

Healthy California 2020: Criteria Discussion

Public Health Advisory
Committee

October 29, 2009

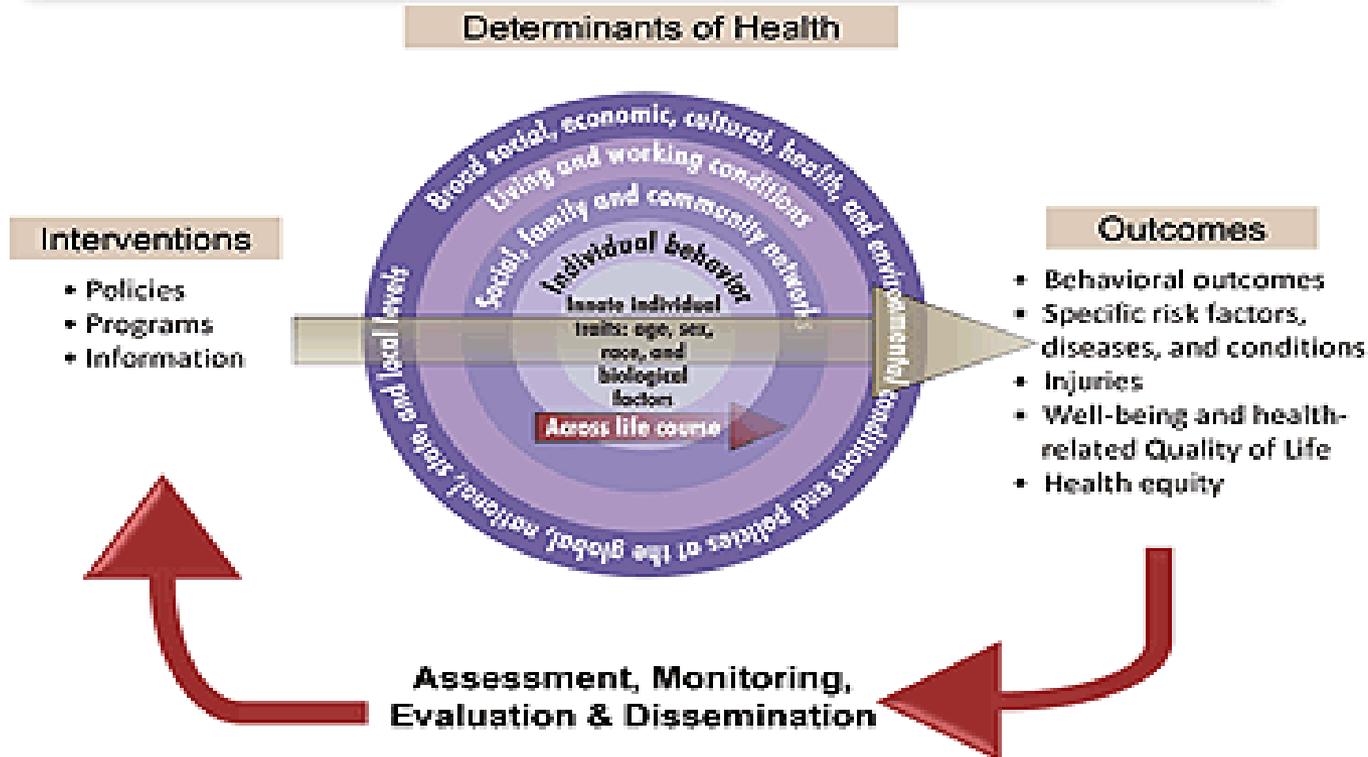


Framework Refresher



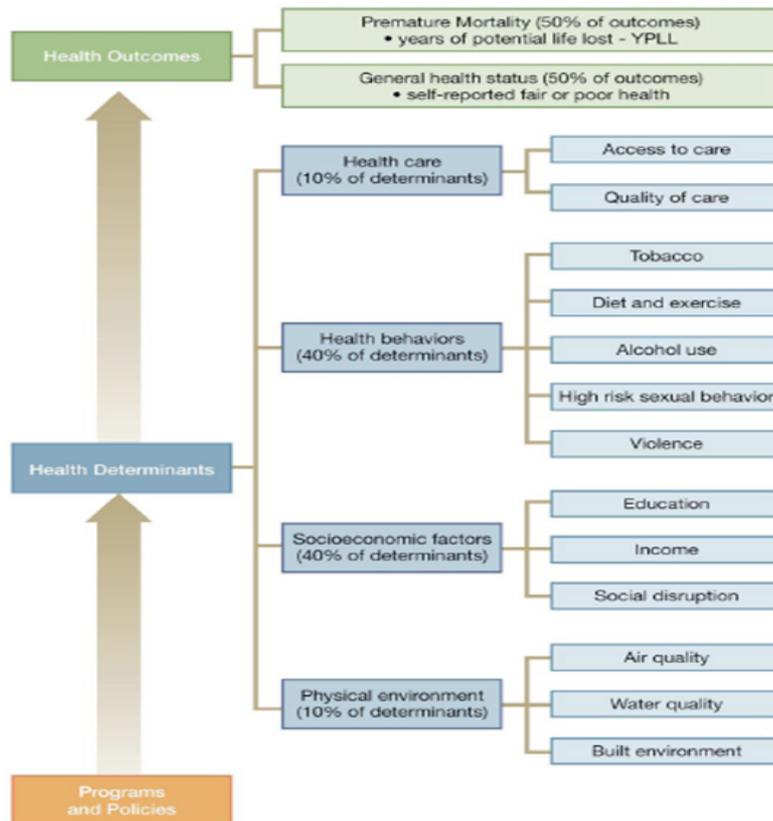
Healthy People 2020 – Moving to Action

Action Model to Achieve Healthy People 2020 Overarching Goals



Continuing the Advances

The Wisconsin Model of Population Health



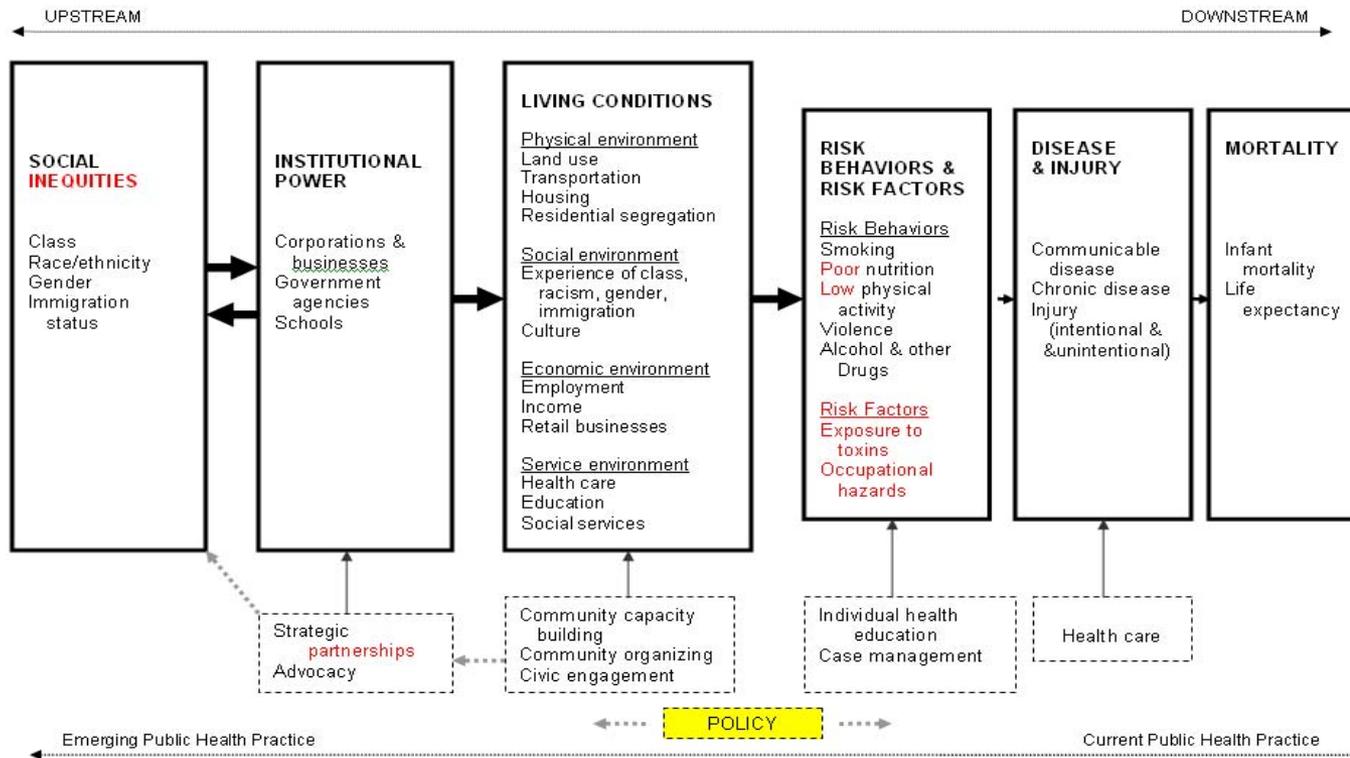
Looking to the root causes of disease and morbidity.

Identify framework for understanding these causes.

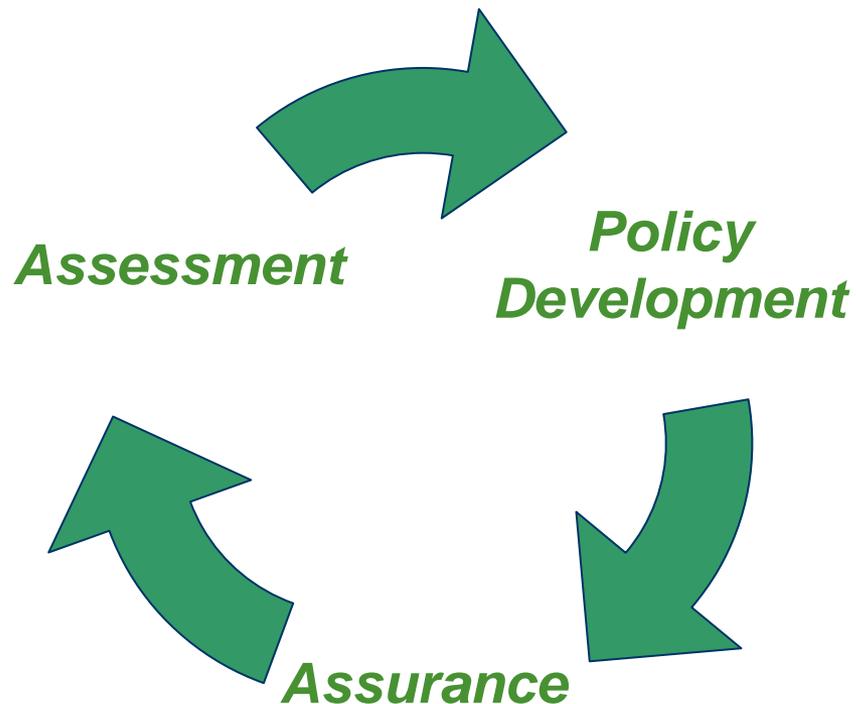
Looking Upstream



A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES BAY AREA REGIONAL HEALTH INEQUITIES INITIATIVE



Core Public Health Functions



Assessment:

The systematic collection, assembly and dissemination of information

Policy development:

Creation of policies based on scientific knowledge

Assurance:

Pledge to constituents that services necessary to achieve agreed-upon goals are provided



Assessment

Policy Development

Assurance

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazard.

3. Give people information they need to make healthy choices.
4. Engage the community to identify and solve health problems.
5. Develop public health policies and plans that support individual and community health efforts.

6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and ensure the provisions of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovate solutions to health problems.



National Healthy People 2020 Framework

Vision

- A society in which all people live long, healthy lives.

Mission

Healthy People 2020 strives to:

- Identify nationwide health improvement priorities;
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress;
- Provide measurable objectives and goals that are applicable at the national, state, and local levels;
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge;
- Identify critical research, evaluation and data collection needs.

<http://www.healthypeople.gov/hp2020/Objectives/TopicAreas.aspx>



National Overarching Goals

- Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development and healthy behaviors across all life stages.



Healthy People 2020 – Objective Selection Criteria from Office of Disease Prevention & Health Promotion

The following eight criteria should be taken into consideration when commenting on the proposed or suggesting additional objectives.

- Objectives should be **measurable and should address a range of issues**, such as: behavior and health outcomes; availability of, access to, and content of behavioral and health service interventions; socio-environmental conditions; and community capacity – directed toward improving health outcomes and quality of life across the life span. (Community capacity is defined as the ability of a community to plan, implement, and evaluate health strategies.)
- **Continuity and comparability** of measured phenomena from year to year are important, thus, when appropriate, retention of objectives from previous Healthy People iterations is encouraged. However, in instances where objectives and/or measures have proven ill-suited to the purpose or are inadequate, new improved objectives and/or new measures should be developed. Whether or not an objective has met its target in a previous Healthy People iteration should not be the sole basis for retaining or deleting an objective.



Healthy People 2020 – Objective Selection Criteria from Office of Disease Prevention & Health Promotion

- The objectives should be **supported by the best available scientific evidence**. The objective selection and review processes should be flexible enough to allow revisions to objectives in order to reflect major updates or new knowledge.
- Objectives should **address population disparities**. These include populations categorized by race/ethnicity, socioeconomic status, gender, disability status, sexual orientation, and geographic location. For particular health issues, additional special populations should be addressed, based on an examination of the available evidence on vulnerability, health status, and disparate care. Data sources are not necessarily a prerequisite for inclusion of a special population in an objective.



