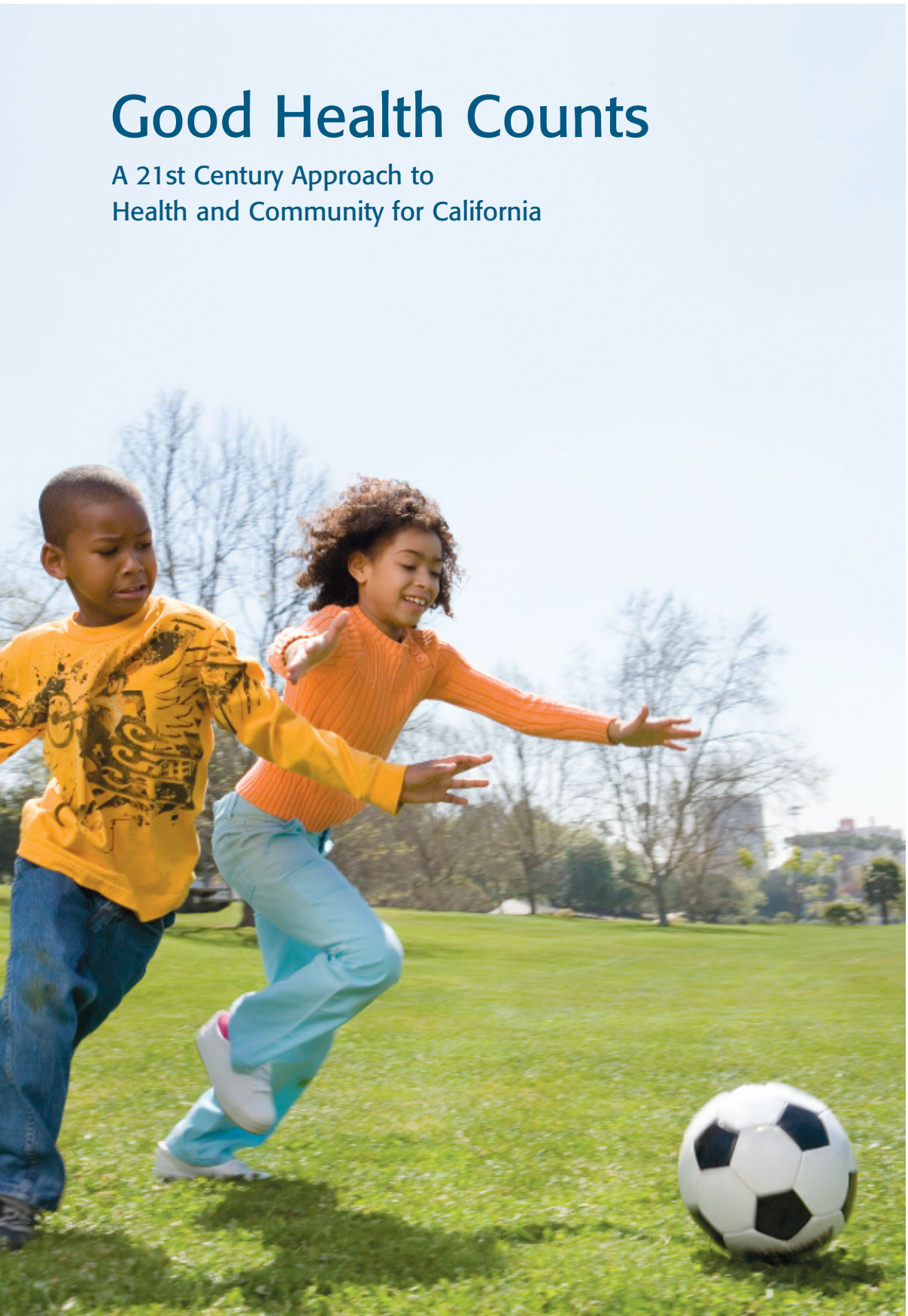
Prevention Institute

Putting prevention at the center of community well-being

NOVEMBER 2007

Good Health Counts

A 21st Century Approach to Health and Community for California



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This report is dedicated to Dennis Hunt *for his vision of and commitment to fostering community health. This document emerged from and is reflective of his dream of a State and nation where communities foster health.*

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Table of Contents

PART ONE

The Value of Good Health for California

Advice for healthy living: eat vegetables, drink wine in moderation, get moderate and mixed exercise, get fresh air, and avoid strong emotions.

— Galen, 180 A.D.

Something is wrong about the way we are approaching health in the United States.... We need a new way to think about health.

— Tom Farley[1]

We need a new way of thinking about health in our communities. Good health is something we all value. It is a critical cornerstone of our quality of life, our productivity and our state's economy. Compared to a hundred years ago, people are healthier and live longer. In fact, every recent generation has exceeded the health status of the generation before it.[2] But we are in danger of reversing this trend; children born today are predicted to have shorter life expectancies than their parents.[3] Rising rates of diabetes and childhood asthma and emerging infectious diseases such as avian flu make us feel vulnerable. As a leader in innovation, California must focus its innovative thinking on restoring good health.

On a personal level, we understand what contributes to good health. This is evidenced by near universal use of car seats, ever-lowering rates of tobacco consumption and the demand for quality medical services. While we don't always act accordingly, most people know that our personal decisions about diet and exercise and whether we smoke or not will affect our future health. However, there are often barriers in the community environment and in accessing basic health care services that make following through on healthy behaviors more challenging. This is even truer in low-income communities and communities of color, which are generally underserved by public and private investments.

Low-income communities are not just underserved but lack essential things such as safe schools with adequate resources and supportive learning environments, accessible transportation, and jobs that pay a living wage. The numerous barriers to medical care also pose significant challenges to good health for many people, as do inequities in health care. Community health–putting in place key elements that promote and maintain health–is one framework to begin to improve health, especially in low-income and other communities that bear the impact of poor health outcomes. This will not solve larger issues such as racism and discrimination; however, it can point us toward tangible ways in which racism and discrimination play out in the community and impact health, thereby informing the actions we can take. The decisions made in our neighborhoods and municipalities about whether and where to site a supermarket, create mass transit options or maintain a neighborhood park affect the future of our collective health. Decisions our businesses make about issues such as safety, employee benefits and air quality will affect workers, as well as residents in the surrounding neighborhoods.

These larger decisions are generally being made without taking health into consideration. On a societal level, we tend to focus narrowly, relying on medical services to foster good health. We frequently overlook the impact that our community environment has on health. We need to build on our personal understanding that good health requires more than health care, and translate it into policies and practices that fully reflect the value we place on good health. As part of the solution, we need community health. Community health encompasses both access to quality, culturally competent medical care *and* community environments that support health.

Strengthening community environments and improving access and quality of medical care are not only the necessary ingredients of community health, they are also mutually supportive. For example, healthy eating and activity habits are crucial not only for preventing disease but for disease management in diabetes, cardiovascular disease, HIV/AIDS and cancer treatment. Likewise, prevention services, timely diagnosis and effective treatment not only reduce demands on the medical system, they also enable people to continue contributing to the community via work and civic participation. Health care institutions can support the local economy by purchasing local products and employing local residents, and can actively encourage community services and policies that keep people healthy.

The Cost of Poor Health

You don't have anything if you don't have your health

Health is a cornerstone for a thriving California. Good health, for ourselves and our loved ones, is precious. Good health enables us to be productive, to learn, to build on the opportunities California offers its citizens. Poor health affects our independence, responsibility, dignity and self-determination.

As the sixth largest economy in the world, California needs healthy workers and a healthy emerging work force. As a nation we are spending one of every seven dollars of our Gross Domestic Product on health care (in California, the cost of health care is one in eight dollars), and it's anticipated that that proportion will soon rise to one of six.[4,5] In fact we spend double that of any other nation.[6] However, by spending primarily on the medical end—after people get injured or sick- we are expending and not investing. It is straining our business capacity:

- Strikes have immobilized facets of our state's economy, with payment for health care one of the key areas of contention.
- Workers' Compensation is in crisis due to the high costs and demands of the system.
- Auto manufacturers report higher costs for health care than steel.
- Reductions in pension and health plans make attracting top staff difficult.

The strain is also taking a toll on government and consequently on California's taxpayers. When public money is used for medical care, there is less money available for other vital services that enable us to thrive, such as education and transportation. For example, the medical costs for uninsured Californians comprise a large proportion of state and local budgets. Costs are exacerbated because uninsured Californians have little access to preventive care and often enter the health system via emergency rooms when conditions get out of hand, making treatment more expensive. Counties are the providers of last resort and must provide health care regardless of lack of funds. For example, medical treatments for gunshots and motorcycle crashes have insurance reimbursement rates under 50 percent, leaving government to pick up the tab.[7,8]

A Shift in Thinking

What is community? *Community* has different meanings, depending on the context. People use it to refer to places as well as groups of people. Probably most often community refers to a physical place–the geographic area that encompasses the places where people live, work and socialize. It can also refer to a group of people who identify around a particular characteristic or experience, such as immigration, faith, age and sexual orientation. All these definitions are important. For the purposes of this analysis, we are using a place-based definition. Research has now shown that after adjusting

for individual risk factors, there are neighborhood differences in health outcomes[9] and certainly it is the relationship of place, ethnicity and poverty that can lead to the greatest disparities. Here, community can refer to a neighborhood, city or region.[10] What is community health? Community health encompasses medical services and the community environment. As one interviewee put it, "Community health is tied to health care and everything else"[11] and research supports this. For example, early deaths have been attributed to a combination of social circumstances, environmental exposures, behavioral patterns, shortfalls in medical care, and genetic predispositions.[12]

It might be helpful to think of the process of creating community health as a new "infrastructure." As individuals drive, we support their efforts with a road system. People need to communicate and we support this with mail service, telephones and now the Internet. We have created a modern power grid and water supply. And we now need to fully shape the community supports for good health.

This is not exclusively a "hard" infrastructure like the roads and phone lines. It means building community health into the decisions we make: in business, in government, in community services, in media, as well as in public health and health care. And it means building community health into the way these groups work together. We must think about good health when entrepreneurs and government discuss new housing developments; we must think about good health when traffic engineers plan to repave our roadways; we must think about good health when companies design their products and the campaigns to sell them; and we must think about good health when cities make decisions about living-wage ordinances and the availability of affordable housing.

When given a choice, people want to raise their families in safe communities, with clean air and water, good doctors, quality hospitals and public services, and a sense of connectedness to their neighbors and local businesses. Granted, many people, especially low-income families, don't get to choose where they live, or their choices are limited, thereby making our commitment to community health even more important. A community health approach needs to be institutionalized, so that doing things because they support good health—and reducing actions that significantly diminish our health—becomes our modus operandi.

In addition to its pre-eminent role in delivering quality medical services, with cultural competence, the health care sector also has a critical role to play in advocating for community health. Health care providers have a tradition of looking beyond their focus of healing the sick and injured to asking why a condition is occurring and playing pivotal roles in change. Health care providers can use

their tremendous influence and credibility to help tip the balance and convey to the public, government and community organizations the value of community health, both to prevent the onset of disease and injury and to maximize the benefits of treatment.

Certainly, the community health approach is not all new; it builds on important healthy communities, social determinants, health impact assessment and place-based efforts from across the state, nation and world. But still, for the most part, when people say "health" they mean medical care; when people recognize the importance of making decisions that encourage good health, they mostly focus on what the medical care system can do, or what individuals and their families can do, and this must change. Changing how people view and act upon issues is not easy work. But we have seen many such changes in concept over the last generation—from smoking as normal to smoking as inappropriate, from throwing everything in the "garbage" to recycling, and to seat belts and car seats becoming essential. And in every case, change of action followed change of perspective. Creating a "new level of consciousness"—an infrastructure of community health—is doable and can help us thrive.


St. John's
Well Child & Family Center
Welcome
Bienvenido
Dr. Louis C. Frayser
Community Clinic
ATTENTION

The problems we face will not be solved by the same level of consciousness that created them.

— *Albert Einstein*

If ... we look at illness in a different way, we will see that the context of the illness is often the more important issue. To look at illness and ask ... what are all the factors involved, is often tremendously complex. The community issues range from access to participation in the solution, from treatment programs to policy and from education to use of specialists.[13]

— *Len Duhl, M.D., UC Berkeley and UC San Francisco*

A Shrewd and Comprehensive Strategy

How do we do this? A shrewd and comprehensive strategy can be the difference between a thriving, healthy California and a less flourishing state. Improving community health cannot be achieved by any one organization, or by addressing one individual at a time. It requires participation from key public and private institutions working in partnership with communities. The range of disciplines, sectors and organizations is long and diverse and includes architects, city planners, transportation engineers, insurers, employers, the home loan and banking sectors, housing, public safety, public works, private businesses, and many others.

The Community Environment

Developing a strategy for a new community infrastructure for health requires stepping back a minute, in fact, taking two steps back to the places where people live, work and play. We know what the leading causes of death are and what sicknesses and injuries we face. If we step back from them, we see the underlying causes. If diabetes is the medical problem, it is eating and activity patterns as well as genetics that underlies it. If injury is the medical concern, it is events such as car crashes, falls and violence that underlie it. And then we need to take a second step back to analyze these underlying causes. In doing so, we need to look at our communities and start to delineate the strategies that will

address these causes and prevent or minimize the medical conditions. We can't change our genetic makeup (and, in fact, we know that many key health concerns are increasing at a rate that couldn't be accounted for simply by genetics anyway). We can change community conditions. We can start by recognizing that key community conditions are associated with health. So we can look at diabetes and see that what is sold and promoted may encourage it. We can look at injuries and see that the way autos are designed, the way we advertise women as sex objects, or the proliferation of guns makes the prevalence of injury greater.

As the Institute of Medicine's report *Promoting Health: Intervention Strategies from Social and Behavioral Research* notes: "One-to-one interventions do little to alter the distribution of disease and injury in populations because new people continue to be afflicted even as sick and injured people are cured. It therefore may be more cost-effective to prevent many diseases and injuries at the community and environmental levels than to address them at the individual level."[14] The community environment has both a direct effect on health outcomes and an indirect effect via its influence on individual behavior.

Direct effect of community environment on health: The "natural" environment, including air, water and soil, is most frequently associated with having a direct influence on health. Environmental degradation, such as toxic sites, lead paint, insect dust, radon, molds, industrial hazards in the workplace, and poor air quality are all harmful to health. Other physical and social conditions—e.g., noise, poverty, violence—may cause stress and contribute to poor mental health and health outcomes. In her application of a weathering framework to explain disparate levels of morbidity and disability in African-American women, Geronimus lists multiple contributing circumstances which can be framed as environmental factors and include, "Cumulative exposure to environmental hazards and ambient or social stressors in residential and work environments and persistent psychosocial stress."[15]

Indirect effect of community environment on health: The community environment also plays an important role in shaping behavior because, as Farley and Cohen put it, "Neighborhoods send cues about how to behave, too."[16] While education and counseling can play a role in influencing individual behavioral choices, addressing environmental variables must be an essential element of a strategy to change behavioral patterns. As Blum noted, "Individual behavior is most markedly affected, if not generated, by various aspects of the environment.... Getting people to behave ... encompasses only a small fraction of the routes to risk reduction and does not stand alone without significant support from major societal mechanisms."[17] The Institute of Medicine affirmed the need to focus on changing the environment in order to

Box 1: Key Community Factors

Equitable Opportunity Factors

1. **Racial justice,** characterized by policies and organizational practices that foster equitable opportunities and services for all; positive relations between people of different races and ethnic backgrounds.
2. **Jobs and local ownership,** characterized by local ownership of assets, including homes and businesses; access to investment opportunities, job availability, the ability to make a living wage.
3. **Education,** characterized by high-quality and available education and literacy development across the life span.

People Factors

1. **Social networks and trust,** characterized by strong social ties among persons and positions, built upon mutual obligations; opportunities to exchange information; the ability to enforce standards and administer sanctions.
2. **Participation and willingness to act for the common good,** characterized by local/indigenous leadership; involvement in community or social organizations; participation in the political process; willingness to intervene on behalf of the common good.
3. **Acceptable behaviors and attitudes,** characterized by regularities in behavior with which people generally conform; standards of behavior that foster disapproval of deviance; the way in which the environment tells people what is okay and not okay.

