

CASE STUDIES IN  
CHRONIC DISEASE  
PREVENTION:  
LOCAL HEALTH  
DEPARTMENTS  
CONFRONT THE  
CHALLENGE OF  
THE 21ST CENTURY

COUNTIES | ALAMEDA | CONTRA COSTA | FRESNO  
LOS ANGELES | NEVADA | SAN DIEGO | SHASTA

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Case Studies in Chronic Disease Prevention:  
Local Health Departments Confront  
the Challenge of the 21st Century

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# INTRODUCTION

The case studies that follow were prepared as background for a conference, *Chronic Disease Prevention in Local Health Departments: The Challenge of the 21st Century*, co-sponsored by the California Conference of Local Health Officers (CCLHO) and the County Health Executives Association of California (CHEAC), held on January 22, 2008 in Sacramento, California.

The title of the conference is both a description of our current situation in public health and a call to action. While the great proportion of preventable illness and premature death in the United States today is attributable to chronic disease, only a small fraction of local health department funding and workforce is dedicated to the prevention of chronic disease. In recent years, categorical programs, especially related to tobacco and nutrition, and time-limited foundation initiatives focused on obesity prevention and asthma, have provided essential building blocks for a more comprehensive approach to chronic disease prevention, but many of these efforts were carried out in relative isolation and lacked the broad base necessary to convert them into a more cogent force.

Against that background, *Chronic Disease Prevention in Local Health Departments: The Challenge of the 21st Century* is a cause for optimism. Its genesis was from the CCLHO Chronic Disease Committee, recently revitalized after a period of inactivity. The committee has assumed new leadership and a commitment to building chronic disease capacity in local health departments, with active participation not only from health officers, but from health administrators and staff who are dedicated to chronic disease prevention in their respective jurisdictions. The co-sponsorship of the conference by CCLHO and CHEAC is itself a reflection of this new and growing consensus.

## Chronic Disease as the Challenge of the 21st Century

Chronic disease accounted for over 70% of all deaths in the United States in 2002-2003.<sup>1</sup> Los Angeles County has documented that 80% of the total burden of preventable illness and premature death is associated with chronic disease.<sup>2</sup> Moreover, since chronic diseases originate in significant part from our social and physical environments, the distribution of chronic disease often reflects underlying patterns of social inequalities that are manifest as health disparities.

Local health departments, however, are hard-pressed to rise to the challenge of chronic disease. For example, although 80% of the total burden of disease in Los Angeles is attributable to chronic disease, only 3% of their budget is dedicated to chronic disease prevention.<sup>3</sup> The situation is even more dire for smaller, rural health departments, where local general fund and other means of support outside of limited federal and state funding streams are minimal at best.<sup>4</sup>

The statutory basis for local health departments and chronic disease is similarly out of alignment with the profile of population health. For example, only two of the 90+ reportable diseases are chronic diseases. In addition, the authorities invested in local health departments through the Health and Safety Code for the control of infectious diseases are not mirrored in similar authorities to address the conditions that contribute to chronic disease.

Perhaps more fundamentally, the challenge of chronic disease goes to the heart of how we understand the origins of diseases and their prevention. Chronic diseases require us to take into account their social etiologies, and how to build a public health infrastructure that is able to focus prevention activities on our social and physical environments. These environmental determinants of chronic disease pose a challenge not only to local health department internal capacities, but also to the kinds of partnerships with communities, non-profit organizations, public agencies and private institutions that local health departments must forge in order to improve the environmental conditions that contribute to chronic disease.

The challenge of chronic disease is not simply how to create new programs, but how to re-think the way local health departments are organized, funded and staffed, how they function and with whom they work in partnership.

## Local Health Department Infrastructure and Chronic Disease Prevention

There are several conceptual frameworks that can help guide local health departments in chronic disease prevention. U.S. Department of Agriculture-funded nutrition programs, for example, use the Social-Ecological Model,<sup>5</sup> as does the Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health (REACH) programs that address health disparities. Particularly in California, many local health departments use the Spectrum of Prevention, which was developed and refined at Contra Costa Health Services and the Oakland-based Prevention Institute.<sup>6</sup> Both frameworks underscore the importance of expanding the scope of prevention activities from individually focused health education to the larger social factors that influence health. As the history of tobacco control has demonstrated, successfully addressing these larger social factors can yield much greater consequences for improving population health.

The case studies provide examples of how some local health departments are attempting to construct capacity to address social determinants of health not only in specific program areas, but through a systematic transformation of their infrastructures. There is no single model or right approach, but these case studies illustrate how some local health departments are attempting to define the path. From the collective experience of local health departments, however, will emerge the new standards of practice for chronic disease prevention that will become permanent features of public health practice over the coming decades.

**Organizational structure.** Local health departments are often organized around categorical funding for specific populations, diseases or risk factors. In part because chronic disease infrastruc-

ture is underdeveloped in general, specific chronic disease programs are commonly dispersed throughout a health department into program areas where they have some other affinity. Tobacco control, for example, can be housed in health promotion, while nutrition is in family health services, injury prevention is part of emergency medical services and asthma programs are integrated with childhood lead poisoning prevention. When local health departments attempt to develop capacities for chronic disease prevention more broadly, such as work with communities or addressing the built environment, they are not always closely integrated with these categorical programs. Similarly, in both urban and rural health departments that have decentralized programs for greater accessibility because of population size and/or geography, the development of centralized capacity for chronic disease prevention is not always well coordinated with more localized community work.

Some local health departments have restructured their organizations to incorporate previously dispersed categorical programs into a single chronic disease and injury prevention unit, with overarching capacities to work with communities, schools, land use planning, etc. Los Angeles and Shasta counties provide examples in both urban and rural settings, although Shasta County subsequently split chronic disease and prevention into two units, with one housing physical activity and nutrition while the other focuses on substance abuse and injury prevention. Contra Costa County has similarly housed its chronic disease and injury prevention programs in two units.

Nearly all of the case studies highlight overtures to land use planning as an important strategy to address the physical environment as host of risk factors for a number of chronic diseases, although the relationship to categorical programs is often unclear. Los Angeles has used strategic planning and leadership development to create a common vision between its centralized Chronic Disease and Injury Prevention Division and decentralized programs in Service Planning Areas (SPAs), while Shasta has attempted to structure coordination between centralized and decentralized programs.

In some instances, local health departments have created specialized units charged with developing and promoting their vision for broad work on chronic disease prevention and health disparities. The Community Wellness and Prevention Program (CWPP) and Public Health Outreach, Education and Collaboration (PHOEC) unit in Contra Costa County, and the Community Assessment, Planning, Evaluation and Education (CAPE) unit in Alameda County are examples. Shasta County's Regional Health Division specializes in building relationships with communities.

**Organizational culture.** Meeting the challenge of chronic disease prevention implies more than rearranging boxes in an organization chart. It also involves creating a collective will to re-think the vision and mission of public health to include the importance of changing social and physical environments that contribute to chronic disease. There are ample reasons to resist this expanded vision, from senior officials whose severe budget constraints make it difficult to even meet current mandates to staff whose training, experience and categorical program subcultures have provided little preparation to address the social determinants of health. The fundamental principle of evidence-based public health, and the incontrovertible evidence about the critical importance of chronic disease, however, require a resourcefulness that can transcend the understandable sources of resistance.

Several of the local health departments featured in the case studies have used strategic planning and leadership development as ways to transform the organizational culture over time. Alameda County, for example, developed strategies to change the organizational culture even before taking on the structural issues. They conducted Public Health 101, leadership development and health equity trainings to create a broader understanding of the importance of social determinants of health and their implications for public health practice. Los Angeles County has used strategic planning and leadership development, including active participation from its Chronic Disease and Injury Prevention Division leadership, to change the organizational culture. Shasta County's strategic planning process

began a decade ago to help shift the orientation of staff toward the social and physical environmental determinants of health. They used the Spectrum of Prevention as a framework, and explicitly made efforts to move program priorities higher up the bands.

Local health departments at the earlier stages of re-tooling their organizations to address chronic disease have also relied heavily on strategic planning. Fresno County, with relatively new leadership, has used its association with five other local health departments in the Central California Public Health Partnership, as well as peer consultations with other local health departments around the state, to inform its strategic planning process focused on

source of support for chronic disease prevention in local health departments. The most comprehensive funding stream was provided through Proposition 99 to support tobacco control, although by design it has been a diminishing resource. The largest source, on the other hand, is for nutrition, but 99% of federal and state funds for local health departments come from the U.S. Department of Agriculture, which places substantial restrictions on their use.<sup>8</sup> Irregular sources, such as Proposition 10 funding for asthma programs, or private foundation initiatives focused on specific diseases and their risk factors, are helpful, but are typically for limited periods and are available to only a subset of local health departments. Other sources of flexible

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establishing a broader vision for public health and chronic disease prevention. They began by clarifying the key functions of public health as a prologue to restructuring the organization. Nevada County began a strategic planning process as a way to gain broader staff and political support for environmental approaches to chronic disease prevention.

Contra Costa County has adopted a unique approach to re-thinking public health, not only in their own department, but among colleagues from other local health departments as well. They created a writers group to help build a revitalizing intellectual culture in Contra Costa County public health. The writers group has also produced important tools for dissemination to other local health departments, including the New Spectrum of Prevention and the Ladder of Community Engagement, as well as monographs on specific public health topics such as health and the built environment, community violence and life-course approaches to improving maternal/child health.<sup>7</sup>

**Financing.** While a statewide revenue stream to support broad approaches to chronic disease is the ideal, categorical funding is currently the primary

funding, such as local general fund or local revenue streams, are similarly limited to a subset of health departments.<sup>9</sup>

Alameda, Contra Costa and Los Angeles counties have all used local sources of flexible funding and foundation grants to supplement their categorical programs. Alameda County passed a ½ cent sales tax specifically to support health services, which includes a small portion dedicated to chronic disease prevention. San Diego County historically had used tobacco settlement funds to support their chronic disease and injury prevention unit. Shasta, Fresno and Nevada counties illustrate the relative difficulty of being in jurisdictions where there is little general fund investment in public health, requiring them to be resourceful in other ways to work beyond the constraints of their categorical programs. Shasta County made the difficult decision to stop doing some things they had done previously in order to free up realignment dollars to reinvest in broad approaches to chronic disease prevention, although the willingness of their board of supervisors to grant such discretion to the public health department is not typical of many other jurisdictions.

Fresno County has determined that they will only seek additional funding that supports their broad vision for chronic disease prevention, which led to a decision to no longer use local match for USDA funds because of their restrictions.

**Workforce.** Chronic disease prevention, particularly a focus on the social and physical environmental determinants, makes new demands on the public health workforce. As local health departments explore relatively new areas of practice, such as land use and transportation planning, parks and recreation, school policies and community mobilization, the training and experience of the current workforce does not always support those directions. Although a substantial momentum around public health and the built environment has been established in California over the last couple of years, for example, it is very rare to have someone who was hired with those skills and that work in mind. Local health departments are faced with the challenge of seeking out and nurturing those employees who demonstrate an interest in these emerging areas of practice and/or recruiting new employees who bring the required skills, while at the same time introducing more general organizational change strategies that make this work central to their mission and culture.

Los Angeles County has made use of a generic Staff Analyst position to recruit staff who have or can develop expertise in urban planning, policy development, public health law, economics, social marketing and advertising, communications, graphic design and other skills uncharacteristic of a health department. Alameda County has made a priority of recruiting staff who have expertise in the communities that have been established as priorities through their health equity work. Contra Costa County has staff responsible for developing public health collaborations. Shasta County has community development coordinators, and they have cultivated skills in land use planning among interested staff. Nevada County, which is still in the early stages of organizational development, has made a priority of hiring people in key management positions who share the broad vision of chronic disease prevention.

**Data.** The challenge that chronic disease poses to local health department epidemiology involves

both staff capacity and sources of data. Some rural health departments do not have a staff epidemiologist, and chronic disease epidemiologists are a luxury that relatively few health departments can afford. Categorical funding for epidemiology is typically restricted to infectious disease control, maternal/child/adolescent health and, more recently, bio-terrorism. Even when local health departments are able to hire chronic disease epidemiologists, however, the sources of data are limited, particularly with respect to social and physical environmental determinants of health. Since only two of the 90+ reportable diseases are chronic diseases,

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it is difficult to monitor trends, although the California Health Interview Survey (CHIS) is attempting to build a longitudinal data base for disease prevalence. Much of the data that highlights risk factors for chronic disease is focused on behavior, such as the Behavioral Risk Factor Surveillance System (BRFSS). While the Environmental Health Investigations Branch of the California Department of Public Health has an environmental indicators tracking project, and the Network for a Healthy California's CX3 program has developed environmental indicators of risk factors for obesity prevention, measures of environmental conditions associated with chronic disease in general are still more likely to be generated locally through original data sources.<sup>10</sup>

Los Angeles County probably has the most developed data capacity of local health departments in the state. In addition to the periodic Los Angeles County Health Survey, burden of disease report and specialized reports on chronic diseases, they have produced reports on childhood obesity and heart disease and stroke by city in part as support for their work with cities on land use and transpor-

tation. They have also developed their capacity to conduct Health Impact Assessments (HIAs) in collaboration with UCLA. San Diego adapted Los Angeles' framework of health indicators for the six regions in their own county, with a particular focus on risk factors for chronic disease. Alameda County's strong emphasis on health equity has led to some pioneering work producing data focused on place, most recently examining life expectancy by census tract, poverty, race/ethnicity and other factors related to the inequitable distribution of disease burden and premature death. Contra Costa County's Community Health Assessment, Planning and Evaluation (CHAPE) unit places a priority on social epidemiology and evaluation rather than routine production of traditional health status reports. Fresno and Nevada counties reveal the uneven data capacity of local health departments in the state. Nevada County only recently received approval to hire a fulltime epidemiologist, who will be charged with producing a county health status report. Fresno County epidemiologists are categorically funded through communicable disease and maternal/child health programs, although they are trying to develop chronic disease data capacity through their regional collaboration with other health departments and the university in CCROPP.

