REQUEST FOR QUOTATIONS FOR
EVALUATION SERVICES: EVALUATION FRAMEWORK
FOR THE CUYAHOGA COUNTY BOARD OF HEALTH

Background

The Cuyahoga County Board of Health (CCBH) seeks qualified contractor(s) to provide evaluation assistance for a local collaborative in Cuyahoga County, Ohio known as Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga). HIP-Cuyahoga is a diverse and committed group of people who care about health. There is a strong and intentional commitment to address health inequities with aspirations that everyone in Cuyahoga County receives a fair chance to reach his or her fullest health potential. Here is a link to the HIP-Cuyahoga website for more information (http://hipcuyahoga.org/).

Our agency, the Cuyahoga County Board of Health, serves as the backbone organization for HIP-Cuyahoga. There is a Shared Measurement and Evaluation (SME) workgroup that supports HIP-Cuyahoga. We would like to identify consultant(s) who can help support our evaluation needs and assist with developing our capabilities.

The SME was formed to assist subcommittees in the development and tracking of their work plans. The SME group has representation from all parts of the consortium (steering committee members, backbone organization members, subcommittee members, etc.). To date, the SME workgroup developed work plan templates and assisted subcommittees with their completion. We are in the early phases of conceptualizing and/or evaluating a "data dashboard" tracking system to show progress on major activities and objectives. We do expect the contractor to work with the SME workgroup, as appropriate and based on the contractor's proposed plan to address the scope of work and the deliverables, the contractor may also be engaging other entities of the consortium (which includes the Steering Committee, subcommittees, workgroups, and other groups).

We are particularly interested in identifying a consultant who: has experience with evaluating complex collaborations that use collective impact as a key approach; and has experience in evaluating work where equity is a primary focus.

Furthermore, we are seeking a consultant who understands that a significant amount of work has been done to date. Specifically, the Collaborative needs assistance with:
1) *building out/enhancing existing efforts through the creation of an evaluation framework that best captures the work*.

Included as part of the RFQ is a series of documents that attempts to provide context for the initiative and the work that has informed and/or been developed to date. A brief summary of the documents included can be found in the document titled: "*Summary of Files and Documents Associated with Eval RFQ 12-16-16.docx*".

Duration of Services

The Cuyahoga County Board of Health is seeking services commencing upon successful execution of the contract with consultant (anticipated to occur in the second quarter of 2017). The Board will have the option to renew for an additional one year extension based on initial date of contract execution and contingent on availability of funding.

Scope of Work

The contractor will be expected to:

1. Propose and guide the development of an overall framework for evaluating the complexities associated with the HIP-Cuyahoga Collaboration. This includes the success of the overall partnership as well as the work of the subcommittees.

The contractor's proposal to complete the scope of work should contain distinct costs. The consultant should also be explicit with how they intend to accomplish the scope of work including the types of formats that will be used to interact with the Collaborative members (e.g. face to face meetings, webinars, conference calls, etc…).

Additional Information

- There will be up to $20,000 available to complete the scope of work in the RFQ.
- If the contractor believes that 12 months is not sufficient to meet the scope of work, they should propose the anticipated time for completion. The Board will have the option to renew for an additional one year extension based on initial date of contract execution and contingent on availability of funding.
- The most important factors associated with the selection of a contractor are: cost, related experience, and ability to provide a comprehensive plan to address the scope of work and deliverables

Please see attachments A-S for additional information that may be of assistance as you develop a response to the RFQ.

Deliverables

- Creation of an evaluation framework
- Pre-authorization prior to generating expenditures
- Monthly invoices for work performed

Information Requested

The following items listed below must be included with quotes, for quotes to be considered.

1. Business establishment date and years of experience performing work of this nature
2. Three references (CCBH form attached)
3. Identify how deliverables will be met
4. List skills and qualifications
5. Pricing document

Information on the Selection of the Contractor

Proposals will be reviewed by members of the SME workgroup to determine if the proposal adequately addresses the elements of the RFQ. Based on this review, prospective contractors may be asked to engage a subset of the Collaborative membership (e.g. the Steering Committee and/or members of the SME workgroup) as part of the selection process.

Insurance Requirements

During the full term of the contractual agreement, the contractor shall have in effect and maintain such insurance as defined herein. Where applicable, to be determined by the Board's Administrative Counsel, the applicable insurance shall name the Board and its employees as a co-insured or additional insured.

This insurance shall protect the contractor, the Board and its employees and any subcontractor performing work covered by the contractual agreement against:
1) general auto liability claims;
2) professional liability claims;
3) personal injury claims;
4) accidental death claims;
5) property damage claims;
6) economic loss claims;
7) general liability claims;
and such other types of claims including but not limited to D&O, employee dishonesty, workers compensation claims which may arise from operations under the contractual

agreement whether such operations be by the contractor or by any subcontractor or by anyone directly or indirectly employed by either of them.

An exact copy of such insurance policy or policies and any declarations pages shall be made available to the contracting authority for review at or before the time of execution of the contract. Such insurance shall include coverages for general liability, professional liability (where deemed necessary), workers compensation, D&O coverage and employee dishonesty (if deemed applicable) in such reasonable and adequate amounts as shall be determined by the Administrative Counsel at the time of negotiation of the contract.

Submission of Quotes

Quotation documents are due by Friday, April 7, 2017 at 4:30 pm.

Documents may be mailed or emailed to the following:

Cuyahoga County Board of Health
Attention: Chris Kippes
5550 Venture Drive
Parma, Ohio 44130
(216) 201-2001 ext.1600
ckippes@ccbh.net

CONTRACTOR REFERENCE SHEET

INSTRUCTIONS: **List a minimum of three (3) organizations to whom you have provided like services to that being requested in the specification. Provide all data requested below for each reference listed. Use additional sheets if desired.**	
ORGANIZATION'S NAME:	**CONTACT PERSON'S NAME:**
ORGANIZATION'S FULL ADDRESS:	**CONTACT PERSON'S TELEPHONE NUMBER:** **DATE SERVICE(S) PROVIDED:**
SPECIFY THE SERVICES PROVIDED:	
ORGANIZATION'S NAME:	**CONTACT PERSON'S NAME:**
ORGANIZATION'S FULL ADDRESS:	**CONTACT PERSON'S TELEPHONE NUMBER:** **DATE SERVICE(S) PROVIDED:**
SPECIFY THE SERVICES PROVIDED:	
ORGANIZATION'S NAME:	**CONTACT PERSON'S NAME:**
ORGANIZATION'S FULL ADDRESS:	**CONTACT PERSON'S TELEPHONE NUMBER:** **DATE SERVICE(S) PROVIDED:**
SPECIFY THE SERVICES PROVIDED:	

Summary of Files and Documents Associated with the
RFQ for HIP-Cuyahoga Evaluation Services
12-16-16

Documents are bookmarked with links.

A. Draft Framework to Evaluating HIP-C 4-21-16.pdf
This document contains a draft list of metrics to evaluating the overall HIP-Cuyahoga collaboration as well as each of the four subcommittees.

B. HIP-C Subcommittee Objectives and Big Picture Questions for HIP-C BG 5-3-16 .pdf
This document contains the current objectives that are listed within each of the four HIP-C subcommittee workplans along with the two overarching questions of the HIP-Cuyahoga collaborative.

C. *Ideas for Collective Impact Eval questions M Halko 5-4-16.pdf*
This document contains some ideas for potential questions complied by the HIP-Cuyahoga Partnership Coordinator for evaluating collective impact. You will notice that there is an FSG http://www.fsg.org/ document that served as the source for these questions. These questions have not been vetted by the HIP-Cuyahoga steering committee or larger consortium.

D. Ideas for Communications Eval questions M Halko 5-4-16.pdf
This document contains some ideas for potential questions complied by the HIP-Cuyahoga Partnership Coordinator for evaluating Communications associated with HIP-Cuyahoga. Members of the Communications and Community Engagement Workgroups provided these questions. These questions have not been vetted by the HIP-Cuyahoga steering committee or larger consortium.

E. Ideas for Community Engagement Eval questions N Shaw 5-5-16.pdf
This document contains some ideas for potential questions complied by the HIP-Cuyahoga Partnership Coordinator for evaluating community engagement associated with HIP-Cuyahoga. Members of the Communications and Community Engagement Workgroups provided these questions. These questions have not been vetted by the HIP-Cuyahoga steering committee or larger consortium.

F. Questions from REACH Grant Evaluation Plan 4-6-16.pdf
This document contains the actual evaluation questions that are contained in a formal evaluation plan that is approved by CDC for the Racial and Ethnic Approaches to Community Health (REACH grant). The REACH grant ties into two of the four HIP-Cuyahoga subcommittees, namely, Chronic Disease Management and Healthy Eating/Active Living (HEAL). There are some members of the SME Workgroup that are also on the evaluation team for the REACH grant.

G. Specific Objectives from REACH Grant Evaluation Plan 4-6-16.pdf
This document contains the actual objectives that are contained in a formal evaluation plan that is approved by CDC for the Racial and Ethnic Approaches to Community Health (REACH grant). The REACH Grant ties into two of the four HIP-Cuyahoga subcommittees, namely, Chronic Disease Management and Healthy Eating/Active Living (HEAL). There are some members of the Shared Measurement and Evaluation (SME) Workgroup that are also on the evaluation team for the REACH grant.

H. REACH FOA Logic Model.pdf
This is the actual logic model we were required to follow that was contained in the Racial and Ethnic Approaches to Community Health (REACH grant) funding opportunity announcement (FOA).

I. Retreat summary table.pdf
This document summarizes the results of the discussion from the HIP-Cuyahoga Steering Committee retreat that was held in September 2016 where the committee was guided through an exercise to identify/gain an understanding of the

following questions as they relate to the four key approaches used by the initiative and the priorities of the subcommittees:

- What do you appreciate and/or value?
- What concerns you the most?
- What do we need to focus on?
- What do we want to know?

J. Outcome definitions.11.15.16.pdf
This document provides a set of definitions to create a common language and understanding of the equity, well-being, and population health.

K. HIP-Cuyahoga Framework for Action.pdf
A Framework for Action was developed to clearly and simply describe and depict the work of HIP-Cuyahoga. It aligns with other national efforts (i.e. RWJF Culture of Health). These key approaches with the mission, vision, and core value guide HIP-Cuyahoga's work and are at the core of the partnerships efforts. While some key priorities may change, there is an intention to sustain and grow efforts around key approaches.

L. HIP-C action plan Collective Impact.pdf
This is the workplan for the Collective Impact key approach.

M. ***HIP-C action plan.community.engagement 11.14.pdf***
This is the workplan for the Community Engagement key approach.

N. HIP-C action planHEiAP.pdf
This is the workplan for the Health and Equity in All Policies key approach.

O. HIP-Cuyahoga ESR Action Plan 111516.pdf
This is the workplan for the Prospective Transformation key approach. This is also the workplan for the Eliminating Structural Racism (ESR) subcommittee. It was recognized that the work of the (ESR) had a natural alignment with the Prospective Transformation key approach so the workplans will be viewed as one in the same.

P. HIP-C action plan_CDM 11.17.16.pdf
This is the workplan for the Chronic Disease Management subcommittee priorities.

Q. HIP-C action plan HEAL sub 12.5.2016 workplan.pdf
This is the workplan for the HEAL subcommittee priorities.

R. HIP-Cuyahoga action plan_PHCC 11.14.16.pdf
This is the workplan for the Public Health and Clinical Care subcommittee priorities.

S. Measuring what works to achieve health equity 06.2015.pdf
This was created by the Prevention Institute for the Robert Wood Johnson to help inform the Culture of Health metrics.

T. Well-Being-in-All-Policies-Promoting-Cross-Sectoral-Collaboration-to-Improve-Peoples-Lives.pdf
This article is a joint publication initiative between Preventing Chronic Disease and the National Academy of Medicine that creates context for the inclusion of well-being in the HIP-Cuyahoga initiative.

DRAFT

4-21-16

HIP- Cuyahoga has selected three key approaches to advance the mission, vision, and core value of the partnership. These three approaches are:

- Collective Impact: Coordination of partnerships, alignment of priorities and actions, and mobilization of resources.
- Community Engagement: Involving community members in planning, decision making, and actions.
- Health and Equity in All Policies: Collaborating to improve the health of all people in Cuyahoga County by incorporating health and equity into decision making across sectors, systems, and policy areas

In order to evaluate the success towards the goals of the: overall partnership; work of the subcommittees; and the integration of the key approaches, the measures in Tables 1 through 3 have been identified as indicators of progress for Health Improvement Partnership-Cuyahoga.

There are two primary "venues" being explored to share progress on these indicators. These venues are the Health Data Matters website maintained at Case Western Reserve University and the HIP-Cuyahoga website. Regardless of the location, a dashboard based approach will be used to display the information.

Table 1. HIP – Cuyahoga Evaluation: Infrastructure Indicators

Domains	Goals	Measures	Key Approaches Used*	Baseline	2016
Overall Partnership	Develop a dynamic partnership with Cuyahoga County to create equity and improve health for everyone in our community	Number of community agencies who are actively participating in the partnership	Community Engagement		
		Number of community sectors who are actively participating in the partnership	Community Engagement, Collective Impact		
		Score of the Collaboration Factors Inventory[1]	Community Engagement, Collective Impact		
	Engage residents, partners, and policy makers in building opportunities for everyone on our county to be healthy	Number of community residents who agree that working together can influence decisions that affect the community.	Community Engagement, Collective Impact		
		Number of community residents who are actively participating in the partnership	Community Engagement, Collective Impact		
		Number of policy makers who are actively participating in the partnership	Collective Impact, Policy		
	Identify and secure funding to: sustain existing infrastructure; identify new community priorities; and implement strategies to address identified priorities	Amount of funding secured to operate the core infrastructure for the partnership			
		Amount of funding to implement strategies to address identified priorities			
		Number of community priorities that have been created by the HIP-Cuyahoga consortium			
		Number of HIP-Cuyahoga strategies that are currently being implemented			

[1] Collaboration Factors Inventory Summary: The Amherst H. Wilder Foundation Collaboration Factors Inventory is a free, online tool which evaluates collaborative efforts through an online questionnaire. The tool automatically calculates a score based on 20 factors. It attempts to measure collaboration at the following levels: 1) the effectiveness of a group, including leadership, decision-making ability and ability to achieve goals; 2) the level of collaboration achieved within the group; and 3)the group members belief in the credibility and image of the collaborative within the greater community. The questionnaire can be completed at any stage of the collaboration, although some questions may seem less applicable at the onset because no opinion or data may be available yet.

*This is just an example attempt to create connections to the key approaches. Also, we are thinking of replacing the words with the symbols/icons used on the HIP-C website that represent the approaches.

Table 2. HIP – Cuyahoga Evaluation: Subcommittee Indicators

Domains	Goals	Measures	Key Approaches Used*	Baseline	2016
Chronic Disease Management	Recruiting residents to become trainers or participants in chronic disease self-management programs	Number of people participating in chronic disease self- monitoring and management practice(s)	Community Engagement		
	Training doctors to care for all patients with chronic disease in ways that are proven to work	Number of identified and trained health leaders in hypertension best practices	Community Engagement, Collective Impact		
	Training doctors to be culturally sensitive and speak in plain language	Number of identified and trained health leaders in culturally and linguistically appropriate services	Community Engagement, Collective Impact		
	Determine the number of community resources available to individuals with high blood pressure	Number of neighborhood clinics implementing hypertension best practices interventions			
		Number of community resources available			
	Encourage engagement in health behaviors to manage chronic conditions	Number of messaging campaigns developed			
Eliminate Structure Racism	Help organizations learn how to recognize and address structural racism	Number of HIP-Cuyahoga affiliated organizations that support and follow racial inclusion and culturally competent work	Policy		
	Encourage organizations to work closely with community members	Number of HIP-Cuyahoga presentations and trainings that include health equity concept	Policy		
	Develop policies to create social and economic opportunities for all people in Cuyahoga County	Number of equity impact tools adopted for cataloging changes to policies and practices	Policy		
	Create perspective transformation around health equity	Number of media campaigns that include health equity to frame discussions	Collective Impact		

*This is just an example attempt to create connections to the key approaches. Also, we are thinking of replacing the words with the symbols/icons used on the HIP-C website that represent the approaches.

Table 2 – continued. HIP – Cuyahoga Evaluation: Subcommittee Indicators

Domains	Goals	Measures	Key Approaches Used*	Baseline	2016
Link Healthcare and Public Health	Encouraging both systems to work together on shared goals	Creation of an integrated system to conduct countywide community and clinical health assessments	Collective Impact		
		Funding secured for the demonstration project that engages both systems			
		Completion of the demonstration project			
	Identifying opportunities of combined data collection to better represent community health needs	Number of hospitals that either partner with or include HIP-Cuyahoga representation in Community Health Needs Assessment (CHNA) planning	Collective Impact		
	Building public health and health equity training into the curriculum of health profession students	Number of curricula with equity training for health professional students	Collective Impact		
Healthy Eating and Active Living	Making healthy food available in neighborhood stores	Percentage of census tracts that have at least one healthy food retail option located within the tract (or within half mile of the tract)	Community Engagement, Collective Impact		
		Number of existing healthy retail establishments			
	Making sure that new streets are built to encourage walking and biking	Develop capacity to (develop, implement, evaluation) shared use agreements			
	Encouraging schools and churches to open their doors for people to be active after hours	Establish capacity to develop, implement, evaluate) shared use agreements			
		Number of potential shared use facilities			

*This is just an example attempt to create connections to the key approaches. Also, we are thinking of replacing the words with the symbols/icons used on the HIP-C website that represent the approaches.

[Consider identifying a subset of indicators from the Community Health Status Assessment to create Table 3]

Table 3. HIP – Cuyahoga Evaluation: Population Health Indicators

Domain	Measure	Baseline	2016

HiP CUYAHOGA

2013 How do we create safe, supportive environments across all levels of community to foster healthy living? **2018**

Collective Impact

Community Engagement

Health and Equity in All Policies

Eliminating structural Racism as a social determinant of health

Objective 1: By December 31, 2016, develop and support the leadership capacity of at least 50 key members of the HIP-C network (general public, organizational/Institutional reps, policy makers etc.) for addressing structural racism through the integration of racial inclusion & cultural competencies in the ongoing practice and culture of their institutions, organizations, networks and communities.

Objective 2: By December 31, 2016, the eliminating racism subcommittee will work with the other HIP-C subcommittees to support the development and/or integration of strategic approaches and/or major activities to address racial inclusion & cultural competence; if the workplans do not reflect these upstream approaches.

Objective 3: By December 31, 2016 a minimum of 10% of the organizations in the HIP-C network have identifiable changes to organizational/institutional or system level policies/practices addressing racial inclusion and cultural competence.

Clinical/Public Health

Objective 1: By December 31, 2016, develop an integrated system to conduct future coordinated, comprehensive countywide community clinical and behavioral health assessment to identify priority focus area(s) through a clinical care and public health multi-stakeholder partnership.

Objective 2: By December 31, 2016, utilize existing community health assessments to identify, select, and develop an intervention strategy for health issue(s) that involve a coordinated public health and clinical approach.

Objective 3: By December 31, 2016, the committee will engage partners to develop and implement a demonstration project addressing respiratory disease, eg. pediatric asthma, that integrates public health and clinical care in Cuyahoga County.

Healthy Eating Active Living

Objective 1: **By September 30, 2017**, increase the percentage of census tracks that have at least one healthy retail option located within the tract or within a half a mile of the tract.

Objective 2: **By September 30, 2017**, increase the number of Cuyahoga County Communities that adopt complete streets policies.

Objective 3: **By September 30, 2017**, increase the number of census tracts with at least one shared use agreement in place in tract or within .5 miles

Chronic Disease Management

Objective 1: By September 30, 2017, 'X'% of Cuyahoga County residents will receive a chronic disease self monitoring and management campaign message(culturally and linguistically appropriate), that targets the population focus described above.

Objective 2: By September 30, 2017, increase the proportion of the targeted population participation in provider-determined(hypertension best practice), combined with evidence-based chronic disease self monitoring /management (SM/M) practice(s) by X% from baseline. Share best practice findings by zip code and with Better Health *Greater* Cleveland disparities data to recommend system level, upstream, scalable changes.

Objective 3: TBD (education summit)

POPULATION HEALTH OUTCOMES

2019

New Community Health Status Assessment

2013 How can we create access to quality and equitable care for all within the community in a variety of settings? **2018**

Collective Impact/Backbone Effectiveness/Policy – What do we want to know?

Questions adapted from FSG.org – Backbone Effectiveness: 27 indicators and Guide to Evaluating Collective Impact – 03.

Guide Vision and Strategy

- Do partners accurately describe HIP-Cuyahoga's common agenda?
- Do partners publicly discuss/advocate for common agenda goals?
- Does partners'' individual work align with the common agenda?
- Do Steering Committee and consortium members, key leaders etc. look to the backbone organization(s) for initiative support, strategic guidance and leadership?
- Is HIP-Cuyahoga decision-making open and transparent?

Support Aligned Activities

- Can partners articulate their role in the initiative?
- Are key stakeholders and decision makers are engaged in HIP-Cuyahoga?
- Do partners communicate and coordinate efforts regularly, with, and independently of, the backbone?
- Do partners report an increasing level of trust with one another?
- Do partners feel supported and recognized in the work as part of HIP-Cuyahoga?

Establish Shared Measurement Practices

- Do partners understand the value of shared data?
- What is the capacity and willingness of partners to share data?
- Do HIP-Cuyahoga partners make decisions based on data?

Build Public Will

- Are community members aware of the key priority issues HIP-Cuyahoga is addressing?
- Do community members express support for the initiative?
- Do community members feel empowered to engage in the key priority issues?
- Are community members increasingly taking action around key priority issues?

Advance Policy

- Are key decision and policy makers increasingly aware of HIP-Cuyahoga?
    - Who we are?
    - What problems/issues we address?
    - What values guide our work?

    - What are our solutions?
- Are relationships with decision/policy makers strengthened?
- Do key decision and policy makers advocate for changes to systems that align with HIP-Cuyahoga goals?
- Are public policies increasingly aligned with HIP-Cuyahoga goals?
- Are decision/policy makers aware of negative consequences or impacts of select policy decisions (benefit vs. burden)?
- Is there increased media coverage tied to HIP-Cuyahoga policy goals?

<u>Mobilize Funding</u>

- Are funders asking nonprofits to align with HIP-Cuyahoga goals?
- Are funders redirecting funds to support HIP-Cuyahoga infrastructure, operations and/or goals?
- Are new resources from public and private sources being contributed to partners and HIP-Cuyahoga?

Ideas for Communications Evaluation Questions

5-4-16

Outcome Evaluation

1. Do decision makers in Cuyahoga County understand health equity?
2. Do decision makers in Cuyahoga County understand institutional racism and other root causes of health disparities?
3. Do community members recognize the connection with place and health?
4. Have community members increased their awareness of with the HIP-Cuyahoga logo?
5. Has attendance at the community day increased?
6. Has HIP-Cuyahoga experienced a change in viewers of the HIP-Cuyahoga website?
7. Has HIP-Cuyahoga experienced a change in Twitter followers, listserve members or Facebook Likes?

Process Evaluation

8. Does HIP-Cuyahoga have a system/process in place to:
    a. Identify policy goals?
    b. Identify decision makers?
9. Does HIP-Cuyahoga have a process for staying abreast of the four subcommittee's media and publications?
10. Does HIP-Cuyahoga have a process for monitoring news related to pertinent issues?
11. Does HIP-Cuyahoga have a set of talking points?
12. Does HIP-Cuyahoga have a speakers' bureau?
13. Does HIP-Cuyahoga have a mechanism to identify the effective spokespeople to talk about HIP-Cuyahoga in general and for each subcommittee?
14. Does HIP-Cuyahoga have an editorial calendar?

Ideas for Community Engagement Evaluation Questions

5-5-16

1. Do partners understand how to define community engagement and the different levels of community engagement?
2. Do partners have a shared understanding and value for meaningful community engagement?
3. Do partners realize the resources needed to engage the community?
4. Do partners know how to engage residents in communities?
5. Do partners know how to engage organizations that represent the residents in our communities?
6. Do partners know how to assess a community's readiness to engage?
7. Do partners understand what motivates community to get and stay engaged?
8. How is community engagement success determined?
9. Does HIP-Cuyahoga as a whole have a community engagement framework?
10. Do the HIP-Cuyahoga subcommittees have community engagement action plans?
11. Does HIP-Cuyahoga have a process for getting the community to rally around issues that the community cares about?
12. Does HIP-Cuyahoga have a process for aligning with partners that are already doing community engagement work?

Questions from the Racial and Ethnic Approaches to Community Health (REACH) Grant Formal Evaluation Plan

Hypertension Best Practice Strategy

To what extent do adults diagnosed with hypertension have improved access to high quality culturally competent care after implementation of a clinic-based hypertension best practice intervention?

Does the proportion of patients with controlled hypertension increase by 5% after implementation of a clinic-based hypertension best practice intervention?

What are the barriers, facilitators, and perceptions of implementation of the hypertension best practice program at neighborhood clinics serving at risk populations?

Produce Prescription Strategy

Can a produce prescription program aimed at pregnant women living in low income areas be modified and successfully implemented in nine neighborhood clinics serving patients with hypertension who have been identified as at-risk for food insecurity to encourage increased fruit and vegetable consumption?

To what extent will providers working in neighborhood clinics serving patients who have been identified as at-risk for food insecurity refer hypertensive patients to one of 20 local farmers markets using a produce prescription model?

To what extent will hypertensive patients living in areas identified as at-risk for food insecurity use vouchers issued by their neighborhood clinic to obtain fresh fruits and vegetables from a local farmers market?

To what extent will there be changes in attitudes and beliefs towards farmers markets and fresh fruit and vegetable consumption among hypertensive patients living in areas identified as at-risk for food insecurity after receiving vouchers issued by their neighborhood clinic to obtain fresh fruits and vegetables from a local farmers market?

To what extent will hypertensive patients living in areas identified as at-risk for food insecurity demonstrate an improvement in select health outcomes after participating in a produce prescription program?

Chronic Disease Self-Management Program (CDSMP)/ Diabetes Self-Management Program (DSMP) Referral Program

To what extent can a system for clinical referral to community CDSM/DSM workshops be established at targeted neighborhood clinics?

To what extent will targeted neighborhood clinics use the established referral system to refer patients to community CDSM/DSM workshops?

To what extent do patients referred to CDSM/DSM workshops use their referral?

To what extent can residents of targeted neighborhoods be trained to lead CDSM/DSM workshops?

To what extent will trained residents conduct CDSM/DSM workshops in targeted neighborhoods?

