

The Partnership for the Public's Health

Implications for Public Health Practice

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Group Health
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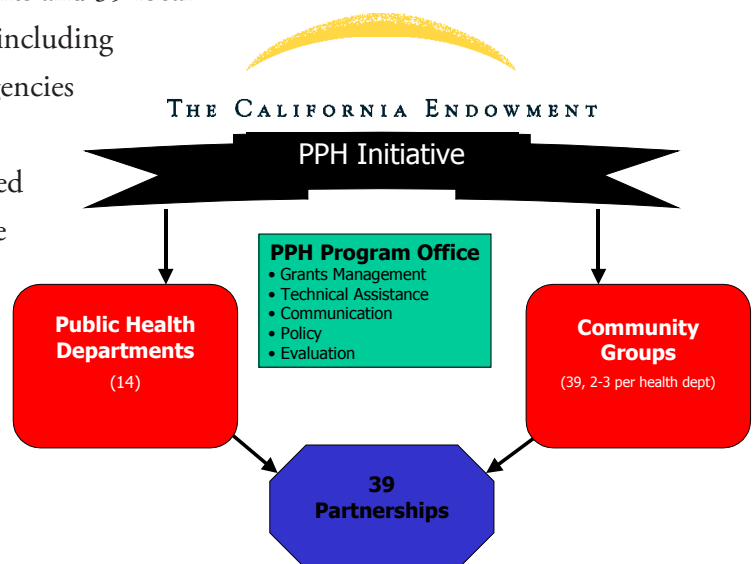
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I. Introduction

The growing recognition that social and environmental factors play a key role in determining health status is spurring a movement among more progressive public health departments to expand their focus beyond activities that had come to define public health practice, such as immunization and infectious disease. Public health departments are also becoming increasingly aware of the need to involve community partners in order to meet many current public health threats. However, the knowledge base regarding how best to address the determinants of health and work in partnership with community is underdeveloped. The ability of health departments to adopt such approaches is challenging because there is a need for greater consensus regarding guidelines and best practices. Recognizing this, The California Endowment (TCE) developed the Partnership for the Public's Health Initiative to demonstrate one approach in addressing these challenges.

PPH was a \$37 million, five-year initiative to develop partnerships between California communities and local health departments. Fourteen county and city health departments and 39 local community groups (including established service agencies and resident-based organizations) received grants as a part of the PPH Initiative.



The Initiative grantees were diverse in terms of ethnicity, geography, types of community groups, and experience in collaborating on community health improvement projects. A Program Office was also established and funded to support the grantees, lead the initiative, and foster sustainability, including statewide policy change.

The Initiative goals were to:

- Strengthen the capacity of communities to engage residents to act on their own and in partnership with health departments and other institutions to protect and improve the community's health and well-being
- Enhance the capacity of health departments to respond to community-based and community-driven priorities
- Create sustainable partnerships between communities and health departments that promote and define mutual responsibility for improving community health
- Develop state and local policies that support and sustain local capacity to improve community health

These overall objectives were translated into five operational goal areas (described below) that structured both the grantee action plans and the evaluation. PPH's emphasis on local public health department collaborations with communities provided an opportunity to analyze and understand the factors associated with health departments that are able to effectively collaborate with communities and neighborhoods in addressing the social determinants of health. PPH partnerships were designed to reach into areas that were grounded in public health's historical foundation in social justice, but have become sublimated by resource limitations and categorical disease-focused programs. Drawing on prior work done by the Turning Point Initiative, The National Association of County and City Health Officials (NACCHO), The

Institute of Medicine (IOM), and others, PPH was designed to include the broader "social determinants of health"¹ (SDOH) — social, economic, environmental, and other “upstream” factors associated with population health status — to improve the health of communities.

Over the course of PPH, a number of health departments and community groups made significant progress in developing effective partnerships that resulted in community health improvements and policy changes. Examples of these community changes include:

- Changes to school nutrition policies
- Reductions in traffic fatalities
- Increased regulation around youth tobacco use
- Increased monitoring and regulation of environmental pollution
- The creation of community parks with features to encourage physical activity

This report examines factors associated with health department success in working with community groups to improve community health, including addressing the social determinants of health. Understanding why some health departments were able to make more progress towards establishing effective approaches to SDOH than others will help identify strategic grant making and technical assistance opportunities. The purpose is to identify effective models, lay the groundwork for practice standards, and suggest policy and

¹ “Social determinants of health” refers to social, economic, and environmental factors that affect the health of communities and individuals. Researchers today have begun to emphasize the “upstream” character of social determinants, that is, their ability to affect individuals long before the physical signs and symptoms of illness have appeared. Social factors include, social relationships, conceptions regarding health (including causes of and remedies for ill health), and health behavior (both prevention and treatment-oriented). A large body of research has documented that gender, ethnicity, and class strongly affect health-related thinking and behavior. Economic factors include personal income, wealth, and access to insurance. Finally, environmental factors such as exposure to residential and industrial pollution and access to open space and resources for physical recreation comprise the final major aspect of the social determinants of health. Social, economic, and environmental determinants of health are believed to contribute to the income gradient in health status and life expectancy observed in the United States and many other countries.

systems changes that will allow health departments to successfully implement community-oriented approaches that focus on the social determinants of health.

This report identifies several dimensions in which PPH health departments provide valuable lessons regarding the core capacities needed to improve community health by addressing SDOH and employing CBPH approaches, including:

- Leadership
- Creative financing
- Planning
- Organizational Change
- Data
- Communication
- Policy Advocacy
- Dissemination
- Community Readiness to Change

In addition, the report:

- Examines the linkages between SDOH and CBPH
- Examines the extent to which PPH models of public health practice align with existing performance standards, and suggests opportunities for modifications to current standards
- Considers the importance of place: the social, environmental, and structural factors that define opportunities and challenges for communities and all the people living there

II. Background: Social Determinants of Health, Community-based Public Health and PPH

Chronic illness is perhaps the most significant challenge for public health today. The three leading causes of death — heart disease, cancer, and stroke — account for nearly two-thirds of all deaths [1]. Reducing the burden of chronic illness requires that health departments address a much broader range of factors, including social and environmental factors

One example of these social and environmental factors is the growing attention to the impact of the built environment on health, particularly as it relates to chronic illness [2-3]. The design of cities and neighborhoods can affect access to basic services, the availability of healthy foods, and the safety and attractiveness of neighborhoods for walking and other physical activity. If health departments are to play a role in changing the built environment, it will require partnerships with a wide set of community-based organizations and institutions, including planning departments, developers, and neighborhood groups.

