



2008 Community Training Needs Assessment Survey Results

Office of Community Wellness and Prevention
Washington Department of Health

December 2008
DOH Pub 140-003



PUBLIC HEALTH
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HEALTHIER WASHINGTON

Information Summary and Recommendations

***2008 Community Training
Needs Assessment Survey Results***

December 2008



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Acknowledgements

The survey and this report were developed for the Office of Community Wellness and Prevention using funds from the Steps to a Healthier WA program (5 U58 DP023317-05) and E2SSB 5930: *An Act Relating to Providing High Quality, Affordable Health Care to Washingtonians Based on the Recommendations of the Blue Ribbon Commission on Health Care Costs and Access*. The survey was developed in consultation with an external advisory group which included:

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- Dennis Worsham, Public Health – Seattle and King County
- John Britt, Tacoma-Pierce County Health Department



This work was also based on the original policy training work conducted and evaluated by Steps Program staff (Hilary Gillette-Walch, RN, MPH, Amy Manchester Harris, MPA, and Jennifer R Reuer, MPH), along with Julia Dilley now with Oregon State Health Services, Program Design and Evaluation Services.

This report meets Public Health Standards 8.1, 8.3, and 12.4.

Background

There is an increasing focus on standards, accountability and outcome measures, and a corresponding understanding that policy changes can affect a broad community to support chronic disease interventions. The Washington State Department of Health, Office of Community Wellness and Prevention mission is to lead and support the development of healthy people and communities in Washington by promoting policies and healthy behaviors to attain lifelong prevention and management of chronic disease.

In April 2005, the Washington State Department of Health and community partners held a successful first statewide community policy institute in Washington. The “Sustaining Prevention through Policy and Organizational Practice Change” training was developed based on fundamental training goals:

- Increase knowledge about what constitutes policy/organizational change (what “the work” is).
- Increase knowledge about the value of policy/organizational change.
- Increase skills for how to engage stakeholders to enact policy/organizational change (convince partners to prioritize policy change, identify joint policy priorities that meet multiple needs, achieve real policy change).

In 2006, The Program Design and Evaluation Program in Oregon completed an evaluation of the Institute for the department. Participants reported also needing technical assistance in one or more of three areas: coalition building, planning policy/ organizational change work, and implementing policy work. Other recommendations from the evaluation report, combined with the desire to support ongoing work, led to the recommendation for additional training.

Discussions began in 2007 to hold a second conference among the department’s internal and external partners. The external partners group recommended that a needs assessment be conducted to pinpoint the training needs of local health jurisdictions and develop training based on those identified needs. During the same time frame, local health jurisdictions received funding from E2SSB 5930. This bill provided local health jurisdictions funding to address obesity and its consequent burden of chronic disease. In implementation planning meetings for E2SSB 5930, we received feedback that local health jurisdictions needed assistance and leadership from the department on community mobilization, policy and community policy work (referred to as community policy in the rest of this document), and collaborative leadership.

This report describes the findings of the Community Policy Needs Assessment Survey conducted by the department’s Office of Community Wellness and Prevention. The survey focused upon local organization and staff capacity to develop and implement local policy to prevent chronic disease.

Executive Summary

This survey was conducted to determine on-going training needs following a statewide Policy Institute attended by local public health staff and contractors delivering department programs. This report describes the findings of that Community Policy Needs Assessment Survey conducted by the department's Office of Community Wellness and Prevention. The survey focused on local organization and staff capacity to develop and implement local policy to prevent chronic disease.

These results give insight into local organization policy capacity and ongoing activities in Washington. The survey yielded details about individual staff's strengths and experience in relationship to policy work and, in a limited manner, which current issues are being addressed at the local level. The key words chosen by respondents to describe elements needed to build healthier communities revealed a passionate workforce that cares and is not focused merely on securing more funding.

Building upon the success of E2SSB 5930 funding expansion to local health jurisdictions, it will be important to create avenues of resources or funding that can support policy work and staff training. In addition to the Standards, the Institute of Medicine's report states that "government should be equipped for this role by the technical knowledge and professional expertise of organization staff" (IOM, 1998). Ideally an open dialogue within and between state and local organizations about ongoing and proposed policy will develop because the survey revealed that some respondents were unaware of ongoing work. The responses indicate a desire to expand individual capacity to create policy change. Providing additional opportunities to monitor and evaluate results after a policy change is also important.

It was also clear that there is a need for training across all areas identified by the survey. While community involvement is desired throughout all aspects of policy development and implementation process, staff may not have the skills to do it. To facilitate community involvement, more training is needed on working effectively with external partners. Including external partners in decision-making helps make policies more effective. It was also demonstrated that counties often fall short of demonstrating how they include partners in the decision-making process (Table 1). Again, this may be an opportunity for coalitions to assist in engaging diverse representatives from the community. In addition to reaching out to new partners, staff should also consider how they interact with external partners. This may mean providing training to allow staff to move beyond just providing information to actually giving partners a voice in the decision-making process. The results indicate that Community Wellness and Prevention contracted agencies demonstrate shared decision making more frequently with partners than local health jurisdiction staff does.

Respondents identified a clear need to expand their knowledge and skills around evaluating policy work and using community-specific data for direction (Table 2). The need for more knowledge and training corresponds directly to the findings that evaluation is the least frequently occurring activity; the lack of skills and knowledge may be a partial explanation for this. The theme of leadership was persistent, both how to lead and how to work with leaders. Respondents

indicated a desire to learn how to engage leaders, educate them, and how to provide leadership in their communities. It is likely that a closer examination of the critical skills for supporting this work may need to occur.

Local health jurisdictions do not appear to be sustaining an ongoing cycle of activities, from assessment, planning, implementation, monitoring, and evaluation based upon the frequency each activity was reported occurring. Addressing the needs of the workforce may assist organizations in building overall capacity. Many local health jurisdictions are just beginning to create coalitions, and many more have yet to begin. The timing is ideal for additional coalition work to be initiated in Washington communities, and it will be important to provide opportunities for skill-building before counties launch more coalitions in order to maximize efforts.

Key Findings

1. About 40 percent identified community involvement, 17 percent identified leadership, 18 percent identified a link with the built environment, and 16 percent identified policy activities as key components to building healthier communities.
2. Most local organizations have ongoing coalitions/advisory groups or are in the process of forming them for the majority of areas listed on the survey: built environment (54 percent), social environment (72 percent), economic development (53 percent), physical activity (85 percent), nutrition (79 percent), and air quality (43 percent).
3. County groups with coalitions in place, or in the process of forming coalitions, to address these policy areas varied widely. The range was from 45 percent for King, Pierce, and Snohomish, to 73 percent for Benton-Franklin, Spokane, and Yakima.
4. The majority of respondents think their organizations are doing “very well” or “somewhat well” at identifying what problems they have and in finding solutions to those problems.
5. Less than half of respondents think their organizations are “always” or “often” planning, monitoring, or assisting other groups in implementing community policy activities.
6. Evaluation and use of evaluation findings appear to be the areas that organizations were working on the least in community policy work.
7. Businesses and local business organizations are not being included as often in discussions around chronic disease work.
8. The greatest need for training was “convincing community partners to prioritize community policy efforts in their work plans” (88 percent).

9. Approximately two-thirds of respondents reported needing training (either basic or advanced) to increase their ability “to convince colleagues or management within their own organization to prioritize policy work.”
10. Policy work is being conducted in some form by 71 percent of the surveyed local health jurisdictions and Community Wellness and Prevention contractors.
11. Just over half of the workforce surveyed had some experience in organizing grassroots support or conducting media campaigns.
12. Seventy two percent of the respondents stated they had experience in disseminating research-based information.
13. The top training needs are about management of the human side of the process, community mobilization, and community leadership.

Key Recommendations

1. Increase the understanding of the role and importance of community involvement, leadership, and how built environment and policy activities build healthier communities.
2. Develop a uniform definition of “healthy” or “healthier” community for wide dissemination in Washington.
3. Develop a resource list of tools and trainings to help local health jurisdictions and Community Wellness and Prevention contractors build competencies.
4. Identify communities, organizations, or local health jurisdictions who are effectively managing coalition/advisory groups for policy change work in their communities. These could be “champions” and provide mentoring to other communities interested in the work.
5. Identify a mechanism or method for sharing work with colleagues in different counties to help ensure coordination of all policy work to avoid duplication of efforts or the creation of conflicting guidance from lead organizations.
6. Continue to support local health jurisdictions in all aspects of community policy work (identification of problems and solutions; planning, monitoring, and assisting other groups in implementing activities; evaluating activities).
7. Continue to seek tools for evaluation (process and outcome) as the research base expands and disseminate the tools as they become available.
8. Expand the understanding of the role of faith-based, city/local planner and business/business leaders can play in a community’s health.

9. Expand the conversation about the importance of community policy change work.
10. Integrate the Directors of Health Promotion and Education core competencies for public health staff at the state and local level as well as Community Wellness and Prevention contractors and demonstration in work plans, job descriptions, and workforce development plans.
11. Work with Directors of Health Promotion and Education to identify training opportunities for Washington on the competencies.
12. Provide education and training to support educating staff, local health jurisdiction leadership, and community partners on the importance and role of community policy work in addressing chronic disease.
13. Institutionalize ongoing workforce development in community policy change work and methods.
14. Link the competencies specifically to the Public Health Standards and contract activities, provide real-world examples of organizations that are actively engaged in policy activities and have begun to integrate daily program work with the standards.
15. Explore ways to effectively disseminate research and articulate data to planning partners.
16. Provide resources and training to build staff competencies covering the human side of policy making, community mobilization, and community leadership.

Introduction and Purpose of the survey

“(c)hronic disease is a serious threat to the vitality of communities nationwide as well as Washington State. Preventing or reducing the impact of chronic disease requires a long-term coordinated approach to reshape social and physical environments, and prevention is our greatest hope.”

- Letter from Mary Selecky, Secretary, Washington Department of Health to Dr. Wayne Giles, Director, Division of Adult and Community Health, Centers for Disease Control and Prevention.

Traditionally, approaches to addressing chronic disease management have been based in medical settings or dealt with through interventions focused on individual behavior changes. While these approaches have shown great results in addressing health issues, evidence has shown that a person’s individual behavior change can be more effective, when they are in environments that support healthier behaviors. To effectively address the current social and health programs facing today’s world, a change is needed that maximizes limited resources and provides equity for our most vulnerable populations. These approaches must move us from after the fact (the medical focus) to the first place (preventative focus) and which goes beyond the individual and provides a comprehensive community focus (Cohen, 2007). It has been recognized that “The shift from authority-focused leadership to collaborative and team-oriented leadership has not been met with adequate leadership education and training.” (Larson, 2002)

Investment in Proven Community-based Chronic Disease Prevention

An investment of \$10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than \$16 billion annually within five years. This is a return of \$5.60 for every \$1.

For Washington State within five years of an investment of \$10 per person per year in strategic disease prevention programs in communities the potential annual net savings is estimated at \$343 million annually and return on investment rate of 5.5 to 1.

- Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities, 2008

In 2006, the Directors of Health Promotion and Education worked with researchers from the University of North Carolina, School of Public Health to identify and develop specialized competencies for the public health workforce. These competencies focused competencies needed to efficiently implement public health solutions through community policies, systems, organizational and/or environment changes.

With an increasing focus on standards, accountability, and outcome measures and the understanding that policy changes can affect a broad community and help to support chronic disease interventions, Washington State Department of Health, Community Wellness and Prevention’s mission is to lead and support the development of healthy people and communities in Washington by promoting policies and healthy behaviors to attain lifelong prevention and management of chronic disease. The community policy needs assessment was developed to identify the training and competencies needs in public health workforce working on chronic disease within local public health jurisdictions and directly funded contractors.

Defining Policy

The broadest opportunity for improving a community's health is through organizational, systems, environmental, or policy changes. Policies typically have greater reach, across time and longevity, which can result in sustainable changes in communities that make health-related interventions more effective (Association of State and Territorial Directors of Health Promotion and Public Health Education, 2001). Policies can be defined as rules, practices, codes, laws and/or expectations related to environments, systems, and organizations. Using the social-ecological model policies work happens at the institutional/organizational, community and policy, system and environmental levels.

Institutes and organizations include schools, places of employment, places of worship, sports teams, and volunteer groups. Organizations can help members make better choices about healthful eating and physical activity through changes to organization

policies and environments as well as by providing health information. A community can be like a large organization; able to make changes to policy and the environment to give residents the best possible access to healthful foods and places to be physically active. Changes to zoning ordinances, improvements to parks and recreation facilities, creating ways to distribute free or inexpensive fruits and vegetables, are a few ways community residents, groups, and organizations can work together to improve nutrition and physical activity. The policy, systems, environment level of the social-ecological model is considered the all-encompassing category involving individuals, organizations, and communities working together for change. New nutrition and physical activity legislation, statewide school policies, media campaigns, and partnerships with business and industry are just some of the ways a comprehensive strategy to address obesity and other chronic diseases takes shape on a large scale (Centers for Disease Control and Prevention, 2001).

This survey's intent was to examine community policy activities and not legislation; focusing largely on work being facilitated by the local health jurisdictions, and work by local partners as well, like tribes, clinics, and coalitions. Throughout discussions and this report, it is important to note that community policy has been and is defined as, "policy including sustainable organizational, environmental, system or policy changes affecting a large population to support individual's healthier behaviors." Examples include cities, including walkable communities, in their long-range plans or schools requiring a certain number of minutes of exercise every day.

Social-ecological Model



Nearly all Washington State health organizations are members of the public health system, even if they are not housed in the health department, because each organization contributes to the overall health of the community. This is an important distinction because health policy is a core function of public health as defined by the Institute of Medicine (IOM, 1998). Furthermore, the core functions come to life for respondents working in local and state health departments as the Standards for Public Health in Washington State. Policy is integrated into each of the standard's twelve functions; the twelve functions that every health department aims to address - either directly or in coordination with local partners (Washington State Department of Health, 2007).