Specific Objectives from the REACH Grant Evaluation Plan

Healthy Eating Active Living

Increase the number of people with improved access to environments with healthy food and beverage options from 12,201 to 40,515 by September 2017.

Increase the number of Convenience Stores which has received healthy food certification from 19 to 22 by September 2017.

Increase the number of people with improved access to physical activity opportunities from 3,144 to 40,515 by September 2017.

Increase the number of Non-Profit Organizations with at least one shared use agreement in place in that tract or .5 miles from 19 to 22 by September 2017.

Chronic Disease Management

Increase the number of people with improved opportunities for chronic disease prevention, risk reduction or management through clinical and community linkages from 7,878 to 11,298 by September 2017.

Increase the number of --Health Care Systems-- that will implement hypertension best practice (HTN BP) from 6 to 9 by September 2017.

Increase the number of Non-Profit Organizations that offer CDSMP or DSMP workshops from from 6 to 9 by September 2017.

Increase the number of --Health Care Systems-- that will refer patients to community based chronic disease or diabetes self-management workshops from 6 to 9 by September 2017.

HEAL and CDM combined

Increase the number of --Health Care Systems-- that participate in the Produce Prescription for chronic disease from 6 to 9 by September 2017.

Increase the number of --Health Care Systems-- that refer patients to community based HEAL resources from 6 to 9 by September 2017.

Increase the number of public and partner education messages promoting healthy eating and active living and chronic disease management from 51 to 72 by September 2017.

Increase the number of messages to public on healthy eating and active living and chronic disease management from 39 to 72 by September 2017.

Increase the number of messages to partners on community needs and planned efforts and achievements from 36 to 72 by September 2017.

REACH LOGIC MODEL

Promote Health Equity

Inputs

- Awardees
- Multi-sectorial community coalition that has been in existence for 2 years or more
- Completed Community Health Needs Assessment
- Community Health Improvement Plan
- Existing infrastructure
- Existing data sources
- Qualified staff
- CDC
- CDC Technical Assistance, Training and Guidance
- Funding

Strategies / Activities

Program Infrastructure and Organizational Capacity
Maintain capacity to carry out activities, strategies, performance measurement and evaluation.

Fiscal Management
Fund local partners or entities; track and report expenditures; and prepare required reports.

Coalition
Engage a multi-sectoral community coalition to implement activities and strategies and where the coalition includes local organizations, decision-makers, and community members.

Performance Measurement and Evaluation
Gather process and outcome measures, assess outcomes and estimate the impact of awardees' efforts.

Communication and Dissemination
Use media and communication to support program efforts and convey program messages, activities and successes.

Risk Factor Related Population-Based Strategies
Implement policy, systems, and environmental improvements in the Community Action Plan:
1. Smoke- and tobacco-free environments
2. Healthy food and beverage options
3. Physical activity opportunities
4. Clinical and community linkages

Short-Term Outcomes

- Increased access to smoke-free or tobacco-free environments*
- Increased access to environments with healthy food or beverage options*
- Increased access to physical activity opportunities*
- Increased opportunities for chronic disease prevention, risk reduction or management through clinical and community linkages*
- Positive changes in attitudes, beliefs, knowledge, awareness, and behavioral intentions for relevant strategies

Intermediate Outcomes

- Reduced exposure to secondhand smoke
- Increased daily consumption of fruit
- Increased daily consumption of vegetables
- Increased physical activity
- Increased use of community-based resources related to better control of chronic disease

Long-Term Outcomes

[Reduce Racial / Ethnic Health Disparities]

- Reduced rates of death and disability due to tobacco use by 5%
- Reduced prevalence of obesity by 3%
- Reduced rates of death and disability due to diabetes, heart disease and stroke by 3%

Impact

- Improved quality of life
- Premature deaths averted
- Medical costs averted

Reduce Disparities in Implementation, Access and Health Outcomes

* Means outcomes that awardee is held accountable for in the project period.

	What do you appreciate and/or value?	What concerns you the most?	What do we need to focus on?	What do we want to know?
Collective Impact	• Groups consistency & commitment • Partnership diversity • Cross collaboration across county • Complexity of our process & collaborative work • Collective learning • Vision maintained while addressing difficult issues • Collective impact • Grateful for partners • Trust among the group • Agility of the partnership • Engagement of the Consortium • Equity frame • Commitment moving forward • Longevity of HIP-Cuyahoga	• Maintaining the momentum • How do we get to the next level and support it • Trusting the process • Continuing to operationalize the work • Operationalizing collective impact • How to continually make connections/alignment • Intersectionality • Thinking about the next cycle • Actualizing this work in tangible ways • Resources • Next funding stream • Sustainability from both a fiscal and policy perspective • Having the right people in the room • High level hospital engagement is missing • Having the right people "unusual" suspects part of decision-making process (to bring different perspectives • Degree to which we are engaging high level decision makers • People acknowledge where others sit	• Everyone staying at the table • Actualizing commitment in tangible ways • Trusting the process • Strategic alignment • Aligning with other work/sectors • Strategy around funding • Right people in the room • High level hospital engagement • Evaluation strategy	• What is the quality of partnerships among our consortium? • Do partners report an increasing level of trust with one another? • Do partners communicate and coordinate efforts regularly with, and independently of the backbone? • Do partners accurately describe HIP-Cuyahoga's common agenda? • What is the capacity and willingness of partners to share data? • Are funders redirecting funds to support HIP-Cuyahoga infrastructure, operations and/or goals? • Exterior framework for collective impact approach • Outreach

	What do you appreciate and/or value?	What concerns you the most?	What do we need to focus on?	What do we want to know?
HEiAP	• Partnership diversity • Cross-collaboration across county • Consistency and vigor for addressing equity and racism • Complexity of our process and collaborative work	• Shift toward policy change • Sustainability from both a fiscal and policy perspective • Degree to which we are engaging high level decision makers	• Policy change • Trusting the process • Strategy around funding • Authentic community engagement • Evaluation strategy	• Are key decision and policy makers increasingly aware of HIP-Cuyahoga? • Are relationships with decision/policy makers strengthened? • Are decision/policy makers aware of the negative consequences or impacts of select policy decisions (who benefits/who is burdened)? • Are public policies increasingly aligned with HIP-Cuyahoga goals? • Is there increased media coverage tied to HIP-Cuyahoga policy goals?
Perspective Transformation	• Collective learning • Vision maintained while addressing difficult issues • Perspective transformation • Equity frame	• High level hospital engagement is missing • How to talk about/communicate about racial equity/inclusion as to not alienate others (open and accessible communication) • Threading the equity discussion into each of the subcommittees and workgroups	• Communication around racial equity discussion • How to weave eliminating structural racism through other subcommittees	• Where are we losing ground? • How do we frame our messaging? • How do we address the assumptions related to perspective transformation? • When is it time to be transactional vs transformational? • How to change conversation (to be accessible, understandable, change win/lose framework)? • On-boarding for new members • Where are we raising the ceiling vs raising the floor?

	What do you appreciate and/or value?	What concerns you the most?	What do we need to focus on?	What do we want to know?
Community Engagement	• Collective impact • Trust among the group • Commitment- moving forward • Scale of the work • Collective learning	• How to maintain momentum • Bringing in community/community residents • Having the right people in the room • Resources • How to talk about/communicate about racial equity/inclusion as to not alienate others (open and accessible communication) • Degree to which we're engaging the community • People acknowledge where others sit	• Right people in the room • Authentic community engagement • Communication around racial equity discussion	• Number of community members participating in HIP-Cuyahoga ie. consortium, subcommittees, steering committee, workgroups? • Do community members express support for the initiative? • Are community members increasingly taking action around key priority issues? • How does community define community engagement? What do they consider to be meaningful engagement? • Broader outreach to "community" than who we typically involve – hear other voices • Enhance/broaden involvement of those who are already engaged • How do we define "the community"? • Matching "the community" to the activity • Develop network of residential teams • Enhancing economic incentives (long term) for this engagement • Mutual empowerment
HEAL	• Group, consistency, commitment • Partnership diversity • Cross-collaboration	• Connecting all the HEAL work, being strategic, how it intersects with other subcommittees - intersectionality	• Authentic community engagement • weave ESR through other subcommittees	

			• Policy change	
	What do you appreciate and/or value?	**What concerns you the most?**	**What do we need to focus on?**	**What do we want to know?**
ESR	• Commitment to very complex social issues – ESR • Equity frame • Consistency and vigor for addressing equity and racism	• How to talk about/communicate about racial equity/inclusion as to not alienate others (open and accessible communication) • Threading the equity discussion into each of the subcommittees and workgroups • intersectionality	• Communication around racial equity discussion • How to weave eliminating structural racism through other subcommittees • Authentic community engagement • Policy change	
Linking Clinical & Public Health	• Group, consistency, commitment • Partnership diversity • Cross-collaboration across county	• High level hospital engagement is missing • Thinking about the next cycle • Threading the equity discussion into each of the subcommittees and workgroups • intersectionality	• Community health assessment frequency – next cycle • Authentic community engagement • High level hospital engagement/funding • Weave ESR through other subcommittees • Policy change	
CDM	• Group, consistency, commitment • Partnership diversity • Cross-collaboration across county	• Threading the equity discussion into each of the subcommittees and workgroups • intersectionality	• Authentic community engagement • Weave ESR through other subcommittees • Policy change	

Outcome - Definitions for Consideration

Our definitions and context for these definitions may be refined as we further shape our work, and as we more clearly describe our outcomes.

Equity

Equity - Just and fair inclusion into a society in which everyone can participate, prosper, and reach their full potential. Improving equity is to promote justice and fairness within the procedures, processes, and distribution of resources by institutions and/or systems. Addressing equity issues requires an understanding of the underlying or root causes of outcome disparities within our society.

Equity Lens: The "lens" through which you view conditions and circumstances to understand who receives the benefits and who bears the burdens of any given program, policy, or practice (CommonHealth ACTION)
.

Well-Being

- There is no consensus around a single definition of well-being, but there is general agreement that at minimum.
- It is a valid population outcome measure beyond morbidity, mortality, and economic status that tells us how people perceive their life is going from their own perspective.
- Shifting to a focus on well-being would place health among the determinants of well-being.

Well-being includes the presence of positive emotions and moods (e.g., contentment, happiness), the absence of negative emotions (e.g., depression, anxiety), satisfaction with life, fulfillment and positive functioning. Well-being can consider the following:

- Physical well-being.
- Economic well-being.
- Social well-being.
- Development and activity.
- Emotional well-being.
- Spiritual well-being
- Life satisfaction.
- Domain specific satisfaction.
- Engaging activities and work.

Population Health

Population Health – The distribution of health outcomes across groups which result from the interactions between individual biology and behaviors; the social, familial, cultural, economic and physical environments that support or hinder wellbeing; and the effectiveness of the public health and healthcare systems. (Adopted from HPIO – What is Population Health)

Framework for Action

HIP CUYAHOGA
Health Improvement Partnership

OUR VISION
Cuyahoga County is a place where all residents live, work, learn, and play in safe, healthy, sustainable, and prosperous communities.

OUR MISSION
HIP-Cuyahoga's mission is to inspire, influence, and advance policy, environmental, and lifestyle changes that foster health and wellness for everyone who lives, works, learns, and plays in Cuyahoga County.

CORE VALUE
Building opportunities for everyone in Cuyahoga County to be healthy.

Health Improvement Partnership – Cuyahoga

Date Created: **Date Updated:** 11/8/16

Key Priority or Key Approach:

Collective Impact – Fostering cross-sector collaboration, coordination of partnerships, alignment of priorities and actions, and mobilization of resources

Population Focus: ***Indicate the geographic area and population of focus.*** Cuyahoga County	**Anchor Organization(s): *(Which organization will guide overall strategic direction, facilitate dialogue among partners, manage data collection and analysis, handle communications, coordinate community outreach, and mobilize funding):*** Cuyahoga County Board of Health, Co-Chairs and Steering Committee members

Goal:
Advance a culture of health and equity in Cuyahoga County by aligning partnerships, values, interests, capacity and resources around key approaches and action areas that foster sustainable community change and better health for all.

SMART Objective 1:

By December 31st, 2017, define the specific HIP-Cuyahoga infrastructure and overall operational processes needed to expand and sustain our consortium and its collective impact efforts long-term.

Dissemination Plans: ***Plans for presentations, abstract/posters submissions, conferences, etc. (Include specific dates)***

Evidence base: ☐ Evidence Based X Evidence Informed X Innovative	***Source(s):***

Indicate Type of Strategic Approach (check all that apply):

- ☐ Education and Awareness (increasing public understanding and knowledge)
- ☐ Providing Direct Services (assistance or support provided directly to community members)
- ☐ Environmental Change Activities (activities that involve physical or material changes to the economic, social, or physical environment)
- X Organizational and institutional change activities (changes that impact all elements of an organization or institution ie. Hospitals, health departments, community service organizations, schools etc.)
- X System Change Activities (changes that impact all elements of a system ie. neighborhood systems, educational systems, economic development systems, healthcare systems, etc.)
- X Policy Change Activities (law, resolution, mandate, regulation or rule – informal or formal; activities not confined to formal legislative process but can occur at an organizational and institutional level)

Major Activities ***Outline the main steps taken to achieve each objective.***	**Organization & Lead Person(s)** ***Identify the organization and person(s) that will carry out the activity & monitor progress.***	**Planned Process Measures** ***Measures effort & the direct outputs of programs/interventions-ie. exposure, reach, knowledge, attitudes.***	**Planned Outcome Measures** ***Measures effect & changes that result from the program & to what extent the program is achieving intended outcomes in the target population – short &***	**Actual Process Measures** ***Measures actual outputs of programs/interventions*** ***(Include specific dates)***	**Actual Outcome Measures** ***Measures actual results from the program*** ***(Include specific dates)***	**Reporting Status** **(Completed, Ahead, On schedule, Behind)**

			mid-term changes in knowledge/awareness, attitude change, beliefs, social norms, behavior change, system/policy change. ***(Include specific dates)***			
Update HIP-Cuyahoga backbone infrastructure	CCBH and key priority subcommittee members	1. Establish and fill new steering committee standing positions 2. Identify any need for new workgroups 3. Select chairs for new workgroups 4. Fill vacant At-large positions filled 5. Fill vacant standing positions 6. By-laws revised to reflect changes to infrastructure (January 2017-June 2017)		1. New steering committee positions established and filled 2. New workgroups identified and created. 3. Chairs for new workgroups selected 4. Vacant At Large positions filled 5. Vacant standing positions filled 6. By-laws revised		
Monitor the effectiveness and efficiency of the collective impact partnership	CCBH, SME and Steering Committee	1. Identify and select tools to assess the quality, effectiveness and efficiency of consortium 2. Conduct network analysis (January 2017-December 2017)		1. Tools identified and selected 2. Network analysis conducted		
Use active outreach and engagement to identify and fill consortium gaps		Identify and fill partnerships in the following areas: 1. Community agencies 2. Community sectors 3. Community residents 4. Policy/decision makers (December 2017 – ongoing)		Number of partnerships actively participating in the following areas: 1. Community agencies 2. Community sectors 3. Community residents 4. Policy/decision makers		
Develop an operational plan which includes	CCBH and Steering	1. Select and define		1. Operational focus areas		

defined focus areas of operations and associated costs i.e. • Communications • Community engagement • Shared measurement and evaluation • Capacity building • Partner engagement • Reassessment - CHNA • Administrative items	Committee	operational focus areas 2. Outline operational costs 3. Develop an operational plan that includes the selected focus areas (January 2017-December 2017)		selected and defined 2. Operational costs outlined 3. Plan developed		

SMART Objective 2:
By December 31st, 2017, develop a plan and process for financing HIP-Cuyahoga infrastructure and operational components long-term (i.e. aligning, leveraging and securing resources).

Dissemination Plans: ***Plans for presentations, abstract/posters submissions, conferences, etc. (Include specific dates)***

Evidence base:
- ☐ Evidence Based
- X Evidence Informed
- X Innovative

Source(s):

Indicate Type of Strategic Approach (check all that apply):
- ☐ Education and Awareness (increasing public understanding and knowledge)
- ☐ Providing Direct Services (assistance or support provided directly to community members)
- ☐ Environmental Change Activities (activities that involve physical or material changes to the economic, social, or physical environment)
- X Organizational and institutional change activities (changes that impact all elements of an organization or institution ie. Hospitals, health departments, community service organizations, schools etc.)
- X System Change Activities (changes that impact all elements of a system ie. neighborhood systems, educational systems, economic development systems, healthcare systems, etc.)
- ☐ Policy Change Activities (law, resolution, mandate, regulation or rule – informal or formal; activities not confined to formal legislative process but can occur at an organizational and institutional level)

Major Activities ***Outline the main steps taken to achieve each objective.***	**Organization & Lead Person(s)** ***Identify the organization and person(s) that will carry out the activity & monitor progress.***	**Planned Process Measures** ***Measures effort & the direct outputs of programs/interventions-ie. exposure, reach, knowledge, attitudes.***	**Planned Outcome Measures** ***Measures effect & changes that result from the program & to what extent the program is achieving intended outcomes in the target population – short & mid-term changes in knowledge/awareness, attitude change, beliefs, social norms, behavior change, system/policy change.***	**Actual Process Measures** ***Measures actual outputs of programs/interventions*** ***(Include specific dates)***	**Actual Outcome Measures** ***Measures actual results from the program*** ***(Include specific dates)***	**Reporting Status** **(Completed, Ahead, On schedule, Behind)**

			(Include specific dates)			
Plan and host a "Philanthropy and Private Sector Forum" in an effort to secure resources to grow and sustain HIP-Cuyahoga	CCBH and Steering Committee	1. Plan Forum 2. Host Forum (Jan - March 2016)	Increased awareness of investment opportunities Identification of new funding sources	1. Forum Planned 2. Forum Hosted		
Develop a resource and sustainability plan to support partnership infrastructure and operational components of HIP-Cuyahoga	CCBH and Steering Committee	1. Outline infrastructure, operational and implementation costs 2. Identify and select financing strategies 3. Develop resource and sustainability plan (January 2017-June 2017)		1. Infrastructure, operational and implementation costs outlined 2. Financing strategies identified and selected 3. Resource and sustainability plan developed		
Identify, secure and leverage funding	CCBH and Steering Committee	1. Identify funding sources and collectively reach out to funders 2. Secure funding from variety of sources 3. Leverage funding Assess funding in the following areas: 1. Core infrastructure 2. Overall operations 3. Program implementation 4. Leveraged resources 5. In-kind support (By December 2017)		1. Funding sources identified and reach out conducted 2. Funding secured from variety of sources 3. Funding leveraged Amount of funding established in the following areas: 1. Core infrastructure operations 2. Overall operations 3. Program implementation 4. Leveraged resources 5. In-kind support		

Health Improvement Partnership – Cuyahoga

Date Created: 9-15-16 **Date Updated:** 11/10/16

Key Priority or Key Approach:

Community Engagement- Involving community members in planning, decision-making, and actions.

Population Focus: *Indicate the geographic area and population of focus.*	**Anchor Organization(s):** ***(Which organization will guide overall strategic direction, facilitate dialogue among partners, manage data collection and analysis, handle communications, coordinate community outreach, and mobilize funding):***
Cuyahoga County	Cuyahoga County Board of Health

Goal: Develop a framework for advancing health equity through equitable and inclusive community engagement practices.

SMART Objective 1: By December 31, 2017, develop and pilot the HIP-Cuyahoga community engagement framework for action.

Dissemination Plans: ***Plans for presentations, abstract/posters submissions, conferences, etc. (Include specific dates)***

Evidence base:	***Source(s):***
☐ Evidence Based **X** Evidence Informed ☐ Innovative	

Indicate Type of Strategic Approach (check all that apply):

- ☐ Education and Awareness (increasing public understanding and knowledge)
- ☐ Providing Direct Services (assistance or support provided directly to community members)
- ☐ Environmental Change Activities (activities that involve physical or material changes to the economic, social, or physical environment)
- ☐ Organizational and institutional change activities (changes that impact all elements of an organization or institution ie. Hospitals, health departments, community service organizations, schools etc.)
- ☐ System Change Activities (changes that impact all elements of a system ie. neighborhood systems, educational systems, economic development systems, healthcare systems, etc.)
- ☐ Policy Change Activities (law, resolution, mandate, regulation or rule – informal or formal; activities not confined to formal legislative process but can occur at an organizational and institutional level)

Major Activities ***Outline the main steps taken to achieve each objective.***	**Organization & Lead Person(s)** ***Identify the organization and person(s) that will carry out the activity & monitor progress.***	**Planned Process Measures** ***Measures effort & the direct outputs of programs/interventions- ie. exposure, reach, knowledge, attitudes.***	**Planned Outcome Measures** ***Measures effect & changes that result from the program & to what extent the program is achieving intended outcomes in the target population – short & mid-term changes in knowledge/awareness, attitude change, beliefs, social norms, behavior change, system/policy change. (Include specific dates)***	**Actual Process Measures** ***Measures actual outputs of programs/interventions*** ***(Include specific dates)***	**Actual Outcome Measures** ***Measures actual results from the program*** ***(Include specific dates)***	**Reporting Status** **(Completed, Ahead, On schedule, Behind)**

Research community engagement best practices.	CCBH and Community Engagement Workgroup	1. Conduct Research (April 2016 – December 2016)	Increased knowledge of community engagement best practices	1. Research conducted		
Develop and administer community engagement assessment tool for Partnership members to determine capacity and alignment.	CCBH and Community Engagement Workgroup	1. Develop community engagement assessment tool 2. Administer community engagement assessment tool (January 2017- March 2017)	Increased knowledge of partners' capacity and alignment with community engagement efforts	1. Community engagement assessment tool developed 2. Community engagement assessment tool administered		
Identify and convene members for a Community Engagement (CE) Community of Practice to assist in the development of the HIP-Cuyahoga community engagement framework for action.	CCBH, Community Engagement Workgroup, identified partners and community members	1.Identify members for a CE Community of Practice 2. Convene meetings for the CE Community of Practice 3. Develop the HIP-Cuyahoga CE Framework for Action (April 2017- July 2017)	Increased understanding of the importance of involving the community in planning Increased understanding of the critical components of a community engagement framework for Cuyahoga County	1. CE Community of Practice members identified 2. CE Community of Practice meetings held 3. HIP-Cuyahoga CE Framework for Action developed		
Pilot the HIP-Cuyahoga Community Engagement Framework for Action.	CCBH and the CE Community of Practice	1.Pilot the CE Framework for Action (August 2017- October 2017)	Increased understanding of the CE Framework for Action and how to operationalize it/how it works	1. CE Framework for action pilot-tested		
Modify the HIP-Cuyahoga Community Engagement Framework for Action based upon the pilot and finalize the framework.	CCBH and the CE Community of Practice	1. Modify the CE Framework for Action (November 2017- December 2017)	Increased understanding of the CE Framework for Action and how best to use it.	1. CE Framework for Action modified and finalized		

Health Improvement Partnership – Cuyahoga

Date Created: 9-26-16 **Date Updated:** 11/2/16

Key Priority or Key Approach:

Health and Equity in All Policies – Creating healthier and more equitable communities by incorporating health and equity into decision-making across sectors, systems, and policy areas

Population Focus: ***Indicate the geographic area and population of focus.*** Cuyahoga County	**Anchor Organization(s): *(Which organization will guide overall strategic direction, facilitate dialogue among partners, manage data collection and analysis, handle communications, coordinate community outreach, and mobilize funding):*** Cuyahoga County Board of Health – or other organization(s) identified to convene a policy work group

Goal: Develop a policy agenda through an equity lens, that addresses issues which impact the health of our residents and reflects the shared interests and priorities of our partners, community and decision makers.

SMART Objective 1: By December 31, 2018, the HIP-Cuyahoga Steering Committee, with consortium member and community input, will select up to 3 policy priorities to implement a policy campaign.

Dissemination Plans: ***Plans for presentations, abstract/posters submissions, conferences, etc. (Include specific dates)***

Evidence base: ☐ Evidence Based **X** Evidence Informed ☐ Innovative	***Source(s):***

Indicate Type of Strategic Approach (check all that apply):

- ☐ Education and Awareness (increasing public understanding and knowledge)
- ☐ Providing Direct Services (assistance or support provided directly to community members)
- ☐ Environmental Change Activities (activities that involve physical or material changes to the economic, social, or physical environment)
- ☐ Organizational and institutional change activities (changes that impact all elements of an organization or institution ie. Hospitals, health departments, community service organizations, schools etc.)
- ☐ System Change Activities (changes that impact all elements of a system ie. neighborhood systems, educational systems, economic development systems, healthcare systems, etc.)
- **X** Policy Change Activities (law, resolution, mandate, regulation or rule – informal or formal; activities not confined to formal legislative process but can occur at an organizational and institutional level)

Major Activities ***Outline the main steps taken to achieve each objective.***	**Organization & Lead Person(s)** ***Identify the organization and person(s) that will carry out the activity & monitor progress.***	**Planned Process Measures** ***Measures effort & the direct outputs of programs/interventions- ie. exposure, reach, knowledge, attitudes.***	**Planned Outcome Measures** ***Measures effect & changes that result from the program & to what extent the program is achieving intended outcomes in the target population – short & mid-term changes in knowledge/awareness, attitude***	**Actual Process Measures** ***Measures actual outputs of programs/interventions*** ***(Include specific dates)***	**Actual Outcome Measures** ***Measures actual results from the program*** ***(Include specific dates)***	**Reporting Status** **(Completed, Ahead, On schedule, Behind)**

			change, beliefs, social norms, behavior change, system/policy change. (Include specific dates)			
Research local and national policies which align with HIP-Cuyahoga priorities to clearly define policy issue/problem.	CCBH and key priority subcommittee members	1. Conduct Research 2. Policy issue/problem defined (February 2016 – March 2017)	Increased knowledge of model policies	1. Research conducted 2. Policy issue/problem defined		
Identify policy focus areas and develop policy goals (Big P and/or small p), tied to current key priorities and/or to other local issues.	CCBH, Steering Committee and key priority subcommittee members	1. Identify policy focus areas 2. Develop policy goals (January 2017-June 2017)	Increased awareness of Big P and small p policies that relate to local issues and priorities	1. Policy focus areas identified 2. Policy goals developed		
Gather input on policy priorities from consortium and community members ie. via survey, focus groups, and/or community events/conversations.	CCBH, Steering Committee and key priority subcommittee members	1. Develop tool to gather input from various settings (June 2017-Sepetember 2017)	Increased understanding of consortium and community members awareness of policy priorities Strengthen cross-collaboration around policy across stakeholders	1. Tool developed 2. Input gathered		
Develop a policy agenda plan for action that includes partner, community, key decision/policy maker, and media involvement.	CCBH and Select Steering Committee Members connected to policy priorities	1. Develop policy agenda (June 2017-December 2017)	Increased alignment between public policies and HIP-Cuyahoga's goals	1. Policy agenda developed		
Assess HIP-Cuyahoga's ability/capacity/resources to undertake a campaign to implement policy goals.	CCBH and Select Steering Committee Members connected to policy priorities	1. Assess ability/capacity/resources (August 2017-December 2017)	Create a sustainable policy resource strategy	1. Assessment Completed		
Develop media action plans which align with HIP-Cuyahoga's communication strategy • Policy briefs and/or fact sheets • Disseminate and communicate policy information and briefs via HIP-Cuyahoga communications vehicles	CCBH and communications & community engagement workgroup	1. Develop policy briefs/fact sheets 2. Disseminate and communicate policy information (January 2017-March 2018)	Increase awareness of positive and negative consequences of policy decisions Increase media coverage tied to HIP-Cuyahoga policy goals	1. Policy briefs developed 2. Policy information disseminated and communicated		
Plan and host 2 key decision/policy maker caucuses to gain support and advance the HIP-Cuyahoga policy agenda.	CCBH and Steering Committee members	1. Plan caucuses 2. Host caucuses (First Caucus March 31, 2017/Second Caucus March, 2018)	Create spaces where health and equity in all policies can be developed by key decision makers Strengthen relationships with decision/policy makers	1. Caucuses planned 2. Caucuses held		

Health Improvement Partnership – Cuyahoga

Date Created: 2/6/14 **Date Updated:** 5/5/14, 8/29/16

Key Priority or Key Approach:

Eliminate structural racism (ESR)

Population Focus: *Indicate the geographic area and population of focus.*	**Anchor Organization(s):** ***(Which organization will guide overall strategic direction, facilitate dialogue among partners, manage data collection and analysis, handle communications, coordinate community outreach, and mobilize funding):***
County-wide with a focus on identifying key individuals who are early adopters among those engaged in the HIP-C initiative.	PolicyBridge Cleveland Neighborhood Progress

Goal: To eliminate structural racism as a social determinant of health in Cuyahoga County.