Healthy People 2020 – Objective Selection Criteria from Office of Disease Prevention & Health Promotion – cont.

- The result to be achieved should be **important and understandable to a broad audience** and support the Healthy People 2020 goals.
- Objectives should be **prevention oriented and/or should address health improvements** that can be achieved through population-based as well as individual actions, systems-based, environmental, health-service, or policy interventions.
- Objectives should **drive actions that will work toward the achievement of the proposed targets** (defined as quantitative values to be achieved by the year 2020).
- Objectives should be **useful and reflect issues of national importance**. Federal agencies, states, localities, non-governmental organizations, and the public and private sectors should be able to use objectives to target efforts in schools, communities, work sites, health practices, and other environments.



Draft HP2020 Objectives

<http://healthypeople.gov/hp2020/Objectives/TopicAreas.aspx>



Healthy People 2020 Topic Areas

- Access to Health Services
- Adolescent Health
- Arthritis, Osteoporosis, and Chronic Back Conditions
- Blood Disorders and Blood Safety
- Cancer
- Chronic Kidney Diseases
- Diabetes
- Disability and Secondary Conditions
- Early and Middle Childhood
- Educational and Community-Based Programs
- Environmental Health
- Family Planning
- Food Safety
- Genomics
- Global Health
- Health Communication and Health IT
- Healthcare-Associated Infections
- Hearing and Other Sensory or Communication Disorders (Ear, Nose Throat - Voice, Speech, and Language)
- Heart Disease and Stroke
- HIV
- Immunization and Infectious Diseases
- Injury and Violence Prevention
- Maternal, Infant and Child Health
- Medical Product Safety
- Mental Health and Mental Disorders
- Nutrition and Weight Status
- Occupational Safety and Health
- Older Adults
- Oral Health
- Physical Activity and Fitness
- Public Health Infrastructure
- Quality of Life and Well-Being
- Respiratory Diseases
- Sexually Transmitted Diseases
- Social Determinants of Health
- Substance Abuse
- Tobacco Use
- Vision



For Each Topic Area

- Objectives Moved From Another Healthy People Topic Area
- Objectives Retained As Is From Healthy People 2010
- Objectives Retained But Modified From Healthy People 2010
- Objectives New to Healthy People 2020
- Objectives Archived From Healthy People 2010



First Impressions

- Many same or slightly modified from HP2010
- Many are still health outcomes or clinically-orientated (doctor counseling for health behavior, etc)
- Data sources very reliant on survey data
- “Social Determinants of Health” section still not written



Example: Nutrition and Weight

- 6 outcome objectives (e.g. % obese)
- 7 behavioral objectives (e.g. eat more fruits & vegetables)
- 6 policy objectives (e.g. State-level incentives to food retailers for healthy foods)
- 2 clinical objectives (e.g. nutrition/weight counseling)



Example: Physical Activity

- 3 behavioral objectives (e.g. % engaged in physical activity)
- 7 policy objectives (mostly around promoting school Physical Education)
- 1 clinical objective (provider counseling exercise)
- 2 (possibly) environmental objectives (increase trips made by walk/bike)



PHAC Work from April



Criteria – April Discussion

Overall	Group A	Group B
<ol style="list-style-type: none"> 1. Overall burden - Is it big enough to have a significant impact on population (health burden)? 2. Will it significantly impact inequities – Improving health of the disadvantaged? 3. Synergy – Multicomponent interventions that are most effective 4. Feasibility – Includes cost-effectiveness, timeframe, accountability, absolute cost, and political will. 5. Net health benefits – Comparative effectiveness of different interventions to improve health of disadvantaged 6. Cross sectoral collaboration, co-benefits. 7. Creative & innovative? Does it address upstream determinants? 8. Does it build on existing capacities – impact community resilience? 	<ol style="list-style-type: none"> 1. Burden - Is it big enough to have a significant impact on population (health burden)? 2. Can we do something about it (Is it preventable)? 3. Will it significantly impact inequities – Improve the health of the disadvantaged? 4. Synergy – Multiple interventions that are most effective 5. Feasibility – Encompasses cost-effectiveness, timeframe, accountability, absolute cost, and political will. 6. Cross-sectoral collaboration 7. Co-benefits 8. Sustainability -Promotes community resilience, capacity, and builds social movement 9. Creative and innovative? 10. Does it build on existing capabilities – important connections, i.e., built environment 	<ol style="list-style-type: none"> 1. Inequity 2. Synergy – Either one intervention impacts multiple behavior (affordable housing impacts physical activity, healthy eating) or multiple strategies impact one health status (afterschool programs and fresh produce impact obesity). 3. Preventable/reducible burden? 4. Overall burden 5. Cost-effectiveness? 6. Net health benefit? 7. Timeframe <p>**Also discussed what's missing – trackable/sustainability/resiliency/co-benefits/scalable/accountability</p> 

PHAC Criteria

1. Overall burden
2. Impact on inequities
3. Synergy between interventions
4. Feasibility of interventions (cost-effectiveness, time frame, political will, etc)

PHAC Criteria (cont'd)

5. Net Health Benefit
6. Cross-sector collaboration
7. Innovative – addresses upstream determinants
8. Builds on existing capacities

Existing data for criteria

1. Overall Burden

- Healthy People 2010 indicators (counts and rates)
- Vital statistics reports: Leading causes of mortality in California, YPLL study, etc
- Potential QALY reports using CHIS or other survey data