Place Factors

1. **What's sold and how it's promoted,** characterized by the availability and promotion of safe, healthy, affordable, culturally appropriate products and services (e.g., food, books and school supplies; sports equipment; arts and crafts supplies; and other recreational items); limited promotion and availability, or lack, of potentially harmful products and services (e.g., tobacco, firearms, alcohol and other drugs).
2. **Look, feel and safety,** characterized by a well-maintained, appealing, clean, and culturally relevant visual and auditory environment; actual and perceived safety.
3. **Parks and open space,** characterized by safe, clean, accessible parks; parks that appeal to interests and activities across the life span; green space; outdoor space that is accessible to the community; natural/open space that is preserved through the planning process.
4. **Getting around,** characterized by availability of safe, reliable, accessible and affordable methods for moving people around, including public transit, walking, biking.
5. **Housing,** characterized by safe, affordable, available housing.
6. **Air, water and soil,** characterized by safe and nontoxic water, soil, indoor and outdoor air, and building materials.
7. **Arts and culture,** characterized by abundant opportunities within the community for cultural and artistic expression and participation, and for cultural values to be expressed through the arts.

Box 2: The Relationship Between the Environment and Health

Foundation of Opportunity

This cluster refers to the level and equitable distribution of opportunity and resources. Access and equity affect health in fundamental ways and over a lifetime. The availability of jobs with living wages, absence of discrimination and racism, and quality education are all important. Underlying economic conditions play out through a variety of effects[22] and poverty is closely associated with poor health outcomes.[23] Economic inequity, racism and oppression can serve to maintain or widen gaps in socioeconomic status.[24] Individual income alone has been shown to account for nearly one-third of increased health risks among blacks.[25] Further, it has been suggested that other factors such as segregation make up the additional risk.[26,27] Lower education levels are associated with a higher prevalence of health-risk behaviors such as smoking, being overweight and low physical activity levels.[28] High school graduation rates correlate closely with poor health outcomes.[29]

The People

This cluster refers to social networks and trust, community engagement and efficacy, and acceptable behaviors and attitudes, all of which influence health outcomes. Strong social networks and connections correspond with significant increases in physical and mental health, academic achievement, and local economic development, as well as lower rates of homicide, suicide, and alcohol and drug abuse.[30,31] For example, children have been found to be mentally and physically healthier in neighborhoods where adults talk to each other.[32] Social connections also contribute to a community's willingness to take action for the common good, which is associated with lower rates of violence,[33] improved food access,[34] and anecdotally with such issues as school improvement, environmental quality, improved local services, local design and zoning decisions, and increasing economic opportunity. Changes that benefit the community are more likely to succeed and more likely to last when those who benefit are involved in the process;[35] therefore, active participation by people in the community is important. Additionally, the behavioral norms within a community, "may structure and influence health behaviors and one's motivation and ability to change those behaviors."[36] Norms contribute to many preventable social problems such as substance abuse, tobacco use, levels of violence and levels of physical activity. For example, traditional beliefs about manhood are associated with a variety of poor health behaviors including drinking, drug use and high-risk sexual activity.[37]

The Place

Decisions about place, including look, feel and safety; transportation; open space; product availability and promotion; and housing can influence physical activity, tobacco use, substance abuse, injury and violence, and environmental quality. For example, physical activity levels are influenced by conditions such as enjoyable scenery,[38] the proximity of recreational facilities, street and neighborhood design,[39] and transportation design.[40] A well-utilized public transit system contributes to improved environmental quality, lower motor vehicle crashes and pedestrian injury, less stress, decreased social isolation, increased access to economic opportunities such as jobs,[41] increased access to needed services such as health and mental health services,[42] and access to food, since low-income households are less likely than more affluent households to have a car.[43] What is sold and how it's promoted also plays a role. For example, for each supermarket in an African-American census tract, fruit and vegetable intake has been shown to increase by 32%.[44] Further, the presence of alcohol distributors in a community is correlated with per capita consumption.[45] Poor housing contributes to health problems in communities of color[46] and is associated with increased risk for injury, violence, exposure to toxins, molds, viruses, pests[47] and psychological stress.[48]

Box 3: Medical Service Factors

Medical Services

1. **Preventive services,** characterized by a strong system of primary, preventive health services that are responsive to community needs.
2. **Access,** characterized by a comprehensive system of health coverage that is simple, affordable and available.
3. **Treatment quality, disease management, in-patient services and alternative medicine,** characterized by safe, effective, timely, and appropriate in-patient and out-patient care.
4. **Cultural competence,** characterized by patient-centered care that is understanding of and responsive to different cultures, languages and needs.
5. **Emergency response,** characterized by timely and appropriate responses that stabilize crisis situations and link those in need with appropriate follow-up care.

ultimately foster behavior change when they asserted, "To prevent disease, we increasingly ask people to do things that they have not done previously, to stop doing things they have been doing for years, and to do more of some things and less of other things.... It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change."[18]

A good example of how the community environment influences behavior comes from a study of the relationship between supermarket access and dietary quality. This landmark study found that African Americans living in neighborhoods with a lower density of supermarkets were less likely to meet dietary recommendations for fruits and vegetables compared to neighborhoods where more markets were available.[19] And Farley found that within supermarkets, "... by doubling the shelf space in the produce section, store managers could increase sales of lettuce and tomatoes by 28 percent, apples and oranges by 44 percent, and squash and eggplant by 59 percent."[20]

Prevention Institute has taken two steps back in looking at issues of health equity and the people and communities who tend to bear the greatest brunt of illness and injury. The Institute identified and tested the key community factors (see **Box 1**) that shape the environments and behaviors that can lead to illness, or better yet, promote health.[21]

The factors were derived from research connecting them to *Healthy People 2010 Leading Health Indicators*. These same factors apply to every community because the differences between more disenfranchised communities and the more privileged is not that they suffer from different illnesses and injuries. Rather, for the most part, it's the same health problems *only more so, with greater frequency and severity*. The factors derive from both the direct impact of the environment on health (e.g., poor air quality exacerbating asthma attacks) and the fundamental role that the environment plays in shaping behavior (e.g., video games stimulating violent behavior). **Box 2** describes some of the research that links the three clusters to health and safety outcomes.

Medical Services

In addition to healthy community environments, over the course of our lives we also all want and need medical care, including good medical, mental health and dental services. Some key factors that encompass medical services are described in **Box 3**. 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, we need reliable, immediate and qualified emergency medical responses. When we suffer from acute or chronic conditions, we hope for quality medical care to treat or cure our conditions, or help us 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.

Over the course of their lives women need more medical care than men because reproductive health care requires routine medical visits, and because on average women live longer than men. Older adults encounter the medical care system more than younger adults because of age-related diseases. Parents of young children become very familiar with the ways of pediatric medical care. We all want and need good medical, mental health, and dental insurance coverage; quality care; and excellent service. It gives us peace of mind knowing health services are accessible and available should the need arise.

There is ample research that indicates that the majority of money spent on medical care goes to treating patients with interrelated health problems, that is, both physical and mental health problems. A key component of community health is recognizing the relationship between mental and physical health and ensuring that services account for that relationship.

Access: People need to be able to obtain quality medical and dental care, which means adequate and affordable health insurance. Certainly the lack of health insurance is a

barrier to receiving care at all. In 1999, 6.8 million Californians were uninsured.[49] Lower-wage jobs do not provide health insurance and employees have insufficient income to purchase it. In situations where people are offered health insurance through their employers, coverage may effectively be inaccessible because of high premiums and co-payments or employees may not be offered additional coverage for their families. In terms of mental health, stigma is a critical issue that interferes with people accessing appropriate services. Reducing the stigma associated with mental health needs and services, including accounting for different cultural beliefs, is an important component of ensuring access.

Preventive services: Getting appropriate medical services has many doors. Individuals may have a personal physician, depend on a community clinic or utilize emergency rooms as a primary entry. Certainly the first two avenues allow for preventive care, which is a critical element for maintaining health. Physician or health care provider counseling on everything from diet to child rearing, immunizations against childhood diseases and adult vaccines against flu and pneumonia, screenings, and routine wellness exams are all critical. This includes ensuring preventive dental care for all Californians. In March 2006, California was ranked as the number one state in reducing unwanted pregnancies, an important outcome of appropriate preventive services.[50]

Treatment and care: According to the Institute of Medicine, "Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge." [51] When we suffer from acute or chronic conditions, we hope for quality medical care to treat or cure our conditions, or help us manage them. Every day seems to bring even more scientific knowledge, new treatments and amazing technologies that we eagerly seek to understand and consider. As individuals and with family members we negotiate the medical system hoping to benefit from all it has to offer. We rely on medical providers to treat us with state-of-the-art knowledge and technology. We expect good hospitals, knowledgeable medical staff, opportunities for rehabilitation, effective drug therapy, and affordable and safe long-term care.

We also hope for a health care system that is respectful. Health care teams, rather than sole reliance on physicians for all care, can improve treatment quality and patient satisfaction, and also work to better serve the varied cultural needs of California's increasingly diverse population. Redesigning the health care system presents an opportunity for increased recognition of the role of nurses and allied health professionals in chronic disease management and long-term care.

Emergency medical response: In crisis situations we need reliable, immediate and qualified emergency medical responses to increase the

chances of survival, minimize long-term disability, address immediate suffering, and give us piece of mind that we or our loved ones are being well taken care of. We need to be able to depend on emergency medical response in individual or family emergencies, as well as in more widespread community emergencies, such as disasters.

Cultural competence: Culturally and linguistically appropriate patient care is critical for communicating with patients and addressing health concerns within the cultural context of the patient. One of the obvious solutions to this particular situation is to ensure that the estimated 4 million new jobs that will be created nationally in the health care industry[52] through 2014 reflect a diverse work force. A single care visit can involve a number of professionals from the front desk to the exam room to the laboratory to the pharmacy. All are opportunities for cultural diversity. All are chances not only to improve patient satisfaction but also to provide excellent education and work opportunities for communities. Mental health services also need to be culturally competent.

Mutually Reinforcing Healthy Community Environments and Quality Medical Services

Strengthening community environments and improving access and quality of health care are not only the necessary ingredients of community health, they are also mutually supportive. For example, healthy eating and activity habits are crucial not only for preventing disease but for disease management in diabetes, cardiovascular disease, HIV/AIDS and cancer treatment. Likewise, prevention services, timely diagnosis and effective treatment not only reduce demands on the medical system, they enable people to continue contributing to the community via work and civic participation. Health care institutions support the local economy by purchasing local products and employing local residents, and can actively encourage community services and policies that keep people healthy.

Positive behaviors and environments equally improve the success of treatment and disease management. For example, improved indoor and outdoor air quality reduces asthma triggers. A reliable, affordable and accessible transportation system transports people to screening and treatment appointments. Literacy improves patients' ability to read and understand prescription labels, including both directions and warnings. Strong social networks are associated with people looking out for each other and taking care of each other during treatment and recovery.

Having the appropriate infrastructure in place to promote community health can improve response to public health emergencies, such as a tuberculosis outbreak.

By fostering, for example, living wage jobs, good transportation, affordable housing, healthy food, and an environment that fosters social connections, we can reduce the number of people needing medical services, increase the impact of medical services provided, and be better able to meet the demand for quality medical services by Californians in the future. This approach represents a vision for California, one that can be achieved through a focus on community health (**Box 4**).

Box 4: A Vision for California—10 Principles for Community Health

1. Every Californian will view health as a resource for living.
2. All Californians will have the opportunity to live in healthy communities.
3. Californians will understand the relationship between their community environment and their health.
4. Californians will understand the value of fostering community health as a critical element in sustaining the state's economic power.
5. Planning, redevelopment and transportation decisions will be made with consideration of their health impact.
6. California businesses will foster and promote healthy community environments.
7. All Californians will have affordable health insurance.
8. Californians will be able to access culturally competent, high-quality medical services when needed.
9. Medical providers in California will reflect the race/ethnicity/culture of the communities they serve.
10. Health insurance and medical providers will promote and support healthy community environments.

Public health needs to encourage trans-disciplinary work to get out of our silos so we can talk about the things that really matter to people.

– Len Syme, UC Berkeley School of Public Health

Putting Community Health at the Center of How We Do Business

Community health is comprised of all these medical and environmental factors. It is a way to focus on the broad set of factors that help keep us healthy in our communities. It is also a way to shape our communities to enable those who are sick or injured to maximize their care and chances of recovery. The businesses, government and community institutions that make decisions every day that affect health must understand the impact of their decisions *on* health and act accordingly. This includes working with communities to identify priorities and enact the policies that will prevent us from getting sick or injured *in the first place*.

Intuitively, people seem to understand that the multitude of systems they come in contact with on a daily basis—transportation, work, school, parks, public works, the media, medical providers—all affect their health. Yet we haven't found a clear and simple way to convey the full range of elements that affect health, how they interact, which ones are most important and what to do about them.

We need to take our understanding of what makes people healthy—quality medical services *and* healthy community environments—and put community health at the center of decision making. This will ensure that we take action

because it will improve health. To accomplish this, we must:

- raise consciousness about community health
- change organizational and government practices
- promote policies that will improve community health

Improving community health cannot be achieved by any one organization or by addressing one individual at a time. It requires participation from key public and private institutions working in partnership with communities. The range of disciplines, sectors and organizations involved is long and diverse: architects, city planners, transportation engineers, insurers, employers, the home loan and banking sectors, housing, public safety, public works, private businesses, and many others. While ultimately we want to encourage all of those listed to consider their impact on health, as a starting point, there are at least six target groups in particular that could have leadership and/or accountability roles as we move forward. They are 1) public health, 2) health care, 3) community stakeholders, 4) business, 5) government, and 6) media.

Public Health

The public health sector has the mandate and funding streams to improve health outcomes. However, given what we know about the elements of community health, public health alone cannot address all the factors that determine health outcomes. Public health has a critical role to play in advancing awareness and understanding of community health and engaging the necessary players in a movement to improve health outcomes. In many ways, community health is the goal of local health officers, and they can be engaged in a major leadership role to drive, push, prod and advocate for community health.

Health Care

The health care sector has a pre-eminent role to play in delivering quality medical services, with cultural competence, in communities throughout California. It also has a much broader and equally critical role to play in advocating for the necessary elements of community health, including access to health care, preventive care services, health care coverage, health care reform and improved community environments. Health care providers have a tradition of looking beyond their focus of healing the sick and injured to asking why a condition is occurring and then playing pivotal roles in change. Health care providers can use their tremendous influence and credibility to help tip the balance and convey to the public and community organizations the value of community health, both to prevent the onset of disease and injury and to maximize the benefits of treatment.

Community Stakeholders

There is such a thing as too top-down. A number of interviewees for this report, for example, noted a primary deficiency of disaster preparedness is that it lacks community engagement. California communities have many strengths on which community health can be built, including strong family ties and social networks, trust and respect among community members, organizations with deep community roots, and health-promoting traditions such as active lifestyles or high fruit-and-vegetable diets. Communities need to be involved in identifying the health problems of greatest concern, and the community health elements of highest priority and most relevance to them. When communities are empowered, they can take appropriate action and hold people accountable.

Business

Businesses, including banks, markets, retail stores, manufacturers, restaurants, the media, and service industries, have a major influence on community health. The decisions they make—such as what kinds of jobs to offer, whether or not to provide health insurance, where to locate alcohol outlets or supermarkets, and what to stock on the shelves—influence health behaviors and health outcomes. As employers, investors and purchasers, each has an impact on the local economy. As providers of services, they influence what is and is not available to community residents. Finally, as prominent facilities within communities, they help establish norms for their employees and the general public. Businesses can set expectations, provide incentives and model

Health Care and Community Environments

In early tobacco-use prevention efforts, health care providers on the boards of the American Heart Association, American Cancer Society and the American Lung Association helped build momentum for the first multi-city nonsmoking laws. They helped design prevention strategies, met with politicians, explained to the media why tobacco laws were critical for health, and provided testimony based on their experiences treating those who had been most damaged by tobacco. Health care providers also called for important institutional changes such as banning smoking in health care facilities, requiring patient counseling about the dangers of tobacco, and discouraging colleagues from advertising for tobacco manufacturers. Building on their unequivocal credibility, health care providers wielded their influence to catalyze, and insist on, changes that fundamentally influenced the population's health.

Some health care providers have looked internally at the quality and nutritional value of the food they serve to patients. Kaiser Permanente has been instrumental in making farmers markets available in neighborhoods that didn't have them. They are also looking at such sustainability issues as the viability of serving local food to patients and how to cut down on hospital waste.

behavior; serve as an example for other organizations; inform related policy; build awareness and buy-in; and affect norms. Getting businesses to think about and modify their health impact on the community is crucial, particularly important is engaging them to think beyond the scope of their own segment of the market.