SMART Objective 1: By December 31, 2017, develop and support the leadership capacity of at least 50 key members of the HIP-C network (general public, organizational/Institutional reps, policy makers etc.) for addressing structural racism through the integration of racial inclusion & equity in the ongoing practice and culture of their institutions, organizations, networks and communities.

Dissemination Plans:

Comment [bg1]: presentations, abstracts, posters, papers (please indicated past and future) and provide a copy of the presentation/abstract, etc.

Evidence base:	***Source(s):***
☐ Evidence Based	Seven Levers to Change a Mind
X Evidence Informed	Leadership & Race: How to Develop and Support Leadership that Contributes to Racial Justice, July 2010
X Innovative	Racism: Combating the Root Causes of Health Disparities, Issue Focus Grant Makers in Health, 2010

Indicate Type of Strategic Approach (check all that apply):

- X Education and Awareness (increasing public understanding and knowledge)
- ☐ Providing Direct Services (assistance or support provided directly to community members)
- ☐ Environmental Change Activities (activities that involve physical or material changes to the economic, social, or physical environment)
- X Organizational and institutional change activities (changes that impact all elements of an organization or institution ie. Hospitals, health departments, community service organizations, schools etc.)
- X System Change Activities (changes that impact all elements of a system ie. neighborhood systems, educational systems, economic development systems, healthcare systems, etc.)
- X Policy Change Activities (law, resolution, mandate, regulation or rule – informal or formal; activities not confined to formal legislative process but can occur at an organizational and institutional level)

Major Activities	Organization & Lead Person(s)	Planned Process Measures	Planned Outcome Measures	Actual Process Measures	Actual Outcome Measures	Reporting Status (Completed, Ahead, On schedule, Behind)
1. Create a foundational communications strategy to include a frame and key messages for addressing racial inclusion & equity as a means for eliminating structural racism	**1.** Communications Consultant; Center for Achieving EquityTeam & subcommittee members	**1.** Create a Communications Strategy	**1.** Increased organizational capacity to dialogue about their role in ensuring equity and inclusion from an org and systems framework; e.g. # of organization adopting key messages and imbedded in org media, communications 1. We will have improved knowledge, awareness, and understanding of the role structural and institutional racism plays as a social determinant of health 1. We will develop and use clear and intentional messaging about the impact of structural and institutional racism on opportunism for health	1. Communications Strategy Created		
2. Conduct a readiness assessment among members of the HIP-Cuyahoga network to determine whether organizations and/or individuals are currently leading, following, or supporting racial inclusion and equity work.		2. A. Create a Readiness assessment 2. B Determine metrics with characteristics of organizations leading, following, supporting; as well as inclusion/cultural competency index 2.C. Conduct Readiness Assessment	2. Results of readiness assessment identify whether HIP-Cuyahoga members are currently leading, following or supporting racial inclusion and equity work; thus, indicating capacity building needs.	2.A. Readiness assessment created 2.B. Metrics identified 2.C. Readiness assessment conducted		

Comment [bg2]: Outcomes measures are a combination of what was originally on the work plan and a crosswalk back to the CHIP summary of goals and intended outcomes

Comment [bg3]: Please provide dates where appropriate

Comment [bg4]: Provide a status for each activity—indicating completed, ahead, on schedule or behind.

3. Identify internal/external stakeholders for the development of a network which will lead a direct, focused approach to eliminating structural racism		3.A Develop process to select primary stakeholders , e.g. representative of effected community	3.A. Identifiable network developed, eg. 3.B Increased alliances and approaches 3.C. Develop policies to create social and economic opportunities for all people in Cuyahoga County 3. More individuals and organizations will acknowledges and discuss the role that structural and institutional racism plays in creating opportunities for healthy people and communities in our county 3. See an improvement in community conditions and the ability of people in all communities to have fair opportunity to improve their health.	3.A. Process developed		
4. Create a capacity building curriculum targeted to followers, supporters and leaders that foster the integration of racial inclusion & equity in the core elements of institutional, organizational, network and community decision making processes.		4A. Create a curriculum to build capacity 4B. Create training modules for leaders, supporters, followers	4.A. Increase in organizations demonstrating increased capacity 4.B. Increase in public officials, org leaders who publicly support agenda 4.C. Identifiable shift in the way the media outlets report on related topics 4.D. Encourage organizations to work closely with community members 4. We will achieve perspective transformation and apply this concept in our organizations to create a change in culture, policies, and	4.A. Capacity building curriculum created 4.A. Training modules created		

			organizational practices.			

SMART Objective 2: By December 31, 2017, the eliminating structural racism subcommittee will work with the other HIP-C subcommittees to support the development and/or integration of strategic approaches and/or major activities to address racial inclusion & cultural competence; if the work plans do not reflect these upstream approaches.

Dissemination Plans:

Comment [bg5]: presentations, abstracts, posters, papers (please indicated past and future) and provide a copy of the presentation/abstract, etc.

Evidence base:	***Source(s):***
☐ Evidence Based	Seven Levers to Change a Mind
X Evidence Informed	Leadership & Race: How to Develop and Support Leadership that Contributes to Racial Justice, July 2010
X Innovative	Racism: Combating the Root Causes of Health Disparities, Issue Focus Grant Makers in Health, 2010
	King County Equity Impact Tool

Indicate Type of Strategic Approach (check all that apply):

- X Education and Awareness (increasing public understanding and knowledge)
- ☐ Providing Direct Services (assistance or support provided directly to community members)
- ☐ Environmental Change Activities (activities that involve physical or material changes to the economic, social, or physical environment)
- X Organizational and institutional change activities (changes that impact all elements of an organization or institution ie. Hospitals, health departments, community service organizations, schools etc.)
- X System Change Activities (changes that impact all elements of a system ie. neighborhood systems, educational systems, economic development systems, healthcare systems, etc.)
- ☐ Policy Change Activities (law, resolution, mandate, regulation or rule – informal or formal; activities not confined to formal legislative process but can occur at an organizational and institutional level)

Major Activities	**Organization & Lead Person(s)**	**Planned Process Measures**	**Planned Outcome Measures**	**Actual Process Measures**	**Actual Outcome Measures**	**Reporting Status (Completed, Ahead, On schedule, Behind)**
1. Review subcommittee work plans and utilize equity assessment and impact tools to identify strategic approaches and/or major activities which could be integrated seamlessly to address racial inclusion & equity.	1. Designated subcommittee members.	1.A. Review work plans 1.B. Complete equity and impact assessments	1. Identify opportunities to integrate upstream strategic approaches and/or major activities to address racial inclusion & equity in other subcommittee work plans	1.A. Work plans reviewed 1.B. Equity and impact assessments completed		

Comment [bg6]: Outcomes measures are a combination of what was originally on the work plan and a crosswalk back to the CHIP summary of goals and intended outcomes

Comment [bg7]: Please provide dates where appropriate

Comment [bg8]: Provide a status for each activity—indicating completed, ahead, on schedule or behind.

2. Provide recommendations to subcommittees for the development and/or integration of upstream strategic approaches and/or major activities to address racial inclusion & equity.	2.	2. A. Create recommendations for subcommittee work plans, e.g. upstream/root cause; downstream/intervention or treatment	2. Increased upstream strategic approaches and/or major activities to address racial inclusion & equity incorporated in work plans 2. The HIP-Cuyahoga priority subcommittees that are not directly focused on structural and institutional racism will include strategies that address it	2. A. Recommendations created for subcommittee work plans 2.B. Recommendations incorporated into work plans		
3. Develop a system and process for providing ongoing technical assistance to other subcommittees for the implementation and evaluation of upstream approaches.		3.A. Develop a system for technical assistance 3.B. Adopt a process for technical assistance	3. Utilization of the process for providing ongoing technical assistance	3.A. System developed for technical assistance 3.B. Process adopted for technical assistance		
4. Establish ESR to be part of the core action framework for HIP-Cuyahoga moving forward						

SMART Objective 3: By December 31, 2017 a minimum of 10% of the organizations in the HIP-C network have identifiable changes to organizational/institutional or system level policies/practices addressing racial inclusion and cultural competence.

Dissemination Plans:

Evidence base:	***Source(s):***
☐ Evidence Based **X** Evidence Informed **X** Innovative	Seven Levers to Change a Mind Leadership & Race: How to Develop and Support Leadership that Contributes to Racial Justice, July 2010 Racism: Combating the Root Causes of Health Disparities, Issue Focus Grant Makers in Health, 2010 King County Equity Impact Tool

Indicate Type of Strategic Approach (check all that apply):

- **X** Education and Awareness (increasing public understanding and knowledge)
- ☐ Providing Direct Services (assistance or support provided directly to community members)
- **X** Environmental Change Activities (activities that involve physical or material changes to the economic, social, or physical environment)
- **X** Organizational and institutional change activities (changes that impact all elements of an organization or institution ie. Hospitals, health departments, community service organizations, schools etc.)
- **X** System Change Activities (changes that impact all elements of a system ie. neighborhood systems, educational systems, economic development systems, healthcare systems, etc.)
- ☐ Policy Change Activities (law, resolution, mandate, regulation or rule – informal or formal; activities not confined to formal legislative process but can occur at an organizational and institutional level)

Comment [bg9]: I added this but the work plan may not be the place for it—hopefully a success story

Comment [bg10]: Need to establish a baseline

Comment [bg11]: presentations, abstracts, posters, papers (please indicated past and future) and provide a copy of the presentation/abstract, etc.

Major Activities	Organization & Lead Person(s)	Planned Process Measures	Planned Outcome Measures	Actual Process Measures	Actual Outcome Measures	Reporting Status (Completed, Ahead, On schedule, Behind)
1. Adopt tools or utilize existing equity impact tools to assess and catalog changes to organizational/institutional or system level policies/practices addressing racial inclusion and cultural competence.		1.A. Existing equity impact tool assessment 1.B. Create equity impact tools 1.C. Create a system for cataloging changes to policies and practices	1. Adoption of org. policy and procedures assessing impact of decisions using an equity lens	1.A. Assessment of existing equity impact tool completed 1.B. Equity impact tools created 1.C. System for cataloging changes to policies and practices developed		
2. Create a process for providing on-going technical assistance to the HIP-Cuyahoga network		2.A. Develop a system for technical assistance 2.B. Adopt a process for technical assistance	2. Utilization of the process for providing ongoing technical assistance 2. Teach organizations how to recognize and address structural racism 2. More organizations will improve their individual and organization competencies around structural and instructional racism, as well as racial inclusion and equity 2. More organizations will have an explicit focus on structural and institutional racism and how to address it 2. HIP-Cuyahoga member organizations will begin to	2.A. System developed for technical assistance 2.B. Process adopted for technical assistance		

Comment [bg12]: Outcomes measures are a combination of what was originally on the work plan and a crosswalk back to the CHIP summary of goals and intended outcomes

Comment [bg13]: Please provide dates where appropriate

Comment [bg14]: Provide a status for each activity—indicating completed, ahead, on schedule or behind.

Comment [bg15]: This might be a good place for Shared Measurement to assist

			create identifiable policies and practices that address structural racism, racial inclusion, and equity. Work will be underway to document these changes, develop incentives, create metrics, and conduct evaluations to ensure accountability. 2. Structural and institutional racism will be addressed explicitly in decisions, policies, and organization and community practices.			

Health Improvement Partnership – Cuyahoga

Date Created: 10/16/13 **Date Updated:** 6/30/14, 8/21/14, 2/10/15, 5/2/16, 9/8/16, 9/27/16, 11/11/16, 11/14/16, 11/17/16

Key Priority or Key Approach: Chronic Disease Management (CDM)	
Population Focus: County-wide with a focus on individuals aged 18-75 with coronary artery disease (CAD) and related conditions (Diabetes, Obesity). Objectives and activities are aligned with a specific demographic, e.g. low income African American population diagnosed with hypertension.	**Anchor Organization(s):** Better Health Partnership
Goal: Improving the management of chronic disease through effective self-management/empowerment messaging and strategies gleaned from evidence-based programs as well as increasing access to high quality culturally sensitive care and community resources.	

SMART Objective 1: By September 2017, develop and disseminate 10 messages to increase awareness of and participation in of the chronic disease management initiatives.	
Dissemination Plans: ***Plans for presentations, abstract/posters submissions, conferences, etc. (Include specific dates)***	
Evidence base: ☐ Evidence Based **X** Evidence Informed ☐ Innovative	***Source(s):*** A. County RoadMaps, CDC, NIH, NCI Cancer Institute B. Community resources available 1. CCBH life expectancy maps 2. Prevention Research Center (CWRU) maps with hypertension, obesity, diabetes prevalence; cigarette use 3. Better Health Partnership 4. Center for Health Affairs – self reported CAD data 5. Million Hearts Campaign (DHHS); American Heart Association; i.e.; check, change, control it! 6. DSAS – Cuyahoga County Dept. of Senior and Adult Services C. Environmental scan of resources with evidence-based messaging appropriate for each/combined conditions and risk factors. 7. Self-management or prevention messaging from evidence-based Chronic Disease Self-Management Program (CDSMP), an evidence-based and widely approved self-management program for older adults (approved by AoA, CDC, NCOA). This program was developed and is coordinated by Stanford (Univ.) Patient Education Research Center. Go to http://www.fairhillpartners.org/sevices/ChronicDisease.html) and (http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/CDSMP-6-30-2011.pdf) 8. Additional sources from American Heart Assoc., American Lung Assoc. could be included in synthesis of messaging 9. Scan for resources that use visuals/photos effectively with messaging D. Environmental scan of community resources to support messaging E. Environmental scan of community resources that people at risk of CAD can use for self-management

Indicate Type of Strategic Approach (check all that apply):

- **X** Education and Awareness (increasing public understanding and knowledge)
- ☐ Providing Direct Services (assistance or support provided directly to community members)
- ☐ Environmental Change Activities (activities that involve physical or material changes to the economic, social, or physical environment
- ☐ Organizational and institutional change activities (changes that impact all elements of an organization or institution i.e. Hospitals, health departments, community service organizations, schools etc.)
- ☐ System Change Activities (changes that impact all elements of a system i.e. neighborhood systems, educational systems, economic development systems, healthcare systems, etc.)
- ☐ Policy Change Activities (law, resolution, mandate, regulation or rule – informal or formal; activities not confined to formal legislative process but can occur at an organizational and institutional level)
- **X** Consistent messaging

Major Activities	Organization & Lead Person(s)	Planned Process Measures	Planned Outcome Measures	Actual Process Measures	Actual Outcome Measures	Reporting Status (Completed, Ahead, On schedule, Behind)
Assess the effectiveness of the educational and outreach campaign from 2016	CDM subcommittee and C/CE members Conceptual Geniuses	Review and summarize: 1. Qualitative responses (via informal input discussion and/or focus groups) from community health ambassadors and providers 2. Page views for CDM, Clinical and Community Linkages, and CDSMP class pages 3. Public and partner inquiries for information 4. Referrals to community resources made based on educational and outreach campaign		Reviewed and summarized: 1. Qualitative responses reviewed and summarized 2. Number of page views for CDM, Clinical and Community Linkages, and CDSMP class pages 3. Number of inquiries for information 4. Number of referrals to community resources		
Develop community outreach and educational campaign with refined targets and at least 10 messages to public.	CDM subcommittee and C/CE members Conceptual Geniuses	1. Develop community outreach campaign 2. Refine target population for education and outreach campaign 3. Identify messages for dissemination and obtain images of advertisements		1. Community outreach and educational campaign completed 2. Targets refined 3. Messages identified and images of advertisements obtained		

Implement campaign in target neighborhoods and clinics	CDM subcommittee and C/CE members Conceptual Geniuses	1. Identify transit locations 2. Schedule radio spots 3. Create social media and website messages 4. Post campaign on various social media platforms 5. Post campaign on HIP-Cuyahoga website	1. Increase value of placements, media impressions and reach	1. Transit locations identified 2. Radio spots scheduled 3. Social Media and website messages written 4. Campaign posted and assessed. 4a. Number of social media views and shares 5. Campaign posted and assessed. 5a. Number of website page views		
Based on assessment and feedback, revise messages, materials, visuals etc. for outreach.	CDM subcommittee and C/CE members Conceptual Geniuses	1. Qualitative responses from community health ambassadors and providers 2. Revise messages 3. Post campaign on various social media platforms 4. Post campaign on HIP-Cuyahoga website	1. Increase value of placements, media impressions and reach	1. Qualitative responses reviewed and summarized 2. Messages Revised 3. Campaign posted and assessed. 3a. Number of social media views and shares 4. Campaign posted and assessed. 4a. Number of website page views		

SMART Objective 2: By Dec. 31, 2017, increase the number of Primary Care clinics from 0 to 9 that will implement an evidence-based program (adapted from Kaiser Permanente's model) for blood pressure management–a hypertension best practice.

Dissemination Plans: The hypertension best practice program and early implementation findings have been disseminated at multiple Better Health Partnership Learning Collaborative sessions since Sept 2014 as well as the 2016 Midwest and National Society of General Internal Medicine conferences. We will continue to disseminate this work as part of the Better Health Partnership Learning Collaborative Summits and regional and national conferences.

Evidence base:	**Source(s):**
X Evidence Based **X** Evidence Informed **X** Innovative	A. Community level resources - 2012 Community Health Assessment - Anticipated 2014 and future Behavioral Risk Factor Surveillance System (BRFSS) surveys (population level prevalence measures) B. Outcomes data - Anticipated 2014 and future Behavioral Risk Factor Surveillance System (BRFSS) surveys (population level measures - Better Health Partnership Blood Pressure Control data pre and post intervention at each of the intervention clinics C. Hypertension best practice - Adapted from Kaiser Permanente (Healthspan) model published in JAMA in August 2013

Indicate Type of Strategic Approach (check all that apply):

- **X** Education and Awareness (increasing public understanding and knowledge)
- ☐ Providing Direct Services (assistance or support provided directly to community members)
- ☐ Environmental Change Activities (activities that involve physical or material changes to the economic, social, or physical environment)
- **X** Organizational and institutional change activities (changes that impact all elements of an organization or institution i.e. Hospitals, health departments, community service organizations, schools etc.)
- **X** System Change Activities (changes that impact all elements of a system i.e. neighborhood systems, educational systems, economic development systems, healthcare systems, etc.)
- ☐ Policy Change Activities (law, resolution, mandate, regulation or rule – informal or formal; activities not confined to formal legislative process but can occur at an organizational and institutional level)
- **X** Consistent messaging

Major Activities	**Organization & Lead Person(s)**	**Planned Process Measures**	**Planned Outcome Measures**	**Actual Process Measures**	**Actual Outcome Measures**	**Reporting Status (Completed, Ahead, On schedule, Behind)**
Identify the diverse population and where they live using: -clinic specific measures -community-level measures	BHP, CCBH, PRC	1. Assess blood pressure control at the clinic-level 2. Identify population		1. Clinic–level blood pressure control assessed 2. Population identified		Completed as part of REACH Grant
Select a diverse population to engage in this objective ie; African Americans, Caucasians	BHP, CCBH, PRC	1. Select a diverse population		1. Diverse populations selected		complete
Describe the social, economic and environmental factors to establish whether there is imbalance w.r.t health equity or not.	BHP, CCBH, PRC	1. Develop criteria to determine a health equity imbalance 2. Describe social, economic and environmental factors		1. Criteria developed 2. Descriptions created		Completed as part of REACH Grant

Perform environmental scan of area providers using hypertension (HTN) best practice interventions for vulnerable populations	BHP	1. Perform environmental scan (providers using HTN best practices)		1. Environmental scan conducted		Completed at start of REACH 9/14
Hypertension best practice implementation and maintenance	BHP	Practice coaches logs, meeting minutes, quality improvement data collected	% of patients under good BP control pre- and post-intervention	Practice coaches logs, meeting minutes, quality improvement data collected	% of patients under good BP control pre- and post-intervention	On schedule
Upstream Impact: Recommend system level changes as appropriate to "hypertension best practice" findings for targeted populations. Report findings through HIP-C website and other communication channels.	BHP	1. Provide recommendations for system level changes 2. Report findings	1. Spreading evidence-based best clinical practices for high blood pressures control in all Cuyahoga County health care systems	1. Recommendations provided 2. Findings reported	% of patients under good BP control at all participating BHP member clinics reporting data at baseline and follow-up	On schedule

SMART Objective 3: By Dec. 31, 2017, increase the number of clinics that refer patients to community resources for healthy eating, active living (HEAL) and disease self-management from 0 to 9.

Dissemination Plans: In 2016, we disseminated findings on linking clinics with community resources for the Stanford Chronic Disease or Diabetes Self-Management Programs (CDSMP/DSMP) at multiple Better Health Partnership Learning Collaborative sessions, as well as regional and national internal medicine and public health conferences.

Evidence base:	***Source(s):***
X Evidence Based ☐ Evidence Informed **X** Innovative	A. Provider accessible resources - Healthy Eating and Active Living (HEAL) Resource Guide and Produce Prescription Program - Chronic Disease or Diabetes Self-Management Programs – Stanford Model B. Outcomes data - Pre-post surveys of target patients and their self-management behaviors and outcomes

Indicate Type of Strategic Approach (check all that apply):

- **X** Education and Awareness (increasing public understanding and knowledge)
- ☐ Providing Direct Services (assistance or support provided directly to community members)
- ☐ Environmental Change Activities (activities that involve physical or material changes to the economic, social, or physical environment)
- **X** Organizational and institutional change activities (changes that impact all elements of an organization or institution i.e. Hospitals, health departments, community service organizations, schools etc.)
- **X** System Change Activities (changes that impact all elements of a system i.e. neighborhood systems, educational systems, economic development systems, healthcare systems, etc.)
- ☐ Policy Change Activities (law, resolution, mandate, regulation or rule – informal or formal; activities not confined to formal legislative process but can occur at an organizational and institutional level)

Major Activities	**Organization & Lead Person(s)**	**Planned Process Measures**	**Planned Outcome Measures**	**Actual Process Measures**	**Actual Outcome Measures**	**Reporting Status (Completed, Ahead, On schedule, Behind**
Perform environmental scan of providers implementing the hypertension best practice and identify those referring patients to community resources for	BHP, Fairhill Partners, PRC, CCBH	1. Environmental scan (providers using hypertension best practice and referring to community		1. Environmental scan conducted		**Completed**

healthy eating, active living and disease self-management programs in a standard manner.		resources for HEAL and CDSMP)				
Select neighborhoods to target intervention	BHP, Fairhill Partners, PRC< CCBH	Target neighborhoods identified		9 target neighborhoods identified		completed
Create list of healthy eating active living resources in selected neighborhoods	PRC, BHP	1. List created	1. We will create and maintain a list of healthy eating and active living community resources to aid providers in referring patients to these resources in order to improve activation in management of patients' chronic conditions.	1. same as planned	1. Number of HEAL Resource Guide distributed as part of REACH Grant 2. Number of patients referred to disease self-management programs	On schedule
Recruit and train lay health leaders to lead the Stanford Chronic Disease or Diabetes Self-Management Programs (CDSMP/DSMP)	Fairhill Partners	Train leaders		# of leaders and master trainers trained		On schedule As of 10/1/16, 42 CDSMP leaders, 8 DSMP leaders and 9 master trainers have been trained.
Develop and implement a clinic referral process for HEAL and CDSMP/DSMP at clinics implementing the HTN Best Practice	BHP	Referral process developed and documented for each health system for HEAL and CDSMP	1. Number of patients referred by clinics to HEAL resources 2. Number of patients referred by clinics to CDSMP/DSMP 3. Number of patients receiving produce prescriptions	Same as planned	Same as planned	On schedule
Implement community CDSMP/DSMP workshops in targeted high-need communities as determined by environmental scan	BHP, PRC, Fairhill Partners, CCBH	Identify community organizations to host workshops	Number of workshops held, and number of people attending a CDSMP/DSMP workshop in the community	Same as planned	Same as planned	Behind schedule
Measure impact of CDSMP/DSMP and Produce Prescription Program on health behaviors	CCBH, PRC, BHP, Fairhill Partners, OSU-EC	Conduct surveys of Produce Prescription and CDSMP/DSMP participants on health behaviors	1.CDSMP/DSMP – depression, general health, quality of life, pain, sleep problems, and chronic disease management self-efficacy pre and post workshop 2.Produce Prescription – Fruit and vegetable intake and fast food intake pre and post program, and farmers' market use (see HEAL workplan)	Same as planned	Same as planned	On schedule

Upstream Impact: Recommend system level changes as appropriate for linking clinics with community resources for HEAL and self-management for targeted populations. Report findings through HIP-C website and other communication channels.	BHP, PRC, Fairhill Partners	1. Provide recommendations for system level changes 2. Report and disseminate findings	BHP clinic level chronic disease outcomes of blood pressure and Hemoglobin A1c over time	Same as planned	Same as planned	On schedule

Health Improvement Partnership – Cuyahoga Nutrition & Physical Activity Sub-Committee Work Plan

Date Created: **10/16/2013** **Date Updated: 11/11/2016, 11/30/16**

Key Priority: Healthy Eating and Active Living (HEAL)

Population Focus: ***Indicate the geographic area and population of focus.*** Cuyahoga County Residents with a focus on communities with the highest need (low income urban core?) as determined by the subcommittee	**Anchor Organization(s):** ***(Which organization will guide overall strategic direction, facilitate dialogue among partners, manage data collection and analysis, handle communications, coordinate community outreach, and mobilize funding):*** Prevention Research Center for Healthy Neighborhoods at Case Western Reserve University

Goal:

- To increase opportunities and access to year round healthy food options for all Cuyahoga County Residents with a focus on communities with the highest need.
- To increase the number of safe and accessible places for all Cuyahoga County residents to be physically active, year round, with a focus on communities with the highest need.
- To increase the number of safe and accessible places for all Cuyahoga County residents to be physically active, year round, with a focus on communities with the highest need.

