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HOUSTON / HARRIS COUNTY
COMMUNITY TRANSFORMATION INITIATIVE

Health Equity Policy Scan Report



**Houston Department of
Health and Human Services**

Harris County

HCPHES

Public Health & Environmental Services

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Health Equity Policy Scan Report prepared by:



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Table of Contents

Background	3
The Community Transformation Initiative	3
Purpose of This Report	3
Supporting Paradigms	4
Health Inequities	4
Social Determinants of Health	5
Health In All Policies	6
Community Health, Autonomy, Agency, and Power	7
Methodology	9
Policy Recommendations by Strategic Area	10
Strategic Direction 1: Tobacco-Free Living	10
Evidence on Tobacco-Free Policies	10
Potential for Inequities	12
Policy Recommendations	14
Gap Analysis	15
Case Studies	20
Policy Recommendations Summary Table	21
Strategic Direction 2: Active Living and Healthy Eating	22
Evidence on Active Living and Healthy Eating Policies	22
Potential for Inequities	24
Policy Recommendations	33
Gap Analysis	35
Case Studies	44
Policy Recommendations Summary Table	46
Strategic Direction 3: High Impact Clinical Preventive Services	47
Evidence on Clinical Preventive Services Policies	47
Potential for Inequities	49
Policy Recommendations	51
Gap Analysis	52
Case Studies	59
Policy Recommendations Summary Table	62
Strategic Direction 4: Social and Emotional Wellness	62
Evidence on Social and Emotional Wellness Policies	62
Potential for Inequities	63
Policy Recommendations	66
Gap Analysis	67

Case Studies	71
Policy Recommendations Summary Table	73
Challenges to Dealing with Inequity through Policy	73
Specificity and Generalizability	74
Long Causal Chains – Social Determinants of Health	75
Next Steps	76
Tobacco-Free Living	76
Active Living and Healthy Eating	76
Clinical Preventive Services	77
Social and Emotional Wellness	77
Key Informants by Strategic Area	78
Appendices	81
Appendix A: Harris County Tobacco-Free Policies Table	81
Appendix B: Healthy Houston Food Access Program Food Deserts Report	82
Appendix C: Houston, Texas Active Living and Healthy Eating Resolution	85
Appendix D: El Paso, Texas Active Living and Healthy Eating Resolution	98
Appendix E: Clark Co. Bicycle and Pedestrian Master Plan: Allocation Assmt. Tool	101
Appendix F: Harris County Social and Emotional Wellness Policies Table	105

Background

The Community Transformation Initiative

The Houston Department of Health and Human Services (HDHHS) - is one of 26 entities funded for five years by the Centers for Disease Control and Prevention (CDC) with a Community Transformation Grant (CTG). The goal of the CTG is to reduce chronic diseases such as heart disease, cancer, stroke, and diabetes. To achieve reductions in these diseases the program is examining the use of structural, systems level interventions that result in the creation of communities where the conditions or circumstances facilitate healthier living.

In the City of Houston and in Harris County, HDHHS has implemented the Community Transformation Initiative (CTI) to meet the goals of the CTG grant. Like all CTG grantees, CTI addresses four priority areas: 1) tobacco-free living; 2) active living and healthy eating; 3) quality clinical and other preventive services, specifically prevention and control of high blood pressure and high cholesterol; and 4) social and emotional wellness (SEW) of children and adolescents. The CTG also emphasizes addressing health disparities and in keeping with this focus, HDHHS considers the concept of “health equity” as an overarching frame for its CTI activities.¹

Purpose of this Report

The purpose of the CTI Health Equity Policy Scan Report is to serve as “a snapshot for understanding and addressing chronic disease through a health equity lens”.² To that end the effort set out to identify public policies, practices, and programs that have as their aim a reduction in group differences in health that result from the differential impacts of policies and practices when experienced by populations distinguished by social status.

For much of the last half-century, the majority of U.S. public health interventions have been predicated on an individualist model of health that assumes that each person has the freedom, capability, skills, and ability to give attention to and take responsibility for their health.^{3,4,5} On the other hand, we now recognize and emphasize the important notion that individuals do not act or live in a vacuum and therefore policies and programs should encompass the multiple factors that influence an individual’s health.

Claiming the context in which we live as the root source that shapes health outcomes, the essential causal statement asserts that the context in which people live, learn, work, and play influence both the choices

¹ For the purposes of this policy scan, we provide a discussion on the concept of health equity under a section of the paper titled “Supporting Paradigms”.

² City of Houston Department of Health and Human Services, Request for Quotation (RFQ) Package, Instructions to Bidders Solicitation No. CTI-RQ0001. March 2012

³ Raphael, Dennis and Toba Bryant. “The state's role in promoting population health: Public health concerns in Canada, USA, UK, and Sweden.” *Health Policy* 78.1 (2006): 39-55. Web. Accessed 8/16/12 via: [http://www.healthpolicyjrnl.com/article/S0168-8510\(05\)00226-5/abstract](http://www.healthpolicyjrnl.com/article/S0168-8510(05)00226-5/abstract)

⁴ Fairchild AL, Rosner D, Colgrove J, Bayer R, and Fried LP. “The exodus of public health: What history can tell us about the future.” *American Journal of Public Health* 100.1 (2010): 54-63. Print.

⁵ Leichter, Howard M. “Evil Habits and Personal Choices: Assigning Responsibility for Health in the 20th Century.” *The Milbank Quarterly* 81.4 (2003): 603-626. Print.

available to them and their ability to choose paths leading to health.^{6,7,8,9} In many instances, the barriers to good health exceed an individual's abilities, even with the greatest motivation, to overcome these obstacles on his or her own. Children—who cannot choose their environments—are particularly vulnerable to the health damaging effects of harmful physical and social conditions, and childhood adversity often results in seriously diminished health in adulthood.^{10,11,12,13}

Although many questions remain unanswered, extensive evidence can now be applied to identify ways to reduce health inequities and their perpetuation across lifetimes and generations. Current knowledge supports the importance of programs and policies that that can constrain or enable healthier living by influencing the contexts and choices available to individuals.^{14,15,16}

To that end we have reviewed public policies that aim to decrease group differences in health (health inequities) by improving the conditions of daily living—that is, the conditions in which people are born, grow, live, work, and age applicable to Houston/Harris County.

Supporting Paradigms

Health Inequities

Throughout the world and across groups huge differences in health exist. There is now a great deal of evidence to support the fact that a person born in certain parts of the world, or even just down the street, can expect to live longer in comparison to another person born across town, in a nearby neighborhood, or in other parts of the world. For example, life expectancy at birth ranges from 34 years in Sierra Leone to 81.9 years in

⁶ World Health Organization. "Closing the gap in a generation: health equity through action on the social determinants of health: Final Report of the Commission on Social Determinants of health." Geneva, Switzerland: World Health Organization, 2008. Web. Accessed 8/17/12 via: http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

⁷ Datta GD, Subramanian SV, Colditz GA, Kawachi I, Palmer JR, and Rosenberg L. "Individual, neighborhood, and state-level predictors of smoking among U.S. black women: a multilevel analysis." *Social Science Medicine* 63.4 (2006): 1034–44. Print.

⁸ Lynch JW, Kaplan GA, and Salonen JT. "Why do poor people behave poorly? Variation in adult health behaviours and psychosocial characteristics by stages of the socioeconomic lifecourse." *Social Science Medicine* 44.6 (1997): 809 –19. Print.

⁹ Yen IH, and Syme SL. "The social environment and health: a discussion of the epidemiologic literature." *Annual Review of Public Health* 20 (1999): 287–308. Print.

¹⁰ Case A, Fertig A, and Paxson C. "The lasting impact of childhood health and circumstance." *Journal of Health Economics* 24.2 (2005): 365-89. Print.

¹¹ Bauer AM, and Boyce WT. "Prophecies of childhood: how children's social environments and biological propensities affect the health of populations." *International Journal of Behavioral Medicine* 11.3 (2004): 164-75. Print.

¹² Davey-Smith G, Hart C, Blane D, and Hole D. "Adverse socioeconomic conditions in childhood and cause-specific adult mortality: prospective observational study." *BMJ* 316.7145 (1998): 1631–5. Print.

¹³ Hertzman C. "The biological embedding of early experience its effects on health in adulthood." *Annals of the New York Academy of Science* 896 (1999): 85–95. Print.

¹⁴ Macintyre S. "The social patterning of exercise behaviours: the role of personal and local resources." *British Journal of Sports Medicine* 34.1 (2000):6. Print.

¹⁵ Marmot M, Friel S, Bell R, Houweling TA, and Taylor S. "Closing the gap in a generation: health equity through action on the social determinants of health." *Lancet* 372.9650 (2008):1661–9. Print.

¹⁶ Frieden TR. "A framework for public health action: the health impact pyramid." *American Journal of Public Health* 100.4 (2010):590-5. Print.

Japan.¹⁷ In the United States, there is a 20-year gap in life expectancy between the most and least advantaged populations.¹⁸

Harris County residents, in general, enjoy very good health, but some groups are not as healthy as others. Major health inequities persist between various groups in Harris County. Health inequities are preventable and unjust differences in health status between different population groups based on social status.¹⁹ Inequities in health are shaped by the conditions in which people are born, grow, live, work and age – the so-called social determinants of health.²⁰



The achievement of health equity ensures that everyone has an equal opportunity to prosper and achieve full health. The policies, rules, and practices of key institutions and systems responsible for regulating economies and governments must establish those opportunities along with social, economic, and physical environments that help all citizens to make healthy choices, and prevent illness and injury in the first place.

Social Determinants of Health

The Social Determinants of Health (SDOH) are considered the channel through which the social world impacts life experiences and exerts direct effects on the human body. The SDOH in turn are linked to macro variables like the class system, the housing stock, the education system, the operation of markets in goods and labor, and so on.²¹

¹⁷ World Health Organization. "The World Health Report 2004: changing history." Geneva: World Health Organization, 2004. Print.

¹⁸ Murray CJL, Michaud CM, McKenna MT, Marks JS. *US Patterns of Mortality by County and Race: 1965–94*. Cambridge: Harvard Center for Population and Development Studies, 1998. Print.

¹⁹ Whitehead, M. "The concepts and principles of equity and health." *Health Promotion International* 6.3 (1991): 217-228. Print.

²⁰ Ibid.

²¹ Solar O, and Irwin A. "Towards a conceptual framework for analysis and action on the social determinants of health." Commission on Social Determinants of Health. Geneva: World Health Organization, 2007 (draft). Web. Accessed 8/16/12 via: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf.

With respect to the social determinants of health, we are able to identify some of the conditions involved in the causation of health inequities:²²

- Poverty
- Hunger
- Occupational exposure to hazards
- Occupational experience of relations at work
- The social and economic effects of aging
- The experience of gender relations
- The experiences of ethnic/racial relations including direct experiences of racism
- Home circumstances
- The degree and ability to exert self-will especially through disposable income
- Dietary intake
- Habitual behaviors relating to food, alcohol, tobacco and exercise
- Position now and in the past in the life course
- The accumulated deficits associated with particular life courses
- Education System
- Marital status
- Socioeconomic status.

Health in All Policies

The traditional biomedical approach to disease and health does not generally embrace causal pathways to illness that originate in public policies, laws, tax systems, the behavior of institutions, or the codes and regulations that determine the design of communities where we live, work, learn, and age. The implication of the social determinants approach, however, is that causal chains run from macro social, political, and economic factors to the causes of disease.

Policies can be considered as determinants of health in themselves, as well as being seen as interventions that aim to diminish harmful consequences that may result from the wider determinants of health. Policy frameworks that regulate or enable actions towards the goal of health equity are a key method by which governments can exert leadership in the effort to decrease group differences in health.²³

Health in All Policies (HiAP) is a policy strategy that targets the key social determinants of health through an integrated policy response across relevant policy areas with the ultimate goal of improving health equity.²⁴

²² Bonnefoy J, Morgan A, Kelly MP, Butt J, and Bergman V. "Constructing the evidence base on social determinants of health: A guide." Geneva: World Health Organization, 2007. Web. Accessed 6/21/12 via:

http://www.who.int/social_determinants/knowledge_networks/add_documents/mekn_final_guide_112007.pdf

²³ Blas E, Gilson L, Kelly MP, Labonté R, Lapitan J, Muntaner C, Östlin P, Popay J, Sadana R, Sen G, Schrecker T, and Vaghri Z. "Addressing social determinants of health inequities: what can the state and civil society do?" *Lancet* 372 (2008): 1684–89. Print.

²⁴ Department of Health, Government of South Australia. "Implementing Health in All Policies: Adelaide 2010." Kickbusch I, and Buckett K, Eds. Web. Accessed 8/30/2012 via:

The rationale behind HiAP is that health is influenced by social, environmental, and economic factors, which lay beyond the realm of the health sector.²⁵

HiAP represents a networked, relational approach to policy-making that acknowledges and works with the different interests in the policy arena and considers the importance of building relationships to ensure policy outcomes.

Some characteristics of the HiAP concept are as follows:

1. It introduces improved population health outcomes as a key dimension of wellbeing and defines the closing of the health gap as a shared goal across all parts of government.²⁶
2. It addresses complex health challenges through an integrated policy response across portfolio boundaries. Health is not in the center but, by incorporating a concern with health impacts into the policy development process of all sectors and agencies, it raises the importance of health issues.²⁷
3. It allows government to address the key determinants of health in a more systematic manner as well as taking into account the benefit of improved population health for the goals of other policy sectors.²⁸

Community Health, Autonomy, Agency, and Power

Several economic philosophers link the concepts of health equity and agency, i.e., one who is capable of directing his or her self- will, actions, and behavior.²⁹ Essentially this link asserts the notion that health enables a person to function with a sense of autonomy and agency, i.e., as an agent.³⁰ Inequalities in health are thus recognized as "inequalities in people's capability to function" which compromises freedom.³¹

The causal linkages between health and agency flow in both directions. Health is a prerequisite for full individual agency and freedom; and at the same time, social conditions that provide people with greater agency and control over their work and lives are associated with better health outcomes.³² In other words, health enables agency, and greater agency and freedom also yield better health. The mutually reinforcing nature of this relationship has important consequences for policymaking.

Theorizing the impact of social inclusion on health suggests that the empowerment of vulnerable and disadvantaged social groups will be vital to reducing health inequities via two routes. Initially, community engagement may have impacts on disproportionate outcomes through a process that expands the public and

<http://www.sahealth.sa.gov.au/wps/wcm/connect/0ab5f18043aee450b600feed1a914d95/implementinghiapadel-sahealth-100622.pdf?MOD=AJPERES&CACHEID=0ab5f18043aee450b600feed1a914d95>

²⁵ Ibid.

²⁶ Ibid.

²⁷ Ibid.

²⁸ Ibid.

²⁹ Anand S. "The concern for equity in health." *Journal of Epidemiology & Community Health* 56 (July 2002): 485-487. Print.

³⁰ Ibid.

³¹ Ibid.

³² Marmot, M. *The Status Syndrome: How Social Standing Affects Our Health and Longevity*. London: Times Books, 2004. Print.

policy agenda to include the needs, concerns, and interests of a broader range of groups that may not have had a voice or role in the public policy process.

Next, civic engagement mitigates the psychosocial health impacts from inequities. Much as the SDOH manifest themselves physiologically (by getting under the skin) to influence health so does civic engagement work in the same way to influence health.