While it is acknowledged that policy is an essential function of public health, policy work often becomes a secondary priority during a typical day in a local health jurisdiction – making way for the inevitable disease outbreaks, restaurant inspections, and funding challenges. Policy work in public health is more often the less glamorous and seemingly slow process of building community consensus, using coalitions to educate and bring together the work of many. While often a complex process, policy changes can result in lasting benefits for all residents. Using the potent tool of policy to combat chronic disease, Washington is working at several levels in the public health system to achieve a healthier population.

Background

In April 2005, Washington State Department of Health and community partners held a successful first statewide community policy institute in Washington. The “Sustaining Prevention through Policy and Organizational Practice Change” training was developed based on fundamental training goals:

- Increase knowledge about what constitutes policy/organizational change (what “the work” is).
- Increase knowledge about the value of policy/organizational change
- Increase skills for how to engage stakeholders to enact policy/organizational change (convince partners to prioritize policy change, identify joint policy priorities that meet multiple needs, achieve real policy change).

In 2006, The Program Design and Evaluation Program in Oregon completed an evaluation of the Institute for the department. Participants reported also needing technical assistance in one or more of three areas: coalition building, planning policy/ organizational change work, and implementing policy work. Other recommendations from the evaluation report combined with the desire to support ongoing work led to the recommendation for additional training.

Discussions began in 2007 to hold a second conference among the department's internal and external partners. The external partners group recommended that a needs assessment be conducted to pinpoint the training needs of local health jurisdictions and develop training based on those identified needs. Concurrent to these discussions in 2007, local health jurisdictions received funding from E2SSB 5930: *An Act Relating to Providing High Quality, Affordable Health Care to Washingtonians Based on the Recommendations of the Blue Ribbon Commission on Health Care Costs and Access*. This bill provided local health jurisdictions with funds to address obesity and its consequent burden of chronic disease. In implementation planning meetings for E2SSB 5930, we received feedback that local health jurisdictions needed assistance

and leadership from the department on community mobilization, policy and community policy work (referred to as community policy in the rest of this document), and collaborative leadership.

This report describes the findings of the Community Policy Needs Assessment Survey conducted by the department's Office of Community Wellness and Prevention. The survey focused upon local organization and staff capacity to develop and implement local policy to prevent chronic disease.

Key Elements to Creating and Developing Healthier Communities

Healthy communities provide an opportunity for individuals to make healthy lifestyle choices for themselves and their families. Community Wellness and Prevention’s mission is to lead and support the development of healthy people and communities in Washington by promoting policies and healthy behaviors to attain lifelong prevention and management of chronic disease. To help lead and support local health jurisdictions and Community Wellness and Prevention contractors to implement healthier communities, Community Wellness and Prevention staff needed to understand how community partners defined “healthier communities.” *Healthy People 2010* defines a healthy community as “...one that continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential.” (Health and Human Services, 2001).

The Community Wellness and Prevention Healthy Communities Integration Team recently defined a healthy community.

A healthy community* is a place where people and the environment are healthy, cared for, and safe. To be healthy, a community:

- Meets the basic needs of all of its residents including food, water, shelter, safety, work.
- Creates quality education and learning opportunities for all ages.
- Provides access to adequate healthcare services.
- Fosters connectedness.
- Protects its natural environment.
- Makes healthy choices easy.

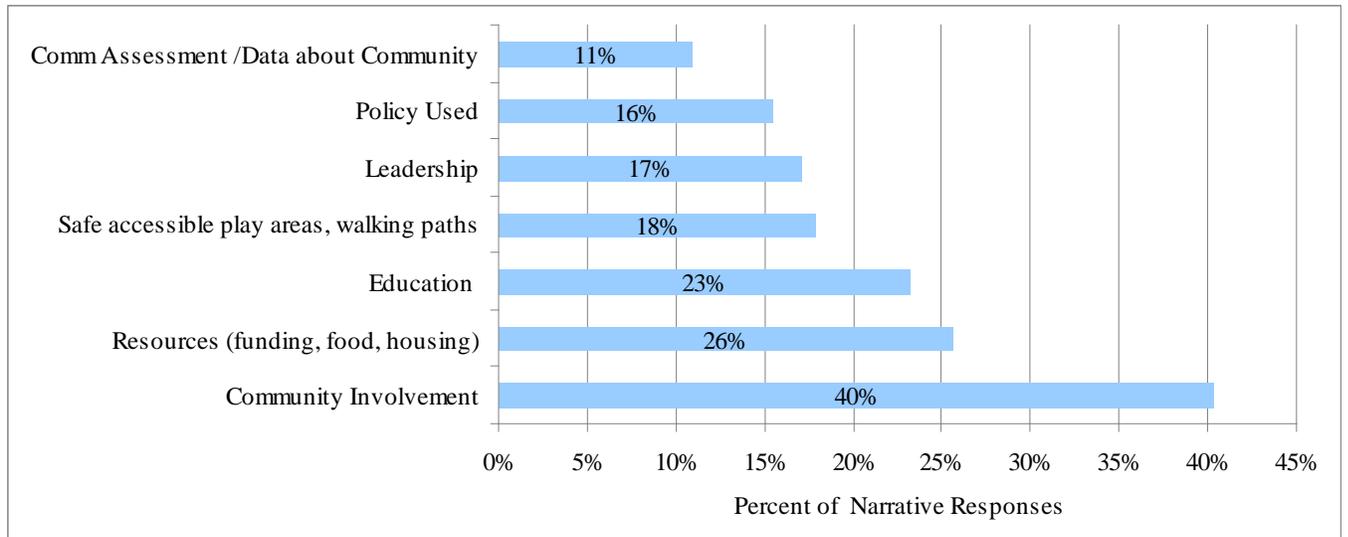
*A “community” encompasses people, some form of proximity or place that enables interaction and interaction that leads to some degree of shared values or culture (Issel, 2004).

The first question asked survey respondents to list or describe the “key components” for creating healthier community (Figure 1) in narrative form. Key words and concepts used in the responses were quantified. All responses (n=129) were included even if the individual did not complete the entire survey (Appendix B). The overwhelming response was that the key component for developing a healthier community was community involvement. Many answers also detailed what that involvement should look like, specifically community’s participation in assessment and planning activities.

Question 1 Asked

What do you feel are the key components to creating and/or developing a healthier community?

Figure 1. The Most Common “Key Components” Reported by Respondents as Necessary for Creating a Healthier Community



Respondents were allowed to list or describe more than one key component. Thus percentages add up to more than 100 percent.

Findings:

About 40 percent identified community involvement, 17 percent identified leadership, 18 percent identified a link with the built environment, and 16 percent identified policy activities as key components to building healthier communities.

Recommendations:

1. There is a need to increase the understanding of the role and importance of community involvement, leadership, and how built environment and policy activities build healthier communities.
2. Utilize survey and other current research to identify “required” elements of building a healthy community and core competencies needed to meet those elements.
3. Develop a uniform definition of “healthy” or “healthier” community for wide dissemination in Washington.
4. Develop a resources list of tools and trainings to help local health jurisdiction and Community Wellness and Prevention contractors build competencies.

Ongoing Local Policy Work

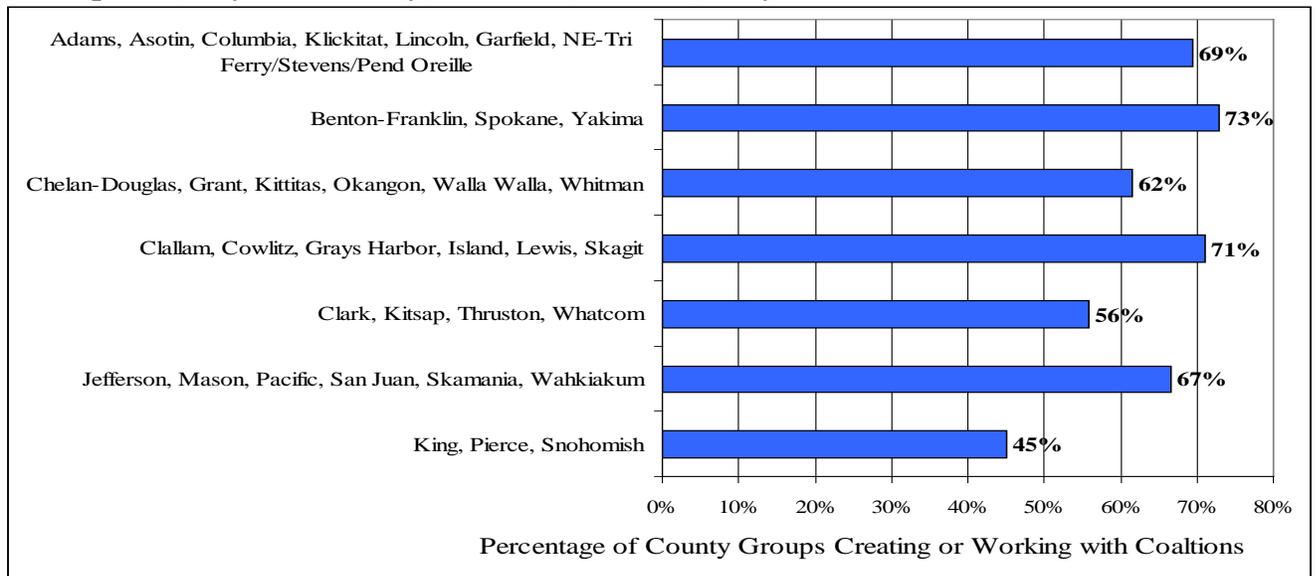
Most local organizations have ongoing coalitions/advisory groups or are in the process of forming them for the majority of areas listed on the survey: built environment* (54 percent), social environment** (72 percent), economic development*** (53 percent), physical activity (85 percent), nutrition (79 percent), and air quality (43 percent). It is not surprising that the areas of physical activity and nutrition rose to the top for topic areas that coalitions were addressing. Funding and substantial programmatic emphasis on these areas by Department of Health and other funding agencies have supported work in these areas for some time. The proportion of organizations that have ongoing coalitions/advisory groups or are in the process of forming them for the areas of interest was averaged across these areas for each county group and is depicted in Figure 2. These averages varied by county group and ranged from 45 percent for King, Pierce, and Snohomish to 73 percent for the Benton-Franklin, Spokane, and Yakima county group.

Question 2 Asked
 Is your organization working with any coalitions/advisory groups who are focusing on promoting healthy choices in an effort to decrease the burden of chronic diseases? (check all that apply)

- Built environment;
- Social environment;
- Economic development;
- Physical Activity (including access);
- Nutrition (including access); and
- Air quality

When asked whether their organization was working with any coalitions/advisory groups (referred to as “coalitions” for the rest of the document) to address chronic disease, the majority indicated that they are currently working with one or more groups (56 percent) or in the process of forming groups (8 percent) in at least one of the six areas of the survey. Some respondents stated they were unaware if their organization was working or forming coalition/advisory groups.

Figure 2. The Percent of County Groups Working with or Forming Coalitions to Manage Chronic Disease through Addressing Built Environment, Social Environment, Economic Development, Physical Activity, Nutrition, or Air Quality.



* Built environment is defined as “the man-made surroundings that provide the setting for human activity, ranging from the large-scale civic surroundings to the personal places” (Wikipedia, 2008).

**Social environment is defined as the aggregate of social and cultural institutions, forms, patterns, and processes that influence life of an individual or community.

***Economic development is defined as the efforts to improve the economic well-being and quality of life for a community by creating and maintaining healthy work environments.

Finding:

1. Most local organizations have ongoing coalitions/advisory groups or are in the process of forming them for the majority of areas listed on the survey: built environment (54 percent), social environment (72 percent), economic development (53 percent), physical activity (85 percent), nutrition (79 percent), and air quality (43 percent).
2. County groups that have collations in place, or are in the process of forming collations, to address these policy areas varied widely. The range was from 45 percent for King, Pierce and Snohomish, to 73 percent for Benton-Franklin, Spokane, and Yakima.

Recommendations:

1. Identify communities, organizations, or local health jurisdictions who effectively manage coalition/advisory groups for policy change work in their communities. These could be “champions” and provide mentoring to other communities interested in the work.
2. Identify a mechanism or method for sharing work with colleagues in different counties to help ensure coordination of all policy work to avoid duplication of efforts or the creation of conflicting guidance from lead organizations.

Organizations Ability to Identify Community Policy Problems and Strategies

In an effort to assess how organizations are equipped to develop policy around chronic disease, the survey asked the respondents to assess their organization’s ability to identify problems needing a community policy solution and strategies to address those problems (DHPE competencies 1 and 2). Overall, most respondents indicated that their organization identified either “very well” or “somewhat well” (81 percent). Slightly fewer respondents (75 percent) reported their organization was able to identify strategies to address problems needing community policy solutions “very well” or “somewhat well.” No difference was observed in responses when stratified by the respondent’s type of organization.

Question 4 Asked

In your opinion, how well does your organization identify and articulate the following for chronic disease (including environmental health)?

- Problems needing a community policy solution?
- Strategies to address problems needing community policy solutions?