Vital Stats: Leading Causes of Death

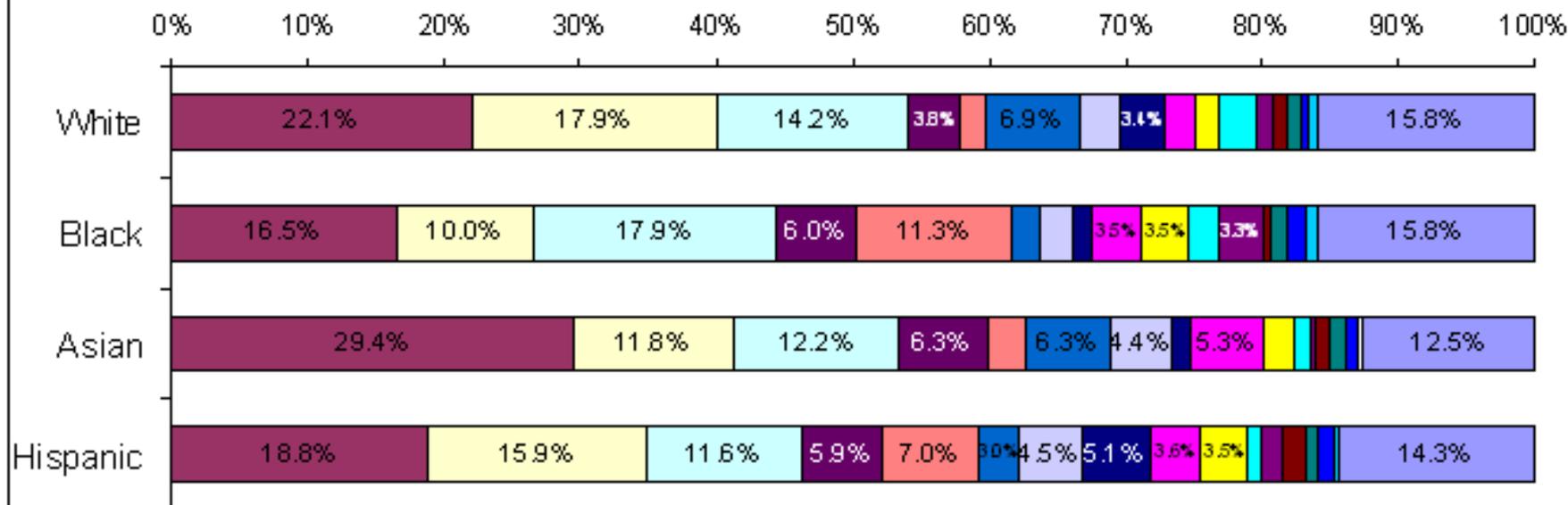
TABLE 5-8. THIRTEEN LEADING CAUSES OF DEATH BY RACE/ETHNIC GROUP¹ AND SEX, CALIFORNIA, 20

RACE/ETHNIC GROUP	TOTAL ALL CAUSES A00-Y89	LEADING CAUSES						
		DISEASES OF HEART I00-I09, I11, I13, I20-I51	MALIGNANT NEOPLASMS C00-C97	CEREBRO-VASCULAR DISEASES I60-I69	CHRONIC LOWER RESP. DISEASES J40-J47	ACCIDENTS V01-X59, Y85-Y86	ALZHEIMER'S DISEASE G30	DIABETES MELLITUS E10-E14
TOTAL RANK:		1	2	3	4	5	6	7
TOTAL	233,467	62,220	54,918	13,724	12,497	11,426	8,495	7,39
HISPANIC	36,737	7,682	7,787	2,144	914	2,990	713	1,94
NON-HISPANIC								
2 OR MORE RACES	1,339	259	318	62	83	120	31	4
AMERICAN INDIAN	1,004	222	202	48	49	83	17	5
ASIAN	17,635	4,285	4,957	1,528	674	669	333	70
BLACK	18,243	4,967	4,041	1,142	633	846	392	87
PACIFIC ISLANDER	705	212	152	46	25	27	13	4
WHITE	157,570	44,547	37,425	8,740	10,106	6,676	6,993	3,72
OTHER RACES	55	9	11	4	-	5	-	
UNKNOWN	179	37	25	10	13	10	3	

RACE/ETHNIC GROUP	TOTAL ALL CAUSES A00-Y89	LEADING CAUSES						
		DISEASES OF HEART I00-I09, I11, I13, I20-I51	MALIGNANT NEOPLASMS C00-C97	ACCIDENTS V01-X59, Y85-Y86	CHRONIC LOWER RESP. DISEASES J40-J47	CEREBRO-VASCULAR DISEASES I60-I69	DIABETES MELLITUS E10-E14	INFLUENZA AND PNEUMONIA J09-J18
MALE RANK:		1	2	3	4	5	6	7
TOTAL MALES:	118,406	31,479	28,111	7,643	5,860	5,726	3,748	2,99
HISPANIC	20,521	4,113	3,965	2,254	488	1,036	986	40
NON-HISPANIC								
2 OR MORE RACES	708	138	161	75	38	21	26	

Vital Stats: Years Potential Life Lost

**Distribution of YPLL-75 Rate
By Selected Causes of Death and Race/Ethnicity
California, 2007**



- Malignant Neoplasms
- Unintentional Injuries
- Diseases of Heart
- Homicide
- Congenital Malformations
- Cerebrovascular Disease
- Chronic Lower Respiratory Diseases
- Viral Hepatitis
- Nephritis, Nephrotic Syndrome and Nephrosis
- All Other Causes
- Conditions Originating in the Perinatal Period
- Suicide
- Chronic Liver Disease and Cirrhosis
- Diabetes Mellitus
- Human Immunodeficiency Virus Disease
- Influenza and Pneumonia
- Sudden Infant Death Syndrome

Los Angeles Public Health Department Report

Based on 1997 mortality data

Rank	Mortality – based on # of deaths in 1997	Years of Life Lost	Disability Adjusted Life Years (DALYs)
1	Coronary Heart Disease	Coronary Heart Disease	Coronary Heart Disease
2	Stroke	Homicide/ Violence	Alcohol Dependence
3	Trachea/Bronchus/ Lung Cancer	Trachea/Bronchus/ Lung Cancer	Homicide/ Violence
4	Pneumonia	Stroke	Depression
5	Emphysema	Motor Vehicle Crashes	Diabetes Mellitus
6	Diabetes Mellitus	Suicide/ Other Self-Inflicted Injury	Osteoarthritis
7	Colon Cancer	HIV/AIDS	Stroke
8	Homicide/ Violence	Cirrhosis	Trachea/Bronchus/ Lung Cancer
9	Breast Cancer	Breast Cancer	Emphysema
10	Hypertension	Diabetes Mellitus	Motor Vehicle Crashes

Blue = falls in the Top 10 for 3 categories; Yellow = falls in the Top 10 for 2 categories