Evidence demonstrates that, in the end, civic engagement can impact population health -particularly for marginalized groups - by increasing the sense of social inclusion, decreasing feelings of alienation, anxiety and exclusion, and increasing a sense of autonomy and control over decisions affecting a person's life.³³ Further, social capital, social cohesion, and collective self-efficacy are increased.³⁴ In other words, civic engagement approaches that involve communities as equal partners or give some or total control to communities are thought to lead to: 1) enhanced equity in public deliberations; 2) more egalitarian policy agendas; and, ultimately, 3) positive health outcomes.³⁵

³³ Andress, L. "[Community Participatory Methods: Positive, Negative or Negligible Benefits for the Community.](http://www.healthypolicies.com/2011/08/community-participatory-methods-positive-negative-or-negligible-benefits-for-the-community/)" *Healthy Policies* (August 2011). Web. Accessed 8/28/12 via: <http://www.healthypolicies.com/2011/08/community-participatory-methods-positive-negative-or-negligible-benefits-for-the-community/>

³⁴ Ibid.

³⁵ Attree P, and French B. "Testing theories of change associated with community engagement in health improvement and health inequalities reduction." Report prepared for National Institute for Health and Clinical Excellence: London (2007). Web. (Available by emailing Pam Attree, p.attree@lancaster.ac.uk)

Methodology

The goals for this policy scan are to:

1. Ensure the existence of a research base to support recommendations.
2. Examine the ethical issues that attach to recommendations.
3. Provide recommendations that approach as much as possible results that do not increase inequities and aim to decrease group differences in health while improving the health of the population.
4. Take into account legal feasibility.
5. Consider implementation mechanisms and issues.³⁶
6. Assess the suitability of the recommendations in relation to the plans and objectives of state and local policy agendas supported by key advocacy groups.

Methods employed in pursuit of the above stated goals include:

1. A review of the best available international and national research, reports, strategic plans, legislative and advocacy documents, websites, newsletters and evidence based program and policy analyses.
2. An Internet search of key websites to identify the current regulatory or policy scheme in existence for municipalities, and school districts within Harris County.
3. Key informant interviews via the telephone and email with policy advocates, program directors, project managers, and regulatory officials.
4. A content analysis of the data collected from interviews with key informants and identification of central themes.

³⁶ We did not have the capacity or a timeline that supported a more expansive examination of enforcement issues, regulatory schemes and related local, state, and federal laws, policies and regulations that work with, against, or alongside recommendations. These are major issues that should be explored with the help of issue area experts, technicians, and advocates. We discuss this further in the section on next steps.

Policy Recommendations by Strategic Area

In this section, we review each Community Transformation Initiative (CTI) strategic area. First, the underlying relationship between health and the strategic policy area is reviewed. In this case, for each strategic area we provide an evidence-based review of the associations between health and policy issues.

In each strategic area we developed a section titled “Potential for Inequities”. These sections review the best available evidence to outline potential inequities, and discuss the possible impacts of policies on different groups based on social status. This is followed by a set of key policy recommendations for Harris County in each strategic area.

Next, in each of the four strategic areas we discuss the gaps in policies/programs across the cities, school districts, and communities that make-up Harris County. The assessment also considers the history of policy action and advocacy, possible alliances and mechanisms that may be considered in order to further a policy. Finally, in each strategic area, a case study of existing programs and policies is presented. Proposed recommendations specifically address increases and decreases in health inequities that might result from the implementation of defined policies/programs recognizing that reactions to and impacts from those recommendations can vary across groups.

Other key factors employed to assess the suitability of recommendations included:

- Historical context and existing arrangements;
- Economic issues;
- Social and policy structures;
- Policies, regulations, programs, and projects authorized and under consideration/review by the State, local authorities, and advocates; and
- Population size.

Strategic Direction 1: Tobacco-Free Living

Evidence on Tobacco-Free Policies

Tobacco use is not a communicable disease or spread by animal vectors, in contaminated water or through airborne droplets. Tobacco use is a behavior that has been addressed with interventions targeting individual motivations and the actions of users.

On the other hand, from an SDOH perspective, tobacco use is also a public health problem because it has been intentionally built into the social structure and environment of most societies by an industry which profits

from continued trade in tobacco products.³⁷ The other major factor shaping the socioeconomic context of tobacco use is governance.

Ultimately, the continued use of tobacco products will be decided by political will, as reflected by governments' commitment to and effectiveness in implementing tobacco control strategies and interventions, at the cost of forgoing revenues derived from the production, manufacturing, and trade of tobacco products.³⁸

Efforts to prevent and control tobacco consumption among disadvantaged groups are not likely to succeed other than through an integrated approach that seeks to reduce underlying social inequities that predispose these groups to tobacco use and confer on them a relative disadvantage in accessing cessation services.³⁹

Consistent with the social determinants of health model, comprehensive health measures to improve access to tobacco prevention and cessation services can be viewed as poverty reduction strategies because they enhance human capital by improving health. The converse is equally vital: social empowerment and poverty reduction can boost the capacity of disadvantaged groups to resist and reject tobacco use.⁴⁰

Two more recently published studies provide a systematic review of population-level tobacco control interventions and their impact on social inequities in smoking.^{41,42} In one study, results showed that measures such as smoking restrictions in schools, restrictions on sales to minors and tobacco price increases had the potential to benefit disadvantaged groups and contribute to the reduction of health inequities.⁴³ The other study concluded that there was preliminary evidence that increases in the price of tobacco may have the potential to produce enough inconvenience (to low income groups) so that the result is a reduction in smoking-related health inequities.⁴⁴



There is a clear relationship between cigarette price and consumption. Increasing the tax on tobacco is an effective upstream intervention reducing tobacco's availability, particularly for the most vulnerable groups.

³⁷ National Association of City and County Health Officials (NACCHO). "Incorporating Principles of Social Justice to Tobacco Control." Issue Brief: (July 2007). Web. Accessed 8/30/12 via:

<http://www.naccho.org/topics/HPDP/tobacco/upload/TobaccoSocialJusticeIssueBrief-Final.pdf>

³⁸ David A, Esson K, Perucic A, Fitzpatrick C. *Equity, Social Determinants And Public Health Programmes*. "Chapter 11, Tobacco Use: Equity and Social Determinants." Blas E & Kurup AS, Eds. World Health Organization (2010):200-217. Print.

³⁹ Ibid.

⁴⁰ Ibid.

⁴¹ Thomas S et al. "Population tobacco control interventions and their effects on social inequalities in smoking: systematic review." *Tobacco Control* 17.4 (2008):230-237. Print.

⁴² Main C et al. "Population tobacco control interventions and their effects on social inequalities in smoking: placing an equity lens on existing systematic reviews." *BMC Public Health* 8 (2008):178. Print.

⁴³ Ibid.

⁴⁴ Ibid.

The two groups that are particularly sensitive to increases in the price of tobacco products are the young and the poor.

Two potentially negative side-effects of tobacco taxation need to be considered.⁴⁵ First, tobacco taxes may disproportionately affect low-income smokers who are already addicted causing them to spend even more on their habit, while their families bear the consequences of a further reduction in household income, making tobacco taxation regressive, i.e., tax on an item that is used more heavily by lower income populations and so takes more from that population than higher income groups.

Second, a reduction in consumption from increased tobacco control could negatively affect tobacco farmers and workers in tobacco-producing developing jurisdictions. In these cases, programs to provide alternative and additional sources of income may be needed.

The provision of low cost or free cessation services to tobacco users constitutes the major service intervention for reducing tobacco consumption, and has the potential to reduce health inequities if designed to target current tobacco users from disadvantaged groups. Cessation interventions are accessibility interventions (requiring government investment to guarantee access to the least advantaged groups in society), and are also compliance and adherence interventions (as they offer remedial services to individuals). Banning tobacco advertising and sponsorship (to which young people and disadvantaged groups are particularly susceptible) is designed primarily to reduce the acceptability of smoking and other tobacco use by changing social norms.

Potential for Inequities

Disparities in tobacco use, exposure, and treatment give rise to the unequal distribution of health outcomes among groups. Tobacco use is significantly greater among males, and among lower socioeconomic groups within countries at all income levels, and is becoming increasingly prevalent in poorer parts of the world.⁴⁶ Young people are at particular risk of tobacco use. A socioeconomic gradient exists in relation to exposure to second-hand smoke and successfully quitting smoking, with consequent health effects.

Tobacco use is associated with low socioeconomic status, whether measured by national income, household or individual income, occupational status or level of education, in many countries around the world. Data from the World Health Survey 2003 indicate that tobacco smoking is most strongly related to household permanent income or wealth.⁴⁷

But it is not the case that tobacco use is just about poverty. The relationship between tobacco use and poverty or, more broadly, socioeconomic status is compounded by factors such as sex and age. We know that smoking occurs at much higher rates among specific communities and populations such as Native Americans and Alaska Natives and the Lesbian, Gay, Bisexual and Transgender (LGBT) population.⁴⁸ Smoking occurs much more frequently among groups with lower income levels and lower education. People on Medicaid, the

⁴⁵ David A, Esson K, Perucic A, Fitzpatrick C. Equity, Social Determinants And Public Health Programmes. "Chapter 11, Tobacco Use: Equity and Social Determinants." Blas E & Kurup AS, Eds. World Health Organization (2010):200-217. Print.

⁴⁶ World Health Organization. "Report on the Global Tobacco Epidemic 2008: The MPOWER Package." Geneva: 2008. Web. Accessed 6/15/09 via: http://www.who.int/tobacco/mpower/mpower_report_full_2008.pdf.

⁴⁷ World Health Organization. "World Health Statistics 2007." Geneva: 2007. Web. Accessed 6/16/09 via:

<http://www.who.int/whosis/whostat2007.pdf>

⁴⁸ Ibid.

government program for lower income persons in the U.S., smoke at rates over 60 percent higher than the general U.S. population, ages 18-65 years.⁴⁹

Interestingly, while African Americans smoke at about the same rate as white Americans they face an increased risk of lung cancer.⁵⁰ Thirty percent of blue-collar workers in the U.S. smoke, compared with 1% of physicians.⁵¹ Smoking prevalence is highest among adults with a GED certificate (49.1%), declines with increasing education, and is lowest among adults with a graduate degree (5.6%).⁵²

While the reasons for this unequal burden are not entirely clear, research presents a compilation of data that examines financial hardship, workplace exposures, genetics, and access to healthcare, discrimination, and social stress, as well as other possible contributors as to why African Americans and Hispanics are disproportionately affected by lung cancer.⁵³

An individual's smoking trajectory is related to the accumulation of social disadvantage over the entire life course.⁵⁴ Groups more likely to smoke include single mothers, the long-term unemployed, new immigrants, the homeless, the mentally ill and members of ethnic minorities – all of whom are also more likely to be in lower socioeconomic groups.

The effects of various forms of social and financial disadvantage appear additive in relation to tobacco consumption. Graham et al. found that four socioeconomic factors contributed independently to smoking status among women: childhood disadvantage, educational disadvantage, early motherhood and current financial hardship.⁵⁵ Of women who experienced all four, 63% were current smokers, compared to 18% of women who had not experienced these disadvantages.

Quit rates for tobacco use also follow a steep socioeconomic gradient⁵⁶ For example, in the United Kingdom, 60% of the most affluent British smokers are now ex-smokers, compared with 15% of those living in the poorest circumstances.⁵⁷

⁴⁹ Ibid.

⁵⁰ American Cancer Society, Cancer NYNJ News. "In honor of Dr. King's birthday the American Cancer Society is talking about cancer inequalities, problems and possibilities." *Facing Disparities, My ACS* (July 2011). Web. Accessed 8/30/12 via: <http://www.cancer.org/MyACS/Eastern/AreaHighlights/cancernynj-news-mlk-facing-disparities> .

⁵¹ Schroeder S, MD, and Warner E, MD. "Don't Forget Tobacco" *New England Journal of Medicine* 363.3 (2010): 201-204. Web. Accessed 8/12/12 via: <http://www.nejm.org/doi/pdf/10.1056/NEJMp1003883>.

⁵² Dube SR, PhD, et al. "Vital Signs: Current Cigarette Smoking Among Adults Aged ≥18 Years--United States, 2009" *Morbidity and Mortality Weekly Report*, US Centers for Disease Control and Prevention 59.35 (2010):1135-1140. Web. Accessed 8/12/12 via: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5935a3.htm> .

⁵³ Ibid.

⁵⁴ Kunst A, Giskes K, and Mackenbach. "Inequalities in smoking in the European Union: applying an equity lens to tobacco control policies." *Journal of Socio-Economics*, European Network for Smoking Prevention (2004). Print.

⁵⁵ Graham H et al. "Pathways of disadvantage and smoking careers: evidence and policy implications." *Journal of Epidemiology and Community Health* 60 (2006):7-12. Print.

⁵⁶ The social gradient refers to findings that demonstrate evidence for a graded association between SES and health where each improvement in education, income, occupation, or wealth is associated with better health outcomes. That is to say, when individuals of different degrees of social status by income (for example) are aligned on a gradient long with health status (e.g., poor health to good health), a clear gradient is displayed so that those at the bottom of the gradient will have the lowest income levels and the poorest health and those with the highest income levels and the best health will be at the top of the gradient. Adler, N. E. and Stewart, J., "Health disparities across the lifespan: Meaning, methods, and mechanisms." *Annals of the New York Academy of Sciences* 2010; 1186: 5-23. Print.

Likewise, the social gradient in smoking results in a social gradient in exposure to second-hand smoke (SHS) for lower socioeconomic families, especially for children.^{58 59} A study of American women aged 18–64 found that nearly one in five women at or below the poverty line reported workplaces with no official smoking policy, compared to 10% of more affluent women.⁶⁰

Like tobacco use itself, deaths from tobacco use follow a marked socioeconomic gradient. A study of adult male mortality rates across different social strata (based on social class, education or neighborhood income) in England and Wales, the United States, Canada and Poland found that the risk of dying from smoking is significantly higher in the lowest social strata than in the highest.⁶¹

Policy Recommendations

1. Support state level activities to increase the price of tobacco products through taxation, with the revenue dedicated for tobacco control.
2. Strengthen existing or adopt additional smoke and tobacco-free ordinances in Harris County municipalities by regulating second hand smoke (SHS) in all public parks, walking trails, and public transit stops.
3. Establish smoke-free policies for apartment complexes and condominium developments.
4. Restrict point-of-purchase advertising or product placement, along with promotions in certain locations.⁶²

⁵⁷ Graham H, Der G. "Patterns and predictors of smoking cessation among British women." *Health Promotion International* 14.3 (1999):231-238. Print.

⁵⁸ Tobacco Advisory Group. "Health Inequalities." Royal College of Physicians, London: (2009). Web. Accessed 6/16/09 via: http://www.rcplondon.ac.uk/pubs/books/tag/4-health_inequalities.ppt.

⁵⁹ The social gradient refers to findings that demonstrate evidence for a graded association between SES and health where each improvement in education, income, occupation, or wealth is associated with better health outcomes. Adler, N. E. and Stewart, J., "Health disparities across the lifespan: Meaning, methods, and mechanisms." *Annals of the New York Academy of Sciences* 1186 (2010): 5-23. Print.

⁶⁰ Shavers VL et al. "Workplace and home smoking restrictions and racial/ethnic variation in the prevalence and intensity of current cigarette smoking among women by poverty status, TUS-CPS 1998-1999 and 2001-2002." *Journal of Epidemiology and Community Health* 60 (2006): ii34-ii43. Print.

⁶¹ Jha P et al. "Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland, and North America." *Lancet* 368 (2006):367-370. Print.