**Political & administrative environment.** The ability of local health departments to respond fully to the challenge of chronic disease is influenced by the political and administrative environments in their respective jurisdictions. Environmental approaches to chronic disease prevention can be difficult to establish in some health departments where public health is part of a larger health or health and human services agency, which often have a service ethos that prevails over the organizational culture. Environmental approaches can also be more difficult in politically conservative jurisdictions, where individual responsibility is regarded as the basis for improving health, while policy advocacy and environmental change are resisted as the misguided efforts of "nanny state" government agencies.

When public health is part of a larger health or health and human services agency, strategic planning can often be guided by customer ser-

vice or other service-oriented principles. The San Diego Health and Human Services Agency strategic planning process is an example. While it is not necessarily at odds with environmental approaches, it can sometimes take a special resourcefulness to establish social and physical environments as priorities along side of providing good services. San Diego has used a board-sponsored county obesity prevention task force and a framework for addressing health disparities as a strategy to insert environmental change into organizational priorities. Contra Costa, on the other hand, has had a consistently positive experience with Contra Costa Health Services strategic planning, where not only the common priority of reducing health disparities has predominated, but a shared understanding of the necessary links between good clinical management and community prevention. There is no simple observation to make about the relative advantages or disadvantages of public health being part of a larger agency, as evidenced by Los Angeles County's recent decision to separate public health from hospitals and clinics, while Shasta County recently decided to create a new combined health and human services agency.

Nearly all of the health departments profiled in the case studies have sought legislative champions in local governing bodies to help gain support for an expanded scope of their work. Health departments in politically conservative jurisdictions have had to adopt strategies specific to their political environments. San Diego, where a considerable portion of the public health workforce has been contracted out, emphasizes public-private partnerships and is using a board of supervisors-sanctioned countywide childhood obesity task force to advance a broad chronic disease prevention agenda. Shasta County initially met resistance over fluoridation of water, but eventually learned how to build a community constituency to help negotiate a conservative political environment. Nevada County is building a base with community leaders and public officials, and is relying on small town values to forge personal relationships and promote healthy living. Fresno, Contra Costa and Alameda counties have been active in regional collaborations of local health departments

which can help establish legitimacy to an expanded scope of public health practice that might be more difficult to establish in a single jurisdiction.

**New partnerships.** The influence that social and physical conditions in neighborhoods have on chronic disease has forced local health departments to re-examine their relationship with communities, and with the public and private institutions that shape those conditions. Much of the existing relationship with communities is formed through categorical programs focused on specific diseases or populations—HIV/AIDS planning council, perinatal council, maternal/child/adolescent health advisory board, etc.—but they do not necessarily establish the basis for work on access to healthy foods at reasonable cost, increased opportunities for regular physical activity, reduced emissions that contribute to respiratory illnesses, improved traffic safety or mixed income housing to reduce social isolation and community violence. Similarly, these issues require new or augmented relationships with public agencies and private businesses whose decisions influence land use, transportation, parks and recreation, education, economic development and housing. Moreover, while local health departments are accustomed to playing a leadership role in the control of communicable diseases, they find that much of their work in chronic disease and injury prevention involves participation in processes led by others (planning agencies and land use, law enforcement and community violence, etc.), where often the initial challenge is to establish the legitimacy of public health's role.

Although the redefinition of relationships with communities has different emphases—community engagement (Contra Costa), community capacity building (Alameda), community development (Shasta), place (Los Angeles), community building (Nevada)—they share in common an effort to broaden their community partnerships to encompass a wide range of issues over time. The meaning of community might vary among jurisdictions, with large, urban health departments more likely to work with specific neighborhoods while smaller, rural health departments are more likely to work with community coalitions representing sub-county regions,

but they have in common an interest in supplementing their specialized and often separate categorical relationships.

Local health departments are also expanding their partnerships with other public and private entities. Cities, for example, have become more important because of their key responsibilities for land use, transportation, housing, parks and recreation, public works and other functions that affect residents' quality of life.<sup>11</sup> While the scale of work with cities varies substantially, with Los Angeles County having eighty-eight cities in contrast to the few cities in Shasta County, nearly all of the case studies reveal a growing interest in work with cities focused primarily on land use and transportation planning. Los Angeles has established a position dedicated specifically to working with cities. Alameda County has a health department employee on the planning commission for the City of Oakland.

There is a similar resurgence of interest in working with schools on broader policy issues, in contrast with the more specialized health education programs or schoolbased clinics that have characterized historical relationships. Los Angeles has created a position dedicated to working with schools. The Director of Student Health Services for the Oakland Unified School District is an Alameda County Public Health Department employee. Nevada County has made schools a priority as they build their community coalitions.

## **Chronic Disease and Health Disparities**

The growing interest in chronic disease prevention is tied inextricably to the concern over health disparities, especially since the social and physical environmental determinants of chronic disease often reflect underlying social inequalities. Stated as one of two overarching national goals in *Healthy People 2010*, the elimination of health disparities, like the effective prevention of chronic disease, is unlikely to occur exclusively through clinical interventions and health education, but must ultimately confront the underlying social factors.

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Several of the case studies illustrate that connection. Alameda County’s organizational change strategy to shift their focus toward the social determinants of health is driven largely by a fundamental commitment to health equity. Contra Costa County’s chronic disease programs have been developed within the context of a health services agency-wide priority to reduce health disparities. San Diego’s chronic disease and injury prevention unit was developed in concert with their commitment to reducing health disparities—the unit was renamed Chronic Disease and Health Disparities. Fresno County’s participation in CCROPP emerged in significant part due to the regional disparities, with the Central Valley having the highest rates of diabetes and obesity in the state. Contra Costa and Alameda counties have joined together with six other bay area health departments in the Bay Area Regional Health Inequities Initiative (BARHII) to transform public health practice in order to reduce health inequities. Los Angeles, Shasta and BARHII are participating in a project funded by The California Endowment and administered through the National Association of County and City Health Officials (NACCHO) to build health department capacity to address health inequities.

### **Next Steps for Chronic Disease Prevention in Local Health Departments**

While the *Chronic Disease Prevention in Local Health Departments: The Challenge of the 21st Century* conference is an important event, it is only one step in what must be a continuing movement to highlight the importance of chronic disease prevention and build strong statewide support for local

health department capacity. Toward that end, follow-up activities to the conference will be conducted over the course of the next year and beyond. Those activities in isolation, however, will make little difference. They will depend on the continued support and involvement of the California Department of Public Health, a productive partnership with public health advocacy groups, strategic investments from private funders, a thriving partnership between CCLHO and CHEAC and strong leadership and commitment from local public health officials.

### **Notes**

1. National Vital Statistics Reports, Vol. 55, No. 10, March 15, 2007.
2. Los Angeles County Department of Health Services, UCLA Center for Health Policy Research. The burden of disease in Los Angeles County. Los Angeles (CA): Los Angeles County Department of Health Services; 2000
3. See the Los Angeles County case study.
4. See a survey of local health department capacity for obesity prevention conducted by Samuels & Associates, <http://samuelsandassociates.com>
5. McElroy KR, Bibdeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. *Health Education Quarterly* 15:351-377, 1988
6. See [www.cchealth.org](http://www.cchealth.org) and [www.preventioninstitute.org](http://www.preventioninstitute.org).
7. See [www.cchealth.org](http://www.cchealth.org)
8. See Nutrition and Physical Activity in California: The Landscape of Funding and the Role of State and Local Health Departments, [www.healthyeatingactivecommunities.org](http://www.healthyeatingactivecommunities.org). The County of Fresno determined that the USDA restrictions were too severe to warrant continued use of local funds to match federal dollars, so they withdrew their participation in what is now called the Network for a Healthy California. (See the Fresno County case study.)
9. See Samuels & Associates, op cit
10. The Bay Area Regional Health Inequities Initiative has developed a conceptual framework for data that attempts to define the broad areas for data development, extending beyond the common mortality, morbidity and risk behavior measures to encompass neighborhood conditions, institutional power and social inequalities. See [www.barhii.org](http://www.barhii.org).
11. See, e.g., [www.healthypanning.org](http://www.healthypanning.org)



## CASE STUDIES

ALAMEDA COUNTY  
CONTRA COSTA COUNTY  
FRESNO COUNTY  
LOS ANGELES COUNTY  
NEVADA COUNTY  
SAN DIEGO COUNTY  
SHASTA COUNTY

The case studies that follow are intended to illuminate some critical issues in chronic disease prevention in local health departments. The jurisdictions were selected to capture examples of urban and rural, north and south, Central Valley and coast, relatively well-established and just getting started. Since there are no formulas, the case studies are not intended to be portrayed as models. They are reflections of local public health officials' best attempts to develop chronic disease prevention capacities under often unique local circumstances and are meant only to provoke thought and discussion among colleagues. Particularly in the absence of adequate statewide resources and support, much of the work at this time is local, so we can benefit from each other's experience and counsel. It is that spirit in which the case studies are offered.

We are especially grateful to the local public health officials who not only gave their time for the interviews, but helped in the editing to make them more accurate reflections of their experience.

ALAMEDA COUNTY

## Vision and Approach to Chronic Disease

The mission of the Alameda County Public Health Department (ACPHD) is “. . . to work in partnership with the community to ensure the optimal health and well being of all people,” which reflects the path they have chosen to pursue their vision of healthy people in healthy communities.

Over a decade ago, ACPHD determined that a medical model emphasizing clinical services, screening and individual education was necessary but not sufficient to prevent chronic disease and eliminate health disparities. As one of the first programmatic shifts to support their new direction, they developed multi-disciplinary community health teams to focus on community-level interventions. Over time, their work with communities and focus on health disparities led to the conclusion that, in order to work with communities with disproportionate burdens of disease on the multitude of issues that affect community health, they had to help those communities build their capacity to take on the work that needed to be done. As a result, community capacity building in priority communities has become a centerpiece of their approach.

Using principles of evidence-based public health, ACPHD has determined that not only the physical environment, but also the social environment and the public policies that create the conditions in which people live, are the larger and more important contributing factors to chronic disease and health disparities. Evidence they have developed in recent years points to education, employment, housing, transportation, discrimination, poverty and exposure to toxic hazards as the major determinants of a population’s health and well-being.

This more comprehensive perspective led ACPHD into a place-based approach to preventing chronic diseases and improving health outcomes. In their view, public health must work in communities and neighborhoods where poor chronic disease outcomes are concentrated. They have begun the slow process of learning how to re-focus public health policy and program efforts to better engage community residents and build community capacity to address

the physical and social conditions that underlie poor health outcomes and health inequities.

## Organizational Strategies

ACPHD has launched a major undertaking to transform the organizational culture, using strategic planning, trainings and leadership development to foster a greater commitment to addressing the social determinants of health and health inequities. As part of that process, division managers are working on a reorganization that better reflects department-wide goals and objectives, as well as applying them to their own program areas.

Currently, chronic disease prevention efforts are primarily housed in two organizational units. *Community Health Services (CHS)* administers a variety of prevention and treatment programs focused on obesity prevention, diabetes, asthma, tobacco, dental services, homelessness, alcohol and drug prevention, and gang violence. In addition to categorical programs that address chronic disease, CHS is centrally involved in department-wide efforts to build community capacity, work with planning agencies on the built environment and promote policy changes to improve neighborhood living conditions.

Most of the department’s health equity work is done with community partners and through complex community-wide coalitions/collaborations. For example, ACPHD is collaborating with community residents, city council staff people, the EPA, and other environmental justice consultants to conduct a health impact assessment on the health consequences of various issues important to community stakeholders. These issues include Port of Oakland policies, industrial land use policies, and proposed developments, including the siting of a power plant in the region. In addition, CHS represents the department in the county’s Everyone Home Plan, a countywide effort to increase the amount of affordable housing in Alameda County. There are also elaborate coalitions addressing asthma, diabetes, and obesity prevention.

*Community Assessment, Planning, Education and Evaluation (CAPE)* is a multi-disciplinary unit

with a centralized capability that includes epidemiologists, demographers, and experts in geographical mapping, as well as community organizers, community health educators and communications experts. The CAPE unit manages a pilot project that is working intensively with two communities with disproportionately high burdens of disease to identify and address their priority social and environment conditions. Providing the evidence base and support for community capacity building, CAPE works with other ACPHD programs and divisions to support the principle that public health must learn from residents and community leaders what they believe are the most pressing concerns facing their neighborhood and what they care most about as a way to build strong and lasting partnerships by combining community perspectives with public health evidence. Community priorities include creating more positive activities for youth, renovating the local parks and streetscape and reducing violence, in particular drug dealing.

To help consolidate an organizational commitment to these developments, a recent reorganization resulted in the creation of a position of Deputy Director of Planning, Policy and Health Equity.

### **Strengths: Public Health Capacities**

**Leadership.** ACPHD senior officials routinely work with the Alameda County Board of Supervisors, city councils, school superintendents, and other institutional partners. As a result of these relationships, there is strong support for public health among public officials. Whenever the department holds community meetings and forums, efforts are made to invite the supervisor of that district to participate in the community discussion. In addition, the department expanded the role of the Legislative Coordinator to include serving as the board liaison. In that capacity, the Legislative Coordinator meets regularly with members of the board of supervisors and their staff to keep policy makers abreast of ACPHD work and priorities. This has resulted in a much stronger relationship between the department and members of the Board.

ACPHD leadership was actively involved in a

campaign to get board of supervisors support to place Measure A on the ballot in 2004, which would increase the local sales tax by 1/2 cent to support health services. The ACPHD leadership team used public health data to brief each supervisor and staff on the importance of chronic disease and health disparities in Alameda County. Measure A was passed by voters, and a portion was used to fund chronic disease prevention programs in ACPHD.