San Francisco Dept PH: Years of Life Lost

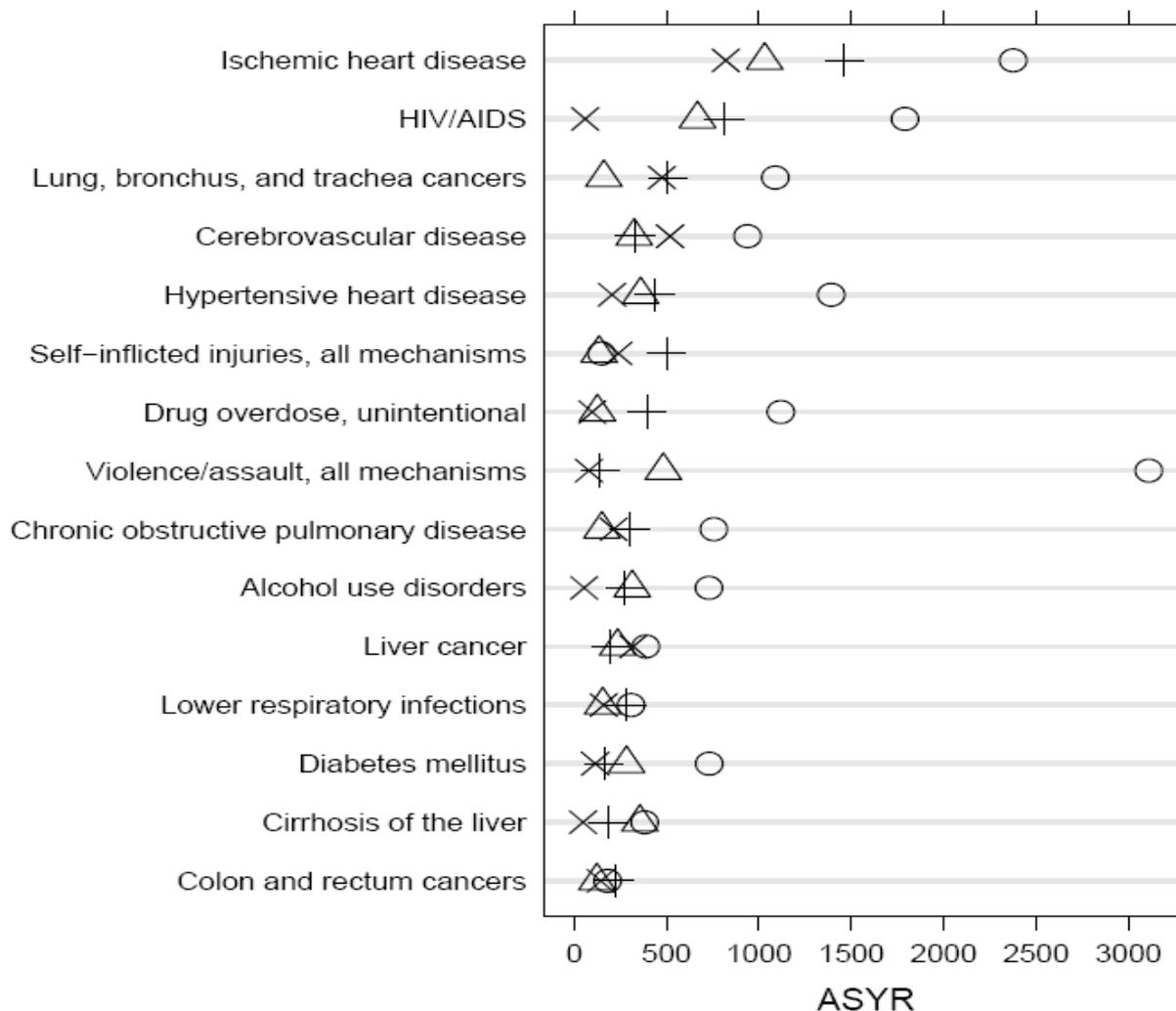


Figure 2: Leading causes of premature death among men (ranked by YLLs), comparing age-standardized YLL rates (ASYR) by cause of death and ethnicity, San Francisco, 2003–2004. Symbols: African American (○), Latino/Hispanic (△), Asian/Pacific Islander (×), White (+)

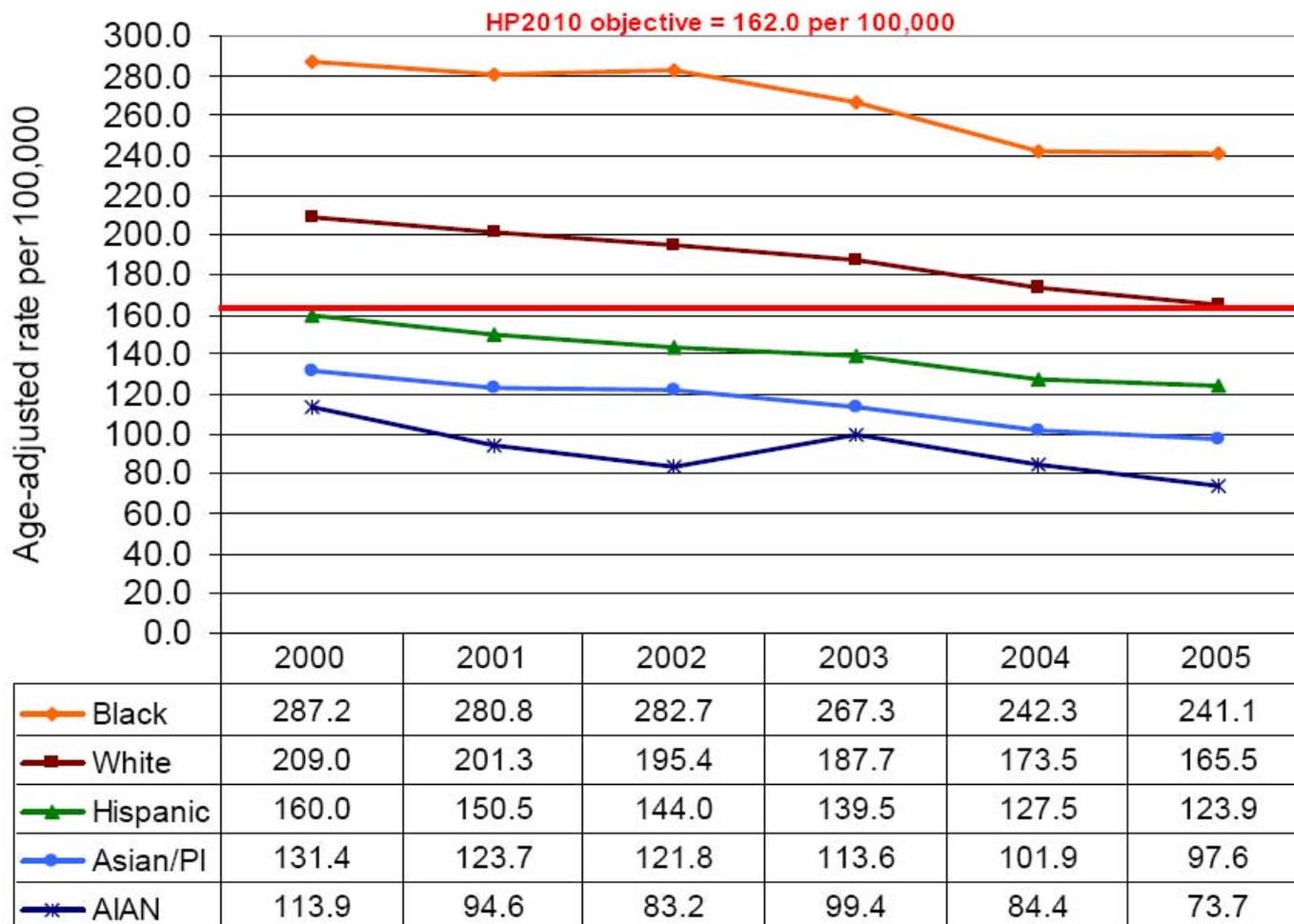
2. Impact on Inequities

- Healthy People 2010 indicators by race/ethnicity, gender, age, education (proxy for SES), disability status
 - ✦ Categories not always available
 - ✦ Of 222 objectives for which data available, 137 (61.7%) have at least race/ethnicity, gender, age
- Build on other initiatives: e.g. BARHII