⁶² Point of sale advertising is designed to target consumers at the place where they will buy the product, drawing shoppers' attention to the advertised brand when they are in the buying mood. It has been found that tobacco impulse purchases increase by as much as 28% when displays are present. Tobacco point of sale advertising increases positive brand user imagery. R J Donovan, J Jancey, S Jones. *Tobacco Control* 11 (2002):191–194. Print.

Gap Analysis

Increase Tax Rates on Tobacco Products Locally

With very few exceptions, 2011 was a regressive year for tobacco control measures at the state level. No new states passed comprehensive smoke-free laws and one state, Nevada, actually weakened its existing law.⁶³ Only two states passed cigarette tax increases—both of which were relatively small, and likely to have little or no effect on youth or adult smoking rates.⁶⁴

Texas, with a cigarette tax rate of \$1.41 per pack of 20, boasts one of the lowest tax rates on tobacco products, having raised the tobacco tax rate most recently in 2006 by \$1.00. This makes Texas number 24 of 50 states for the level of a tobacco taxation rate. New York continues to have the highest cigarette tax (\$4.35 per pack), while Missouri continues to lag behind all others at 17 cents per pack. Vermont (by 38 cents) and Connecticut (by 40 cents) were the only two states to raise cigarette taxes in 2011.⁶⁵ In Texas, a policy recommendation related to taxation would have to go through the state legislative process. The enforcement of tobacco laws is regulated by the Comptroller of Public Accounts.⁶⁶ Our research indicates that the powers of local governments to assess tobacco taxes is not one of the enumerated privileges authorized by the Texas Constitution or Texas Tax Code, Title 3 on local taxation. All local taxes are prohibited unless specifically authorized by the state constitution or statute.⁶⁷

During the 2011 Texas Legislative session State Senator Rodney Ellis⁶⁸ introduced Senate Bill 1052 relating to an increase in the cigarette tax to fund the child health plan program. The bill died in the Finance Committee shortly after being introduced.

Reduce Second Hand Smoke Exposure

We considered the area of tobacco policies that control second hand smoke (SHS). Texas' statute prohibiting smoking is Title 10 of the Penal Code: Offenses Against Public Health, Safety, and Morals, chapter 48. Conduct Affecting Public Health, sec. 48.01. Under Texas' smoking law a person commits an offense if they are in possession of a burning tobacco product or smoke tobacco in any of the following facilities: a public primary or secondary school or an elevator, enclosed theater or movie house, library, museum, hospital, transit system bus, or intrastate bus, as defined by Section 541.201, Transportation Code, plane, or train which is a public place.

A person may be allowed to smoke or rather it is a defense to the law if the location does not display a reasonably sized notice that smoking is prohibited by state law. Further, smoking is permissible if someone is

⁶³ American Lung Association. "State of Tobacco Control 2012." Web. Accessed 8/23/12 via:
http://www.stateoftobaccocontrol.org/SOTC_2012.pdf

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ The Texas Comptroller of Public Accounts is the state government's chief financial officer, serving as its highest-ranking tax collector, accountant, revenue estimator and treasurer. The comptroller is elected statewide and serves four-year terms. The Comptroller's Office has more than 3,500 employees and 30 field offices across the state.

⁶⁷ Kang, W. Oil & Gas, Fuels & Miscellaneous Taxes Section, Tax Policy Division, Texas Comptroller of Public Accounts (August 1, 2012). Email.

⁶⁸ Senator Rodney Ellis was elected to the Texas Senate in 1990. He is an African-American politician, representing Texas' Senate District 13, which is largely comprised of democrats with geographic areas in both Fort Bend and Harris Counties. He is the current Chairman of the Senate Committee on Government Organization, and sits on the Senate State Affairs, Criminal Justice, Transportation and Homeland Security, and Open Government Committees.

in possession of a burning tobacco product or smokes tobacco exclusively within an area designated for smoking tobacco or as a participant in an authorized theatrical performance. Because the Texas law does not preempt the passage of local smoke-free laws, local governments may follow Texas law or pass a local ordinance. After looking at local smoking ordinances within Harris County and upon further analysis, we recommend strengthening smoke-free ordinances in all Harris County cities by adding public parks, walking trails, and public transit stops to existing smoke-free laws.

Because families, children, and young adults frequent these areas, this recommendation should be the least controversial and have the smallest amount of opposition along with the greatest amount of support. Smoke-free ordinances vary in their definitions of public places, as do methods of implementing protection against second hand smoke in these locations. Because of these variations, comparing across settings and communities can be difficult. The analysis of Harris county municipalities' smoke-free ordinances made use of the focal settings where smoking is restricted as established by the Texas Smoke-Free Ordinance Database, i.e., municipal worksites; private sector worksites; restaurants; bars – in restaurants; bars – not in restaurants.⁶⁹

Appendix A presents the outcomes from a gap analysis that reviewed smoke-free ordinances for the City of Houston and all other municipalities within Harris County. There are now 36 cities across Texas with comprehensive ordinances in place that protect more than 45% of the population from the harmful effects of secondhand smoke.⁷⁰

In Harris County, Houston and three other cities (Baytown, Humble, and Spring Valley Village) are smoke-free.⁷¹ While having limited coverage, Bellaire's ordinance, which covers only municipal buildings, includes public parks. All Harris County cities and most specifically those with coverage in the five focal areas could strengthen outdoor smoking bans to include public parks, walking trails, and public transit stops. Eight of the municipalities (Bunker Hill Village, Galena Park, Hedwig Village, Hillshire Village, Hunters Creek Village, Piney Point Village, Shoreacres, and Southside Place) are only subject to the Texas law regarding smoking, as they lack any local ordinance in place. Nine municipalities have very limited smoking ordinances which only refer to smoking within city buildings and/or vehicles. These municipalities are Deer Park, Friendswood, Jacinto City, Jersey Village, Katy, Nassau Bay, South Houston, Taylor Lake Village, and West University Place.

Nationally, no states passed comprehensive smoke-free legislation in 2011, leaving the number of states plus the District of Columbia that have passed comprehensive smoke-free laws at 27.⁷² Lawmakers in Texas failed to pass a comprehensive smoke-free law again—despite widespread public support for the law. During the

⁶⁹ Texas Department of State Health Services (TDSHS) and University of Texas Medical Branch. "Texas Smoke-free Ordinance Database." (February 2012). Web. Accessed 7/6/12 via: <http://www.utmb.edu/shsordinances/methods.aspx>.

⁷⁰ Ibid. Comprehensive ordinances would cover the five focal areas established by the Texas Smoke-free Ordinance Database: Municipal worksites; Private sector worksites; Restaurants; Bars-in restaurants; Bars-not in restaurants.

⁷¹ This data is not conclusive. We reviewed actual ordinances as published on municipal websites. The Texas Smoke-free Ordinance Database has fewer cities with total protection in all five focal areas within Harris County. The problem seems to be with the interpretation of definitions of "public places," by the Database. When an ordinance states a uniform standard (e.g., smoke-free) for all public settings, restaurants and bars are so classified, barring other restrictions or exemptions in the ordinance. However, when the definition of public places specifically indicates other settings but contains no references to restaurants or bars, they were not be scored as covered by the Database as opposed to our scoring.

⁷² American Lung Association. "State of Tobacco Control 2012." Web. Accessed 8/23/12 via: http://www.stateoftobaccocontrol.org/SOTC_2012.pdf

2011 session, the Lung Association along with its coalition partners in Smoke-Free Texas strongly advocated for passage of the Texas Smoke-Free Workplace Law (Senate Bill 46/House Bill 670). The law as introduced would have prohibited smoking in virtually all public places and workplaces throughout Texas, including restaurants and bars.

The measure enjoyed majority support from both the Senate and the House, but was unable to move to the floor of the House or Senate due to various procedural roadblocks and key lawmaker opposition. Over 100 statewide and local organizations endorsed the proposed law, including the Texas Restaurant Association, diversity groups and faith-based organizations. Over 10,000 voters in targeted legislative districts reached out to their elected officials to show their overwhelming support in favor of smoke-free legislation.

Public support crossed party lines with 67 percent of Republican, 69 percent of Independent and 74 percent of Democratic self-identified voters favoring a statewide smoke-free law.⁷³ The issue also had strong endorsements from major newspapers across Texas, and multiple media outlets printed editorials in response to the Texas legislature's failure to pass the measure.⁷⁴ The Lung Association along with fellow public health advocates in the Smoke-Free Texas coalition are well positioned to once again push for a smoke-free workplace law in Texas during the 2013 legislative session.

Ban Smoking in Multi-Family Housing

We considered the possibility of regulating second hand smoke (SHS) in multi-family housing. Our research focused on public housing.

The Office of Public and Indian Housing of the U.S. Department of Housing and Urban Development (HUD) released a Notice: PIH-2012-25 in May 2012 which strongly encouraged Public Housing Authorities (PHAs) to implement smoke-free policies in some or all of their public housing units at their discretion, subject to state and local law.⁷⁵ Many HUD letters state that public & subsidized housing operators are free under federal & state laws to make their buildings totally smoke-free, so long as they adhere to state law notice requirements. Nationally, many of the public housing smoke-free policies grandfather current residents who are smokers for as long as they remain living in their apartment unit. Consequently, many of the HUD buildings are transitioning to being completely smoke-free while others are totally smoke-free.

As of January, 2011, at least 230 local housing authorities had adopted smoke-free policies for some or all of their apartment buildings, with about 214 being adopted since the beginning of January, 2005; an average of over 2.9 per month.⁷⁶

Attorneys from the Smoke-Free Environments Law Project recommend multi-unit housing facilities add no-smoking provisions to lease agreements for apartment complexes, or to the "house rules" in public Housing

⁷³ Ibid.

⁷⁴ Ibid.

⁷⁵ Bergman J, JD. "Smoke-Free Public Housing: It's Legal, Profitable & HUD Supports It." Texas Housing Association Annual Conference (Aug. 26, 2009). Smoke-Free Environments Law Project, The Center for Social Gerontology, Inc. Web. Accessed 8/7/12 via: <http://www.tcsg.org/sfelp/TexasHA8-26-09.pdf> .

⁷⁶ The Smoke-free Environments Law Project. "Listing Of Public Housing Authorities/Commissions Which Have Adopted Smoke-Free Policies." Web. Accessed 8/7/12 via: <http://www.tcsg.org/sfelp/apartment.htm> .

Authority buildings.⁷⁷ To implement a smoke-free policy in a multi-unit dwelling where smoking residents already live, the Law Project provides the following guidance:

- Establish a date on which all new residents must not smoke inside.
- Decide how much time current resident smokers will have before their lease will include the smoke-free requirement, i.e., grandfathering.

Currently, the Houston Housing Authority (HHA) permits smoking in residents' units but not in public spaces inside the complexes. HHA is considering banning smoking in their properties in the coming year.⁷⁸

Harris County Housing Authority (HCHA) does not own or manage public housing property. They provide multi-family housing by partnering with the private sector and making use of tax credits. These developments are separate business corporations. Each management company enforces its own community smoking policy based upon the requests of the residents.

At this time, two of HCHA's eight properties (Baybrook Park and Cypresswood Estates) are non-smoking communities. The other six HCHA communities have general smoking policy statements for the tax-credit communities that allow smoking in housing units, but prohibit smoking in the hallways of buildings, elevators, common areas, clubhouses, or on the front patio of the clubhouse.⁷⁹

Restrict Tobacco Advertising

We do not recommend that the City of Houston attempt to regulate tobacco advertising at the municipal or local level. At this time it is a highly volatile, litigious regulatory area where the courts and laws are not settled.



Currently, Texas state law regulates the placement of tobacco advertising within 1,000 feet of a church or school. However, after *Lorillard v. Riley*,⁸⁰ a case in which the Supreme Court declared unconstitutional the Massachusetts statute on tobacco advertising, the Texas State Comptroller backed off on enforcing Texas' law under the assumption that the Texas law, if challenged, would also be ruled unconstitutional by the Supreme Court.⁸¹

There are possible avenues for tobacco advertising regulations to flourish eventually. The Family Smoking Prevention and Tobacco Control Act, signed into law under the Obama

⁷⁷ Bergman J, JD. "Smoke-Free Public Housing: It's Legal, Profitable & HUD Supports It." Texas Housing Association Annual Conference (Aug. 26, 2009). Smoke-Free Environments Law Project, The Center for Social Gerontology, Inc. Web. Accessed 8/7/12 via: <http://www.tcsg.org/sfelp/TexasHA8-26-09.pdf>.

⁷⁸ Meehan J. Vice President of Administration, Houston Housing Authority. (July 30, 2012) Email.

⁷⁹ Burns P. Director of Development, Harris County Housing Authority. (July 16, 2012) Email.

⁸⁰ *Lorillard v. Reilly*, 533 U.S. 525 (2001), was a case brought on by Lorillard Tobacco Company when Massachusetts instituted a ban on tobacco ads and sales of tobacco within 1,000 feet of schools and playgrounds.

⁸¹ Sharp B, MSHP, MCHES. Tobacco Prevention & Control Program Coordinator, Substance Abuse Services Unit, Mental Health and Substance Abuse Division (July 30, 2012). Email.

administration in 2009, prescribes stronger health warning labels and warning label formats on cigarette and smokeless tobacco product packages and advertisements, and authorizes the U.S. Food and Drug Administration (FDA) to establish warning labels on other tobacco products.

The new law also expands states' ability to restrict tobacco advertising and marketing by amending the Federal Cigarette Labeling and Advertising Act (FCLAA), which no longer prohibits states from restricting cigarette advertising and promotion specifically based on concerns related to smoking and health.

At the same time, the new law prohibits states from placing requirements on cigarette or smokeless tobacco product labeling or on the content of cigarette advertisements. State and local governments can, however, impose warning mandates that do not affect tobacco product packages or ads. For example, a local government may require tobacco retailers to prominently display point-of-sale warnings and cessation messages, including graphic images depicting the adverse health effects of tobacco products. Some municipalities outside Texas have passed laws to regulate tobacco advertising.⁸² The Tobacco Control Legal Consortium recommends the passage of local laws on the face-to-face sale of cigarettes.⁸³

With this strategy, vending machines and self-service displays are prohibited from making tobacco products accessible only to store personnel. The results are that customers must ask for tobacco products. Store personnel may then request and check identification to ensure compliance with the minimum age sales law. Twenty-six states have adopted this face-to-face sales requirement for cigarettes and some have enacted a face-to-face requirement for other tobacco products.⁸⁴ Additionally, face-to-face sales laws have been tested and upheld in the federal courts, including the 2001 case *Lorillard Tobacco Co. v. Reilly*.⁸⁵ The Supreme Court ruled that face to face restrictions acted upon conduct instead of speech and therefore did not call into question First Amendment issues.

According to key informants, no municipality in Texas has decided to address tobacco advertising. While many cities outside of Texas have moved forward on this issue, state-level advocates in Texas believe that the tobacco industry has sued or will pursue litigation against those jurisdictions that attempt to regulate marketing and advertising of tobacco products.⁸⁶

⁸² A New York City law, currently pending judicial review, requires tobacco sellers to post graphic images of diseased teeth and gums, lungs and brains to deter people from buying cigarettes and other tobacco products. The Buffalo, NY City Council proposed legislation banning many outdoor advertising displays for tobacco, as well as any tobacco advertising that uses colorful images. The Santa Clara, CA County Board of Supervisors passed a law prohibiting retailers from covering more than 15 percent of windows and clear doors with tobacco ads or signs.