SMART Objective 1:

By December 2016, increase the percentage of census tracts that have at least one healthy retail option located within the tract or within a half a mile of the tract.

Comment [bg1]: Date edit or is this correct?

Comment [bg2]: Will there be an attempt to increase by a certain amount (%), what is the baseline

Dissemination Plans: See additional dissemination plan for details

Evidence base: X Evidence Based ☐ Evidence Informed ☐ Innovative	***Source(s):*** Robert Wood Johnson Foundation HEAL Research Network YMCA Pioneering Healthy Communities Centers for Disease and Prevention Control (CDC) National Prevention Strategy

Indicate Type of Strategic Approach (check all that apply):

- X Education and Awareness
- ☐ Providing Direct Services
- X Environmental Change Activities
- X Organizational and institutional change activities
- X System Change Activities
- X Policy Change Activities

Major Activities ***Outline the main steps taken to achieve each objective.***	**Organization & Lead Person(s)** ***Identify the organization and person(s) that will carry out the activity & monitor progress.***	**Planned Process Measures** ***Measures effort & the direct outputs of programs/interventions-ie. exposure, reach, knowledge, attitudes.***	**Planned Outcome Measures** ***Measures effect & changes that result from the program & to what extent the program is achieving intended outcomes in the target population – short & mid-term changes in knowledge/awareness, attitude change, beliefs, social norms, behavior change, system/policy change.*** ***(Include specific dates)***	**Actual Process Measures** ***Measures actual outputs of programs/interventions*** ***(Include specific dates)***	**Actual Outcome Measures** ***Measures actual results from the program*** ***(Include specific dates)***	**Reporting Status** **(Completed, Ahead, On schedule, Behind)**
Identify census tracts in Cuyahoga County that lack a healthy retail outlet within the tract or ½ mile of tract boundary.	CHC Team PRCHN	1. Create a map and database of census tracts.	Interactive, flexible database of compiled information	1. Created a process tracking spreadsheet that indicates which stores were eligible, and targeted for intervention 2. Maps of neighborhoods divided into census tracts with all potential HFR stores identified		
Develop criteria to	HIP-C HEAL Sub-	1. Create high-	List of priority	1. High-need criteria	Communities identified for targeted strategies to address	

Comment [bg3]: Needs completed

identify high-need census tracts for targeted healthy retail strategies	Committee; CHC Team	need criteria 2. Identify census tracts and communities	tracts and/or communities	developed targeting census tracts meeting the poverty and education criteria (>30% living in poverty and >25% of adults age 25 without a HS education) 2. Census tracts identified (22 census tracts across the city of Cleveland and East Cleveland)	poor nutrition and poor clinic-community linkages.	
Establish definition of "Healthy Retail"	HIP-C HEAL Sub-Committee; CHC Team	1. Define Healthy retail		1. Robust Healthy Food Retail program/definition was developed		
Create an inventory of past and current healthy retail initiatives in Cuyahoga County.	HIP-C HEAL Sub-Committee Healthy Cleve Sub-Comm. Tremont HCS Initiative CHC Team	1. Create an inventory of healthy retail initiatives in Cuyahoga County 2. Distribute inventory	Online, paper documents available to stakeholders	1. Inventory created 2. inventory distributed		
Engage additional stakeholders within priority communities	HIP-C HEAL Sub-Committee CHC Team	1. Create partnerships with Community stakeholders		1. Partnerships created with Ohio State University Extension, Stephanie Tubbs Jones health center, Forest City weingart produce		
Identify evidence-based strategies and policy interventions to support expansion of healthy retail options in Cuyahoga County.	HIP-C HEAL Sub-Committee CHC Team	1. Identify strategies and policy intervention	Summary document of evidence-based strategies and policies.	1. Strategies and policy interventions identified		
Identify program partner(s) that can implement identified strategies and provide technical	HIP-C HEAL Sub-Committee CHC Team	1. Identify program leads for implementation 2. Provide technical assistance	Increase healthy retail in priority census tracts	1. Program lead identified 2. Technical assistance provided		

assistance to the healthy retail initiative.						
Host food retail business forums to discuss barriers and opportunities to increase healthy options available in stores.	No Lead Currently Identified; Suggestion to engage new partners to carry out this work (Greater Cleve Ptr/COSE)	1. Plan a retail business forum 2. Host a retail business forum	Identify barriers and opportunities to increase healthy options available in stores	1.Retail business forum planned 2.Retail business forum hosted		
Engage community and store owners in planning, implementation stages of this initiative to ascertain program is implemented in realistic/culturally sensitive manner	No Lead Identified; Potential to engage players through Sub-Committee work	1. Recruit community stakeholders to participate in planning process 2. Train community stakeholders to recruit select stores and formulate a community sensitization and engagement strategy	Increase in number of interested retail owners committed to healthy retail.	1. Number of community stakeholders who participated in planning process (2 community ambassadors identified and paid short-ter) 2. Number of community stakeholders trained (store selection, community sensitization, engagement)		
IF PLANNING SUPPORTS ACTIVITY: Incentivize store owners to stock, promote healthy food options	No Lead Currently Identified; Requires engagement of municipal governments	1. Identify Number of healthy food items; number of healthy retail outlets;		1. Number identified as follows (as of 11/16/16): a. No. of healthy retail outlets: 15 b. No. of Stores introduced and maintained with new healthy items: approx 12 c. No. of store owners received $100 incentive check: approx. 7		
Identify current programming in target neighborhoods and align with healthy stores if possible. (E.g	HIP-C Sub-Committee	1. Identify and align current programming	Programming encourages residents to purchase healthy items	Identified number of supportive programming offered as follows: Identified 2 partners. 1. OSU-E holds expertise in nutrition education sessions and food demonstrations	Partners came together to strategize and implement an in-store nutrition ed session	

cooking class/demo)				2. Stephanie Tubbs jones (STJ) health center to provide in-store health screenings		
IF PLANNING SUPPORTS ACTIVITY: Educate public about importance of healthy eating, how/where to eat/prepare healthy foods	No Lead Identified; may need to develop better understanding of the specifics of this activity	1. Strategize an in-store nutrition ed. session pilot 2. Develop a media campaign for promotion of sessions 3. Implement the in-store nutrition ed. session and record reach 4. Distribute HEAL resource list	Percentage increase in healthy food items purchased in food desert communities and in use of farmers markets/Double Value Produce Perks program	1. In-store pilot session held a. Pilot held at 1 E.Clev store (attended by 96 residents, and 17 received health screening) 2. Media campaign developed 3. Number of in-store nutrition educations sessions 4. HEAL resource list distributed		
Adopt Ohio Department of Health's Ohio Healthy Retail brand to promote healthy options at retailers.	PRCHN ODH CHC	1. Identify eligible stores 2. Initiate MOU 3. Distribute marketing materials to stores (After eligible stores sign an MOU and move through Phase 1, they are given Good Food Here (ODH) marketing materials to display at the store) 4. Create restocking policy that aligns with store phases	Ohio Healthy Retail Brand is in use at food retail locations in Cuyahoga County.	1. Process tracking spreadsheet tracks which phase each eligible store is in at any given time. 2. Number of MOUs initiated 3. Number of marketing materials/kits distributed 4. Restocking policy created		
Work with local food processing/distribu		1. Identify local food processing/distrib		1. Local food processing/distributors identified		

Comment [m4]: Research policies that aligns with HFR program - ie. Restocking policy or checkout line policy

tors to utilize processing and packaging of grab and go foods		utors 2. Develop a processing/packaging implementation plan		2.Processing and packaging plan developed		
Work with Community Development and Economic Development to offer additional services/programs to resource stores		1. Identify Community Development and Economic partners 2. Develop a plan to offer additional resources	Incorporated HFR within other process to support store improvements	1. Partners identified 2. Plan developed		

SMART Objective 2:
By December 31, 2016, increase the number of Cuyahoga County Communities that adopt complete streets policies.

Comment [bg5]: Date ok?

Comment [bg6]: Baseline and increase to what?

Dissemination Plans: See additional dissemination plan for details

Evidence base:

- X Evidence Based
- ☐ Evidence Informed
- ☐ Innovative

Source(s):

Robert Wood Johnson Foundation HEAL Research Network

YMCA Pioneering Healthy Communities

Centers for Disease and Prevention Control (CDC)

National Prevention Strategy

APHA Safe Routes Everywhere

Indicate Type of Strategic Approach (check all that apply):

- X Education and Awareness
- ☐ Providing Direct Services
- X Environmental Change Activities
- X Organizational and institutional change activities
- X System Change Activities
- ☐ Policy Change Activities

Major Activities ***Outline the main steps taken to achieve each objective.***	**Organization & Lead Person(s)** ***Identify the organization and person(s) that will carry out the activity & monitor progress.***	**Planned Process Measures** ***Measures effort & the direct outputs of programs/interventions-ie. exposure, reach, knowledge, attitudes.***	**Planned Outcome Measures** ***Measures effect & changes that result from the program & to what extent the program is achieving intended outcomes in the target population – short & mid-term changes in knowledge/awareness, attitude change, beliefs, social norms, behavior change, system/policy change.*** ***(Include specific dates)***	**Actual Process Measures** ***Measures actual outputs of programs/interventions*** ***(Include specific dates)***	**Actual Outcome Measures** ***Measures actual results from the program*** ***(Include specific dates)***	**Reporting Status** **(Completed, Ahead, On schedule, Behind)**
Implement Complete & Green Streets practices on streets planned for resurfacing in City of Cleveland	Cleveland Public Works; Office of Sustainability; Bike Cleveland; YMCA CIM	1. Annual Capital Improvement Plans detailing streets scheduled for improvements	Increase number of completed miles of new or enhanced bicycle and pedestrian accommodations		Number of completed miles of new or enhanced bicycle and pedestrian 13 additional miles installed in 2016; (wouldn't necessarily classify them as complete OR green, though)	
Finalize Complete Streets Tool Kit for Cuyahoga County	County Planning; County Executive's Office; County Public Works; Bike Cleveland	1. Finalize and publish toolkit	Summary document of evidence-based strategies and policies.	1. Tool kit was completed and published (available from County Planning Commission as a model for communities to use in adopting ordinances/resolutions and implementing complete and green streets)		
Conduct targeted trainings in Complete & Green Streets Best Practices	County Planning; County Executive's Office; County Public Works; Bike Cleveland; YMCA CIM	1. Identify targeted suburban communities and attendees to participate in training sessions	Increased number of trainees receiving CEU's for attending the training	1. Number of training sessions held, number of attendees, number of suburban communities participating as follows: One training was held in 2014. If I recall there were about 20 attendees (Alison Ball from Cuyahoga County would know more details)		
Adoption of Complete Street Policies at	Local councils,	1. Adopted ordinances	Increased utilization of roadways by vulnerable	1. Number of ordinances/resolutions adopted (Currently policy		

Comment [bg7]: Needs completed

Comment [bg8]: This might be a process measure instead of outcome?

Comment [bg9]: is this only for suburban communities?

local level	govern-ing boards	and/or resolutions	users like bicyclists and pedestrians	only exists at city of Cleveland level. Tool kit is available for other communities)		
Complete District-wide Safe Route to School plans for cities of Cleveland & Euclid	Cleveland Metropolitan School District; City Planning; Office of Sustainability; Healthy Cleveland Initiative; Euclid Public School District; Bike Cleveland; County Planning; CCBH-HIP-C	1. Hold parent/ stakeholder meetings held 2 Present to council and committees	Adopted District-wide Safe Routes to Schools	1. Number of parent/ stakeholder meetings held 2. Number of council and committee presentations Submitted documents	Adopted plan led to successful submission for Safe Routes implementation funding, which was awarded to CMSD from ODOT. Calley Merrsman would have details on what specifically is being funded, but generally it is a sub-set of Safe Routes plan recommendations	
Develop plan for a network of protected bike facilities in Cuyahoga County	Bike Cleveland; YMCA CIM; NOACA; Cleveland Metroparks; County Planning; Cleveland Office of Sustainability	1. Develop and complete Midway Plan	Formal adoption of the plan by NOACA, Cleveland City Council, County Council; Cleve Metroparks	1. Midway plan developed and completed. (Midway plan for Cleveland has last formal public hearings at noon and in the late afternoon of 12/7. Final plan recommendations by year end. Ad Hoc Financing Committee being constituted to look at financing plan recommendations)		
Construction of pilot network of protected bike facilities	Cleveland Public Works/Traffic Engineering; Suburban Public Works/Traffic Engineers	1. Construct pilot network	Increased number of miles of protected facilities constructed Media Coverage	1. Pilot network constructed (2017, two-segment, Downtown pilot being recommended by the Midway Plan Steering Committee; Ad Hoc Financing Committee about to form to determine how to pay for it)		

SMART Objective 3:
By December 31, 2016, increase the number of census tracts with at least one shared use agreement in place in tract or within .5 miles

Comment [bg10]: What is taking place to move this forward and what other communities are considering adopting

Comment [bg11]: This was on the work plan but I am not sure what it refers to

Comment [bg12]: Is there an update on this

Comment [m13]: What about the Eastside Greenway plan? Does that include bike facilities?

Comment [bg14]: Date correct?

Comment [bg15]: Baseline and increase to what?

Dissemination Plans: See additional dissemination plan for details

Evidence base:	***Source(s):***
X Evidence Based ☐ Evidence Informed ☐ Innovative	Robert Wood Johnson Foundation HEAL Research Network YMCA Pioneering Healthy Communities Centers for Disease and Prevention Control (CDC) National Prevention Strategy

Indicate Type of Strategic Approach (check all that apply):

- X Education and Awareness
- ☐ Providing Direct Services
- X Environmental Change Activities
- X Organizational and institutional change activities
- X System Change Activities
- X Policy Change Activities

Major Activities ***Outline the main steps taken to achieve each objective.***	**Organization & Lead Person(s)** ***Identify the organization and person(s) that will carry out the activity & monitor progress.***	**Planned Process Measures** ***Measures effort & the direct outputs of programs/interventions-ie. exposure, reach, knowledge, attitudes.***	**Planned Outcome Measures** ***Measures effect & changes that result from the program & to what extent the program is achieving intended outcomes in the target population – short & mid-term changes in knowledge/awareness, attitude change, beliefs, social norms, behavior change, system/policy change.*** ***(Include specific dates)***	**Actual Process Measures** ***Measures actual outputs of programs/interventions*** ***(Include specific dates)***	**Actual Outcome Measures** ***Measures actual results from the program*** ***(Include specific dates)***	**Reporting Status** **(Completed, Ahead, On schedule, Behind)**
Organize, advertise and deliver training to build capacity among community-serving governmental and non-government institutions on how to develop, implement and evaluate shared used agreements	PRC CHC	1. Organize training 2. Advertise training 3. Deliver training # of organizations		1. Training organized 2. Training advertised 3. Number of organizations attended training: a. Over 35 individuals attended a workshop held at Bethany Baptist Church led by (CDC TA) Change Lab Solutions DATE: 9/2015		
Develop Shared Use Local Resource Guide, locally branded materials to assist	PRC	1. Develop Shared Use		1. Resources guide developed		

Comment [bg16]: Needs completed

Comment [m17]: Survey results? For actual outcome measures

in developing and implementing SUAs, including model policies, local data, local success stories, and opportunities for technical asst.	CHC	Local Resource Guide 2. Distribute Resource Guides distributed		2. Resource guide distributed a. Resource guides have been widely distributed to all workshop attendees, to Creating Greater Destinies members, to neighborhood partners and potential shared use sites throughout the REACH-focused neighborhoods DATE: 9/2015 to on-going b. Resources guides are available for download from the PRCHN website		
Collect and map data to identify potential shared use facilities, such as school building, parks, churches, and recreation facilities.	PRC CHC	1. Create a map of potential facilities		1. Maps were created using ARC GIS to determine if potential facilities are located within the REACH target census tracts or in .5 miles buffer DATE: May 2016		
Resident teams review community asset maps and provide feedback, input and interpretation. Identify opportunities to promote physical activity through SUAs.	PRC	1. Review community asses maps and collect feedback and specific needs and goals for SUA facilities in neighborhoods 3. Identify opportunities to promote physical activity through SUAs.		1. Resident teams became a main source of locating and securing SUA within the REACH target neighborhoods. on-going Key resident leaders are intimately involved with feedback, input and interpretation. (In year 3, key resident leaders will be spearheaded the identification and promotion of PA activities at SUA locations DATE: ongoing)		on-going
Engage resident team in advocating for prioritized SUAs. Draw from organizational resources in consortium to move prioritized PA opportunities to action.	PRC CHC Creating Greater Destinies	1. Engage resident teams 2. Increase # new SUA agreements in place 3. Increase # facilities offering new programming to residents	Increased number of facilities offering new programming to residents Move prioritized PA opportunities to action.	1. Resident teams engaged Number of new SUA agreements in place: As of 11/14/2016 there are 15 signed policies in place (goal-22); in year 3 the focus will shift developing programming DATE: on-going 2. Number of new SUA agreements in place 3. Number of facilities offering new programming to residents		on-going

Develop and implement community-specific materials to market and communicate shared use opportunities to target community	PRC CHC Creating Greater Destinies	1. Develop community specific materials 2. Implement community specific materials 3. Update and distribute HEAL Resources list	Increased residents using SUA facilities and programs	1. Community specific materials developed. 2. Number of residents using SUA facilities and programs. 3. HEAL resource list updated and distributed		In process
With input from resident teams and community org partners, develop and implement sustainability plan focused on leveraging existing funds, establishing policy, and maintaining environmental and systems change.	HIP-C HEAL Sub-Committee , CHC, Healthy Cleveland Active Living Committee	1. Develop sustainability plans 2. Implement sustainability plans		1. Sustainability plans developed: Number of sustainability plans created 2. Sustainability plans implemented: Number of sustainability plans implemented		In process

Other Questions/Considerations

PRX, FARE, Farm to School—will these be included and if so, needs to be developed/reflected in the workplan

FARE—how does this interface with or integrate with HEAL workplan ? Or does FARE implementation help support programming? Should the FARE recommendations be integrated (i.e. clinic/community linkage)

What is the overlap with the other HIP-Cuyahoga priorities (Racism, CDM, Clinical/Public health)

Health Improvement Partnership – Cuyahoga

Date Created: **October 16, 2013** **Date Updated: 1/16/14, 1/22/14, 2/6/14,2/13/14, 2/27/14, 3/27/14, 9/6/16, 11/14/16**

Key Priority: Clinical and Public Health

Population Focus:	**Anchor Organization(s):**
County-wide with a focus on identifying agency and core stakeholders to sustain HIP-Cuyahoga subcommittee work, and affected by asthma	Environmental Health Watch Case Western Reserve University School of Medicine

Goal: To establish a multi-stakeholder infrastructure for sharing tasks, values, and foundational knowledge through an equity lens (among public health, healthcare, behavioral health, community partners, payors, business and other consortium partners)

SMART Objective 1: By December 31, 2018, develop an integrated system to conduct future coordinated, comprehensive countywide community, clinical and behavioral health assessments to identify priority focus area(s) through a clinical care and public health multi-stakeholder partnership.

Comment [bg1]: A local approach to a regionalized process; new statewide process (Gullett comment)

Dissemination Plans: Numerous presentations have been provided sharing information on the need for this objective and then considering how this might be operationalized (need for database to centrally track such dissemination, including local, regional and national conferences).

Evidence base:
- ☐ Evidence Based
- X Evidence Informed
- ☐ Innovative

Source(s):
Prevention Institute Population Intervention Model - http://www.preventioninstitute.org/component/jlibrary/article/id-298/127.html
Maine State-wide CHA. http://chna.emh.org/
Colorado Standards for State-wide CHA based on PHAB. http://www.colorado.gov
Oregon Public Health/Health System Transformation. http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/Pages/index.aspx
Wisconsin Coordinated Community Health Needs Assessment http://www.wicancer.org/documents/Reardon_Westrick_1pm.pdf
North Carolina Coordinated CHA. http://publichealth.nc.gov/lhd/cha/
Public Health and Primary Care Integration: ASTHO Collaborative Evidence Review. www.astho.org
IOM Public Health and Primary Care Integration: http://www.iom.edu/Activities/PublicHealth/PrimaryCarePublicHealth.aspx

Indicate Type of Strategic Approach (check all that apply):
- X Education and Awareness
- ☐ Providing Direct Services
- X Environmental Change Activities
- X Organizational and institutional change activities
- X System Change Activities
- X Policy Change Activities

Major Activities	Organization & Lead	Planned Process Measures *(Include specific dates)*	Planned Outcome Measures *(Include specific dates)*	Actual Process	Actual Outcome	Reporting Status

	Person(s)			**Measures**	**Measures**	**(Completed, Ahead, On schedule, Behind)**
Develop a compelling message (business/value proposition case – for diverse audiences, including a communication plan) and messengers to identify and recruit potential stakeholders (thorough evidence review of other PH-CC endeavors to identify best practices around a coordinated CHA – possibly at state level)	Gullett/Craciun/Frank/Stange	Develop message Develop Communication Plan	Written value proposition case	Message developed Communication Plan developed Tallied participation in planning meetings at local and state levels	Written value proposition case	Completed
Review 2014 IRS guidelines around community health assessment requirements, including coordination of hospital systems with local public health entities	Craciun/Golembiewski	Assess IRS guidelines		IRS guidelines assessed within subcommittee Center for Health Affairs IRS consultant review session		Completed
Identify alternate strategies for conducting CHA	Frank/HPIO	Identify alternate strategies for conducting CHA	Collaboration between local public health and clinical care organizations will be a standard business practice Identify opportunities for combined data collection to better represent community health needs	Alternate strategies for conducting CHA identified		Completed
Identify and recruit stakeholders with ability to make decisions on behalf of their organization regarding CHA		Recruit stakeholders	Obtain buy-in from stakeholder organizations regarding a coordinated CHA with identification of when this will next occur	Stakeholders recruited (#)	Buy-in obtained with defined commitment to participate in coordinated primary data collection and secondary data assessment	On Schedule
Engage state level public health leaders for inclusion of coordinated community health assessments in SHIP(synchronization of assessment cycles)	Allan/Craciun/Gullett/Hospital representation (Misak/Gartland)	Engage state level public health leaders	Encourage both systems to work together on shared goals State-level policies will reflect the importance of collaboration for CHSA and CHNA. Secure funding to support clinical care and public health working together to write	State level public health leaders engaged Participation in Population Health Advisory Planning meetings Fall 2015 Participation in SHIP Planning meetings Summer/Fall 2016	State level policy signed by Gov. Kasich June 2016	Completed

			community benefit and community health improvement			
Commitment for coordinated CHA from stakeholders (Develop charter, commitment form, and common language) *–if state-wide policy changes do not mandate change in timeline and coordination within a certain geographical area*		Develop plan for commitment from stakeholders	Northeast Ohio hospitals will include HIP-Cuyahoga representatives in planning their next CHNA. Local hospital leadership will participate in HIP-Cuyahoga	Plan developed		
Develop plan with coordinated stakeholders on establishing the new system		Develop plan	Create a clear path to coordinate the next CHSA and CHNA in Cuyahoga County Work collaboratively on the next CHSA and CHNA during every stage of the process – from planning through implementation and development of community benefit plans	Engagement with Healthy Communities Inc regarding comprehensive product to address coordinated needs assessment and consortium management Plan developed	Financial commitment to system in place Website with measures live for HIP-Cuyahoga and partners Plan for primary data collection measures for coordinated assessment Collaborative CHSA/CHNA 2018/2019	In progress On Schedule with 2018/2019 target?
Establish PH/CH coordination to be part of the core action framework for HIP-Cuyahoga moving forward (upon successful completion of Objective 1)						

SMART Objective 2: By December 31, 2016, utilize existing community health assessments to identify, select, and develop an intervention strategy for health issue(s) that involve a coordinated public health and clinical approach.

Dissemination Plans:

Evidence base:

- ☐ Evidence Based
- X Evidence Informed
- ☐ Innovative

Source(s):

Partnerships between Federally Qualified Health Centers and Local Health Departments for Engaging in the Development of a Community-Based System of Care. NACCHO. October 2010.

See list of resources above for development of SHIPs and CHIPs from coordinated and/or available CHAs.

Indicate Type of Strategic Approach (check all that apply):

- X Education and Awareness
- X Providing Direct Services
- ☐ Environmental Change Activities
- X Organizational and institutional change activities
- ☐ System Change Activities
- ☐ Policy Change Activities

Comment [bg2]: I added this but the work plan may not be the place for it—hopefully a success story

Comment [bg3]: This may be more of a process measure. Consider incorporating into Objective 1 or keeping as its own objective and highlighting Dr. Franks work and pretentions given to the subcommittee to inform (by Dr. Franks work)

Major Activities	Organization & Lead Person(s)	Planned Process Measures *(Include specific dates)*	Planned Outcome Measures *(Include specific dates)*	Actual Process Measures	Actual Outcome Measures	Reporting Status (Completed, Ahead, On schedule, Behind)
Identify and describe five community health issues occur through reviews of existing CHAs in our County, including early HIP-C work/surveys.	Frank/Golembiewski/HPIO Partners (others conducting thorough reviews and synthesis of themes – Matloub, Craciun, Chappelle)	Identify five community health issues		Health issues identified	Scott presented his findings in detail to steering committee and in other venues	**Completed**
Describe evidence-base for addressing each community health issue and underlying determinants	Frank	Describe evidence base		Description created		**Completed**
Identify knowledge gaps for each issue.		Conduct gap analysis		Gap analysis conducted		
Coordinate review with other 3 HIP-Cuyahoga committees to assess areas of overlap.		Assess overlap with HIP-C subcommittees		Overlap assessed		
Engage stakeholders from objective 1 in identification of community health issues for future work.		Engage stakeholders		Stakeholders engaged (#)		
Select a priority area(s) for future integrated work.		Select priority Engagement with other groups: HHAC, GUCCHI, BHP and BHP CHI	The health and quality of life in our community will improve Coordination efforts with other local place-based strategies around key health issues	Priority selected		
Coordinate with other local, place-based strategies to address identified issues						

SMART Objective 3: By December 31, 2016, the committee will engage partners to develop and implement a demonstration project addressing pediatric asthma that integrates public health and clinical care in Cuyahoga County.