Disparities in health outcomes related to race and class are another area where social and environmental determinants play a critical role. Recent research reveals an increasing gap in health outcomes based on race and class [4]. This trend is rooted in deep structural inequalities that restrict choices and opportunities. The nature of these problems requires health departments to be conscious of the role of public health in understanding and addressing the effects of social inequality. In acknowledging this role, health departments

will be required to address issues that have not historically been within their purview.

Health departments in California are uniquely situated to address disparities in health since they are the governmental entity that has been charged with protecting and promoting health for the entire population. Local health departments often have the infrastructure and understanding of local issues needed to work with community and promote local collaboration around the social determinants of health. Furthermore, the historical legacy of local public health departments as key governmental agencies provides an institutional anchor for collaborative efforts. It is critical to support and develop the capacity of local health departments to engage in strong partnerships, and maintain a solid infrastructure and secure funding base.

The need for health departments to partner with a wide range of community stakeholders has brought about a corresponding increase in the use of principles of community-based public health (CBPH). Strong evidence, moreover, suggests that health promotion on the community level takes place most effectively when carried out by community residents and coalitions of diverse stakeholders [5-12].

Collaboration enhances results produced by agencies and organizations working separately [13]. Individuals and groups within communities have local knowledge and experience of hazards and chronic diseases afflicting their neighborhoods and communities. When a collaborative process combines the complementary knowledge of different individuals, agencies, and groups, partnerships can build on community assets tailored to local conditions and connect multiple services, programs, policies, and sectors [14]. By combining the skills and resources of diverse participants, local health departments and their community partners have the potential to take actions that go beyond

the capacity of any single person, organization, or sector and look at issues in relation to each other and the broader community context. These partnerships are especially valuable in addressing the challenging problems of chronic disease and preventable injury.

Models and Tools to Support a Focus on Broader Determinants of Health

A number of models, tools, and projects have been designed to promote and develop best practices for community-based approaches to public health. These include the Spectrum of Prevention Model, the Turning Point Initiative, NACCHO's Assessment Protocol for Excellence in Public Health (APEXPH), NACCHO's Mobilizing for Action through Planning and Partnership (MAPP), and the PPH Initiative. The Spectrum of Prevention has led to an increased focus on collaboration and policy change with tools designed to promote collaboration among diverse stakeholders. The Turning Point Initiative was multifaceted, involving both state and local public health departments, but focused more heavily on state-level public health leadership and systems. APEXPH is an organizational and community self-assessment designed to focus on a "health department's administrative capacity, basic structure and role in its community, and on the community's actual and perceived problems, rather than on technical performance in specific programs or compliance with a set of objective standards [15]." MAPP takes APEXPH a step farther, emphasizing the public health system with its many stakeholders. Collaboration is central to MAPP's strategic planning philosophy.

PPH brought together an emphasis on addressing social determinants of health with the use of CBPH principles. Although the projects described above have resulted in a wealth of knowledge around collaboration and assessment needs, only PPH specifically targeted local public health departments and emphasized

building durable partnerships with community-based organizations. Participating PPH health departments undertook these capacity building efforts without the benefit of state and/or federal collaboration or involvement. The lack of state or federal involvement allowed the health departments a great deal of flexibility and creativity. However, it also meant that there was not an overarching structure in place to guide or sustain the work and to disseminate the lessons learned. Recognizing these challenges, TCE established and funded a PPH Program Office that included significant resources for grantee support, statewide policy development, and advocacy. The Program Office was expected to provide leadership that would enhance, sustain, and increase the number of partnerships created under PPH.

National and local standards and accreditation assessments for local health departments are another important source of strategic planning and assessment guidance. Until recently, performance standards have not focused on community, even in the broadest sense. Recent work by NACCHO attempts to provide standards that assume that local health departments will work closely with community [16]. However these standards do not have indicators and have not been tested.² Lessons from the PPH Initiative may help inform how health departments interpret, prioritize, and implement these standards.

² In the course of this analysis, CCHE has identified several of the Functional Local Health Department Standards that emphasize working on SDOH and collaborating with community, including standards promoting the engagement of community in strategic planning (Standards 4a, 5c, & 7a.), developing relationships with the community and facilitating information exchange (1b & 3b), and promoting community understanding and advocacy for policy that improve public health (4b, 5a, 5b, 6a-c). One notable gap in the standards concerns leadership, given the key role this capacity plays in promoting an SDOH/CBPH approach.

III. Methods

The PPH Initiative’s evaluation team was led by the Center for Community Health and Evaluation (CCHE), working with PPH staff and local evaluators based in each of the health jurisdictions. Since PPH was primarily a capacity-building effort, the emphasis of the evaluation was on intermediate outcomes, including organizational change, community health improvement projects, and policy and systems changes. Data collection and analysis were organized around the five goal areas prescribed by the PPH Office:

- 1) community group capacity building,
- 2) health department capacity building,
- 3) partnership capacity building,
- 4) community health improvement, and
- 5) policy and systems change.

The evaluation included case studies, key informant interviews, surveys, participant observation, focus groups, document review, and a tool designed to assess progress. The evaluation focused on tracking partnership accomplishments and understanding the contribution that the PPH Initiative made to the development of community-based public health in the 39 partnerships. Performance was documented using both qualitative and quantitative measures, including a participatory progress assessment process that provided a quantitative assessment of each partnership’s progress in each of the five goal areas (for a description of the participatory progress assessment process see Appendix A).