HP2010 Indicators

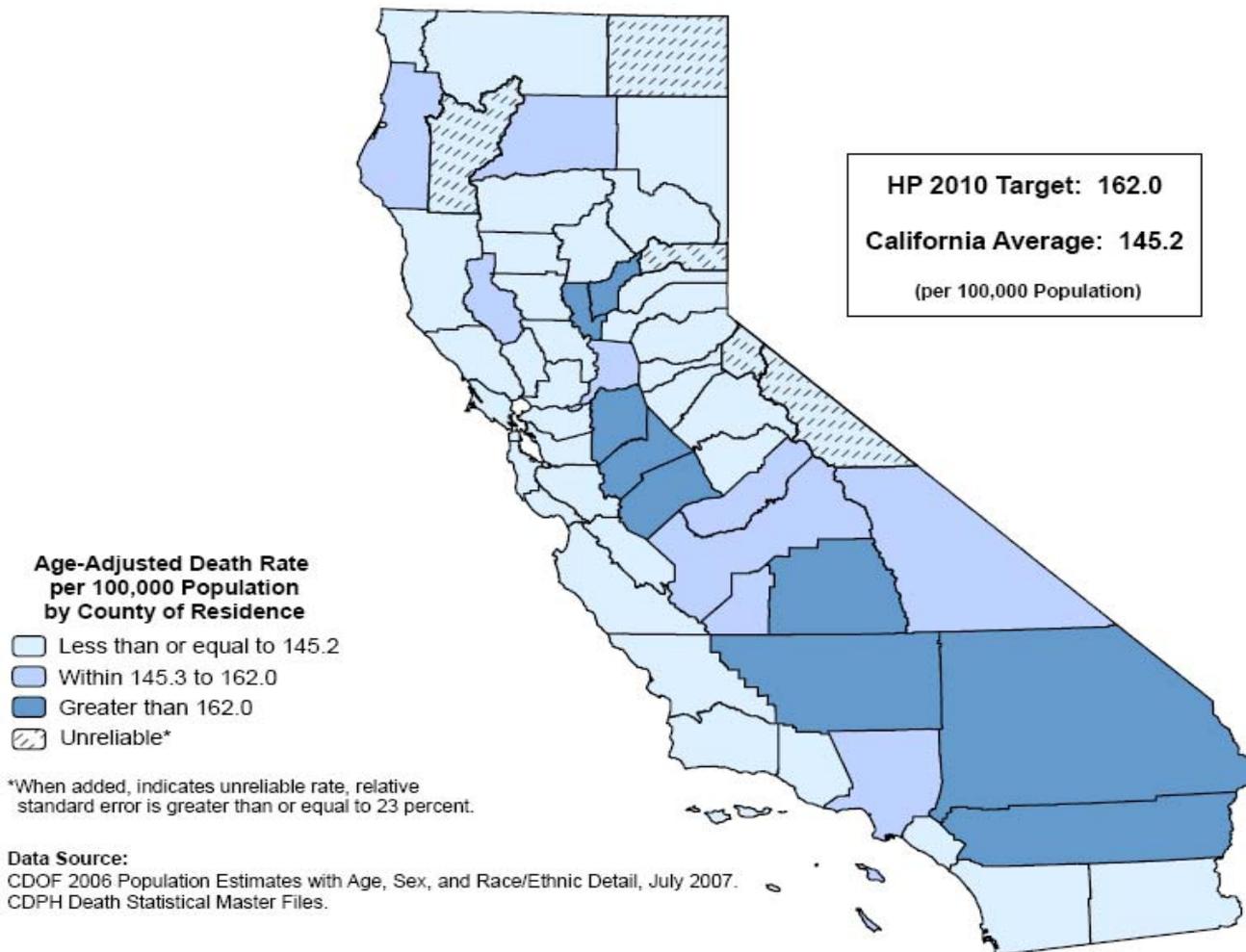
Figure 12-1.2. Coronary Heart Disease (CHD) Death Rates By Race and Ethnicity, California, 2000-2005



SOURCE: DATA2010 (May 2008), National Vital Statistics System - Mortality (NVSS-M), CDC, NCHS.

CDPH County Health Status Profiles

DEATHS DUE TO CORONARY HEART DISEASE, 2005-2007



3. Synergy Between Interventions

- CDC Guide to Community Prevention Services
- Other sources of information?

Leveraging Chronic Disease Prevention Plans



CALIFORNIA OBESITY PREVENTION PLAN SUMMARY

A VISION FOR TOMORROW, STRATEGIC ACTIONS FOR TODAY

Executive Summary



California's Master Plan for Heart Disease and Stroke Prevention and Treatment
2007-2015

Recognition of California's growing obesity epidemic, competing environmental forces and fragmented efforts, the Legislature mandated that California Department of Health Services (CDHS) create this strategic plan to guide a statewide response to this crisis. (Budget Act of 2005, SB 77, Item #4260.001.0001, Provision 7)

NEED FOR ACTION: California, like much of the rest of the world, is experiencing an obesity epidemic for which there is no single cause or simple cure. The case for action to address this epidemic is based on three principal factors:

California's Current Health Status - Poor nutrition and inactivity are causing serious health problems – including type 2 diabetes, heart disease, stroke, and cancer – now, and if left unchecked will lead to worsening conditions in the future.

Competing Environmental Forces – Choices that lead to poor nutrition and inactivity are often more available, affordable, and convenient than healthier options.

Fragmented, Uncoordinated Efforts – Many actions are being taken by government, industry, voluntary, and philanthropic sectors, but without concordance.

GOAL FOR ACTION: We have a vision for a healthier California. Governor Schwarzenegger developed a 10 Step Vision for a Healthier California and convened the Summit on Health, Nutrition and Obesity in September 2005 as a call to action to create the focus and momentum to the transformation that is needed to create the healthy California in which we all want to live. Through California's internationally recognized tobacco control programs, we have experience and success in creating a major societal change that resulted in significantly improved health for the people of our state. It was a difficult change, but we did it. And we can do it again. As California has been a leader in reducing tobacco use, we can be a leader in a campaign to reduce obesity.

MISSION: This California Obesity Prevention Plan serves as a guide for each sector of society to take part in creating



California Heart Disease and Stroke Prevention and Treatment Task Force

California Department of Public Health

Intervention Resources

GUIDE TO
COMMUNITY
Preventive Services - **The Community Guide**
What works to promote health



California Diabetes Program

Providing Leadership, Promoting Quality, and Taking Action.

Our mission is to prevent diabetes and its complications in California.

What is the Community Guide?