Government

Government has a primary responsibility for the well-being of people and the financial means, through taxes, to deliver services and influence outcomes. The delivery of government programs and the policies that are created can support community health or work against it. For example, it is the role of government to zone our cities, pave our roads, provide public transportation and oversee a host of other factors that influence elements of community health. Local and state governments have a critical role to play. They do this through policy, administrative procedures, contract procurement, program delivery and the bully pulpit. For example, changes in local, state and federal laws, as well as the adoption of formal policies by boards and commissions, can affect large numbers of people. In some cases, laws and policies already exist to protect public safety and improve health, but could be strengthened by an additional law, a change in policy or enforcement. As the spenders of our tax dollars and the recipients of our votes, government has a particular responsibility to promote our best interests. Since health is crucial for us individually and for our state economy, government needs to be a major player in fostering community health.

We need citizens—not consumers, but citizens—who will think about how our buildings are designed, whether our children can walk safely to school, what kind of food we want in our school and worksite cafeterias, where people should be allowed to smoke and drink, and what kind of images we should see on our movie screens. Those citizens need to goad our democratic leaders to use their powers to make the world a healthier place.

— ***Tom Farley and Deborah Cohen***
Prescription for a Healthy Nation, *pg. 240*

Media

Media is omnipresent in U.S. society and includes radio and television, film, music, print news and magazines, the Internet, video games, and numerous other industries. The overabundance of media entertainment directly and indirectly influences health. For example, media can have both positive and negative effects on sexual behavior, violence, obesity, mental health stigma,

substance abuse and other health threats. Young children between the ages of 2 and 5 spend approximately 27 hours per week watching television; on average, 3 of those 27 hours are commercials. Over half of advertisements targeting children are for food, especially foods high in fat and sugar and low in nutrients.[53] It has also been shown that violent television programs and video games produce a lower sensitivity to violence as well as contribute to violent behavior in youth.[54,55] The media is not just an observer of our culture but also a shaper of it, and this is not only true of entertainment media. In choosing what to cover and not to cover, and in choosing how to cover various topics, the public's understanding about the world is influenced. Media has an important role to play in helping to propagate community health.

Corporations and governments, working sometimes independently, sometimes together, sometimes in opposition, ultimately decide whether our neighborhoods have sidewalks, what food is on grocery store shelves, whether billboards we pass advertise beer, how much we pay for cigarettes, and how many people are murdered on prime time. Individually we have very little to say about their decisions—about as much influence as one vote in an election or one grocery purchase in a manager's calculation of what to put on shelves. But collectively—if we want to—we can have plenty of influence in the decisions of these major organizations. There is no reason why we cannot require the designers of the world we live in to act responsibly about our health if we want them to.

— ***Tom Farley and Deborah Cohen***
Prescription for a Healthy Nation, *pg. 224*

As we strive to ensure that community health is at the center of our decisions and priorities throughout California, it will be helpful to have a way to convey and assess the elements of community health. A community health report can serve as such a tool. Tools are valuable because they can provide a common language, capture the critical elements, concretize priorities, and bring the many parties together; are translatable for different sectors and the diversity of communities in California; and can be a draw for the media. The rich history of indicator and community reports, coupled with advances in technology and access to data, provide valuable information about what kind of tools might be of most value in improving community health in California.

PART FOUR

Good reports are inarguable. They are what they are. When the community has been involved in identifying the indicators and measures, the community can accept and argue about what they want to do about it, and not argue about the information in the report and not trusting or believing it.

— ***Ben Warner,***
Jacksonville Community Council, Inc.

Counting Health: Summary of Research and Findings on Community Indicator Reports

The Value of Reports and Report Cards

Community indicator reports are comprehensive evaluations of community well-being that include multiple categories reflecting the various ways people live and the living conditions of neighborhoods, cities, counties, states or countries. The reports then attempt to quantify those categories. For example, in an effort to improve regional transportation choices, a report may ask, "What percentage of the population takes public transportation?" As a group, community indicator reports serve many purposes. In trying to describe the status of a population at a certain point in time, they provide a mechanism for broad community education, advocacy, policy change, and collaboration and coordination of efforts. They also inform funding and resource allocation decisions, provide benchmarks for evaluating progress, and encourage government accountability. In cities throughout the United States, the use of indicators has served to better engage multiple stakeholders in collaborative planning.

Community indicator reports offer opportunities to define and measure health-sustaining conditions linked to place—where we live, work, go to school and socialize—including

Terms in Brief

Community Indicator Report: published report using a carefully selected set of indicators to track the social, health and economic conditions in a defined geographic area.

Report Cards: community indicator reports that use letter grades or rankings.

medical services and the community environment. As Charlotte Kahn, executive director of the Boston Indicators Project, puts it, "Reports can connect the dots for people, they can tell a story through data." As tools for communities, indicator reports can define needs, can be used to engage diverse key sectors, and can promote accountability by monitoring how well each sector is doing in terms of community health. Most importantly, the process of developing and disseminating community indicator reports can be the catalyst for paradigm shifts in the framing and perception of health in specific communities.

History of Community Indicator Reports in the United States

The notion of community indicator reports is not a new one. Over the past two decades, community indicators and indicator reports have proliferated. There have been many reports produced, both in California and throughout every region of the United States. They have covered broad issues from health to quality of life. They have examined far more narrow topics such as the health of one age group or ethnicity, or the state of one indicator such as traffic congestion, water pollution or waiting room time. Needless to say, current work would not be possible without all the efforts that have gone on before.

There are three broad themes associated with the widespread use of indicator reports: the existence of many locally -based initiatives aimed at improving general community well-being and quality of life; the evolution of a broadened definition of health, which has shaped the content of indicators; and the influence of the expanded availability and use of data.

First, indicator efforts designed to improve general well-being and quality of life in communities have multiplied. Concerns about environmental sustainability, social equity, economic opportunity and other fundamental issues have motivated these initiatives and associated indicator reports. In health, indicator reports started gaining attention and traction with the movement to improve the quality of health care services. Continuous quality improvement (CQI) initiatives in the 1990s led to the concept of performance measures for medical service providers in the same way these types of measures had been used to

monitor government accountability since the 1930s. The energy in CQI has now overflowed to population-based community health programs and preventive services.

A series of tools published in the early 1990s evidenced the growing use of indicators in assessment and community health improvement and helped to guide those activities. These included *Healthy Communities 2000: Model Standards* from the American Public Health Association (1991)[56] and the *Assessment Protocol for Excellence in Public Health* from the National Association of City and County Health Officials (1991). *Healthy People 2000*, released in 1991 by the Centers for Disease Control and Prevention (CDC), laid out a compendium of goals and measures important to assess in prevention-oriented medicine and community health. With these tools individual public health departments, such as the Pasadena Public Health Department through the California Healthy Cities Project in 1992 (see *Healthy Cities/Pasadena* text box), the Seattle-King County Public Health Department in 1993, and what was then called the Boston Department of Health and Hospitals in 1993, began to develop indicators intended to improve community services, including health care services. These efforts were used to engage communities and institutions. Some health care institutions were becoming interested in community assessments as they were attempting to implement community oriented primary care into the practice of medicine, and as nonprofit hospitals were implementing newly defined community benefit standards. Community indicator reports complemented these initiatives because they could pinpoint community needs and prevention opportunities.

Second, our definitions of health have broadened over time, as has our general understanding of the wide range of factors that influence health. Both trends have impacted the content and use of indicators. The 1986 *Ottawa Charter*,[57] which defined health as "a resource for everyday life," represented an important milestone. The *Charter* reflected an international consensus that responsibility for promoting health goes well beyond the health sector, and beyond the adoption of healthy lifestyles, to the "fundamental conditions and resources needed for good health: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equality." This broader conceptualization was complemented by a growing knowledge base, aptly summarized by Evans and Stoddart in their "Health Field Model,"[58] which identified the "determinants of health" as those conditions in the social and physical environment (behaviors, access to health care, genetic predisposition), which influence health. Building on this broadened definition of health and the Field Model domains, a 1997 report from the Institute of Medicine called *Improving Health in the Community*[59] discussed the importance of collaboration in community health and the role of indicators in monitoring community health.

The California Healthy Cities and Communities Program

The California Healthy Cities and Communities Program is the longest running statewide program of its kind in the nation, working with communities since 1987. The program, coordinated by the Center for Civic Partnerships in Sacramento, currently involves 70 communities in California. Healthy Cities uses a place-based approach to improving community health, and focuses on broad, cross-sector participation. The statewide goal of the program is to improve population health through health-promoting plans, programs and policies that are developed collaboratively by government, residents and the private sector. The program also provides seed grants, consultation services and training, and convenes an annual conference that focuses on community health and quality of life issues.

The California Healthy Cities project was originally designed to build on the World Health Organization's Healthy Cities Campaign in Europe. The California program originally focused solely on cities, but later broadened to include many other kinds of communities. This decision was made in part in response to the fact that in California, many key health leaders are actually at the county level, as opposed to the city level.

The communities participating in this program are representative of diverse regions. Participating cities include Oakland, Riverside, Glendale and Pasadena.

1. The Environment
2. Health
3. Alcohol, Tobacco and Other Drugs
4. Education
5. The Economy and Employment
6. Housing
7. Arts and Culture
8. Recreation and Open Spaces
9. Transportation
10. Community Safety

Pasadena

The Pasadena *Quality of Life* indicators report serves as a long-range planning, priority-setting and resource allocation tool. The report looks at ten factors, including education, housing and transportation, all of which contribute to health. This inclusive definition of health was the result of a collaborative effort by fifty Pasadena residents and civic professionals, encompassing a cross section of the city's diverse neighborhoods and communities. Over the years the report has catalyzed productive community dialogues. For example, the report informed Pasadena's successful application for funds from the CDC for the MAP Campaign, which links community coalitions and engages them in planning. Two years ago, members of these community coalitions chose four focal areas: access to health care, work force development in the health professions, healthy behaviors, and community engagement. Last year 1,500 Pasadena residents gave suggestions and input for each of the focus areas, with one-third of those participating being children and adolescents. As a result, Pasadena has secured funding for a youth development program called "Asset Development Network." The report is also used by teachers in elementary schools to help students choose community-service program activities. For more information please visit www.civicpartnerships.org.

Third, the quality and accessibility of data has improved markedly over the past 25 years, which has strengthened our capacity to measure and monitor health. Information technology combined with expanded new data sources transformed health assessment dramatically. As the quality and availability of data for these reports increased, the reports became more comprehensive. In 1994 the Chicago Public Health Department published *The Big Cities Health Inventory* to focus specifically on the health of cities with populations over 350,000 and "to stimulate a discussion that will lead to a healthier city population."

The Institute of Medicine's 1988 report, *The Future of Public Health*,[60] challenged state and local health departments to improve their core functions and to play a central role in providing high-quality, population-based health data. As a consequence, community health reports in the United States proliferated. Innovations in epidemiological methods enhanced the ability to quantify disease burden and strengthen the case for prevention. While a boon to public health, comprehensive health profiles could be too overwhelming to be summarized easily and widely understood. Nonetheless, indicators provided a tool for measuring and tracking important, actionable health issues and communicating information to broad audiences. The use of national indicators provided a valuable resource for comparing local to national estimates and tracking

Jacksonville, Florida

Currently in its 21st year, Jacksonville's *Quality of Life Progress Report* produced by the Jacksonville Community Council, Inc. (JCCI) is updated annually. The report is one of the oldest, continuous reports of its type in the country. Many of the report's impacts result from JCCI's early collaboration with the Jacksonville Chamber of Commerce and a key funder, the United Way of Northeast Florida. According to Ben Warner, deputy director of JCCI, the report "challenges the concept of responsibility silos" and emphasizes that the "problems of some are the responsibility of all." In general, the report functions as an annual government and community services accountability measure that underscores the value of data-driven decision making. As such, the report has become an essential tool in funding decisions by the United Way, and has been used in government benchmarking initiatives by the Chamber of Commerce. The report informed the creation of new early childhood development and senior programs in the community and serves to monitor the impact and effectiveness of services provided by a variety of community-based organizations, not only among their own client population but in the larger community. More information at www.jcci.org.

progress. For example, *America's Children: Key Indicators of Well-Being* released by the Federal Interagency Forum on Child and Family Statistics in 1999 was a massive indicator project and a big collaborative milestone for changing federal data systems. The project figured out how to allow government data systems to talk to each other, making it easier to look across sectors at child health and to create data standards. Local jurisdictions now look to those standards for guidance on child-focused data development at the state and local level.

In summary, community indicator reports have become a commonly used tool to inform community change. For example, the Jacksonville, Florida, *Quality of Life Progress Report* was first published in 1986, before many of the seminal developments in more health-focused reports. Also, reports from the sustainability movement such as Sustainable Seattle and Sustainable Santa Monica are widely respected. Measurable progress and collaboration have been important values in the use of indicators in all of these various projects. When viewed as a whole, they form what could be considered a national indicators movement that is concerned with current and future conditions in specific geographic areas. Redefining Progress, a nonprofit organization that works in the area of sustainability, describes indicators and indicator reports as maturing into an indispensable component of community change and improvement efforts[61] (see *Redefining Progress* text box). While many community indicator reports are not focused on health per se, they have incorporated either some or most elements of community health.

The Evolution of Indicators and Indicator Reports

Community indicators and indicator reports continue to evolve in content and style. Four major emerging trends in data accessibility, methods of data collection, and perception of data are impacting the nature of indicators and reports. These trends include: the Internet; Internet-based geographic information systems (GIS); popular acceptance of indicator measures; and community-relevant data collection.

The Internet: The Internet has drastically changed the accessibility and availability of both data and reports. We almost take for granted the proliferation of information and communication technology, but there has been a profound expansion of data available through the Internet. Online databases offer a wealth of material and, sometimes, interactive formats to support user defined queries. Consequently, communities have access to more and different types of data.

Internet-based geographic information systems: These systems have provided a whole new perspective on the relationship between geographic location and data collected. GIS has greatly aided our understanding (and ability to see) the impact of geographic location on health, broadening the possibilities for new

Redefining Progress: Description of the National Indicators Movement

A community indicators movement has arisen around the nation, as local government, business, and grassroots leaders seek better ways to measure progress, to engage community members in a dialogue about the future, and to change community outcomes. Currently, communities around the country–from Missoula, Montana, to Jacksonville, Florida–have developed sets of indicators that illuminate long-term trends of economic, environmental, and social well-being and chart the path to a changed future.

While some communities develop indicators within the framework of sustainability, others use the framework of healthy communities or quality of life. Whatever the framework, project organizers--whether in local governments, the business sector, or community-based organizations–are discovering that the process of developing indicators can bring many different sectors of the community together, foster new alliances and relationships, provide all citizens with a better compass for understanding community problems and assets, and be used to drive community change. Unique partnerships for improving communities can be formed as community members begin to appreciate the linkages among seemingly unrelated aspects of community life. For example, an environmentalist sees new connections among jobs, housing, and habitat preservation and a business leader begins to comprehend the environmental and public health impacts of traffic patterns and an increasing demand for parking.

and innovative reports. Geocoding has aided in the flexibility of analysis, modeling methods, and greater compatibility in information architecture, which has facilitated greater data sharing across sectors. More recently, GIS Internet technology has enabled access to user-defined geographic areas, using census data and other sources. Leading innovators in geographic access include Neighborhood Knowledge California (http://nkca.ucla.edu) based at University of California, Los Angeles, and Neighborhood Information System based in Philadelphia at the University of Pennsylvania (http://www.cml.upenn.edu/nis). In addition, the Los Angeles-based *Healthy City* project (http://www.healthycity.org) is using GIS to map community resources and services, as well as demographic, health and other data available for specifically defined geographies.

Popular acceptance of indicator measures: Popularizing the notion of indicators in conversation and culture is helping to normalize the concept of measuring and scoring as impetus for change. There are several popular report cards that use rankings to bring attention to particular institutions or individuals, including educational test scores and five

star hotels and restaurants. These report cards rank or rate everything from vacation destinations to hospitals to places to live or go to college, and these report cards get media attention. Like community indicator report cards, they have proliferated and can be effective in raising awareness.

Community-relevant data collection: Despite the wealth of data and proliferation of indicator reports, it is sometimes true that communities do not see themselves in such data. There are several initiatives that have actively sought to broaden input about indicators using novel approaches. This not only serves the indicators but may also serve to broaden the audience for reports. Community needs assessments have evolved to catalog community strengths, and many methods exist for "community asset mapping" and related purposes. Other indicator processes have stretched to include voices that are typically absent, such as youth, recent immigrants or disenfranchised community residents. These processes use forums, recruit representatives from particular populations and employ other means to better incorporate diverse perspectives into the indicators.