Very well; Somewhat well; Not well; Not at all; Don’t know

Organizations Ability to Influence, Monitor and Evaluate Community Policy

Question 7 Asked

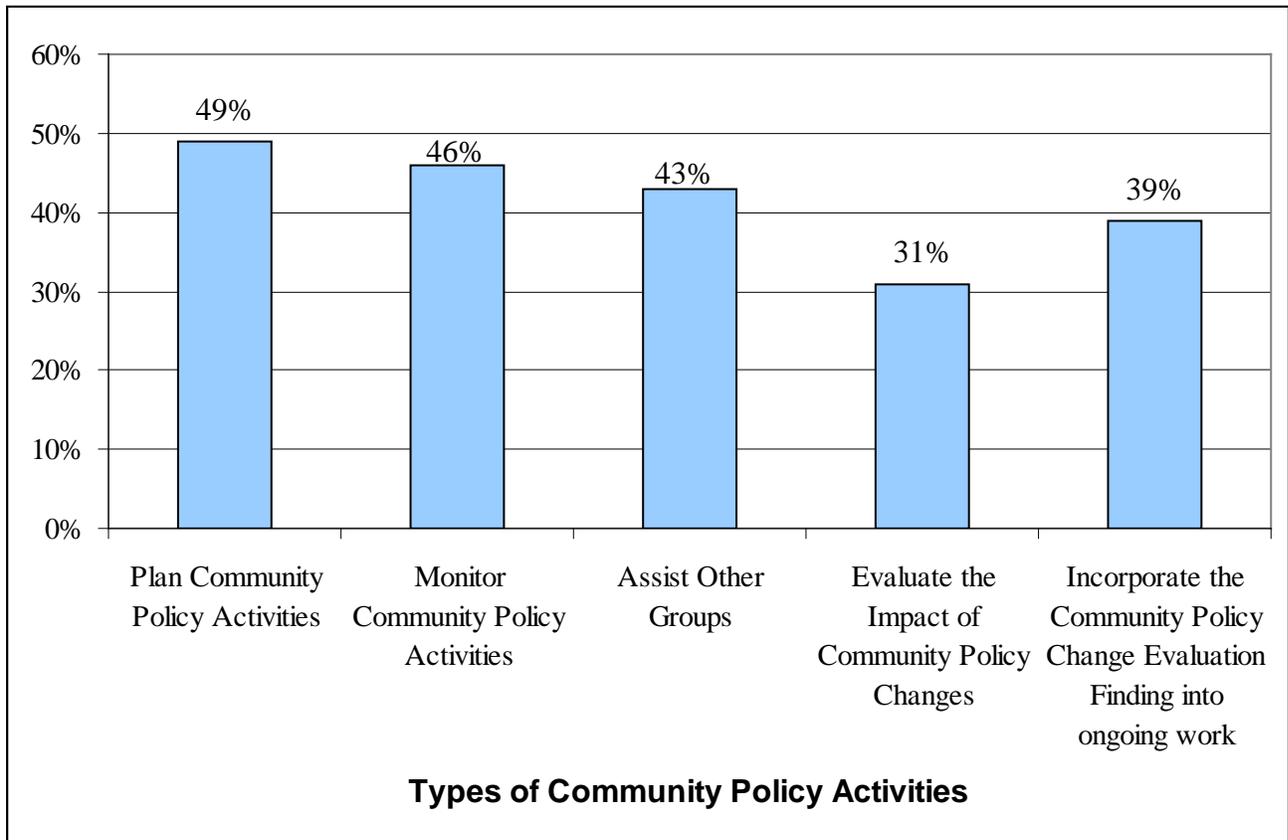
Does your organization do the following?

- Plan community policy activities?
- Monitor community policy activities?
- Assist other groups in planning or monitoring community policy activities?
- Evaluate the impact of community policy changes?
- Incorporate the community policy change evaluation findings into the ongoing planning process?

Question seven assessed how respondents saw their organizations being involved in influencing, monitoring, and evaluating community policy change (Directors of Health Promotion and Education competencies 3-5). Less than half of respondents thought their organizations “always” or “often” planned, monitored (implementation), or assisted other groups in planning/monitoring, or evaluating community policy activities (Figure 3). Respondents who saw their organizations as “always” or “often” doing these things also saw them using planning, monitoring, and assisting others more often than using evaluation findings in ongoing planning.

This finding is not surprising given the complexity and difficulties of evaluating community policy efforts. While the ultimate goals of policy change may be to decrease rates of chronic disease in the community, changes in many outcome measures are too far into the future to be useful in evaluating activities while they are being implemented and shortly after. Numbers of meeting and participants can be counted, but these short term measures don’t always give useful information on where a change in community policy is in its maturation. Activities are often started by one group and passed off to another before implementation is “complete.” This complicates data collection unless a plan for it has been determined in the beginning. Intermediate measures specific to the activity being evaluated need to be carefully planned ahead of time to monitor progress. More resources are being developed to assist in evaluation of this type of work, but are still lacking.

Figure 3. Percentage of Agency’s Reporting That They “Always” or “Often” Conduct These Policy Activities When Working on Chronic Disease Prevention Policy (from the Directors of Health Promotion and Education competency domains)



Respondents were allowed to list or describe more than one key component. Thus percentages add up to more than 100 percent.

Findings:

1. The majority of respondents think their organizations are doing “very well” or “somewhat well” at identifying and articulating problems that need a community policy solution and solutions to those problems.
2. Less than half of respondents think their organizations are “always” or “often” planning, monitoring, or assisting other groups in implementing community policy activities.
3. Evaluation and use of evaluation findings appear to be the areas that organizations were working on the least in community policy work.

Recommendations:

1. Continue to support local health jurisdictions in all aspects of community policy work (identification of problems and solutions; planning, monitoring, and assisting other groups in implementing activities; evaluating activities).
2. Continue to seek evaluation tools (process and outcome) as the research base expands and disseminate these tools as they become available.
3. Identify ways to help local health jurisdictions and contractors use evaluation data in ongoing planning and activity implementation

Public Participation in Community Policy

Public participation in community policy creation is considered essential, with decisions about policy being informed by the local residents they directly affect. Throughout the Directors of Health Promotion and Education core competences, the importance of public participation (referred to as partner) in all areas of the competences is highlighted, recognizing their important role in decision-making. Some literature makes a distinction between public participation and stakeholders, describing stakeholders as a select group of people. The International Association for Public Participation describes public participation in the broadest sense, as a process which promotes sustainable decisions by recognizing and communicating the needs and interests of all participants, including decision makers, and seeks out and facilitates the involvement of those potentially affected by or interested in a decision. (International Association for Public Participation 2, 2008)

Most scholars on the topic of public participation cite the most common feedback on citizen involvement is that the decisions have actually already been made by the government and the citizen involvement is seen as “tokenism.” This type of citizen involvement breaks down credibility and increases cynicism about government actions. Genuine public participation does not occur unless citizens have influence in the decision-making process. Citizen involvement must be viewed as being supported by some high-level, well-known, trustworthy leader and that the right people or agencies are present and have the power to implement decisions (Chrislip, 1994).

Many times the technical side of a project or policy is well maintained and managed and the process is clearly outlined. However, the more problematic human side of the process seems to be managed in a more ad hoc planned way (Connor, 1997). The Directors of Health Promotion and Education competencies recognize the importance of involving partners in the early phases of policy work and throughout the process. The International Association for Public Participation 2 identifies five levels of participation (IAP2, 2007). These levels reflect different ways citizens may be involved in decision-making - from receiving information to being responsible for making all final decisions. Depending on the task, the level at which partners and/or citizens are involved may vary.

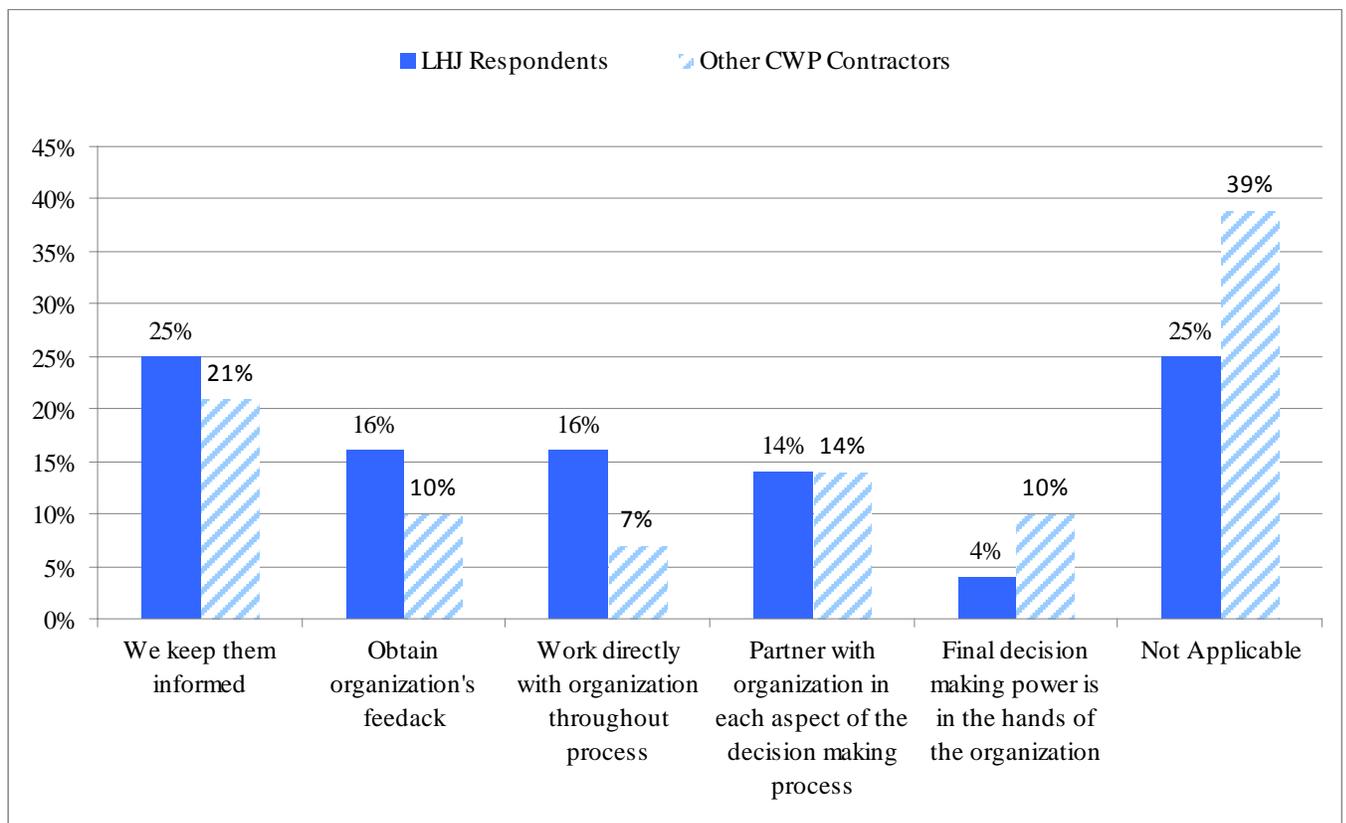
Question 3 Asked : In general, how much participation do the following organizations have in your organization’s decisions around chronic disease prevention?

Tribal Nations	Local County Board of Health
Local Health Department	City Council
Chamber of Commerce	Business Leaders
Parks and Recreation	City Planners
Local planning organizations or companies	Transportation organizations
Physical activity organizations	Food/food access organizations
Non-governmental agencies/ community based organizations	Faith-based organizations
Minority organizations	Gay/lesbian organizations
Groups that advocate for low-income populations	Aging organizations
Medical Community (doctors, hospitals, clinics, etc)	Schools
Local media	

The survey asked respondents about their organization’s level of involvement in their decision-making process around chronic disease prevention with various types of partners. Respondents were asked to score each type of organization using the International Association for Public Participation 2’s spectrum of roles of public participation (see Appendix I), ranging from just keeping partners informed to delegating final decision making power to the partners. The survey results were:

- Twenty three percent reported that they kept their partners informed through fact sheets, web sites, open houses, etc.
- Fourteen percent reported that they obtained an organization's feedback on analysis, alternatives, and/or decisions.
- Fourteen percent work directly with the organization throughout the process to ensure their concerns are consistently understood and considered.
- Fourteen percent partner with organization in each aspect of the decision including the development of alternatives and identification of the preferred solution.
- Six percent indicated that the final decision making power is in the hands of the organization.
- Twenty nine percent stated they did not work with that type of organization (scored as “not applicable”).

Figure 4. Level of Partner’s Participation in Decision-making: Local Health Jurisdiction versus Other Community Wellness and Prevention contractors



After the survey was completed, we determined that the response “we keep them informed” was too passive a function and probably should not have been included in the original survey. We removed it from the scoring to provide a more meaningful picture of the real world. On a scale of one-to-four with one corresponding to “we obtain the organization’s feedback” up to four representing the greatest amount of involvement “they make the final decision,” mean scores ranged from business leaders having the lowest score of 1.74 up to local Board of Health at 3.18 (See Table 1.) The “not applicable” responses were excluded from the scoring formula. The top five highest scores following the local Board of Health were the local health jurisdiction and tribal nations, see Appendix D for the complete table and scores.

Table1. Strength Partners Seen by Survey Participants to have Strongest or Weakest Role in Decision-Making on the Public Participation Spectrum (Maximum Score was four).

	Organization	Mean Score	Rank
Strongest Decision Making Role	Local Board of Health	3.18	1
	Local Health Jurisdiction	3.15	2
	Tribal Nations	2.51	3
	Schools	2.32	4
	Non-governmental organizations/ community based organizations	2.20	5
Weakest Decision Making Role	Faith-based organizations	1.98	17
	City Planners	1.97	18
	Chamber of Commerce	1.96	19
	Local planning organizations or companies	1.85	20
	Business Leaders	1.74	21

The majority of respondents included most of these public health partners in their decision-making. It was also somewhat surprising to note how many and which groups were most frequently considered unimportant to policy work, indicated by the fact they were marked “not applicable.” The groups reported most frequently as “not applicable” included gay/lesbian organizations, city planners, and transportation organizations. At least 40 percent of respondents described these groups as not applicable to their work to partner with in creating policy. Another finding showed that the local Board of Health’s level of involvement in decision-making varied - with 14 local health jurisdiction respondents reporting that they “only provided information.” This presents an opportunity to expand local staff’s understanding of the role of the Board of Health in local public health.

The organizations most frequently seen as the weakest in decision-making were faith-based, city/local planner, and business/business leaders. These partners can be extremely important in making policy changes and building a healthier environment within communities and worksites. These partners also can bring additional resources to bear to deal with health inequities.

During the analysis of this survey question, it was determined that there were at least three possible reasons why respondents would select “not applicable” for involving a specific organization type. It could mean that:

- (a) The respondent did not know anything about this organization or type of organization in their own community.
- (b) The respondent perceived the organization as irrelevant to chronic disease prevention.
- (c), This organization type represented their current employer and therefore would not be considered as a partner to itself.