⁸³ Banthin C. "Regulating Tobacco Retailers: Options for State and Local Governments." Tobacco Control Legal Consortium (2010). Print.

⁸⁴ Ibid.

⁸⁵ Ibid.

⁸⁶ Sharp B, MSHP, MCHES. Tobacco Prevention & Control Program Coordinator, Substance Abuse Services Unit, Mental Health and Substance Abuse Division (July 30, 2012). Email.

Case Studies

Case Study: Austin, Texas Bans Smoking in Public Parks^{87,88}

As of December 26, 2011, the City of Austin smoke-free ordinance extends to public parks. Violations of the ordinance may result in a Class C misdemeanor and a fine of up to \$2,000.

The smoking restriction applies to the following areas:

- all Austin Parks and Recreation Department property
- parks
- athletic fields
- recreation centers
- senior centers
- nature preserves
- swimming pools
- golf practice facilities: driving ranges and putting greens
 - smoking *not* banned on golf courses

The ban is enforced by park rangers. In the case of special events held in city parks such as the Austin City Limits Music Festival and Eeyore's Birthday Party, the ban could be waived by a city administrator.

Case Study: Town of Sunnyvale in Dallas County, Texas Bans Smoking in Parks⁸⁹

The Sunnyvale Town Council voted 3-2 in July 2012 to enact a smoking ban on all park property. The ban includes restrictions on smoking in vehicles parked in parking lots on park property. After the vote, council members discussed the possibility of smoking bans in other public places such as restaurants and bars. Sunnyvale administrators were tasked with developing a web-based survey to gauge residents' opinions and priorities on this issue.

⁸⁷ "Smoking Restriction in Parks in Effect: Fine Can Be Up To \$2,000." *KXAN Austin* 10 January 2012. Web. Accessed 8/7/12 via: <http://www.kxan.com/dpp/news/local/austin/smoking-restriction-in-parks-in-effect>

⁸⁸ Toohey, Marty. "Austin Poised to Ban Smoking in Parks." *Austin American Statesman* 7 December 2011. Web. Accessed 8/7/12 via: <http://www.statesman.com/news/local/austin-poised-to-ban-smoking-in-parks-2019195.html>

⁸⁹ Markovic, Zach. "Lights Out: Council Bans Smoking in All Park Spaces." *The Sunnyvale View* (July 25, 2012). Web. Accessed 8/16/12 via: http://www.scntx.com/articles/2012/07/25/the_sunnyvale_view/news/1576.txt

**Case Study: San Antonio, Texas Housing Authority
Bans Smoking in Public Housing⁹⁰**

The San Antonio Housing Authority (SAHA) is responsible for 15,800 residents living in 6,175 housing units at 70 public housing sites in the city. San Antonio city ordinance already bans smoking in government buildings, parks, restaurants and bars. The SAHA now plans to prohibit smoking indoors and anywhere except designated outdoor locations at each of 70 public housing properties. The stated goals of the ban include protecting nonsmokers, especially children, from second hand smoke.

San Antonio will become the largest housing authority in Texas to adopt a smoking ban at public housing sites, joining Corpus Christi. The national trend to go smoke-free in public housing puts agencies like SAHA at the forefront of a broader movement to take the fight against tobacco smoke into the private sphere. Some experts concede that enforcement of such rules can be tricky, but housing officials said extensive public education campaigns like the one SAHA has undertaken boost support for the change.

Policy Recommendation Summary Table

Tobacco-Free Living	Focal Point	Policy	Program	Project	Recommended Point of Entry	Recommended Action	Likely to impact inequities
Increase Tax Rates	State	X			Support existing groups	Support ongoing efforts	Increases possible
Smoke Free Ordinance- Parks, Trails, Transit stops	Local	X			Initiate with existing partners	Build case; support efforts	No evidence at this time
Smoke Free Multi-family Public Housing	Local	X			Collaborate with existing partners	Build case; support efforts	Increases possible

⁹⁰ King, Karisa. "SAHA to Ban Smoking in Public Housing: People Won't Be Allowed to Light Up in Own Homes." *San Antonio Express News* (July 27, 2011). Web. Accessed 8/7/12 via: http://www.mysanantonio.com/news/local_news/article/SAHA-to-ban-smoking-in-public-housing-1561214.php#ixzz22tr0Rmxr

Strategic Direction 2: Active Living and Healthy Eating

Evidence on Active Living and Healthy Eating Policies

The built environment in a neighborhood and its impact on health through physical activity and healthy eating is the focus of this strategic direction.⁹¹

Levels of physical activity and nutrition influence individual health.^{92, 93} In addition to a focus on how individuals eat and exercise, current research is also now studying the role of neighborhoods in health through physical characteristics as well as through the structure and composition of the built environment. Examples of physical characteristics of a neighborhood that may impact health include the availability of places for physical activity and affordable nutritious food, air and water quality, and proximity to facilities that produce or store hazardous materials.

Evidence also demonstrates a relationship between the negative characteristics of neighborhoods and low income and/or minority communities.^{94,95, 96} With the high prevalence of chronic diseases in these communities across the country, governments are looking at programs, policies, and projects that have the ability to impact neighborhoods resulting in communities that either improve or worsen the burden of illness. There has been substantial progress made in identifying environmental and policy factors related to healthy eating and physical activity that can point toward solutions many chronic diseases including obesity or diabetes. Numerous cross-sectional studies have consistently demonstrated that some attributes of built and food environments are associated with physical activity, healthful eating, and obesity.⁹⁷

Residents of walkable neighborhoods who have good access to recreation facilities are more likely to be physically active and less likely to be overweight or obese. Residents of communities with ready access to healthy foods also tend to have more healthful diets. Disparities in environments and policies that disadvantage low-income communities and racial minorities have been documented as well.⁹⁸

⁹¹ The built environment encompasses all buildings, spaces and products that are created, or modified, by people. It includes homes, schools, workplaces, parks/recreation areas, greenways, business areas and transportation systems. It extends overhead in the form of electric transmission lines, underground in the form of waste disposal sites and subway trains, and across the country in the form of highways. It includes land-use planning and policies that impact our communities in urban, rural and suburban areas. National Institutes of Health (NIH). "NIH Guide: Obesity and the Built Environment." (August 2004). Web. Accessed 8/28/12 via: <http://grants.nih.gov/grants/guide/rfa-files/rfa-es-04-003.html>.

⁹² Powell KE, Martin LM, Chowdhury PP. "Places to walk: Convenience and regular physical activity." *American Journal of Public Health* 93.9 (2003):1519-1521. Print.

⁹³ U.S. Department of Health and Human Services. "The Surgeon General's call to action to prevent and decrease overweight and obesity." Public Health Service, Office of the Surgeon General (2001). Web. Accessed 8/30/12 via: <http://www.surgeongeneral.gov/topics/obesity>.

⁹⁴ Morland K, Wing, S, Diez Roux A, Poole C. "Access to healthy foods limited in poor neighborhoods." *American Journal of Preventive Health* 22.1 (2002):23-29. Print.

⁹⁵ Vallianatos M, Shaffer A, Gottlieb R. "Transportation and food: the importance of access." Center for Food and Justice, Urban and Environmental Policy Institute (2002). Web. Accessed 8/29/09 via: http://departments.oxy.edu/uepi/cfj/publications/transportation_and_food.pdf.

⁹⁶ Flores G, Abreu M, Olivar MA, Kastner B. "Access barriers to health care for Latino children." *Archives of Pediatrics & Adolescent Medicine* 152.11 (1998):1119-1125. Print.

⁹⁷ Sallis JF, Glanz K. "Physical activity and food environments: solutions to the obesity epidemic." *Milbank Quarterly* 87.1 (Mar 2009):123-54. Print.

⁹⁸ Popkin, B. M., K. Duffey & P. Gordon-Larsen. "Environmental influences on food choice, physical activity and energy balance." *Physiology & Behavior* 86 (2005):603-13. Print.

Government can help to ensure that communities are designed to ensure active living with parks, bike and walking trails, and transportation systems that encourage walking.

The layout, or design, of a neighborhood is a determinant of physical activity; higher rates of physical activity are associated with walkable neighborhoods.^{99, 100} Walkable neighborhoods typically have higher residential density, an adequate land use mix (primarily of housing and retail), wide sidewalks, connected streets, shade trees, and are safe.¹⁰¹

In 2007, Kipke et al. found that access to goods, specifically quality food – can provide improved nutrition.¹⁰² The findings from this study of an East Los Angeles community with one of the highest rates of childhood obesity in Los Angeles, revealed that there were 190 food outlets in the study community, of which 93 (49%) were fast-food restaurants. Of the fast-food restaurants, 63% were within walking distance of a school. In contrast, there were 62 grocery stores, of which only 18% sold fresh fruits and/or vegetables of good quality. Of the stores that did sell fruits and/or vegetables, only four were within walking distance of a school. Although well maintained, the five parks in this community accounted for only 37.28 acres, or 0.543 acres per 1000 residents. These findings suggest a relationship between community resources, obesity rates, and children's easy access to fast food, and limited access to both healthy food options and parks in which to engage in physical fitness activities. A Los Angeles study, also reported in the *American Journal of Preventative Medicine*, found that a longer distance traveled to reach a grocery store was associated with higher BMI.¹⁰³

Neighborhood crime affects walkability. Residents that live in neighborhoods, which they perceive to have high crime, have lower rates of physical activity.¹⁰⁴ One way to mitigate crime is through urban design that increases walkability. For instance, installing pedestrian-scale lighting, in which the lights are low down and oriented towards the sidewalks, can help reduce the fear of crime.

According to research conducted by Dellinger and Staunton in 2002,¹⁰⁵ traffic safety is a key determinant of whether or not children will walk or bike to school. The study found that in order to increase the number of children who walk or bike to school, traffic safety must be improved.

Kravitz and Nolan demonstrated in 2012 that pedestrian crashes occur significantly more often in low-income neighborhoods.¹⁰⁶ Possible reasons for these findings include: lack of car ownership which leads to more

⁹⁹ Sallis, J., Saelens, B., Frank, L., Conway, T., Slymen, D., Cain, K., Chapman, J., & Kerr, J. "Neighborhood built environment and income: examining multiple health outcomes." *Social Science & Medicine*, 68.7 (2009):1285-93. Print.

¹⁰⁰ Van Dyck D, Deforche B, Cardon G, & De Bourdeaudhuij I, "Neighborhood walkability and its particular importance for adults with a preference for passive transport." *Health & Place* 15 (2009):496-504. Print.

¹⁰¹ Ibid.

¹⁰² Michele D. Kipke, Ph.D., et al. "Food and Park Environments: Neighborhood-level Risks for Childhood Obesity in East Los Angeles." *Journal of Adolescent Health* 40.4 (2007):325-333. Print.

¹⁰³ Kahn EB. "The effectiveness of interventions to increase physical activity." *American Journal of Preventative Medicine* 22 (2002):87-88. Print.

¹⁰⁴ Galster G, Jackie C, and Malega R. "The Social Costs of Concentrated Poverty: Externalities to Neighboring Households and Property Owners and the Dynamics of Decline." National Poverty Center Working Paper Series #06-#42 (2006). Print.

¹⁰⁵ Dellinger A., & Staunton C. "Barriers to children walking and biking to school-United States, 1999." *Morbidity and Mortality, Weekly Report*, 51 (2002). Print.

¹⁰⁶ Kravits D, & Noland RB. "Spatial Analysis of Income Disparities in Pedestrian Safety in Northern New Jersey: Is There an Environmental Justice Issue?" Submitted for Presentation at the 91st Annual Meeting of the Transportation Research Board and for Publication in *Transportation Research Record* (January 2012).

walking and increased exposure to cars; and lack of even the most basic pedestrian infrastructure often found in older poorer neighborhoods.

A report released early in 2012 by Transportation Alternatives, a New York advocacy group, showed that child traffic fatalities and injuries in that city are clustered near Manhattan public housing, and hypothesized that the design of streets leading to more midblock crossings might be one contributing factor.¹⁰⁷ The report, titled “Child Crashes: An Unequal Burden,” suggested that the areas near public housing should potentially be marked as “slow zones.” It also called for stricter enforcement of traffic laws.

Many governments are intensifying their efforts to promote a culture of healthy eating and active living. So far, governments in other countries and at the local level in the U.S. have given priority to initiatives aimed at school-age children, including changes in school meals, more time dedicated to recreation/physical activity, and the regulation of advertising targeting children. While the effectiveness of their interventions is still unknown, the private sector (i.e. employers, the food and beverage industry, the pharmaceutical industry, and the sports industry) has made a potentially important contribution to efforts to address unhealthy diets and sedentary lifestyles, often in co-operation with governments.¹⁰⁸ Key areas in which governments expect a contribution from the food and beverage industry are: food product reformulation; limitation of marketing activities, particularly to vulnerable groups; and transparency and information about food contents.¹⁰⁹

Potential for Inequities

With the relationship between neighborhood characteristics and group differences in health receiving greater scrutiny, interventions are now taking aim at community changes that feature street and sidewalk improvements, walking/bike trails, and changes to building codes, and design guidelines with the hope that this will improve access to physical activity and healthy eating. Alternatively, we are also beginning to see that the quest for healthier neighborhoods through new development and redevelopment may not be as effective or have desirable consequences for more vulnerable groups including seniors, inner city residents, low income groups, and racial or ethnic populations.

The concerns with inequitable outcomes resulting from this emphasis on the built environment, neighborhoods, and the health of groups seem to fall into two sometimes overlapping areas. First, are the



¹⁰⁷ Godzeno JS, & Jimenez M. “Child Crashes: An Unequal Burden: A Case Study of Motor Vehicle Crashes with Children on Manhattan’s East Side.” Transportation Alternatives (2012). Web. Accessed 8/14/12 via:

http://transalt.org/files/newsroom/reports/2012/Child_Crashes_An_Unequal_Burden.pdf

¹⁰⁸ Sassi F, Cecchini M, Devaux M. *Obesity and the Economics of Prevention: Fit not Fat, Executive Summary*. Organization for Economic Cooperation and Development (September 2010). Web. Accessed 6/5/12 via:

<http://www.oecd.org/dataoecd/21/19/46004918.pdf>.

¹⁰⁹ Ibid.

ideas of justice and sustainability¹¹⁰ where an attempt is made to establish the link between the concepts of environmental justice and sustainability and, specifically, the possibility of creating a “*just sustainability.*” Second, are more substantive concerns that may come from the redevelopment or development of communities that have the potential to result in disproportionate harm to certain groups.

Just Sustainability

The increasingly prominent U.S. movement and related discourses around Complete Streets, Transit Oriented Development, Livable Streets, sustainable development and healthy communities is combining with another narrative that frames the message that streets and communities are ultimately public spaces. Accordingly, everyone in local communities should have equal rights to space within them, regardless of who they are, their social status, and whether or not they walk, own a car, use public transportation or make use of a bicycle for recreation or transport.¹¹¹

Adonia Lugo, a doctoral candidate in anthropology, captures the issue of just sustainability in her research about bicycling in Los Angeles. Her research has focused on the issue of equity and bicycle infrastructure. Lugo says that in the United States, bike infrastructure projects have increasingly become part of a “green” development trend, meaning that marginalized communities are identifying bike projects with displacement and gentrification.¹¹² She is currently researching this issue in Seattle.