ACPHD is in the early stages of developing relationships with non-traditional institutional partners, including land use and transportation planners, port authority officials, and developers. An ACPHD staff member is on the City of Oakland Planning Commission, which helps advance their work on health and the built environment. Similarly, ACPHD has cultivated relationships with schools, including having an ACPHD employee serve as the Director of School Health Services for the Oakland Unified School District.

ACPHD also works with community residents and organizations to provide data and information that will help them successfully advocate with the board of supervisors on important social and environment issues, as well as helping communities make public agencies more accountable to their priorities. For instance, ACPHD responds to various community members' requests for analysis of the health impacts of planning department decisions. Both the requests and the community groups making them are quite varied, including a coalition of neighborhood groups and pilots concerned about plans to construct two power plants, transportation justice groups interested in the nexus between transit affordability and health outcomes, and a coalition of affordable housing advocates looking for analysis linking the use of redevelopment money to health outcomes. All ACPHD responses include in-depth analysis of available data, as well as written and oral official public testimonies.

**Financing.** ACPHD uses realignment and categorical funding whenever possible to support social and environmental approaches to chronic disease prevention. ACPHD officials were also able to successfully negotiate with the state on the

use of bio-terrorism funds to support some of their community work. They demonstrated that those communities in which ACPHD was involved were the neighborhoods most likely to develop trust and positive relationships with public health and consequently found to be better prepared for any potential bio-terrorism event.

Much of the community capacity building work, however, falls outside even flexible categorical parameters. For example, categorical funds do not

dens of chronic disease. Accordingly, ACPHD has developed a curriculum, Public Health 101, which reviews the basics of public health practice and creates a shared perspective throughout its various divisions. In addition, a more advanced curriculum on health inequities and the social determinants of health, and a leadership development program, are trying to move the entire organizational culture toward a vastly expanded understanding of the mission and practice of public health. The curriculum

“ . . . (A) MORE ADVANCED CURRICULUM ON HEALTH INEQUITIES AND THE SOCIAL DETERMINANTS OF HEALTH, AND A LEADERSHIP DEVELOPMENT PROGRAM, ARE TRYING TO MOVE THE ENTIRE ORGANIZATIONAL CULTURE TOWARD A VASTLY EXPANDED UNDERSTANDING OF THE MISSION AND PRACTICE OF PUBLIC HEALTH. ”

typically cover the costs of community organizing not directly related to a definable health outcome. ACPHD officials, on the other hand, are committed to establishing the importance of the spectrum of prevention and of addressing social and environmental determinants of health, and will continue to advocate with state and federal agencies that fund categorical programs to allow support for a broader range of strategies including, but not limited to, community capacity building.

ACPHD has also had some success in generating local revenue sources. About \$3 million of the \$100 million provided through Measure A (see above), for example, is allocated to ACPHD for chronic disease prevention, reducing health disparities, and promoting school health.

**Workforce.** ACPHD leadership understands that in order to work effectively with communities to reduce health inequities, it is also important to build the health department’s internal capacity to address the social and physical environmental conditions that contribute to disproportionate bur-

denes of chronic disease. Accordingly, ACPHD has developed a curriculum, Public Health 101, which reviews the basics of public health practice and creates a shared perspective throughout its various divisions. In addition, a more advanced curriculum on health inequities and the social determinants of health, and a leadership development program, are trying to move the entire organizational culture toward a vastly expanded understanding of the mission and practice of public health. The curriculum

includes specific focus areas on class, racism and other sources of social inequalities that are reflected in patterns of health inequities. Skills in community capacity building are particularly emphasized. ACPHD has hired people from priority communities specifically because they know the neighborhoods, and they have trained staff in community capacity building to further reinforce the primary importance of working with communities.

**Data.** ACPHD has also made a priority of producing evidence to support and guide their expanded vision of public health practice. They have produced health status reports that increasingly focus on health inequities, using GIS mapping and other methods to demonstrate the inequitable distribution of the burden of disease. In addition, working with colleagues from other bay area health departments through the Bay Area Regional Health Inequities Initiative (BARHII), they have produced a social gradient analysis that looks at life expectancy by census tract, which also shows the significant influence of income inequality, race/ethnicity, education

and home ownership. ACPHD is using the BARHI conceptual framework to help guide their data development through the CAPE unit.

The CAPE unit is the basis both for the production of innovative data reports, and supporting the development of a corresponding public health practice that can better address the social and physical environmental factors that influence health.

## Lessons

ACPHD has made a strong commitment to the principle of evidence-based public health. They created a strong epidemiology unit to not only analyze traditional public health data bases of morbidity and mortality, but began to explore the social and environmental conditions that lead to preventable illness and premature death. They have also explored reasons for the inequitable distribution of the burden of disease, and made health equity a central focus of their work.

ACPHD has also combined a concern for a different public health practice, emphasizing community capacity building, healthy public policy, public health capacity and developing partnerships with key public and private institutions whose policies affect neighborhood living conditions, with a concerted effort to shift the orientation of the workforce and internal organizational culture to support this vision of public health practice. (See Framework for Change on ACPHD website)

They have also made a systematic effort to build support among key public officials as they take the scope of public health practice into largely uncharted territory. In many jurisdictions, it can provoke great risk when involving a local health department in land use planning, school policies, redevelopment or other matters not traditionally regarded as the domain of public health. ACPHD has combined a willingness to take those risks with a political savvy to gain key support for the enlarging scope of public health concerns.

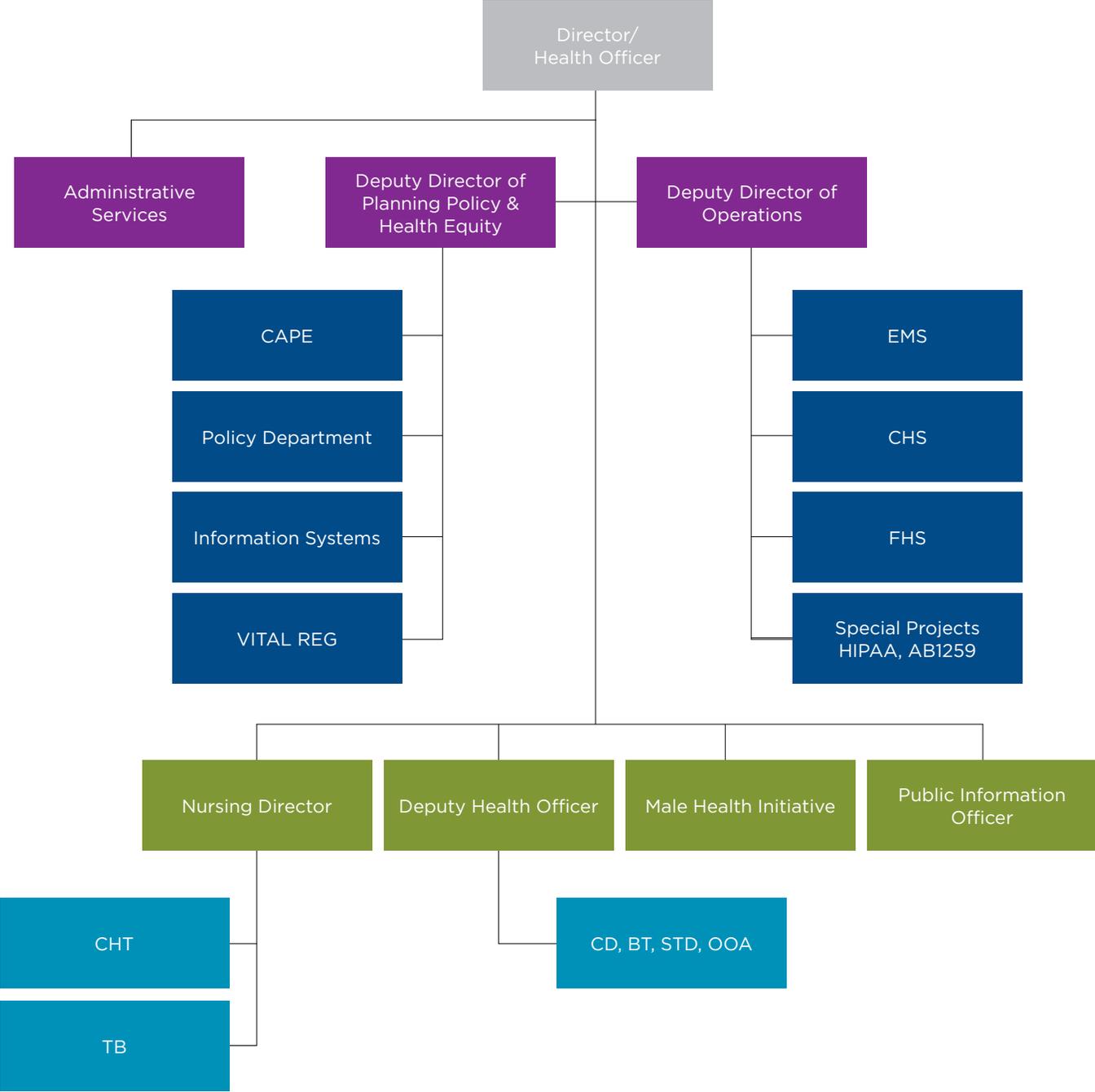
The department is beginning to look at effective ways to expand the continuum to include not only downstream direct service but also more upstream strategies within the context of existing categorical

programs and with existing staff. ACPHD realizes it is relatively easy to create the “sexy” program on the side that embodies new approaches and strategies, but changing public health practice within a local public health department will require a more complicated process. Changing public health practice necessarily means re-training staff, re-thinking partnerships and integrating new approaches into the existing categorically funded work.

## Resources

Alameda County Public Health Status Report found at: [http://www.acphd.org/AXBYCZ/Admin/DataReports/00\\_chsr2006-final.pdf](http://www.acphd.org/AXBYCZ/Admin/DataReports/00_chsr2006-final.pdf)

# Alameda County Public Health Department



CONTRA COSTA COUNTY

## Vision and Approach to Chronic Disease

The vision of the Contra Costa Health Services Department affirms that chronic disease prevention efforts require multiple layers of policy development and must include all sectors of the health system if it is to succeed in reducing morbidity and mortality related to chronic diseases:

*To control chronic disease and to address health disparities, there must be universal health coverage, delivered through organized health systems using a chronic care model, coupled with adequately funded community programs directed at the environmental determinants of health.*

The health services department's commitment to chronic disease management and prevention encompasses direct patient care, administration of a health plan (county organized health system), adoption of a chronic care model and commitment to community-based approaches to addressing the environmental determinants of health.

It is the primary role of the Contra Costa Public Health Division (CCPHD) to focus on the environmental determinants, in coordination with other programs in the health services department. CCPHD's work is guided by the recognition that chronic disease is the leading cause of morbidity and mortality, supersedes communicable disease as the leading public health issue and is the leading cause of health inequities.

## Organizational Strategies

CCPHD created its first prevention unit in 1982, where the Spectrum of Prevention was developed as a framework to help guide and direct the design and implementation of primary prevention programs. With lessons learned over the last decade, CCPHD updated the prevention framework by adding a band related to mobilizing neighborhoods and communities and renamed it the New Spectrum of Prevention: A Model for Public Health Practice ([www.cchealth.org](http://www.cchealth.org)).

The New Spectrum of Prevention now includes:

- Influencing policy and legislation

- Mobilizing neighborhoods and communities
- Fostering coalitions and networks
- Changing organizational practices
- Educating providers
- Promoting community education
- Strengthening individual knowledge and skills

In recognition of the central importance of working with communities on the environmental determinants of health, the New Spectrum of Prevention has since been augmented by the development and publication of the Ladder of Community Engagement. While the New Spectrum of Prevention provides an overall framework for prevention, the Ladder of Community Engagement ensures that community residents, leaders and non-traditional partners play a key role in identifying and addressing the factors that most affect community health.

CCPHD includes the following programs:

- Clinic Services
- Communicable Disease/AIDS
- Public Health Laboratory
- Family, Maternal and Child Health
- Homeless Programs
- Older Adult Program
- Public and Environmental Health Advisory Board
- Hazardous Materials Commission
- Community Wellness and Prevention Program
- Public Health Outreach, Education and Collaboration
- Community Health Assessment, Planning, and Evaluation

In 1996, Contra Costa Health Services Public Health Division re-organized and invigorated its emphasis

on primary prevention by creating the Community Wellness and Prevention Program (CWPP). Housed within the CWPP unit are some of the key programs that address chronic disease:

- Asthma Prevention
- Injury Prevention
- Tobacco Prevention
- Lead Poisoning Prevention Project
- Obesity Prevention
- Nutrition and Physical Activity Promotion
- Advisory Boards
- Built Environment

Also created was a specialized unit called Public Health Outreach, Education, and Collaboration (PHOEC), which includes the Healthy Neighborhood Project and Violence Prevention. PHOEC's roles include:

- Working directly with residents in communities with the highest risks to identify their interests and help build their capacity to address health disparities;
- Consulting and supporting direct service programs within the health services department to better engage and respond effectively to community priorities;
- Creating bridges and pathways among communities, community collaboratives and CCPHD; and,
- Promoting a community dialogue process within categorical program mandates such as violence prevention and environmental justice.

CWPP and PHOEC work together and with all other CCPHD programs to become more conscious about how the New Spectrum of Prevention and the Ladder of Community Engagement can be woven into the fabric of all programs CWPP and PHOEC are also both involved in environmental justice and community engagement efforts.

CCPHD determined early on that it helps their prevention mission to have distinct programs that are highly visible and that can operate without rigid funding limitations. CWPP and PHOEC provide a critical mass of programs that directly address prevention and help reinforce the more specific prevention efforts being accomplished by traditional categorical programs. The visibility and influence of CWPP and PHOEC far exceed their small percent of the total CCPHD budget.