Throughout the PPH Initiative, the primary unit of analysis for the initiative-wide evaluation was the individual partnership. The analysis reported here focuses on the health department. A sample of 10 health departments was drawn, including the five that most closely approximated an effective model for working with community partners to influence the social determinants of health³ and the five that had the most difficulty making progress toward this model.

³ The activities of these five model health departments were monitored as a result of participation in the PPH Initiative and are therefore highlighted here. While there may be other health departments in the state of California that engage in activities that optimize this ideal, they were not included in the scope of this evaluation.

IV. Results: Health Department Performance

CORE CAPACITIES

- Leadership
- Financing of CBPH
- Planning
- Organizational Change
- Data
- Communication
- Policy Advocacy
- Dissemination
- Community Readiness to Change

A close examination of the 10 health departments selected for this analysis revealed core capacities associated with success in addressing social determinants of health using a CBPH approach. These included: leadership, financing of CBPH, planning, organizational change, data, communication, policy advocacy, dissemination, and community readiness.

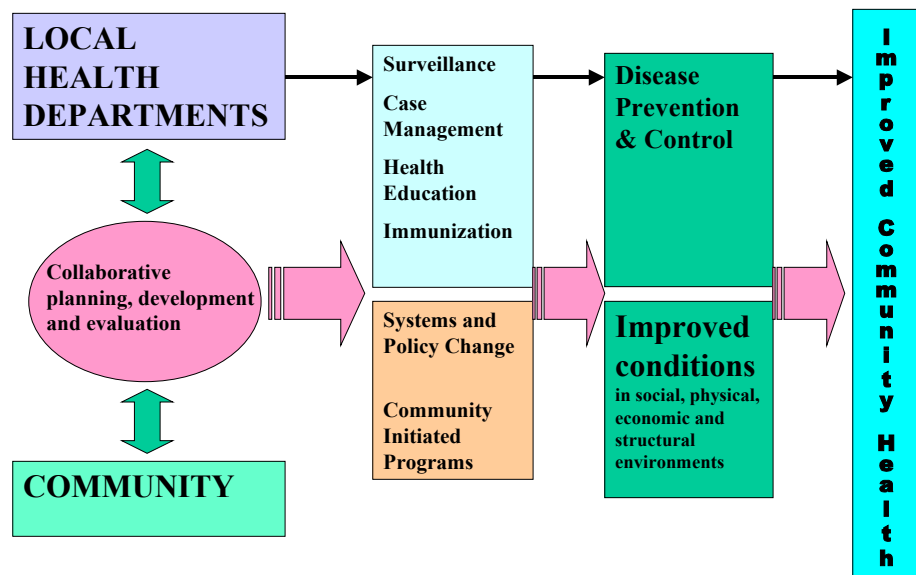
The factor of “place” was built into the PPH design, and found to be an important consideration in readiness and capacity for partnering for both the health department and the community. Each health department had two or three (five in Los Angeles) “places,” or communities where work was targeted. The evaluation detected variation in levels of progress among communities, even among communities partnering with the same health department. The elements of place that contributed to progress are detailed within the core capacities described in this report, as well as in the comprehensive evaluation of the PPH initiative.

The analysis also showed that SDOH and CBPH were mutually reinforcing. Health departments that focused on broader determinants needed to work with an expanded set of community partners and use CBPH principles to engage them effectively. Health departments that worked closely with community groups to prioritize health issues found that the community groups were most interested in addressing social determinants such as employment, education, and the environment. Given the close relationship between the two, we use the term “SDOH/CBPH” in what follows as shorthand to represent the two concepts.

Figure 1 illustrates the different approaches health departments can take to improve community health. The upper track is the approach that has historically been more common, emphasizing disease surveillance, health education, and immunization. Collaborating with community partners around SDOH is a path that many health departments have not taken, for a variety of reasons, but is one that may have the potential to address key public health challenges more effectively.

Figure 1 SDOH/CBPH APPROACH TO PUBLIC HEALTH

SDOH/CBPH Approach to Public Health Practice



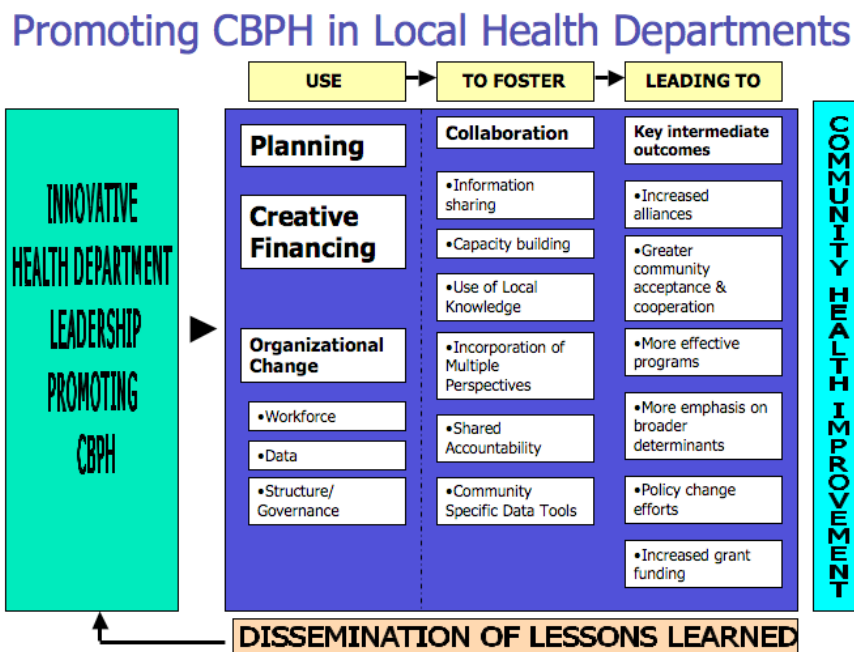
As Figure 1 shows, work in SDOH generally requires partnerships with other community stakeholders using a community-based approach (CBPH). That collaborative work can lead to environmental, systems and policy change, specific community-initiated programs, as well as the more common health department activities (surveillance, health education, etc.). Community health is broadly defined to include social and economic conditions as well as disease.