Comment [bg4]: Consider broadening to include Healthy Homes?

Dissemination Plans:

Evidence base:
- X Evidence Based
- ☐ Evidence Informed

Source(s):
Woods et al., Community Asthma Initiative: Evaluation of a Quality Improvement Program for Comprehensive Asthma Care, Pediatrics 129:465, 2012.- paper Dr. Dearborn assigned for 429- Boston project.
http://innovations.ahrq.gov/content.aspx?id=3220

☐ Innovative	

Indicate Type of Strategic Approach (check all that apply):

- **X** Education and Awareness
- **X** Providing Direct Services
- **X** Environmental Change Activities
- **X** Organizational and institutional change activities
- **X** System Change Activities
- **X** Policy Change Activities

Major Activities	Organization & Lead Person(s)	Planned Process Measures *(Include specific dates)*	Planned Outcome Measures *(Include specific dates)*	Actual Process Measures	Actual Outcome Measures	Reporting Status (Completed, Ahead, On schedule, Behind)
Develop an executive summary (this implies summary would be inclusive of existing evidence base)	**Dearborn/ Foreman/Sobolewski/ Allan/Gullett**	Develop an executive summary		Executive summary developed		**Completed**
Identification and engagement of key stakeholders with content/process knowledge		Engage stakeholders		Stakeholders engaged (#)		**Completed**
Develop a value proposition/business case for coordinated efforts and funding/value-based payment schemes for services that provide value and improve outcomes		Develop a value proposition/business case	Ohio Medicaid consistently will fund public health efforts around asthma home interventions and consider funding for other collaborative initiatives that address other chronic conditions	Value proposition/business case developed		**Completed**
Obtain organizational commitment from key stakeholders	**Dearborn/Foreman/ Allan/Sobolewski**	Obtain commitment		Commitment obtained (# of organizations)		**Completed**
Identification of funding opportunities for demonstration project (joint visits, PH environmental evaluation, necessary remediation work)	**Dearborn/ Foreman/Sobolewski/ Allan/Gullett**	Identify funding opportunities		Funding opportunities identified and applied (#)		**Completed**
Engagement of Medicaid decision-makers at state level (meeting w/state Medicaid director and/or meeting at quarterly Medicaid MD mtgs)	**Dearborn/Foreman**	Engage decision-makers	Ohio Medicaid leadership will be engaged in discussing the cost effectiveness of financially reimbursement clinical care and public health partnership efforts around improved asthma outcomes. Secure external	Decision-makers identified (#)		**Completed**

			funding to support and sustain subcommittees work			
Engagement of potential funding sources (ACOs, QI Institutes, Insurers – 5 Medicaid managed care – quarterly meeting, ?commercial insurers)	**Dearborn/Foreman/ Allan/Sobolewski**	Identify funding opportunities	Ohio Medicaid leadership will be engaged in discussing the cost effectiveness of financially reimbursement clinical care and public health partnership efforts around improved asthma outcomes. Secure external funding to support and sustain subcommittees work	Funding opportunities identified and applied (#) CareSource pilot		**Completed**
Frame and implement demonstration project	**Dearborn/Foreman/ Allan/Sobolewski**	Outline demonstration project	Create and implement a demonstration project on pediatric asthma with a defined Medicaid population	Demonstration project outline created		**Completed**
Implement demonstration project	**Dearborn/Foreman/ Allan/Sobolewski**	Implement demonstration project	Create and implement a demonstration project on pediatric asthma with a defined Medicaid population	Demonstration project implemented	**Contracts signed** **Participant enrollment**	**On Schedule**
Evaluate demonstration project		Evaluate demonstration project	Create and implement a demonstration project on pediatric asthma with a defined Medicaid population	Demonstration project evaluated		
Share results of the project		Identify information sharing opportunities	Create and implement a demonstration project on pediatric asthma with a defined Medicaid population	Information sharing opportunities identified and submitted (#)		
Coordination of Healthy Homes Advisory Council and HIP-Cuyahoga PH-CC Subcommittee	**Foreman/Gullett/Allan/ Gordon**	HHAC and PH/CC meetings held in conjunction with one another	Combined meetings			**On Schedule**

SMART Objective 4: By December 31, 2016, build public health and health equity training in to the curriculum of health profession students.	
Dissemination Plans:	
Evidence base: ☐ Evidence Based ☐ Evidence Informed ☐ **X Innovative**	***Source(s):***
Indicate Type of Strategic Approach (check all that apply): ☐ **Education and Awareness (increasing public understanding and knowledge)**	

- Providing Direct Services (assistance or support provided directly to community members)
- Environmental Change Activities (activities that involve physical or material changes to the economic, social, or physical environment)
- **Organizational and institutional change activities (changes that impact all elements of an organization or institution ie. Hospitals, health departments, community service organizations, schools etc.)**
- **System Change Activities (changes that impact all elements of a system ie. neighborhood systems, educational systems, economic development systems, healthcare systems, etc.)**
- Policy Change Activities (law, resolution, mandate, regulation or rule – informal or formal; activities not confined to formal legislative process but can occur at an organizational and institutional level)

Major Activities	Organization & Lead Person(s)	Planned Process Measures	Planned Outcome Measures	Actual Process Measures	Actual Outcome Measures	Reporting Status (Completed, Ahead, On schedule, Behind)
HIP-Cuyahoga steering committee participation in SOM curriculum	Gullett	Number of didactic/teaching sessions provided to SOM students (MD, MPH, PA) Number of sessions provided to faculty/professional development seminars		Tallied sessions provided at SOM (2011-present) SOM/UH/BHP, etc		On Schedule
Evaluation of students' perceptions of health equity and upstream determinants of health			TBD with new research project - CSU			
HIP-Cuyahoga steering committee participation in non-SOM health professions curricula		Number of sessions provided to other health professions students in community				
HIP-Cuyahoga steering committee participation in health equity capacity building regionally	Gullett/Halko	Number of sessions delivered to regional or statewide colleagues		Mahoning Valley Foundation Health Equity movement		

Comment [HG5]: May actually better be placed in key approach work plans than in this one as objective is specific to health professions students.

Measuring What Works to Achieve Health Equity: Metrics for the Determinants of Health

Prepared for the
Robert Wood Johnson Foundation

Original to the Foundation: June 2014
Revised for dissemination: June 2015

Prevention Institute
Prevention and equity | at the center of community well-being
www.preventioninstitute.org

In spring 2014, the Robert Wood Johnson Foundation (RWJF) commissioned Prevention Institute to develop a set of metrics to inform its broader set of metrics for its Culture of Health. In its original form, this document served as a background document for RWJF staff to inform discussion around disparity metrics for the Foundation and the nation. This version has been slightly modified for broader dissemination, including adding an executive summary.

Prevention Institute is a nonprofit, national center dedicated to improving community health and wellbeing by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on community prevention, injury and violence prevention, health equity, healthy eating and active living, positive youth development, health system transformation and mental health and wellbeing.

Principal Author:
Rachel Davis

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ACKNOWLEDGEMENTS

Prevention Institute would like to thank the following individuals for providing input via interviews, which helped direct, shape and refine our thinking and approach:

Kelly Brownell, Dean and Professor of Public Policy, Duke University
Natalie Burke, Common Health Action
Nadine Chan, King County Department of Public Health
Mark Cervero, Common Health Action
Mari Egan, Pritzker School of Medicine, University of Chicago
Erima S. Fobbs, Common Health Action
Rejane Frederick, Common Health Action
Tony Iton, The California Endowment
Nicole Kravitz-Wirtz, University of Washington
Neil Maizlish, California Department of Public Health
Dan Perales, San Jose State University
Patrick Remington, County Health Rankings
Kara Ryan, Common Health Action
Brian Smedley, Joint Center for Political and Economic Studies, Health Policy Institute in June 2014; National Collaborative for Health Equity in June 2015
Katy Weeks, Common Health Action
Sandra Witt, The California Endowment
Elva Yanez, Colibri Strategies Inc. in June 2014; Prevention Institute in 2015 and the California State Park and Recreation Commission

INTRODUCTION

The Robert Wood Johnson Foundation (RWJF) has laid out a bold and ambitious agenda of achieving a Culture of Health in the U.S. RWJF's new vision of a Culture of Health requires that the Foundation become more explicit about the need to expand the opportunity for good health for all. As such, RWJF has adopted health disparities[i] as a major priority. RWJF recognizes that persistent health disparities linked with disadvantages experienced by particular populations undercut our nation's founding principle of equal opportunity to life, liberty, and the pursuit of happiness. The Foundation has set an ambitious goal of measurably reducing health disadvantages and disparities.

In spring 2014, RWJF commissioned Prevention Institute to develop a set metrics to inform its broader set of metrics for its Culture of Health. This paper is the outcome of that work. It provides a framework for understanding how disparities in health outcomes are produced and how health equity can be achieved, particularly by addressing the determinants of health. It lays out the determinants of health – structural drivers, community determinants, and healthcare – that must be improved to achieve health equity. It also describes the methods and criteria that Prevention Institute applied to identify health equity metrics. Finally, the paper delineates a set of metrics that could reflect progress toward achieving health equity.

We count what matters. Metrics that measure and track our progress on the determinants of health can help set priorities and inform necessary actions to keep *all* Americans healthy, lower the cost of healthcare, increase productivity, improve quality of life, and ensure that everyone has an equal opportunity to prosper and achieve his or her full potential.

We count what matters. Metrics that measure and track our progress on the determinants of health can help set priorities and inform necessary actions to keep all Americans healthy, lower the cost of healthcare, increase productivity, improve quality of life, and ensure that everyone has an equal opportunity to prosper and achieve his or her full potential.

UNDERSTANDING HEALTH INEQUITY AND HEALTH EQUITY

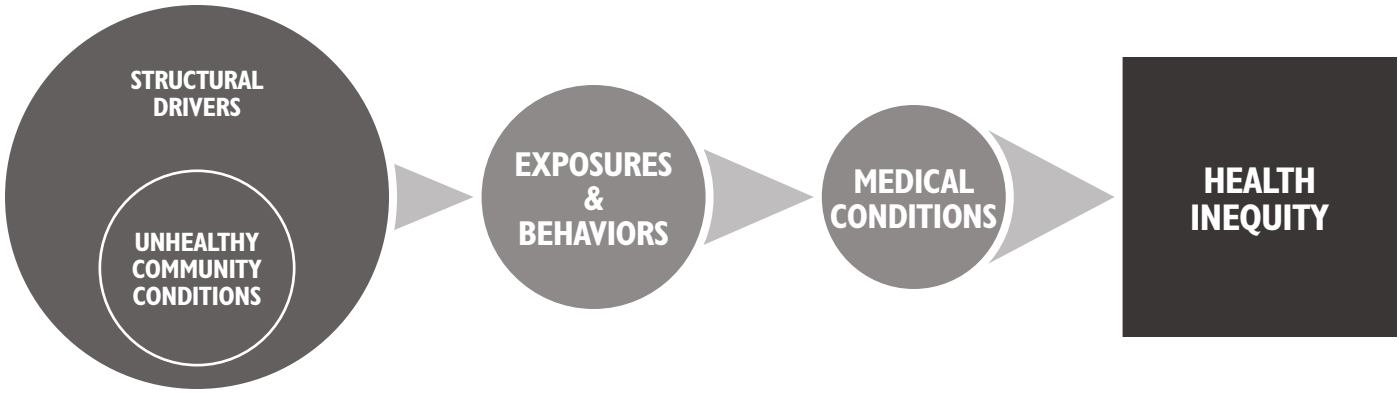
Good health is precious. It enables us to enjoy our lives and focus on what is important to us—our families, friends, and communities. It fosters productivity and learning, and it allows us to capitalize on opportunities. However, good health is not experienced evenly across society. Health inequity is related both to a legacy of overt discriminatory actions on the part of government and the larger society, as well as present day practices and policies of public and private institutions that continue to perpetuate a system of diminished opportunity for certain populations.

The Trajectory of Health Inequity (Diagram A) depicts how inequity in health outcomes are produced. It shows the relationships between structural drivers and unhealthy community conditions (community determinants), exposures and behaviors, medical conditions and health inequity. Structural drivers and community determinants generate inequity, which are exacerbated by exposures and behaviors, and further exacerbated by how medical conditions are addressed in

i At the time of the final production of this paper the RWJF Eliminating Health Disparities team has changed its name to the Achieving Health Equity team. This paper reflects the language in use at the time of the project.

healthcare. The accumulation of inequity across the trajectory is represented by the increasing size of the arrows moving from left to right, indicating that inequity in health outcomes increase at each stage. The diminishing size of the circles from left to right indicates a diminishing contribution to health inequity. The determinants of health have the biggest impact on inequities in health outcomes.

Diagram A: Trajectory of Health Inequity



The Trajectory of Health Inequity (Diagram A) reflects Prevention Institute's Two Steps to Prevention methodology, which traces a pathway from medical conditions to the behaviors and exposures that led to them, and then to the structural drivers and community determinants that are at the root of the behaviors and exposures. Prevention Institute's analysis started with identifying leading medical conditions that reflect health inequity and are leading causes of death, illness and injury. The first step of the Two Steps approach is from examining these leading medical conditions to identifying exposures and behaviors associated with them. Limiting unhealthy exposures and behaviors enhances health and reduces the likelihood and severity of disease. Through an analysis of the factors contributing to medical conditions that cause people to seek care, researchers have identified a set of nine behaviors and exposures strongly linked to the major causes of death: tobacco, diet and activity patterns, alcohol, microbial agents, toxic agents, firearms, sexual behavior, motor vehicles, and inappropriate drug use.[1] These behaviors and exposures are linked to multiple medical diagnoses and addressing them can improve health broadly.

The Trajectory of Health Inequity reflects Prevention Institute's Two Steps to Prevention methodology, which traces a pathway from medical conditions to the behaviors and exposures that led to them, and then to the structural drivers and community determinants that are at the root of the behaviors and exposures.

Exposures and behaviors are determined or shaped by the environments in which they are present. The second step is from the exposures and behaviors to the environment, identified here as the determinants of health (structural drivers, community determinants, and healthcare). Taking the second step from exposures and behaviors to the environment presents a tremendous opportunity to reduce health inequities by preventing illness and injury before their onset. In analyzing the social determinants of health and health inequities, the World Health Organization (WHO) has identified structural drivers—the inequitable distribution of power, money, opportunity and resources—as a key determinant of inequity in health and safety outcomes.[2] Poverty, racism, and lack of educational and economic opportunities are among the fundamental determinants of poor health, lack of safety, and health inequity, contributing to chronic stress and building upon one another to create a weathering effect, whereby health greatly reflects cumulative experience rather than chronological or developmental age.[3]

Structural drivers deeply shape community conditions – the places where people live, learn, work and play. [4] On the whole, a person's zip code is a better predictor of his/her health status and life expectancy than his/her genetic code.[5] Prevention Institute's THRIVE (Tool for Health and Resilience in Vulnerable Environments) framework delineates community determinants that fall into three interrelated clusters: the social-cultural environment (people cluster), the physical/built environment (place cluster), and the economic environment (equitable opportunity cluster). These community determinants fundamentally impact health and health inequity and represent an important place for action to achieve health equality.

Access to quality healthcare services is also an important determinant of health. People want and need high-quality medical care, including good medical, mental health, and dental services, and access to quality, culturally and linguistically appropriate medical and dental care, and emergency medical responses.

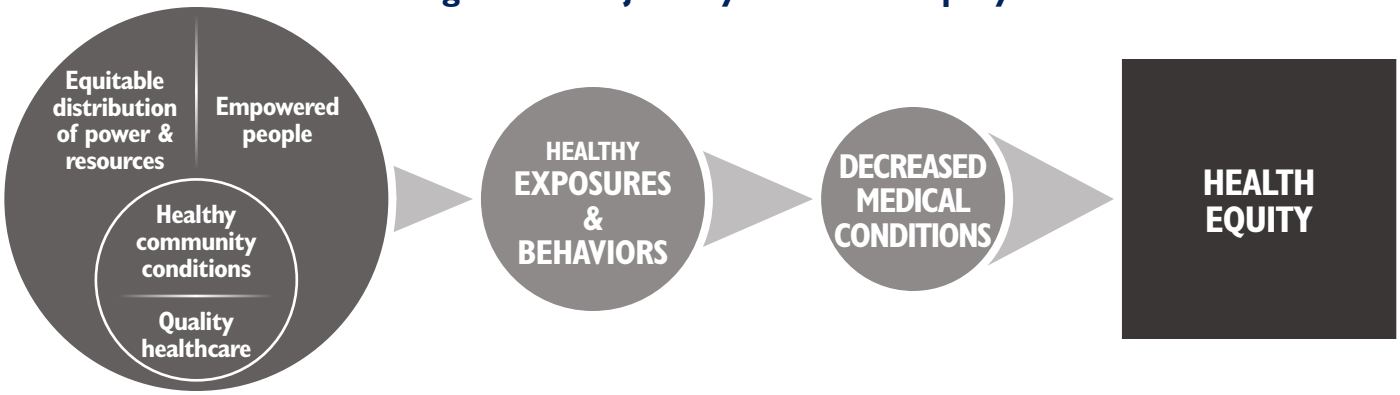
Table A shows the determinants of health, the related sample behaviors and exposures, and the medical conditions. Community determinants are organized into three interrelated clusters: the social-cultural environment (people cluster), the physical/built enviornment (the place cluster), and the economic environment (equitable opportunity cluster).

Table A: Determinants of Health, Related Behaviors and Exposures, and Medical Conditions

Determinants of Health	Behaviors and Exposures	Medical Conditions
STRUCTURAL DRIVERS ■ Inequitable distribution of power, money, opportunity and resources ■ Disempowered people **COMMUNITY DETERMINANTS** **Social-cultural environment (people cluster)** ■ Social networks & trust ■ Participation & willingness to act for the common good ■ Norms & culture **Physical/built environment (place cluster)** ■ What's sold & how it's promoted ■ Look, feel & safety ■ Parks & open space ■ Getting around ■ Housing ■ Air, water & soil ■ Arts & cultural expression **Economic environment (equitable opportunity cluster)** ■ Education ■ Living wages & local wealth **QUALITY HEALTHCARE**	Tobacco/smoking Excessive alcohol Diet/Nutrition Physical activity Chemical exposures and air pollution Sexual behaviors Infections pollens, dust Automobiles Falls Poisoning Weapons Violence Drug use and abuse Trauma and adverse experiences	Heart Disease Cerebrovascular Diabetes Mellitus Malignant Neoplasms Chronic Lower Respiratory Disease Unintentional Injury Suicide Homicide HIV Infant mortality Liver disease Nephritis Mental health conditions and trauma Occupational exposures Drug/substance use and abuse

The Trajectory of Health Equity (Diagram B) shows how improving the determinants of health will generate health equity. Improving structural drivers focuses on equitable distribution of power and resources and empowered people. Improving community determinants leads to healthy community conditions. Healthcare is also determinant of health. Improving this determinant results in quality healthcare. The Trajectory of Health Equity reflects that improving the determinants of health contribute to healthy exposures and behaviors, and decreased medical conditions. The contributions to greater health equity across the trajectory are represented by the increasing size of the arrows moving from left to right.

Diagram B: Trajectory of Health Equity



METRICS FOR HEALTH EQUITY

Altering the determinants of health (structural drivers, community determinants and healthcare) supports health equity. Therefore, the recommended health equality metrics are focused on the determinants of health. Metrics that capture the determinants of health can account for inequity across multiple dimensions including not only race/ethnicity and socio-economics but also geography-, gender-, sexual orientation- and disability-based inequity.

Building on the understanding of health inequity, and the determinants that need to be improved to achieve health equity, Prevention Institute developed a set of metrics. In May and June of 2014, Prevention Institute reviewed existing metrics and measurement projects, particularly for social determinants of health, and interviewed 17 people, including academics, people implementing place-based strategies, researchers who have or are developing metrics and indicator sets, and experts in specific topical areas. Prevention Institute considered health equity principles, terminology used in association with measurements, and criteria to assess individual metrics as well as the composite set of metrics. Numerous considerations were taken into account, including the strengths and limitations of indicators, indexes, and composite measures, the distribution of metrics across the determinants of health, and the need to frame the metrics in a manner that illuminates potential solutions.

Terminology

There are many terms used in association with measurements, including index, measures, metrics, and indicators. For the purpose of this paper, the following terminology is used:

- ***Indicator:*** An indicator is a single measurement.
- ***Index:*** An index is a measurement that includes multiple indicators and is in use by others – particularly for research purposes.
- ***Composite measure:*** A composite measure includes multiple indicators and is not necessarily in use by others but includes specific indicators that correlate strongly with health outcomes.

A set of health equity principles provided guidance and informed the criteria for the selection of the recommended metrics, including, but not limited to, understanding historical forces that have left a legacy of racism and segregation and the acknowledgment of the cumulative impact of stressful experiences and environments. Criteria were developed and applied to evaluate and prioritize potential individual metrics as well as the composite set of metrics. The criteria used to evaluate and prioritize individual metrics consisted of, but was not limited to, such factors as feasibility, measurability, and validity. The criteria used to evaluate and prioritize the set of metrics consisted of, but was not limited to, such factors as whether they align with a Culture of Health metrics and are grounded in health equity principles.

Consideration was given to the strengths and limitations of indicators, indexes, and composite measures. For example, indicators can be straightforward in what they express and can convey direction for policy and action. However, because they are single measures, they don't necessarily reflect complexity. Because indexes include multiple indicators, they are able to account for more complexity than a set of single indicators; yet at face value, they may not appear as actionable as single indicators. Composite measures can account for complexity and fill a gap in the field, but also may not appear as actionable as single indicators. The recommended metrics reflect a mix that maximizes the strengths and minimizes the limitations of indicators, indexes, and composite measures. It is recommended that additional composite measures be developed to fill gaps in the field. For example, a composite measure is recommended to address the strong relationship between community safety and health inequity in a manner that accounts for the complexity of community safety.

Metrics are important both as a tool for measurement of health inequity for the country as well as for clarifying the sources of inequity and fostering understanding of solutions. The recommended metrics also consider the need for effective framing that communicates clear direction and spurs action.

Determining how to distribute the metrics across the determinants (structural drivers, community determinants, and healthcare) is important. The recommended metrics reflect the overall set of determinants while giving balanced consideration to the distribution: about one-third of the set of metrics reflect the structural drivers, about one-half of the set of metrics reflect community determinants, and one-sixth of the set of metrics reflect healthcare. The recommended metrics for structural drivers include attention to: 1) the equitable/inequitable distribution of resources, power, money and opportunity; and, 2) empowered/disempowered people. The recommended metrics for community determinants include: 1) the social-cultural environment (people factors); 2) the physical/built environment (place factors); and, 3) the economic environment (equitable opportunity factors). The recommended metrics for healthcare include attention to access.

Metrics are important both as a tool for measurement of health inequity for the country as well as for clarifying the sources of inequity and fostering understanding of solutions. The recommended metrics also consider the need for effective framing that communicates clear direction and spurs action.

The following recommended health equity metrics reflect the determinants of health (structural drivers, community determinants, and healthcare).

STRUCTURAL DRIVERS

1. Neighborhood Disinvestment Index (index)
2. Gini Index[6] (index)
3. Index of Dissimilarity[7] (indicator)
4. Rates of incarceration by race/ethnicity (indicator)
5. Percent of residents from traditionally marginalized communities in positions of influence (indicator)
6. Geographic distribution of health: life expectancy by zip code (indicator)
7. Community Trauma (composite measure)
8. Community Readiness (composite measure)
9. Number of communities with indicator projects (indicator)

COMMUNITY DETERMINANTS

Social-cultural environment

10. Collective efficacy[8] (index)
11. Civic engagement (composite measure)

Physical/built environment

12. Physical activity environment[9] (index)
13. Retail Food Environment Index (index)
14. Food Marketing to Kids Group (index)
15. Housing Index[10] (index)
16. Affordability of Transportation and Housing[11] (index)
17. Pollution Burden Score[12] (index)
18. Mobility and Transportation[13] (index)
19. Opportunities for engagement with arts, music and culture[14] (index)
20. Per capita dollars spent for park space per city/neighborhood (indicator)
21. Safe place to walk within 10 minutes of home (indicator)
22. Alcohol outlet density (indicator)
23. Number of comprehensive smoke-free policies in places that prohibit smoking in all indoor areas of work-sites and public places (indicator)
24. Community Safety Scorecard[15] (index)
25. Number of cities with a comprehensive, multi-sector violence prevention plan (indicator)

Economic environment

26. Number of living wage policies in place (indicator)
27. Academic achievement (composite measure)
28. Local wealth (composite measure)
29. Complete and livable communities[16] (index)
30. School Environment[17] (index)
31. Percent of families who say it's hard to find the child care they need (indicator)
32. Workplace safety (composite measure)

HEALTHCARE SERVICES

33. Percent of patients that can access a place they call their "medical care home" within two weeks' time (indicator)
34. Patient satisfaction with medical encounters as a measure of culturally and linguistically appropriate care (indicator)
35. Number of medical schools that integrate healthcare disparities and community learning throughout entire curriculum and training (indicator)

A BOLD NEW VISION FOR AMERICA

The Robert Wood Johnson Foundation (RWJF) has laid out a bold and ambitious agenda of achieving a Culture of Health in the U.S. RWJF's new vision of a culture of health requires that the Foundation become more explicit about the need to expand the opportunity for good health for all. As such, RWJF has adopted health disparities[1] as a major priority, acknowledging the need for the Foundation to become a leading voice and a powerful driver in the movement to minimize the barriers that continue to compromise the health of so many in our society. RWJF recognizes that persistent health disparities linked with disadvantages experienced by particular populations undercut our nation's founding principle of equal opportunity to life, liberty, and the pursuit of happiness. The Foundation has set an ambitious goal of measurably reducing health disadvantages and disparities. Metrics will help inform the Foundation and the nation of its progress.