### **Strengths: Public Health Capacities**

**Leadership.** CCPHD has significantly benefited from having consistent high-level leadership over the last 25 years. Senior officials are highly visible and not only exercise leadership within the health services department, but also with other public agencies, advisory boards, board of supervisors, city councils, community-based organizations and community leaders. CCPHD officials also exercise leadership with other health departments through active participation in regional and statewide organizations, and through policy advocacy. CCPHD enjoys strong support from the board of supervisors and many city council members.

One unique method in which CCPHD influences statewide public health practice is through the documentation, publication, and distribution of monographs on chronic disease prevention and public health models that describe their experiences, innovations, and lessons learned. Members of a writers group enjoy the intellectual stimulation that comes from engaging with each other to clarify, understand and articulate what has actually been accomplished. Documenting and sharing these experiences with other counties in California and United States provides recognition and appreciation that also helps reinforce the county's commitment to prevention work. The widespread distribution of CCPHD monographs has built internal integrity, confidence and commitment to continued learning and professional development within the organization. The writers group includes members from throughout CCPHD, who enjoy the process of inquiry and reflection about innovative actions

taken within public health, mistakes made, challenges solved and lessons learned

**Financing.** CCPHD braids general fund and realignment dollars with categorical funding streams to diffuse an emphasis on prevention throughout every categorical program, and to allow flexibility. Staff in categorical programs are encouraged to incorporate the New Spectrum of Prevention and the Ladder of Community Engagement into their work. Even if a categorical program may work on only one or two bands of the New Spectrum of Prevention or rungs of the Ladder of Community Engagement that are most realistic within their program restrictions, managers can appreciate through these models how their work fits into a more holistic public health

Engagement. Public Health Monographs developed by the writers group are shared with all members of the health services department. Since there has been recent staff turnover and mobility, CCPHD plans to conduct a new round of training and orientation on their prevention framework and chronic disease prevention work in the near future.

The PHOEC unit is building capacity within the health services department as well as within communities to appreciate the value of community involvement and to develop the skills needed to lead community engagement activities. They have trained almost all public health staff in *The Dialogue Process*. The CWPP program regularly holds staff development programs on issues such as the built

“ (CONTRA COSTA COUNTY) . . . BRAIDS GENERAL FUND AND REALIGNMENT DOLLARS WITH CATEGORICAL FUNDING STREAMS TO DIFFUSE AN EMPHASIS ON PREVENTION THROUGHOUT EVERY CATEGORICAL PROGRAM, AND TO ALLOW FLEXIBILITY. ”

effort. Program leaders are encouraged to form alliances with other community-based organizations or public agencies to take on those bands of the spectrum not feasible within their particular program and funding constraints.

Private foundation funds are blended with county, realignment, and categorical dollars to allow more flexibility in working with communities. This blending allows staff to spend time working with collaboratives and partnerships as well as engaging community members. Even the various health emergency funding streams can legitimately help support ongoing community engagement and collaboration strategies, which will prove invaluable in responding to any community disaster.

**Workforce.** Over five years ago, all CCPHD employees were trained on the New Spectrum of Prevention, and later on the Ladder of Community

environment, promotoras and African- American health conductors, and other emerging strategies, to which all CCPHD staff are invited.

**Data.** CCPHD has established a Community Health Assessment, Planning and Evaluation (CHAPE) unit, which organizes data into reports responsive to requests from program managers and provides coaching and consultation with program leaders on evaluation design and implementation. With an emphasis on social epidemiology as well as traditional public health data analysis, CHAPE helps CCPHD leadership design and evaluate programs directed at environmental determinants.

### Challenges

One of the major challenges that program staff face is that policy makers and the general public do not feel the sense of urgency about chronic disease

prevention that is associated with infectious disease or emergency preparedness. CCPHD has not yet developed a compelling way of helping people realize what can be done in the present to prevent future suffering and poor quality of life due to chronic diseases.

The CWPP and PHOEC units are not tied to categorical funding streams and must spend much of their time on resource development. Because there is no dedicated funding stream for engaging and mobilizing communities, program managers can end up chasing funding instead of focusing on their own and the community's priorities. It can be hard for program managers faced with funding shortfalls to ignore funding opportunities that might be accessible but not appropriate, in order to maintain a focus on the public health priorities.

Chronic disease prevention requires a holistic approach, which can be complicated and difficult to communicate, implement and/or fund. While holding onto the big picture, CCPHD staff are required to be ready and willing to exploit an unexpected funding opportunity or program development option that may only incrementally increase the achievement of their countywide prevention vision and goals.

## Lessons

CCPHD has learned how valuable and important it is to work directly with community residents and organizations to address social and environmental conditions that interfere with healthy living. CCPHD has learned that success depends on their ability to build trust with community leaders. Building trust requires first of all that public health leaders demonstrate their willingness to listen and to hear what the community is asking for, share some of the power and decision making, be reasonably responsive, and not promise more than can be delivered. The bond between CCPHD and the community is more likely to form if public health staff recognize, believe, and act as if community members have expertise and the sophistication needed to help solve the communities' priorities.

## Resources

All publications mentioned in the case study are available at [www.cchealth.org](http://www.cchealth.org).



FRESNO COUNTY

## Vision and Approach to Chronic Disease

It is the vision of the Fresno County Department of Community Health (FCDCH) that *all people in Fresno have access to a healthy lifestyle*.

The approach to chronic disease prevention is based on an array of interventions, including health education, social marketing and county, regional and statewide policy development. FCDCH has made a priority of working with coalitions, forming partnerships with communities and schools and seeking out non-traditional partners to jointly address the built environment and its contribution to the health and well-being of Fresno communities.

## Organizational Strategies

Over the past 20 years, FCDCH has attempted to make the most of categorical programs as a base to provide chronic disease risk reduction through health education focused on lifestyle and behavior change, particularly in relation to nutrition, physical activity and early, periodic screenings for children and families. Early demonstration projects addressed chronic disease risk reduction for cancer, diabetes, and heart disease and focused mostly on individual behavior change as required under strict funding guidelines regarding program activities and eligible populations. The programmatic base included 5-a-day for Better Health, which emphasized nutrition education, social marketing and coalition building for cancer risk reduction; Project LEAN Central Valley to promote healthy eating and physical activity strategies for low income communities and schools; On the Move to address physical activity needs of underserved populations, including walking clubs in local Parks and Recreation Departments; California Nutrition Network for nutrition education; and, tobacco prevention, which supported activities ranging from individual behavior change, social marketing and coalition building to work on policy and organizational change.

Current chronic disease prevention programs, housed within the Education and Prevention Services Division, address tobacco, women's health, diabetes and obesity prevention. While chronic

disease prevention programs encompass the entire Spectrum of Prevention, the two largest program areas, obesity prevention and tobacco control, are most heavily focused on organization and policy change. Staff in the Education and Prevention Services Division are also taking the lead on health and the built environment in Fresno County.

Two years ago, FCDCH initiated a department-wide strategic planning process with the goal to reorganize programs and services to more efficiently and effectively use categorical and realignment funding and staff expertise. The planning process has been highly inclusive bringing together the senior management team representing central administration and each FCDCH division (see attachment on Vision, Mission, and Values). As a result of the last two years of planning, FCDCH has achieved a department-wide consensus on the major functional areas of public health (see attached). The strategic planning group will next determine how each of these functional areas will be organized, funded, and held accountable for improving health outcomes.

## Strengths: Public Health Capacities

**Leadership.** FCDCH senior officials have become visible and articulate spokespeople for public health and disease prevention, including efforts to focus policy makers' attention on the relationship of obesity and chronic disease to the design and construction of the built environment. They participate in county, regional and statewide organizations and activities promoting the need for public health to partner with non-traditional partners from city and county planning departments, as well as with developers and builders to jointly address the impact of the built environment on community health.

They are involved in the regional blueprint planning process currently underway in the Central San Joaquin Valley. They are also actively involved with CCLHO and CHEAC, and with the California Department of Public Health, to establish a sustainable funding source to enable local health departments to pursue comprehensive approaches to obesity and chronic disease prevention.

FCDCH has successfully cultivated support from the Board of Supervisors, which actively champions health issues. They also work with community leaders and community based organizations that regularly advocate on behalf of healthy eating, physical activity and obesity prevention efforts.

FCDCH participates actively in the Central California Public Health Partnership with other Central Valley health departments and California State University, Fresno. As they develop strategies to advance funding, work on the built environment and engaging non-traditional partners, public health directors, health officers and staff are meeting with leaders from among city and county planners, builders and developers, and transportation, education, and public safety officials. Through this partnership, FCDCH is better prepared and ready to take action when new funding opportunities and environmental conditions emerge that is aligned with their county-wide vision, goals and outcomes.

FCDCH has used the regional partnership to advance its work on obesity prevention through the Central California Obesity Prevention Project (CCROPP), funded by The California Endowment. They have taken advantage of the additional support, training, and technical assistance provided through the regional partnership, as well as expand their peer consultations with Los Angeles, Shasta and Contra Costa counties to further develop their chronic disease prevention capabilities.

**Financing.** FCDCH relies primarily on state and federally funded categorical programs and realignment to support their work on chronic disease prevention. With limited funding, they have made a decision that they will only seek funds that are aligned with and support their vision, goals, and desired outcomes. Accordingly, FCDCH did not reapply for California Nutrition Network funds in 2005 because U.S. Department of Agriculture restrictions limits their ability to provide comprehensive efforts to promote healthy eating and active living through environmental change.

FCDCH has pursued grant funding to help develop their chronic disease prevention capacity. They receive funding from The California Endow-

ment through CCROPP, as well as a grant from Kaiser Permanente.

**Workforce.** The department-wide strategic planning process and FCDCH involvement with the Central California Public Health Partnership have created opportunities for increasing cross-categorical program communication and better coordination of internal resources on behalf of obesity prevention. FCDCH continues to build capacity in ways to address the built environment, as it also pursues strategic planning to better utilize its available staff and funding resources. FCDCH's work plan in CCROPP includes a goal in the area of workforce capacity building to address obesity prevention.

**Data.** FCDCH epidemiology functions are primarily funded through categorical programs, including state Maternal and Child Health, HIV/AIDS and other communicable disease and emergency preparedness. Epidemiology functions are currently used exclusively in these areas within FCDCH, which limits access to data analysis relevant to chronic disease prevention. Through the Central California Public Health Partnership, an inter-departmental leadership group has been formed to explore what can be done to assemble data that better informs work on chronic disease and the built environment. One avenue being explored is how to increase FCDCH's ability to more critically examine their own client data and learn more about the chronic disease risks that exist among Fresno County residents who use their services.

“ WITH LIMITED FUNDING,  
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DESIRED OUTCOMES. ”

## Challenges

FCDCH's greatest challenge is the lack of discretionary funding that supports a comprehensive, environmental approach to chronic disease and obesity prevention. For the past two years, much of the built environment work has been supported with realignment funding; however, the funding level has been reduced and competing priorities within FCDCH for realignment support have increased. In particular, FCDCH houses not only the community health activities of a local public health department, but also the county's environmental health services, emergency services, and jail medical services, all of which rely on some degree of realignment support. Although chronic disease prevention is a top priority, it must compete for limited funding with other mandates and priorities.

FCDCH is similarly challenged by public health competing with other priorities in the county. Although the Fresno County Board of Supervisors supports FCDCH, it does not allocate county general funds to chronic disease prevention or efforts to improve the built environment. Few constituents are demanding obesity prevention programs, but many are asking for funding to support mental health and police services.

## Lessons

FCDCH has learned how important it is to develop allies and champions for health. One year, the Chair of the County Board of Supervisors partnered with FCDCH as a spokesperson for healthy eating and active living promotion. FCDCH has taken every opportunity to discuss its vision and goals around the built environment as well as the critical need for sustainable funding for obesity prevention efforts with local legislators and state officials. FCDCH's well-established partnerships with community-based organizations, a regional nutrition network, and the American Cancer Society has provided them with able and willing spokespersons that advocate with local decision makers on behalf of community health issues.

FCDCH values and uses the lessons learned by its colleagues in other local public health depart-

ments. Los Angeles, Shasta, and Contra Costa counties, among others, have helped to inform FCDCH's strategic planning process through information gained from strategic planning documents, conference speakers and workshops.

Most importantly, FCDCH has learned from the initiative it has taken in the built environment arena, regardless of funding availability. FCDCH retains a strong commitment to work with community partners to identify significant public health needs and to strategize solutions for long-term change within Fresno County.

## Resources

See the Fresno County Department of Community Health Organizational Chart and the Public Health Functions Vision, Mission and Values Statement on following pages.

[www.fresnohumanservices.org/communityhealth/](http://www.fresnohumanservices.org/communityhealth/)

# Fresno County Department of Community Health

## Public Health Functions



\*Example of Executive Functions: Director Responsibilities, Health Officer Duties

\*Example of Administrative Functions: Personnel Services, Facilities, Contracts, Purchasing

\*Example of Health Care Services: Indigent Services Contract, Medi-Cal Managed Care, Jail Medical Services, CA Children's Services.

\*Example of Community Health: Public Health Nursing, MCAH, Communicable Disease, EPS

\*Example of Emergency Preparedness and Response: OES, EMS, BT and related grants

\*Example of Service Support Functions: Public Health Lab, ACU, ISD





## Fresno County Department of Community Health

### Core Purpose

To promote, preserve and protect the well-being of the community and to ensure the optimal health of the public.

### Vision

The Fresno County Department of Community Health is the recognized leader in addressing the public health needs through: employee integrity, dedication, knowledge and expertise; exemplary service to our diverse community; and effective community partnerships.

### Mission

The mission of Fresno County Department of Community Health is the promotion, preservation and protection of the community's health.

We accomplish this through identifying community health needs, assuring the availability of quality health services and providing effective leadership in developing public health policies.

We are committed to working in partnership with our communities to eliminate health disparities.