One example of an innovative method of obtaining the perceptions of local residents and facilitating communication is called Photovoice. Photovoice is a method of descriptive photography that enables people to define for themselves and others, including policymakers, what is worth remembering in a neighborhood and what needs to be changed.[62] The project's three major goals are: 1) to enable people to record and reflect their communities strengths and concerns; 2) to promote critical dialogue and knowledge about personal and community issues through large and small group discussions of photographs; and, 3) to reach policymakers.[63]

The Purposes of Reports and Report Cards in Health

Community indicator reports facilitate community improvement in a number of different ways. They do this through fostering community engagement and collaboration, improving health care quality, framing accountability, and informing policy, and gaining the attention of media.

Community engagement and multiple stakeholder collaboration: Historically, movements such as Healthy Cities (see *Healthy Cities/Pasadena* text box) valued broad community and multi-sector engagement in creating solutions, not only for public health problems but for environmental, social and economic problems as well. The Healthy Cities approach has been successful in many California cities, and indicators and reports have been used to build and sustain broad-based partnerships. Similarly, over the past 15 years, the Los Angeles Children's Planning Council has used its indicator report, *Children's Scorecard*, to engage stakeholders at the community level, institutional leaders at the county level, and policymakers in the work of improving outcomes for children.[64]

Popular Culture Reports and Rankings

Many Internet-based scorecards have gained high esteem and credibility in both popular and academic media. For example, U.S. News and World Report's "America's Best Colleges," is released every year, both in print and Web-based, and is one of the most highly trusted and utilized academic institutional references in the United States. Other popular examples include CNNmoney.com's "Best Places to Live," as well as Fortune Magazine's "Best Companies to Work For."

Credibility and trustworthiness seem to be the factors most important in determining the reputation of these reports. They are all produced by, or at least affiliated with, highly credible media sources. They also tend to be referred to by other noteworthy sources as trusted resources or references. Most importantly, credibility is either created or enhanced when entities being judged (whether academic institutions, corporations or cities) vie for positive, image promoting coverage and ranking. For example, on many levels, U.S. News and World Report's ranking of top colleges literally has an effect on the value of the institution. As a school's ranking increases or decreases over the years, this theoretically significantly affects alumni contribution and support.

It seems as though there may be certain features, in addition to historical credibility, that make some of these reports more intriguing, accessible and user-friendly. The Internet is accessible to a majority of potential users. In our scan of "popular" Internet-based scorecards, interactive capabilities appear to be a new trend. On both U.S. News and World Report's "Best Colleges" and CNNmoney.com's "Best Places to Live," there are interactive search capabilities. Users of the site are able to easily navigate the ranked material by sorting according to their own priorities. One can search top schools by region, majors, best values, student indebtedness, and a number of other factors. One can search for a place to live based on affordable housing, plentiful leisure activities, cultural options, low pollution, low crime, etc. Clearly, Americans value the idea of personal choice and control in their lives; however, there seems to be a need for personal choice within predetermined boundaries. People do not want to blindly choose the college they go to, and they do not want to do all of the research themselves. It is most appealing for a well-respected authority to evaluate all of the options.

The trend to include community thinking in public decision making, described as "street science" in a book of that name by Jason Corburn,[65] is growing. Improved information for communities has nurtured a foundation for prevention and health improvement that has been built through community participation and engagement. New tools for communicating health concerns have represented an important part of this landscape.

Using indicator reports to improve health care quality: Indicator report cards are used to identify opportunities for better collaboration between medical services and community environments to improve community health. The National Committee on Quality Assurance pioneered early efforts to monitor the use of preventive health services using report cards, which served public health and health care system interests alike

and promoted increased use of secondary prevention (screening, early detection and treatment of disease) to improve health outcomes. Performance measurement and indicators are used in most health care systems to look at quality and effectiveness. More recently, efforts by both physician groups and hospitals currently underway in California to improve health care quality are using performance measures and releasing annual report cards. Initially it was assumed that consumers would use these report cards to choose providers, thus encouraging improvement in the quality of care. However, according to Dr. David Carlisle, director of the Office of Statewide Health Planning and Development, consumers have largely not used these report cards to make health care decisions; although the reports seem to have been a catalyst within the industry as hospitals have paid attention to them.[66]

Framing accountability: Indicators and report cards are used to hold institutions, alone or in collaboration, accountable for the results that they produce. At an institutional or program level, performance measurement uses indicators to describe the effectiveness of programs and services for the purposes of affecting a larger goal. Performance measures tend to be used in government benchmark reports in which local or state governments analyze improvements in public services. The use of indicators in performance measurement and related report cards has motivated more effective governance and decision-making models in both public and private arenas. Performance measures help to foster accountability in generating, leveraging and allocating resources. By providing a framework for accountability, community indicator reports are an excellent tool for aligning planning activities by multiple government agencies. "At the end of the twentieth century, leaders, professionals, and citizen activists working in our public, nonprofit, and civic sectors had a lot to be proud of ... [M]any of them brought about important performance-minded reforms focused on getting better results for people and communities. Government organizations and nonprofit service providers ... have become more proficient at measuring service performance and managing for results."[67]

The West Oakland Environmental Indicators report helped put the community activists on the same level as the decision-makers.

— ***Margaret Gordon, West Oakland Environmental Indicators Project***

Informing policy: An important use of indicator reports and report cards is to advocate for policy. Community indicator reports are used to educate residents and policymakers by raising awareness about important issues. Reports organized by legislative district and other

West Oakland, California

Released in 2002, *Neighborhood Knowledge for Change: The West Oakland Environmental Indicators Project* (EIP) report was a collaboration between the 7th St./McClymonds Corridor Neighborhood Improvement Initiative and the Pacific Institute for Studies in Development, Environment, and Security. For two years these two organizations, West Oakland residents, and other partners worked together to research and identify 17 indicators to monitor environmental, health and social conditions for the West Oakland neighborhood. West Oakland residents then used the data in the indicators report to garner support from the media, elected Oakland officials and public health to close down the Red Star Yeast factory, the largest toxic air polluter in West Oakland. The indicators report gave a core group of community activists credibility, according to Margaret Gordon, Co-Chair of the West Oakland Environmental Indicators Project. The West Oakland EIP is now an independent nonprofit organization and continues to work on community issues, such as land use, air quality, and community impacts from goods movement at the Port of Oakland. More information at www.pacinst.org/reports/environmental_indicators.htm.

political jurisdictions can inform policymakers about critical issues among their constituents and in doing so, hold elected officials accountable. The Oregon Benchmark Performance Report (see **Appendix 4**) included a report card for the legislature to be able to easily see how the state's performance was improving or decreasing over time in key priority areas.

Gaining the attention of media: Indicator report cards, in particular, can be effective in getting media attention. Report cards are short, judgmental, and visual. The best of them contain an uncomplicated take-home message. They often work to bring attention to the longer data-packed indicator reports. Single-issue report cards work best, for example Children Now's *California Report Card: An Assessment of Children's Well-Being*. But multiple component distillations of longer reports can also be successful (see **Box 5**) as long as they are to the point and contain new or vibrantly presented and relevant information.

An example of a strategy for communicating messages from indicators to the media to foster health literacy and understanding of the broad determinants of health can be gleaned from work out of the Annenberg School for Communication at the University of Southern California. Based on extensive research of formal and informal communication structures in neighborhoods, Sandra Ball-Rokeach's *Metamorphosis Project* (www.metamorph.org/) has developed a "geo-ethnic map," which can be used to direct indicator report results to

Santa Monica, California

In February 2003, the Santa Monica City Council adopted the Sustainable City Plan, an updated version of the original 11 year-old Sustainable City Program. The plan is based upon a set of *guiding principles* that serve to direct sustainable city policies. Each of the eight goal areas have indicators to measure progress toward desired outcomes. The indicator data are continuously updated on the city's Web site as information becomes available. Target goals for the indicators have motivated the City Council to direct the actions of city agencies. For example, the city exceeded the goal for increased bus ridership and developed an award winning bus system because the indicator for ridership was not improving over time. In another example, the indicator for increasing the number of trees in the city revealed that the staffing for counting trees and sustaining the tree canopy was inadequate. As a result the City Council created a new position of Community Forester, who developed a master tree plan that allowed the city to exceed the goal for the indicator. More information at www.smepd.org/scpr.

Box 5: Strengths and Limitations of Community Indicator Reports

Strengths

- Educates and raises awareness about community conditions.
- Measures improvement by following trends over time.
- Can galvanize multi-sector action.
- Useful monitoring tool that can lead to government accountability.
- Useful communications tool.

Limitations

- Potential for community stigmatization.
- No standard language for levels of information, the term *indicator* can mean different things to different people.
- No formal evaluations of report impacts.

appropriate communication channels (local ethnic media or other media as appropriate) and by humanizing indicators through stories based on everyday life.

The ABC's of Community Indicator Reports: Structure, Elements and Characteristics

Definitions

For the purposes of this paper, the generic term *community indicator reports* means reports published using a carefully selected set of indicators to track the social, health and economic conditions in a defined geographic area. *Report cards* are those community indicator reports that use letter grades or rankings for each of the report indicators or elements. Community indicator reports often have different naming conventions for the way they categorize information. For example, the term *indicator* can mean the actual data itself, or it can refer to an aggregation of data measures. There was no standard definition found among reports. For consistency in this paper, *indicators* are defined as a construct consisting of more than one measure, with *measures* being the actual data. Indicators either relate to the entire population, a subpopulation, or, in the case of a *performance measurement*, the effectiveness of a service or program.

Report Types

The following section describes the basic elements of community indicator reports that are currently in use.

Although they share many common features and criteria for development, community indicator reports can have many different purposes and approaches. The reports we reviewed can be categorized as quality of life, sustainability, health status, social well-being, and government performance reports (see **Box 6**). Although many specialized reports exist that depict the status of particular industries, sectors, professions or populations, for the most part overall community health is included in the community indicator reports described in **Box 6**.

Criteria for Indicators

A critical step in community indicator reports involves developing criteria for indicator selection. Unlike many aspects of reports, the characteristics of a good indicator are fairly standard, or at least there is a high degree of consensus (see **Box 7**). This consensus is based on some of the well-known national efforts to standardize indicators[68, 69, 70] and is generally applied by those involved in developing indicators. In addition, many constructs for indicators have been developed from practical experience. Unique indicator criteria are often developed or modified to meet local or specific project needs. For example, if there is a compelling need to quantify geographic or racial/ethnic disparities, the criteria for indicators may depend on the availability of data by census tract or major racial/ethnic categories. But even these localized indicators have, or attempt to have, the agreed upon listed standard characteristics of good indicators.

Box 6: Types of Community Indicator Reports

Report Type	Description
Quality of Life	These reports generally include a broad set of indicators across categories, including education, environment, economy, health, civic engagement, and housing, that attempt to take a full snapshot of life in the target community. Goals for these types of reports include providing accountability for government and identifying areas of need.
Sustainability	Sustainability focuses on meeting human needs while protecting natural resources. Indicators in these reports track negative human influences on natural resources while monitoring community health.
Health Status	These reports are concerned with issues of human morbidity, mortality and disability, and are sometimes focused on a specific disease such as asthma or diabetes within a given population.
Social Well-Being	These reports use individual-level as well as community-level indicators to describe the health of a community. They tend to focus on measuring well-being through the life course, with particular attention to health, social and economic factors.
Government Performance or Benchmarking Reports	These reports generally use government administrative data to monitor government performance. They tend to track and report on the progress of economic, social and environmental health over time and identify the government sectors responsible for improvement in each benchmark area.

Box 7: Standard Criteria for Individual Indicators

- **Important:** measures conditions or activities identified as important by the community.
- **Understandable:** the indicator is easily understood by citizens and leaders.
- **Measurable:** data can be collected and reported in a timely manner.
- **Valid:** the indicator accurately measures what it's designed to measure.
- **Reliable:** the data for the indicator are collected in a consistent manner that can be repeated from one time interval to another.
- **Data available:** data are available and there is established ongoing collection. If a selected indicator requires primary data collection, it should be cost-effective and have the potential for funding.
- **Demographics:** data can be disaggregated by age, gender, race/ethnicity, and/or income when appropriate.
- **Geographic detail:** an appropriate geographic unit is specified and geographic differences (i.e., a particular city or neighborhood) can be analyzed.
- **Actionable:** the indicator provides information that suggests opportunities for action to address concerns, prevention of the problem, and/or promotion of health and well-being or measures conditions or activities that can be changed in a positive direction by local action.
- **Asset orientation:** where possible, the indicator measures a positive aspect of the community's quality of life (the community's assets rather than its liabilities) so that an increase in the indicator's trend line reveals community improvement (e.g., high school graduation rate rather than dropout rate).

Another way to consider indicators was laid out by economist Mark Friedman, who has written extensively on government performance measures.[71] His overall concept of government is that public agencies need to focus on big-picture goals so as not to become consumed by minutiae. For example, it is more effective to create interventions for children in public programs generally rather than for children in single programs. Friedman believes that government programs should have expansive visions and emphasize broad community goals rather than narrow objectives. His three components for good community indicators are: data power, proxy power and communication power. Data power is whether the indicator is reliable, consistent and geographically appropriate. Proxy power is

whether the indicator is valid and can accurately represent what is being measured. An indicator with high proxy power reduces the total number of indicators required resulting in a tighter focus on the final outcome. Communication power is an indicator's ability to communicate to a broad and diverse audience. It is sometimes also called the public square test: if you had to stand in a public square and explain a result to your neighbors, what two or three pieces of data would you use? Comprehensive indicators are well assessed in all three of these components.

Data Issues: Measuring for Results

Geographic Level

There is great diversity in the geographic area selected for community indicator reports. The range is anywhere from a school or neighborhood to census tract, county, state, or the nation. The selection of geographic scope is dependent on a number of factors ranging from the purpose of the report to data availability.

Deciding on the appropriate geographic area for community indicator reports is not a simple matter. There is no consensus in the field about the best or most effective geographic level. State level data would require state government to be committed to acting on the results. City level data suffer from the reality that many community health issues are regional, such as air or water pollution and transportation. Regional government, however, is not an established accountable governmental body; therefore, responsibility for producing and acting on indicator reports is difficult to determine among the many players, and few voluntarily step up to the plate.[72]

Often the decision about geographic level depends on the desired audience for the report. Several people interviewed mentioned the importance of data at the legislative district level to capture the attention of statewide politicians and decision makers,[73] thereby encouraging action to support community change. Others suggested having reports at different geographic levels. In that way, counties, which are often the source of funding for programs, can be aware of the general issues requiring attention, but also know which cities within the counties and which parts of those cities need more resources.[74]

There is considerable demand for information for small geographic areas to demonstrate disproportionate burden and need. Tom Kingsley of the National Neighborhood Indicators Partnership at the Urban Institute describes the geographic decision this way: "In most cities, there are a number of disadvantaged neighborhoods, and that's where all the asthma is. If you only have data at the city level, it's not worth doing." Eventually neighborhood level data are necessary to determine where the problems are and where interventions should be developed. So projects might as well start with neighborhood level data. Kingsley also notes that "the problem with large reports

is that they dilute the needs of the most vulnerable people because the data is aggregated."[75] However, neighborhood level data run the risk of stigmatizing poorly performing communities that lack adequate resources even in the best of circumstances.

Several community indicator projects that tried to capture neighborhood level information found that communities are interested in data specific to them and that by involving residents, measuring community assets in addition to deficits, and assessing conditions and not individuals, the reports could respect the dignity of all involved.[76]

Currently, however, the technical difficulties with neighborhood level data are considerable. Community means something different to every person and it is difficult to decide on (and commit to) boundaries, making it tough to find data for locally defined communities. In addition, data sources for small geographic areas are more limited than for larger standard areas. Most data used in indicator reports are not geocoded, so it is difficult to circumscribe neighborhoods. Small populations within a community may mean multiple years of data are necessary to accumulate adequate sample sizes to detect significant differences, making it difficult to follow the short-term trends that often capture the attention of politicians and the general public. Using small geographic areas for trends analyses is risky because it is possible to see large shifts or changes over a short time period that may be entirely within normal variability. For example, several people injured in an apartment fire may skew that year's data to show fires as a major problem, when only the one residential fire occurred that year or in the previous five years. Furthermore, collecting data at the neighborhood level is often prohibitively expensive for nonprofit organizations or even city governments.

Sources of Data for Community Indicator Reports

There are many sources of data for community indicator reports. It is important to consider some attributes of the data (as mentioned in the criteria for indicator selection) as well as the population(s) the data represent. The following provides examples and a general description of the types of data used for community indicators.