Findings:

1. The groups reported most frequently as “not applicable” to being involved in policy making included gay/lesbian organizations, city planners, and transportation organizations; each were found by at least 40 percent of respondents as not applicable.
2. Businesses and local business organizations are not being as often included in discussion around chronic disease work.
3. The local Board of Health’s role in decision-making was varied with 14 local health jurisdiction respondents reported that they “only provide information.”

Recommendations:

1. More understanding of why some groups are considered to be non-applicable in community coalitions/advisory group work.
2. Expand the understanding of the role of faith-based, city/local planner, and business/business leaders can play in a communities’ health.
3. Expand local staff’s understanding of the role of the Board of Health in local public health.

Individual Trainings Needs to Convincing Organization, Management, and Community

The Directors of Health Promotion and Education core competencies (3 – Influencing the Change Process) recognizes that state and local agencies vary in how much they allow staff to engage in the political process based on agency policies, rules, and/or managerial restrictions. It states that “constraints that are not legal, might be alleviated by staff helping upper management better understand what is needed to accomplish this type of health promotion work and demonstrating their competency” (Emery, 2006).

The survey asked what training is needed to convince colleagues or management within their own organization or community partners to prioritize policy efforts in their work plans. Results indicate that more than half of respondents indicated a need for advanced training whether needing to convince colleagues or management within their own organization or community partners. The greatest need for training was “to convince community partners to prioritize community policy efforts in their

Question 5 Asked

Today, in considering your ability and experience, what training (No training needed, basic training needed, advanced training needed) do **you** need to convince?

- colleagues within your organization to prioritize community policy efforts in their work plans?
- management within your organization to prioritize community policy efforts in their work plans?
- community partners to prioritize community policy efforts in their work plans?

work plans” (88 percent). Approximately two-thirds of respondents reported needing training (either basic or advanced) to increase their ability “to convince colleagues or management within their own organization to prioritize policy work.” The data showed no difference in the need to convince management more than colleagues.

When examining the difference in training needs by the type of organization the respondent works in, there was a nearly twice the need for advanced training found among respondents employed by Community Wellness and Prevention contractors (60 percent) when compared to those working at local health jurisdictions (31 percent). The need for basic training was nearly identical by type of organization a person worked in, with one-quarter of respondents identifying basic training needs across the three groups. There was no statistical difference found in the report of training needs when examined against whether the respondent had participated in the 2005 policy institute, few respondents attended the institute (n=11).

Findings:

1. The greatest need for training was “convincing community partners to prioritize community policy efforts in their work plans” (88 percent).
2. Approximately two-thirds of respondents reported needing training (either basic or advanced) to increase their ability “to convince colleagues or management within their own organization to prioritize policy work.” The data showed no difference in the need to convince management more than colleagues.

Recommendations:

1. Expand the conversation about the importance of community policy change work.
2. Integrate the Directors of Health Promotion and Education core competencies for public health staff at the state and local level as well as Community Wellness and Prevention contractors and demonstration in work plans, job descriptions and workforce development plans.
3. Work with Directors of Health Promotion and Education to identify training opportunities for Washington State on the competencies.
4. Provide education and training to support staff, local health jurisdiction leadership, and community partners on the importance and role of community policy work in addressing chronic disease.
5. Institutionalize ongoing workforce development in community policy change work and methods.
6. Link the competencies specifically to the Public Health Standards and contract activities. Provide real-world examples of organizations that are actively engaged in policy activities and integrating daily program work with the standards.
7. Conduct an assessment of state staff related to core competences needed to support local

Question 6 Asked

In your daily work, what type of community policy work are **you** currently working on and in what sectors? (sectors and policy work listed in table)

- Built environment
- Social environment
- Economic development
- Physical Activity
- Nutrition
- Other health risk reduction – e.g., diabetes self care
- Air quality

health jurisdiction and Community Wellness and Prevention contractors in doing community policy change work.

Currently Engaged in Community Policy Work

Respondents were asked if they are actively engaged in policy work. Seventy one percent of the respondents replied that they were. If the response was that they were not currently engaged in policy work, the survey skipped them forward to the next question. No statistical difference was found between those who currently do policy work and those who were not when compared to position type, county group, or years of experience. Those currently engaged in policy work were directed to a table that was intended to describe which domains specific work was being done in, like physical activity work in the workplace domain. Unfortunately, the table was not set up in an ideal manner, and the final format forced respondents to answer. They had to choose a response from one of four domains (community, health care, school, worksite) when “not applicable” should have also been made available and/or the respondent not be forced to select a response on each row. Therefore, the responses to this question were dropped from analysis (note narrative comments related to this in Appendix C).

Findings:

Policy work is being conducted in some form by 71 percent of the surveyed local health jurisdiction and Community Wellness and Prevention contractors.

Recommendations:

1. This type of information would be useful to identify areas of current work and possible gap analysis of policies within sectors. This information could help identify additional training needs or resources.

Individual Skill Assessment

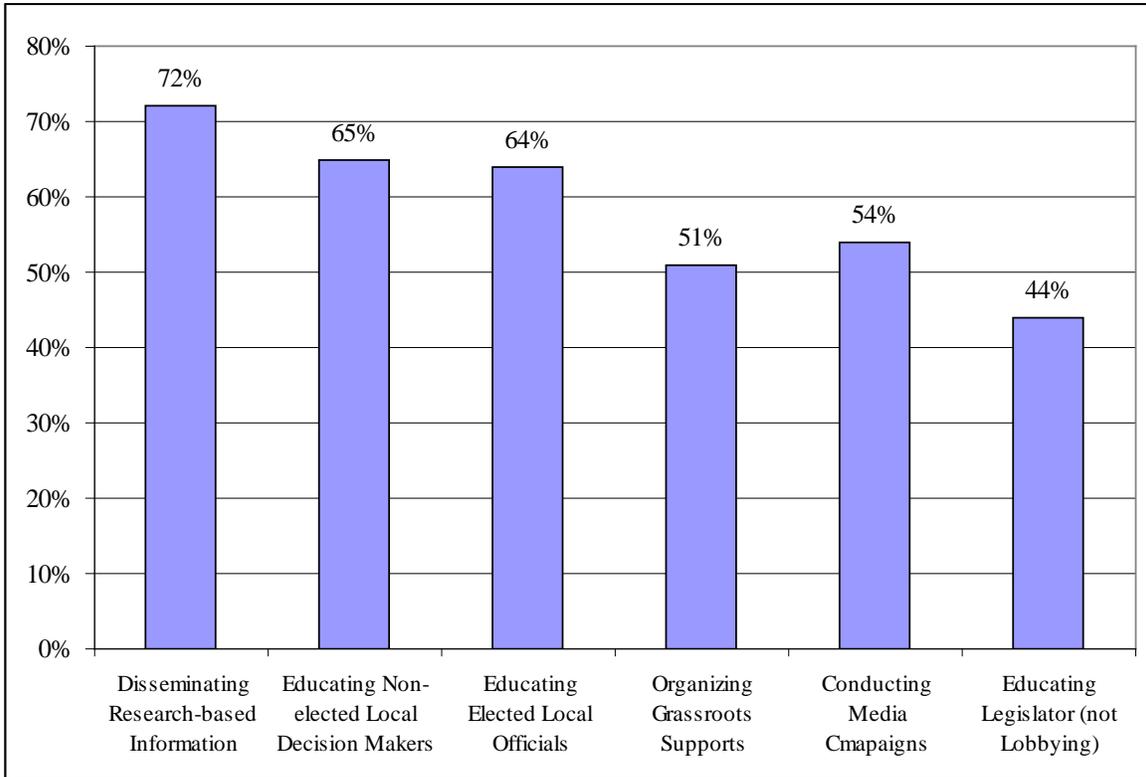
The survey assesses the respondent’s experience in policy-related activities. The experience categories were taken from the Directors of Health Promotion and Education competency domains document but greatly evolved over time through multiple iterations of the survey tool. These skills are essential to the broader work of public health and to policy work, but not unique to the field of public health. There was a significant statistical association between the level of experience reported in performing some of the listed skills and the number of years of experience in public health. Specifically if the respondent reports more than five year’s experience in public health, they were three-times more likely to report greater skill in educating elected local officials (OR=3.48, CI: 1.46,8.52) and educating legislators (not lobbying) (OR=3.26, CI: 1.36, 8.21).

Question 8 Asked

In general, how much experience do **you** have with the following for chronic disease (including environmental health)?

- Organizing grassroots supporters
- Educating non-elected local decision makers
- Educating elected local officials
- Educating legislators (not lobbying)
- Disseminating research-based information
- Conducting media campaigns

Figure 5. Percent of Respondents with "Some" or "Extensive" Experience by Skill



Respondents were allowed to list or describe more than one key component. Thus percentages add up to more than 100 percent.

Findings

1. Increase in years of experience showed an increase in some skills specifically, educating decision makers.
2. Just over half of the workforce surveyed had some experience in organizing grassroots supports or conducting media campaigns.
3. Seventy-two percent of the respondents stated they had experience in disseminating research-based information.

Recommendations

1. Continue to provide information on research-based chronic disease interventions.
2. Explore ways to disseminate research and effectively share data for use by partners in planning.

- Identify resources and training opportunities for local health jurisdictions and/or Community Wellness and Prevention contractors to gain experience and to practice these new skills on a small scale, skills including educating legislators versus lobbying, organizing grassroots supporters, and conducting media campaigns.

Question 9 Asked
 What knowledge, skills, and/or resources do **you** need most in using community policy to help create healthier communities?

Most Critical Knowledge, Skills and/or Resources

The final question regarding policy was an assessment of the individual’s knowledge, skills, and/or resources that the individual found to be the most critical for making healthier communities. The options provided were drawn from three key documents: the Directors of Health Promotion and Education competency domains, Collaborative Leadership, and Community Mobilization. (See note at bottom of table) Each respondent was limited to no more than five possible responses. Table 2 shows the top ten responses for this question.

Table 2. Ten Highest Ranked Knowledge, Skills or Resources Need for Developing and Implementing Policy to Address Chronic Disease Prevention

	Knowledge, Skill or Resource	N	Source Document
1	Evaluating the impact of community policy work- including data analysis and interpretation.	42	DHPE
2	Developing synergy of people, organizations, and communities to accomplish a shared vision.	41	CL
3	Engaging leadership.	39	CM
4	Defining shared values and engaging people into positive action.	39	CL
5	Strategies for leveraging additional funds.	39	CM
6	How to train decision makers and the community about the importance of community policy.	36	CM
7	Influencing the change process related to community policy.	30	DHPE
8	Maintaining community leadership.	28	CM
9	How to bring the right people to the table	28	CM
10	Conducting, analyzing, and disseminating qualitative and quantitative data from community-based studies	28	DHPE

DHPE= Directors of Health Promotion and Education (Emery, 2006) , CL=Collaborative Leadership (UW, 2001), CM=Community Mobilization (CTED, 2008)

Findings:

The top training needs are about managing the human side of the process, community mobilization, and community leadership.

Recommendations:

1. Identify what is in place to provide training around the human side of the process, community mobilization, and community leadership.
2. Provide resources and training to build staff competencies in these areas.

Background Information about Respondents

The respondents provided information on their years of experience in public health, the organization that they work for, their level within the organization, in the county group that they serve, for the populations served, and within program areas. One-fifth (20 percent) of respondents reported have less than two years experience in public health, 22 percent have two to five years, 19 percent with six-ten years, and 40 percent with more than ten years of experience in public health. The majority of respondents work in local health departments (76 percent). The next most common employers reported were the tribes and academic institutions at six percent each. There was distributed among executive, mid-management, and staff as follows:

- Twenty-two percent of respondents were executives or senior management.
- Thirty-six percent were mid-management or staff supervisors.
- Forty-two percent were staff.

This was important to Community Wellness and Prevention staff in order to collect a variety of perspectives on each organization's capacity for policy work. In addition, each county group had at least two respondents of each position type who participated in the survey.

One-quarter of respondents surveyed identified their community as being King, Pierce, or Snohomish counties. The balance of respondents were distributed among the other six county groups: Adams, Asotin, Columbia, Ferry, Garfield, Klickitat, Lincoln, Pend Oreille, Stevens (ten percent), Benton, Franklin, Spokane, Yakima (12 percent), Chelan, Douglas, Grant, Kittitas, Okanogan, Walla Walla, Whitman (12 percent), Clallam, Cowlitz, Grays Harbor, Island, Lewis, Skagit (15 percent), Clark, Kitsap, Thurston, Whatcom (16 percent), and Jefferson, Mason, Pacific, San Juan, Skamania, Wahkiakum (eight percent). These new groupings are designed to have some loose geographic association and to mix up the county sizes. The secondary aim was to distribute current Steps to a Healthier WA communities across the different groups.

The majority of respondents indicated that they serve the general population (70 percent). They were also allowed to select more than one response, and the two-thirds of those who serve the general population also reported serving a subpopulation. Respondents were also asked about the program areas that they work in; again they were able to select multiple areas. The most common topic areas were tobacco (64 percent), nutrition (43 percent), physical activity (38 percent), obesity (35 percent), WIC (24 percent), and oral health (22 percent). Direct emailing to the tobacco contractors and WIC staff enhanced the responses coming from the staff of these programs.

As almost 50 percent have ≤ 5 years of experience, there appears to have been a large amount of staff turnover since 2005, when the first policy institute was held. Only 11 percent of the

respondents had attended that event. In addition to turnover, a factor likely contributing to this low figure is that staff was transferred within their organization. This is even more likely for those with extended experience in that organization. It is not uncommon for public health staff to work in multiple programs over time as funding ebbs and flows. Many of the institute's attendees may have moved into other program areas from chronic disease and vice versa.

Findings:

1. Various types of staff, with varying amounts of education, training and experience, were well represented in the survey.
2. Only 11 percent of the respondents stated they attended the 2005 policy institute.