This paper describes Prevention Institute's health equity framework, including an analysis of the trajectories that produce either health inequity or equity, and the determinants of health (structural drivers, community determinants, as well as healthcare) that must be improved to achieve health equity. It also describes the methods and criteria that were applied to identify a set of recommended health equity metrics. Finally, the paper identifies a set of metrics that could reflect progress toward achieving health equity.

DISPARITIES: DEFINITIONS AND DIMENSIONS

The Foundation has noted that a number of organizations generally define health disparities as differences in health that negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion, e.g., race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. "Health equity" occurs when all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

Health disparities in the U.S. occur across many dimensions. Given changing and projected racial/ethnic demographics and the growing wealth divide in this country, racial/ethnic and socio-economic disparities are predominantly considered in the selection of metrics. Further, both dimensions are conflated with geographic disparities – including rural and urban disparities and disparities in the Southern region of the US – and therefore, consideration of geographic disparities is also strongly emphasized.

WE COUNT WHAT MATTERS

The decision to establish a set of metrics for RWJF and the nation reflects the importance of addressing health disparities. Good health is precious. It enables us to enjoy our lives and focus on what is important to us—our families, friends, and communities. It

1 At the time of the final production of this paper the RWJF Eliminating Health Disparities team has changed its name to the Achieving Health Equity team. This paper reflects the language in use at the time of the project.

fosters productivity and learning, and it allows us to capitalize on opportunities. However, good health is not experienced evenly across society. Heart disease, cancer, diabetes, stroke, injury, and violence occur in higher frequency, earlier, and with greater severity among low-income people and communities of color—especially, African Americans, Native Americans, Native Hawaiians, certain Asian groups, and Latinos.

Health inequity is related both to a legacy of overt discriminatory actions on the part of government and the larger society, as well as present day practices and policies of public and private institutions that continue to perpetuate a system of diminished opportunity for certain populations. Historically, African Americans, Native Americans, Alaska Natives, and Native Hawaiians, in particular, have to varying extents had their culture, traditions, and land forcibly taken from them. It is not a mere coincidence that these populations suffer from the most profound health inequity and shortened life expectancies.

...the idea of equity is based on core American values of fairness and justice – the moral imperative to ensure everyone has an equal opportunity to prosper and achieve his or her full potential.

In many of the low income and racially segregated places where health inequity abounds, a collective despair and sense of hopelessness is pervasive and social isolation is rampant. Individual and community-level despair fuels chronic stress, encourages short-term decision making and increases the inclination towards immediate gratification which may include tobacco use, substance abuse, high fat, salt, and caloric intake, and physical inactivity. And continued exposure to racism and discrimination may in and of itself exert a great toll on both physical and mental health.[18] Poverty, racism, and lack of educational and economic opportunities are among the fundamental determinants of poor health, lack of safety, and health inequities, contributing to chronic stress and building upon one another to create a weathering effect, whereby health greatly reflects cumulative experience rather than chronological or developmental age.[19] Inequities in the distribution of a core set of health protective resources also continue to create and maintain clear patterns of poor health throughout the U.S.

Health equity is everyone's issue, and finding solutions will significantly benefit us all. As the U.S. population becomes increasingly diverse, achieving a healthy, productive nation will depend even more on keeping *all* Americans healthy. An equitable system can drastically lower the cost of healthcare for all, increase productivity, and reduce the spread of infectious diseases, thus improving our collective quality of life, and physical and mental well-being. Lastly, and most importantly, the idea of equity is based on core American values of fairness and justice – the moral imperative to ensure everyone has an equal opportunity to prosper and achieve his or her full potential.

Establishing metrics not only underscores the importance of addressing health disparities, it directs the Foundation and the country to a set of priorities and actions that can and will make a difference in the health and well-being of those populations in the U.S. who are most at risk for poor health and safety outcomes. If something is important, we note it, count it, measure it, and track it. RWJF's commitment to metrics reflects the Foundation's commitment to achieving health equity.

DETERMINANTS OF HEALTH: A FRAMEWORK TO INFORM HEALTH EQUITY METRICS

The determinants of health that must be improved to achieve health equity include: 1) structural drivers; 2) community determinants; and, 3) healthcare. This section lays out Prevention Institute's Two Steps framework, to identify these key determinants.

TWO STEPS TO PREVENTION — THE DETERMINANTS OF HEALTH

RWJF has long acknowledged the influence of the places that people live, learn, work and play on health. Similarly, Prevention Institute has focused on the impact of community environments on health, safety and health equity, and developed a methodology – Two Steps to Prevention. Two Steps to Prevention was developed as a tool to analyze the underlying causes of illness and injury and health inequities and identify the key opportunities for intervention and prevention. Two Steps to Prevention presents a systematic way of first looking at medical conditions, then at the exposures and behaviors that affect illness and injury, and then at the underlying determinants that shape patterns of exposure and behavior or directly influence the onset of medical conditions. To inform the development of metrics most closely associated with inequity across major health problems, Prevention Institute applied this methodology in recommending health equity metrics for RWJF.

Starting with Medical Conditions

The Centers for Disease Control and Prevention has identified the Leading Causes of Death by Age Group for the US (see Appendix A[2]).[20] By looking at leading causes of death across the lifespan, a more complete set of medical conditions that reflect inequity is revealed. For example, African Americans experience significant disparities in infant mortality, HIV and homicide. Yet none of these conditions is reflected in the top 10 leading causes of death in the US annually. In addition to focusing on medical conditions associated with the leading causes of death across the lifespan, several key medical conditions for which inequity abounds – mental health conditions/trauma, occupational hazards and substance abuse – were included. The overall set of key medical conditions that are leading causes of death and ill-health is shown in Table 1.

Table 1: Medical Conditions
Heart Disease
Cerebrovascular
Diabetes Mellitus
Malignant Neoplasms
Chronic Lower Respiratory Disease
Unintentional Injury
Suicide
Homicide
HIV
Infant mortality
Liver disease
Nephritis
Mental health conditions and trauma
Occupational exposures
Drug/substance use and abuse

Take a Step: From Medical Conditions to Exposures and Behaviors

The first step of the Two Steps approach is from examining medical conditions to identifying exposures and behaviors. Limiting unhealthy exposures and behaviors enhances health and reduces the likelihood and severity of disease. Through an analysis of the factors contributing to medical conditions that cause people to seek care, researchers have identified a set of nine behaviors and exposures strongly linked to the major causes of death:

2 The most current complete data set at the time of the development of this paper was for 2010. Preliminary data from 2011 available at the time revealed few overall differences in leading causes of death in the US.

tobacco, diet and activity patterns, alcohol, microbial agents, toxic agents, firearms, sexual behavior, motor vehicles, and inappropriate drug use.[21] These behaviors and exposures are linked to multiple medical diagnoses and addressing them can improve health broadly. For example, tobacco is associated with a number of health problems including lung cancer, asthma, emphysema, and heart disease. Diet and activity patterns are associated with cardiovascular and heart disease, certain cancers, and diabetes, among other illnesses. Table 2 shows a brief sample of behaviors and exposures associated with the leading causes of death/medical conditions.

Table 2: Sample of Behaviors and Exposures and Associated Medical Conditions

Behaviors and Exposures	Medical Conditions
Tobacco/smoking	Heart Disease
Excessive alcohol consumption	Cerebrovascular
Diet/Nutrition	Diabetes Mellitus
Physical activity	Malignant Neoplasms
Chemical exposures and air pollution	Chronic Lower Respiratory Disease
Sexual behaviors	Unintentional Injury
Infections, pollens, dust	Suicide
Automobiles	Homicide
Falls	HIV
Poisoning	Infant mortality
Weapons	Liver disease
Violence	Nephritis
Drug use and abuse	Mental health conditions and trauma
Trauma and adverse experiences	Occupational exposures
	Drug/substance use and abuse

Take a Second Step: From Exposures and Behaviors to the Determinants of Health

The second step is from understanding the exposures and behaviors to identifying the determinants of health. Our collective knowledge of how underlying factors influence health, safety, and health equity has deepened significantly over the past decade, to include structural drivers and community determinants, as well as healthcare. The determinants of health are interrelated. Altering the determinants of health supports health equity. Therefore, the recommended metrics are focused on the determinants of health. Metrics that capture the determinants of health can account for inequity across multiple dimensions including not only race/ethnicity and socio-economics but also geography-, gender-, sexual orientation- and disability-based inequity.

THE DETERMINANTS OF HEALTH

The determinants of health include structural drivers, community determinants, and healthcare services.

Structural Drivers

In analyzing the social determinants of health and health inequities, the World Health Organization (WHO) has identified structural drivers—the inequitable distribution of power, money, opportunity and resources—as a key determinant of inequity in health and safety outcomes.[22] At a fundamental level, inequity in health outcomes can

be understood as a disparity in power. Groups with less power tend to suffer worse health outcomes. Further, for those without power, money and resources, the stressors can directly impact health in a negative way, as is increasingly understood. Poverty, racism, and lack of educational and economic opportunities are among the fundamental determinants of poor health, lack of safety, and health inequuity. These factors contribute to chronic stress and build upon one another to create a weathering effect, whereby health greatly reflects cumulative experience rather than chronological or developmental age.[23]

Poverty, racism, and lack of educational and economic opportunities are among the fundamental determinants of poor health, lack of safety, and health inequity.

Community Determinants: the Social-Cultural, Physical/Built, and Economic Environment

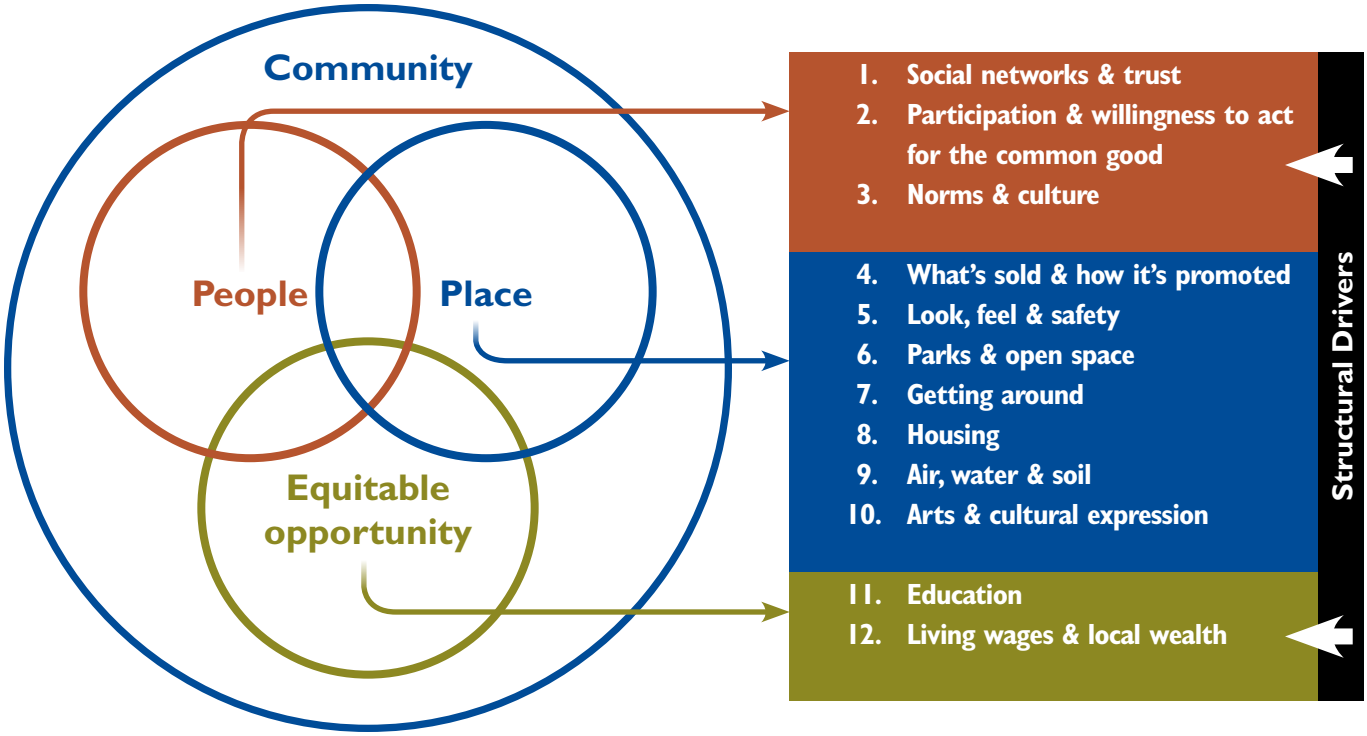
Another way that structural drivers influence health outcomes is by shaping the circumstances in which people are born, and grow, live, work, and age. WHO also identified community environments as a key contributor to inequity in health outcomes.[24] Drivers such as structural racism and socio-economic inequity, for example, play out at the community level to deeply impact community conditions. On the whole, a person's zip code is a better predictor of his/her health status and life expectancy than his/her genetic code. Research has now shown that after adjusting for individual risk factors, there are neighborhood differences in health and safety outcomes.[25] Thus, community environments fundamentally impact health and inequity and represent an important place for action to achieve health equity.

Another way that structural drivers influence health outcomes is by shaping the circumstances in which people are born, and grow, live, work and age. ...community environments fundamentally impact health and health inequity and represent an important place for action to achieve health equity.

For this analysis, Prevention Institute utilized its THRIVE (Tool for Health and Resilience in Vulnerable Environments) framework to delineate key community determinants that impact health, safety and health inequity. THRIVE emerged from an iterative process conducted from July 2002 to March 2003. The development team scanned peer-reviewed literature and relevant reports and conducted interviews with practitioners and academics. It also performed an internal analysis, which included brainstorming, clustering of concepts and information, and searching for supportive evidence as the analysis progressed. The literature scan began with *Healthy People 2010 Leading Health Indicators* (a forecast of indicators that Surgeon General Satcher identified as having a role in eliminating health disparities[26]) and with the "actual causes" of death identified by McGinnis and Foege.[27] Reviewers then gathered and evaluated subsequent information linking the *Leading Health Indicators* with social, behavioral, and environmental elements.[28]

The resulting set of 12 community factors fell into interrelated clusters, reflecting the social/cultural (people cluster), physical/built (place cluster), and economic environments (equitable opportunity cluster). THRIVE's national expert panel reviewed and ratified the factors and clusters, incorporating them into a tool that was pilot tested. The THRIVE research was updated in 2011–2012, and this included a review of new literature in the field of social determinants of health. The updated research also reviewed multiple social determinants of health frameworks, which revealed remarkable consistency across local, regional, state, national, and international models. The research that supports the connection between these clusters and factors and health, safety and health equity has also been provided to Foundation staff in a document entitled, *Community Clusters and Factors related to Health, Safety and Health Equity*. The 3 clusters and 12 community factors are depicted in Diagram 1: THRIVE Clusters and Factors — Community Determinants.

Diagram 1: THRIVE Clusters and Factors — Community Determinants



Healthcare Services

Access to quality healthcare services is also an important determinant of health. People want and need high-quality medical care, including good medical, mental health, and dental services. As a starting point, people need to be able to obtain quality medical and dental care, which means people need adequate and affordable health insurance. To help maintain health, people need preventive care and chronic disease management. In crisis situations, people need reliable, immediate, and qualified emergency medical responses. When people suffer from acute or chronic conditions, they need quality medical care to treat or cure their conditions, or help manage them. For all of these services, culturally and linguistically appropriate patient care is critical for communicating with patients and addressing health concerns within the cultural context of the patient.

The Determinants of Health, Related Behaviors and Exposures, and Medical Conditions

Table 3 shows the determinants of health, the related sample behaviors and exposures, and the medical conditions. (Refer to Appendix B for a list of specific factors within each cluster of community determinants associated with behaviors and exposures and medical conditions).

Table 3: Determinants of Health, Related Behaviors and Exposures, and Medical Conditions

Determinants of Health	Behaviors and Exposures	Medical Conditions
STRUCTURAL DRIVERS ■ Inequitable distribution of power, money, opportunity and resources ■ Disempowered people **COMMUNITY DETERMINANTS** **Social-cultural environment (people cluster)** ■ Social networks & trust ■ Participation & willingness to act for the common good ■ Norms & culture **Physical/built environment (place cluster)** ■ What's sold & how it's promoted ■ Look, feel & safety ■ Parks & open space ■ Getting around ■ Housing ■ Air, water & soil ■ Arts & cultural expression **Economic environment (equitable opportunity cluster)** ■ Education ■ Living wages & local wealth **QUALITY HEALTHCARE**	Tobacco/smoking Excessive alcohol Diet/Nutrition Physical activity Chemical exposures and air pollution Sexual behaviors Infections pollens, dust Automobiles Falls Poisoning Weapons Violence Drug use and abuse Trauma and adverse experiences	Heart Disease Cerebrovascular Diabetes Mellitus Malignant Neoplasms Chronic Lower Respiratory Disease Unintentional Injury Suicide Homicide HIV Infant mortality Liver disease Nephritis Mental health conditions and trauma Occupational exposures Drug/substance use and abuse

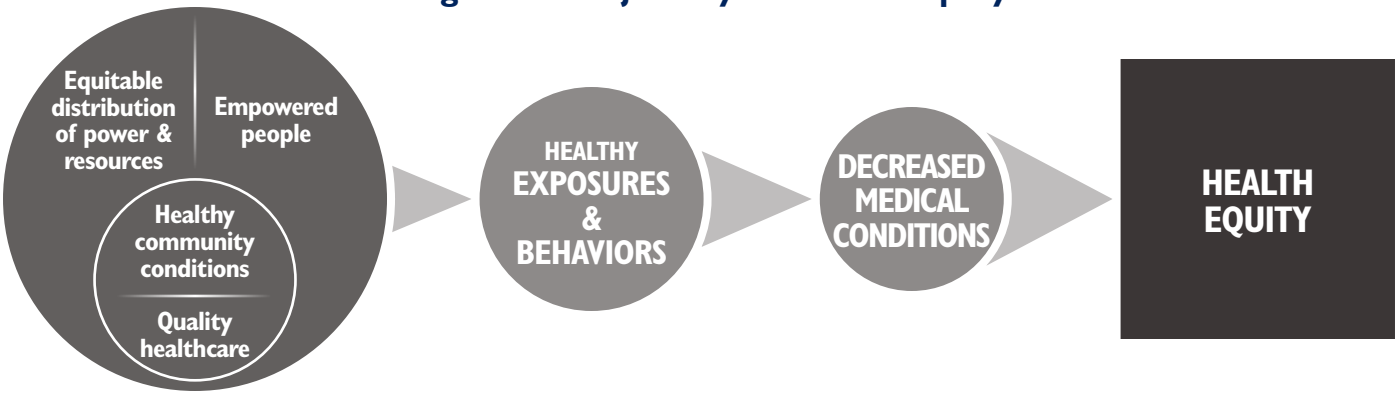
THE TRAJECTORIES OF HEALTH INEQUITY AND HEALTH EQUITY

Another way to understand Two Steps to Prevention and the determinants of health is to examine Prevention Institute's trajectories of health inequity and health equity. Diagram 2, the Trajectory of Health Inequity, shows the relationships between structural drivers and unhealthy community conditions (community determinants), exposures and behaviors, medical conditions and health inequity. Structural drivers and community determinants generate inequity, which are exacerbated by exposures and behaviors, and further exacerbated by how medical conditions are addressed in healthcare. The accumulation of inequity across the trajectory is represented by the increasing size of the arrows moving from left to right.

Diagram 2: Trajectory of Health Inequity

Diagram 3, the Trajectory of Health Equity, shows how improving the determinants of health will contribute to health equity. Improving structural drivers focuses on equitable distribution of power and resources and empowered people. Improving community determinants leads to healthy community conditions. Efforts to improve the determinant of healthcare focus on quality healthcare. The trajectory shows that improved structural drivers and community determinants and quality healthcare contribute to healthy exposures and behaviors, and decreased medical conditions. The contributions to greater health equity across the trajectory are represented by the increasing size of the arrows moving from left to right.

Diagram 3: Trajectory of Health Equity



HEALTH EQUITY METRICS DISCUSSION

Though the timeline for the development of recommended metrics was significantly expedited, Prevention Institute engaged several methods and applied disparity metrics criteria to identify a set of recommended metrics. This section describes the methodology and criteria, and the recommended set of metrics.

METHODS

In May and June of 2014, Prevention Institute reviewed existing metrics, related to social determinants of health. This included measurements in the literature as well as indicator and measurement efforts at the national, state, regional and local levels. Between May 15 and June 9, Prevention Institute reviewed existing metrics, particularly for social determinants of health. This

included measurements in the literature as well as indicator and measurement efforts at the national, state, regional and local levels. We identified and considered over 37 indicators, 24 indexes, and 39 composite measures and categorized them across the determinants of health (structural drivers, community determinants, and healthcare). In addition, Prevention Institute also interviewed 17 people (see Acknowledgments, page 3), including academics, people implementing place-based strategies, researchers who have or are developing metrics and indicator sets, and experts in specific topical areas. The interviews informed and affirmed the overall approach, principles and metrics criteria; revealed additional metric projects and indicators; and contributed to shaping the considerations, recommendations and metrics included here.

HEALTH EQUITY METRICS CRITERIA

Prevention Institute considered health equity principles, terminology used in association with measurements, criteria to assess individual metrics as well as the composite set of metrics, and other concerns, in order to identify a set of recommended metrics.

Principles[3]

The following principles provide guidance in addressing health inequity and informed the criteria for the selection of the recommended metrics:

Prevention Institute considered health equity principles, terminology used in association with measurements, criteria to assess individual metrics as well as the composite set of metrics, and other concerns, in order to identify a set of recommended metrics.

- Understand and account for the *historical forces* that have left a legacy of racism and segregation, as well as structural and institutional factors. This is key to enacting positive structural changes.
- Acknowledge the *cumulative impact of stressful experiences and environments*. For some families, poverty lasts a lifetime and even crosses generations, leaving its family members with few opportunities to make healthful decisions. Further, continued exposure to racism and discrimination may in and of itself exert a great toll on both physical and mental health.[29]
- Recognize the *role of privilege* in contributing to inequity in health outcomes and acknowledge that policies have afforded privilege to some groups at the expense of others.
- *Encourage meaningful public participation* with attention to outreach, follow-through, language, inclusion, and cultural understanding. Government and private funding agencies should actively support efforts to build resident capacity to engage. Foster civic engagement.
- Adopt an overall approach that recognizes the cumulative impact of multiple stressors and focuses on *changing community determinants,* not blaming individuals or groups for their disadvantaged status.
- Strengthen the *social fabric of neighborhoods*. Residents need to be connected and supported and to feel empowered to improve the safety and well-being of their families. All residents need a sense of belonging, dignity, and hope.
- Promote equity solutions that address urgent survival issues for low-income people and people of color, while simultaneously responding to *national and international concerns*, such as the global economy, climate change, U.S. foreign policy, and immigration reform.
- Address the developmental needs and transitions of *all age groups*. While infants, children, youth, adults, and elderly require age-appropriate strategies, the largest investments should be in early childhood, which establishes the foundation for adult health.

3 Adapted from Alameda County Public Health Department's *Life and Death From Unnatural Causes: Health and Social Inequity in Alameda County* (2008) and featured in Prevention Institute's *A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety* (2009), commissioned by the Institute of Medicine's Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

- *Work across multiple sectors* of government and society in order to make the necessary structural changes. Such work should be in partnership with community advocacy groups that continue to pursue a more equitable society.
- *Measure and monitor the impact of social policy* on health and safety to ensure equity goals are being accomplished. Institute systems to track governmental spending by neighborhood. Monitor changes in health equity over time and place to help identify the impact of adverse policies and practices.
- *Enable groups heavily impacted by inequities to have a voice* in identifying helpful policies and in holding government accountable for implementing them.
- Recognize that eliminating inequities provides a huge *opportunity to invest in community.* Inequity among us is not acceptable, and we all stand to gain by eliminating it.
- Efforts should build on the *strengths and assets* of communities, recognizing that communities are resilient and have a strong history of making change.

Terminology

There are many terms used in association with measurements, including index, measures, metrics, and indicators. For the purpose of this paper, the following terminology is used:

- ***Indicator:*** An indicator is a single measurement. *Example: Number of suspensions and expulsions from school.*
- ***Index:*** An index is a measurement that includes multiple indicators and is in use by others – particularly for research purposes. Some are validated and/or weighted. Others are groupings of indicators related to the index title. *Example:* The Virginia Health Equity Report 2012 Education Index[30] is comprised of 2 factors: attainment and enrollment, both of which are comprised of several sub-factors.
- ***Composite measure:*** A composite measure includes multiple indicators and is not necessarily in use by others but includes specific indicators that correlate strongly with health outcomes. *Example: For education: high school graduation rates, 3rd grade literacy levels and number of suspensions and expulsions.*

Individual and Composite Metrics Criteria

Criteria were developed and applied to evaluate and prioritize potential individual as well as the composite set of metrics.

Individual Metrics Criteria

The criteria used to evaluate and prioritize individual metrics are:

- **Be feasible,** capitalizing on existing data or utilizing data that can be collected in a timely manner.
- **Be measurable**, emphasizing the quantifiable and the ability to track over time.
- **Have face validity,** characterizing or reflecting the concept(s) they intend to measure.
- **Be cross-categorical,** capturing multiple categories or domains of inequity.
- **Be based on the best available evidence,** reflecting the best available evidence including research, contextual and experiential evidence.[31][4]
- **Foster an understanding of the problem and solutions,** clarifying sources of inequity in a way that will point the way towards solutions.

- **Be actionable and inform policy,** informing community-level action and key policies/policy arenas that address health inequity.
- **Foster public engagement and engage multiple sectors,** elucidating opportunities for community change across multiple sectors and informing the roles and contributions of multiple sectors and the public in addressing health inequity.
- **Elevate health for all and the opportunity for health for all,** focusing on key health disparity considerations to inform actions that will support health and well-being for groups that experience the greatest inequity.