The SDOH framework adds value and efficacy to public health practice by addressing the root causes of poor health in collaboration with other agencies and community entities. It draws on local knowledge and establishes community support for health department activities. However, it requires the local health department to adopt a new way of working with community and different methods for bringing about change.

Promoting SDOH/CBPH in Local Health Departments

The PPH experience suggests a model for promoting SDOH/CBPH in local health departments. This model is outlined in Figure 2 and elaborated on further in Section IV below. The model highlights the critical importance of health department leaders with a strong commitment to SDOH/CBPH. These leaders use planning, financing of CBPH, and organizational change to promote effective collaboration with community groups.

Figure 2: PROMOTING CBPH IN LOCAL HEALTH DEPARTMENTS



The organizational changes create and sustain more effective community collaborations that in turn lead to a number of community-level changes, including policy and systems changes. Examples of high-impact changes that occurred during the PPH Initiative include: changes in school policies regarding food and nutrition, decreased highway fatalities, increased access to ambulatory care, increased regulation regarding youth tobacco use, funding for a water and sewer project, and development of a park designed to encourage physical activity.

The next section of this report describes in more detail the key elements of the model outlined in Figure 2, providing concrete examples from the PPH experience. Key impacts of these activities and strategies for promoting an SDOH/CBPH approach are also included for each element. It is important to note that while PPH contributed to changes described, the initiative was rarely the sole reason for these changes. The evaluations emphasized documentation of contribution rather than attribution.

Core Capacities that Foster Health Department Performance

LEADERSHIP

Effective leadership was the most important factor contributing to a successful broad-based, community-oriented approach to public health. All the health departments effectively implementing the SDOH/CBPH model (referred to as “model health departments” from this point forward) had dynamic executive leadership (i.e., health director and/or health officer) that was strongly committed to changing the way public health approached its mission. These leaders were skilled at presenting the argument for building strategic alliances to address SDOH with stakeholders — both within and outside of governmental structures — to ensure support for change. Leaders in these

model health departments (i.e., health departments effectively implementing the SDOH/CBPH model) also were willing to take considerable risks in order to work with community (such as agreeing to approach other agencies on the community's behalf) and were flexible when it came to approving the types and/or scope of projects the health department worked on with the community.

In contrast, the health departments that made the least progress toward implementing the SDOH/CBPH model lacked effective leadership. Leaders in those departments were unable to build stakeholder support, were not fully empowered (e.g., lacked budgetary authority or operated under an interim appointment), and/or did not understand/support a SDOH/CBPH approach.

Health departments with strong, innovative leadership were able to reinforce a SDOH/CBPH approach by hiring management and line staff that support community-based approaches, and building the community's leadership capacity. Model health departments have mechanisms for training staff internally and providing leadership training and opportunities for community members, as well.

Governmental support of leadership was also a critical issue. In some model health departments, the county board of supervisors was explicitly supportive of SDOH/CBPH approaches or at least open to considering them. Other model health departments did not have county support and had to find ways to promote SDOH/CBPH approaches despite opposition. The state public health department also did little to support local health departments in advocating for an approach that prioritizes SDOH and working with community. Indeed, health department leaders reported that in many cases, state and federal health departments require that programs be administered

in ways that undermine community-based approaches and follow narrow categorical funding mandates.

IMPACT:

- Implemented innovative approaches to SDOH/CBPH approaches
- Created cultural change within the local health department and in related agencies
- Created organizational change designed to sustain work with community
- Viewed community members as actual or potential leaders and as true peers in community health

ALAMEDA: LEADERSHIP ON MANY LEVELS

The leadership in the Alameda County Public Health Department started at the top with county leadership recruiting a Health Director, Arnold Perkins, with a background in community organizing. Mr. Perkins' commitment to CBPH is a core value he brings to his role, "I could sit in this office and make all the decisions. A lot of them would be the right decisions for the organization—for public health—but the wrong decisions for the community...*I'm an employee of the residents.* I drill into my colleagues over and over again, we are employees of the people that are living in this county. The most appropriate way to be a good employee is to go to my employer's workplace, which is my employer's community, and serve my employer as their employee within the context of their community." As a result of this leadership, the culture in the Alameda health department is gradually changing in support of CBPH. Currently, individuals who have both the skills and commitment to promote CBPH occupy key management positions. The health department also has started a program to build the capacity of line staff to work with community. The Internal Capacity Building project is engaging staff that has historically focused on individual services, such as nutritionists, in trainings that promote population approaches and engage communities, rather than individuals.

STRATEGIES FOR PROMOTING SDOH/CBPH:

- Support the recruitment, hiring, and development of local health department leaders who use SDOH/CBPH approaches
- Support the education of elected officials in SDOH/CBPH approaches to improve community health
- Provide leadership training for local health department leaders and staff who are supportive of SDOH/CBPH approaches but are struggling to effect organizational change
- Provide local health department leaders with evidence and materials that help them make the case for SDOH/CBPH approaches to policymakers, community, and staff
- Provide venues for local health department leaders to share expertise and provide peer support/learning
- Create/support changes in federal, state and local policy environments and institutions that support leadership for SDOH/CBPH
- Support building relationships between PH leaders and leaders in other sectors (e.g. business, media, faith groups, etc.) to work toward common goals for improving community health

FINANCING CBPH

Model health departments were able to find ways around categorical funding constraints in order to support SDOH/CBPH efforts. The models of funding varied due to the uniqueness of each local health department's funding streams, but some general themes emerged. Health departments: 1) built the capacity of community partners to apply for grants that increase health promotion resources, 2) designated a portion of relevant categorical (MCH, HIV, etc.) funding toward work in SDOH/CBPH, and 3) used limited flexible funds to promote the work with communities around SDOH. As mentioned earlier, some of the model health departments had a board of supervisors supportive of broader community-based approaches, making financing easier than for those health departments that had to work around an unsupportive county

MENDOCINO: FINANCING PUBLIC HEALTH THROUGH COMMUNITY

The Mendocino Public Health Department is unique in the extent to which community-based work is funded through grants to community groups. Carol Mordhorst, the health director, has found that building the capacity of community groups to apply for grants allows for the health resources to be more flexible and adaptive to community needs. “I feel like community gets community health much faster and much better than government organizations do.”

leadership. The health departments with the least progress, in contrast, were never able to find the money needed to support work with community. Some, however, were able to support a minimal level of community work on an ongoing basis. The ability to finance work on SDOH/CBPH is closely linked to the leadership’s organizational and networking skills.