The Guide to Community Preventive Services is a free resource to help you choose programs and policies to improve health and prevent disease in your community. Systematic reviews are used to answer these questions:

- Which program and policy interventions have been proven effective?
- Are there effective interventions that are right for my community?
- What might effective interventions cost; what is the likely return on investment?

More than 200 interventions have been reviewed and the Task Force on Community Preventive Services has issued recommendations for their use. Learn more about the guide, our systematic review methods, and the Community Guide team.

All Community Guide Topics

- Adolescent Health
- Alcohol
- Asthma
- Birth Defects
- Cancer
- Diabetes
- HIV/AIDS, STIs & Pregnancy
- Mental Health
- Motor Vehicle
- Nutrition
- Obesity
- Oral Health
- Physical Activity
- Social Environment
- Tobacco
- Vaccines
- Violence
- Worksite

Ways To Use The Community Guide

Policies

Legislation, organizational policies...

Research

Identifying gaps, setting priorities, study quality...

Programs or Services

Planning, preventive services, employee health and wellness...

Education

Course development, training...

News & Announcements



Increased Alcohol Taxes Can Prevent Excessive Alcohol Use and Other Harms.

Increased alcohol taxes save lives! Find out how these taxes reduce alcohol use, motor vehicle crashes and fatalities, and other alcohol-related deaths.

[More >>](#)



Cancer Screening Reviews Updated

If everyone who should be screened for cancer got screened, many of the 17,175 leading cancer deaths per year could be prevented!

[More >>](#)



Did You Know?

Summer means fun in the sun! See what education & policy interventions work to promote sun safety.

Other Key Information

- About the Community Guide
- Message from the Community Guide Director
- Task Force Findings
- Community Guide 101
- Systematic Review Methods
- Economic Review Methods
- Community Guide Publications
- Community Guide Team
- The Guide to Clinical Preventive Services

DIRC

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Research

Information about scientific, academic, and clinical trial research a prevention and control of diabetes and other chronic diseases.

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[Research Resources \(83 Records Found\)](#)

[Diabetes Prevention Program \(DPP\)](#)

The Diabetes Prevention Program (DPP), a large, multi-site, national trial that type 2 diabetes can be prevented or delayed through modes of physical activity.

Author: Centers for Disease Control and Prevention
Contributed By: [California Diabetes Program](#)

[Diabetes Detection Initiative \(DDI\): Finding the Undiagnosed](#)

A broad-based community effort that encouraged individuals to get undiagnosed diabetes using a customized paper risk assessment from the American Diabetes Association.

Author: California Diabetes Program
Contributed By: [California Diabetes Program](#)

[Smoking Cessation and Diabetes](#)

Smoking exacerbates the harmful effects of diabetes by increasing and worsening diabetes control. Use the California Smokers' Helpline to quit smoking now.

Author: California Diabetes Program
Contributed By: [California Diabetes Program](#)

[U.S.-Mexico Border Diabetes Project](#)

This is a multi-year U.S.-Mexico collaborative project to determine the prevalence of diabetes along the U.S.-Mexico border and to develop and implement programs.

Author: Centers for Disease Control, Paso del Norte Health Foundation, California Community Foundation, and the Border Health Foundation.

Contributed By: [California Diabetes Program](#)

4. Feasibility of Interventions

- CDC Guide to Community Prevention Services
- Other sources of information?

5. Competitive Effectiveness

- CDC Guide to Community Prevention Services
- Other sources of information?

6. Cross-Sector Collaboration

- CDPH: e.g. CDC Connector Team
- Local Health Departments: e.g. Los Angeles PLACE Built Environment grants
- Other state and local initiatives: e.g. California Endowment, BARHII



CDC Connector Team Objectives

6 CDC Mandated Target Areas



1. Increase Physical Activity
2. Increase Consumption of Fruits and Vegetables
3. Decrease Consumption of Sugar Sweetened Beverages
4. Increase Breastfeeding Initiation, Duration, and Exclusivity
5. Reduce the Consumption of High-Energy-Dense Foods
6. Decrease Television Viewing



Policies for Livable, Active Communities and Environments (PLACE)

<http://publichealth.lacounty.gov/place/>

AAA

Search



Navigate PLACE Web Site

- PLACE Home
- About PLACE
- PLACE Initiative Grants
- Built Environment Resources
- LA County Workplace Food Policy
- PLACE Staff Directory

Contact Information

County of Los Angeles
 Department of Public Health
 Chronic Disease and
 Injury Prevention Division
 PLACE Program
 3530 Wilshire Boulevard, Suite 800
 Los Angeles, CA 90010
 E-mail: place@ph.lacounty.gov
 Phone: (213) 351-7862

Policies for Livable, Active Communities and Environments (PLACE) Program

The PLACE Program is dedicated to fostering policy change that supports the development of healthy, active environments for all Los Angeles County residents.

PLACE News

Bike and Pedestrian Counts in Glendale: A method of assessing traffic patterns and improving bicycle infrastructure

In early September, Glendale residents and community advocates took part in a Citywide Bike and Pedestrian Count. The Count is a method of collecting data for traffic patterns and usage. Not only will results be used to determine frequently used routes to be included in the City's Safe and Healthy Streets Plan, but to also steer the City's efforts to enhance Glendale's bicycle infrastructure.



El Monte Holds First Community Meeting

The City of El Monte held a community meeting to gather input on how to become a healthier city. Approximately 150 community members attended and provided suggestions such as more healthy food choices and more areas to bicycle and walk. These ideas will help shape the new Health and Wellness Element of the city's general plan.

City of Long Beach Hires Bike Expert

Bike expert Charlie Gandy is the City of Long Beach's new mobility coordinator. Can he build a more bikeable Long Beach?

Department of Public Health Awards Built Environment Grants

The PLACE program is pleased to announce the funding of five organizations within Los Angeles County. Over the next three years, each grantee will develop a policy and physical project aimed at increasing physical activity in their community. Examples of policies include incorporating a Health Element into a city's General Plan and revising a city's Bicycle Master Plan to make it easier for residents to bike around their community.

PLACE's Picks

Article: Recommended Community Strategies and Measurements to Prevent Obesity in the United States

Recent reports have shown that approximately two-thirds of U.S. adults and one-fifth of U.S. children are obese or overweight. This trend is a growing epidemic and is dependent upon many built environment factors. For this reason, it is important to promote healthy communities and lifestyles.