Recommendations:

1. Because staff turnover may affect policy skills, institutionalize ongoing workforce development in community policy change work and methods.

APPENDIX A: Survey Methodology

Creating the Survey Tool

The *Steps to a Healthier Washington* (Steps) program staff took lead with the survey for the Department of Health in 2008 and completed the survey tool in June 2008. As department staff began working on the survey, they also developed an external advisory group to provide assistance and input to the process. The following Washington State and national reports/tools on community collaborative leadership/mobilization and community policy work was reviewed and used to help develop the survey:

Policy Guides:

- Directors of Health Promotion and Education's Public Health Solutions Through Changes in Policies, System and the Built Environment: Specialized Competencies for the Public Health Workforce and Policy (Emery, 2006)
- Directors of Health Promotion and Education's Environmental Change: New Direction for Public Health (ASTDHPPE, 2001)
- Washington State's Sustaining Prevention through Policy and Community Policy Evaluation Report

Collaborative Leadership/Mobilization Groups:

- University of Washington School of Public Health & Community Medicine, Turning Point's Collaborative Leadership Learning Modules: A Comprehensive Series (University of Washington, 2001)
- Michigan Department of Community Health's Healthy Community Checklist (Michigan Department of Community Health, 2005)
- University of Kentucky's Community Readiness Assessment (University of Kentucky, 2008)
- International Association of Public Participation Foundations for Public Participation (International Association of Public Participation 2, 2008)

Department staff met with the authors of the Directors of Health Promotion and Education's Public Health Solutions through Changes in Policies, System and the Built Environment: Specialized Competencies for the Public Health Workforce and Policy to discuss utilizing the tool for assessment and survey development. They also met with the Arizona Department of Health Services; Alabama Department of Public Health, and the Cherokee Nation to discuss lessons learned on implementing the Washington State 2005 policy institute model in their communities. Based on these essential tools and conversation, the survey focused on

Community Leadership

The process, activities, and relationships in which a group and its member engage in collaboration (exchanging information and sharing or pooling resources for mutual benefit) (UW, 2001).

Community Mobilization

Successful community-based prevention programs build upon the efforts of a variety of grassroots and locally based organizations. CM leadership stimulates change and ensures that prevention efforts are culturally appropriate and effective. One of the most important prevention lessons learned throughout the last two decades is that prevention cannot be imposed from the outside; it must be led from inside the community to be effective. Community mobilization brings local leaders to the table. (CTED, 2008)

assessing the competencies of local public health professionals and the capacity of the local health jurisdiction.

Implementing the Survey

The survey was only available online, created by the department using the *Opinio* software. The final version was approximately 13 screens and included questions on community policy, collaborative leadership, and community mobilization (Appendix A). The survey was anonymous, collected no names and discarded Internet Protocol addresses. Information on counties was aggregated to ensure anonymity for small jurisdictions. This survey was designed specifically for persons working in communities and not intended for use by State Department of Health staff. The counties were grouped roughly by region and included either a mix of large and small jurisdictions or several small jurisdictions. In addition, counties with Steps to a Healthier Washington or Healthy Community programs were distributed among the county groups.

Survey Pilot

The survey pilot occurred in May 2008 with local county public health workers and local Community Wellness and Prevention contractors (like those working in local health organizations that are not health jurisdictions). Based on the results of the pilot and feedback from the external advisory group, the final survey was distributed using the Washington State Association of Local Public Health Officials (n=186) email listserv. It was also emailed directly to key contractors working on chronic health issues (n=214) on June 11, 2008. The survey ran through June 30, 2008. Recipients were asked to forward the email on to two or three additional persons in their organization that work on chronic disease prevention. We only received 81 responses during June, so the survey was reopened from July 2 to 11 and a reminder email was sent to the listserv; 16 additional complete responses were collected. Ninety-seven people completed the survey with 143 additional respondents partially completing the survey.

Survey Respondents

Because individual staff and contractors may appear on more than one list used to solicit survey responses, there was considerable potential for cross posting. Therefore, determining a true denominator is not viable for this survey.

APPENDIX B: Complete list of recommendations

1. There is a need to increase the understanding of the role and importance of community involvement, leadership, and how built environment and policy activities build healthier communities.
2. Utilize survey and other current research to identify “required” elements of building a healthy community and core competences needed to meet those elements.
3. Develop a uniform definition of “healthy” or “healthier” community for wide dissemination in Washington.
4. Develop a resources list of tools and trainings which help local health jurisdictions and Community Wellness and Prevention contractors to build competences.
5. Identify communities, organizations or local health jurisdictions who are effectively managing coalition/advisory groups for policy change work in their communities. These could be “champions” and could provide mentoring to other communities interested in the work.
6. Identify a mechanism or method for sharing work with colleagues in different counties to help ensure coordination of all policy work to avoid duplication of efforts or the creation of conflicting guidance from lead organizations.
7. Continue to support local health jurisdictions in all aspects of community policy work (identification of problems and solutions; planning, monitoring, and assisting other groups in implementing activities; evaluating activities).
8. Continue to seek tools for evaluation (process and outcome) as the research base expands and disseminate the tools as they become available.
9. Identify ways to help local health jurisdictions and contractors use evaluation data in ongoing planning and activity implementation.
10. More understanding of why some groups are considered to be non-applicable in community coalitions/advisory group work.
11. Expand the understanding of the role of faith-based, city/local planner and business/business leaders can play in a communities’ health.
12. Expand local staff’s understanding of the role of the Board of Health in local public health.
13. Expand the conversation about the importance of community policy change work
14. Integrate the Directors of Health Promotion and Education’s core competencies for public health staff at the state and local level as well as Community Wellness and Prevention contractors and demonstration in work plans, job descriptions and workforce development plans.
15. Work with Directors of Health Promotion and Education to identify training opportunities for Washington State on the competencies.
16. Provide education and training to support educating staff, local health jurisdiction leadership and community partners on the importance and role of community policy work in addressing chronic disease.
17. Institutionalize ongoing workforce development in community policy change work and methods.

18. Link the competencies specifically to the Public Health Standards and contract activities, provide real-world examples of organizations that are actively engaged in policy activities and have begun to integrate daily program work with the standards.
19. Conduct an assessment of state staff related to core competencies needed to support local health jurisdictions and Community Wellness and Prevention contractors in doing community policy change work.
20. This type of information would be useful in identifying areas of current work and possible gap analysis of policies within sectors. This information could help identify additional training needs or resources.
21. Continue to provide information on research-based chronic disease interventions.
22. Explore ways to disseminate research and articulate data effectively for use by partners in planning.
23. Identify resources and training opportunities for local health jurisdictions and/or Community Wellness and Prevention contractors to gain experience and to practice these new skills on a small scale, skills including educating legislators versus lobbying, organizing grassroots supporters, and conducting media campaigns.
24. Identify what is in place to provide education
25. Provide resources and training to build staff competencies

APPENDIX C: Survey Tool

Welcome to the Washington State Dept of Health's Community Policy Needs Assessment Survey. This is an anonymous survey and should only take a few minutes of your time. The purpose of this survey is *to assess the* need for training and other resources to support work in community policy to prevent chronic disease. The data collected here will inform the Office of Community Wellness and Prevention about community-level policy work that is occurring in Washington State and help identify ongoing training needs to support this work. The survey results will be available in early August via the WSALPHO list serve and on the Office of Community Wellness and Prevention's website.

If you currently work in more than one county, please proceed through the survey with the county that you primarily work with in mind. Or, you are welcome to complete the survey for every county that you work with tailoring your responses accordingly.

As you proceed through the survey consider the definition provided for community policy and examples of it in action. Community policy work includes sustainable organizational, environmental, systems, or policy changes that affect a large population to support individuals adopting healthier behaviors. Examples of community policy:

- Smoke-free public housing or businesses
- City includes walkable communities in long range plan
- Schools have physical activity education guidelines
- Schools/cities/counties ban trans fat
- Restaurants implement healthy labeling

1. What do you feel are the key components to creating and/or developing a healthier community?

2. Is **your organization** working with any coalitions/advisory groups who are focusing on promoting healthy choices in an effort to decrease the burden of chronic diseases? (check all that apply)

	Working with one or more groups	In the process of forming one or more groups	Not working with any groups	Don't know
Built environment				
Social environment*				
Economic development§				
Physical Activity (including access)				
Nutrition (including access)				
Air quality				

*Social environment is defined here as, "the aggregate of social and cultural institutions, forms, patterns, and processes that influence life of an individual or community.

§ Economic development is defined here as efforts to improve the economic well-being and quality of life for a community by creating and maintaining healthy work environments.

3. In general, how much participation do the following organizations have in **your organization's** decisions around chronic disease prevention? Please select one option below that best describes the organization's level of participation. Blank spaces are provided to list other organizations.

Organization	We keep them informed (fact sheets, web sites, open houses, etc)	Obtain organization's feedback on analysis, alternatives, and/or decisions	Work directly with organization throughout the process to ensure their concerns are consistently understood and considered	Partner with organization in each aspect of the decision including the development of alternatives and identification of the preferred solution	Final decision making power is in the hands of the organization	N/A
Tribal Nations						
Local County Board of Health						
Local Health Department						
City Council						
Chamber of Commerce						
Business Leaders						
Parks and Recreation						
City Planners						
Local planning organizations or companies						
Transportation organizations						
Physical activity organizations						
Food/food access organizations						
Non-governmental agencies/ community based organizations						
Faith-based organizations						
Minority organizations						
Gay/lesbian organizations						
Groups that advocate for low-income populations						
Aging organizations						
Medical Community (doctors, hospitals, clinics, etc)						
Schools						
Local media						
Other: _____						
Other: _____						
Other: _____						

Self-Efficacy for Public Health Community Policy Promotion

4. In your opinion, how well does **your organization** identify and articulate the following for chronic disease (including environmental health)?

a. Problems needing a community policy solution?

- Very well
- Somewhat well
- Not well
- Not at all
- Don't know

b. Strategies to address problems needing community policy solutions?

- Very well
- Somewhat well
- Not well
- Not at all
- Don't know

5. Today, in considering **your** ability and experience, what training do **you** need to:

	No training needed	Basic training needed	Advanced training needed	Don't know
Convince <u>colleagues within your organization</u> to prioritize community policy efforts in their work plans?				
Convince <u>management within your organization</u> to prioritize community policy efforts in their work plans?				
Convince <u>community partners</u> to prioritize community policy efforts in their work plans?				

Public Health Community Policy Capacity

6. In your daily work, what type of community policy work are **you** currently working on and in what sectors? (Check all that apply) A blank space is provided below for you to add other policy areas.

Not working on community policy in our community (*this will cause the respondent to skip the table below*)

	School	Community	Healthcare	Worksite
Built environment				
Social environment*				
Economic development§				
Physical Activity				

Nutrition				
Other health risk reduction – e.g., diabetes self care				
Air quality				
Other – note it will appear as a blank space)				
*Social environment is defined here as, “the aggregate of social and cultural institutions, forms, patterns, and processes that influence life of an individual or community.				
§ Economic development is defined here as efforts to improve the economic well-being and quality of life for a community by creating and maintaining healthy work environments.				

7. Does **your organization** do the following?

	Always	Often	Sometimes	None	Don't Know
Plan community policy activities? (e.g. identify/describe/prioritize problem; engage stakeholders; decide on best solution)					
Monitor community policy activities? (e.g. monitor implementation of solution; collect data for evaluation)					
Assist <u>other groups</u> in planning or monitoring community policy activities?					
Evaluate the impact of community policy changes? (e.g. formulate evaluation questions; analysis and interpretation of results)					
Incorporate the community policy change evaluation findings into the ongoing planning process? (e.g. communicate findings with stakeholders/decision makers; share lessons learned; ensure the use of evaluation findings in decision making)					

8. In general, how much experience do **you** have with the following for chronic disease (including environmental health)?

	None	Little	Some	Extensive
Organizing grassroots supporters				
Educating non-elected local decision makers				
Educating elected local officials				
Educating legislators (not lobbying)				
Disseminating research-based information				
Conducting media campaigns				

9. What knowledge, skills, and/or resources do **you** need most in using community policy to help create healthier communities? A blank space is provided if your resource is not listed.
 (Lined out items to be deleted – highlighted alone is a reworded statement)

Choose up to 5	
	Engaging Leadership
	Maintaining Community Leadership
	How to bring the right people to the table
	Creating a safe place for developing shared purpose and action
	Developing synergy of people, organizations, and communities to accomplish a shared vision
	Facilitating meetings/discussions to get the desired results
	Defining shared values and engaging people into positive action
	Understanding the context for change before acting
	Influencing the change process related to community policy
	Preparing and proposing solutions to advisory groups or the community on community policy
	Conducting, analyzing and disseminating qualitative and quantitative data from community-based studies
	Monitoring the implementation process of community policy work
	Evaluating the impact of community policy work- including data analysis and interpretation
	How to train decision makers and the community about the importance of community policy
	Strategies for leveraging additional funds
	Media advocacy consultation
	Help with clarifying lobbying vs. advocacy and education
	Other: _____

Public Health Background

10. How long have you worked in public health?

- Less than 2 years
- Between 2-5 years
- Between 6-10 years
- More than 10 years

11. What kind of organization do you currently work for?

- Local Health Jurisdiction
- DOH Contractor (if so, please indicate which type below)
 - Community Based Organization/Non-profit
 - Healthcare/Clinical organization
 - Academic Institution
 - Native American Tribe

Other (Specify: _____)

12. What is your level within your agency?

- Executive/Senior Management
- Mid-Manager/Supervisor
- Staff
- Other (specify: _____)

13. Please indicate which of the following group of counties you primarily work in (select one).

- Adams, Asotin, Columbia, Ferry, Garfield, Klickitat, Lincoln, Pend Oreille, Stevens
- Benton, Franklin, Spokane, Yakima
- Chelan, Douglas, Grant, Kittitas, Okanogan, Walla Walla, Whitman
- Clallam, Cowlitz, Grays Harbor, Island, Lewis, Skagit
- Clark, Kitsap, Thurston, Whatcom
- Jefferson, Mason, Pacific, San Juan, Skamania, Wahkiakum
- King, Pierce, Snohomish

14. Which of the following populations does **your** daily work serve?

(Check all that apply)

- General population
- Rural or small town area
- Suburban area
- Urban area
- Race/ethnic/sexual minority
- Low income
- Other (Specify: _____)

15. Which of the following risk factors, diseases, or programs do you **mainly** work with in your daily work?

(Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Physical Activity |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Oral Health | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Steps or Healthy Communities | <input type="checkbox"/> WIC |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Environmental Health |
| <input type="checkbox"/> Other (specify: _____) | |

16. Did you participate in the Dept of Health's *Sustaining Prevention Through Policy and Organizational Practice* training at the Tacoma Convention Center in April 2005?