Model health departments also distinguished themselves in their ability to leverage PPH resources and experience to bring in additional funding. Two of the model health departments concentrated their efforts on support of community partners in grant writing. In these jurisdictions, community groups received the highest dollar amount of grants, totaling \$1.8 million. Two of the model health departments were selected to participate in TCE’s Health Eating, Active Communities (HEAC) Initiative.

According to the data gathered for PPH, the majority of health departments with the least progress had brought in no additional grant funding to support work with community. In most cases, these health departments did not report having applied for additional grant funding to work with community.

IMPACT:

- Increased funding available for population and community-based approaches addressing SDOH
- Increased capacity and sustainability among community organizations

STRATEGIES FOR PROMOTING SDOH/CBPH:

- Build capacity for health department staff and community stakeholders to develop the advocacy base for deeper public investment in SDOH/CBPH
- Support peer learning among local health department leaders regarding financing strategies
- Build grant writing capacity in both health departments and their community partners
- Investigate and develop methods and policies to increase funding for SDOH/CBPH, including more flexibility in categorical funding and the ability to combine funding streams

PLANNING

All the model health departments demonstrated a strong commitment to community inclusive strategic planning and had used planning processes prior to PPH to develop and promote major organizational change. Planning was used to revise mission statements, make major organizational changes designed to support and sustain work with community, and promote changes in workforce. Three of the five model health departments had used the APEX-PH tool prior to PPH and mentioned its utility in fostering organizational change toward SDOH/CBPH approaches. During PPH, all the model health departments implemented MAPP. Most found the MAPP process to be useful, despite the fact that the tools needed to be adapted to each health department's unique context.

Only one of the health departments with the least progress participated in MAPP. One of the health departments that made the least progress stated explicitly that it did not undertake MAPP because of a lack of organizational readiness, especially in the key area of strong connections to external partners. Another completed an internal strategic planning process, but did not use APEX-PH or MAPP.

A number of elements were required for the PPH planning process to be successful, including strong visionary leadership, organizational capacity (to both engage stakeholders — internal and external — and sustain an often time-consuming assessment process) and dedicated funding.

IMPACT:

- Carried out quality strategic planning processes that resulted in changes in organizational structures and culture
- Initiated and strengthened collaboration with other agencies and community stakeholders through strategic planning

STRATEGIES FOR PROMOTING SDOH/CBPH:

- Support comprehensive and collaborative community health planning processes that require effective leadership and the capacity for change in both the health department and in the community
- Train and mentor health department staff to engage in collaborative strategic planning with communities, focusing on communities where social and environmental inequities are greatest
- Support the continued development of the evidence base for SDOH/CBPH, including practice models in a wide variety of settings
- Change state policy so that funding and technical support is provided for local health departments to engage in strategic planning that includes community and implement resulting plans

ORGANIZATIONAL CHANGE

Changing the organizational infrastructure and governance of a local health department is a crucial step towards promoting SDOH/CBPH. All but one of the model health departments made significant organizational changes (both cultural and structural) to effectively collaborate with community.

Organizational changes included increasing organizational flexibility, increasing the workforce resources dedicated to working with community, creating units or offices designed to work with community partners, and developing mechanisms for community input into health department planning and practice.

CONTRA COSTA: PROMOTING COLLABORATION THROUGH ORGANIZATIONAL CHANGE

The Public Health Division of Contra Costa Health Services has been a leader in making organizational change in support of community collaboration. Most of the health department's units and programs have a community component. However, the Public Health Outreach, Education and Collaborations (PHOEC) Unit demonstrates an even greater commitment to community. According to the health department Web site:

The Public Health Outreach, Education and Collaboration (PHOEC) unit brings together the unique expertise of two key community engagement strategies in CCHS, the Healthy Neighborhoods Project and the Partnership for the Public's Health Initiative. PHOEC provides expertise in grassroots community mobilizing, resident leadership development and building health department-community partnerships to solve complex public health problems.

PHOEC supports CCHS and community residents to work together on community-identified health priorities by:

- Building the capacity of multicultural, under-resourced communities to identify and mobilize around their own public health concerns
- Developing the skills of the health department staff and other relevant institutions to respond to and work effectively with these communities
- Creating and institutionalizing pathways for jointly determining public health priorities and developing innovative and appropriate multicultural solutions
- Providing technical assistance and consultation to other local health departments interested in our community engagement approach.

EXAMPLES OF POSITIVE ORGANIZATIONAL CHANGES

Flexibility

- Increased flexibility and efficiency around hiring processes
- Less prescriptive and categorical job descriptions and responsibilities

Workforce

- Training work force to work with community
- Creating job descriptions and positions designated to work with community (e.g. Community Health Outreach Workers, Community Health Advocates, *Promotoras*, etc.)
- Changing job descriptions to include work with community
- Hiring community members and individuals committed to CBPH

Organizational structure and governance

- Reorganizing to desegregate categorical and/or professional silos
- Creating units specifically designated to work with community
- Creating community advisory boards and other institutional mechanism to solicit input and feedback from community

In contrast, health departments with the least progress struggled to make organizational changes. The changes that did occur were limited in scope, such as customer service trainings, and changes in employee evaluation criteria. Several of the health departments with the least progress had difficulty recruiting and retaining staff due to geographic and economic challenges; the chronic understaffing that resulted was detrimental to any organizational change, especially to those supporting major shifts in philosophy and practice, such as addressing SDOH and CBPH.