Composite Criteria

The criteria used to evaluate and prioritize the set of metrics are:

- **Align with Culture of Health metrics,** building off of key findings and themes identified in the process of developing a broader set of Culture of Health metrics, as appropriate.
- **Be grounded in Health Equity Principles,** reflecting a core set of principles that recognize the history and legacy, as well as the structural and institutional factors behind disparities and the kinds of practices and policies that are needed moving forward (see Principles, page 19).
- **Be a mix of risk and resilience-based measures,** featuring risk-based measures that are associated with factors or conditions that increase the risk of poor health and safety outcomes in low-income communities and communities of color and/or increase health inequity between these groups and the general population. It will also feature resilience-based measures that are associated with factors or conditions which are protective of health and safety outcomes in low-income communities and communities of color even in the presence of risk factors, and/or reduce health inequity between these groups and the general population. Resilience-based measures will also incorporate community assets.
- **Be a mix of quantitative and qualitative,** primarily utilizing measurements that can be expressed as a number (quantitative); however, some data, particularly for seminal sites may not be expressed as numbers (qualitative).
- **Account for multiple kinds of inequity,** primarily focusing on racial/ethnic, socio-economic, and geographic inequity (e.g. rural, urban and regional inequity).
- **Consider implications across the lifespan,** recognizing that needs and solutions vary from birth, through childhood, adolescence young adulthood, middle age, and older age and that different age groups experience different health disparities.
- **Account for what's contributing to health inequity and how such determinants play out at the community level, within services and, institutions and through policy, while pointing to solutions,** reflecting an understanding of the causes of inequity in order to inform a set of solutions and actions.
- **Account for the social and physical environments in which people live, work and play,** reflecting key elements in the community environment that impact inequity in health outcomes.
- **Inform collaborative processes among the multiple sectors that impact health and health inequity**, informing how change can be made among all government sectors as well as private sectors (e.g., community health organizations, businesses, and education).
- **Include healthcare measures,** recognizing the important role that access to quality, affordable and culturally/linguistically appropriate healthcare plays in reducing health inequity.
- **Reinforce understanding that health disparities are interdependent and mutually reinforcing across society,** reflecting the interconnected nature between underlying determinants of health inequity, the cumulative impact of multiple determinants and nature of how these elements are mutually reinforced.
- **Gain the attention of the public**, being designed not only as a measurement tool but also as a communications tool to help inform the public about health inequity and what will reduce it.

- **Frame in a manner that population groups experiencing inequity in health outcomes are not blamed for them**, reinforcing the influence of environmental factors rather than individual responsibility, behavior and choice.

Considerations

To develop a set of metrics, numerous considerations were taken into account. These include: the strengths and limitations of indicators, indexes, and composite measures, the distribution of metrics across the determinants of health, and the need to frame the metrics in a manner that illuminates potential solutions.

Level of Measurement

Indicators, indexes, and composite measures each have strengths and limitations in terms of their contributions to a set of metrics.

- **Indicators** (single measurements):
  - **Strengths***:* Indicators can be straightforward in what they express and can convey direction for policy and action. Indicators are also specific, and progress can be measured accurately over time, providing an important tool for advocates.
  - **Limitations**: Because indicators are single measures, they don't necessarily reflect the complexity of health inequity. Further, a complete set of metrics with only individual indicators may not adequately reflect an accurate overall understanding of the challenges and shortcomings of our country's "system of health" or the actions and policies needed to address health inequity.

- **Indexes** (include multiple indicators and are in use, particularly for research purposes)**:**
  - **Strengths***:* Because indexes include multiple indicators, they are able to account for complexity and a wider range of conditions than a set of single indicators. Many indexes are already validated and widely used in research and/or metrics projects. Utilizing indexes builds on these existing efforts. Selecting and utilizing accepted and/or validated indexes could leverage current investments of RWJF, lend credibility to existing efforts, and further scalability by increasing the use of existing indexes.
  - **Limitations**: Because indexes account for multiple, interrelated factors, at face value, they may not appear as actionable as single indicators.

- **Composite Measures** (include specific indicators, not necessarily in use by others, that correlate strongly with health outcomes):
  - **Strengths**: Like indexes, composite measures can account for complexity and for a wider range of conditions than single indicators. Composite measures provide the ability to include indicators that most closely align with health outcomes and health inequity. They also provide an opportunity for innovations that could advance the field of health equity.
  - **Limitations:** Like indexes, composite measures account for multiple, interrelated factors and, therefore, may not appear as actionable as single indicators. Unlike indexes, composite measures are not validated or weighted and would likely require development to ensure that they accurately reflect what they are intended to reflect.

    Given the strengths and weakness of indicators, indexes, and composite measures, the recommended metrics (see Recommended Health Equity Metrics, page 23) include a balanced mix of the three

that maximizes the strengths of each and minimizes the limitations. Prevention Institute recommends that 2-4 composite measures be developed to fill a gap in the field. For example, most measures of community safety include crime rates but don't account for the complexity of community safety, nor do they inform action. Given the strong relationship between community safety and health inequity, this is an area in which it is recommended that a composite measure be developed.

Balance across the Determinants of Health

The determinants of health (see Determinants of Health, page 14) are complex and interrelated. Determining how to distribute the metrics across the determinants (structural drivers, community determinants, and healthcare) is important. Across interviewees, there were calls for both an emphasis largely on structural drivers as major drivers of health inequity and on community factors because of the strong correlation between place and health, as well as the notion that community-level conditions are very actionable. The goal is to both reflect the overall set of determinants while giving balanced consideration to the distribution. To achieve a balance, Prevention Institute recommended that about one-third of the set of metrics reflect the structural drivers, about one-half of the set of metrics reflect community determinants, and one-sixth of the set of metrics reflect healthcare.

Framing the Need to Address Disparity

Metrics are important both as a tool for measurement of health inequity for the country as well as for communicating what's needed to improve health equity. Metrics benefit from being framed or contextualized in a way that communicates solutions. As such it may be helpful to identify policies and/or sectors associated with specific metrics. For example, the Index of Dissimilarity[32] reflects residential segregation, which is highly correlative with disparities in health outcomes. The co-efficient represents the percentage of people who would need to move from the community to achieve a demographic distribution equal to the whole population. A more useful framing may be around housing mobility and fair housing policies that ensure, for example, that people using Section 8 Housing Vouchers have true choice and real options in terms of where they live.

Further, as a core set of priority metrics emerged, Prevention Institute looked to lift up metrics that are cross-categorical, capturing multiple categories or domains of inequity. As an example, Seattle/King County's metric of salmon spawning reflects economic health and environmental health. While this is a very local metric not easily transferable across the country, appropriate cross-categorical metrics can be identified. Finally, framing considerations also included the extent to which disparities are explicit or implicit in the presentation of metrics. For example, the California Department of Health utilizes a Place-Based Equity Composite (100 X Σ Count of indicators with significant difference between the highest and lowest quintiles of census tracts/number of indicators).[33]

RECOMMENDED HEALTH EQUITY METRICS

The recommended metrics reflect a balance across the determinants of health (structural drivers, community determinants and healthcare) and are a mix of indicators, indexes and composite measures, with consideration given to framing that communicates clear direction and spurs action. The recommended metrics for structural drivers include attention to: 1) the equitable/inequitable distribution of resources, power, money and opportunity; and, 2) empowered/dis-empowered people. The recommended metrics for community determinants include attention to: 1) the social-cultural environment (people factors); 2) the physical/built environment (place factors); and, 3) the economic environment (equitable opportunity factors). The recommended metrics for healthcare include attention to access. See Appendix C for the rationale for including each metric and the status of each metric. For a select number of metrics, brief text related to framing, policy or investment implications, and/or various sectors that have a role in solutions has also been included in Appendix C.

The following recommended health equity metrics reflect the determinants of health (structural drivers, community determinants, and healthcare).

STRUCTURAL DRIVERS

1. Neighborhood Disinvestment Index (index)
2. Gini Index[6] (index)
3. Index of Dissimilarity[7] (indicator)
4. Rates of incarceration by race/ethnicity (indicator)
5. Percent of residents from traditionally marginalized communities in positions of influence (indicator)
6. Geographic distribution of health: life expectancy by zip code (indicator)
7. Community Trauma (composite measure)
8. Community Readiness (composite measure)
9. Number of communities with indicator projects (indicator)

COMMUNITY DETERMINANTS

Social-cultural environment

10. Collective efficacy[8] (index)
11. Civic engagement (composite measure)

Physical/built environment

12. Physical activity environment[9] (index)
13. Retail Food Environment Index (index)
14. Food Marketing to Kids Group (index)
15. Housing Index[10] (index)
16. Affordability of Transportation and Housing[11] (index)
17. Pollution Burden Score[12] (index)
18. Mobility and Transportation[13] (index)
19. Opportunities for engagement with arts, music and culture[14] (index)
20. Per capita dollars spent for park space per city/neighborhood (indicator)
21. Safe place to walk within 10 minutes of home (indicator)
22. Alcohol outlet density (indicator)
23. Number of comprehensive smoke-free policies in places that prohibit smoking in all indoor areas of work-sites and public places (indicator)
24. Community Safety Scorecard[15] (index)
25. Number of cities with a comprehensive, multi-sector violence prevention plan (indicator)

Economic environment

26. Number of living wage policies in place (indicator)
27. Academic achievement (composite measure)
28. Local wealth (composite measure)
29. Complete and livable communities[16] (index)
30. School Environment[17] (index)
31. Percent of families who say it's hard to find the child care they need (indicator)
32. Workplace safety (composite measure)

HEALTHCARE SERVICES

33. Percent of patients that can access a place they call their "medical care home" within two weeks' time (indicator)
34. Patient satisfaction with medical encounters as a measure of culturally and linguistically appropriate care (indicator)
35. Number of medical schools that integrate healthcare disparities and community learning throughout entire curriculum and training (indicator)

Appendix A: 10 leading causes of death by age group, US – 2010

The 10 leading causes of death in 2010 by age group shown with color coding.

Age Groups	Rank	1	2	3	4	5	6	7	8	9	10
	Less than 1	Congenital Anomalies 5,107	Short Gestation 4,148	SIDS 2,063	Maternal Pregnancy Comp. 1,561	Unintentional Injury 1,110	Placenta Cord. Membranes 1,030	Bacterial Sepsis 583	Respiratory Distress 514	Circulatory System Disease 507	Necrotizing Enterocoliyis 472
	1 - 4	Unintentional Injury 1,394	Congenital Anomalies 507	Homicide 385	Malignant Neoplasms 346	Heart Disease 159	Influenza & Pneumonia 91	Septicemia 62	Benign Neoplasms 59	Perinatal Period 52	Chronic Low. Respiratory Disease 51
	5 - 9	Unintentional Injury 758	Malignant Neoplasms 439	Congenital Anomalies 163	Homicide 111	Heart Disease 68	Chronic Low. Respiratory Disease 60	Cerebrovascular 47	Benign Neoplasms 37	Influenza & Pneumonia 37	Septicemia 32
	10 - 14	Unintentional Injury 885	Malignant Neoplasms 477	Suicide 267	Homicide 150	Congenital Anomalies 135	Heart Disease 117	Chronic Low. Respiratory Disease 73	Benign Neoplasms 45	Cerebrovascular 43	Septicemia 35
	15 - 24	Unintentional Injury 12,341	Homicide 4,678	Suicide 4,600	Malignant Neoplasms 1,604	Heart Disease 1,028	Congenital Anomalies 412	Cerebrovascular 190	Influenza & Pneumonia 181	Diabetes Mellitus 165	Complicated Pregnancy 163
	25 - 34	Unintentional Injury 14,573	Suicide 5,735	Homicide 4,258	Malignant Neoplasms 3,619	Heart Disease 3,222	HIV 741	Diabetes Mellitus 606	Cerebrovascular 517	Liver Disease 487	Congenital Anomalies 397
	35 - 44	Unintentional Injury 14,792	Malignant Neoplasms 11,809	Heart Disease 10,594	Suicide 6,571	Homicide 2,473	Liver Disease 2,423	Cerebrovascular 1,904	HIV 1,898	Diabetes Mellitus 1,789	Influenza & Pneumonia 773
	45 - 54	Malignant Neoplasms 50,211	Heart Disease 36,729	Unintentional Injury 19,667	Suicide 8,799	Liver Disease 8,651	Cerebrovascular 5,910	Diabetes Mellitus 5,610	Chronic Low. Respiratory Disease 4,452	HIV 3,123	Viral Hepatitis 2,376
	55 - 64	Malignant Neoplasms 109,501	Heart Disease 68,077	Chronic Low. Respiratory Disease 14,242	Unintentional Injury 14,023	Diabetes Mellitus 11,677	Cerebrovascular 10,693	Liver Disease 9,764	Suicide 6,384	Nephritis 5,082	Septicemia 4,604
	65+	Heart Disease 477,338	Malignant Neoplasms 396,670	Chronic Low. Respiratory Disease 118,031	Cerebrovascular 109,990	Alzheimer's Disease 82,616	Diabetes Mellitus 49,191	Influenza & Pneumonia 42,846	Nephritis 41,994	Unintentional Injury 41,300	Septicemia 26,310
	Total	Heart Disease 597,689	Malignant Neoplasms 574,743	Chronic Low. Respiratory Disease 138,080	Cerebrovascular 129,476	Unintentional Injury 120,859	Alzheimer's Disease 83,494	Diabetes Mellitus 69,071	Nephritis 50,476	Influenza & Pneumonia 50,097	Suicide 38,364

Source: US Centers for Disease Control and Prevention.

http://www.cdc.gov/injury/wisqars/pdf/10LCID_All_Deaths_By_Age_Group_2010-a.pdf. Accessed June 7, 2014.

Appendix B: Take Two Steps to Prevention — Community Determinants

The table below shows that using the Two Steps to Prevention tool, the first step is from medical conditions to associated behaviors and exposures. The second step is from behaviors and exposures to determinants of health. (This table does not include structural drivers and healthcare, which are also determinants of health.)

		Heart Disease	Cerebro-vascular	Diabetes Mellitus	Malignant Neoplasms	Chronic Low. Respiratory Disease	Unintentional Injury	Suicide	Homicide
Medical conditions									
Behaviors and exposures		Smoking Excessive alcohol consumption Diet Activity Air pollution	Diet Activity Smoking	Diet Activity Smoking	Smoking Diet Chemicals Alcohol Sexual behaviors	Air pollution, Tobacco smoke, Factory fumes, Cleaning solvents, Infections Pollens, Dust, Chemicals	Alcohol Automobiles Falls Poisoning	Weapons Depression Life stressors Alcohol	Weapons Alcohol Trauma Stressors Violence
Community Determinants	Social-cultural (people)	Social networks & trust	Norms & culture	Norms & culture	Norms & culture	Norms & culture	Norms & culture	Social networks & trust	Social networks & trust Collective efficacy Norms & culture
	Physical/built (place)	What's sold & promoted Look, feel & safety Parks & open space Getting around Air, water, & soil	What's sold & promoted Look, feel & safety Parks & open space Getting around Arts & cultural expression	What's sold & promoted Look, feel & safety Parks & open space Getting around Arts & cultural expression	What's sold & promoted Look, feel & safety Parks & open space Getting around Housing Air, water, & soil	What's sold & promoted Look, feel & safety Parks & open space Getting around Housing Air, water, & soil Arts & cultural expression	What's sold & promoted Look, feel & safety Parks & open space Getting around Housing Air, water, & soil	What's sold & promoted Look, feel & safety Parks & open space Arts & cultural expression	What's sold & promoted promoted Look, feel & safety Parks & open space Arts & cultural expression
	Economic (equitable opportunity)	Education Living wages & local wealth	Education Living wages & local wealth	Education Living wages & local wealth	Education Living wages & local wealth	Education Living wages & local wealth	Education Living wages & local wealth	Education Living wages & local wealth	Education Living wages & local wealth

Appendix B: Take Two Steps to Prevention — Community Determinants *continued*

Medical conditions		**HIV**	**Infant mortality**	**Liver Disease**	**Nephritis**	**Mental health conditions Trauma**	**Occupational exposures**	**Drug use and abuse**
Behaviors and exposures		Alcohol Drug use Sexual behaviors	Alcohol Drug use Stressors Chemical exposure Nutrition/ diet	Alcohol Drug use Diet Activity	Medication	Stress Violence Loss Trauma	Chemicals Heat Biological agents, Adverse ergonomic conditions Allergens, Safety risks	Drug use Trauma Stressors
Community Determinants	**Social-cultural (people)**	Norms & culture	Social networks & trust	Norms & culture	Norms & culture	Social networks & trust	Participation & collective efficacy	Participation & collective efficacy
	Physical/built (place)	What's sold & promoted Look, feel & safety Parks & open space	What's sold & promoted	What's sold & promoted Look, feel & safety Parks & open space	What's sold & promoted	Arts & cultural expression	Air, water, & soil	What's sold & promoted Look, feel & safety Arts & cultural expression
	Economic (equitable opportunity)	Education Living wages & local wealth	Education Living wages & local wealth	Education Living wages & local wealth	Education Living wages & local wealth		Education Living wages & local wealth	Education Living wages & local wealth

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications

Appendix C delineates the list of 35 recommended health equity metrics, organized according to determinants of heath, with a description of the rationale for including the metric in the set, and a description of the status of the metric. For a select number of metrics, brief text related to framing, policy or investment implications, and/or various sectors that have a role in solutions are also included.

Determinant of Health: Structural Drivers

The metrics for structural drivers include attention to 1) the equitable/inequitable distribution of resources, power, money and opportunity and 2) empowered/dis-empowered people.

Metric (Type)	Rationale for inclusion	Metric Status	Sample framing, policy and/or investment implications	Relevant sectors
1. Neighborhood Disinvestment Index (index)	Conveys concentrated underinvestment utilizing 7 common indicators. 1. Percent of residents in poverty; 2. Percent of (male) unemployed residents; 3. Percent home ownership (or some other measure of residential stability such as average length of current residence); 4. Percent single parent/single income households; 5. Percent of residents with low educational attainment (and/or the reverse, percent residents with college degrees); 6. Percent of residents in management/professional occupations; sometimes the age structure and/or the racial/ethnic composition of the neighborhood are also included. This is well-accepted in research and utilizes standardly collected data. The name implies disinvestment rather than blaming individuals.	There are variations of this index, which is utilized in research. The indicators listed under the rationale are some of the most commonly used indicators of neighborhood disinvestment/neighborhood resources. These indicators are generally measured at the census tract level (for ease of data availability via the Census Bureau): Sometimes, the age structure and/or the racial/ethnic composition of the neighborhood are also included. The indicators within the index are standardly collected, but calculating the index itself is not necessarily widely done.		

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Structural Drivers *continued* The metrics for structural drivers include attention to 1) the equitable/inequitable distribution of resources, power, money and opportunity and 2) empowered/dis-empowered people.				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
2. Gini Index (index)	The Gini index measures the extent to which the distribution of income or consumption expenditure among individuals or households within an economy deviates from a perfectly equal distribution.[46] A Gini index of 0 represents perfect equality, while an index of 100 implies perfect inequality. While there is some controversy as to whether or not this is exactly the right metric to measure the wealth gap, particularly at a local or regional level, it is included as a placeholder for a metric to measure the gap. The U.S. has the world's largest gap between its wealthiest and poorest members - a gap which continues to grow -exacerbating health disparities and poor health outcomes.[47]	This is a validated index commonly used in global income inequality. It's applicability at the local level is not clear. The calculation of this specific co-efficient is based on widely available data as it reflects the proportion of the total income of the population that is cumulatively earned by the bottom % of the population.		
3. Index of Dissimilarity (indicator)	A demographic measure of the evenness with which two groups are distributed across the component geographic areas that makes up a larger area. [48] The index score can also be interpreted as the percentage of one of the two groups included in the calculation that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area. The index of dissimilarity can also be used as a measure of inequality. This metric is a proxy for residential segregation, which is highly predictive of poor health and safety outcomes.	This is a validated index. It utilizes standardly collected data (via the Census). There are multiple methodologies accepted for measuring neighborhood segregation but this is the most commonly used one.	Fair housing policies that support choice and mobility.	Housing Economic development Education

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Structural Drivers *continued* The metrics for structural drivers include attention to 1) the equitable/inequitable distribution of resources, power, money and opportunity and 2) empowered/dis-empowered people.				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
4. Rates of incarceration by race/ethnicity (Indicator)	The criminal justice system – law enforcement, courts, detention and prison systems – disproportionately engage and detain males of color, particularly African American and Latino. The legacy of mass incarceration cycles has contributed to a breakdown in the social and economic fabric of these communities. Further, it has been increasingly documented that institutional policies and practices, such as mandatory sentencing and zero tolerance have contributed to disproportionate minority contact (DMC).	Derived from nationally collected data.		Education Courts Law enforcement Prisons Mental health Economic and workforce development Community development
5. Percent of residents from traditionally marginalized communities in positions of influence (indicator)	Community engagement and leadership in identifying and implementing solutions will be critical in shifting community determinants. Further, this metric is a proxy for power of community members because disparities are present when power is unequally distributed.	This is not standardly collected. It would be a new measurement.		
6. Geographic distribution of health: life expectancy by zip code (indicator)	This indicator can explicitly present the power of geography in determining health outcomes while implicitly conveying the unfair nature of the distribution of health. This will measure geographic disparities, reinforcing the value of place-based approaches to reducing inequities in health outcomes.	Derived from nationally collected data.	A person's zip code is more predictive of life expectancy than one's genetic code.	

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Structural Drivers *continued* The metrics for structural drivers include attention to 1) the equitable/inequitable distribution of resources, power, money and opportunity and 2) empowered/dis-empowered people.				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
7. Community Trauma (composite measure)	Though it's critical that communities be part of the solution, the legacy of institutional and governmental practices has left many communities dis-empowered and traumatized. Understanding this can help inform strategies and approaches for engaging and empowering communities for community changes. Indicators could reflect community exposures to *historical forces* that have left a legacy of racism and segregation, as well as structural and institutional factors that contribute to an inequitable distribution of power, resources, money and opportunity; as well as exposure to violence, loss, incarceration, and displacement.	This would be a new metric/ measure that would need development.		
8. Community Readiness (composite measure)	This metric is a more positive frame on community trauma. Developing this metric could guide investments in communities with the goal of reducing disparities. Indicators would reflect the level of readiness for a community to engage in solutions to promote health outcomes and reduce disparities in outcomes.	This would be a new metric/ measure that would need development.		
9. Number of communities with indicator projects (indicators)	The community-driven process of developing, tracking and working to improve prioritized conditions is a proven health equity strategy. It engages community members in defining and shaping their own community.	This would be a new metric/ measure that would need development.		Public health Community residents Private sector

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Community Determinants social-cultural environment (people cluster)				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
10. Collective Efficacy (index)	Collective efficacy is a validated measurement that also accounts for social cohesion and trust- or willingness to act on behalf of the community.[49] Pages 4-6 of the Prevention Institute supplemental document, *Community Clusters and Factors Related to Health, Safety and Health Equity,* detail the research that connects these factors to health, safety and health equity. The index combines two related scales: The first is a five-item Likert-type scale of shared expectations for social control. Residents are asked about the likelihood that their neighbors could be counted on to take action if: children were skipping school and hanging out on a street corner, children were spray-painting graffiti on a local building, children were showing disrespect to an adult, a fight broke out in front of their house, and the fire station closest to home was threatened with budget cuts. Social cohesion/trust was measured by asking respondents how strongly they agreed that "People around here are willing to help their neighbors"; "This is a close-knit neighborhood"; "People in this neighborhood can be trusted"; "People in this neighborhood generally don't get along with each other"; and "People in this neighborhood do not share the same values". Social cohesion and informal social control are combined into a summary measure of the higher-order construct, 'collective efficacy'.	This is a validated index that has been used in research. The data is not widely collected.	Strong networks and trust Willingness to take action for the community's good	

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Community Determinants *continued* **social-cultural environment (people cluster)**				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
11. Civic Engagement (composite measure)	Some interviewees noted that there is often a focus on community engagement without a focus on civic engagement. Within communities that experience the greatest disparities, people have been disenfranchised from the decision making processes and opportunities that influence their lives. Civic engagement is about an explicit focus on these processes and opportunities. Civic engagement includes: [50] Percent of adult population registered to vote; Percent of registered voters that voted in general elections; Percent of registered voters that voted in municipal elections); Adults and youth involved in decision-making roles in government and community-based organizations; and consideration of those not eligible to vote due to felony convictions or immigration status.	This is a metric that would need development. It includes some indicators that are widely available (e.g. % of registered voters, % voted, etc.) and includes measures that are not standardly collected (e.g. adults and youth involved in decision-making roles…).		

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Community Determinants physical/built environment (place cluster)				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
12. Physical activity environment (index)	This index underscores the value of focusing on environmental factors to foster and support physical activity. Elements include: Joint/shared use of community facilities; Policies that promote physical activity and the built environment; Adult active transport by walking; Active commuting to school; Bicycling by adults; Recreational facility outlet density; Child and adolescent physical-activity related attitudes and perceptions; Non-school organized physical activity-related activities; Physical activity requirements for licensed child care.[51]	These indicators are not standardly collected. The Index comes from an Institute of Medicine publication so there is a lot of research and deliberation behind the selection of indicators.		Education/schools Planning/zoning Transportation and street design Transit Parks and recreation Community organizations
13. Retail Food Environment Index (index)	This index underscores the value of focusing on environmental factors to foster and support healthy eating. This food system measure accounts for the mix of healthy and unhealthy options by identifying the number of healthy and unhealthy food retailers in an area and presents the % that are healthy [e.g., number of fast-food restaurants and convenience stores/total number of supermarkets and produce vendors (produce stores and farmers markets)].	Derived from national data that is standardly collected by the CDC.		

