial. By the end of Phase I, the website had been viewed 13,736 times by 6,451 visitors.

Media attention. Thanks in part to proactive media partnerships and dedicated reporting from the St. Louis American and St. Louis Beacon, media attention was significant. Both the American and the Beacon published news stories announcing the project, and subsequent stories appeared with the release of each of the policy briefs and the final report. Both publications also published complementary pieces such as editorials, commentaries, and letters to the editor. In addition to this coverage by media partners, the project team and community stakeholders appeared on St. Louis Public Radio to discuss each of the briefs and the final report. This combination of proactive media partnership and sustained interest spurred additional coverage of the project by the local daily newspaper, the St. Louis Post-Dispatch, as well as other local print, radio, and television outlets. By the end of the first phase, For the Sake of All had 48 media appearances in 13 outlets, several local and one national (i.e., Al Jazeera America).

Policy engagement. Beginning in March of 2014, initial briefings were held for the Missouri Legislative Black Caucus, staff members in the Office of Missouri’s governor, the mayor of the City of St. Louis and his cabinet, the city treasurer, and the St. Louis Board of Aldermen president and the board’s Health & Human Services and Ways and Means committees. Several members of St. Louis County government were also engaged, particularly in the Office of the County Executive, Department of Health, and Department of Planning.

Additional engagement. In total, more than 50 meetings, presentations, and briefings were held with numerous community organizations and stakeholder groups in the first phase of the project.

Phase II

Before presenting preliminary results from the ongoing second phase of the For the Sake of All project, it is critical to place this phase and the broader
project itself within the context of the fatal, police-involved shooting of Michael Brown in the suburban town of Ferguson in August of 2014, just months after the release of the report. It represented an historic crisis point for the region, which became an international symbol of modern-day struggles with racial inequality. It was within this context that *For the Sake of All* took on increased resonance, and it is against this backdrop that engagement with the project, particularly post August 2014, must be understood.

**Discussion guides and action toolkits.** As of March 2016, four discussion guides and action toolkits for the general public have been released on the recommendation areas of economic opportunity, early childhood, school-based health, and quality neighborhoods. Figure 6 shows an example of the first set of materials on economic opportunity. Compelling graphics, accessible language, examples of effective or promising local and national activities, and discussion questions are common features of the discussion guides. Action toolkits give community members guidance on how to educate and inform themselves and their networks, where they can donate or volunteer to causes aligned with areas of recommendation, and ideas about advocacy and civic engagement. There are sample social media posts, tips on writing a letter to the editor or op-ed, and suggested talking points provided as well. From the
first release in October 2014 to March 2016, discussion guides and action toolkits have been downloaded from the project website 2,035 times (in order of release, 881 downloads for economic opportunity, 499 for early childhood, 332 for school-based health, and 323 for quality neighborhoods).

A fifth set of materials is currently under development on mental health. In addition to FOCUS St. Louis, the project team is partnering with an initiative raising awareness about toxic stress and trauma-informed communities called Alive and Well, and with the Regional Health Commission and the Behavioral Health Network, both of which coordinate health care services with an emphasis on the uninsured or underinsured. A sixth and final set of materials will be produced for release in the spring of 2016.

Legislative tracking. During the 2015 session of the Missouri General Assembly, 61 proposed bills whose content was related to one or more of the For the Sake of All recommendation areas were identified. Most \((n = 25; 41\%)\) were related to early childhood, followed by coordinated school health \((n = 18; 30\%)\), chronic disease prevention \((n = 16; 26\%)\), economic opportunity \((n = 15; 25\%)\), quality neighborhoods \((n = 10; 16\%)\), and mental health \((n = 7, 12\%)\). Only two of these bills were passed. One modified provisions related to the Division of Youth Services so that youth in that division’s custody could receive wages for certain work done while in custody and would receive any excess upon release from residential care. The other required sexual education instruction to include information on sexual predators, online predators, and the consequences of inappropriate texting. Prominent bills regarding early childhood and school health are also under consideration during the ongoing 2016 legislative session. In perhaps the clearest example of the project’s influence, the treasurer of the City of St. Louis established two initiatives directly in line with For the Sake of All recommendations: the establishment of an Office of Financial Empowerment that provides advice and services to residents and the College Kids program, which established college savings accounts for kindergarteners in city public and charter schools (see the article on Child Development Accounts by Sherraden et al., in press).