IMPACT:

- Increased capacity to work collaboratively
- Institutionalized SDOH/CBPH and community-based approaches and increased likelihood these approaches would be sustained
- Developed leadership for SDOH/CBPH and community-based approaches throughout the health department

STRATEGIES FOR PROMOTING SDOH/CBPH:

- Increase the capacity of health department leadership to make organizational change that reflects values and priorities for SDOH and CBPH
- Focus on crucial areas for change, including: flexibility of organizational processes, workforce policies and practices, and creation of an organizational structure that prioritizes and rewards work with community around SDOH
- Examine models that leverage inter-sector relationships and trans-disciplinary staffing as means to advance SDOH/CBPH
- Provide training in SDOH/CBPH across diverse disciplines in academic settings to prepare and orient multiple sectors for collaboration in CBPH
- Train the public health workforce on evidence-based, or promising practice-based SDOH/CBPH approaches to prevent chronic diseases, injuries, and community health improvement measures, and to integrate these into daily practice across programs

DATA

Model health departments emphasized gathering useful data for community stakeholders over collecting data for scientific purposes. The focus was on providing community stakeholders with data that could be used for strategic planning, grant writing, and policy and systems change. Data also were shared with communities to balance concerns for hot button issues (e.g., teen pregnancy) with issues that represented more significant public health problems (e.g., cardiovascular disease, breast cancer) for specific communities and neighborhoods. All the model health departments had processes for participatory engagement of the community in data collection, analysis, and reporting. They also used data collection capacity to engage in evaluation and strategic planning.

Health departments making the least progress toward the SDOH/CBPH model tended to use a more hierarchical approach to data collection, analysis, and reporting. These health departments had trouble reconciling community data needs and requests with their own concerns regarding data quality, validity, and reliability.

STANISLAUS: USING DATA TO BUILD COMMUNITY CAPACITY

Stanislaus County Public Health has done an exceptional job of engaging communities in data collection, analysis, and reporting. The health department has worked with three PPH communities and three additional communities around data issues. The health department epidemiologists attend community meetings and work in collaboration with community members. The community partners “were involved in this whole process of trying to identify the questions, the tools that we would use. They were excited about it because they understand the importance of data and they understand, even now, when you go to the board or anybody...the importance of data.” Community partners were trained to collect data in their local communities. These local connections increased the health department’s ability to collect data from communities that can be difficult to access.

IMPACT:

- Increased grant funding for community groups as a result of having data demonstrating need
- Supplied data that communities used to advocate for policy and systems changes
- Implemented strategic planning and assessment processes
- Produced community/neighborhood profiles

STRATEGIES FOR PROMOTING SDOH/CBPH:

- Place greater emphasis on producing data that is useful to the community
- Increase the capacity of health departments to engage and work cooperatively with communities around data collection, analysis, and reporting
- Increase the capacity of community groups/members to collect, analyze, and present data

COMMUNICATION

As with data, effective communication strategies around SDOH/CBPH emphasized community engagement in the development and implementation of collaborative approaches to community health. Model health departments communicated *with* the community rather than *to* the community. Communication strategies for these health departments were almost always designed to build capacity or support community needs for policy and systems change. Use of mini-grants and programs to build the leadership and public health capacity of community members were other commonly used approaches.

Communication Strategies

- Mini-grants to community
- Communication of data for community use
- Attendance by health department personnel at community events
- Evaluation training and resources
- Community-friendly resource guides
- Improved Web page content and format
- Trainings for community members regarding HD functions and ways to access services
- Community forums
- Celebrations and health fairs
- Outreach workers (*promotoras*, community organizers, etc.) providing information about HD services, health education, and recruiting community participation
- Workgroups designed to increase influence of community residents in policy and program decisions
- Shared trainings
- PPH-funded liaison
- Leadership and capacity building programs for community members

IMPACT:

- Used communication activities to build community collaboration capacity
- Supplied information that was used to sustain community work around health improvement
- Supplied information to the community that was used to change policies and systems that affect the community's health
- Increased understanding of the health department's role and improved utilization of services
- Increased the extent to which communities felt valued and respected, and community willingness to address issues in partnership

STRATEGIES FOR PROMOTING SDOH/CBPH:

- Encourage culturally competent communication strategies that actively engage the community, with a special emphasis on traditionally marginalized populations
- Provide support for programs that build the capacity of community members to work with the health department around information sharing
- Support venues that focus on SDOH/CBPH models, and provide learning and networking opportunities for health department staff and community stakeholders

POLICY ADVOCACY

As part of their efforts to promote SDOH/CBPH work, model health departments placed a strong emphasis on policy advocacy. This included supplying community residents with the data and information needed to successfully advocate for policy positions, building the community's policy advocacy skills, and providing community advocates with access to decision-makers (including advice on how best to approach decision makers). The need

to work with community to develop advocacy skills and strategies is critical since they are often able to approach state and county decision makers in a way that local health department employees cannot. Community members are seen as representing authentic voices of need from an official's constituency rather than government employees making requests out of self-interest. Examples of policy changes that resulted from effective community advocacy included healthier foods at youth activities and in the schools, changes in the monitoring of environmental pollution, increased regulation of youth tobacco use, changes to the built environment in terms of increased parks and recreation facilities, and changes in access to health care services. Health departments making the least progress toward the SDOH/CBPH model did little to participate in community policy advocacy and the only policy changes that occurred were internal to the health department.

SHASTA: USING DATA AND EDUCATION TO PROMOTE HEALTHY POLICIES CREATES MUTUAL SUPPORT

The Shasta County Department of Public Health has had a number of successes in supporting community groups to advocate for local policy change. Using the Spectrum of Prevention model as a guide, health department leaders see the importance of supporting policy change. Their approach has been to supply community groups with the information and data they need to advocate for policy positions. They also provide social marketing expertise to community advocacy campaigns. Most importantly, they are open to the requests of their community partners and remain ready to support them when issues of importance arise. This approach has resulted in a number of key policy changes around highway safety, nutrition in schools, and the built environment. The flip side of this collaborative approach to policy advocacy is that when funding was threatened, the health department's partners initiated a letter-writing campaign and preserved key organizational structures needed to work with community.