- Yes No Don't Know

Additional Comments

17. We welcome any additional comments you have about your current knowledge or experience with community policy.

Thank you for taking our survey. Please look for the results of this survey on the Community Wellness and Prevention website in early August. Contact the Survey Coordinator, Hilary Gillette-Walch at hilary.gillette-walch@doh.wa.gov or at 360-236-3638 with any questions about the survey.

You will now be redirected to the DOH Community Wellness and Prevention website.

APPENDIX D:

Question 1 narrative responses

“What do you feel are the key components to creating and/or developing a healthier community?”

1	Highly motivated staff, resources and community participation.
2	1. accessibility to amenities, such as food, post office, transportation (mass transit), library, etc. for everyone 2. availability of resources for those in need, such as WIC, Workplace, etc.
3	1. Community involvement in the development, implementation, and ongoing oversight of any community health plan, 2. Social justice and a system dedicated towards social justice is the only way to construct a truly health community. This includes consideration of social, economic, and health factors that impact health. Without candidly addressing the social determinants of health, a community cannot experience equitable 'health' as defined by the World Health Organization - as being 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.' 3. Resources are a key component of community health. Resources include tangible and intangible elements such as expertise, capital, expertise, etc. 4. Diversity. This may be redundant to social justice and community involvement; however most policy makers and agencies are woefully homogenous in terms of representation. Workforces, healthcare services, and agencies must understand the relationship between diversity in the workplace at all levels, and healthy communities. Without these elements, a community cannot experience 'health.'
4	1. Adequate infrastructure that provides basic needs of community, i.e., schools, roads, waste management, water, jobs, businesses etc. 2. Residents have a sense of community and a long term commitment to their neighborhoods 3. Community leaders are focused on the common good not on individual short term gain.
5	1. Community Involvement - The development of a healthy community can only take place with community involvement during the planning, development, implementation, and oversight of any type of community plan. 2. Accurate Community Assessment - In order to create a healthy community, the community must be thoroughly assessed to determine the needs of the community. This process must include both qualitative and quantitative evaluation. Too, reliance upon the BRFSS is inadequate to capture true community dynamics, particularly as it pertains to marginalized populations. 3. Political and Agency Will - Too often, the needs of marginalized communities are poorly considered during the development process. Lack of meaningful involvement, lack of understanding by the administering agency of public policy makers, and fear of majority criticism often deters policy-makers and agencies to do what is truly necessary to ensure that all populations have the factors necessary to experience relative health. Agencies and policy makers too often rely upon the majority voice to dictate the direction of health considerations, considering the health concerns of minority populations to be 'special interests' or worse yet 'too costly to implement.' This results in health inequities, poor health outcomes, unhealthy communities for populations of color, and, at its crux, questionable civil rights standards. Policy makers and agencies must meet the 'charge' for which they were elected/created. 4. Resource Management - Too often resources are directed towards majority populations RATHER than to the communities that demonstrate the greatest need of resources. This results in inequitable health outcomes. 5. Communication - Public Health Agencies must improve communication systems on a multi-jurisdictional basis so that the root causes of poor health outcomes are addressed - to include the Social Determinants of Health. Unfortunately, many agencies depend upon short-term outcomes and fail to effect true prevention by addressing the root causes of illness. Too, there is a general lack of understanding in

	regards to the Social Determinants of Health, as manifest by a general inability (by Public Health Agencies) to intentionally work multi-jurisdictionally to address the underpinnings of health disparities. 6. Education - Most educational efforts have focused upon educating the public in terms of the risks associated with certain behaviors. Unfortunately, the ongoing education of Public Health professionals and policy makers has not been considered to be of equal import. This is manifest by the large emphasis placed upon personal behaviors with little or no attention (or resources) being directed to addressing the environments which contribute to poor health outcomes. This need decisive attention. Public health professionals MUST be educated. Diversity - Staff diversity is another element necessary to the development of a healthy community. Diverse populations bring a wealth of expertise framed within the scope of their cultural experiences. Homogenous hiring practices leads to a misunderstanding of cultural dynamics - which in turn impacts policy development and public health perspectives. A lack of diversity in staffing speaks to a public health agency that has yet to understand the import of diverse perspectives and lacks the ability to fully address multi-cultural communities.
6	1. Consistent, healthy messages 2. Targeting community norms 3. Consistent, equitable enforcement of policies
7	A healthy community is one in which: 1. People are aware of the individual, family, and community factors that affect health issues they care about, 2. They understand the changes in themselves and their community that must occur and the tools needed to make those changes, 3. They are able to create a collective vision of health and to build strong relationships with their fellow citizens to work toward the future they envision and 4. They are able to commit for the long term and be persistent, patient and flexible as they learn how best to bring their desired future into the present.
8	Ability of partners to commit access to funding. accurate information regarding the subject matter
9	Access to care, including primary care, specialty care, nutrition and lifestyle counseling, mental/behavioral health; opportunities for active living, including safe areas to play, access to shopping w/in walking distance
10	Access to health care, playgrounds, and walkable environments.
11	Access to health care, public parks, do physical activity, options at work, community gardens. Problem is the public should be asked. Surveying public sector is not what you should be doing. Have public forum and ask individuals what they feel they need. Quit doing the same thing and not effectively addressing the issue with the folks who need it.
12	Access to physical activity and healthy foods (affordable and safe). Policies in place, but environment must support the policies.
13	Access to public resources within the community that encourage and support a healthy lifestyle.
14	Address high school dropout rates/on time graduation rates, doing social marketing around healthy life styles, healthy choices, engaging the business owners (where people work) to encourage healthy snacks, exercise during the work day, having a comprehensive, research based health curricula in the K-12 schools with a Physical Education component.
15	Addressing environmental determinants of health (social and physical) that determine behaviors and health outcomes. Also, addressing health inequities
16	Addressing issues of inequity
17	Addressing the social determinants of health with income and education at the top of the list. Second focus should be on birth to three. Overall we need to migrate as far to the primary prevention end of the spectrum as possible.

18	All programs, agencies, health care providers, etc, giving and sharing the same messages and asking all clients where their obstacles to health were: \$ for fruits/veggies, environment/time for exercise, etc and a coalition that yearly reviewed what people themselves feel their obstacles were. All on the same track, Actively taking part in the solutions
19	Assessing, an involved community that helps assess, develop, plan and implement steps to a healthier community, an enduring active & motivated core group of the community, financing.
20	Assuring that long-range planning includes looking at health and chronic disease. Factoring financial impacts of not doing something vs. financial impacts of acting. Getting community input.
21	Being active in Communities. Leading by example.
22	'Buy in' and support from the business community, local governments and schools
23	Buy-in from schools, the community, institutions, etc. Political support and a champion to advocate for policy changes Community-based coalition to set and address community health priorities Strong partnerships involving local health agency
24	changes in environment, systems and policy and public education
25	Changing social norms that support the behavior changes people need to make in order to become or stay healthy. As the social norms change to provide support people will begin to think about how their community fits into their personal goals to maintain healthy behaviors such as walkable communities and workplace wellness.
26	Clean air, clean water, safe food, safety from violence and hazards, recreational opportunities, citizen participation. I have no real hope of creating development that promotes physical activity or alternative modes of transportation because developers here seem very much opposed to such activities.
27	Collaboration and partnership for public education
28	Collaboration between agencies with common goal Community Input and Ownership Support and action by governing entities: County Commissioners, city planner, state government, etc...these people also need to lead by example Those in charge need to be there for the tight reason, not money or acclaim
29	Collaboration between public and private sectors. Understanding the social determinants of health. Focus on long term.
30	collaborative work with all entities involved
31	Communities readiness for change, interest in health, leadership
32	community assessment of want they feel most urgent
33	Community collaboration -Community participatory planning -Ensuring Community connectedness - Coordinated school health systems county-wide
34	Community collaboration and funding
35	Community engagement Community connectedness/reducing social isolation Champions/leaders Focus on children/prevention
36	Community involvement and community-driven priorities; initial community assessments in order to identify areas of greatest need and greatest potential for change
37	Community or stakeholder buy in and support. Support of key policy makers. Adequate, well prepared information that defines 'healthy' as it pertains to the issue being considered. Some sort of policy or regulation that supports the program (i.e. the clean indoor air law).
38	Community safety, affordable and clean/available housing, building community capacity, increase programs for free/low cost activities for families and children.

39	Community support and awareness. community partnerships with good communication and working relationship
40	Community-grass roots interested, timing of initiative, use of positive approach, making access easy and affordable.
41	Coordination and collaboration between the various agencies and organizations involved with supporting healthier behaviors.
42	Coordination of community services and resources. Agencies that provide the community with services and resources should work together to support and refer clients. I think it's also important that resources are readily accessible to all people, not just those in more urban settings.
43	Creating community partnerships, especially with policy-makers (such as government officials). Giving tools to advocacy groups who can then lobby for legal changes.
44	Data confirming methods implemented to create behavioral change for a healthier environment/community Collaboration of community stakeholders willing to commit the time and effort through activities and education to promote sustainable change, organizationally, environmentally, or policy change within communities.
45	Data that indicates what the greatest risks are; expressed concerns of community members and 'experts' re: risks; partnerships or coalition-based approached; developing strategies that are sustainable; performance measure and indicators; outcome-based evaluation information; resources to conduct the activities
46	Data to outline and clarify the issue(s) Engagement of Communities on the issue Network development, Support and training for community partners addressing the issue Support to effect change (funding) Evaluation and demonstration of effectiveness (Repeated and periodic)
47	Developing community, worksite, and school norms that value time for physical activity, support to build environments that make it easy to be physically active and make healthy nutrition choices.
48	Dollars Interested groups, businesses or individuals Community buy-in Interest from Elected Officials
49	Educating stakeholders about current needs based on local assessments and then developing unified plans to address the needs.
50	Education and economic development
51	Education and money to implement the components
52	Education and outreach; easy access to good nutrition and physical activity; engage the business community and other community partners in supporting healthy choices; consider health in land-use decisions, targeted and culturally competent outreach and education.
53	Education for all ages
54	Education on what constitutes a health community. Education on parenting skills. Involving young people in the process of developing a healthier community.
55	Education regarding nutrition, physical fitness, legal drugs, drugs that are not legal, a safe water supply, and air quality standards that are enforceable.
56	education to people of all age groups
57	Education, partnerships, motivation, resource access
58	Education. Getting local physicians on board. Areas that are conducive to exercise. Paths, indoor recreation, etc. Also, areas for all ages and fitness levels.
59	Education. Utilizing small instrumental groups to teach others. Invest in educating young adults so that they can conduct various educational presentations to be demonstrated at local youth camps, YMCA programs, etc.

60	Effective educational/awareness campaigns about specific issues, these 'campaigns' need to be tailored to the audience so that the messages resonate and the ideas stick. Once community members have the ideas, action will follow.
61	For success, a large portion of the population base must buy into the program, and get involved.
62	Funding, champions in the community, data collection and reporting, community needs assessment and planning.
63	Getting buy-in from many different populations and constituencies.
64	Getting community members involved and support of leaders.
65	Getting the whole community involved beginning with policymakers.
66	Good advertisement of the change trying to be made through TV, Radio, Print, etc.
67	Good data on the needs of your community & CDC Best practices for promoting model as how to achieve healthier behaviors in the needed areas. The desire for community stakeholders to commit time and effort to educating and promoting activities towards developing healthier behaviors.
68	Guided education with the purpose of effecting positive policy change.
69	Have public health administration onboard with community needs and supporting ideas from its staff. Sometimes we are not informed on decisions that directly affect the outcome of our prevention and education work in the community.
70	Health care providers have an onsite tobacco intervention specialist so providers can refer patients to the interventionists as part of their routine treatment of the patients who smoke. Part of the disease prevention efforts may be enhanced if the behavior side of issues such as smoking, obesity, and other conditions causing chronic diseases are addressed by incorporating intervention assistance into the patient visits as determined by need. An example process could include a referral from the provider for the patient to immediately have a one-on-one appointment with the wellness specialist (i.e. tobacco, obesity) after the physician appointment and then directing the patient to further support programs specifically addressing tobacco dependence, obesity, and etc.
71	I tend to be much more interested in strengthening laws and policies, as well as institutional norms toward the end of achieving health, rather than throw money at the safety net. Affect change in the built environment, codes, regulations etc to 'make the easy/right/legal choice the healthy choice'
72	I think it is very important to develop strong partnerships, be sure everyone's voice is being heard. Making people part of the process will help with the norm change. Also it is important to look at why a community isn't healthy- what barriers are in place. We need to address poverty and disparate populations and the unique stressors they face when looking to develop a healthier community.
73	I think that having community activities is very important. Working in a small community, it is always great to have those close ties with community partners and citizens. Partnerships within the community are another important part; I think that we all need to make sure we are working together and towards the same goal.
74	Identifying champions from the community who can provide strong leadership and help framing Healthy Communities concepts into larger community concerns. I think it is also important that people working on projects have an opportunity to develop close working relationships through training, conferences, meetings, retreats, etc.
75	In my opinion one key component would be the quality of care we give our community if the care is excellent our community will feel better. Also, having a place that is sanitary for children and infants.
76	Information on Tribal Casinos that have gone smoke free (if there are any)and the impact on profits.
77	Input from the groups with the power to make the changes