Adonia’s research also seems to indicate that while biking may seem like a physical activity that everyone agrees is positive, the activity is not uniformly beneficial among all groups. Her research demonstrates that the outcomes of physical activity from biking are shaped by the experiences one has had in the past, and that biking often occurs “in historic urban landscapes where communities have struggled with displacement for decades”.¹¹³

It must also be noted that the possibility exists for the (re)development of well-planned, healthy, sustainable communities to result in gentrification which could lead to even greater inequality. Such development or neighborhood revitalization projects must consider whether low income and underserved populations will be able to effectively access the improved services or built environment.

A recently released study by the Pew Research Center points out that residential income segregation is increasing across the



¹¹⁰ Professor Julian Agyeman Ph.D. FRSA, is Chair of the Department of Urban and Environmental Policy and Planning at Tufts University. Agyeman J. “Incomplete streets?” *Just Sustainabilities: Re-imagining equality, living within limits* (May 2012). Web. Accessed 8/14/12 via: <http://julianagyeman.com/2012/05/incomplete-streets/>

¹¹¹ Ibid.

¹¹² Lugo A. Anthropology Doctoral Candidate, University of California Irvine (July 9, 2012). Email.

¹¹³ Lugo A. Urban Adonia. Web. Accessed 8/12/12 via: <http://www.urbanadonia.com/>.

country and especially in Texas and the southwest.¹¹⁴ According to Pew researchers, Houston leads the way (along with Dallas and San Antonio) among the nation's 10 largest metropolitan areas when it comes to affluent individuals and families living among others who are affluent, and poor living with poor. Pew's Residential Income Segregation Index findings for Houston make obvious the fact that the percentage of upper-income households in census tracts with a majority of upper-income households increased from 7% in 1980 to 24% in 2010. Likewise, low-income households in majority low-income tracts jumped from 25% to 37%.¹¹⁵ While the Pew study did not demonstrate why Texas' major cities lead what has become a national trend, the report says that the increases in communities segregated by class or income levels is related to the long-term rise in income inequality, which has led to a shrinkage in the share of neighborhoods across the United States that are predominantly middle class or mixed income.¹¹⁶

The real trial for the health of America and efforts to close the health divide lies not only in challenges with health care access or the creation of healthy communities, but also with structural issues that create and maintain income and social inequalities. There is a distinct possibility that as income inequalities grow, groups without the means will be unable to access the healthy communities that are being created.

Government sponsored activities around sustainable development and improving the built environment indicate that decision makers are aware that communities can become healthier through carefully considered development strategies. In response to increased activities promoting healthier neighborhood development, vulnerable groups around the nation are organizing in response to a sense that they are being swept aside on a tide that makes assumptions about their needs, likes, dislikes, and what they should be doing about their neighborhoods.

Groups are being formed in places all across the United States from Portland to Detroit. In New York City's Chinatown, a group known as "Local Spokes" emerged in 2010 in response to a perceived lack of community involvement in the planning process around a growing bicycle movement in New York City, particularly among low-income residents, people of color, immigrant communities, and youth.¹¹⁷

Since 2010, Local Spokes used a participatory process, multilingual outreach, and a youth ambassadors program to develop a neighborhood action plan meant to increase resources, address potential barriers and increase accessibility to bicycling. Consisting of a coalition of nine community-based organizations Local Spokes was derived out of a goal of creating a new model for inclusive and sustainable development. In Detroit, an effort titled "Building Movement Detroit- Uniting Detroiters" has been meeting to cover an ambitious set of objectives around the justice of new land use and political geographies taking shape in the efforts to rebuild Detroit.¹¹⁸

¹¹⁴ Tolson M. "Segregation by income in Houston is among the starkest in U.S." *Houston Chronicle* (Aug. 1, 2012). Web. Accessed 8/12/12 via: <http://www.chron.com/default/article/Segregation-by-income-in-Houston-is-among-the-3755755.php>.

¹¹⁵ Ibid.

¹¹⁶ Ibid.

¹¹⁷ Local Spokes. "Neighborhood Action Plan, Executive Summary." Web. Accessed 8/9/12 via: http://localspokes.org/images/Local_Spokes_ActionPlan_Exec_Summary.pdf

¹¹⁸ Building Movement Detroit. "Uniting Detroiters Project Convening." Web. Accessed 8/14/12 via: <http://www.buildingmovement.org/news/entry/325>.

The Detroit group aims to engage residents around the following ideas:

- The implications of the socio-political reconfiguration underway as seen in several projects: the Detroit Works Project, Michigan State University’s proposed research farm/laboratory, the foreclosure crisis, the Consent Decree, council redistricting, the dominance of Community Development Corporations and foundations.
- The various ways that politicians, financiers, planners, and developers are remapping Detroit.
- Detroit’s “land questions” – To whom do Detroit’s “abandoned” lands belong? Who decides? By what processes? What would we like to see done differently?
- The possibilities and limitations of the following concepts: land justice, land sovereignty, land restitution, the commons, community land control, land reform, land distribution, autonomous zones, and liberated territory.
- A political, ethical, and conceptual framework adequate to the efforts in the city that can orient and guide their independent and collective work.¹¹⁹

Substantive Impacts and Harms

The substantive impacts from efforts to address the built environment and population include: gentrification, increased injuries and illness, underutilization of bike and walking trails by low income and racial/minority groups, along with the inequitable allocation of municipal resources for street, sidewalk, and infrastructure projects.

Gentrification

In the pursuit of reconstructing communities, adding biking and walking trails, and redeveloping older communities many cities have arrived at the age of regeneration in pursuit of better health for all and a standard of living that should benefit everyone. While the positive impacts from this kind of development, growth, and renewal are touted as one response to poor population health the other side of the equation demands a look at the process, who is affected and how based on socioeconomic status.¹²⁰

In an upcoming book Marisela Gomez, an activist and scholar in Baltimore, describes how residents who lived north of the Johns Hopkins medical campus were negatively impacted by the East Baltimore revitalization effort.¹²¹ Household displacements occurred as part of a \$1 billion redevelopment project that was meant to redevelop the area in and around Hopkins by constructing five life science buildings, retail space and housing.¹²²

¹¹⁹ Building Movement Detroit. “Uniting Detroiters.” Web. Accessed 8/14/12 via:
http://www.buildingmovement.org/pdf/UD_Convening_82012.pdf.

¹²⁰ Slater T. “The Eviction of Critical Perspectives from Gentrification Research.” *International Journal of Urban and Regional Research* 30.4 (December 2006):737-757. Print.

¹²¹ Gomez MB. Race, Class, Power, and Organizing In East Baltimore: Rebuilding Abandoned Communities In America. Lexington Books (November 2012). The book focuses on the patterns of rebuilding in this primarily African American and working poor and low-income community with an emphasis on a current rebuilding project.

¹²² Harvey D, & Gomez MB. “Baltimore: A conversation between David Harvey and Marisela Gomez.” *Indydependent Reader* 1 (2006). Web. Accessed 8/11/12 via: <http://indyreader.org/content/baltimore-conversation-between-david-harvey-and-marisela-gomez>.

Makani Themba, activist and Executive Director of the Praxis Project,¹²³ describes the impacts from an infrastructure project in Gary, Indiana:

I think one of the challenges of the data on this is that I have often observed that cities use monies for paths, bike and complete streets improvements as a gentrification strategy - or to improve more affluent neighborhoods in cities that have otherwise high pockets of low income residents. It looks as if the improvements are in communities that are low income, communities of color but looking below the city level, you can see the disparity of access. A great example is the Miller area of Gary, IN where \$28 million was invested in redevelopment, trails and bike paths for the beach area there - about 30 times the Parks and Rec budget for the entire city of Gary. On its face, it looks like a project bringing biking and walking trails to one of the poorest cities in America - and it is but in the whitest pocket of the city. There is a proposal to have an express bus to the beach so that more residents can have access. Hopefully, that will pass and it will help. The city ceding a 50 year lease of the historic building on the property and its rental revenues to a local group that had the connections to raise the money for the upgrades does not help with public accountability. I wish I could say Gary was the only place with such challenges but that would be far from the truth.¹²⁴

Other possible adverse outcomes from (re)development initiatives include the loss of local retail outlets, small business owners, nonprofit organizations, or corner restaurants and grocery stores.¹²⁵ An often cited goal of redevelopment is to attract or diversify retail outlets. In the end, the community may get larger stores, restaurant franchises, or profit making healthcare practitioners along with the loss of local retail outlets, small business owners, nonprofit organizations, or corner restaurants and grocery store.

The losses remove venues that may have been more accessible to residents in a variety of ways. Residents are able to walk to these locales. Low cost primary healthcare or social services may have been provided within walking distance at little or no cost. These community venues might have supplied culturally appropriate food or monetary and in kind donations for community efforts.

The locally-based, smaller businesses can provide vital employment opportunities (part-time jobs in particular), and so have a positive impact on the quality of life of people living in these communities particularly for those groups such as lone parents and the elderly for whom it may not be feasible or realistic to enter the workforce on a full-time basis. Small retailers can also serve as local hubs or sites of informal social interaction and providers of local information (as opposed to more formal mechanisms of social interaction like community groups and housing associations) which aides in the development of bonds

¹²³ The Praxis Project is a nonprofit movement support intermediary and an institution of color that supports organizing and change work at local, regional and national levels. Focused on movement building for fundamental change, their mission is to build healthy communities by changing the power relationships between people of color and the institutional structures that affect their lives.

¹²⁴ Themba M. Executive Director, Praxis Project (July 10, 2012). Email.

¹²⁵ U.K. Department of Health, Policy Action Team 13. "Improving Shopping Access for People Living In Deprived Neighbourhoods."

National Strategy For Neighbourhood Renewal (1999). Web. Accessed 8/13/12 via:

http://webarchive.nationalarchives.gov.uk/+http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/pat_report_13.pdf

between residents. This informal interaction is important for groups such as the elderly or new immigrants. Smaller local outlets can also help to reduce the sense of social isolation that may be experienced by groups such as the elderly.

Utilization and Misallocation

In this section we discuss the possibility that vulnerable populations may not utilize biking and walking trails at all or in ways that we expect, the reasons that this may occur, and what groups are doing to address these issues. We also look at efforts to ensure equity in the allocation of resources to fund infrastructure projects. The City of Portland Oregon is characterized as a bicycle friendly city. Nearly 10% of Portlanders regularly ride on its 274-mile bicycle network. More than 25% of Portlanders and over 45% of school children in its public schools are people of color, yet according to studies conducted by the Community Cycling Center ridership does not reflect this.¹²⁶

In 2008, the Bicycling Center began a study aimed at understanding the needs of their program participants, which are predominantly low-income and communities of color. The Understanding Barriers to Bicycling Project was launched as a community needs assessment to increase understanding about what were people interested in and concerned about as it related to bicycling. Their study demonstrated the complex barriers to bicycling, and revealed that giving people bicycles is not enough to support ongoing bicycle usage.¹²⁷ The organization reports that since completing the assessment they are collaborating with community partners to develop projects and support community leaders to broaden access to bicycling and its benefits. They hope to ensure that those benefits from bicycling are accessible to all and accrue to groups by serving their interests and needs in a way that has meaning to them.

In other parts of Portland, the community revolted in the spring and summer of 2011 against efforts to alter the street landscape in what was once a predominantly African-American neighborhood. While the bike lanes were the starting point for the community's anger, it has now become clear that much of the anger was the result of perceived and actual neglect over many centuries when the community asked for help to fight problems with violence, drugs, and urban blight.

Midge Purcell, policy director of the Urban League of Portland said, "The City of Portland's policies want to encourage increased cycling and environmental friendliness. That's all very well and good. But when people feel that those values are imposed upon them, especially when there have been all the other historic impositions on the community, then it really does become about a lot more than just putting in a bicycle lane. In a lot of ways, this is a real test. To see whether some of the lessons have been learned from previous projects where the outcomes have been really, really poor."¹²⁸

The City of Portland put the project on hold and added another eight months (until March 2012) of dialogue in response to the outcry over gentrification and "top-down" city planning.¹²⁹ The project to make the area more

¹²⁶ The Community Cycling Center is a nonprofit organization founded in 1994 in Northeast Portland, Oregon. Their stated mission is to broaden access to bicycling and its benefits and to build a vibrant community where people of all backgrounds use bicycles to stay healthy and connected.

¹²⁷ The Community Cycling Center. "Understanding Barriers to Bicycling Final Report." Portland: (July 2012). Web. Accessed 7/16/12 via: <http://www.communitycyclingcenter.org/index.php/community/understanding-barriers-to-bicycling/>

¹²⁸ Mirk S. "It's Not About the Bikes, Pinning the North Williams Uproar over Bikes Misses the Point—and the History." The Portland Mercury (February 16, 2012). Web. Accessed 8/14/12 via: <http://www.portlandmercury.com/portland/its-not-about-the-bikes/Content?oid=5619639>

¹²⁹ Ibid.

bike-friendly and healthy seemed to hit a raw, sensitive spot in a rapidly changing community that had become increasingly white and middle income in recent years. In June 2012, after 17 months of deliberation, Portland's Bureau of Transportation ethnically diverse Stakeholder Advisory Committee (SAC) for the N. Williams Traffic Operations Safety Project concluded its work and approved Option 4B, which in technical terms is a "Left-Side Buffered Bike Lane with One Motor Vehicle Travel Lane and Turn Lanes (Segments 2 to 5) and Shared Left-Turn Lane/Bikeway in Segment 4."¹³⁰

There are planning and biking advocates giving consideration to the issue of biking, redevelopment, and gentrification. For example, Samuel Stein, a master's candidate in the urban planning program at Hunter College, City University of New York observes how in recent years, New York City has focused a great deal of attention and resources on construction "in the most intense flashpoints of gentrification where the bicycle network reflects and reproduces the city's transportation injustices".¹³¹

Stein also notes that local governments, planners, and other community development advocates should acknowledge "needs-based infrastructure construction."¹³² Under this concept high-need areas, where working-class people bicycle every day under increasingly dangerous conditions, would receive the same level of attention as other middle to upper income parts of the city. According to Stein, "...city agencies need to reframe their priorities in order to serve those most vulnerable to gentrification, rather than those who profit from it."¹³³

Another example of the clash between community and government interests in healthy development and sustainability occurred in New York. When Local Spokes of Chinatown came together the neighborhood was experiencing clashes among the diverse interests of groups in that community.¹³⁴ The bike lanes in Chinatown engendered varied reactions among residents. Business owners reportedly argued that the bike lanes made commerce harder, accidents between bicyclists and local pedestrians were said to be commonplace, polite-but-frustrated bicyclists were bewildered by the number of trucks parked in bike lanes, and bicyclists were frequently seen yelling at elderly Chinese-American pedestrians. The interests of the residents and business owners along with experiences around bicycling needed to be accounted for, recounted, and included in the planning process. Local Spokes has taken on that challenge.

A report published in 2012 by Agyeman, chronicles similar challenges to bicycle lanes and cycling in other cities.¹³⁵ According a New York Times article published in 2011, Chicago resident and founder of the African American Pioneers Bicycle Club, Oboi Reed, reproached Chicago's prioritization of bike plans. Reed is quoted in the article saying: "The lion's share of the resources of the city's \$150 million bike plan are going to go [to

¹³⁰ Agyeman J. "Incomplete streets?" *Just Sustainabilities: Re-imagining equality, living within limits* (May 2012). Web. Accessed 8/14/12 via: <http://julianagyeman.com/2012/05/incomplete-streets/>

¹³¹ Stein S. "Bike Lanes and Gentrification: New York City's Shades of Green." *Progressive Planning* 188 (2011). Web. Accessed 9/17/12 via: http://www.plannersnetwork.org/publications/pdfs/2011/PNmag_Summer_Stein.pdf.