### Values

We hold the following values in the Department of Community Health:

<b>Accountability</b>	Acceptance of ownership and responsibility of actions.
<b>Adaptability</b>	Responsiveness to ever-changing needs.
<b>Creativity</b>	Thinking in innovative ways.
<b>Integrity</b>	Demonstration of consistent, credible character and honesty.
<b>Mutual Respect</b>	Acknowledgment of individual differences and demonstration of patience and acceptance.
<b>Professionalism</b>	Knowledge, competence, discipline and commitment.
<b>Teamwork</b>	Coordination of effort for collective efficiency and effectiveness.

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LOS ANGELES COUNTY

## Vision and Approach to Chronic Disease

The mission of the Los Angeles County Department of Public Health is to “. . . protect health, prevent disease, and promote health and well-being.”

In particular, it is the vision of the Chronic Disease and Injury Prevention Division that “*Los Angeles is a place where social and physical environments and societal conditions provide all children and adults with maximum opportunity to live healthy lives.*”

Although chronic disease was established early as an organizational priority in Los Angeles County, it was further bolstered by a seminal burden of disease report (2000) which indicated that 80% of preventable illness and premature death is associated with chronic disease. A subsequent strategic planning process surfaced three priority action areas for chronic disease and injury prevention:

- Obesity prevention, including both individual and community-level programs;
- Physical environment, including land use, transportation and air quality; and,
- Social environment, including housing, social connection and health disparities.

As both the vision statement and strategic planning priority action areas indicate, Los Angeles County has concluded that the most effective approach to chronic disease prevention must include a focus on the social and physical environments.

## History

Los Angeles County had created a Chronic Disease and Injury Prevention unit in the late 1990s, but was forced to partially dismantle it as a result of record state deficits that cascaded down to local health departments in the early part of the current decade. However, a combination of partial financial recovery, political support from the board of supervisors and a local revenue source enabled Los Angeles County to reconstruct its Chronic Disease and Injury Prevention unit in 2005. In addition, the board of

supervisors created a new Public Health Department in 2006 which, among other things, allowed the former Public Health Division to emerge from the shadows of recurring hospital deficits when it was part of the larger Los Angeles County Department of Health Services.

With new leadership, supported by strategic planning, a leadership development process and a more secure revenue base, chronic disease and injury prevention has a more stable position within the priorities of the still relatively new Los Angeles County Public Health Department.

## Organizational Strategies

Los Angeles County has created its revitalized Chronic Disease and Injury Prevention Division in part by relocating key categorical programs within a single administrative unit. Taking its place among other public health divisions—maternal/child/adolescent health, alcohol and drug program administration, communicable disease control and prevention, emergency preparedness, and environmental health—the Chronic Disease and Injury Prevention Division is based largely on major groupings of risk factors rather than diseases:

- Nutrition
- Physical activity
- Tobacco
- Violence and injury
- Senior health
- Policies for Livable, Active Communities and Environments (PLACE)

The specific program areas have been supplemented with overarching capacities to address cities and communities, schools, businesses, communications and research.

Los Angeles County has also institutionalized a strong connection between the evidence base for, and program response to, chronic disease. The current Director of the Chronic Disease and Injury Prevention Division was previously Director of the Health Assessment and Epidemiology Division,

which is a fortuitous reinforcement of an organizational commitment. Much of the work in the early stages of the reconstituted Chronic Disease and Injury Prevention Division has been buttressed by specialized data reports to support emerging areas of practice, including heart disease and stroke by city and a report linking childhood obesity to place, which provide an evidence base for work on the built environment.

The PLACE unit is an important example of Los Angeles County's commitment to work on the built environment. It has launched a campaign to encourage employers to adopt healthier policies for vending machines and meetings, is conducting Health Impact Assessments (HIAs) to measure the potential health consequences of public and private policy decisions and has initiated a mini-grant program that enables cities and community-based organizations to work together to improve neighborhood physical environments. PLACE has also made a concerted effort to learn important lessons from its sibling programs in the Chronic Disease and Injury Prevention Division, including work with cities on key policy issues (tobacco), safe routes to schools and pedestrian safety (injury prevention and senior programs).

The Chronic Disease and Injury Prevention Division is also exploring ways in which centralized categorical programs and their overarching functions can work more effectively with decentralized programs in the Service Planning Areas (SPAs). While the centralized/decentralized coordination is not unique to Los Angeles County, the sheer size of SPAs, which are larger than most California counties, creates its own set of challenges.

### **Strengths: Public Health Capacities**

**Leadership.** The commitment to chronic disease prevention has had active and consistent support from senior leadership in the Department of Public Health. With encouragement from public health leadership, *LA Care*, the public sector Medi-Cal managed care plan, has invested a million dollars in community benefit funds to support expanded tobacco cessation efforts, and is considering addi-

tional funding to support efforts to reduce childhood obesity. In addition, key support has been established on the board of supervisors, which has backed important initiatives from creating a new Department of Public Health to mandating the provision of calorie and other nutrition information on restaurant menus.

Leadership on chronic disease prevention is not confined to senior officials. Through strategic planning and leadership development processes, a common vision for an approach to chronic disease prevention that emphasizes changes in the social and physical environments has been more broadly embraced.

**Financing.** In spite of committed leadership from senior officials and political support from the board of supervisors, funding dedicated to chronic disease prevention still represents only 3% of the Los Angeles County Public Health Department's budget, even though it accounts for 80% of the total burden of disease. A local revenue created with the support of the board of supervisors made it possible to reconstitute the Chronic Disease and Injury Prevention Division, but funding for its program base is still largely categorical, and the overarching functions are still minimally funded at best. Although Los Angeles County is often viewed by smaller, rural jurisdictions as having the luxury of local financing to support chronic disease prevention, they too must contend with funding levels dramatically at odds with the burden of chronic disease and are working with public health colleagues from around the state to create new and adequate funding streams.

**Workforce.** To support a significantly expanded vision for public health practice with respect to chronic disease prevention, the Los Angeles County Department of Public Health is attempting to develop a multi-disciplinary workforce that includes skills in urban planning, policy development, public health law, business and communications. In addition, they want to expand their epidemiological capacity to include more innovative approaches to measuring elements of the physical and social environments that affect health, and in communications and graphic design to more effectively convey their messages.

As is the case in other jurisdictions, the workforce skills required are often at odds with civil service categories and the professional training of the current staff. Los Angeles County has made use of the general classification of Staff Analyst that allows them to design specific job descriptions that fit their emerging needs. They have made it a practice to recruit capable people with high-level skills and rely on their ability to learn specific skills while on the job.

Strategic planning, leadership development and trainings have been employed extensively to build a stronger base of knowledge and skills within the current workforce. Trainings and symposia on the built environment, a public health curriculum that emphasizes the importance of physical and social

of public and private policy decisions. Two recent reports—"Premature Deaths from Heart Disease and Stroke in Los Angeles County," and "Preventing Childhood Obesity: The Need for Healthy Places"—have been used specifically to support their work with cities on the built environment. They have also determined that data reports in themselves are not sufficient, but must be tailored in form and message to the particular audiences they are trying to address, which has required supplementing their epidemiology staff with specialists in communications and graphic design.

**Partnerships and Collaborations.** In contrast to communicable disease control, where local health departments are generally expected to take the lead, chronic disease prevention brings with it a greater

“LOS ANGELES COUNTY HAS CREATED ITS REVITALIZED CHRONIC DISEASE AND INJURY PREVENTION DIVISION IN PART BY RELOCATING KEY CATEGORICAL PROGRAMS WITHIN A SINGLE ADMINISTRATIVE UNIT.”

environments, and statewide resources to develop chronic disease infrastructure have all been used to strengthen the capacity of existing staff.

**Data.** The Los Angeles County Department of Public Health has a highly developed data capability. With an Office of Health Assessment and Epidemiology that includes approximately 20 epidemiologists and research analysts, they have been able to gather and analyze data from traditional public health sources—including the Behavioral Risk Factor Surveillance System, California Health Interview Survey, FitnessGram, etc.—while supplementing them with original sources, including the periodic Los Angeles

Health Survey and data from other public agencies, including schools. They are also developing capacity in the use of Health Impact Assessments (HIAs) to measure the prospective health effects

responsibility to develop new partnerships and convene coalitions that can address the wide range of associated environmental factors. Consistent with this expanded vision of public health practice, the Chronic Disease and Injury Prevention Division has made a priority of building relationships with county and city planners. Joint conferences and meetings have been convened to help establish the critical relationship between planning and public health. In addition, they have created special liaisons with cities and communities, schools and businesses as they attempt to broaden the base of these partnerships.

### Challenges

Los Angeles County, like other jurisdictions, is challenged by the relative absence of adequate, sustainable funding for chronic disease prevention. They must also confront workforce issues, as

the new skills being sought can be a challenge to the civil service system, union collective bargaining agreements and current employees. In addition, the decision to organize chronic disease prevention around broad groupings of risk factors rather than diseases has made it more difficult to work with some traditional public health organizations and community groups whose activities have been more disease-specific. And, even in Los Angeles, which many regard as cosmopolitan and relatively free of political backlash from innovation, the Department of Public Health has had to contend with occasional criticisms for their “paternalistic” attempts to change physical and social environments as their approach to chronic disease prevention.

## Lessons

The Los Angeles County Department of Public Health has learned that an organizational commitment to chronic disease prevention, in the face of funding and staffing that are at great odds with the actual burden of disease, requires a resolve and persistence from senior leadership, and a willingness to seek whatever incremental steps are possible to begin to move the health department in the right direction. Careful courtship of support from political and community leaders, together with organizational change processes designed to create a supportive base among the workforce, are critical elements of those early efforts. In addition, public health departments must undergo a culture change, from a clearly established leadership role in communicable disease control to a much more ambiguous role in chronic disease prevention. Public health departments must be willing not only to sometimes relinquish the leadership role, but also to think strategically about how to function effectively in the context of others’ leadership, as the developing relationship with land use and transportation planning demonstrates.

## Resources

Public health reports:

<http://phps.hds.co.la.ca.us/ph/phrep.htm>

<http://lapublichealth.org/statrpt.htm>

Health Disparities Loom as LA County Fares Poorly in Health Report Card: Obesity, Access to Care, and Homicide Rates Reveal Unequal Health Burden Across Region:

[http://lapublichealth.org/media/docs/key\\_ind\\_040307.pdf](http://lapublichealth.org/media/docs/key_ind_040307.pdf)



NEVADA COUNTY

## Vision and Approach to Chronic Disease

The Nevada County Public Health Department (NCPHD) is part of the Nevada County Health and Human Services Agency, whose mission is “. . . to provide residents access to quality care and services, in partnership with other community service providers. Services will be delivered in a confidential, impartial, efficient, and cost effective manner, to improve, promote and protect the health and mental health of residents to prevent disease, promote healthy lifestyles and encourage self-sufficiency.”

Still in the early stages of development of a comprehensive approach to chronic disease prevention, NCPHD has determined that the primary risk factors that contribute to chronic diseases to be addressed include lack of access to health care, tobacco, healthy choices, air quality, environmental hazards, stress and low income.

## Organizational Strategies

NCPHD is using a combination of public health models to guide their organizational development for chronic disease prevention. The Social-Ecological Model is being used as a framework for focusing on the environmental factors that increase individual choices for healthy behavior. The New Spectrum of Prevention is being used as a planning tool to guide efforts to increase the focus on fostering coalitions and networks, mobilizing communities, changing organizational practices and influencing policy. Community organizing models, including locality development, social planning and social action, are the foundation for building relationships with communities for health policy development. The Stage Theory of Organizational Change is guiding internal capacity building and norm change.

As NCPHD attempts to solidify its programmatic base to build a comprehensive approach to chronic disease prevention, they have cast several of their programs and activities along the New Spectrum of Prevention:

- Strengthening Individual Knowledge and Skills—Breastfeeding and nutrition education

at WIC, promotion of nutrition and physical activity at community outreach events.

- Promoting Community Education—Breastfeeding proclamation for Breastfeeding Awareness Month, board of supervisors resolutions related to wellness coinciding with national awareness campaigns.
- Educating Providers—Offering providers webcasts related to obesity prevention, provider information notices through CHDP, disseminating information regarding immunization rates.
- Fostering Coalitions and Networks—Coordinated School Health Workgroup to work with schools on development and evaluation of wellness policies, development of obesity prevention community collaboratives.
- Changing Organizational Practices—Proposed policy regarding food at meetings and promoting physical activity, maps at worksites.
- Mobilizing Neighborhoods and Communities—Community wellness summits, community action committees for bikeability and walkability.
- Influencing Policy and Legislation—CCLHO support for nutrition labeling bill, support for Bicycling Master Plan, support for grassroots advocacy to direct transportation funds toward pedestrian access, smoke-free parks and tobacco retail licensing ordinances.

A strategic planning process is attempting to build upon that programmatic base. While NCPHD has not yet integrated categorical programs such as WIC and CHDP, they have involved all key leaders of those programs to participate in both community wellness summits and staff meetings to discuss and develop strategies for integration. NCPHD's major advantage is that even without formal reporting structures there is good communication, cooperation, and coordination between the discrete categorical programs and their staff. When addi-

tional funding is procured, the Health and Wellness Section will be expanded and become the umbrella for all chronic disease prevention efforts.

### Strengths: Public Health Capacities

**Leadership.** Under relatively new leadership, NCPHD is attempting to build a public health leadership team committed to addressing the social and physical environments that contribute to chronic disease and health disparities, and to building relationships with communities, cities, schools and other public agencies and partners essential for carrying out that commitment. The new leadership team includes people with formative public health

NCPHD is also facilitating a collaborative community-building process and engaging a diversity of community leaders to develop a shared understanding of chronic disease prevention that supports healthy. The collaborations include:

- Participation in the Healthy Employees Run Our Schools (HEROS), a partnership of parents, school employees, nutritionists, food/nutrition advocates, and health department staff. Their attention had been on implementation of school wellness policies and environmental and social norm change approaches to obesity prevention.