Population-based data: Population data provides the most universal information because it is basically collected from everyone. Examples of population-based data include census, birth and death records. Population-based surveys that are sampled to represent the overall population are also a valuable source. Examples of these surveys are the Behavioral Risk Factor Survey System or the National Health Interview Survey (both from the CDC) and the American Communities Survey or the Current Population Survey (both from the U.S. Census Bureau). At the state level the California Health Interview Survey and at the local level the Los Angeles

County Health Surveys are examples of surveys that are representative of adults and children. Some surveys capture important subpopulations and collect in-depth information, such as patterns of childhood vaccination in the National Immunization survey. In some cases, data might not be available for the entire population, but nonetheless are included because they illuminate an issue. For example, the Youth Risk Behavioral Survey or Healthy Kids may only be available in certain schools or districts, but they fill important gaps in information about adolescents.

Surveillance and administrative data: While some surveillance systems (like surveys) are population-based, others are based on information from hospital stays (using hospital discharges or emergency room reports), laboratory reports, or physician-reported diseases or conditions. The data are only as complete as they are reported, and can vary considerably. Administrative data are derived from agencies and reflect people who are receiving services, enrolled in programs, attending schools, or otherwise known to an organization or agency. How representative these data are can vary. For example, the population using WIC services is very representative of pregnancies and births among low-income women. Children in fifth, seventh, and ninth grade in public schools participate in physical fitness testing, which provides a valuable tool for monitoring overweight and obesity among children by age, race and ethnicity, gender, and school district (geography). While the data do not represent all children, collection is reliable and the data represent those age groups. Other forms of administrative data can be misleading and may only reflect who has become known to an agency or service. For example, the number of women seeking restraining orders or staying in protective shelters is not representative of all women affected by domestic violence.

Information such as vital statistics like births, deaths, marriages and divorces; reportable acute and chronic disease statistics as for cancer, pneumonia or HIV infections; injury statistics like car crashes; social conditions statistics such as poverty rates, incarcerations or housing; and environmental conditions like pollution or toxic spills are often used in indicator reports. However, these data are considered limited for the purposes of report cards. Among several people with whom we spoke, the general view of these data is summed up by Charlotte Kahn of the Boston Indicators Project: "Administrative data is very deficit oriented. It doesn't measure community assets like resilience." America Bracho of Latino Health Access said that one of the limitations of community indicator reports and report cards is that they might not fully capture efforts in the community.

Nevertheless, such data are important information that can generate ideas and hypotheses that may lead to other more community-oriented data collection efforts,

like surveys, or other assessments about the patterns in the burden of poor health. While there are many data sources describing poverty, for example, not many sources exist that can track strategies to reduce poverty. One example of such an indicator might build upon living wage estimations, which would illuminate how adequately wages are enabling people to meet their basic needs; such an indicator could measure the proportion of adults earning a "living wage" in a city or community.

Learnings About Reports and Report Cards: What Works, When and How

Our review of nearly 100 reports and interviews with more than 60 individuals (see **Appendices** for methods, interviewees and reports), revealed many lessons about what makes an effective report or report card and the process that needs to accompany reports or report cards in order to gain traction and contribute to change. One theme that emerged pertaining to both was the notion of getting back to basics. Conveying the elements of community health in a report while also establishing a process to use the tool to get traction on those elements is critical for success. This section details two types of findings: elements of an effective tool and gaining traction for change.

Elements of an Effective Tool

While community indicator reports and report cards serve various purposes, there are elements of reports that facilitate their use by

What Works, When and How?

Elements of an Effective Tool

- Tracks progress and trends
- Actionable
- Establishes accountability
- Asset orientation
- On the whole, captures what is important
- Credibility and trustworthiness
- Meaningful language
- Accessible and user-friendly
- Values-based
- Grounded in a plausible theory of change

Elements of an Effective Process

- A vision for community health
- Focused goals based on key opportunities
- Relationship-based inter-sector collaboration
- Selection of the right indicators for maximum leverage in a given sector
- Establishment of accountability
- A commitment to data source development
- A commitment to ongoing community input

advocates, community members and other stakeholders. Though there truly are no standards within the indicator movement and across the range of sectors that use reports and report cards, a number of elements emerge that must be considered or incorporated into an effective tool. In essence, these constitute a list of criteria for an effective tool.

Tracks progress and trends: A successful tool is able to monitor trends over time and offers some interpretation about the magnitude and direction of the change and why the indicator is changing. The tool should also reflect an understanding of the direction that the trend will take based on alternative scenarios, i.e., if nothing is done or if investments (or policy decisions) are made. Sustaining a tool (and the measures and process that go into it) takes a significant commitment of resources, coordination and solid technical infrastructure. Committing to tracking progress implies that the report or report card will be developed more than once, although the frequency of the report is often dictated by availability of resources. In some cases, trends can also be established by going backward and using or reanalyzing data from earlier to give a sense of current trends (e.g., current breast-feeding rates might be monitored and could be compared to the 90 percent plus rate of the early 20th century).

Actionable: The information needs to be framed in a way that it can lead to action. Both actions and relevant policies must be clear. Indicators are limited in what they can accomplish alone and by themselves are insufficient to instigate action for improvement because they reveal little about the underlying causes of trends, and they usually provide no clear direction about how to accomplish improvement.[77] Many interviewees noted that if people don't know what to do with the information, it won't lead to action. Therefore, the tool, or the accompanying information, should clarify relevant policies and actions that can be undertaken to improve the indicator. Beyond the data, it is critical that someone is prepared to recommend strategies and best practices to policymakers that will address the issues. Policymakers would not necessarily know what to do purely based on a good or bad score on a report card. Additionally, the content needs to be neutral enough that it can garner support from all political parties.

Establishes accountability: Successful tools foster accountability by reflecting those factors that need to change and those sectors, systems or institutions that are responsible to act. In Santa Monica, both the longer report and the report card are effective because they are connected to an accountable entity—the Santa Monica City Council—which is committed to acting on the information.[78] In fact, reports and report cards appear to work best in a context of accountability, that is, when the agencies, organizations or individuals responsible for acting on the information are clearly identified. It is also important to involve

organizations and agencies who are authorized to generate solutions and then integrate some type of performance measures to monitor how well those solutions are working. This engenders accountability on an individual program level, which ultimately contributes to a larger result. Friedman offers several key steps in population accountability (see *Population Accountability* text box).[79]

Asset orientation: Community indicator reports are important tools for identifying community elements that need attention and resources. As such, they can be used by communities to prioritize needs and advocate for policy changes. While this is an important value of indicator reports, reports should not contribute to the deficit orientation by communicating problems alone. An effective indicator report pays equal attention to existing community assets, highlighting systems and relationships that contribute to health and well-being. One way to do this is by engaging community members in a dialogue about the positive elements in their community. These can include racial and ethnic diversity, strong social networks, meaningful opportunities for youth, and the presence of a broad range of services and institutions.

On the whole, captures what is important: The indicator set must be organized around a common vision that people can look at and, on the whole, agree that it basically reflects

The Seven Population Accountability Questions

1. **What are the … conditions we want for the children, adults and families who live in our community?**
2. **What would these conditions look like if we could see them?**
3. **How can we measure these conditions?**
4. **How are we doing on the most important of these measures?**
5. **Who are the partners who have a role to play in doing better?**
6. **What works to do better, including no- and low-cost ideas?**
7. **What do we propose to do?**

In framing these questions, Friedman suggests that in addition to developing indicators, baseline trends be developed to project how the "curve" on selected indicators will behave if nothing changes, e.g., the proportion of affordable housing, and what it would take to increase that proportion. The partners involved would base strategies and actions on what is known to work (information based on research and from experience), where leverage points are, feasibility and reach, and values.

the vision and the critical elements. Some indicator efforts get stuck at the drawing board because everyone will never agree on the exact same set of elements and indicators. While interviewees warned us about this, they also suggested an alternative. We can acknowledge that the specifics won't be perfect for everyone, but overall they should conceptually make sense, have some face credibility (e.g., that people can say "yes, these are generally the things I would include").

Credibility and trustworthiness: Credibility and trustworthiness are among the most important elements in determining the reputation of these reports. To establish this kind of reputation, ensure that the report comes from a credible source, that the associated data seems appropriate for the indicator it is measuring, and that at the local level, community members have a say in the selected indicators and in what change they want to see.

Meaningful language: Language matters. It is important to keep in mind that different audiences will respond to and be touched by language in different ways. For example, professionals tend to think in domains such as transportation, housing and nutrition, whereas the general public tends to think in questions, such as: Can I get to work? Can I afford a place to live for my family? and What will my child eat for lunch? Since improving community health cannot be achieved by any one organization, participation from key public and private institutions working in partnership with communities is required. This means that the language should be meaningful to different audiences, so there may need to be different versions depending on the purpose and the intended audience. The intended audience is key because it will dictate the content, involvement of stakeholders and marketing of the report. No matter the audience, language should be clear and consistent, and there should be disciplined choices about terms because many of them are interchangeable.

Accessible and user-friendly: Community indicator reports, whether in print or on the Internet, must be attractive, easy to read (and interpret), and catch the attention of the audience. Innovations in design and technology have contributed, as has integrating the knowledge of communications, journalism, public relations, marketing and graphic design specialists. Current environments are not only information-rich, but visually rich. Attention spans have shortened. For all these reasons, it is worthwhile to think about new media and applications of technology for conveying information. For example, King County has a report summary that was actually formatted and printed as a newspaper insert. This colorful digest grabs the attention of the reader by focusing on a few salient indicators that call attention to positive attributes of King County and to where county residents need more resources. In other cases, interactive Web design draws people in to issues they care about.

Values-based: People are not necessarily moved by numbers; they are moved by their values. We need to convey the notion of community health from a values perspective. Fortunately, people strongly value health, and they value what comes with good health. As we convey the notion of healthy communities, we will be more effective if it is grounded in these values. A good report or report card can help clarify some key things that must be taken care of so more people have the ability to take advantage of opportunities. Further, it will give people the capacity to understand and respond to problems and create change. Understanding what fundamentally promotes health can foster local responsibility, pragmatism and innovation—all things we value. Good reports and report cards can help. One interviewee asked to what degree healthfulness has been incorporated into our core values. This is an opportunity to reflect the intrinsic link between healthfulness and our core values. Along with conveying the relationship between healthy communities and our core values, we need to weave our values into a report or report card. We value individual responsibility; however, we have to reflect the relationship between individual responsibility and having the freedom or opportunity to exercise it. For example, when healthy food is available, people are more likely to eat it. Therefore, part of reflecting community health is reflecting the degree of opportunity, choice and freedom for each of the major elements of community health. Do children have the opportunity to walk safely to school? Do people have the freedom to breathe clean air? Do people have the choice to buy fresh fruits and vegetables? Helping communities account for their degree of options and freedom can help

King County, Washington

In 2005, the Seattle-King County Public Health Department published *Communities Count: Social and Health Indicators Across King County.* It is the third report to identify the strengths and needs in Seattle-King County. Over the years the report has had many impacts. For example, the United Way looks to the report for program direction in strategic planning from safety services to programs that reflect their focus areas, e.g., early childhood programs and homelessness. The Seattle Foundation used the 2002 report to inform local donors on where to invest in the community. The indicator measure about parents reading to their children motivated the Public Health Department to facilitate a south county coalition of library staff, WIC and others to promote reading to children among WIC clients. Community-based organizations use data in the report for grant applications and the county Children and Communities Commission requires applicants to choose an indicator from the report to address. More information at www.communitiescount.org.

identify specific priorities for action and advocacy, while conveying the importance of specific elements of healthy communities.

Grounded in a plausible theory of change: There are examples of reports that have a lot of information, but it is not clear what the underlying theory of change is, how a focus on the particular issues highlighted in the report will lead to change, or what kind of change will be achieved. In order to ensure that a report or report card catalyzes or contributes to change, it is critical that it be grounded in a theory of change. Based on what is known about the elements of community health (described earlier in this paper) and what is needed for widespread change, it is critical that the report or report card is grounded in an understanding of the ways in which organizational practices, policies and multisectoral collaborations with the community are critical elements of changing norms around health.

Getting Traction: Elements of an Effective Process

Community indicator reports can play an important role in the community change process. Early on, they provide a picture of where residents stand on issues and conditions that they believe are important. Later on, they serve to monitor progress toward the original vision, and over time, they document trends.[81] The process of developing community indicators is at the center of report creation, but there are several additional elements of the process that are important for a successful outcome.

A vision for community health: The community indicator report development process can facilitate dialogue on what really matters, translate collaboration into a meaningful product, and allow communities to think through a vision for a healthy future. An effective process begins with an understanding not only of community health, but also what residents already value in their communities, as well as areas they consider in need of attention or improvement. In defining a vision for community health, the voice of youth, ethnic communities, sexual minorities, the disabled, and disenfranchised groups must be represented. A clearly articulated vision and set of positively stated values can be used as the anchor for the report. While this process can take a considerable amount of time and resources, and there are many ways to go about it, the report will be richer with community input. An example of a full community engagement process is the King County *Communities Count* report. The report's

Community indicator reports are not about the indicators, they are about community change.

— ***Ben Warner, Jacksonville Community Council, Inc.***

Powerful Indicators of Community Health

These kinds of indicators are reflective of a number of conditions that influence health. Most of them tell us about more than one domain or community health element and therefore they are powerful individual indicators of what is going on in the community. They can help answer key questions about community health, including: Do medical services meet the needs of the community? Are the basic needs of all community members met? Does everyone have the opportunity to be self-reliant? Are people safe in the community? Are people connected and engaged? Is the community a place where people want to be and feel good about? Our research revealed some of the following, many of which are used in existing reports, as being particularly reflective of community health:

- Number of preventable ER visits
- Number of preventable hospitalizations
- People have a personal relationship with a doctor or clinic
- Race/ethnicity of service providers reflects the community
- Number of people per housing unit
- Percentage of owner-occupied housing
- Can a 12-year-old walk to buy a quart of milk?
- Farmers markets
- Community and private gardens
- Locally-owned businesses
- Living wage jobs in the neighborhood
- Foot traffic in the neighborhood
- Perceived neighborhood safety
- Alcohol outlet density
- Amount of time spent in a car per week
- Average commute time
- Percentage of parents reading daily to their children
- Number of suicides/attempted suicides
- Number of out of home placements
- Number of hours TV is on
- Percentage of families who eat dinner together
- Percentage of parents who say it is difficult to find the child care they need
- Number of employers who provide child care assistance
- Percentage of parents reporting workplace has "family friendly" policies
- Percentage of parents who say they can easily get to a park, playground or other safe place to play
- Percentage of kids who watch three or more hours of TV per day
- Percentage of teens home alone between 3 p.m. and 6 p.m.
- Voter activity
- Conservation and park land
- Local wild salmon runs*
- Percentage of electricity generated by solar power

* In certain communities such as Seattle, wild salmon runs are linked to key community factors such as the local economy, recreation, food production, and the environment.[80]

indicators are drawn primarily from various community surveys and forums and only minimally from the county's own administrative data. The King County report is also an example of commitment by government to conduct business differently—to make positive change (and reverse negative change) by using an entirely different community involvement process. The process is what makes the difference; the tool is a significant result of the process.

Focused goals based on key opportunities: Defining a vision of community health provides a forum for identifying key opportunities and goals. This can come from the ground up or from leadership, but it should include some form of legitimacy (e.g., a "mandate" or charge as from a governmental commission or agency). It is crucial that the goals or key opportunities be clearly articulated. They can be framed in a number of ways including categories or questions. The *Social Well-Being of Vermonters* report phrases goals as affirmative statements, for example, "Families, youth and individuals are engaged in their community's decisions and activities," or "Elders and people with disabilities live in settings that they prefer." These goals then have individual indicators associated with them. Government benchmark reports tend to articulate related policies and a plan of action for specific categories and indicators. Oregon's report outlines "What Needs to be Done" with each benchmark and proposes the appropriate program development, the responsible agencies and the current budgetary allocation for the benchmark.

Relationship-based inter-sector collaboration: Community indicator development efforts both large and small require a diverse group of partners and stakeholders. It is important to include many perspectives and to involve community representatives and nonprofessionals. Facilitators in these efforts may convene representatives from organizations and agencies with sufficient resources, oversight, policy influence or presence in the community to shape services and interventions, to nurture community capacity for improvement and to influence a given outcome. Throughout the process, the level of interaction among individuals and the organizations they represent is probably the most essential ingredient. These collaborators share a willingness to form or strengthen relationships and work together for community improvements. Stakeholders make and secure commitments to take action on the indicators in the reports. A diversity of representation by organization, sector or expertise is the hallmark of many of the most successful indicator reports.