¹³² Ibid.

¹³³ Ibid.

¹³⁴ Su C. "New Chinatown Biking Coalition: Local Spokes." *Open City: Blogging Urban Change* (June 2, 2011). Web. Accessed 8/14/12 via: <http://openthecity.org/?p=3291>.

¹³⁵ Agyeman J. "Incomplete streets?" *Just Sustainabilities: Re-imagining equality, living within limits* (May 2012). Web. Accessed 8/14/12 via: <http://julianagyeman.com/2012/05/incomplete-streets/>.

the wealthier neighborhoods] downtown and to the North Side-the South and West will only see a sprinkling.”¹³⁶

In New York City, a report by graduate students from the Urban Affairs and Planning Program at Hunter College wrapped up its analysis saying: “Traditionally underserved areas outside of the core of Manhattan and northwest Brooklyn have inadequate bicycle infrastructure. These areas have many cyclists and residents who are largely new immigrants and people of color.”¹³⁷

Some local jurisdictions have made efforts to apply an allocative formula or equity analysis to help prioritize spending on public works infrastructure projects. Starting again with Portland, we examine well-meaning efforts to develop methods for the equitable allocation of resources and funding for projects across communities and groups. The Portland Bicycle Plan for 2030 was adopted unanimously by Portland's City Council on February 11, 2010. The plan aims to increase bicycle ridership to 25% citywide and to reach “all Portlanders.” In the creation of the Bicycle Plan, the city of Portland incorporated a Health, Equity & Bicycles working group. The working group requested a network gap analysis. The analysis was guided by a Public Health/Equity Objective developed during the planning process.

The Health Equity objective urged action to “perform [an] equity gap analysis that included demographic and income indicators overlaid with an existing bike facility gap analysis to inform priority settings where people live, learn, work, and play.” In addition to these four categories, the equity analysis also addressed bicycle access to transit in recognition of the reality that many outlying neighborhoods were not within a three mile bike-able distance to important destinations.¹³⁸ The 2009 Equity Gap Analysis Report was carried out by the Portland State University Center for Transportation Studies.¹³⁹

Clark County in Washington State has developed a tool for prioritizing projects in their bike/pedestrian plan. The development of the tool came about as a result of a Health Impact Assessment (HIA) carried out by Clark County Public Health Department in May 2010.¹⁴⁰

Major recommendations from the HIA advised the County to add the following considerations and actions to the Clark County Bicycle and Pedestrian Plan:

- Prioritize projects and adopt policies that increase the following measures of walkability: connectivity, urban design, land use mix, and residential density.
- Create policies to increase bicycle and pedestrian access to nutritious food.

¹³⁶ Lepeska D. “City Bike Plan is Accused of a Neighborhood Bias.” *New York Times* (October 15, 2011). Web. Accessed 10/4/12 via: <http://www.nytimes.com/2011/10/16/us/chicago-bike-plan-accused-of-neighborhood-bias.html>.

¹³⁷ Applebaum M, Camp A, Clarke C, Delia J, Harris-Hernandez J, Park S, Paul B, Richmond S, Stein S, Wallach M, & Sung HY. “Beyond the Backlash: Equity and Participation in Bicycle Planning.” Hunter College Department of Urban Affairs & Planning. (May 2011). Web. Accessed 10/4/12 via: <http://www.streetsblog.org/wp-content/uploads/2011/05/BeyondBacklash2011.pdf>.

¹³⁸ Dill J, PhD, & Haggerty B. “Equity Analysis of Portland’s draft Bicycle Master Plan – Findings.” Portland State University Center for Transportation Studies (September 24, 2009). Web. Accessed 8/14/12 via: <http://www.portlandoregon.gov/transportation/article/264747>.

¹³⁹ Ibid.

¹⁴⁰ Clark County Public Health. “Rapid Health Impact Assessment: Clark County Bicycle and Pedestrian Master Plan.” Clark County Washington, Public Health Department (May 2010). Web. Accessed 8/14/12 via: http://www.co.clark.wa.us/public-health/reports/documents/FINAL_RapidHIA.pdf.

- Design for inexperienced cyclists.
- Include health and equity in project evaluation criteria.
- Recognize increased numbers of bicyclists and pedestrians as a safety strategy.

In response, the Clark County Bicycle and Pedestrian Advisory Committee developed evaluation criteria for bicycle and pedestrian projects that included Health Outcomes. The defining characteristics for these criteria are the following: project is in block group with unfavorable social determinants of health and high walkability potential, project improves connectivity, and project involves low-speed/low-traffic designs.¹⁴¹

Illness

In the haste to build and redevelop healthier communities the potential health hazards and precautions are overlooked as they apply to the people who live and work near the site of the development.¹⁴² For example, a 2007 study found that children living in low-income areas with significant demolition activity “showed significantly higher levels of lead in their blood than in children where no demolition had taken place.”

The report goes on:

Despite such findings, federal laws and regulations provide no protections to ensure that lead exposure is minimized during demolition... likewise, states and municipalities typically do not require contractors to ensure lead exposure is minimized.¹⁴³

A few organizations are looking into the concept of responsible redevelopment that includes communicating the potential health hazards, necessary health precautions and the contractor’s responsibilities to community residents.

In a 2011 report by the Annie E. Casey Foundation, residents, and local advocates in Baltimore established demolition practices that sharply reduced the risk of adverse health consequences.¹⁴⁴ The practices were established in response to the demolition of several hundred structures as part of the 88-acre East Baltimore Revitalization Initiative (EBRI). In addition, the report identified how these responsible demolition protocols are being adopted or considered by jurisdictions outside of East Baltimore and offers lessons learned for policymakers, advocates, and redevelopment professions.

The location of bike/walking trails in areas of high traffic have been associated with higher levels of risk for certain chronic diseases. In 2010, Rioux et al. found that traffic exposure at roadway volumes as low as 20,000–40,000 vehicles/day may increase cardiovascular disease risk through adverse effects on blood

¹⁴¹ Clark Communities Bicycle and Pedestrian Advisory Committee. “Clark County Bicycle and Pedestrian Master Plan-Appendix C.” Clark County Community Planning (Nov. 2010). Web. Accessed 10/4/12 via: http://www.clark.wa.gov/planning/bikeandped/documents/10-1110_BPMP-Appendices_PC_approved.pdf.

¹⁴² Fullenwide K. “A Demolition Dictionary: A Glossary of Terms for Understanding Demolition in Your Community.” Next American City (Feb. 2012). Web. Accessed 8/13/12 via: <http://americancity.org/daily/entry/a-demolition-dictionary>.

¹⁴³ F.A. Rabito, S. Iqbal, C.F. Shorter, P. Osman, P.E. Philips, E. Langlois, L.E. White. “The association between demolition activity and children’s blood lead levels.” *Environmental Research* 103.3 (2007): 345-35. Print.

¹⁴⁴ The East Baltimore Revitalization Initiative. “Responsible Demolition: A Baltimore Case Study with National Implications.” (June 2011). Web. Accessed 8/13/12 via: http://www.communityprogress.net/filebin/pdf/new_resrcs/AECF-Responsible-Demolition-Report.pdf

pressure and inflammation. The authors conclude that individuals with elevated inflammation profiles could be more susceptible to cardiovascular effects of traffic exposure. These results also suggest risks from residential roadway exposure at lesser volumes than previously reported in the literature.¹⁴⁵

These findings suggest that the location of walking/bike trails in poorer, inner city neighborhoods near major thoroughfares, highways, and freeways may not result in reductions in health inequities particularly for groups most at risk for obesity, elevated blood pressure and cardiovascular disease.

Policy Recommendations for Active Living and Healthy Eating

1. Municipalities should be encouraged to establish funding mechanisms to address access to affordable, culturally appropriate, healthy food through retail opportunities that are compatible with the community that take into account miles traveled and walkability. The funding mechanisms should be arranged to fit the needs of different localities (cities, small towns, rural areas); and offer several financial products (grants, loans, loan guarantees and tax credits) tailored to meet a diverse group of businesses financing needs.
 - a. Municipalities should consider the use of Community Development Block grant (CDBG) funds granted to the City by the Department of Housing and Urban Development (HUD) and the State of Texas to address food access issues in low-income, underserved communities by providing financing for capital, real estate and related expenses, pre-development, site assembly and improvement, construction and rehabilitation, equipment installation and upgrades, staff training, security, and start-up inventory and working capital. Funds may be used to either:1) open a self-service supermarket , grocery retail outlet primarily selling fresh produce, seafood, meat, dairy, and other groceries; 2) renovate and substantially improve a store’s ability to stock and sell a variety of fresh fruits and vegetables; or 3) develop a real estate project that will lease space to a grocery retail tenant.
 - b. Municipalities may also establish a funding mechanism using Chapter 380 of the Texas Local Government Code where the local government is able to loan or grant public money in exchange for public infrastructure, drainage and/or utility improvements and job creation. The 380 Agreement is an economic development tool to incentivize food retailers by offsetting the high, initial costs associated with site acquisition and infrastructure and/or offer assistance with facility rehabilitation to allow operators to expand existing stores. 380 Agreements offer a performance-based rebate to commercial and residential development projects on the city’s portion of ad valorem taxes, sales and use taxes. The performance-based rebates are determined solely upon proven increases in taxes assessed and collected after the projects are operational and taxes can be accurately measured.
2. In establishing a funding mechanism and agreements municipalities should give special consideration to agreements that include any of the following:

¹⁴⁵ Rioux CL, Tucker KL, Mwamburi M, Gute DM, Cohen SA, et al. “2010 Residential Traffic Exposure, Pulse Pressure, and C-reactive Protein: Consistency and Contrast among Exposure Characterization Methods.” *Environmental Health Perspectives* 118.6 (2010). Print.

- a. Arrangements that use a variety of fresh food retailers (full service supermarkets, small grocery stores, farmers markets, food retail cooperatives and community supported agriculture (CSA) projects where local farmers are included as sources for produce, dairy, and fruit and vegetable products.
 - b. Rental agreements, shared space arrangements, and other mechanisms that protect small community based corner stores or smaller retailers when establishing subsidy programs to encourage large grocery store developers to build in a community.¹⁴⁶
3. Municipalities should be encouraged to adopt a policy of using Complete Streets design in all projects. The policies should express clear directives using direct language and cover construction and reconstruction projects and include maintenance, operations, or other projects. Where appropriate, when the streets are dug up, they should be replaced with wide sidewalks, ADA compliant intersections, and safe and clear bike lanes, as well as adequate, safe travel lanes for automobiles, transit, and freight operators.
 4. Municipalities should adopt an equity method for allocating funds in the Capital Improvement Program (CIP) or any funds that that pay for infrastructure projects including new or replacement sidewalks, streets, and bike and walking trails.
 5. Municipalities should implement the practice of executing Health Impact Assessment (HIAs) for select policies and large-scale development projects to evaluate the potential effects on: (1) the socioeconomic viability of vulnerable populations, and (2) the built environment including impacts to access to physical activity, availability of nutritious foods, and impacts to neighborhoods.
 6. Municipalities should be encouraged to adopt Healthy Eating & Active Living resolutions¹⁴⁷ that represent their community values, skills and resources, and political ideology. The resolutions may be prescriptive or aspirational.
 - a. An aspirational resolution provides descriptive goals and objectives along with guidance on the issues to consider. For example:
 - i. Establishing an ongoing Task Force to identify concrete actions that could be taken to address healthy eating and active living including infrastructure and policy changes that support and improve access to fresh, affordable foods and safe places for physical activity, and report annually on progress toward reducing obesity in the City.

¹⁴⁶ A master plan proposed that small, low margin retailers would be protected in terms of rental agreements in order to prevent the community and the high street from being monopolized by large scale multi-national retailers.

Melia S. "A sustainable new community at Sherford health impact assessment: technical report for Devon County Council, South Hams District Council and Devon Primary Care Trust." *Ben Cave Associates Ltd.* (2007) Web. Accessed 10/16/12 via: <http://www.apho.org.uk/resource/view.aspx?RID=116032>

¹⁴⁷ A resolution versus an ordinance. The ordinance is a local law. Although the method of enacting an ordinance will vary from municipality to municipality, they are generally passed by a legislative body (city council) and signed by a city executive (mayor), and subsequently enforced by local police and district attorneys. Resolutions are non-binding, unenforceable, statements made by a municipalities legislative body. They are often not signed or endorsed by the city executive.

- b. The second option is a resolution that is more prescriptive enjoining specific actions that should be carried out. Possible elements include the following:
 - i. Directing the City Manager to identify any land acquisition, health permitting and transportation barriers to accessing supermarkets or farmers' markets and determine where there are opportunities to increase access to healthy food and report to the City Council with findings and recommendations.
 - ii. Coordinating a bi-annual equity review of building and design codes, bike and pedestrian walking plans, policies, regulations, and neighborhood planning codes for their impact on access to food and physical activity. The process should include a process that involves community members and stakeholders. In addition to city personnel (City managers, representatives from the public health department, parks, public works and planning departments), the process should be multi-sectored including experts from outside the government. A report should be presented to city policymakers for review.
 - iii. Directing the City Manager to procure a Health Impact Assessment for any new large-scale development project to evaluate the potential effect of a development project on physical activity, availability of nutritious foods, and potential impacts on population health.
 - iv. Directing the City Manager to review and revise all policies and practices that might erect unnecessary barriers to breastfeeding, community gardening, farmers' markets, or related activities, and reporting the findings and recommendations to the City Council.

Gap Analysis

Funding Mechanisms for Food Accessibility

CDBG

Community Development Block Grant (CDBG) funds may be used to provide affordable housing, services, and jobs for vulnerable groups in communities. Generally, appropriations are allocated to states and local jurisdictions from the Department of Housing and Urban Development (HUD).

The U.S. Department of Housing and Urban Development (HUD) determines the amount of each grant by using a formula comprised of several measures of community need, including the extent of poverty, population, housing overcrowding, age of housing, and population growth lag in relationship to other metropolitan areas. Not less than 70 percent of CDBG funds must be used for activities that benefit low- and moderate-income persons. In addition, each activity must meet one of the following objectives: benefit low- and moderate-income persons, prevention or elimination of slums or blight, or address community development needs having a particular urgency because existing conditions pose a serious and immediate threat to the health or welfare of the community for which other funding is not available.

HUD grants the CDBG funds based on the type of community, entitlement or non-entitlement. Entitlement communities are comprised of central cities of metropolitan statistical areas; metropolitan cities with

populations of at least 50,000; and qualified urban counties with a population of 200,000 or more (excluding the populations of entitlement cities).

Non-entitlement cities are located predominately in rural areas and are cities with populations less than 50,000 persons; cities that are not designated as a central city of a metropolitan statistical area; and cities that are not participating in urban county programs. Non-entitlement counties are also predominately rural in nature and are counties that generally have fewer than 200,000 persons in the non-entitlement cities and unincorporated areas located in the county.

Harris County is considered an entitlement community (e.g. they get the funds directly from HUD. Harris County receives funding to cover unincorporated areas. Non-entitlement communities (<50K population in city or <200K population in county) are funded through the CDBG block grant which goes through the Texas Department of Agriculture (TDA). However, TDA does not fund any cities in Harris County because they are considered entitlement communities.¹⁴⁸ Relevant counties and cities funded directly through HUD in FY2012 include: Harris County, Baytown City, Houston, Pasadena and Pearland.¹⁴⁹ Recently, during a vote in the U.S. House of Representatives on H.R. 5972, the T-HUD bill, (the Transportation, Housing and Urban Development, and Related Agencies Appropriations Act for FY 2013) several members of the Texas Congressional District voted to cut off CDBG funding to Texas cities.¹⁵⁰ That vote failed.