IMPACT:

- Developed the capacity to use policy advocacy as a key tool for community health improvement
- Increased the capacity of community groups to advocate for policy changes
- Changed local policies affecting community health

STRATEGIES FOR PROMOTING SDOH/CBPH:

- Provide training and support for health department leadership and staff to better understand their role in policy advocacy
- Provide training for state and local policymakers regarding public health's role in policy advocacy
- Provide training for community organizations in policy advocacy in support of improved community health
- Support the development of a collaborative, community driven voice and constituency for public health among public health workers, stakeholders, and the general public

DISSEMINATION

There were limited examples of effective dissemination of strategies and lessons learned by the model health departments. While some health departments were able to mobilize resources and energy toward SDOH/CBPH, few were able to allocate time and resources for the dissemination of these strategies. Examples of formal strategies for dissemination of lessons learned included journal publications, development of toolkits, and presentations at national conferences and websites with extensive material on collaboration. More informally, some health departments have shared their strategies through regional conferences (such as the County Health Executives Association of California, or CHEAC) and workgroups (such as the Bay Area Regional Health Inequities Initiative, or BARHII). Some health department leaders

noted a lack of interest in SDOH and CBPH on the part of other local health departments in California, limiting the opportunities for mentorship and for sharing best practices with peers.

The California Department of Health Services also has been slow to recognize the innovations that PPH health departments have championed (op. cit. Contra Costa's Web site is replete with models and tools for CBPH). This lack of uptake is cause for great concern and calls for further engagement with CDHS leadership around this issue.

IMPACT:

- Limited venues for health department leadership to learn about best practices for health departments interested in promoting SDOH/CBPH
- Lack of statewide support for SDOH/CBPH
- Lack of an effective framework for communicating the value of SDOH/CBPH approaches to public health

STRATEGIES FOR PROMOTING SDOH/CBPH:

- Provide model health departments with high-profile venues to share their vision and best practices
- Support model health departments to develop publications and presentations that promote the practice of SDOH/CBPH
- Provide incentives for health departments that are not fully committed to CBPH to participate in workshops and roundtables that demonstrate the value and feasibility of SDOH/CBPH practices
- Find ways to encourage state and federal agencies to take a more active role in supporting development of models and in disseminating lessons learned regarding the SDOH/CBPH approach

- Promote networking and collaboration amongst local health departments around SDOH/CBPH approaches
- Develop and disseminate a set of tools for health departments to utilize SDOH/CBPH approaches and strategies

COMMUNITY READINESS FOR CHANGE

Community readiness can have a significant effect on the health department's ability to collaborate effectively around SDOH. Indeed, community organizations need a number of capacities in order to be strong partners to health departments (see final evaluation report for discussion of community capacity). Recognizing this, most of the model health departments invested significant energy building the capacity of community groups. This included bringing in consultants to assist struggling community partnerships.

Health departments making the least progress were less likely to invest time and resources providing technical assistance to troubled community groups — thus making it more likely that a weak community group's problems would persist (and continue to undermine health department efforts).

Not only were model health departments willing to build capacity, when partnering with a struggling community group, they also were more willing to stick with these groups on a long term basis. For example, in Contra Costa, one of the PPH community groups was newly formed and had a great deal of difficulty building the capacity needed to partner effectively. From the outside, the partnership appeared to be a lost cause. However, the health department continued to participate and a consultant was brought in to assist the partnership. Over a year after PPH ended, the partnership remains intact and has received funding to implement joint projects.

Model health departments recognized that “community” can be defined in many different ways (i.e. ethnic communities, political communities, neighborhood), but found that a place-based approaches were most effective, since people who live in the same place have a large set of issues in common such as schools, safety, environmental hazards, housing, jobs, and transportation. They also found that, while community organizations were an important collaborative partner, connections also needed to be developed with individual community members. Developing leadership in the community allowed for a stronger connection to community and increased the likelihood that efforts could be sustained if a specific community organization was no longer able to continue partnering

IMPACT:

- Strengthened capacity of community groups to partners with health departments on community health issues
- Created partnerships between community and the health department that were productive and were sustained over time

STRATEGIES FOR PROMOTING SDOH/CBPH:

- Provide resources and technical assistance to community groups interested in working with health departments to help them partner effectively
- Support research and development of community-driven models
- Allow enough time for relationships to develop

V. Summary

The PPH Initiative demonstrated that it is possible for health departments to address the social determinants of health using a community-based approach. Several local health departments participating in PPH were able to prioritize upstream prevention and a population-based perspective and collaborate effectively with a range of community-based organizations.

Specific ways in which PPH advanced the areas of SDOH and CBPH included:

- Providing model partnerships that have effectively joined forces to implement programs and institute policy and systems changes
- Reinforcing and increasing capacity in health departments that were already leaders in the area of SDOH/CBPH
- Introducing the SDOH/CBPH approach to health departments and community groups that had not worked together previously
- Providing insights used to shape other TCE Initiatives, especially the Community Action to Fight Asthma (CAFA) program and the Healthy Eating Active Communities (HEAC) Initiative
- Playing a key role in the development of the Bay Area Region Health Inequities Initiative (BARHII), which brings together health department representatives from around the Bay Area to better address the social determinants of health
- Creating a platform of knowledge and skills for working in SDOH/CBPH that successor community health improvement initiatives have and can build upon, including CAFA, HEAC, BARHII, Kaiser Permanente's Healthy Eating, Active Living projects, and many others, some in counties that were not part of PPH

- Influencing NACCHO through the participation of eight PPH sites in the MAPP process. Some of the health departments have been asked to sit on NACCHO committees regarding MAPP
- Providing a numerous lessons related to organizing and evaluating large community-based initiatives
- Demonstrating the ways in which health departments can serve as community anchors, since they have the advantage of being well-established institutions designed to promote the health of local communities

A community-based approach to improve community health that included a focus on the social determinants of health required a number of changes in health department structure and processes. This report outlined nine key core capacities that health departments developed and/or changed in order to allow them to partner effectively with community groups to change local systems and policy in support of improved community health. Of these, **leadership** was the most critical core capacity. Innovative and effective leadership was needed to promote and support changes in all other areas, including financing, planning, communication, policy advocacy, dissemination and promoting community readiness through leadership and capacity building. This report also identified a number of strategies where PPH's ground-level work on models for SDOH/CBPH can inform and advance evolving standards for local public health department practice.