Selection of the right indicators for maximum leverage in a given sector: The indicator selection process can be cumbersome. It is best accomplished by convening a diverse subcommittee of data and statistical experts to provide input to community members and others on the validity and reliability of potential measures and available scientific data. Indicator selection criteria should be made clear and the number of indicators kept to a manageable few. Indicators should be selected to provide

Communities Count: Social and Health Indicators Across King County

In 1993, the King County Council established the King County Children and Family Commission. The commission's charge was twofold: 1) to develop a vision for a healthy community for the children and families of King County, and 2) to find ways of measuring advancement of that vision. Three years later, emerging interest in indicators led to the formation of the Indicator Steering Committee. Seeking to broaden the list of 16 preliminary benchmarks suggested by the commission, the committee expanded its membership and sought out wider citizen input on social and health indicators for King County.

More than 1,500 residents were engaged in developing the indicators for King County. The 18-month process included a random-digit-dial telephone survey, a series of focus groups, two civic forums and five public forums. The 1,320 residents who participated in the telephone survey and focus groups were asked what they valued most in their neighborhoods and communities, and their main concerns with the health, social and economic conditions in King County. A Technical Advisory Group worked with the committee to translate the results from the telephone survey and focus groups into an initial set of indicators and measures that were scientifically sound and responded to the expressed values and concerns of King County residents. This group was responsible for integrating input from residents throughout the indicator development process.

Two civic forums gave citizen activists, program planners, social and health service providers, and program administrators, along with the Steering Committee, an opportunity to develop the set of "valued conditions" for King County, as well as propose and give feedback on the indicators. Final review and prioritization of indicators took place during a total of five public forums held throughout King County. In the final report, the indicators were drawn primarily from this community input.

continuity in monitoring progress over time as well as flexibility to respond to emerging priorities. Issues of data availability and data development always become central to this discussion. In the end, the geographic level of the indicator report, as well as available resources for data collection, will significantly influence which indicators are selected.

Establishment of accountability: Well-regarded indicator reports are useful in establishing and engendering accountability. They are

useful in holding both governmental and nongovernmental partners responsible for making changes that produce results and "move the needle" on indicators. In the most successful efforts, those who will be accountable should be pulled into the work early. This allows trust to build and relationships to gel to make any meaningful future progress on indicators. Commitment to moving indicators often means that partnering organizations need to do business differently or change internal policies or systems to impact the indicators. Indicator reports can provide a mechanism for better aligning the work of governments or organizations to the stated priorities of communities.

A commitment to data source development: Data development is a crucial part of the indicators development process. Many times communities want to measure outcomes for which no data are available from existing sources. For example, a reliable count of school days missed by California children due to illness is not available in any of the education or health status databases. Creating data sources is usually expensive and time-consuming; therefore, it is important to agree on a method for selection. If an indicator is high in communication power and proxy power, but low on data power, it is an ideal candidate for data source development. Not all communities have the resources to develop data sources, but an indicators report process could include a "wish list" should funds ever become available.

A commitment to ongoing community input: Community indicator reports have grown to include the "community voice." In the past, indicator reports, particularly government generated reports, were not much more than a summary of official statistics. One study of collaborative health efforts between public agencies and communities found that community concerns coming from personal experience generally were not reflected in statistical summaries. In fact, statistical summaries were often seen as valueless to communities. One observation of the study included, "if it's just numbers, then it's not worth anything."[82] More recent indicator projects seek to reflect community perceptions in reports and even in the indicators themselves. Local surveys, like the Los Angeles County Health Survey, complement more traditional sources of community data by presenting resident opinion on health status, behaviors, access to care and other issues. Other indicator reports survey residents on a wide range of issues, including transportation needs, perceptions of neighborhood safety or recreation choices. These surveys help the reports stay relevant to local priorities and help keep the meaning of indicators transparent and clearly understood by people from a variety of backgrounds.

The community should own the indicators, otherwise the report will have diminished impact. Though large surveys are expensive to field, even small surveys with a few questions can reflect community input in an indicator

Los Angeles County, California

For over 15 years, the Children's Planning Council (CPC) in Los Angeles County has facilitated interdepartmental and community collaboration to improve outcomes for children and families. In 1995, CPC adopted five important outcome areas for children and families: good health; social and emotional well-being; safety and survival; economic well-being; and education and work force readiness. Data have been central for changing perceptions and creating a willingness to reframe these outcomes. Two results of the CPC process are the Children's Budget, which is now conducted by the county and quantifies expenditures on programs and services for children and families, and the Children's Scorecard, which reports on population-based indicators of child health and well-being, as well as administrative data for specific departments or programs, (e.g., child protective services, youth probation). The CPC process helps answer the following questions: How well are children doing? How well are we using available resources? Could better use of resources improve results for children, families and communities? The next scorecard from CPC is in preparation. More information at www.childrensplanningcouncil.org.

report. But even in the best processes where community members have been involved in selecting indicators and the report addresses important community priorities, the technical and data-oriented process can obfuscate the community perspective to the point where indicator reports appear sterile and removed from community concerns. Making the reports continuously relevant to communities is an ongoing challenge.

An appreciation of media coverage: Many times community indicator reports languish on shelves never to be read by anyone. Government benchmark reports used to monitor government performance usually can be effective without much media attention because the purpose is clear and the responsible agencies identified. But the report may get more traction if the media are asking questions about accountability. Report cards with grades or rankings are particularly useful in generating media attention (see *Strengths of Community Indicator Report Cards* next). Poor media coverage can severely diminish the credibility and usefulness of a report or scorecard. A lack of substantial media coverage unfortunately tends to mean that reports and rankings do not receive adequate attention or credibility.

Strengths of Community Indicator Report Cards

Generally, community indicator reports are comprehensive summaries of community status that include several indicators with

School Readiness, Los Angeles County

"All children in Los Angeles County begin school healthy and ready to learn." A work group convened in January 2003 by First 5 LA and the Children's Planning Council (CPC) was charged with the task of defining the indicators that would identify fundamental elements required to achieve that result, and informing the organizer about whether progress was being made over time. Moreover, the group needed to come up with a set of goals and indicators that could be used to engage the broader community and public, so that "school readiness" would not only be understood, but would inform parents, child care providers, politicians and all citizens about how they could contribute.

The work group was comprised of representatives from many fields, including education, social work, health, child development, philanthropy, research, child care, advocacy, and representing public and private organizations. This group had to think about the full range of conditions required to achieve school readiness in consideration of current resources and opportunities, and they had to develop a framework made up of goals and indicators that included the availability and quality of the data for baselines and the proposed indicators. It was not enough to consider the child alone, out of the influence of his or her family, community and school environment. It was necessary to consider the whole child. The framework for the indicators would be constructed around the 1997 National Education Goals Panel's working definition of school readiness: children's readiness for school, school's readiness for children, family and community supports and services that contribute to children's readiness for school success. Within the five outcome areas established by the CPC*, the work group came up with goals and indicators based on available data and data that needed to be developed (the data development agenda).

The end product—goals and strategies to improve school readiness countywide—was a huge achievement, and much more than a list of indicators and data. It could not have happened without the collaboration and commitment of many organizations and individuals. The goals and strategies defined school readiness in a way that transcended pencils and test scores to encompass the whole child, the family and community. Adopted by the Los Angeles County Board of Supervisors and the First 5 LA Commission, these goals and strategies have provided the basis for ongoing work to engage many agencies and individuals working with young children and families in a dialogue about creating a better future for all of the county's children.

* health, family economics, social and emotional well-being, safety, and education/work-force readiness.

explanations of each indicator. Occasionally, community report cards are created from highlights of the larger reports. Simpler meaning is given to the information by adding grades, rankings or comparisons as away to track progress or performance over time in a way that readers recognize. These report cards are by definition selective in what they report, but the use of grades and other types of judgments can be effective in communicating priorities and trends.

It's eye candy for the media.

— *Victor Rubin, PolicyLink*

Intuitive: People grow up with report cards so they intuitively understand what the letters symbolize; rankings provide a clear comparison.

Attention getting: The consensus of everyone we interviewed is that report cards are very successful in getting the attention of media, policymakers and the general public. The media appreciates visual communication with easy take-home messages and therefore report cards lend themselves to press coverage.

Conversation starters: Scorecards and rankings by legislative district are meaningful for legislators and can bring them into the conversation about community well-being in a way they understand.

Summarizes a lot of information: Dean Kubani, Acting Environmental Programs Manager for the City of Santa Monica, uses the Sustainable Santa Monica report card as an adjunct to its larger online indicators progress report. The larger report is constantly updated, but has too much information for the City Council

Strengths and Limitations of Community Indicator Report Cards

Strengths	Limitations
• Intuitive	• Marginalizing effect
• Attention getting	• Potential for inaction
• Conversation starters	• Potential for irrelevance
• Summarizes a lot of information	• Grade Inflation
• Awareness raising	• Challenge in establishing a baseline
• Simple	

Carrot or Stick: What works best?

Grades and rankings can be used as incentives or as embarrassment. If the final goal is improved health outcomes, the strategic question is: which is more effective and when? Many indicator, ranking and report card examples inform the answer.

The Carrot

The carrot is a reward for a job well done. In the world of report cards and rankings, this seems to be a much more promising strategy for change. People and organizations seem to get on board when they have a say in shaping things and when it has value for them. Some of the most successful report cards were not examples of judging others, but rather of a state or municipal group rating itself. In Oregon, grades were reported to the legislature as a meaningful tracking of how well they were doing over time. When gradees are engaged in the process, there is a buy-in into what is important and into changing associated outcomes. In these cases, grades become a way to track progress on things people at the table care about as opposed to punishing groups for under performance. This seems to mirror the most successful indicator processes in general: the key stakeholders, often meaning the community, come together to define the key indicators and set priorities. People will rally around their own self-defined priorities, which contributes to ownership and to action around the solutions. The success of popular culture ratings mirrors these findings. Universities put a lot of energy and effort into being rated by U.S. News and World Report; companies invest time and resources into being rated as the best companies to work for or the best employers for working moms. In these cases, they buy into the ratings and are rewarded (good press, etc.) for achieving the indicators that they have chosen to buy into. Clearly the most powerful examples of local indicator work are those that involve community members and other stakeholders in identifying the indicators for themselves and in these being the basis for change. This seems to also be the case in engaging other key sectors, such as business, health care and government, in working toward improved outcomes and achieving change.

The Stick

The stick says that low rankings and low grades will encourage low performers into action. While there is some evidence that low performers might rally to improve their performance, in general, this approach doesn't seem to catalyze the greatest change. For example, in the health care field, low performing hospitals tend to notice low rankings as flags, but overall the industry has not transformed as a result. According to one interviewee, "Hospitals did not really change as a result of the rankings."[83] In fact, it seems that when groups are shamed or degraded by rankings or grades, the response is not to improve accordingly, but rather to distance themselves from the rating or grading system. And given the possibilities for debate over what the right indicator is, there is a lot of room for argument over the indicators instead of the outcome. Therefore, when the stick is chosen as the strategic approach, the dialogue can be lost in fighting over the right indicator as opposed to figuring out how to improve health outcomes. The only time the stick approach might work is when there is a strong enough constituency to hold the party accountable. For example, if a government achieves failing grades, it might only matter if the voters refuse to re-elect them. Similarly, if a business achieves failing grades, it might only care if business is boycotted or otherwise affected.

and the general public to regularly absorb. The report card therefore serves as a type of "executive summary" for the audience. He went on to explain that what people want to know is, "How are we doing? Are we more sustainable or less sustainable?" The report card quickly provides the answers.

Awareness raising: In getting a great deal of attention, report cards increase awareness about the more detailed indicators report, thereby helping to publicize the report and putting it "on the radar screen."

Simple: The report card is valuable as a convenient, simple communications tool. Charlotte Kahn of the Boston Indicators Project noted that report cards are valuable because they generate attention and because not everyone can think hard about everything, "The challenge is to help people see the connections" between the report card and action.

Limitations of Community Indicator Report Cards

Report cards are valuable communications tools but they should be used carefully. There are a number of potential limitations, depending on their use.

Marginalizing effect: The principal concern with community indicator report cards is the potential harm such a reductive approach to serious issues may have on communities. Resource distribution among communities in the nation is not even. Communities without many resources for historical or political reasons would seem to be performing badly by most indicator report standards. This has the potential to further marginalize already underserved communities. That is not to say that disadvantaged communities should not be assessed. But report cards need to go the extra step to communicate the assets of communities as well as the problems, that is, to show what is important and working in communities. This necessarily requires partnering with communities since residents are the most knowledgeable about assets. Report cards should bring attention to the root causes of community disadvantage without bringing negative consequences to the community.

There are huge questions about the efficacy of the tool and if unintended consequences might outweigh the benefits.

— ***Maria Campbell Casey, Partnership for the Public's Health***

Potential for inaction: As stand-alone reports, report cards may not lead to action. While many of the popular culture report cards mentioned earlier in this paper inform choices individuals might make in their own lives, community indicator report cards often reveal the need for action by government agencies,

businesses or multi-sector collaborations. Therefore, using report cards as a tool to improve community health needs to be accompanied by a range of engagement and skill-building strategies. In describing why the Jacksonville report does not use grades or rankings, Ben Warner notes that while grades and rankings are good for press releases, sound bites do not identify specific areas for change. He goes on to say that action gets lost in report cards because people focus on the grading and discussions about what needs changing never occur.

Potential for irrelevance: Restaurant grades are useful to diners at the moment they are looking for a place to eat and are therefore of particular relevance. Indicator report cards do not necessarily have the same kind of immediate relevance because they tend to be about long-term, systemic issues.

Grade inflation: Report cards are susceptible to grade inflation. A recent study from RAND found that report cards on hospital care likely overestimate quality because too few indicators are evaluated, resulting in inflated grades.[84] When researchers studied a broader set of indicators they found that hospitals did not perform as well as the report cards claimed. As in school, people can learn how to "game" the system to get better grades. Report card grades are usually intended to measure improvement over time and to the extent that they can be manipulated, they will not achieve that goal.

Challenge in establishing a baseline: One challenge to assigning letter grades is that it can be difficult to identify the baseline or the measure against which a grade is set. As result, it is not clear exactly what the grade stands for. Letter grades, for example, might indicate level of performance on an indicator or set of indicators or might indicate a comparison, such as to performance in other places or years. To maximize effectiveness, these need to be established early on so that the grades and rankings have meaning.

The Opportunity for Counting Health

This is only a brief overview of community indicator reports. Even so, it is possible to see that while many of these reports in different fields capture social and environmental conditions conducive to health and prevention efforts, they are not called "health" indicators. The processes for developing indicators and reports are the same: convening stakeholders and engaging communities to define and measure those elements that are in service to quality of life or sustainability or government performance, all of which relate in basic ways to health as broadly defined. But even in the health sector, many times the use of indicators and reports has been restricted to measurements of health status. We have an opportunity to articulate a vision of health that includes both community environment *and* medical services and frames these as the key factors that contribute to health. The proliferation of data and exciting

new technologies has led to an abundance of reports and has contributed to increasing savvy among the public. This is a promising and exciting time to count health so that we can count on health in the future.

PART FIVE

Putting What Counts Where It Counts: A Menu of Options for Advancing Community Health in California

The rich history of the indicator movement and community change clearly points to an opportunity to use indicators as a tool for increasing an understanding about community health and catalyzing change. The history and lessons also reveal that the most effective approach will include engaging all of the key stakeholders in the process of developing the most appropriate indicators and/or in buying into the measurement tool. The following menu of options provides suggested directions for moving community health forward in California in a way that includes the use of indicators that are reported by ranking and grades or through another report form. They are particularly designed to engage the stewards of community health in a meaningful way.

All of the tools would be based on agreed upon elements of community health. The suggested elements are included in **Box 1**—Key Community Factors. These elements would be the basis of any tool because they reflect critical elements of community health. Several prototypes appear at the end of this chapter to assist those working to advance community health in California.