Chapter 380 Agreements¹⁵¹

The City of Houston has created a Chapter 380 initiative called the Healthy Houston Food Access (HHFA) program. It is designed to assist food retailers in expanding, relocating, rehabilitating or developing new stores in underserved communities known as food deserts (see Appendix B for a description of this initiative). Chapter 380 is a reference to the Texas Local Government Code. This chapter of the Texas Local Government Code authorizes Texas municipalities, both home-rule and general law municipalities to provide assistance for economic development. Texas cities may provide monies, loans, city personnel, and city services for promotion and encouragement of economic development. Cities are authorized to “provide for the administration of one or more programs, including programs for making loans and grants of public money and providing personnel and services of the municipality.” Nonetheless, the programs must serve the purpose of promoting state or local economic development by stimulating business and commercial activity within the city, within the extraterritorial jurisdiction (ETJ) of the city, or an area annexed by the city for limited purposes.¹⁵²

¹⁴⁸ Conversation with Becky Dempsey Texas Department of Agriculture, State CDBG Coordinator. 8/13/12.

¹⁴⁹ U.S. Department of Housing and Urban Development. “Community Planning and Development Program Formula Allocations for FY 2012” Web. Accessed 8/13/12 via: <http://www.hud.gov/offices/cpd/about/budget/budget12/>

¹⁵⁰ Texas Municipal League. “Texas Reps Vote to Eliminate CDBG Funding,” (July 3, 2012). Web. Accessed 8/13/12 via: http://www.tml.org/leg_updates/legis_update070312d_CDBG_funding_eliminated.asp

¹⁵¹ Code Jeff Moore Brown & Hofmeister, L.L.P. Texas City Attorneys Association; Chapter 380 of the Texas Local Government Code, Riley Fletcher Basic Municipal Law Seminar Lubbock, Texas. February 24, 2006 Website accessed 8/13/12 via: http://www.tml.org/legal_pdf/Chapter380-Local-GovCode.pdf

¹⁵² TEX. LOC. GOV'T CODE ANN. § 380.001(a) (as amended by Texas House Bill 918, 79th Legislature, Regular Session (2005) (effective date May 17, 2005).

Texas Legislature – Senate Bill 343

In 2009, Senate Bill 343 by Texas Senator Jane Nelson¹⁵³ called for the creation of the Healthy Food Advisory Committee. The Committee, set to expire in 2011, was directed to submit to the legislature by September 1, 2010, a report outlining:

1. the costs, benefits, and feasibility of a statewide financing program to bring fresh food retailers into areas of this state that are underserved in regard to the retail availability of fresh fruits and vegetables and other healthy foods; and
2. a plan for implementing the program.

In order to address the lack of fresh food availability in Texas, the 2010 report issued to the legislature examined a variety of financing mechanisms and funding resources that have the potential to provide necessary equipment and support for fresh food retailers.¹⁵⁴

The final report summary had seven recommendations:¹⁵⁵

1. Maximize existing grant, loan, and other financing programs available in the state to ensure appropriate distribution-levels to the most underserved areas across Texas, and to create innovative public-private partnerships to provide incentives for the redevelopment and expansion of fresh and healthy food retail outlets that are sustainably self-sufficient.
2. Encourage and enable the temporary use of existing food assistance tools as mechanisms to close the gaps between time periods of individual food insecurity or as primers to enable privately sustainable healthy foods retail investment into communities.
3. Gather and share lessons learned from the community-based outcomes of the Texas-based Fresh Food Financing Initiative project with community and state-level stakeholders and decision-makers.
4. Establish regional, city or county food policy councils to improve policies related to the food system as a whole (E.g. farm to table).
5. Encourage communities to promote awareness of direct-to-consumer marketing outlets such as farmers markets, community gardens, farm-to-work and community-supported agriculture (CSA).
6. Encourage local-level discussion of changes and improvements in transportation routes and public transportation options needed to increase access to healthy food retail outlets and venues for the purpose of including in long-range community planning.

¹⁵³ Senator Jane Nelson is a businesswoman and a former teacher who represents Senate District 12, encompassing parts of Denton and Tarrant counties. She was elected to the Senate after serving two terms on the State Board of Education in which she led the fight to correct more than 5,000 factual errors in school textbooks.

¹⁵⁴ Report of the Healthy Food Advisory Committee. "Fresh Food Availability in Texas September 1, 2010" Web. Accessed 10/1/12 via: <http://www.squaremeals.org/Portals/8/files/publications/SB%20343%20Final%20Complete.pdf>

¹⁵⁵ Ibid.

7. Encourage participation in national food assistance programs that enable residents to purchase locally grown fresh fruits and vegetables. (E.g. Promotion of the use of Women, Infant and Children (WIC) cash value vouchers, WIC and Senior Farmers Market coupons, and Supplemental Nutrition Assistance Program (SNAP) benefits in farmers markets).

Complete Streets¹⁵⁶

Some cities have in place policies that allow various obstructions in sidewalks for utility poles and other uses, as well as widespread deterioration of sidewalks that impair the access and opportunities of the mobility impaired, the elderly, and children. Still other neighborhoods have unsafe, broken or non-existent sidewalks. As of May 1, 2012, 1,045 people were reported to have signed the petition for Complete Streets for Houston. Advocates in and around Houston working with the Houston Coalition for Complete Streets and Houston Tomorrow believe that the adoption of Complete Streets across Harris County would mean long-term improvements to health, safety, and the city spending.

The Houston Coalition for Complete Streets submitted a packet of information to Houston's Mayor and members of the Houston City Council in 2011. The packet expressed the interest of the citizens in Complete Streets through a petition, and presented a plan of action detailing reasonable and efficient short term solutions the City could implement while beginning work on transformative changes that may take five to ten years.¹⁵⁷

The National Complete Streets Coalition has just issued standards to use to develop and evaluate these policies. The report and companion workbook highlight successful Complete Streets policies from across the United States.¹⁵⁸



The National Complete Streets Coalition's 2011 Policy Analysis surveys the over 350 Complete Streets policies that have been approved by communities across the country. Only two states do not have a Complete Streets policy at any level of government, while ten states have over 15 policies on the books.¹⁵⁹ Leading the policy adoption charge are the states of Michigan, Minnesota, and New Jersey, with 63, 29, and 28 policies, respectively. Just over 18% of Complete Streets policies are passed as legislation and encoded in statutes, while nearly half are expressed through non-binding resolutions.¹⁶⁰

¹⁵⁶ Special thanks to Houston Tomorrow for providing access to several policy briefings sent to the City of Houston on their requests for Complete Streets. The longer report "Toward Complete Streets for Houston" is the primary document that we reviewed for recommendations. <http://houstoncompletestreets.org/2012/06/12/our-request-to-the-city-of-houston/>

¹⁵⁷ Ibid.

¹⁵⁸ Seskin S. "Complete Streets Policy Analysis 2011." (August 2012). Web. Accessed 8/26/12 via:

<http://www.completestreets.org/webdocs/resources/cs-policyanalysis.pdf>

¹⁵⁹ Ibid.

¹⁶⁰ Ibid.

Internal policies, adopted by top-level departmental leaders, made up about 8.5% of all policies, and fewer than 10% are contained inside planning documents such as comprehensive plans. Growing in number are city policies that are approved by the legislative branch; such policies, which are generally more detailed, make up nearly 11% of all Complete Streets policies.¹⁶¹

Houston's key city departments are reviewing the Complete Streets recommendation at this time. There has been no discussion about whether to adopt an ordinance, a resolution, or implement an internal policy.¹⁶² If Houston adopts a Complete Streets ordinance at this point, it could be the largest city in the nation to fully embrace the safety of all users of the street. However, San Antonio, Austin, Dallas, and El Paso have all made moves in the direction of Complete Streets.

According to the National Complete Streets Coalition, the ideal result of a Complete Streets policy is that all transportation improvements are viewed as opportunities to create safer, more accessible streets for all users. Policies that apply only to new construction and reconstruction projects are ranked lower than those policies that clearly include maintenance, operations, or other projects.¹⁶³

The Complete Streets National Coalitions says that policies that do not apply to projects beyond newly constructed roads, or ones that are not clear regarding their application, are insufficient.¹⁶⁴

The strongest policies are those that are clear in intent, saying facilities that meet the needs of people traveling on foot or bicycle "shall" or "must" be included in transportation projects.¹⁶⁵ The 'strong' label is also applied to policies in which the absolute intent of the policy is obvious and direct, even if they don't use the words "shall" or "must".

Policies are ranked as 'average' when they are clear in their intent – defining what exactly a community expects from the policy – but use equivocating language that weakens the directive.¹⁶⁶ An example is when the policy says that the needs of pedestrians and bicyclists "will be considered" or "may be included" as part of the process.

Within Harris County there are several complementary opportunities with which to coordinate a move toward Complete Streets. Along with the Houston



¹⁶¹ Ibid.

¹⁶² Blazek Crossley J. Program Development and Research, Houston Tomorrow. Phone Interview 8/24/12.

¹⁶³ Seskin S. "Complete Streets Policy Analysis 2011." (August 2012). Web. Accessed 8/26/12 via:

<http://www.completestreets.org/webdocs/resources/cs-policyanalysis.pdf>

¹⁶⁴ Ibid.

¹⁶⁵ Ibid.

¹⁶⁶ Ibid.

Department of Health and Human Services Community Transformation Grant from the Centers for Disease Control, Harris County Public Health and Environmental Services is currently forming a committee for their recently launched Obesity Collaborative that seeks to improve health through “upstream” solutions such as encouraging healthy eating and active lifestyles by improving the built environment. The City of Houston TIGER IV grant application is a positive step toward connecting the Bayou Greenways and the regional bicycle and pedestrian transportation network. A Complete Streets approach would find the most efficient ways to provide safe access from nearby neighborhoods to connect to this system.

In 2011, Texas State Senator Rodney Ellis (D-Houston) filed Senate Bill 513, Complete Streets legislation which would have required agencies with projects receiving federal or state funding to consider all modes of transportation when building or renovating roads. However, the bill was not passed into law during the 82nd Legislative Session.

Active Living & Healthy Eating Resolutions

Two major cities in Texas have experience with resolutions that address the social determinants of health using structural changes and a policy approach.

El Paso

The City of El Paso adopted a resolution that directs the City Manager to implement an action plan for five years from the time of passage and report progress annually to the City Council.

Prescriptive elements of the resolution cover:

- **Built Environment:** The City Manager – after reviewing comprehensive plans, zoning ordinances, subdivision regulations, smart growth policies, and other plans, codes, policies, and regulations – will propose action that could increase access to healthy foods, and increase opportunities for physical activity. The City Manager will then initiate a Health Impact Assessment for any new large-scale development project. The City Manager will also review and revise all policies that might erect unnecessary barriers to use of local parks, recreation facilities, physical activity programs, or related activities.
- **Access to Healthy Food:** the City Manager will review and revise all policies and practices that might erect unnecessary barriers to breastfeeding, community gardening, farmers’ markets, or related activities. The City Manager will identify any transportation barriers to accessing supermarkets or farmers’ markets and determine where there are opportunities to increase access to healthy food through public transportation. The City Manager will also review existing beverage, snack, and food service contracts, and revise contracts to reduce access to sugar-sweetened beverages and food high in sugar and fat.
- **Employee Wellness Program and Policies:** the City Manager will work with key stakeholders to enhance the municipal employee wellness program emphasizing improved nutrition, physical activity, and safety.

Houston

In October 2011 the Mayor’s Advisory Council on Health and Environment convened a Council Task Force for the purpose of developing a resolution for adoption by the City of Houston to address the problem of obesity.

The Task Force was asked to develop a resolution that could be recommended to the Mayor and establish an advisory group from the effort to develop additional recommendations and initiatives for the Mayor.

The Houston resolution would: address the need to improve the health and wellbeing of Houston families through reducing the incidence of obesity and obesity-related diseases, reducing food insecurity, and promoting the availability of wholesome, nutritious, locally grown foods throughout the city. The resolution would encourage the development of sustainable food systems and organically grown food products and promote recreational opportunities. Additionally, the Task Force was asked to consider how their work could “provide a framework for the city’s current and future activities in establishing community gardens and farmers’ markets.”¹⁶⁷ In May 2012, the Task Force delivered the resolution to the Mayor of Houston (see Appendix C for full text).

In addition to recommendations from several Task Force Work Groups, the resolution included the following broad elements:

- Recommendation to establish a Healthy Houston Task Force;
- Statement of support for urban agriculture and education on problems and solutions associated with obesity; and
- Recommendations to consider infrastructure changes to promote access to healthy food and physical activity and enable programs such as bike trails, safe playgrounds pedestrian friendly walkways that increase physical activity.

The Resolution was given to a subcommittee of Houston’s city council. After a review and comment period from that subcommittee, the Mayor has decided to enact an executive order from the resolution that is in progress.

[Texas Interagency Obesity Council](#)

The 80th Session of the Texas Legislature, in 2007, saw passage of Senate Bill 556, which created the Interagency Obesity Council. S.B. 556 amended Section 1. Subtitle E, Title 2 of the Health and Safety Code by adding Chapter 114 to construct a Council” made up of the Commissioners of Texas Department of Agriculture (TDA), the Texas Education Agency (TEA) and the Department of State Health Services (DSHS), or a staff member designated by each commissioner.¹⁶⁸

The Council’s express directive is to (1) discuss the status of each agency’s programs that promote better health and nutrition and prevent obesity among children and adults, and (2) consider the feasibility of tax incentives for employers who promote activities designed to reduce obesity in the workforce.

¹⁶⁷ Email received from Margaret Kripke, Ph.D., Task Force Chair and Lisa J. Mellencamp, Task Force member, General Counsel, Constellation Energy Partners LLC; documents sent including letter of invitation and Task Force resolution (8/15/12).

¹⁶⁸ Texas Department of State Health Services. “Texas Interagency Obesity Council.” Web. Accessed 10/1/12 via: <http://www.dshs.state.tx.us/obesity/NPAOPcouncil.shtm>

The Council is directed to report to the governor, lieutenant governor, and speaker of the house of representatives on activities of the council by January 15 of each odd-numbered year, including (1) a list of programs in each agency designed to promote better health and nutrition, (2) an assessment of the steps



taken by each program, (3) progress made by taking these steps, (4) areas of improvement that are needed in the programs, and (5) recommendations for future goals or legislation.

The Council's most recent Legislative report from 2011 highlights strategies and programs that the three State agencies have implemented to help communities and employers make healthy living choices easier to adopt for their employees and citizens through policy and environmental change.¹⁶⁹

Health Impact Assessments

Health Impact Assessments (HIAs) are seen as a tool that will lead to significant improvements in population health as they are put to use when developing policies, programs, plans, and projects, particularly in sectors that historically have been viewed as unrelated to health, such as transportation, education, agriculture, and housing.

Health impact assessments are seen as an especially promising way to factor health considerations into the decision-making process. It is a structured process that uses scientific data, professional expertise, and stakeholder input to identify and evaluate the public-health consequences of proposals and suggests actions that could be taken to minimize adverse health effects and optimize beneficial ones.¹⁷⁰

HIAs help to determine the potential effects of a proposed policy, plan, program or project on the health of a population and the distribution of those effects within the population. HIA provides recommendations on monitoring and managing those effects.