“ (NEVADA COUNTY) . . . IS ATTEMPTING TO BUILD A PUBLIC HEALTH LEADERSHIP TEAM COMMITTED TO ADDRESSING THE SOCIAL AND PHYSICAL ENVIRONMENTS THAT CONTRIBUTE TO CHRONIC DISEASE AND HEALTH DISPARITIES, AND TO BUILDING RELATIONSHIPS WITH . . . PARTNERS ESSENTIAL FOR CARRYING OUT THAT COMMITMENT. ”

experience in other jurisdictions, that has included extensive work in chronic disease prevention, community engagement, organizational development and policy advocacy.

NCPHD has begun to change the organizational culture to better support a comprehensive approach to chronic disease prevention by reinforcing with employees that they, as the embodiment of the health department, should be leaders for the rest of the county government and the county at large. Changing the internal environment and gaining support by staff is considered the first logical step in making changes within Nevada County, where informal culture and interpersonal relationships are paramount.

- Collaboration with the manager of the Central Kitchen (serving the schools in Western Nevada County) and the Coordinator of School Health Services for Nevada County Superintendent of Schools to develop policy strategies related to nutrition and physical activity.
- Exploratory relationship with the Department of Transportation concerning Nevada County’s Master Bike Plan. These discussions have sparked new collaborative efforts towards alternative forms of transportation through planning safe and continuous routes.
- Work with the Community Collaborative of Tahoe-Truckee, the Nutrition Coalition, Tahoe

Truckee Unified School District, the Sierra Business Council, Truckee Trails Foundation, and the Truckee Family Resource Center in Eastern County to identify ways to collaborate around engaging the Latino community in improving transportation, bikeability, and walkability in the region.

- Meeting with key leaders among local growers in the Western Region to join in the movement to create greater access and awareness about local food sources and forge partnerships between growers and the schools.
- Convening a task force of committed community leaders from diverse sectors including the hospital, First 5, schools, environmentalists, bike advocates, disability access, fitness professionals, nutritionists, planners, growers, injury prevention, maternal and child health, parents, and others to implement the priorities identified recent Community Wellness Summits.
- Preliminary discussions with the County Planning Director regarding health issues related to land use planning. Further conversations will also be had between city planners and the health officer with the goal of developing mechanisms for providing public health input.
- The health officer is working with the 11 separate school districts to discuss a variety of health related issues, including nutrition and exercise.

**Financing.** While personal relationships might be the glue for getting work accomplished in Nevada County, it will require additional funding to adequately finance chronic disease prevention. NCPHD needs at least some discretionary funds to supplement categorical programs to more effectively braid funding for a comprehensive approach to chronic disease prevention. NCPHD has not yet received any significant private funding, although a mini-grant from The California Endowment has enabled them to outline a comprehensive framework for obesity prevention (see attachment). The only other source

of flexible funding is realignment, which is needed to support current mandates and programs. The leadership team is researching how other counties have financed their prevention activities and will launch an aggressive fund-raising campaign for chronic disease prevention. Safe Routes to School is one of their initial priority areas.

**Workforce.** NCPHD has many workforce strengths to build upon. Senior officials are committed to chronic disease prevention and a broad vision of public health. Staff have great empathy for community residents and make every effort to provide effective services. Because of the small size of the health department, most people within the department know each other and their programs. While communication between programs is common and people do not feel as if they are working in program silos, energy and interest for chronic disease prevention exists primarily in NCPHD's Health & Wellness Programs, which includes tobacco control, obesity prevention, HIV prevention, dental health, and teen health.

Recent training activities of key staff have been instrumental in developing a shared perspective of prevention strategies and the importance of expanding beyond the lower levels of the New Spectrum of Prevention.

- Staff have attended close to 20 trainings and conference calls on the built environment, smart growth, and reaching underserved populations. In addition, Nevada County joined the Sierra Cascade Collaborative for Health and Movement Promotion. Staff, including a newly hired epidemiologist, have been trained by the State Department of Public Health in the Communities of Excellence in Nutrition, Physical Activity and Obesity Prevention (CX3) process.
- The Health and Wellness Program Manager has been internally training staff on logic model development and principles of community-based public health in the process of preparing for the Community Wellness Summits and the development of the County's Obesity Prevention Project.

**Data.** NCPHD recently received approval to hire a full-time epidemiologist. One of the first tasks for the epidemiologist will be to finish the development of the county’s community health status report (the first report of this type in over seven years) and support primary data collection and analysis to focus chronic disease prevention efforts.

NCPHD currently has access to and uses vital statistics data, the California Health Interview Survey (CHIS), California Healthy Kids, WIC, and school lunch programs. NCPHD has access to good teen data and will soon be using the CX3 mapping data. They are exploring ways to gain access to injury data and hospital discharge data and are developing plans to collect primary care data, a mix of quantitative and qualitative measures related to risk factors. One of the challenges for NCPHD and other similar size health departments is that statewide databases do not have a large enough subsample for smaller counties thereby limiting accurate interpretation and use of the data. The cost of oversampling is beyond the means of Nevada County.

## Challenges

The major challenge facing Nevada County is the lack of any dedicated funding streams for chronic disease prevention beyond limited categorical programs.

Workforce issues are also significant. The workforce is aging, and rural counties have had difficulty in recruiting and hiring staff due to their remote locations and traditionally low wages. Several positions in public health have been unfilled due to a nursing shortage. Furthermore, there are very few in the local workforce with a public health background or who have the training or experience to work within a more comprehensive chronic disease prevention framework.

In Nevada County, the political environment is mixed. While there is an active constituency supportive of health and environmental protections, there are a significant number of residents who generally don’t support government involvement in prevention programs apart from individual health education. Opposition to the “nanny state” is a factor.

Another challenge is that the Latino population

is isolated and lacks visibility due to transportation, cultural and language barriers.

## Lessons

Small Sierra Nevada rural counties are in unique situations. On the positive side, they are often populated by a mix of individuals who are more active than that of the average Californian, being drawn to the wonderful opportunities afforded by the close proximity to a number of outdoor recreational areas. These individuals are also more likely to value and consume more healthful foods.

On the other hand, in rural counties, individual freedoms are stressed and many residents oppose government influencing what they see as their right to make individual decisions. Local funding for health and human service efforts are usually very limited, as priorities for government resources mostly center on roads, sanitation and public safety. Mobilizing community residents and organizations as partners is key to developing the necessary critical mass to begin to address chronic disease issues.

NCPHD has discovered that framing environmental prevention as “developing community supports to allow individuals to make healthy choices” is an important strategy for gaining support. They have also learned that gaining support from within the department requires its own strategy, which they have carried out by replacing some leadership positions with new employees who believe in environmental approaches to chronic disease prevention, using morbidity and mortality data to provide an evidence base for the paramount importance of chronic disease prevention, and introducing the concept of community driven public health and placing high value on engaging and working with the larger community, especially with staff who are interested in working on these issues.

There are additional requirements for a relatively small, rural health department attempting to take on the magnitude of chronic disease prevention:

- A statewide funding stream;
- Engaging community in defining issues, selecting strategies, and empowering them

to work together with public health leaders;  
and,

- Evaluation so programs can document improved health status and reduced public costs.

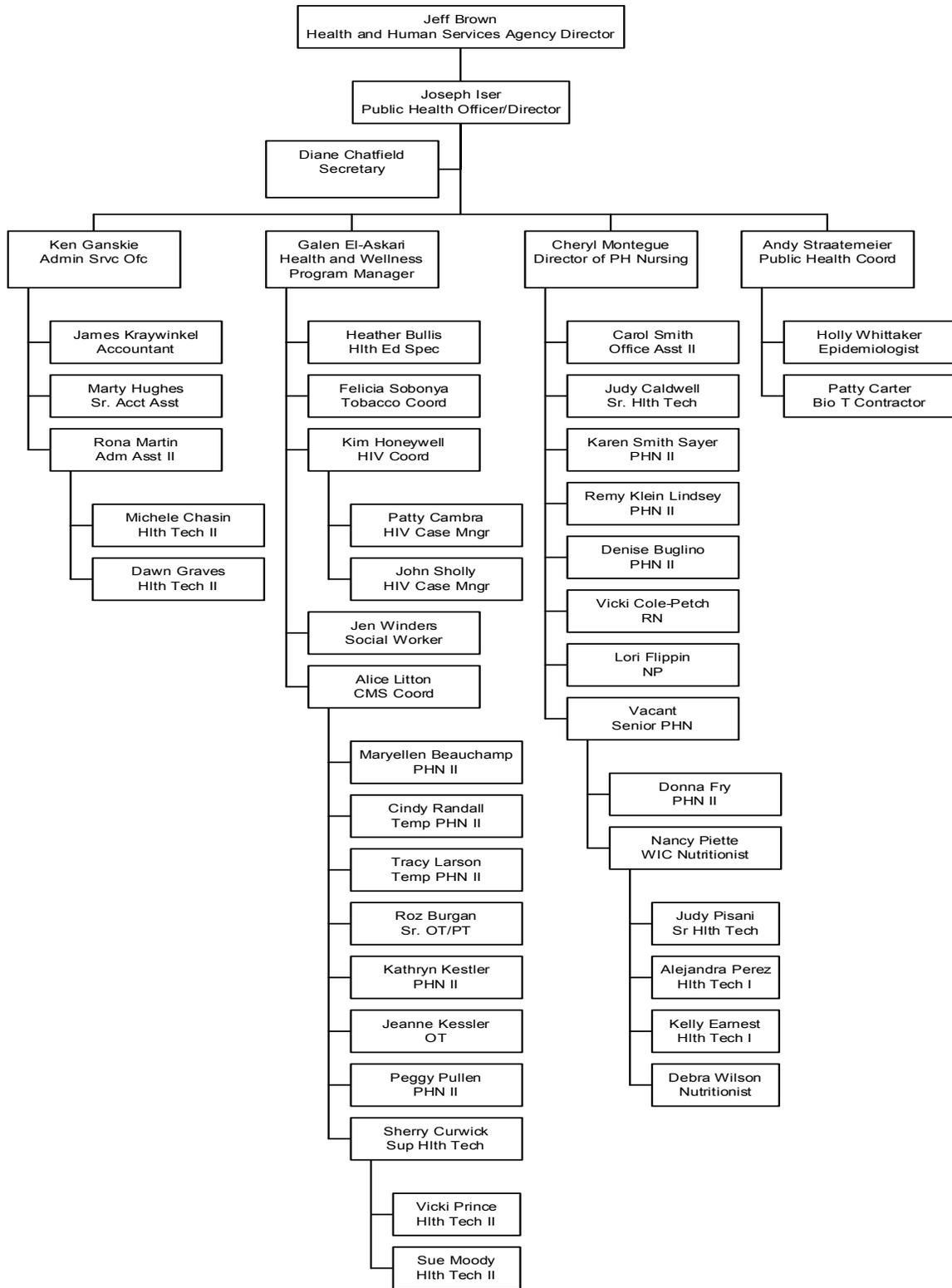
NCPHD leadership has learned that when faced with great opportunities, and yet significant and persistent challenges, it is important to consider the work in terms of a marathon rather than a sprint. One must have faith that it is possible to make a difference and must share that belief and optimism with each other. It is also helpful to have a persistent resolve and a confidence in the importance of doing what is right and good.

## Resources

See the Nevada County Public Health Department Organizational Chart and Logic Model for Obesity Prevention on the following pages.

[http://new.mynevadacounty.com/  
ph/index.cfm?ccs=692](http://new.mynevadacounty.com/ph/index.cfm?ccs=692)

# Nevada County Public Health Organizational Chart 07/08



# Nevada County Obesity Prevention Project (Logic Model)

## Assumptions:

- Improving the bikeability and walkability of the community (including sidewalks, bike paths, and greater density with mixed use in future development) so that frequently used destinations are connected by safe walking and biking routes, will encourage more physical activity and decrease traffic and pedestrian/bike safety problems.
- Improvements to local infrastructure (i.e. sidewalks and bike paths) will be most successful if built upon a representative, informed, and mobilized constituency; and
- Strategies that change community norms and environments are more likely to lead to sustained improvements in individual and community health and well-being.

INPUTS	ACTIVITIES	OUTCOMES		
		Short Term (1-3 years)	Long Term (4-7 years)	Impact (7-10 years)
Access to local media City/County planners' buy-in External technical assistance Local elected officials' support Parent and other resident involvement Parks and Recreation support Public Health Department staffing School personnel involvement Transportation Commission support Walkability and bikeability advocates' involvement	<b>YEAR ONE</b> Convene stakeholder committee Assess needs through review of existing data, CX3 process, online survey, focus groups at existing community meetings, and street polling. Community-based projects  <b>YEAR TWO</b> Develop community education campaign Media advocacy Resource development for infrastructure improvements (i.e. sidewalks and bike paths)	Active participation by those who have authority from key stakeholder groups Identification of improvements needed for walkability and bikeability Increased resident awareness of the benefits of safe streets for biking and walking Increased community involvement in health and safety advocacy Increased opportunities for physical activity in target communities Identification of resources for infrastructure improvements	Increased health literacy among County residents Increased participation in physical activity in target communities Increased pedestrian and bike safety in target communities Decreased traffic problems in target communities Increased social, community, and physical environments that support healthy choices	Decreased obesity and overweight in Nevada County Decreased chronic disease in Nevada County Increased quality of life and wellness of the community Decreased health disparities in the County

SAN DIEGO COUNTY

## Vision and Approach to Chronic Disease

The vision of the San Diego Health and Human Services Agency (HHS) is *safe, healthy, thriving communities*, and the mission is “. . . to make people’s lives safer, healthier, and self-sufficient by managing essential services.” The five business operating groups of the County of San Diego, including the Health and Human Services Agency, operate under the County Strategic Initiative, which requires that each group establishes goals, actions and results. All groups and Agency managers are required to document achievement of outcomes.