78	Involvement and coordination of diverse agencies, organizations, and individuals, including informal community leaders and elected officials. This helps focus other key components: resources and energy to develop policies that are more likely to make a difference. This helps build political will for change, another key component.
79	Involvement of Stakeholders good/accurate assessment data Common goals and the ability to community the data and goals (Risk Communication skills.) Intervention strategies that have a good reliability of having an impact
80	Leaders need to initiate and support changes
81	-lots of support from the top (e.g. BOCC or BOH), including financial support or being willing to make the tough calls that are in the best interests of the county residents, but potentially highly unpopular with voters in the short term -lots of interest
82	Making it just as easy to make the healthy decision as it is to make the less healthy one.
83	more bike trails, better rapid transit, more public transportation
84	More multidisciplinary health appointments, more places for kids/families to be active, mandatory gym classes and/or recess, more time to eat school lunch, better health messages on TV
85	no smoking in indoor public areas, exercise programs and outdoor exercise areas/trails, emissions control, flexibility for staff to determine how scheduling works for them, learning programs to help people adopt healthier behaviors
86	Partnerships across a wide spectrum of institutions, organizations and sectors in the community (including governmental and non-governmental, business, neighborhood, and health care leadership) and collaboration to effect: Policy change among these partner groups, and Modification of the built environment in a wide array of contexts... both of the above to support increased availability and access to healthy choices such as regular, moderate physical activity and healthy eating. The emphasis on a broad spectrum of leadership all cooperating around similar objectives comes from our experience and also the recommendations of best practice - grass roots support is important, too, but the sustained commitment that comes from champions or at least informed and willing upper level managers and directors is what seems to be working well in our community.
87	Partnerships and collaboration among health care providers, city/county planners, transportation, public health, social service, schools, tourism, sports councils, insurance companies, and private business/worksites, etc...for sustainable policy and environment change.
88	Physical activity, reduced barriers to health care, smoke free living and reduced smoking, better nutrition, food and water safety
89	Policies that discourage substance use (including tobacco) & encourage physical activity, injury prevention, & healthy nutrition.
90	Policy and environmental changes, not just individual education
91	Policy change such as Initiative 901 affects the greatest number of people and is the most sustainable. Written policy and systems change within specific agencies (like a health care facility or school system) are sometimes easier to accomplish but much more susceptible to change or loss of sustainability due to administrative changes. Underlying all of this however, it is important to develop community norms that support these changes.
92	Policy changes and shift of community attitude

93	Policy makers, elected officials and community leaders must understand, support, and promote healthy community activities. The local health jurisdiction must have at least one FTE dedicated to healthy communities work. The Healthy Communities program must promote community ownership of projects and policies. Essentially, the key components to a healthier community are 1- policy makers pass laws, legislation, resolutions, policies, and procedures ensuring the built environment and local laws provide as many opportunities as possible for residents to eat healthy and exercise. 2- Community groups work together to promote behavior change in the community, at a personal and professional level. Employers should provide opportunities for employees to exercise and eat healthy, and employees should take the initiative to exercise and eat healthy foods. 3- Exercise and healthy eating must become social norms - this will happen through individual efforts and community involvement and leadership.
94	Prevention efforts aimed at youth that includes nutrition, exercise, primary care, and emotional health.
95	Prevention, community activities, evaluation of existing procedures, involvement of various champions
96	Providing education for the youth. We can't get the adults to commit to attending trainings, or quit smoking classes. If we can get more information out to the youth we can use their influence on their parents to help them see the dangers of tobacco use.
97	Providing free access to healthier lifestyle activities and providing healthy role models throughout the community
98	providing information and options so that people learn by example
99	Providing opportunities for communities to make healthy choices. The easier it is for a community member to make a healthy decision, the better.
100	providing safe walking/cycling areas for residents
101	Public access and social marketing of health behaviors, and physical, attractive environment that encourages outside activity.
102	public education, capacity and sustainability, informed government reps (city, county and state), ability to engage public in the efforts
103	Reducing or repairing domestic violence. Education about behaviors that put the individual at risk or behaviors that the individual does that put the community at risk for communicable disease. It should start in grade school.
104	Reform community norms, particularly around healthful eating and alcohol use. Have healthy alternatives available, i.e. family activities, community centers, rec centers, senior meal programs, farmers markets and farm stands offering fresh veggies and incentives like WIC coupons and SFMNP coupons to get them started using these venues.
105	Right people at the 'table', policy work, budgeting
106	safe environment, affordable housing, walkability, local food sources
107	saturated media campaign, powerful people backing it, making the community feel how it actually impacts them all
108	Stakeholder awareness and buy-in, community support, funding, evidence based strategies
109	Starting with the children of ages 5-12. More opportunities for teens to stay busy on the weekend to keep them out of trouble.
110	Stating the case, building support among various constituent groups,
111	Strengthening communities ability to address chronic disease intervention and prevention, i.e., greater access to care, promote early screening for heart disease, cancer etc., promote healthier design of neighborhoods that encourages more physical activity, smoke free environments etc., help people to stop smoking.

112	Strong and cooperative coalitions all working toward the same cause.
113	Strong commitment and leadership from local elected officials. A community that is stable enough to place this as a priority, i.e., not worried about the sole, large employer closing. A core group of volunteers who will follow through.
114	Support from the city council (& residents) for parks & recreation depts. for the development and maintenance of walkways and exercise facilities or opportunities. (There are fitness clubs available but not much available for lower income residents)
115	Sustainable change: environmental and policy once the community has been educated. Consistent application of policy.
116	Sustainable funding
117	sustainable funding, policy work, prevention and education
118	Sustained funding - the health dept. is one bake sale away from being as needy as the school system. Involving community in process of choosing priorities and best actions to take, as well as determining direction and meaning of assessments. Health care available to all in spite of income.
119	The same as they have always been immunizations, hygiene, and sanitation. Walking trails and bike lanes are completely trivial by comparison.
120	This is a big question, but I believe in starting from BEFORE the beginning of the life cycle: Family planning, supporting healthy pregnancy, ensuring children get a healthy start, addressing determinants of health (Public Health needs to educate and encourage, not responsible for assurance of all), holistic approach.
121	To have community involvement, if everyone works together
122	To have community stakeholders and local government officials all on the same page and to have community be involved with decision making or at least to hear what they have to say
123	Trained, current on science and evidence-based practices, workforce
124	Trying to offer more programs with physical and other recreational activities for kids and adults may be thru the Counties, Pierce, King, etc. using parks and recreation centers for their communities as well promoting health information is school and media.
125	Understanding how city government works and political dynamics so that policy change can be implemented. Identifying when is the 'right time' for communities to take on these changes.
126	Walkable routes, sidewalks, public transportation and mixed housing.
127	Walking and bike paths- even just sidewalks Access to healthy foods
128	Working with community to identify their needs related to a healthy community for them. Serving as a facilitator in working with communities.
129	You need to have the backing and support from high ranking county officials.

APPENDIX E:

Question 17 narrative response

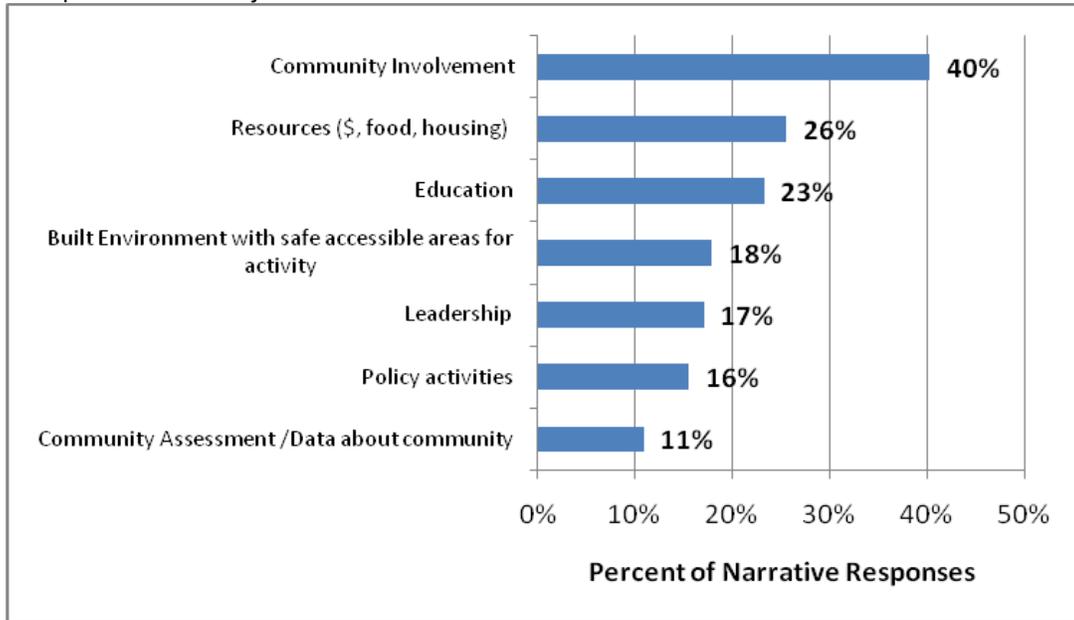
“We welcome any additional comments you have about your current knowledge or experience with community policy.”

1	Chronic disease prevention and intervention are within the responsibility of public health. Work in this arena should be mandated just as communicable disease, immunizations and environmental health are.
2	I understand that Health Disparities are a part of Public Health agendas currently. However, it appears that most public health jurisdictions are failing to embrace the notion that health equity is a human right, not to be treated as a special interest. Too, every employee (at all levels of decision-making) must thoroughly understand the Social Determinants of health, and how they impact health outcomes in marginalized communities. It is not enough to simply offer these communities funds to 'fix it on their own,' health equity must be viewed and addressed as a public health priority. In order to do this, education must take place at the agency level, and too, policy makers must be educated. The lack of candid conversation in regards to the underpinnings of health disparities reinforces discriminatory ideologies - particularly those 'unspoken' ones that tend to blame marginalized communities for their relatively poor health. This is unacceptable. Too, the inability to candidly discuss these issues further prolongs the problems caused by not addressing health disparities. Our agencies and policy makers must begin to be champions for public health - to include ensuring that all communities have opportunities to experience relative health. The ability to experience health must not be dependent upon resources, social or economic status, race or ethnicity, gender or identity, age or physical ability, geographic or environmental proximity. We have our work cut out for us. Let's not water down our efforts by purposive planning and evasive posturing.
3	In a small rural area one person is often 'it' when working on a particular cause. For example, as the County Tobacco Program Coordinator I am really the only person in my county who has tobacco prevention and control designated as a priority in my job. It is difficult to find community partners who are able to offer staff time or funding toward TPC efforts. If I don't make it happen, it probably won't happen at all. And tobacco is only one of the community health issues I am assigned to work on. I guess my greatest need is learning how to create effective change with minimal resources.
4	It is very difficult to compare success in rural communities and larger urban communities. Personal and professional image is important and transparent in rural communities. Relationships and protecting one's reputation becomes utmost important. So for parents to attend a parenting class, for example, there is a subtle message sent out to the community that there must be something wrong in their family. Like living in a gold fish bowl, personal actions can be witnessed by the entire community. People look for similarities with little room for diversity and/or individual thinking and expression. Tradition for problem solving is handed down from one generation to the next. Individuals come together to solve issues because of shared concerns. The diffusion theory applies directly to Wahkiakum County. People listen and follow examples of community gate keepers; who set the tone (social norms) by voicing their opinions in weekly newspapers and/or discussion at the local grocery store or public gatherings. Recycling is a good example. In this rural community, people see recycling as affecting employment. While in an urban community, people think of saving the planet.

5	Question #7 is problematic as it requires you to select an item from each row even if you are not working in all of the areas. I am currently in early stages of working on community policy issues for physical activity, nutrition and built-environment in schools, built-environment and physical activity in the community, and physical activity in the workplace.
6	Rural communities need help -- less and less access to quality health care in isolated areas means we need more work in preventive care.
7	Thank you for the opportunity to provide input on this important work! I look forward to trainings that improve our ability to develop and implement effective policies. By 'our,' I'm thinking of everyone working to improve the health of their communities!
8	The approach of collaborative partnership is truly embedded in our LHJ's basic approach and values to carry out our mission. Steps to a Healthier US (CDC program administered through DOH) and its work with Prevention Institute have provided much of the capacity for our department to work on community policy change for chronic disease prevention. We are working now to sustain many good projects that have been initiated under Steps - much of which will need to be done without continuous funded support from our department. It is too early to tell whether these policy changes will endure in our community - a test of whether we have done well enough to educate and involve other organizations in the important public health objectives of increasing physical activity and fostering more healthy eating, as well as addressing avoidance of asthma triggers. Thank you for this opportunity to provide our survey response.
9	This is a huge problem in our county. We do not have an administrator who feels it is a problem and that we can do anything to help the situation. So, we just basically ignore it at this time. Maybe in the future....
10	This survey has some problems - for example Question 7 would only allow me to move along the survey if I checked boxes for areas of policy I do not work in - so the results do not reflect at all what I do and what areas I cover. Question 1 was so vague and open-ended I found myself skipping it altogether. After finishing the survey - I am still very unclear about what it was the survey was trying to determine... It seems that this would be best completed by someone with an extensive knowledge of the workings of the individual agency (IE the Director or Program managers) and not day-to-day staff.
11	This survey was written using language and frameworks of public health. I don't work in public health, so am not entirely sure I understood some of the questions. Also, #7 didn't include an option of N/A, and I had to check 'one for each row', even though I'm not focusing on many of the issues.
12	This was not an easy survey to fill out. There was no way to complete the survey without filling in some questions inaccurately.
13	We're always able to gather the appropriate agency representatives throughout the community. All agency's share certain concerns about the overall health of our community, but aren't willing/able to work together. There's a division between county and city and nobody wants to pay for health.
14	When leaders do not understand or care about the issues, it goes nowhere
15	You did not define chronic disease up front. There are many of us who do not agree with the federal and state view concerning PH and its role in preventing chronic disease. We are starting to do what the Hospitals and Hospital districts have done in the past. Why? The format of this questionnaire was not very good and too wordy.