The PPH Initiative highlights the risks and challenges in implementing and sustaining an SDOH/CBPH approach. Broad replicability is still in question, as the PPH model has had limited (although in some cases, noteworthy) uptake by other California health departments. The reasons for this include: lack of discretionary resources in spite of desire to implement changes, a concurrent distracting focus on bioterrorism preparedness, marginal buy-in

from some health department leaders for an SDOH/CBPH approach, and concerns about politics and turf when addressing issues beyond the traditional scope of public health. Furthermore, the PPH model of intensive partnerships with specific, geographically-based communities proved to be extremely time and resource intensive. A number of health departments participating in PPH felt that the model was only practical when certain conditions could be met (e.g. sufficient staff time, expertise, resources, etc).

PPH demonstrated that the SDOH/CBPH approach can be effective in a variety of conditions (rural/urban, supportive/unsupportive local politics, etc.), and can be sustained and replicated. However all participants acknowledged the difficulty of this work and emphasized that substantial time and resources were needed to sustain meaningful community partnerships. Additional follow up in the PPH communities is required to assess the extent to which the partnerships were in fact sustained. Such a “legacy evaluation” would provide valuable lessons regarding factors related to long-term partnership success.

Another important factor in creating and sustaining public health partnerships for promoting the SDOH/CBPH approach is governmental support. While individuals may be partially responsible for their personal health, research is increasingly demonstrating that the environments in which individuals live and work have a much greater effect on their health than the individual choices they make. The costly epidemics of chronic disease and substance abuse have deep roots embedded in community and neighborhood conditions. These conditions are influenced and structured by the built environment, economic, and social life. Given these challenges, state and local public health departments that are able to effectively partner with their communities will be positioned to play key roles in addressing these environmental and social factors. State and federal agencies need to step forward to build and sustain capacity for SDOH/CBPH to improve community health and address the

environmental and social inequalities that produce health disparities. This will require sustained commitment to collaborative models of partnership, and the strategic vision to develop policy approaches and strategies required by a new generation of challenges to the public's health.

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APPENDIX A

Description of the PPH Evaluation's Progress Self-Assessment Process

CCHE used a variety of data collection methods to evaluate the PPH Initiative, including case studies, key informant interviews, surveys, participant observation, focus groups, document review, and a tool designed to assess progress. The focus of the evaluation was on tracking and understanding the contribution that the PPH Initiative made to the development of community-based public health in the 39 partnerships. Due to the variation amongst the partnerships, findings regarding progress and accomplishments cannot be directly attributed to the PPH Initiative. A great deal of contextual data was collected on each of the partnerships, however these data are difficult to fully present in the context of a relatively brief report.

The emphasis of this report is on summarizing the progress made by grantees and the PPH Office toward achieving the Initiative goals, as well as identifying and understanding the factors most responsible for progress and barriers to progress. To capture progress at the local partnership level, Partnership Summaries were developed for the 39 partnerships. In the spring of 2004, local evaluators were trained in preparing the final Partnership Summaries and instructed to use a participatory process with their community groups to update the Summaries. Partnership Summaries include sections that document community characteristics, partnership history, accomplishments to date, factors associated with success (or lack of success) in achieving partnership goals, resident involvement, sustainability, lessons learned, and recommendations.

In order to provide a summary assessment of each partnership's progress, CCHE designed a specific methodology for determining progress in each of the five goal areas: (1) community group capacity building, (2) health department capacity building, (3) partnership capacity building, (4) community health improvement, and (5) policy and systems change. This report presents the final iteration of the progress assessment process, which evolved over the course of the Initiative into a process that solicited input from a number of key stakeholders, including the partnerships. For the 2003 report, the CCHE staff alone assessed progress using the Grant Year 2 data from Partnership Summaries using a scale of high, moderate, and low progress for each goal area. In Grant Year 3, the scale was expanded to high, high moderate, moderate, and low and additional stakeholders were brought into the process, including PPH Office staff, local evaluators, and some grantees. Progress assessments from CCHE staff, PPH staff, and the PPH Office jurisdictional teams were reconciled in order to produce the Grant Year 3 final progress assessment results.

In Grant Year 4, progress assessments were completed using a standardized process that included a grantee self-assessment. CCHE designed tools, criteria, and process guidelines to guide the grantee self-assessment process that took place in each partnership. Local evaluators were trained to lead and document the process and outcomes of the partnerships' self-assessment process. After the grantee self-assessment process was completed, CCHE organized and facilitated a face-to-face discussion among the local evaluator, the PPH program officer, the PPH evaluation coordinator, and at least one CCHE staff member to determine the final initiative-level progress assessment results for each partnership. Information from the Partnership Summaries, the grantee self-assessment tools, progress reports, and the experiences of the local evaluators and the program officers were used to determine the final Initiative

Evaluation Team progress assessment results during these meetings, which occurred during September and October of 2004.

A comparison of the two sets of final assessment results (grantee and Initiative Evaluation Team) revealed that overall grantees were more positive in their assessments and that grantees and the Initiative Evaluation Team provided the same results 48% of the time. However, the results were similar (high vs. high moderate, or moderate vs. low) 77% of the time.

The final step in this process was an offer from CCHE to share the final results of the Initiative scores with the partnerships. Twenty-four partnerships requested and received these results along with customized feedback. One partnership contacted CCHE to discuss its scores. After a telephone meeting with partnership representatives, one of the scores was revised, based on information that had been missing from the Partnership Summary.