Public Health Services (PHS) is one of five divisions within HHS, which also includes behavioral health, public administrator/guardian, aging, child welfare, as well as six HHS regions. The Agency operates under a strategic agenda which links to the countywide strategic initiative. From the Agency’s Strategic Agenda, there are three action indicators (or performance measure categories) most related to chronic disease prevention:

- Receipt of education and prevention services,
- Impact of chronic and acute disease, and provide prevention and protective services to maximize health, safety, and independence; and,
- Impact on awareness and/or behavior as a result of education or health promotion efforts.

## Organizational Strategies

In 1998, the San Diego Board of Supervisors approved the creation of the HHS. PHS (then the Office of Public Health) became one of five divisions within the Agency (see attached organizational charts).

PHS is organized into seven branches (see organizational chart), with four programmatic services, two medical services branches, and one administrative services branch. The programmatic services include Maternal, Child, and Family

Health Services (MCFHS) Branch, which houses the chronic disease unit.

Created in 2001, Chronic Disease and Injury Prevention was once a distinct branch, but during the severe state and local budget cuts five years ago (2003), tobacco settlement funds that had been used to support chronic disease were diverted to other purposes. Chronic Disease and Injury Prevention, now called Chronic Disease and Health Disparities (CDHD), became a program unit within the MCFHS Branch. The Unit uses the Social-Ecological Model and the Spectrum of Prevention to guide its programs under a framework that emphasizes *healthy lifestyles through supportive environments*. CDHD programs include the Childhood Obesity Initiative, Diabetes Coalition, Tobacco Control, and the Reduce or Eliminate Health Disparities Initiative (REHDI).

In 2001, PHS established REHDI with a focus on the reduction or elimination of disparities in ten priority health conditions, linked to the Healthy People 2010 objectives, and implemented through a local process involving community stakeholders. The priority areas are cancer, heart disease and stroke, diabetes, HIV/AIDS, immunization, infant mortality, asthma, lead poisoning, obesity, and suicide/depression.

CDHD is a centralized program unit that must work with six regional centers serving sub-county areas of approximately 1/2 million each. Public health programs are carried out through a matrix management system with the regions and rely on opportunities for functional or “cross threading” to ensure that public health policies, categorical programs, performance standards, and procedures are faithfully implemented at the regional level.

While the regional centers are focused heavily on service delivery, with public health nurses, mental health workers, social workers, and eligibility workers serving clients in an integrated fashion, they are also where work with communities, schools, cities, health care providers, etc. is carried out at the local level. CDHD’s work with countywide coalitions will ideally complement and reinforce that local infrastructure. A countywide Childhood Obesity Initiative, created by the Board of Supervisors, is an

example of how agency priorities can both inform and build upon activities at the local level.

The County of San Diego has policies limiting the size of the public sector workforce, which means that many public health programs and much of the workforce are contracted out. As a result, the overall strategy to build support for chronic disease prevention and reducing health disparities necessarily includes a strong reliance on public/private partnerships and work with community and countywide coalitions.

### **Strengths: Public Health Capacities**

**Leadership.** Upon its launch seven years ago, REHDI comprised a coalition of over 200 private and public agencies, as well as community leaders from each of the six regions. More recently, PHS leadership is redirecting momentum, through REHDI staff, Emergency Medical Services' Community Health Statistics Unit, and community partners, to generate the following activities:

- Mapping out critical pathways for each chronic disease, identifying for each the contributing risk factors and social determinants;
- Developing fact sheets, community profiles, and other resources;
- Conducting community workshops to educate the community; and,
- Placing all information for public access on the agency web site.

In 2006, the County of San Diego completed and published its Childhood Obesity Action Plan. The plan was initiated as a direct result of two county supervisors who recognized a need and pushed for formation of a broad-based, highly inclusive public/private partnership to address obesity. The Childhood Obesity Action Plan focuses its work in seven societal domains using the social-ecological model to guide countywide prevention efforts. The Childhood Obesity Initiative (COI) is tasked to implement the Action Plan. The Public Health Officer is co-chair (public partner) of the COI Leadership

Council, the CDHD Program Manager is co-chair of the COI government domain, and MCFHS staff is co-chair of the schools domain. COI partners are committed to addressing community design interventions rather than concentrating solely on individual behavior change to achieve their goals for reducing childhood obesity rates. They have engaged such partners as schools, school garden pilot programs, the Restaurant Association, Junior League, city libraries, La Mesa Wellness Task Force, the Youth Commission, the Safe Routes to School program, and Chula Vista Healthy Cities Initiative.

More generally, CDHD has taken a lead in developing and facilitating countywide coalitions made up of public and private organizations, as well as community leaders. CDHD has attempted to make environmental approaches to obesity, diabetes, and health disparities a greater priority by bringing in key experts from around the state to make presentations on the Spectrum of Prevention, health disparities, childhood obesity, and the built environment. These strategies embody the CDC's framework for working with coalitions.

**Financing.** PHS relies primarily on categorical funding, realignment and private foundation grants to fund chronic disease prevention efforts. Tobacco Settlement funds were initially used to support the former Chronic Disease and Injury Prevention Branch activities, but subsequent budget cuts resulted in the diversion of those funds for other purposes. Although San Diego does not receive funding from the Network for A Healthy California's Communities of Excellence (CX3) program, they did secure local funds to develop two hybrid projects in conjunction with CX3 staff.

**Workforce.** HHSa has a strong customer service orientation, as indicated in its strategic planning documents and in the programmatic organization built around regional multi-service centers. Shifting the focus toward social determinants of health and environmental approaches to chronic disease prevention can pose particular challenges with a workforce accustomed to providing services. New leadership, in PHS and CDHD, is using the Board of Supervisors' Childhood Obesity Initiative and the

“ SAN DIEGO’S COUNTYWIDE/REGIONAL PARTNERSHIPS HAVE ALLOWED PUBLIC HEALTH TO CONNECT WITH AND ENGAGE A HIGHLY DIVERSE AND INCLUSIVE COALITION OF LOCAL RESIDENTS, SCHOOLS AND COMMUNITY-BASED ORGANIZATIONS. ”

REHDI framework as ways to introduce and reinforce the importance of the social and physical environments as key influences on health. Program managers are also using technical assistance from other state and local resources to help make environmental approaches to chronic disease prevention a more widely accepted component of public health practice.

A segment of the public health workforce in San Diego is not directly employed by the county. By policy of the Board of Supervisors, there is a limit on the number of employees that can be hired by any county department. When PHS is awarded a private foundation grant that requires additional staffing, for example, these funds must be contracted out to community-based organizations for implementation and fulfillment of grant goals and objectives. Strategies to change any culture and practice of the public health workforce must therefore include that portion of the workforce that is not county employed.

San Diego has made some attempts to redefine the work of existing employees. In a management review of public health nursing caseloads, for example, it was discovered that nearly half of public health nurses in the South Region supported with non-categorical funds were managing a relatively small number of TB cases. A business reengineer process plan resulted in some public health nurses working on obesity prevention and other non-communicable disease programs.

**Data.** In 2004, the public health officer charged staff of the Community Epidemiology Branch (CEB) with the task of developing a health indicators report. Through this effort, the Community Health Statistics

Unit was developed to analyze data that could be utilized by the Agency, particularly the regions, and the general public. The Unit’s first effort created a data framework that adapted Los Angeles’s Health Assessment and Epidemiology Division’s data framework of 100 health indicators. It was determined that 40 of these 100 indicators were most relevant to promoting positive health outcomes in San Diego’s six regions. The Community Health Statistics Unit produced a report that provides each region with its own profile on the 40 indicators. PHS sponsored community forums in each region to review and discuss the public health regional profiles. Now, each region has the ability to select their health priorities, based on evidence about what appears to pose the greatest threat to health and well-being in the particular area. The six regional profiles are posted on the HHSA website. Today, the Unit is housed in the Emergency Medical Services Branch.

The Community Health Statistics Unit is also working closely with the Childhood Obesity Initiative in mining and generating data that can inform their work and track their progress in reducing obesity among children.

PHS has developed critical pathways and identified risk factors for each of the ten health conditions identified through the REHDI process to address health disparities. In 2008, PHS will provide data relevant to the risk factors and social determinants for each of the ten health conditions on their web site. It is also the Division’s intent to make it possible for anyone to go to the website and produce their own health data report by region, by disease, and by population group.

## Challenges

The County has an organizational culture that emphasizes customer service, a centralized/decentralized structure that requires complex matrix management, and is intermittently challenged by budgetary cuts imposed by state and federal governments. In times of budgetary constraints, continuing high standards of customer service can be difficult. While some may ascertain that a disadvantage of matrix management is that it can be confusing, a properly managed cooperative environment can neutralize this factor. The Division, like other Agency divisions, is also operating with limited revenue, and as a result is not able to expand the chronic disease and health disparities infrastructure from a program within MCFHS to a separate branch.

## Lessons

PHS is committed to turning challenges into productive lessons. The Division garnered the political support for a countywide childhood obesity initiative to give chronic disease prevention greater prominence, and to highlight the importance of environmental factors. The Division is developing experience in “cross-threading” to maximize the skills, abilities, and strengths of central programmatic branch staff to support health promotion teams located in regional centers as they implement countywide vision, mission, goals, and outcomes. Agency divisions and regions assist each other to tailor data, services, and prevention approaches that meet the needs of the unique population groups found in each region. The reliance on countywide public/private partnerships and coalitions to accomplish operational efforts provides an opportunity to learn ways in which public health might maximize and align financial and human resources around a common vision, goals, and action plans and across a large number of highly diverse organizations. San Diego’s countywide/regional partnerships have allowed public health to connect with and engage a highly diverse and inclusive coalition of local residents, cities, schools, and community-based organizations.

The Division has also become committed to greater utilization of statewide resources, including public health organizations and other local health departments. The California Department of Public Health could be another valuable resource by providing technical assistance, funding, and program mandates to better serve our local community.

## Resources

San Diego Health and Human Services Agency Web Site: <http://www2.sdcounty.ca.gov/hhsa/ProgramDetails.asp?ProgramID=4>

San Diego Strategic Plans: <http://www2.sdcounty.ca.gov/hhsa/DocSearchResults.asp?DocumentTypeID=6>

Childhood Obesity Action Plan: <http://www2.sdcounty.ca.gov/hhsa/documents/CalltoActionFinalVersion.pdf>

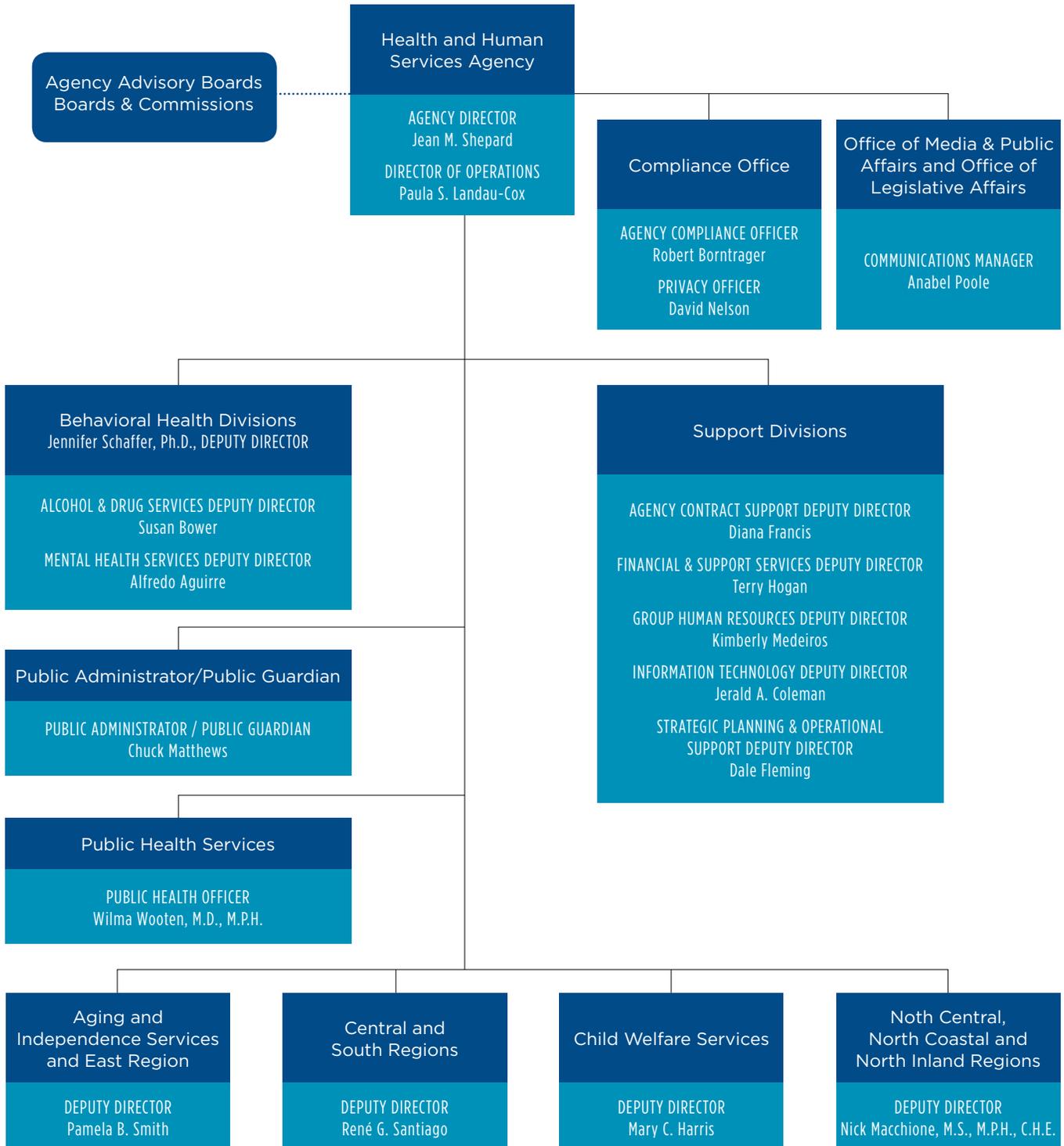
San Diego County Strategic Plan Agenda for 2007–2012: <http://www2.sdcounty.ca.gov/hhsa/documents/07-12StrategyAgenda.pdf>