Website and social media tracking. As of March 2016, the project website had been viewed 70,786 times by 24,163 visitors. This translates into an additional 57,050 views and 17,712 visitors since the end of Phase I. In addition to local and national interest in the project, there has been international interest. The website has been viewed in 125 countries outside of the United States.

A Twitter account was established for the project in September of 2014. Since that time, it has gained 765 followers and posted 947 tweets regarding
project updates, events, products, and relevant news stories. Excluding months for which there is only partial data, there have been an average of 12,556 impressions (i.e., views within user timelines or search results) per month for project tweets, and the project has gained an average of 43 new followers each month. According to Twitter Analytics, followers are 68% female, and the top three interest categories are “politics and current events” (85%), “business and news” (85%), and “business news and general info” (80%).

**Media attention.** When the events in Ferguson drew international attention to the St. Louis region, many in the national and international media turned to *For the Sake of All* for explanations of the origins of the crisis. Outlets as varied as *Bloomberg Businessweek*, NPR, the *Washington Post*, the Canadian weekly magazine *Mclean’s*, and the *Korea Times* all cited the project in their coverage of the events in Ferguson and their aftermath. Strong media interest in *For the Sake of All* continues, with 107 news items or program appearances to date, including more recent stories in the daily *St. Louis Post-Dispatch*, the African American weekly *St. Louis American*, St. Louis Public Radio, and the *St. Louis Business Journal*. Also, in March of 2016, the project’s *Gateway Gauntlet* video produced in partnership with St. Louis Public Radio won a Telly Award, a national recognition for non-broadcast and online video content.

**Community Action Forums.** A total of 426 people have attended the four Community Action Forums held to date. Average attendance has been 107 community members, with the number ranging from 95 to 112 people. On average, attendees have come from 36 unique zip codes in the City of St. Louis and St. Louis County, and they have been predominantly female (63%-84%), highly educated (70%-86% with at least a bachelor’s degree), and most commonly affiliated with a community organization (23%-45%) and with higher education (14%-21%). In terms of race, between 41% and 53% of attendees have been Whites, 25% to 34% Blacks, 5% to 7% Others, and 15% to 20% unreported. Each subsequent forum appears to be drawing new attendees, as those reporting that they have never attended a prior *For the Sake of All* event ranges from 48% to 57%. Speakers at the forums also have been influential stakeholders, including the Missouri Commissioner of Education, a state senator, a state representative, the Treasurer of the City of St. Louis, a school superintendent, several non-profit executives, health professionals, academics, and other community leaders.

There is some evidence that attendance at Community Action Forums influences perceptions related to the social determinants of health. Results of a paired-samples *t* test comparing the mean difference in pre-event and 12
weeks post-event survey responses (n = 73; 17% response rate) pooled across the three forums with completed follow-up reveal small but significant changes in attitude regarding the extent to which health is affected by level of income (Pre: M = 8.71, SD = 1.84; Post: M = 9.45, SD = 1.00), t(72) = −4.21, p < .001; level of education (Pre: M = 8.03, SD = 1.78; Post: M = 8.95, SD = 1.33), t(72) = −4.99, p < .001; community safety (Pre: M = 8.49, SD = 1.71; Post: M = 9.27, SD = 1.06), t(70) = −3.80, p < .001; and having health insurance (Pre: M = 8.85, SD = 1.68; Post: M = 9.25, SD = 1.16), t(72) = −2.37, p = .02. There were no significant changes with respect to the influence of personal health practices, access to affordable care, or genetic makeup on health (all ps > .05).

Key stakeholder engagement. Partnership with the Washington University Institute for Public Health (IPH) on a two-part series of cross-sector, action-oriented meetings called “Next Steps: Evidence into Action For the Sake of All” has moved community and key stakeholder engagement from an emphasis on dissemination to focus on implementation. Prior to the first meeting in September 2015, invited participants from advocacy, business, non-profit, government, philanthropic, and academic sectors completed an online survey to rank the For the Sake of All sub-recommendations within the six major areas by both importance and feasibility. Results provided a framework for a daylong discussion among 60 stakeholders in six groups to prioritize strategies to address the recommendations. A planning group consisting of the project team, IPH staff, and community partners culled a list of 34 strategies to eight, after assessing the evidence of need and potential effectiveness of intervention, existing work in the area, local champions and potential funders, and the ability of the academic team to support the work through technical support, research, and evaluation. The eight strategies are to