Appendix F: Data Tables

1. What do you feel are the key components to creating and/or developing a healthier community? Key phrases were abstracted and tallied from the narrative responses. Other themes noted (<10 responses each): access to health care, social norms, motivated & experienced staff, SDOH, transportation, social justice.



2. Is your organization working with any coalitions/advisory groups who are focusing on promoting healthy choices in an effort to decrease the burden of chronic diseases? (check all that apply)

	Built Environment	Social Environment	Economic development	Physical Activity	Nutrition	Air Quality	Total N	Total%
Working with one or more groups	47	61	41	70	69	38	326	56.0
In the process of forming one or more groups	5	9	10	12	8	4	48	8.2
Not working with any groups	23	11	26	10	15	40	125	21.5
Don't know	22	16	20	5	5	15	83	14.3
Total	97	97	97	97	97	97	582	100.0

3. In general, how much participation do the following organizations have in your organization's decisions around chronic disease prevention? Please select one option below that best describes the organization's level of participation. Blank spaces are provided to list other organizations.

Organization	We keep them informed (fact sheets, web sites, open houses, etc)	Obtain organization's feedback on analysis, alternatives, and/or decisions	Work directly with organization throughout the process to ensure their concerns are consistently understood and considered	Partner with organization in each aspect of the decision including the development of alternatives and identification of the preferred solution	Final decision making power is in the hands of the organization	Mean score	Rank	N/A %
Local County Board of Health	18	6	12	11	36	3.18	1	14.4%
Local Health Jurisdiction	10	4	10	21	27	3.15	2	25.8%
Tribal Nations	22	8	11	9	9	2.51	3	39.2%
Schools	23	16	20	23	7	2.32	4	8.2%
Non-governmental agencies/ community based organizations	15	17	22	24	3	2.20	5	16.5%
Physical activity organizations	13	12	19	19	1	2.18	6	34.0%
Gay/lesbian organizations	20	10	11	11	2	2.15	7	44.3%
Medical Community (doctors, hospitals, clinics, etc)	25	21	13	24	2	2.12	8	12.4%
Food/food access organizations	19	13	20	14	2	2.10	9	29.9%
Groups that advocate for low-income populations	22	16	22	20	1	2.10	10	16.5%
Minority organizations	22	15	15	13	3	2.09	11	29.9%
Local media	51	10	8	6	3	2.07	12	19.6%
Aging organizations	22	17	10	16	2	2.07	13	30.9%
Parks and Recreation	24	15	15	14	2	2.07	14	27.8%
City Council	32	16	5	9	4	2.03	15	32.0%
Transportation organizations	15	14	16	11	2	2.02	16	40.2%
Faith-based organizations	23	17	11	12	2	1.98	17	33.0%
City Planners	18	14	14	9	2	1.97	18	41.2%
Chamber of Commerce	32	11	8	6	2	1.96	19	39.2%
Local planning organizations or companies	20	20	7	12	1	1.85	20	38.1%

Business Leaders	33	20	11	6	2	1.74	21	25.8%
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4. In your opinion, how well does **your organization** identify and articulate the following for chronic disease (including environmental health)?

	Very well (N)	Somewhat well (N)	Not well (N)	Not at all (N)	Don't know (N)
<u>Problems</u> needing a community policy solution?	24	51	14	4	4
<u>Strategies to address problems</u> needing community policy solutions?	16	53	20	3	5

5. Today, in considering **your** ability and experience, what training do **you** need to:

	No training needed	Basic training needed	Advanced training needed	Don't know
Convince <u>colleagues within your organization</u> to prioritize community policy efforts in their work plans?	29	25	33	10
Convince <u>management within your organization</u> to prioritize community policy efforts in their work plans?	27	24	35	11
Convince <u>community partners</u> to prioritize community policy efforts in their work plans?	11	30	50	6

6. In your daily work, what type of community policy work are **you** currently working on and in what sectors? (Check all that apply) A blank space is provided below for you to add other policy areas.

Not working on community policy in our community (*this will cause the respondent to skip the table below*)

q6 - do you do policy work now?		
Freq.	Percent	Cum.
No	28	28.87%
Yes	69	71.13%
Total	97	100

7. Does **your organization** do the following?

Activity	Plan community policy activities? (e.g. identify/describe/prioritize problem; engage stakeholders; decide on best solution)		Monitor community policy activities? (e.g monitor implementation of solution; collect data for evaluation)		Assist <u>other groups</u> in planning or monitoring community policy activities?		Evaluate the impact of community policy changes? (e.g. formulate evaluation questions; analysis and interpretation of results)		Incorporate the community policy change evaluation findings into the ongoing planning process? (e.g. communicate findings with stakeholders/decision makers; share lessons learned; ensure the use of evaluation findings in decision making)		
	Freq.	N	%	N	%	N	%	N	%	N	%
always		11	11.34	13	13.4	8	8.25	7	7.22	6	6.19
often		37	38.14	32	32.9	34	35.05	23	23.71	32	32.99
sometim es		38	39.18	39	40.2	38	39.18	43	44.33	39	40.21
none		6	6.19	8	8.25	9	9.28	17	17.53	12	12.37
don't know		5	5.15	5	5.15	8	8.25	7	7.22	8	8.25
Total		97	100.0								

Plan community policy activities? (e.g. identify/describe/prioritize problem; engage stakeholders; decide on best solution)						
	always	often	sometimes	none	Score	don't know
Adams. Asotin. Columbia. Ferry. Garfield. Klickitat. Lincoln. Pend Oreille. Stevens	0	4	5	0	1.444	1
Benton. Franklin. Spokane. Yakima	2	4	5	1	1.583	0
Chelan. Douglas. Grant. Kittitas. Okanogan. Walla Walla. Whitman	1	0	8	3	0.917	0
Clallam. Cowlitz. Grays Harbor. Island. Lewis. Skagit	2	5	7	0	1.643	1
Clark. Kitsap. Thurston. Whatcom	2	6	7	1	1.563	0
Jefferson. Mason. Pacific. San Juan. Skamania. Wahkiakum	0	6	2	0	1.750	0
King. Pierce. Snohomish	4	12	4	1	1.905	3
All counties	11	37	38	6	1.576	5
Monitor community policy activities? (e.g monitor implementation of solution; collect data for evaluation)						
	always	often	sometimes	none	Score	don't know
Adams. Asotin. Columbia. Ferry. Garfield. Klickitat. Lincoln. Pend Oreille. Stevens	0	3	5	1	1.222	1
Benton. Franklin. Spokane. Yakima	3	4	5	0	1.833	0
Chelan. Douglas. Grant. Kittitas. Okanogan. Walla Walla. Whitman	1	2	6	3	1.083	0
Clallam. Cowlitz. Grays Harbor. Island. Lewis. Skagit	4	1	7	2	1.500	1
Clark. Kitsap. Thurston. Whatcom	2	6	7	1	1.563	0
Jefferson. Mason. Pacific. San Juan. Skamania. Wahkiakum	0	4	4	0	1.500	0
King. Pierce. Snohomish	3	12	5	1	1.810	3
All counties	13	32	39	8	1.543	5
Assist <u>other groups</u> in planning or monitoring community policy activities?						
	always	often	sometimes	none	Score	don't know
Adams. Asotin. Columbia. Ferry. Garfield. Klickitat. Lincoln. Pend Oreille.	0	2	4	2	1.000	2

Stevens						
Benton. Franklin. Spokane. Yakima	1	7	4	0	1.750	0
Chelan. Douglas. Grant. Kittitas. Okanogan. Walla Walla. Whitman	1	3	7	1	1.333	0
Clallam. Cowlitz. Grays Harbor. Island. Lewis. Skagit	2	3	6	3	1.286	1
Clark. Kitsap. Thurston. Whatcom	2	4	6	2	1.429	2
Jefferson. Mason. Pacific. San Juan. Skamania. Wahkiakum	0	5	3	0	1.625	0
King. Pierce. Snohomish	2	10	8	1	1.619	3
All counties	8	34	38	9	1.461	8

Evaluate the impact of community policy changes? (e.g. formulate evaluation questions; analysis and interpretation of results)						
	always	often	sometimes	none	Score	don't know
Adams. Asotin. Columbia. Ferry. Garfield. Klickitat. Lincoln. Pend Oreille. Stevens	0	1	5	3	0.778	1
Benton. Franklin. Spokane. Yakima	0	5	6	1	1.333	0
Chelan. Douglas. Grant. Kittitas. Okanogan. Walla Walla. Whitman	0	2	8	2	1.000	0
Clallam. Cowlitz. Grays Harbor. Island. Lewis. Skagit	2	1	6	5	1.000	1
Clark. Kitsap. Thurston. Whatcom	2	3	7	2	1.357	2
Jefferson. Mason. Pacific. San Juan. Skamania. Wahkiakum	0	2	5	1	1.125	0
King. Pierce. Snohomish	3	9	6	3	1.571	3
Total	7	23	43	17	1.222	7

Incorporate the community policy change evaluation findings into the ongoing planning process? (e.g. communicate findings with stakeholders/decision makers; share lessons learned; ensure the use of evaluation findings in decision making)						
	always	often	sometimes	none	Score	don't know
Adams. Asotin. Columbia. Ferry. Garfield. Klickitat. Lincoln. Pend Oreille. Stevens	0	1	5	3	0.778	1
Benton. Franklin. Spokane. Yakima	2	3	6	1	1.500	0
Chelan. Douglas. Grant. Kittitas. Okanogan. Walla Walla. Whitman	0	4	5	3	1.083	0
Clallam. Cowlitz. Grays Harbor. Island. Lewis. Skagit	1	3	8	2	1.214	1
Clark. Kitsap. Thurston. Whatcom	1	5	7	1	1.429	2
Jefferson. Mason. Pacific. San Juan. Skamania. Wahkiakum	0	2	6	0	1.250	0
King. Pierce. Snohomish	2	14	2	2	1.800	4
Total	6	32	39	12	1.360	8

9. In general, how much experience do **you** have with the following for chronic disease (including environmental health)?

	None	Little	Some	Extensive
Organizing grassroots supporters	21	27	33	16
Educating non-elected local decision makers	13	21	43	20
Educating elected local officials	16	19	43	19
Educating legislators (not lobbying)	33	21	34	9
Disseminating research-based information	10	17	44	26
Conducting media campaigns	18	27	43	9

10. What knowledge, skills, and/or resources do **you** need most in using community policy to help create healthier communities? A blank space is provided if your resource is not listed.

n	
42	Evaluating the impact of community policy work- including data analysis and interpretation
41	Developing synergy of people, organizations, and communities to accomplish a shared vision
39	Engaging Leadership
39	Defining shared values and engaging people into positive action
39	Strategies for leveraging additional funds
36	How to train decision makers and the community about the importance of community policy
30	Influencing the change process related to community policy
28	Maintaining Community Leadership
28	How to bring the right people to the table
28	Conducting, analyzing and disseminating qualitative and quantitative data from community-based studies
23	Monitoring the implementation process of community policy work
21	Preparing and proposing solutions to advisory groups or the community on community policy
18	Understanding the context for change before acting
14	Media advocacy consultation
13	Facilitating meetings/discussions to get the desired results
9	Help with clarifying lobbying vs. advocacy and education
8	Creating a safe place for developing shared purpose and action
	Other: _____

11. How long have you worked in public health?

	Freq.	Percent
Between 2 - 5 years	19	19.59
Between 6 - 10 years	21	21.65
Less than 2 years	18	18.56
More than 10 years	39	40.21
Total	97	100

12. What kind of organization do you currently work for?

	N	Percent
Academic Institution	6	6.19
Community-based Organization/Non-Profit	4	4.12
Educational Service District	1	1.03
Healthcare/Clinical Organization	3	3.09

Local Health Jurisdiction	74	76.29
Native American Tribe	6	6.19
Schools	1	1.03
Total	97	100

13. What is your level within your agency?

	Freq	Percent
Executive/Senior Management	21	21.65
Mid-Manager/Supervisor	34	35.05
Staff	41	42.27
combo between staff and mid-management	1	1.03
Total	97	100

14. Please indicate which of the following group of counties you primarily work in (select one).

	Freq	Percent
Adams, Asotin, Columbia, Ferry, Garfield, Klickitat, Lincoln, Pend Oreille, Stevens	10	10.31
Benton. Franklin. Spokane. Yakima	12	12.37
Chelan, Douglas, Grant, Kittitas, Okanogan, Walla Walla, Whitman	12	12.37
Clallam, Cowlitz, Grays Harbor, Island, Lewis, Skagit	15	15.46
Clark. Kitsap. Thurston. Whatcom	16	16.49
Jefferson, Mason, Pacific, San Juan, Skamania, Wahkiakum	8	8.25
King. Pierce. Snohomish	24	24.74

15. Which of the following populations does your daily work serve?

(Check all that apply)

N	Percent	Population category
68	70.1%	General population
65	67.0%	Rural or small town area
26	26.8%	Suburban area
29	29.9%	Urban area
44	45.4%	Race/ethnic/sexual minority
64	66.0%	Low income

16. Which of the following risk factors, diseases, or programs do you mainly work within your daily work? (Check all that apply)

N	Percent	Daily Work
62	63.92	Tobacco
42	43.3	Nutrition
37	38.14	Physical Activity
34	35.05	Obesity
23	23.71	WIC
21	21.65	Oral Health
17	17.53	Steps or Healthy Communities
16	16.49	Diabetes
11	11.34	Cancer
9	9.28	Cardiovascular disease
8	8.25	Asthma

17. Did you participate in the Dept of Health's *Sustaining Prevention Through Policy and Organizational Practice* training at the Tacoma Convention Center in April 2005?

	N	Percent
Don't Know	4	4.12
No	82	84.54
Yes	11	11.34

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