7. Innovative (Addresses Upstream Determinants)

- National health indicator projects similar to HP2020:
 - ✦ Community Health Status Indicators (DHHS)
 - ✦ MATCH Rankings (RWJ Foundation and U of WI)
- NACCHO: Health Equity and Social Justice
- California Endowment:
Building Healthy Communities
- Local initiatives: e.g. BARHII





Community Health Status Indicators CHSI

Our Mission: Provide Information for Improving Community Health

Select State

Select a State

Select County

Select a County

[Home](#) | [About the Data](#) | [About the Project](#) | [How to Use Report](#) | [Partners](#) | [Resources](#)

Community Health Status Indicators Report

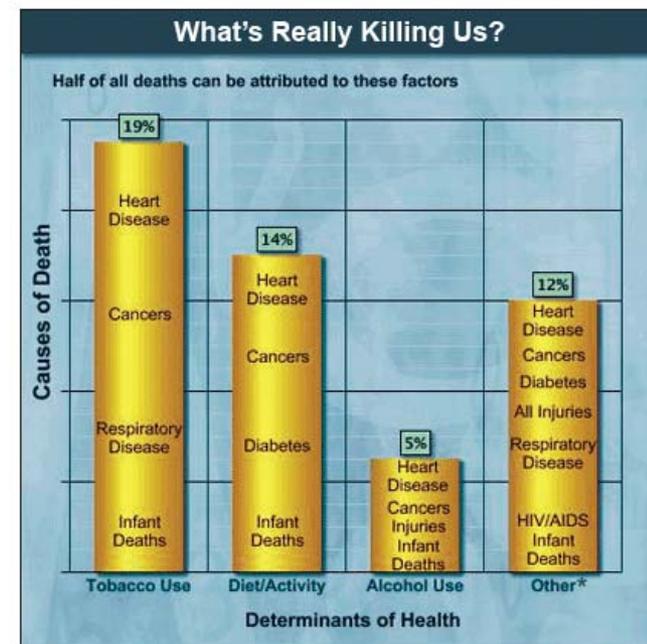
The goal of Community Health Status Indicators (CHSI) is to provide an overview of key health indicators for local communities and to encourage dialogue about actions that can be taken to improve a community's health. The CHSI report was designed not only for public health professionals but also for members of the community who are interested in the health of their community. The CHSI report contains over 200 measures for each of the 3,141 United States counties. Although CHSI presents indicators like deaths due to heart disease and cancer, it is imperative to understand that behavioral factors such as tobacco use, diet, physical activity, alcohol and drug use, sexual behavior and others substantially contribute to these deaths (see chart).



In addition to the web pages, community profiles can be displayed on maps or downloaded in a brochure format. The CHSI mapping capability allows users to visually compare similar counties (termed peer counties) as well as adjacent counties with their county. The downloaded CHSI report allows broad dissemination of information to audiences that may not have access to the internet.

The CHSI report provides a tool for community advocates to see, react, and act upon creating a healthy community. The report can serve as a starting point for community assessment of needs, quantification of vulnerable populations, and measurement of preventable diseases, disabilities, and deaths. The CHSI report is accompanied by a companion document entitled [Data Sources, Definitions, and Notes](#) (PDF - 261KB). This document gives detailed descriptions on data estimations, definitions, caveats, methodology, and sources.

To access a community profile, select a state and county name on the left navigation bar and select display data. The demographic characteristics of the selected county will appear as well as its peer counties (if applicable, counties similar in population size and frontier status). To move to another page, select the health indicator section from the list in the left navigation bar. To print the CHSI brochure, select the print report option at the top right-hand corner of the page; do not use the browser print option. To access the CHSI mapping tool, select the mapping option at the top right-hand corner of the page.



Source: McGinnis, J.M & Foege, W.H. (1993). Actual causes of death in the United States. *JAMA*, 270(18), 2207-2212

Programs

- » Community Health
- » Environmental Health
- » Public Health Infrastructure and Systems
- » Public Health Preparedness

Other Topics

- » Alliance to Make US Healthiest
- » Demonstration Sites
- » Funding Opportunities
- » H1N1
- » Health Equity and Social Justice
- » Model Practices
- » Peer Assistance Network
- » Workforce Training
- » Programs A-Z

Programs and Activities

Health Equity and Social Justice

Policy Statements | Staff Contacts

NACCHO's Health Equity and Social Justice initiatives explore *why* certain populations bear a disproportionate burden of disease and mortality and what health departments can do to better address the causes of these inequities. The goal of NACCHO's Health Equity and Social Justice initiatives is to advance the capacity of local health departments (LHDs) to tackle the root causes of health inequities through public health practice and their organizational structure. NACCHO's Health Equity and Social Justice initiatives include:

- The [LHD National Coalition for Health Equity](#), a network to build solidarity and share experiences among LHDs, as well as develop public policy agendas, identify the need for training, and increase public awareness;
- The [Health Equity Campaign](#), which brings together health departments and others using the PBS documentary film series *Unnatural Causes: Is Inequality Making us Sick?* in their jurisdictions to host community dialogues about health equity;
- The [Health Equity and Social Justice Toolkit](#), a searchable database of Health Equity tools, publications, and resources, available in NACCHO's Toolbox; and
- Publications tailored to local health departments, including the anthology *Tackling Health Inequities through Public Health Practice: Theory to Action* (revised and expanded version forthcoming, Oxford University Press, February 2010) and NACCHO's *Guidelines For Achieving Health Equity in Public Health Practice*.

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Related Content

-  [Environmental Justice](#)
-  [Health Equity Campaign](#)

Don't Miss!

Tackling Health Inequities through Public Health Practice: Theory to Action



Oxford University Press will release *Tackling Health Inequities through Public Health Practice: Theory to Action* in February 2010. Edited by NACCHO Senior Analyst Richard Hofrichter and the Director of the San

<http://naccho.org/topics/justice/>

inequities. This reorientation involves restructuring the organization, culture and daily work of public health.



Building Healthy
Communities



<http://www.calendow.org/healthycommunities/index.html>

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Welcome to Our New Strategic Vision Web Site: Building Healthy Communities



In 2010, The California Endowment will embark on a new, 10-year strategic direction: *Building Healthy Communities*. Our goal is to support the development of communities where kids and youth are healthy, safe and ready to learn.

This special Website was designed to answer your questions about The California Endowment's new strategic direction.



A Message on our strategic vision from The California Endowment's Board of Directors and President and CEO

The California Endowment's Community Partners

The California Endowment recently identified 14 communities throughout California that we would like to partner with to achieve the goals outlined in our 10-year strategic initiative, *Building Healthy Communities*-- places where kids and youth are healthy, safe and ready to learn.



[View Community Partner Maps](#)
[View Community Descriptions](#)

What's New on the Strategic Vision Site?

Please check this site often as we will be updating content on a regular basis.

- [Evaluation FAQs 9_11_2009](#)
- [Evaluation Logic Modeling FAQs 9_11_2009](#)
- [Building Healthy Communities: California Living Summary 8_2009](#)
- [Building Healthy Communities: California Living Summary 8_2009 \(Spanish\)](#)
- [Ten Outcomes](#)
- [Ten Outcomes \(Spanish\)](#)
- [The Four Big Results](#)

8. Builds on Existing Capacities

- Healthy Communities – Dr. Rudolph
- Previously mentioned local, state and national initiatives: e.g. Los Angeles DPH PLACE initiative, BARHII, NACCHO work on Health Equity