1. increase quality of early childhood programs and increase knowledge and utilization of existing resources;
2. increase access and support for Child Development Accounts;
3. build capacity around the coordinated school health model;
4. establish school-based clinics in high-need areas;
5. develop a regional data center to collect, analyze, and share mental health data;
6. address violence as a public health issue;
7. establish a coordinating organization to advocate for development, tax, and zoning policies for inclusive, affordable housing; and
8. address social and economic barriers to health in medical settings.
At a follow-up meeting in February 2016, 100 stakeholders met to begin initial implementation planning. Prior to the meeting, group members were given extensive background information that included brief reviews of the available evidence supporting each strategy, relevant local data describing the need for intervention, and best practices and guiding principles. The eight groups were facilitated by project management professionals from a large local health system, BJC, through its Center for Clinical Excellence. The convening was co-hosted by Forward Through Ferguson, the organization charged with carrying out the work of the Ferguson Commission appointed by the governor of Missouri to investigate the social and economic root causes of the unrest in the summer of 2014.

Briefings and meetings with policy makers have continued in Phase II as well. These have included the federal Congressional delegation representing the St. Louis area, including U.S. Representative William (Lacy) Clay and his staff as well as the St. Louis-area staff for U.S. Senators Roy Blunt and Claire McCaskill. The project has continued to gain national recognition as well, including presentation as part of a panel with former Secretary of State and Democratic presidential candidate, Hillary Rodham Clinton, in June of 2015. Significant progress also has been made in engaging the region’s corporate leadership through individual meetings and presentations with organizations representing business interests, including the St. Louis Regional Chamber and an organization of the largest corporate CEOs called Civic Progress. A gift of US$100,000 in support from Wells Fargo Advisors, which is based in St. Louis, is another example of corporate commitment to For the Sake of All. Whether meetings or presentations are with policy makers, business leaders, or community organizations, schools, and churches, engagement continues to be crucial to raising awareness and mobilizing action. To date, a total of 137 such engagements have occurred.

Beyond these meetings themselves, For the Sake of All has influenced public understanding and the policy agenda in the St. Louis region. The 18-year gap in life expectancy between the zip codes of 63105 and 63106 is now well known enough to be quoted by local and national officials and many others in media interviews. There is additional anecdotal evidence that the report and its findings are being used in grant proposals, classroom curricula, program planning, and broader community discussions that are not sponsored by the project. A collective impact initiative focused on optimal development for children and youth called “Ready by 21 St. Louis” has also used For the Sake of All in its planning process and in the development of goals. Perhaps, most importantly, the project lead provided testimony before the Ferguson Commission in February 2015, and most of the major recommendations and several specific sub-recommendations made by For the Sake
of All are reflected in some form among the “signature calls to action” in the Commission’s report released in September 2015 (Commission, 2015). Now, the project is aligning its actions with the Forward Through Ferguson organization in implementation of recommendations, as evidenced in the “Next Steps” convening mentioned above.

**Discussion**

In the 3 years since its inception, *For the Sake of All* has had significant impact on the policy environment in the St. Louis region. Through civic education, multiple key stakeholder groups and the general public have been informed about the magnitude of disparities, not just in health but in a range of critical areas such as education and economic status. Preceding the crisis occasioned by the shooting death of Michael Brown and the ensuing events in Ferguson, the project was uniquely positioned to contribute to regional discussions of potential solutions to lingering disparities as well.

There are ways in which the process, products, and outcomes of civic education in *For the Sake of All* are related to more traditional CBPR approaches to influencing policy-level change in communities around the country (Minkler, 2010; Minkler et al., 2008). Meaningful partnerships with a wide range of community-based organizations and other institutions have been critical to the success of the project to date. *For the Sake of All* and its project team have also emerged as trusted resources within the community, based upon continuous engagement of community partners and the presentation of credible data, accessible research translation, and evidence-based solutions. Attending to the policy process through agenda setting and direct outreach to educate policy makers has also been central to the work. More recently, the project has moved from dissemination to assisting in building cross-sector coalitions to begin implementation of strategies associated with the major areas of recommendation.