Tools: Reports and Report Cards—Options and Opportunities

Community

Community Health Assessment Tool: Communities can benefit from a tool that defines the elements of community health and enables them to come up with their own indicators. This tool should provide some sample indicators, but ultimately communities will need to define their own. It should be recognized that the process of bringing multiple sectors together to identify priorities and solutions has been shown repeatedly to be an effective process. For communities, it might be beneficial to word the major elements of community health as values or questions, such as "Getting Around: Can we safely and affordably get where we need to be?" The tool could be made accessible throughout the state via the Internet. (see prototype *CHOICE: Changing Health Opportunities in Community Environments*)

Sim City,™ Community Health Version: Sim City™ is a popular computer game that allows users to build a model city starting with an undeveloped patch of land and an initial development fund. Users literally build a city from the ground up, choosing where and what kinds

Tool for Health & Resilience In Vulnerable Environments

T.H.R.I.V.E is a community resilience assessment tool that helps communities bolster factors that will improve health outcomes and reduce disparities experienced by racial and ethnic minorities. It provides a framework for community members, coalitions, public health practitioners, and local decision makers to identify factors associated with poor health outcomes in communities of color, engage relevant stakeholders, and take action to remedy the disparities. The tool is grounded in research and was developed with input from a national expert panel. It has demonstrated utility in urban, rural and suburban settings. Within months of piloting, several communities had initiated farmers markets and youth programs. At the community level, the T.H.R.I.V.E tool contributed to a broad vision about community health, confirmed the value of upstream approaches, challenged traditional thinking about health promotion, organized difficult concepts and enabled systematic planning, and proved to be a good tool for strategic planning at community and organizational levels.

For more information: Davis R, Cook C, Cohen L. *A Community Resilience Approach to Reducing Ethnic and Racial Disparities in Health*, The American Journal of Public Health. December 2005 (Vol. 95, No. 12).

T.H.R.I.V.E website: http://www.preventioninstitute.org/thrive/index.php

of things to build, making zoning decisions, and laying down roads and transportation lines. As users become more advanced in the game, they are encouraged to develop strategies that stimulate economic growth and build up the population to gain approval from the "Sims." Theoretically, the game could be designed to encourage any definition of growth, for example, community health. If this were the case, approval ratings by the Sims would be based on how well the city design promotes community health, and adding and subtracting factors would instantly produce health results translating to an approval rating. Such a game would convey community health to users by accounting for decisions about the major elements of community health. While Sim City™ is a model, comparable interactive or board games that feature key elements of community health could be developed.

Public Health

Community Health Intersectoral Report Card: As the lead public entity responsible for the health of a community, public health could utilize a tool that allows it to convene the major governmental sectors that influence community health. For example, it needs to be able to engage transportation, planning and economic development agencies in taking community health considerations into account when making decisions. It should start with the major elements and work with sectoral partners to determine which are relevant to their mandates and activities and what the associated indicators would be. In this way, a report card could be developed that grades each of the sectors on their contribution to community health on a county level. It is critical that the process be set up in a way that the other sectors are engaged; they must buy into the process, community health, and the indicators they are being graded on. Further, it would be valuable to track efforts over time to assess the trend as opposed to performance in a given year. (see prototype)

Health Care

There are a number of required measurement and reporting efforts that the health care sector participates in. Given the resource investment in these efforts and buy-in from the sector, it makes sense to explore opportunities with the health care sector to integrate community health elements into their existing efforts and to integrate accepted health care indicators into other community health report and report card efforts as appropriate.

Community Health Care Needs Assessment—SB697: This community needs assessment is required of all California not-for-profit hospitals every three years and the data is reported to the Office of Statewide Health Planning and Development (OSHPD). It is based on the IRS community benefit standard which states that "the promotion of health ... is deemed beneficial to the community as a whole."[85] Not-for-profit hospitals can be

convened to discuss opportunities to integrate the identified elements of community health into their assessments and/or utilize the *Community Health Assessment Tool* described above. Kaiser Permanente has expressed an interest in playing a leadership role in this endeavor.

California Hospital Assessment and Reporting Taskforce (CHART): The goal of CHART has been to produce a statewide hospital report card through a collaborative process, and the first public report card is expected in winter 2006-07. The team adopted more than 50 hospital performance indicators that include process and outcome measures in specific clinical areas as well as hospital-wide outcomes. The measures are aligned with national initiatives such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Quality Forum (NQF). More than 200 California Hospitals have agreed to participate and to contribute resources to cover data collection costs. Additionally, the major health plans working in California will use the data collected by CHART as the basis for quality reporting. Government and regulatory agencies are actively supporting the effort, including OSHPD and JCAHO. This group could be valuable to connect with to identify opportunities to insert indicators of community health as appropriate and could also inform the development of medical service indicators for that particular category of indicators.[86]

The company I worked for put a lot of effort into the application for the ranking on the best places to work for working mothers. The process itself forced executives to think about how they were in fact supporting working mothers and catalyzed changes in the workplace.

— Fortune 500 Employee

Business

The 100 Top Businesses in California Promoting Community Health: When featured by highly credible media outlets with significant reach, rankings can be an effective way to garner voluntary participation in raising awareness about an issue and in examining organizational policies and procedures. A credible council could be established to invite applications and could partner with a large media source to get the word out and to publicize the rankings. The annual ranking would also be read by people throughout California and could be framed in a way that further promotes an understanding of all the elements of community health.

Community Health Business Certification: The green business certification programs assist, recognize and promote businesses and government agencies that volunteer to operate in a more environmentally responsible way. It raises awareness among

participants and changes their practices to promote sustainability, including conserving resources, preventing pollution and minimizing waste.[87] A similar certification program could be established for businesses in California that could allow them to learn more about community health and promote it through their practices and policies not only for their employees but more generally for the communities in which they do business.

Government

County Rankings on Community Health: There are 59 counties in California, and they have oversight for a number of functions and services that contribute to community health. A ranking could be developed based on standardized indicators that ranks counties across the state on the percentage of the county budget allocated to the key elements of community health. This will give the public a sense of their county's priorities in regard to community health and can establish trend data for the counties over time to see how they are doing in relation to one another. Presumably, as a greater understanding of community health develops across the state, interest in this ranking could grow for the public and the media. (see prototype)

Hurts Us/Helps Us: An Analysis of State Policies and Community Health: There is a direct relationship between state policies and community health. On an annual basis, state policies and ballot propositions could be assessed with consideration of the elements of community health and key indicators. An assessment for each such as "promotes community health," "hinders community health," and "no effect on community health" could be given. The goal of this tool would be to deliberately connect the notion of community health to policy for the general public. (see prototype)

Media

Grading the Media: The national media influences California's community health. Using the key elements of community health, we can work with representatives of the entertainment and news media to develop key indicators on which the media would be graded. Indicators could include data about product placement in movies and television shows, and measure reporting on various elements of community health.

Capacity and Skill Building: Ensuring the Requisite Skills to Promote Community Health

While the various tools described can help advance an understanding of community health, people need a range of skills to advance changes, particularly in fostering coalitions and ensuring organizational practice and policy change. Capacity and skill-building efforts can support outcomes associated with each of the tools. For example, communities could benefit from support for a process that enables them to utilize the tool to discuss what's important to them, prioritize elements and indicators, and make the necessary

changes. The public health sector can be even more effective in being better able to articulate the need for a community health approach and to engage multiple sectors in a meaningful process.

Spreading the Word

It's not enough to just have tools; they need to be promulgated through the media, in the public, and with leaders in many sectors and communities. In addition to making sure the tools are widely disseminated and that users have the skills to maximize their intent, it could also be valuable to use other vehicles to spread the word throughout California about community health. This could include, for example, weekly community health broadcasts on community and college radio throughout the state and making these available via podcasts.

Next Steps

The report and report card opportunities described above, particularly when undertaken together, can propagate an understanding of what really makes us healthy and can be the basis for changes in practices and policies in order to improve community health. If undertaken, it is critical to commit to sustaining the effort for at least a particular amount of time, such as a decade, in order to support the kinds of changes—in understanding and action—that need to take place in order to ensure we are promoting health in a way that aligns with the value we all personally place on it.

To start with, there are immediate actions:

- Convene a multi-sectoral group to provide input on community elements of health and how to implement measurement tools to convey the notion and catalyze change.
- Hold a symposium to garner input from multiple sectors and diverse communities.
- Launch a statewide group of stakeholders devoted to community health to advance the notion of community health and associated changes in the state.

CHOICE: Changing Health Opportunities in Community Environments
Prototype

EQUITABLE OPPORTUNITY FACTORS: Does everyone have access to opportunities?

Elements of Community Health	Sample Indicators	Community Rating Options
Racial justice	Racially balanced schools; Discrimination; Infant death disparities; Workplace discrimination; Ethnic diversity of teachers; Equity in justice; Perceptions of racism	For each element or indicator: • Priority (high, medium, low) • How well the community is doing • Degree of freedom/ opportunity to attain
Jobs and local ownership	Business ownership; New business development; Living wage; Unemployment/employment rates; Salaries; Community reinvestment; Local ownership of assets; Access to capital; Investment opportunities (e.g., loans); Community members with requisite skills	
Education	Reading level; School success (dropout/graduation); Teacher quality; Adult literacy; Readiness to learn; High school dropout rates; Teachers with advanced degrees; School readiness; People ready for employment; Percentage of parents reading daily to their children; Vocational training	

PEOPLE FACTORS: Are people connected and engaged?

Social networks and trust	Neighborhood involvement; Local/indigenous leadership; Willingness to intervene on behalf of the common good; Sense of community; Commitment to community among its members; Perceptions of social cohesion; Organizational resources and relations; Reciprocity/ mutual obligation; Trust; Neighborhood social cohesion; Teen pregnancy; Single parent households	For each element or indicator: • Priority (high, medium, low) • How well the community is doing • Degree of freedom/ opportunity to attain
Participation and willingness to act for the common good	Voter activity; Union activity; Understanding tax system; Commuting; Library participation; Volunteerism; Feeling of community; Involvement in community organizations; Institutional support for community service; Tendency to intervene or act to achieve community aims; Ability to solve problems; Access to resources	
Acceptable behaviors and attitudes	Belief in the moral order; availability of alcohol and/or cigarettes to minors; Drinking/driving arrests; Teen smoking rates; Teen pregnancy	

PLACE FACTORS: Is the community environment conducive to health?

What's sold and how it's promoted	Residents who eat 5 servings of fruits and vegetables; Adequate food; # & types of supermarkets; Alcohol outlet density; Ease of access to shops and services; Perceived availability of certain products; Billboard ads; Availability and promotion of safe, healthy, affordable, culturally appropriate products and services (e.g., books and school supplies, sports equipment, arts and crafts supplies, and recreational items); Limited promotion and availability, or lack, of potentially harmful products and services (e.g., tobacco, firearms, alcohol and other drugs)	For each element or indicator: • Priority (high, medium, low) • How well the community is doing • Degree of freedom/ opportunity to attain

Continued on next page.

Prototype *(continued):*

PLACE FACTORS: Is the community environment conducive to health? *(continued):*

Elements of Community Health	Sample Indicators	Community Rating Options
Look, feel and safety	Tree planting; Well-maintained; Blight; Abandoned buildings; Life on the street (foot traffic, etc.); Nightlife; Local shops; Tree-lined streets; Architectural aesthetic; Community plan; Response times; Shelters, Community networks	For each element or indicator: • Priority (high, medium, low) • How well the community is doing • Degree of freedom/ opportunity to attain
Parks and open space	Conservation and park land; Places to play; Public land; Wildlife habitat; Outdoor recreation; Open space near urban villages; Safe, clean parks; Green space; outdoor space that is accessible to the community; Natural/open space that is preserved through the planning process	
Getting around	Public transit use; Bikeable streets; Walkable streets; Pedestrian and bicycle friendly streets; Access to transportation; Public transport availability; Transportation for people with disabilities; Commute times; Travel time to work; Average weekday bus ridership per 1,000	
Housing	Housing affordability; Housing availability; Owner-occupied; Rental costs; Density; People per unit; Commute times	
Air, water and soil	Local wild salmon runs; Resident toxic exposure; Asthma rates; Air quality; Beach closures; Water use; Recycling; Water quality; Pollution in neighborhoods; Farmland treated with chemicals	
Arts and culture	Employment in arts and culture; Participation in life-enriching activity; Murals and exhibitions; Participation in arts and culture; Funding for arts and culture	

MEDICAL SERVICES: Do medical services meet the needs of the community?

Preventive services	Prenatal care; Immunization rates; Vaccination rates for flu and pneumonia; Mammography; Wellness care; Dental cleanings and exams; Number of preventable ER visits; Number of preventable hospitalizations	For each element or indicator: • Priority (high, medium, low) • How well the community is doing • Degree of freedom/ opportunity to attain
Access	Health insurance rates; Access to dental care; Regular source of care; Relationship with a doctor or physician	
Treatment quality, disease management, in-patient services and alternative medicine	Number of preventable ER visits; Number of preventable hospitalizations; Length of stay	
Cultural competence	Race/ethnicity of providers, race/ethnicity of providers matches community; Cultural barriers; Language of providers/translators	
Emergency response	Response times; Call-response rates	

Community Health Intersectoral Report Card
Prototype

Sample Sectors	Sample Community Health Indicators (sector selected)	Grade Year 1	Grade Year 2
Transportation	• Parents who say that they can easily get to a park, playground or other safe place to play • Amount of time spent in a car per week • Average commute time • Walkable streets • Foot traffic in downtown • Emergency response times • Access to medical service • Can a 12-year-old walk to buy a quart of milk?	B+	B+
Planning	• Parents who say that they can easily get to a park, playground or other safe place to play • Alcohol outlet density • Foot traffic • Amount of time spent in a car per week • Average commute time • # of people/housing unit • % of owner-occupied housing • Conservation and park land • Clinics and hospitals • Can a 12-year-old walk to buy a quart of milk?	A-	A
Parks and recreation	• Parents who say that they can easily get to a park, playground or other safe place to play • # hours TV is on • Conservation and park land	C+	C+
Library	• Percentage of kids read to daily by a family member • # hours TV is on	B-	B+
Economic development	• Locally-owned businesses • Living wage jobs in the neighborhood • Foot traffic • Amount of time spent in a car per week • Average commute time • Farmers markets • Alcohol outlet density • Race/ethnicity of service providers reflects the community • Can a 12-year-old walk to buy a quart of milk?	B	B-
Law enforcement	• Can a 12-year-old walk to buy a quart of milk? • Foot traffic • Walkable streets • Emergency response times • Perceived neighborhood safety	B	A-

County Rankings on Community Health - ***Prototype for county X***

Community Health Elements	(Sample) Standardized Indicators (to be selected for all counties across the state)	State Ranking (based on percentage of county budget allocated to the standardized indicators)
Equitable Opportunity Factors 1. Racial justice 2. Jobs and local ownership 3. Education	• Percentage of parents reading to their children • Locally-owned businesses • Living wage jobs in the neighborhood • Families have access to affordable child care • Parents who say it is difficult to find the child care they need	23
People Factors 4. Social networks and trust 5. Participant and willingness to act for the common good 6. Acceptable behaviors and attitudes	• # of suicides/attempted suicides • # of out of home placements • # hours TV is on • % families who eat dinner together • Voter activity • Perceived neighborhood safety • Alcohol outlet density	28
Place Factors 7. What's sold and how it's promoted 8. Look, feel and safety 9. Parks and open space 10. Getting around 11. Housing 12. Air, water and soil 13. Arts and culture	• Foot traffic • Conservation and park land • Performing arts • Museums • Amount of time spent in a car per week • Average commute time • # of people per housing unit • % of owner-occupied housing • Can a 12-year-old walk to buy a quart of milk? • Farmers markets • #/type of supermarkets • % of electricity generated by solar power • Households below 300% of poverty that are food insecure	45
Medical Services 14. Preventive services 15. Access 16. Treatment quality, disease management, in-patient services and alternative medicine 17. Cultural competence 18. Emergency response	• Number of preventable ER visits • Number of preventable hospitalizations • Immunization rates • Percent insured • % people have a personal relationship with a doctor or clinic • Response times • Race/ethnicity of service providers reflects the community	37

Hurts Us/Helps Us: An Analysis of State Policies and Community Health
Prototype

Community Health Elements	State policies and ballot propositions (Sample) (to be selected annually and analyzed according to selected indicators and community health elements)	Helps Us/ Hurts Us
Equitable Opportunity Factors 1. Racial justice 2. Jobs and local ownership 3. Education	• Qualified teachers must be placed in low-performing schools and school districts must ensure teachers are qualified to teach the subjects they are assigned. AB3001, by Assemblyman Mervyn Dymally, D-Compton.	❑ promotes community health ❑ hinders community health ❑ no effect
People Factors 4. Social networks and trust 5. Participant and willingness to act for the common good 6. Acceptable behaviors and attitudes	• High school students would have been allowed to serve as members of election precinct boards without their schools losing state aid due to absences for election purposes. AB1944, by Assemblywoman Loni Hancock, D-Berkeley.	❑ promotes community health ❑ hinders community health ❑ no effect
Place Factors 7. What's sold and how it's promoted 8. Look, feel and safety 9. Parks and open space 10. Getting around 11. Housing 12. Air, water and soil 13. Arts and culture	• SB469 (Scott). Co-sponsored by CAAE and the CA State PTA, the bill elevates the Visual and Performing Arts in the Instructional Materials bill that was passed last year. • Requires big rig operators to provide evidence that the engine meets federal air quality standards. AB1009 from Assemblywoman Fran Pavley, D-Agoura Hills. • Would have earmarked up to $1 million in state housing bond funds for a metropolitan Sacramento experiment to make 10 percent of its housing affordable to moderate, low and very low income residents. AB1426, by Assemblyman Darrell Steinberg, D-Sacramento. Vetoed.	❑ promotes community health ❑ hinders community health ❑ no effect
Medical Services 14. Preventive services 15. Access 16. Treatment quality, disease management, in-patient services and alternative medicine 17. Cultural Competence	• Levies a "quality assurance fee" on nursing homes to draw federal matching funds to improve care at the homes and raise pay and benefits for nursing home workers. AB1629 from Assembly Majority Leader Dario Frommer, D-Los Angeles.	❑ promotes community health ❑ hinders community health ❑ no effect

Appendix 1: Methods

In preparing this paper we reviewed 79 community indicator reports, interviewed 64 people and reviewed 9 popular culture report cards. A number of important books and articles also informed our work.