South Region Community Profile: [http://www2.sdcounty.ca.gov/hhsa/documents/CHS-CommunityProfile\\_Region4\\_7-07.pdf](http://www2.sdcounty.ca.gov/hhsa/documents/CHS-CommunityProfile_Region4_7-07.pdf)

Core Public Health Indicators: <http://www2.sdcounty.ca.gov/hhsa/documents/corepublichealthindicatorsdocument2004.pdf>

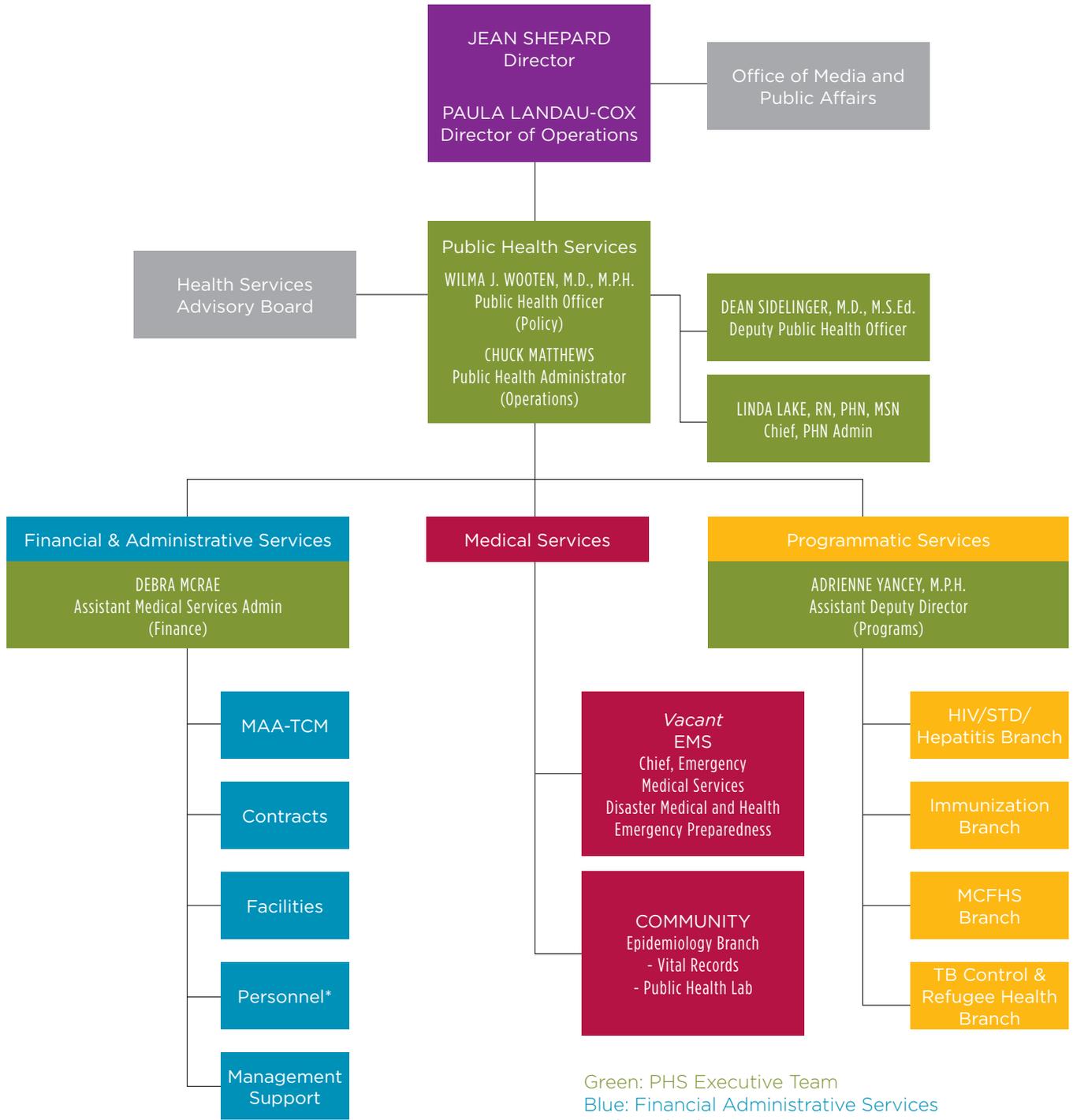
# San Diego County Health and Human Services Agency

## Organizational Chart (September 2007)



# San Diego County Health and Human Services Agency

## Public Health Services Division (December 28, 2007)



\*Also reports to HR

Green: PHS Executive Team  
 Blue: Financial Administrative Services  
 Red: Medical Services  
 Yellow: Programmatic Services



SHASTA COUNTY

## Vision and Approach To Chronic Disease

The vision of the Shasta County Public Health Department (SCPHD) is *healthy people in healthy communities*. Its mission is *working with communities to protect and improve health*. They have defined their core values as:

- Compassion-Caring about people
- Community Collaboration-Working with partners
- Prevention-Creating and preserving health
- Equality-Serving everyone
- Integrity-Accountable and honest

## Organizational strategies

Over the last 20 years, SCPHD has created a public health department that serves as a model for putting prevention, population health and healthy communities at the center of public health's mission and vision. Involving community representatives in strategic planning activities has been a key tool for cultivating community engagement in chronic disease prevention. Over the last decade, SCPHD has engaged in the APEX and the MAPP planning processes, both of which mandate multi-sector forums and community engagement in public health planning. SCPHD also established a Public Health Advisory Board which meets regularly and plays a significant role in on-going strategic planning processes.

In 2007, SCPHD updated their long term strategic plan in collaboration with the communities they serve. This revised strategic plan strengthens SCPHD's commitment to the prevention of chronic health issues.

The strategic plan emphasizes that community collaboration is based on believing "residents know their communities best and have a vested interest in their well-being." Prevention is focused across the full Spectrum of Prevention, including policy and systems change. The value of equality is explicitly linked to elimination of health disparities. The values section concludes with the statement, "We are

committed to honesty in all of our activities, transparency in decision-making and information sharing, and sincerity in our relationships."

More important than committing this vision and mission to paper, SCPHD has enacted this vision and commitment to these values in both their completed and on-going work. SCPH has partnered with schools and community groups to implement nutrition, physical fitness, tobacco prevention and injury prevention programs that continue to be sustained and improved upon based on outcomes and the changing needs of the community. Examples of this are the support of the Sports, Play and Active Recreation of Kids (SPARK) physical fitness program in nearly all Shasta County schools districts, which provides activities that have demonstrated effectiveness in developing life long fitness. SCPHD has successfully created an organizational culture that prioritizes partnership, collaboration and a broad perspective on creating health in the communities they serve.

In order to facilitate work around chronic disease and community health, SCPHD changed their organizational structure. The transition involved moving away from a department structure that was primarily organized around professional specialties (Family Health-public health nurses, Community Health-health educators, Community Nutrition-nutritionists) toward an organizational structure that was organized around broader, health outcome areas of focus and that utilized multidisciplinary teams. A new division was created called Chronic Disease and Injury Prevention and included programs and activities related to nutrition/healthy eating, physical activity, tobacco control, and motor vehicle crash and fall prevention. To accommodate increased activity in the area of healthy eating and physical activity, this unit more recently was divided into two separate units: the Physical Activity and Nutrition Promotion Division and the Injury and Substance Abuse Prevention Division.

In addition to these divisions, the health department also has a Regional Community Health Improvement Division which has personnel at regional offices throughout the county. This division is specifically designed to cultivate relationships with local communities and establish and maintain

working partnerships, while attempting to deliver the same types of prevention programs to county residents regardless of where they live.

## Strengths: Public Health Capacities

**Leadership.** The leadership of the SCPHD has been forward thinking in their approach to public health and instrumental in placing the health department on the cutting edge of chronic disease prevention. Senior leadership has encouraged an approach that emphasizes the needs of communities and actively engages communities in health improvement. This approach was aided by several long term grants that funded collaborative health improvement including the Sierra Health Foundation's Community Partnerships for Healthy Children Initiative and The California Endowment's Partnership for the Public's Health initiative. The relationships and capacities that were developed under these prior initiatives are now being brought to bear on chronic disease prevention through Healthy Eating Active Living grant from The California Endowment. However, these opportunities would not have resulted in the level of organizational change seen in SCPHD were it not for clarity and consistency of the leaderships vision.

**Financing.** SCPHD is financed using a combination of realignment, county funds, fees for service, and grant funding. SCPHD has been able to use realignment money fairly extensively to support their community partnership and chronic disease prevention work, in part because the services supported by state funds at the time realignment occurred<sup>1</sup> did not include high cost services like operating a public hospital or a primary care clinic, nor jail health care. Indigent care is provided through community clinics and jail health care is paid out of the county's general fund. SCPH also has made cutbacks in direct services such as family planning and well child visits in order to increase the focus on prevention and population-based health issues. These services are now provided by other private providers in the county, although SCPH maintains an assurance role.

SCPHD is aggressive about seeking out grant funding opportunities. Many of the programs that

address chronic disease issues are supported by grant funds, including funds to address perinatal tobacco cessation and preschool nutrition and physical activity from First 5 Shasta, HEAC funding for nutrition and physical activity promotion among residents of the southwest portion of the county, and support from local partners for a community collaborative called Healthy Shasta.

SCPHD has built a constituency (through the cultivation of community partnerships) that provides public support and advocacy to maintain the infrastructure needed to work in partnership with communities. When public health funding is threatened, there is a group of active citizens who can be counted on to advocate for the public health department. This was put to the test in 2004 when the governor repealed a tax that had a significant impact on public health funding. Drastic cuts were proposed which included the closing of regional offices and the Regional Community Health Improvement Division. Advocacy from the community was strong and the County Board of Supervisors agreed to provide temporary funding for public health to compensate for lost funding.

**Workforce.** SCPHD strives for a workforce that is diverse in training and interests. The leadership believes public health nursing is only one of the many professions needed to successfully implement public health improvement in their county. Since chronic disease is a multifaceted problem that requires multifaceted solutions, the department cultivates a workforce that also includes dietitians, health educators, epidemiologists, and data analysts who are able to work collaboratively with other organizations and provide a variety of skills and perspectives.

Training also is an important factor in developing a workforce that is able to meet the challenges of collaboration around chronic disease prevention. SCPHD provides a variety of training opportunities for personnel on policy and capacity building around health disparities. SCPHD also seeks to cultivate the interests of personnel when they intersect with departmental needs. For example, an employee who is interested in land use has been supported by the department to get additional training on the topic.

Finally, SCPHD has made an effort to hire people from the communities in which they work. This ensures that public health employees have strong connections to the communities they work in and have first hand knowledge of the neighborhoods served by SCPH.

**Data.** SCPHD has an assessment and evaluation division that provides data collection and analysis support to the department. One strategic choice of the department has been to emphasize using the data the department collects more effectively, rather than collecting more data. For example, there is a great deal of data that gets collected but is poorly analyzed and/or not reported back to the public. SCPHD also tries to provide small communities with useful data about the residents of their area so they can make data driven priorities and not have to depend only on county-wide data.

## Challenges

While SCPHD faces a number of challenges, the leadership and staff seem to have an unflagging sense of optimism about what is possible. While elected officials tend to be fairly conservative and emphasize personal responsibility, SCPHD has been able to interest them in a variety of chronic disease issues. One county supervisor recently approached the department about wanting to lose weight and is now the “poster boy” for a county workplace wellness effort called “Healthy for Life Challenge.” On a more general level, the rhetoric of personal responsibility means that many leaders want to focus on individual behavior and personal choice when dealing with chronic disease prevention rather than the social and built environment. This can make a comprehensive population based approach to chronic disease prevention challenging.

SCPHD (like many health departments) has found working in partnership with community to be a time and resource intensive endeavor. SCPHD has found that effective partnerships require that time and resources be devoted to relationship building and process work. If partnership building is not done early on, there will eventually come a time when it is required for the work to move forward. Finding the

time and resources for relationship building is an on-going struggle.

Economic development can often work at cross purposes with the changes needed to create a healthier environment for people to live and work in. In Shasta County, there is an obvious need to carefully balance the economic development needs of the region with the movement to build a healthier environment:

## Lessons

SCPHD leadership emphasize that much of their success is linked to getting the right people on staff. This often means looking outside of traditional public health fields. One example is the success they have had with tobacco control and enforcement, which they can link directly to the hiring of effective enforcement officers many of whom are retired police officers. In addition to eradicating smoking from bars through stringent enforcement, the current enforcement officer has recruited apartment complexes to adopt voluntary smoke-free policies. SCPHD also has looked to the community for personnel and successfully hired staff from the community to work in the regional offices.

Another major lesson that SCPHD has learned as a result of their experiences working on chronic disease prevention is that policy changes need to be vetted within the community to various degrees before pushing for a major policy change. A number of years ago the department tried to get the county to fluoridate the water, but after much effort the fluoridation change was unsuccessful. The department has used this experience, however, to learn better ways of approaching policy and systems change.

## Resources

[www.co.shasta.ca.us/Departments/PublicHealth/Index.shtml](http://www.co.shasta.ca.us/Departments/PublicHealth/Index.shtml)

## Notes

1. The distribution of state funding was locked in at the time realignment occurred and therefore counties that were providing these types of high cost services must continue to use their realignment dollars for these same services. This means that some counties are not able to be flexible with their realignment dollars.