There also are crucial ways in which *For the Sake of All* differs from previous CBPR partnerships for policy change. One of the key differences is the breadth of topic coverage in this project. In most of the cases reviewed by Minkler and colleagues (2008), a specific issue within a defined geography (e.g., environmental justice concerns related to diesel bus emissions in Harlem) was the focus, and a range of research methods were used to answer questions posed by the community. *For the Sake of All* was concerned with a much wider range of complex factors driving health and other developmental outcomes across the City of St. Louis and St. Louis County. As there was not a single issue under consideration, there also was not a single community partner organization in this project, and it was not the case that an
already-established community-based organization approached the initial academic partners to solve a particular problem or answer a particular research question. The community has guided and informed the work since its inception, first through the CPG and more recently through the broader group of stakeholders involved in the Community Action Forums and the Next Steps planning sessions, but the idea for the project originated with the academic partners.

It is clear that the project would have been much different without community demands to expand engagement efforts and keep the report released at the end of the first phase from becoming yet another document detailing disparities that “collected dust on a shelf.” Indeed, the decision to present secondary data analysis (rather than additional primary data collection) alongside translation of existing research, including previous reports on the region, was informed by direct feedback from community partners that the residents of affected communities felt that they had been “studied to death.” The focus was on providing actionable solutions to problems that had been identified before—while also using novel, strategic communication methods that would help to influence new thinking to reset the policy agenda (Niederdeppe et al., 2008; RWJF, 2010). The project team also remains engaged in moving recommended solutions into action.

Some of the most promising and important implications for initial action are at the intersection of education and health. Not only are schools the site of the most momentous project-related policy change to date in the form of college savings accounts for kindergarteners, but also the two cross-sector groups that emerged from the Next Steps convening in February 2016 with the most energy and commitment were the groups examining school-based health clinics in high-need areas and the Whole School, WSCC (formerly coordinated school health) model of the CDC, and ASCD (Lewallen et al., 2015). Both efforts recognize the need to address the health and social needs of students to have meaningful impact on educational outcomes. The clinic group has committed to sustaining the two existing school-based clinics in the region and establishing two more within the next 18 months, and the WSCC group is focused on building regional infrastructure to disseminate and implement the model.

There are many limitations, challenges, and lessons learned inherent in the work that have been undertaken in For the Sake of All and in the broader approach of civic education. With breadth comes the danger of losing both focus and precision. Any one of the recommendations and related strategies alone requires significant investments of time and human and financial resources. To have several such strategies moving toward implementation simultaneously is complex, and evinces the need for community-driven
prioritization. This work would not be possible without the support of the Missouri Foundation for Health and the institutional support provided by Washington University in St. Louis. Therefore, those interested in replicating these efforts should identify sustainable sources of both financial and institutional support. Support must come from community-based sources as well for the work to have credibility. While organizational and professional-level engagement with For the Sake of All has been substantial, the project has struggled to reach residents of both affected and perceptually unaffected areas of the St. Louis region. Efforts like the St. Louis Public Radio Listening Project and more recent partnerships with faith-based organizations can aid in this outreach, but ultimately the project needs to meet residents where they are. Future plans are to engage some pilot neighborhoods in a recommendation prioritization process similar to the Next Steps process for key stakeholders, which will result in neighborhood-level community health action plans.

Conclusion

Although it is difficult to attribute policy and programmatic change to any single initiative, it seems clear that For the Sake of All has raised awareness and encouraged some action in the St. Louis community regarding the social determinants of health and health disparities. As a unique example of civic education, the project has presented data and translated research findings to a broad audience based on principles that prefer strategic communication, sustained community engagement, and changing systems through a pragmatic set of policy and programmatic recommendations.

Of course, St. Louis is not alone in struggling with the legacy of racial inequality in the United States. Urban centers from Cleveland to Baltimore to Chicago have seen tragedies similar to the events in Ferguson and share a common sense of frustration with the status quo of inadequate opportunities and shortened lives. What St. Louis may offer in efforts like For the Sake of All is a blueprint for a way forward. It is a form of civic education that must begin with the best available information about the current state of affairs, but in the finest traditions of education, it must also call forth action on the part of community members from all sectors and segments. Sustained, informed action will be the only means of transforming decades of division into a future of opportunity that is truly for the sake of all.

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