Community Indicator Reports

The reports reviewed for this paper were self-identified as indicator reports, available on the Internet and published in English. Reports were suggested by individuals, mentioned in other indicator reports and/or in the community indicators literature, or discovered by Internet search engine inquiries by issue area (e.g., "quality of life reports"). The geographic scope was limited to the United States; Canada; the United Kingdom; Australia; other English speaking countries; Europe, in particular Sweden, Finland and Denmark; Japan; and Hong Kong. Reports from national and international nongovernmental agencies, such as the World Health Organization (WHO) and Healthy Cities were also reviewed. Finally, we posted inquiries on the Web-based listserv, spirit of 1848. (See **Appendix 4** for full list of reports.)

Most reports reviewed for this paper sought to educate their audiences and bring awareness to problems. Reports measured a variety of domains, for example, civic participation, health status, environmental policy, economic growth, and culture and recreation. Most reports sought to set agendas for public

resource distribution, set baselines for government performance, monitor trends or progress in government performance or community health and wellbeing, inform public policy development and advocate for specific policies, or a combination of all of these purposes. Some were focused on a particular sector while others included indicators across sectors and domains.

We performed an initial scan of all reports making note of some basic features including type of report, report goals, issue areas covered by the report, the report's geographic area, and the type of organization creating the report. We then selected several to read more closely. We chose these reports using several criteria:

- the reports were most mentioned in other reports or in indicator literature
- we received strong recommendations
- the report had a unique analytical framework, or process, e.g., significant community input; or the report covered a unique diversity of issue areas and/or indicator types
- the report was used by multiple communities or groups, e.g., chapter or affiliate type organizations
- the report included one or more of the factors Prevention Institute had identified in previous projects as important for community health.[88]

In the reports we reviewed, the populations were circumscribed by geography: city, state, country and regional. Community reports can also describe the status or well-being of subpopulations, such as children or the elderly. We generally did not review reports that described populations solely by age, gender, race or ethnicity, or other like identifying factors. We did review some child well-being indicator reports because they are so numerous and were often recommended to us by others as interesting reports. However, overall, we chose to focus mainly on geographic communities while recognizing that community can be defined in many ways. We looked at reports from a range of jurisdictional levels (neighborhood, city, state, nation and region).

Some community reports describe the state of specific community sectors, such as health care, the environment and housing. These reports also have an education and awareness purpose, but are generally concerned with improving outcomes only in that specific sector. In our review, we looked at some health care reports and environment reports, but the scope of the project did not allow us to expand much beyond those two sectors. Many of these single issue assessments were also part of the broader community reports we were able to review.

Key Informant Interviews

The list of key informants was developed using a snowball interviewing technique. We began with an initial list of contacts derived from recommendations from staff at The California Endowment and used Prevention Institute's long history of working with recognized experts in the fields of community development and change, health, social determinants of health, and other related issues. We sent e-mail invitations to interviewees describing the project and asking for permission to contact them. We then set interview dates with those who responded affirmatively. During the course of the interviews we asked for the names of others who could be helpful to us. We developed a "leads" list from these suggestions from which we drew other key informants. By the end of the project we had spoken to 50 experts with experience in a range of fields including policy development, research, government service, and program development and implementation (see **Appendix 3** for a full list of key informants).

Popular Culture Report Cards

In choosing popular reports cards to review, we first brainstormed a list of scorecards already known to us in areas such as vacation destinations and places to live. We also performed an Internet search using phrases such as, "best of," "top 10," and "top 100." By the end of the project we had reviewed ten report cards to get a view of "best practices" in promoting report cards in the popular media (see **Appendix 4** for a full list of report cards).

Appendix 2: Examples of Data Sources for California Indicator Reports and Report Cards

National Center for Health Statistics

- Provides links to all of the major government sponsored health surveys. Some surveys are regularly conducted and others are periodic. http://www.cdc.gov/nchs/fastats/map_page.htm

U.S. Department of Commerce, the Census Bureau

- Provides regular demographic data, including counts by census tract every 10 years. The American Communities Survey is a new annual survey that provides estimates from the Census Long Form which were previously available only every decade, www.americanfactfinder.census.gov. The link will also take you to other Census surveys and data sources.

California Department of Health Services

- Provides vital statistics with population-based data about births and deaths. California DHS provides an online Vital Statistics Query System (birth and death records). http://www.applications.dhs.ca.gov/vsq

- Also available are surveillance records based on tracked conditions, such as reportable diseases, injuries, and other

conditions. The California Injury Data Online is available at this link. http://www.applications.dhs.ca.gov/epicdata/default.htm

Statewide Surveys

- Provide sampled data representative of the population. The California Health Interview Survey (CHIS) provides data on adults, children and adolescents for the state and most counties (data are not available for counties with smaller population sizes). The online query system is available at www.askCHIS.org. Other statewide surveys include the California Dietary Practices Survey, the Behavioral Risk Factor Survey System (BRFSS) and the Women's Health Survey.

Local and Special Surveys

- Provide sampled data representative of the population. Examples of local surveys include the Los Angeles County Health Survey (www.lapublichealth.org) and the Los Angeles Families and Neighborhood Study (www.rand.org).

California Office of Statewide Health Planning Data

- Provides hospital and emergency room discharge data, and data on health care quality, http://www.oshpd.ca.gov. The hospital data are dependent on complete hospital reporting and restricted to only those conditions requiring hospital admission.

The California Department of Finance

- Provides demographic estimates and projections. http://www.dof.ca.gov/HTML/DEMOGRAP/Druhpar.asp

California Department of Education

- The Educational Data Partnership provides fiscal, demographic and performance data on California's K-12 schools. http://www.ed-data.k12.ca.us/welcome.asp

California Air Resources Board

- Provides information on poor air quality days, levels of ozone, particulates and other pollutants, http://www.arb.ca.gov/aqd/aqdpage.htm
- The regional Air Quality Management Districts also provide air quality data.

Scorecard

- A pollution information website that provides scorecards on toxic releases, air and water pollution, and animal waste. http://www.scorecard.org

Appendix 3:

We Would Like to Thank the Following for Their Contributions to This Paper

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Cheryl Wold, MPH, Community Health Consultant, Wold & Associates

Appendix 4: Community Indicator Reports and Report Cards

	Organization	Year
United States		
National		
America's Health Rankings: A Call to Action for People & Their Communities	United Health Foundation, American Public Health Association and Partnership for Prevention	2005
Big Cities Health Inventory 2003: The Health of Urban America	Chicago Department of Public Health	2003
The Economics of Food, Farming, Natural Resources and Rural America	Economic Research Service, U.S. Department of Agriculture	2006
Quality of Life in the Nation's 100 Largest Cities and their Suburbs	State University of New York Downstate Medical Center	2004
Health, United States, 2005	U.S. Department of Health and Human Services, Centers for Disease Control and Prevention's National Center for Health Statistics	2005
Healthy People 2010	U.S. Department of Health and Human Services	2000
Putting data to work: Occupational Health Indicators from 13 Pilot States	Council of State and Territorial Epidemiologists, In Collaboration with the National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention	2000
Your State's Health	Trust for America's Health	2006
America's Children: Key Indicators of Well-Being	Federal Interagency Forum on Child and Family Statistics	2005
States		
Arizona		
What Matters: the Maturing of Greater Phoenix	Morrison Institute for Public Policy, Arizona State University and School of Public Affairs, College of Public Programs	2004
California		
California Environmental Health Indicators	California Department of Health Services, Environmental Health Investigations Branch	2002
Sustainable Santa Monica	City of Santa Monica, Environmental Programs Division	2005
Time to Lighten up? Report on Sonoma County Ecological Footprint Project	Sustainable Sonoma County & Redefining Progress	2002
Key Indicators of Health	Los Angeles County Department of Health Services	2002-03
Children Now Report Card: An Assessment of Children's Well-Being	Children Now	2005
California County Data Book	Children Now	2005
Indicators for a Sustainable San Mateo County: 2005 Report Card on Our County's Quality of Life	Sustainable San Mateo County	2005
Health Indicators for California's Children and Youth	University of California, San Francisco Family Health Outcomes Project	2001

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(continued):

	Organization	Year
States		
California - continued		
The Quality of Life in Pasadena: An Index for the '90s and Beyond	City of Pasadena, Public Health Department	1992
Vital Signs: A Report on the Quality of Life in Shasta and Tehama Counties	The Northstate Institute for Sustainable Communities	2001
The State of the Great Central Valley of California: Assessing the Region	Great Valley Center	2002
State of Black Los Angeles: LA Equality Index	Los Angeles Urban League and United Way of Greater Los Angeles	2005
Community Health Status Report—Alameda County California	Health Resources and Services Administration (HRSA), National Association of County & City Officials (NACCHO), The Association of State & Territorial Health Officials (ASTHO), Public Health Foundation (PHF)	Jun-05
State of the Bay Area Report: Measuring Progress toward Sustainability	Bay Area Alliance for Sustainable Communities	2003
2005 Index of Silicon Valley	Joint Venture Silicon Valley Network	2005
Neighborhood Knowledge for Change: The West Oakland Environmental Indicators Project	Pacific Institute for Studies in Development, Environment, and Security	2002
Sierra Nevada Wealth Index	Sierra Business Council	1999-00
Los Angeles County 2004 Children's Scorecard: Health, Families and Income: Key Areas of Child Well-Being for School Readiness & Success	Los Angeles County Children's Planning Council	2004
Latino Scorecard 2006: Road to Action	United Way of Greater Los Angeles	2006
Quality of Life 2002	City of Glendale, Community Development & Housing, Neighborhood Services	2002
California Youth Violence Prevention Scorecard	Choices for Youth	2002
Hayward Health Profile	Alameda County Public Health Department	2004
Colorado		
Larimer County Index of Community Well-Being	Larimer County Health and Human Services and United Way of Larimer County	2004
Delaware		
2005 Delaware Children	Nemours Health & Prevention Services	2005
Florida		
Quality of Life Report for Tallahassee/Leon County	21st Century Council	1996
Quality of Life Progress Report: A Guide for Building a Better Community	Jacksonville Community Council Incorporated: Citizens for Building a Better Community	2004

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(continued):

	Organization	Year
Florida - continued Sarasota County Community Report Card: 2004-2005	SCOPE: Saratosa Openly Plans for Excellence	2004-05
Maine Measures of Growth: Performance Measures & Benchmarks to Achieve a Vibrant & Sustainable Economy for Maine	Maine Economic Growth Council	2004
Massachusetts Thinking Globally, Acting Locally: A Summary of the Boston Health Indicators Report 2002	Boston Indicators Project, The Boston Foundation	2002
Minnesota Minnesota Milestones: Measures that Matter	Minnesota Planning	2002
Missouri Building a Healthier St. Louis: A Report on the Integrity of St. Louis' Health Care Safety Net	St. Louis Regional Health Commission	2003
Montana Missoula Measures	Missoula City-County Health Department	2006
Nevada Quality of Life: The Key to Our Future	Truckee Meadows Tomorrow	2005
New Jersey Living with the Future in Mind: Goals and Indicators for New Jersey's Quality of Life	New Jersey Department of Environmental Protection	2000
New York New York City Community Health Profiles	New City Department of Health and Mental Hygiene	2005
North Carolina Charlotte Neighborhood Quality of Life Study 2002	City of Charlotte Neighborhood Development & Charlotte-Mecklenburg Planning Commission	2002
Oregon Achieving the Oregon Shines Vision: The 2005 Benchmark Performance Report	Oregon Press Board	2005
The Health of Multnomah County	Multnomah County Health Department	2004
Pennsylvania Social Capital and Health: Does a relationship exist?	Philadelphia Health Management Corporation	2002
Texas Analyze Dallas	Analyze Dallas, a project of the Foundation for Community Empowerment	2006

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	Organization	Year
Vermont The Social Well Being of Vermonters: A Report on Outcomes for Vermont's Citizens	Vermont Agency of Human Services Planning Division	2005
Washington Sustainable Seattle: Indicators of Sustainable Community	Sustainable Seattle	1998
Communities Count: Social and Health Indicators Across King County	Seattle-King County Public Health Department	2005
International Health for All in the 21st Century	World Health Organization	1998
Society At A Glance	Organization for Economic Co-operation & Development	2005
State of the World's Children	UNICEF	2006
Special Report: Top 10 Cities	Asia Week	2000
Australia Indicators of a Sustainable Community, Newcastle	Newcastle City Council	2000
Canada Canada's Performance 2002: Annual Report to Parliament	President of the Treasury Board	2002
City of Richmond State of the Environment, 2001 Update Report	City of Richmond	2001
Community In Action Report, Delta Community Snapshot	United Way of the Lower Mainland	2003
Environmental Signals: Canada's National Environmental Series	Environment Canada	2003
Halton Health Promotion Plan	Halton Regional Health Department	1997
Provincial Sustainability Report for Manitoba	Manitoba Government	2005
Saskatchewan Environment: Annual Report 2002-03	Saskatchewan Environment	2002-03
Vision 2020: Hamilton's Commitment to a Sustainable Community	City of Hamilton	2004
Finland Government Resolution on the Health 2015 Public Health Programme	Ministry of Social Affairs and Health	2001
Turku Health Profile	Healthy Cities	2006
Sweden Stockholm's Environmental Programme: En Route to Sustainable Development	Stockholm City Council & Environment and Health Administration	2003

Continued on next page.

(continued):

	Organization	Year
United Kingdom UK Government Sustainable Development Framework Indicators	Department for Environment, Food and Rural Affairs, Sustainable Development Unit	2005
The Health of the Population 2001: Report of the Director of Public Health	Avon Health Authority	2001
The Edinburgh Milestones: Social Justice Report & Action Plan 2000-2003	Capital City Partnership	2003
Health in London 2005	London Health Commission, London Health Observatory, Greater London Authority	2005
Community Health & Well-Being Profiles	Public Health Institute of Scotland & Health Scotland	2004
Indicators of Sustainable Development for Scotland: Progress Report 2004	Scottish Executive Environment Group	2004
Online Databases National Women's Health Indicators Database	Office of Women's Health: US. Department of Health and Human Services	2001-03
Baltimore Citistats	City of Baltimore	2005
Providence Plan	Providence Plan	2006
Advancement Project Los Angeles	Advancement Project	2004
Kids Count State-Level Data Online	Annie E. Casey Foundation	2006
Popular Report Cards Bay Area Infrastructure Report Card, Citizen Advisory	American Society of Civil Engineers, San Francisco Section	2005
Best Companies to Work For 2006	Fortune Magazine	2006
2005 100 Best Companies	Working Mother Magazine	2005
Ecological Scorecard, San Francisco Bay Index	The Bay Institute	2003
100 People of the Century	Time Magazine	2000
Top Cities To Live In	CNNmoney.com	2000
America's Best Colleges 2006	U.S. News and World Report	2006
The Web's Best Sites	Web100.com	2005
100 Best Novels	The Modern Library	2003

Appendix 5: Authors and Contributors

Based in Oakland, California, Prevention Institute is a national center dedicated to improving community health and well-being by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. Since its founding in 1997, Prevention Institute has focused on a range of issues such as injury and violence prevention, traffic safety, nutrition and physical activity, and health disparities. The Institute provides training, technical assistance, and facilitates strategy development processes with community coalitions, foundations, professional associations, and local, state, and national government agencies to develop comprehensive prevention initiatives. Detailed information on our approach and projects is available at our website: www.preventioninstitute.org.

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