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Community Determinants *continued* **physical/built environment (place cluster)**				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
14. Food Marketing to Kids Group (index)	This metric underscores the powerful and pervasive influence of marketing to children to influence food choices and patterns, including: The percent of food ads on children's English-language television programing that promote unhealthy foods, compared to that of Spanish-language children's television programming; The average number of television ads for unhealthy foods viewed by children, compared by race and ethnicity; Number of visible advertisements of unhealthy food and beverages within a school or school district; Number of billboards in a census tract displaying advertisements for unhealthy foods, alcohol, or tobacco products.	This metric would need development. TV advertising data could come from Nielsen's Ratings. The other data is not widely collected.	Restrict marketing to children	
15. Housing Index (index)	This index[52] includes a number of indicators that are indicative of stressors associated with housing and lack of adequate housing and therefore contribute to disparities. These include: Crowded Housing as a percent of total households; Gross rent as percent of household income; Number of subsidized housing units per 1000 local residents; Owner occupied housing as a percentage of total housing units; Percent of households paying over 30% of income for mortgages; Percent of households paying over 30% of income for rent; Percent of households that have moved in the last 5 Years; Rental vacancy rates as a percentage of rental units.	This index comes from the Connecticut Health Equity Index. The individual indicators are standardly collected and/or can be derived from census data.	Access to affordable housing	

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Community Determinants *continued* **physical/built environment (place cluster)**				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
16. Affordability of Transportation and Housing (index)	The affordability indicator[53] is composed of three variables. (1) Housing cost, (2) transportation cost and (3) total income. Because this metric measures the proportion of income spent on housing and transportation, it is indicative of disparities in access to affordable housing and transportation. Access to quality housing and transportation both correlate with health, safety and health equity and good transportation also enables access to other resources associated with improved health outcomes (medical care, employment, grocery stores, etc.). For more on the links between housing and transportation and health, safety and equity, see pages 14–17 of Prevention Institute's supplemental document, *Community Clusters and Factors Related to Health, Safety and Health Equity*.	This index comes from the Virginia Health Opportunity Index. At this point, we are unsure if it is validated but believe the individual indicators are standardly collected.		
17. Pollution Burden Score (index)	This index accounts for the inherent "burdens" of living in low-income communities, communities of color and urban communities that are disproportionately burdened by pollution. This Score[54] represents the average % of six exposure indicators and four environmental effects indicators. The six exposure indicators include ozone, PM concentrations, diesel PM concentrations, pesticide use, toxic releases from facilities, and traffic density. The four environmental effects indicators include cleanup sites, impaired water bodies, ground water threats, and solid waste sites and facilities and hazardous waste facilities.	This includes a combination of standardly collected indicators and indicators that are not standardly collected.		Transportation design Transit Economic development Industry Employers

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Community Determinants *continued* **physical/built environment (place cluster)**				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
18. Mobility and Transportation (index)	Getting around correlates with health, safety and health equity. See pages 14–15 of Prevention Institute's supplemental document, *Community Clusters and Factors Related to Health, Safety and Health Equity.* Often without access to a vehicle in a society that is designed expressly for automobiles, low-income communities suffer disproportionately in terms of access. This index includes:[55] Cost per commute; Proximity to express bus stops; Average transit fare; Percent of commuters who walk.	The data is not standardly collected.		Transportation design Transit Planning/zoning Economic development
19. Opportunities for engagement with arts, music and culture (index)	Arts and cultural expression support health, safety and health equity (see pages 13–14 of Prevention Institute's supplemental document, *Community Clusters and Factors Related to Health, Safety and Health Equity)*. This index[56] includes: Per capita revenue in nonprofit arts organizations; Percent of workers employed in artistic occupations.	Not yet validated. We believe the data is widely collected.		
20. Per capita dollars spent for park space per city/ neighborhood (indicator)	Parks and open space support health and safety outcomes (see pages 13–14 of Prevention Institute's supplemental document, *Community Clusters and Factors Related to Health, Safety and Health Equity*). However, park access, quality, availability, and programming, for example, are not distributed evenly across communities let alone in a way that prioritizes investment in marginalized communities to counter previous disinvestment. This metric would be a starting point to look at investment and then to be able to compare investments across jurisdictions.	Not widely collected.		
21. Safe place to walk within 10 minutes of home (indicator)	According to the Office of Minority Health, people who had a safe place to walk within 10 minutes of home were 40% more active than others. This metric is cross-categorical accounting for safety and access.	Not widely collected.		

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Community Determinants *continued* **physical/built environment (place cluster)**				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
22. Alcohol Outlet Density (indicator)	Alcohol availability increases the likelihood of high-risk behaviors associated with violence, unintentional injury and sexually transmitted diseases. Long-term alcohol abuse is a risk factor for heart and liver disease. Alcohol density is more concentrated in low-income communities. Additionally, liquor stores in low-income neighborhoods often sell alcohol chilled in larger containers for immediate consumption which increases the likelihood of excessive drinking, public drunkenness, automobile crashes, and physical violence.[57] [58] [59]	Data is widely available.		
23. Number of comprehensive smoke-free policies in places that prohibit smoking in all indoor areas of work sites and public places, including restaurants and bars	The Centers for Disease Control and Prevention included this as a policy recommendation in its recent release: *A Practitioners Guidebook to Health Equity*.	This would need to be collected.	Prohibit smoking in all indoor areas of work sites and public places, including restaurants and bars.	

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Community Determinants *continued* **physical/built environment (place cluster)**				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
24. Community Safety Scorecard (index)	Unlike other community safety indexes, the Scorecard[60] not only includes measures of violence but also of risk and protective factors in a specific area. This informs the development of strategies not only focused on enforcement and suppression but also on changing the underlying factors that increase or decrease the risk of violence. Further, the Scorecard was successfully used in L.A. to make the case for investments in specific communities that are high risk for violence rather than distributing resources evenly across all neighborhoods. The Scorecard could include violence rates as well as risk and resilience factors closely associated with rates of violence. Sample measures include: Rates of youth violence (e.g., youth arrests for violent crime, homicides involving youth victims, injuries and hospital visits, % of youth who report carrying weapons, fighting, or bullying); School achievement and engagement (e.g., high school and middle school Academic Performance Index, truancy rate, and high school graduation rate); Youth violence risk factors (e.g., youth arrests for alcohol and substance abuse, youth delinquency, % of families living in poverty, % unemployment); Youth violence protective factors (e.g., violence prevention services rate, % active voting population).	This would need to be developed by locale, utilizing available data. The LA Scorecard includes data available in LA, for example.	Comprehensive, multi-sector plans in place to prevent community violence.	

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Community Determinants *continued* **physical/built environment (place cluster)**				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
25. Number of cities with a comprehensive, multi-sector violence prevention plan in place (indicator)	Cities that have the most collaboration and coordination across multiple sectors also have the lowest rates of violence.[61] Further, cities that are putting comprehensive, multi-sector plans in place and coordinating investments into neighborhoods most impacted by violence are experiencing trending success in reducing community violence.	This would need development.		Mayor's office Law enforcement Education Public health Public works Faith Economic and workforce development Parks and recreation Community groups Businesses Mental health

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Community Determinants economic environment (equitable opportunity cluster)				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
26. Number of living wage policies in place (indicator)	Poverty, concentrated poverty and persistent poverty are all associated with poor health outcomes and health disparities. Living wage policies lift families out of poverty, reduce health disparities and increase an individual's ability access quality healthcare.	This would need development.	Number of living wage policies in place	
27. Academic Achievement (composite measure)	This measure includes: 3rd grade literacy; graduation rates; and suspensions and expulsions. Each of these measurements correlates closely with health outcomes and disparities that cross racial/ethnic and socio-economic lines.	This is not a validated composite. Though education data is widely collected, it is not necessarily standardized or available.		
28. Local Wealth (composite measure)	This metric would allow for a focus on economic development in specific areas with a goal of reducing health disparities associated with low socio-economic status. Indicators would include the % of homes and businesses owned by people who live in the community. Local wealth is associated with neighborhood stability which is predictive of social cohesion/ trust and efficacy, for example.	This would need development.		
29. Complete and livable communities (index)	Services and institutions provide access to goods and services that promote health and foster economic vitality. Such access can be limited in marginalized communities. This index includes Neighborhood Completeness Index (<½ mile radius for 8 out of 11 common public services and 9 of 12 common retail services).[62]	This index includes data that is not necessarily widely collected.		
30. School Environment (index)	Young people spend much of their time in school. This index includes measures that support health and well-being. It includes: Daily school physical education; School recess time; Availability of healthy food; School Breakfast Program in schools; Federal school meal standards.[63]	This includes data widely collected by school districts.		

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Community Determinants *continued* **economic environment (equitable opportunity cluster)**				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
31. Percent of families who say it's hard to find the child care they need (indicator)	Affordable and quality childcare fosters positive early development and allows a family to earn a living that is not significantly jeopardized by child care costs, leaving resources for food, housing, transportation and medical care, among others.	This is not widely collected or standardly available.	The soon to be released documentary, *The Raising of America*, by the makers of *Unnatural Causes*, may present an opportunity to elevate this metric to one of national significance.	
32. Workplace Safety (composite measure)	Low-income communities and individuals are disproportionately exposed to hazards in the work place. This measure combines Nonfatal Work-Related Injuries and Illnesses[64] and Fatal Work-Related Injuries, including:[65] Estimated number and percentage of workers employed in high-risk★ occupations, by selected characteristics; Estimated percentage of private sector wage and salary workers employed in six high-risk★ injury and illness occupations† (each with >1 million workers), by selected characteristics such as number and rate★ of fatal occupational injuries; Number and rate★ of homicide deaths.	This is derived from national data set that CDC collects	Safe working conditions for all	

Appendix C: Recommended health equity metrics, rationale, status, relevant sectors and implications, *continued*

Determinant of Health: Healthcare The following metrics for healthcare include attention to access.				
Metric (Type)	**Rationale for inclusion**	**Metric Status**	**Sample framing, policy and/or investment implications**	**Relevant sectors**
33. Percent of patients that can access a place they call their 'medical care home' within two weeks' time	Access to care is a critical determinant of health. This is the metric that the VA is now using. It includes the notion that people should have a medical home as well as time limits in accessing it.	Not widely or standardly collected.		Healthcare providers Insurers
34. Patient satisfaction with medical encounters as a measure of culturally and linguistically appropriate care	According to the IOM's *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, patient satisfaction is an important way to measure cultural and linguistic competency and appropriateness of care.	Not widely or standardly collected.		
35. Number of medical schools that integrate healthcare disparities and community learning throughout entire curriculum and training program	Currently, medical schools typically integrate a four week curriculum on health disparities into the entire medical school training/curriculum. Getting schools to include attention to health disparities throughout the curriculum could create a sea of change in outcomes. Further, service learning rotations in historically under served communities would enhance understanding and appropriate care within these communities.	Not widely or standardly collected.		Medical schools Accreditation bodies

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Discussion Paper

"Well-Being in All Policies": Promoting Cross-Sectoral Collaboration to Improve People's Lives

Thomas E. Kottke, Matt Stiefel, Nicolaas P. Pronk

April 14, 2016

This article is a joint publication initiative between *Preventing Chronic Disease* and the National Academy of Medicine.

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“Well-Being in All Policies”: Promoting Cross-Sectoral Collaboration to Improve People’s Lives

Thomas E. Kottke, HealthPartners; Matt Stiefel, Kaiser Permanente; Nicolaas P. Pronk, HealthPartners

“*The ultimate test of [health] policy is whether or not it adds to the well-being of the population served*.”

Robert G. Evans and Gregory L. Stoddart (1)

INTRODUCTION

In “A New Perspective on the Health of Canadians,” Marc Lalonde, the Canadian Minister of National Health and Welfare, concluded that health care does not have the power to fully mitigate the threats posed by unhealthful environments and behaviors (2). This 1974 report broke new ground by creating a comprehensive framework for the determinants of health based on 4 health fields — human biology, environment, lifestyle, and health care organization.

In 1990, perceiving that health care policy continued to dominate the formulation of health policy despite the Lalonde report, Robert G. Evans and Gregory L. Stoddart wrote “Producing Health, Consuming Health Care” (1). This landmark essay presented a series of progressively richer models that described the relationships among health, health care, the determinants of health, and well-being. They started with a model that they considered dominant at the time — a simple feedback loop between health care and disease as defined by the medical care system (Figure 1).

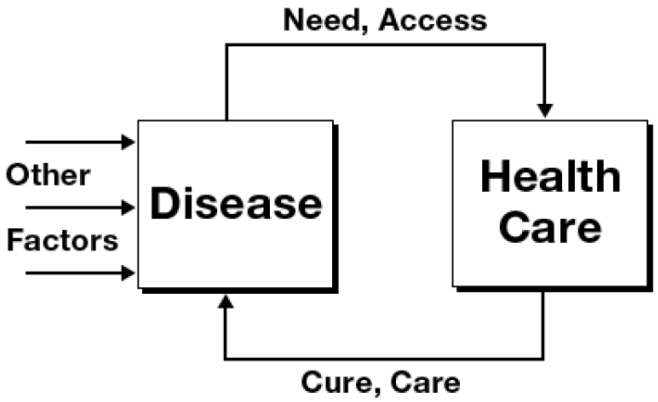

Figure 1. A model published by Evans and Stoddart (1) showing that health care was considered by many in 1990 to be the predominant determinant of disease. Reproduced with permission from Elsevier and G.L. Stoddart, 1990. [A text description of this figure is also available.]

In this simple, essentially circular model, health care (via cure and care) is the predominant determinant of disease, and disease determines

Regarding this model as too simplistic because it ignored the determinants of health identified in the Lalonde report (2), they also expanded the outcome measure progressively from the absence of disease as defined by the medical care system, to health and function as experienced by the individual, and finally to well-being, which they defined as the sense of life

satisfaction of the individual. They postulated that a more complex model was a more accurate representation (Figure 2).

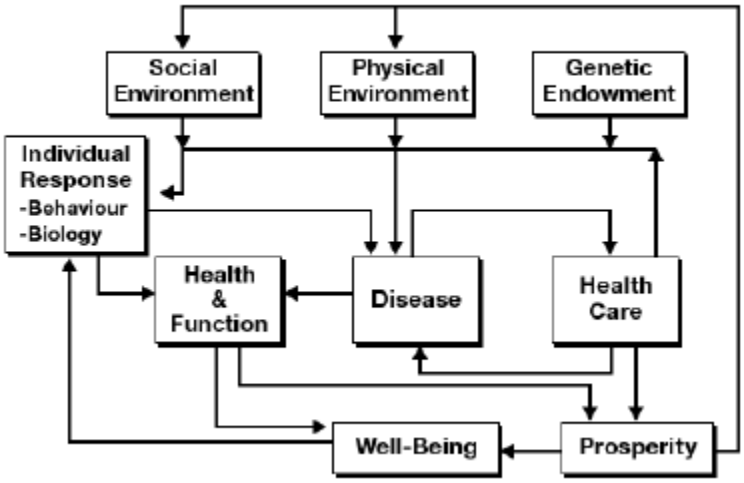

Figure 2. A model published by Evans and Stoddart (1) that accounted for multiple determinants of disease and health and function and defined well-being as the goal of policy. Reproduced with permission from Elsevier and G.L. Stoddart, 1990. [A text description of this figure is also available.]
This complex model shows how the following elements interact with each other to create well-being: the social environment, the physical environment, the genetic environment, individual response (behavior and biology), health and function, disease, health care, and prosperity.

As did the World Health Organization (WHO) in 1948 (3), Evans and Stoddart viewed health as more than the absence of disease, but as the WHO did not, they explicitly distinguished health from well-being. They expressed the opinion that the WHO definition of health, “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,” conflated health with well-being. Since then others have agreed. In a critique of the WHO definition in 1997, Rodolfo Saracci wrote, “Common existential problems — involving emotions, passions, personal values, and questions on the meaning of life — can make your days less than happy or even frankly uncomfortable, but they are not reducible to health problems” (4). Similarly, Christopher B. Forrest wrote in 2013 that the WHO definition “conflates health with happiness and life satisfaction, key dimensions of well-being” (5).

Evans and Stoddart wrote that well-being “is or should be (we postulate) the ultimate objective of health policy” and “[t]he ultimate test of [health] policy is whether or not it adds to the well-being of the population served.” However, they chose to focus their discussion on health, rather than well-being, as an outcome.

In 1986 the WHO Ottawa Charter for Health Promotion emphasized well-being as an end point, declaring that “[h]ealth is, therefore, seen as a resource for everyday life, not the objective of living” (6). Others have also framed health as an instrumental variable, as a means to the end of well-being (5). This perspective is consistent with that of contemporary social psychologists (7). Meanwhile, in health care circles, recognition of the importance of the social determinants of health is increasing, with health framed as the end goal, but recognition of the role of health as a means to the end of greater well-being is less well appreciated.

In 2003 Evans and Stoddart published a retrospective (8) on "Producing Health, Consuming Health Care." Although they did find some cause for optimism, their frustration with the lack of interest in promoting the nonclinical determinants of health became clear when they quoted Homer Simpson: "Just because I don't care doesn't mean I don't understand." The United States does not seem to heed the message that the most significant determinants of health are not health care. Relative to other countries in the Organisation for Economic Co-operation and Development, a consortium of 34 countries dedicated to improving the economic and social well-being of people around the world, the United States continues a practice of overinvesting in health care and underinvesting in the other determinants of health (9). Between 1990 and 2014, health care spending in the United States increased from 12.1% to 17.5% of gross domestic product (GDP) (10). Despite this high level of investment, health outcomes declined relative to other developed countries during the same period (11).

The Words We Use Influence Our Thinking

In the 19th century, linguists introduced the concept that language determines thinking (12). We believe that linguistic reasons explain why the broader determinants of health might not be taken into consideration when social policy is formulated in the United States. We wish to draw attention to 3 reasons in particular:

- Well-being is a positive concept. Despite all of the discussion that health is more than the absence of disease, the health metrics in current use are framed as the extent to which disease burdens the individual or the population. For example, disability-adjusted life years (DALYs) and quality-adjusted life years (QALYs) are defined as decrements from a year in perfect health; one of the most common measures of overall health in US national and state health surveys is the percentage of people with fair or poor self-reported health.
- The association of the word "health" with "health care" is so strong that it creates a conflation of "health care policy" with "health policy" that is impossible to break at times (1, 13). This may be due in part to the size and powerful influence of the health care sector on public policy.
- In health care circles the expression "social determinants of health" is used frequently. Yet in educational or employment policy forums, the discussion is flipped to talk about the health determinants of educational attainment or productivity. Shifting the broad aim to well-being would appropriately place health among the determinants of well-being, as opposed to the ultimate aim. Policy makers, including those in health plans and care delivery organizations, may not recognize the nonclinical opportunities that they have at hand to improve well-being while staying true to their missions (14).

We believe that there is a way to mitigate these communication problems. Because "well-being" would simultaneously be a widely endorsed policy goal and a relatively empty space, we suggest that moving the policy discussion from health to well-being might be a way to negate the impact of conflating health care policy with health policy. A focus on well-being might also increase the willingness of policy makers in nonhealth sectors to join the challenge of improving health by addressing well-being. For individuals, opening the conversation with a discussion of their well-being goals might help them consider how their behaviors and environments contribute to or threaten their sustained well-being. Finally, a focus on well-being might help health policy makers recognize when their decisions will have a negative impact. For example, recognition is growing in Massachusetts that the increasing costs of health care have resulted in reduced spending for education, infrastructure, human services, and other public spending priorities that contribute to well-being (15).

Evans and Stoddart also stated in 1990 that “Our purpose is not to try to present a comprehensive, or even a sketchy, survey of the current evidence on the determinants of health. . . . Rather, we are trying to construct an analytic framework within which such evidence can be fitted” (1,16). Likewise, our goal for this essay is not to present a comprehensive framework for well-being as an end point of policy but rather to present a compelling enough argument that, if well-being is the end point, additional progress toward population health and well-being might occur. We therefore suggest, for the United States, the expression “well-being in all policies” be used instead of “health in all policies.” In the following paragraphs we present the evidence that supports this suggestion.

Well-Being Is Not Just Physical Health

Although physical health and well-being are related, this relationship is much weaker than might be expected (17). The association between subjective health and life satisfaction is somewhat stronger but still far from unitary. For example, in a study based on nationally representative samples from the 32 countries that participated in the first 6 rounds of the European Social Survey, self-reported health ratings explained, on average, about 9% of the individual-level variance in life satisfaction; in no country did it explain more than 15% of the variance (18).

Subjective well-being is a broad category of phenomena that includes people’s emotional responses, levels of satisfaction in various domains, and global judgments of life satisfaction (17). It is not just the absence of mental illness; in fact, subjective well-being is a different psychological construct (19). Numerous scales have been created to measure subjective well-being, and these scales correlate to a great extent (17). “Flourishing,” a multicomponent construct that represents the state of complete mental health, is a widely accepted measure of subjective well-being (19). Although less robust than a multicomponent scale, both self-reported happiness and life satisfaction are also considered to be indicators of well-being (20).

Well-Being Is Meaningful and Influential for Populations, Organizations, and Individuals

The Midlife in the United States (MIDUS) cohort follow-up study categorized participants as flourishing or languishing. Flourishing individuals reported the fewest health limitations of activities of daily living, the fewest missed days of work, the fewest half-day work cutbacks, and the healthiest psychosocial functioning (low levels of helplessness, clearly defined life goals, high levels of resilience, and high levels of intimacy) (19). After 10 years, the risk of death for individuals who were languishing was 60% higher than that for individuals who were flourishing (21).

Well-Being Is Associated With Positive Social Policies

Evidence is clear that policies from diverse sectors — law, economics, public safety, and education, to name a few — affect well-being. Diener et al (22) observed that the happiest nations are economically developed and relatively wealthy, perhaps because the basic needs and desires of citizens are met to a larger extent in rich nations than in poorer nations. However, Diener et al also summarized the results of multiple studies listing several other modifiable characteristics of societies that have high levels of well-being. These societies have the following qualities:

- Strong rule of law and human rights
- Low rates of corruption
- Efficient and effective government

- Progressive taxation
- Income security programs, including adequate pensions, unemployment benefits, and support for the ill and disabled. They also have active public employment policies, including job training, employment incentives, and direct job creation.
- Political freedoms, with property rights, employment laws, and sound money
- Generous unemployment policies
- More healthful natural environments, for example, clean air and ample green space

Although the causes of a poor sense of well-being that lie in the physical or social environments — poverty, social isolation and exclusion, and unremitting stress, among others (23) — must be addressed if population-wide levels of well-being are to be significantly improved, individuals can improve their own well-being by practicing appreciation (24), gratitude (25), and kindness (26). It has also been observed that people who act happy tend to make other people happy (27).

Momentum Is Building Toward Well-Being as a Policy Aim

Although the field of economics recognizes well-being as a goal (but has used the term "welfare" instead of "well-being") (28), GDP has been the dominant measure of the prosperity of nations. However, there is a powerful movement away from using only economic indicators like GDP to represent prosperity and well-being in a population (20,29). Joseph E. Stiglitz, Amartya Sen, and others have advocated for well-being as a driver of social policy (30,31). National accounts of subjective well-being have been adopted in some form in more than 40 countries (22). In 2014 the Legatum Institute's Commission on Wellbeing and Policy laid out the case for using well-being as the overall measure of prosperity and therefore as the yardstick for public policy (30).

Recognition is also growing at national policy levels of the benefits that accrue from greater integration of health care with social services to address the upstream determinants of health. For example, Finland has had a joint health and social services budget under the Ministry of Social Affairs and Health for many years (P. Puska, written communication, January 2016), and in 2009 Finland merged the National Public Health Institute of Finland and the National Research and Development Centre for Welfare and Health to form the National Institute for Health and Welfare. In 2014 the Scottish Parliament passed landmark legislation that "joined up" the health care and social services budgets (32).

In January 2016 the U.S. Department of Health and Human Services announced the Accountable Health Communities Model. This funding opportunity focuses on linking clinical and community-based services that address a range of social needs, including transportation and housing (33).

In addition to merging health budgets and social services budgets, Finland created an initiative to expand the focus of health policy beyond health care policy (34). In contrast to the efforts of Evans and Stoddart to focus health policy on determinants other than health care, the Finnish initiative focuses on the health impact of policies formulated in sectors other than health, which they refer to as "health in all policies." The goal is to ensure that the impact of all policies is to improve, or at least not threaten, public health and well-being. Considerable international experience in operationalizing the approach has accrued since Finland introduced it in 2006 (35).

Opportunities to Improve Community Well-Being Exist Within the Missions of Both Public and Private Sectors

By their very nature, public sector organizations have an obligation to improve the well-being of the populations they serve. The focus of their activities include energy (clean, renewable energy vs polluting power sources), transportation (energy-efficient transit strategies that encourage active transport vs strategies dominated by private automobiles), community design (walkable, livable communities vs communities dominated by private automobile traffic), and education (early childhood education).

Evidence suggests that the private business sector can also do well by doing good. A recent report by the Vitality Institute connects integrated health and corporate social responsibility reporting with the "triple bottom line," an accounting framework with 3 parts: social, environmental (or ecological), and financial (or economic) (36). Evidence that companies that intentionally create cultures of health, well-being, and safety are more profitable than their peer organizations is accumulating rapidly (37–40).

Because of the size of the health care sector (approaching a fifth of the US economy), the respected position of health care organizations in the communities they serve, the size of their physical plants, and their large number of employees, this sector has great potential to exert a positive impact on community well-being. However, not all leaders of health care organizations may recognize the benefits of broad-based initiatives or their opportunities to engage in them.

The following are examples of what Kaiser Permanente, HealthPartners, and selected other health care organizations are doing, and others could be doing, to improve community well-being.

Kaiser Permanente. The nation's largest nonprofit integrated health system, Kaiser Permanente is advancing the concept of "total health," an innovative framework focused on using all its assets to maximize physical, mental, and social well-being for its members and the communities it serves. To deliver on its total health ethos, Kaiser Permanente emphasizes using high-impact approaches such as workforce wellness initiatives for its employees and customers, increasing access to healthful foods and physical activity in thousands of schools, and reducing the organization's institutional carbon footprint by purchasing green energy. To help drive local economic development in racial/ethnic minority communities across the country, Kaiser Permanente prioritizes supplier diversity, purchasing more than $1.5 billion from women- and minority-owned firms in 2014 alone (14,41).

HealthPartners. To promote its mission — to improve health and well-being in partnership with its members, patients, and community — HealthPartners adopted a community business model addressing nonclinical determinants of health in partnership with schools, foundations, nonprofits, and local and state government agencies (42). HealthPartners leaders are accountable to the board of directors for progress toward nonclinical goals just as they have traditionally been accountable for clinical care goals. Program examples include child-focused activities promoting healthful nutrition and physical activity (43–45), an advance care planning initiative to increase well-being at end of life (46), and a multisectoral campaign to eliminate stigma surrounding mental illness (47). HealthPartners is active in urban initiatives supporting education and health (48) and recently launched a 10-component Children's Health Initiative with a goal of improving children's health and well-being from birth through age 5 (49).

More examples of health plan programs that address the nonclinical determinants of health and well-being can be found at the Alliance of Community Health Plans (ACHP) website

(50). ACHP recognizes the importance of taking a community-wide approach to improving health and well-being and describes these programs online as a resource for other organizations that wish to address the broad range of determinants of health and well-being.

CLOSING COMMENTS

Evans and Stoddart are only two of the many respected thinkers and political leaders who advocated for defining well-being as the ultimate goal of social policy after the Lalonde report was published. Adopting this convention could avoid the problems caused when health care policy is conflated with health policy. It may also increase the willingness of policy makers in all sectors to discuss how their policies add to or detract from the overall well-being of the individuals and populations they serve. Well-being is a widely endorsed concept and is associated with positive outcomes for individuals, organizations, and populations. Finally, it is measurable, modifiable, and influential. The words of Atul Gawande in Being Mortal (51) present a poignant description of why Americans would benefit from "well-being in all policies":

> We've been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being. And well-being is about the reasons one wishes to be alive.

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Suggested Citation

Kottke, T. E., M. Stiefel, and N. P. Pronk. 2016. *"Well-being in all policies": Promoting cross-sectoral collaboration to improve people's lives*. National Academy of Medicine, Washington, DC. http://nam.edu/wp-content/uploads/2016/04/Well-Being-in-All-Policies-Promoting-Cross-Sectoral-Collaboration-to-Improve-Peoples-Lives.pdf.