In Texas, the city of El Paso passed an Obesity resolution in 2011 that made extensive use of HIAs. To address the connection between obesity and the built environment the resolution calls for the City Manager to assess the impact of new large scale development projects using an HIA. (See ordinance in Appendix D and Case Studies for more details).

¹⁶⁹ Texas Department of State Health Services, Texas Interagency Obesity Council. "A Report to the Texas Legislature from the Interagency Obesity Council: A collaborative effort among these Commissioners and their Agencies (2011)." Web. Accessed 10/1/12 via: <http://www.dshs.state.tx.us/obesity/NPAOPcouncil.shtm>

¹⁷⁰ Committee on Health Impact Assessment of the National Academy of Sciences; National Research Council of the National Academies. "Improving Health in the United States: The Role of Health Impact Assessment." *The National Academies Press* (2011). Web. Accessed 8/15/12 via: http://www.nap.edu/catalog.php?record_id=13229.

As of 2012 four total Health Impact Assessments have been completed in Texas:¹⁷¹

1. Replacing Public Housing Units Destroyed by Hurricane Ike: An HIA to provide recommendations on the siting and upgrading of public housing to replace units that were destroyed by Hurricane Ike. (Supported by funding from The Kresge Foundation). The Georgia Health Policy Center and Department of Sociology at Georgia State University.¹⁷²
2. Southern Edwards Plateau Habitat Conservation Plan: An HIA to inform the implementation of a habitat conservation plan. San Antonio Metropolitan Health District.¹⁷³
3. Houston Transit Oriented Development: An HIA to examine the health impacts of possible development patterns that could occur in the neighborhood near a planned station on a 30-mile, five-corridor light rail expansion. Texas Southern University, Houston Tomorrow, Andress & Associates, Baylor College of Medicine.¹⁷⁴
4. School Siting Policies: An HIA that will address the health implications of choices regarding where to site and build schools, with a focus on how school siting affects whether children walk, bike, or use motorized transportation to get to school. University of Texas at Austin Southwest Region University Transportation Center, and CDC Division of Nutrition and Physical Activity.¹⁷⁵

It is worth noting that in the 2011 session of the Texas Legislature a bill was introduced that would add a public health perspective to regional mobility planning efforts. Senate Bill 1155, introduced by Senator Lucio,¹⁷⁶ would have allowed the appointment of a non-voting person with experience and training in public health policy to the board of directors of a regional mobility authority.

The commissioners courts of each county participating in the authority by agreement, or the governing body of a municipality that created an authority, would have been able to appoint a person with experience and training in public health policy to serve as a nonvoting director. The nonvoting director appointed under this subsection was directed to provide the board with an assessment of the public health impact of each proposed transportation project of the authority. This bill, which seems to have had the capacity to function like a health impact assessment, failed in committee during that legislative session.

¹⁷¹ Health Impact Project. "HIA in the United States" Web. Accessed 8/15/12 via: www.healthimpactproject.org/hia/us

¹⁷² Health Impact Project. "Replacing Public Housing Units Destroyed by Hurricane Ike" Web. Accessed 8/15/12 via: <http://www.healthimpactproject.org/hia/us/replacing-public-housing-units-destroyed-by-hurricane-ike>

¹⁷³ Health Impact Project. "Southern Edwards Plateau Habitat Conservation Plan" Web. Accessed 8/15/12 via: <http://www.healthimpactproject.org/hia/us/southern-edwards-plateau-habitat-conservation-plan>

¹⁷⁴ Health Impact Project. "Houston Transit Oriented Development" Web. Accessed 8/15/12 via: <http://www.healthimpactproject.org/hia/us/houston-transit-oriented-development>

¹⁷⁵ Health Impact Project. "School Siting Policies" Web. Accessed 8/15/12 via: <http://www.healthimpactproject.org/hia/us/school-siting-policies>

¹⁷⁶ Senator Eddie Lucio, Jr., a native of Brownsville, was elected to the Texas Senate in November 1990. He is a member of the Senate Finance Committee, Chairman of the International Relations and Trade Committee and sits on the Senate Committees on Business and Commerce, State Affairs and Government Organization. He was recently appointed Chair of the Joint Legislative Committee on Aging and also serves on the Interagency Task Force on Children with Special Needs and the Texas Tourism Caucus.

Allocation Formula with Health Equity Component

To ensure that budget and spending allocations reach the groups, neighborhoods, and communities that are worse off some efforts have been implemented to develop tools for this purpose.

We found that no cities in Texas and very few outside cities use an allocation formula based on public health and equity principles to prioritize Capital Improvement Program (CIP) spending (infrastructure projects that involve streets, sidewalks, and biking/walking trails). Clark County in Washington State has developed a tool for prioritizing projects in their bike/pedestrian plan. The development of the tool came about as a result of a Health Impact Assessment (HIA) carried out by Clark County Public Health Department in May 2010.¹⁷⁷

The allocation assessment utilizes a 100-point prioritization scoring process. Of these, 20 were allocated to health outcomes, allocated based on neighborhood socioeconomic status and potential to increase physical activity.

Examples of components in the plan include the following: 20 points are allocated to a project if it is in a block group with unfavorable social determinants of health and high walkability potential, project improves connectivity, and project involves low-speed/low-traffic designs; or, 25 points are allocated to a project within a 1/8 mile of existing bicycle or pedestrian facilities (The Clark County allocation assessment tool is located in Appendix E).

Case Studies

Case Study: New Orleans Fresh Food Retailer Initiative

New Orleans has initiated the Fresh Food Retailer Initiative (FFRI), a \$7 million citywide program to encourage supermarket and grocery store development in low-income, underserved communities of Orleans Parish. The FFRI program is partially funded by Disaster Community Development Block Grants (D-CDBG) granted to the City of New Orleans by the Department of Housing and Urban Development (HUD) and the State of Louisiana. The program is meant to enable operators to open, renovate, or expand retail outlets that sell fresh fruits and vegetables by providing financing for capital, real estate and related expenses. The program is made possible by the City of New Orleans and administered by Hope Enterprise Corporation in partnership with The Food Trust.

The FFRI Program provides forgivable and interest-bearing loans to support grocery store development. Eligible activities include: pre-development, site assembly and improvement, construction and rehabilitation, equipment installation and upgrades, staff training, security, and start-up inventory and working capital.

Applicants must plan to either:

- Open a self-service supermarket or other grocery retail outlet primarily selling fresh produce, seafood, meat, dairy, and other groceries;
- Renovate and substantially improve a store's ability to stock and sell a variety of fresh fruits and vegetables; or
- Develop a real estate project that will lease space to a grocery retail tenant.

¹⁷⁷ Rapid Health Impact Assessment: Clark County Bicycle and Pedestrian Master Plan Prepared by Clark County Public Health May, 2010 Website accessed August 14, 2012 http://www.co.clark.wa.us/public-health/reports/documents/FINAL_RapidHIA.pdf

Case Study: El Paso Anti-Obesity Resolution

On January 6, 2011, El Paso City Council passed an anti-obesity resolution, voting 7-1, to commit the city to developing programs to improve healthy options and increase physical activity. Before approving the resolution, council members modified the document, deleting a line requiring the City Manager to decrease access to unhealthy food retail outlets. Additionally, the resolution directs the City Manager to implement a five-year action plan to fight obesity among the city's workforce of over 6,000. Annual progress reports from each City Department are required as a part of the action plan.¹⁷⁸

An El Paso community group called the Healthy Eating Active Living Coalition was responsible for developing the resolution. The group includes member organizations such as: Paso del Norte Health Foundation, the Pan American Health Organization, Centro San Vicente, the El Paso Diabetes Association, the El Paso Independent School District and the YMCA.¹⁷⁹

According to Sue Beatty, Health Education and Training Manager, City of El Paso Department of Public Health, there are five main components to the resolution:¹⁸⁰

1. Built Environment – change zoning policies to increase physical activity and food access. This component also includes a requirement for conducting Health Impact Assessments (HIA). The City of El Paso was awarded a grant from the Paso Del Norte Health Foundation (a foundation local to the El Paso, TX area) to help train and prepare staff to conduct HIA.
2. Access to Healthy Foods – implement healthy food purchasing policies. This component requires the City Purchasing Department to review contracts for food purchased by the city and consider requesting healthy options to be included in each bid. Since the resolution passed, the Purchasing Department has compiled a list of vendors and the renewal dates of their food contracts.
3. Employee Wellness – identify best practices for employee benefits plans. This component involves the Human Resources Department working with a third-party vendor, and the local health department to gain insight into best practices in employee wellness benefits. The City of El Paso has over 6,000 employees and is self-insured.
4. Community Involvement – encourage additional city departments to participate in the Healthy Eating and Active Living Coalition.
5. Implementation – require the City Manager to annually report to the City Council on each department's progress. The City has implemented an Employee Suggestion Program enabling employees to propose ideas, and if accepted, the employee will take a month to implement their program.

According to the El Paso City Manager's first annual report on the resolution, significant progress is underway across participating city departments.¹⁸¹

¹⁷⁸ Monroy M, "City Council Approves Obesity Prevention Resolution." *KVIA El Paso* (1/6/2011). Web. Accessed 8/24/12 via: <http://www.kvia.com/news/City-Council-Approves-Obesity-Prevention-Resolution/-/391068/542338/-/x4n8kmz/-/index.html>

¹⁷⁹ Burge D, "El Paso City Council Resolution Urges Fight on Obesity." *El Paso Times* (1/6/2011). Web. Accessed 8/24/12 via: http://www.elpasotimes.com/news/ci_17030903?IADID=Search-www.elpasotimes.com-www.elpasotimes.com

¹⁸⁰ Emails from Sue Beatty, Health Education and Training Manager, City of El Paso Department of Public Health. Sent August 13-16, 2012.

¹⁸¹ City of El Paso Annual Report. Web. Accessed 8/11/12 via: <http://www.elpasoannualreport.com/human-resources.html>

Policy Recommendations Summary Table

Active Living & Healthy Eating	Focal Point	Policy	Program	Project	Recommended Point of Entry	Recommended Action	Likely to impact inequities
Establish funding mechanisms to address access to food	Local	X	X		Initiate, Identify and approach partners	Educate; Provide evidence-examples; refine replicate existing effort	Increases Possible
Increase access to food with special arrangements	Local	X	X		Initiate, Identify/Approach partners	Build a case; Provide evidence, examples, Educate	Mitigate inequities
Adopt Complete Streets Design	Local	X	X		Collaborate with existing partners	Replicate-refine existing effort	Possible increases
Adopt an equity method to review the allocation of funds for CIP	Local	X			Initiate; Collaborate with existing groups	Build a case; Provide evidence, examples, Educate	Mitigate inequities
Adopt a Active living Healthy eating Resolution	Local	X			Initiate; Collaborate with existing groups	Build a case; Provide evidence, examples, Educate	Mitigate inequities
Adopt an HIA review for for select policies and large-scale development projects	Local	X		X	Initiate; Collaborate with existing groups	Build a case; Provide evidence, examples, Educate	Mitigate inequities

Strategic Direction 3: High Impact Clinical Preventive Services

For the purposes of this policy scan, we focused our research efforts on preventive services targeting chronic diseases such as high blood pressure, high cholesterol, stroke, and cardiovascular disease.

Evidence on Clinical Preventive Services Policies

Chronic diseases cause seven out of 10 deaths among Americans each year, and nearly half of adults have at least one chronic illness. Three of every four dollars spent on health care in the United States are related to chronic diseases. The indirect costs of chronic conditions—including missed days of work or school, disability, and reduced work output—may be several times higher than the direct medical costs.¹⁸²

Of all the chronic diseases, heart disease and stroke continue to be leading causes of death for the population. High blood pressure and high blood cholesterol are major risk factors for developing heart disease or stroke, and are contributors to complications of diabetes. Therefore, particular attention should be given to increasing the access to and usages of interventions that can treat, prevent, and control high blood pressure and high cholesterol.¹⁸³

Many more people will receive needed preventive care if logistical, financial, cultural, and health literacy barriers to care are removed and if information, resources, and clinical supports are available to clinicians. Furthermore, quality of care will be improved if clinical, community, and complementary services are integrated and mutually reinforcing.¹⁸⁴

In low-income families, people are often unable to pay for needed care, particularly for screenings or non-communicable diseases such as cardiovascular disease. They may fail to get preventive services that control or prevent high blood pressure or high cholesterol and lack resources to secure timely treatment before it is too late and thus risk deterioration of their health condition. For example, a hypertensive patient may postpone seeking treatment due to lack of affordability and develop a stroke or a heart attack as a result. Such an acute major illness will compel the household to pay for the patient's care using a large portion of the household income, drastically increasing debt and further impoverishment.

To increase the availability of clinical preventive services, the Affordable Care Act ensures that new private health plans and Medicare cover certain preventive services without cost sharing, and provides incentives for states to do so through Medicaid.

Making preventive services free or low cost at the point of care is critical to increasing their use, but it is not sufficient.¹⁸⁵ Delivery of clinical preventive services increases when clinicians have billing systems in place to facilitate appropriate reimbursement for providing these services.

¹⁸² Centers for Disease Control and Prevention, Chronic Disease Overview. Web. Accessed 8/23/12 via: <http://www.cdc.gov/chronicdisease/overview/index.htm>

¹⁸³ Ibid.

¹⁸⁴ U.S. Department of Health and Human Services, Office of the Surgeon General, National Prevention Council. "National Prevention Strategy, 2011." Washington, DC (2011). Web. Accessed 7/1/12 via: <http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf>

¹⁸⁵ U.S. Department of Health and Human Services. "National Strategy for Quality Improvement in Health Care, 2011." Web. Accessed 5/17/12 via: <http://www.healthcare.gov/center/reports/quality03212011a.html>

Furthermore, policies that create payment systems to incentivize quality and value of care (e.g., by increasing reimbursements for improving patient outcomes) can increase the delivery of preventive services. Many health care analysts and advocacy groups have stressed the need for payment reform in order to increase the capacity of new health care models to serve patients.^{186, 187}

While discussions coming out of the Affordable Care Act focus largely on Accountable Care Organizations (ACO), they also acknowledge that unless primary care, the foundation of the ACO, undergoes payment reform the model may have trouble delivering the promised benefits.¹⁸⁸

It is also thought that reimbursement mechanisms focused on proven interventions (including those that support team-based care; use non-physician clinicians such as nurse practitioners, physician assistants, pharmacists, and community health workers; and implement bundled payment systems) and measurable treatment outcomes can increase delivery of preventive services.^{189,190} In addition, preventive services and medications can be made more affordable through approaches such as health benefit design or facilitating entry of generic drugs into the market.¹⁹¹

Increasing use of preventive services depends on the health care system's ability to deliver appropriate preventive services as well as people's understanding of the benefits of preventive care and their motivation and ability to access services. The Affordable Care Act expands access to clinical preventive services by helping more people obtain health coverage and removing cost-sharing for clinical preventive services ranked "A" or "B" by the U.S. Clinical Preventive Services Task Force. Many more people will receive needed preventive care if logistical, financial, cultural, and health literacy barriers to care are removed and if information and clinical supports are available to clinicians. Furthermore, quality of care will be improved if clinical, community, and complementary services are integrated and mutually reinforcing.¹⁹²

Access to clinical preventive services in various medical care and community settings must also address logistic factors, such as adequate transportation and time off for workers, to help them get the care they need. Addressing these determinants is the key to reducing health disparities and improving the health of all Americans.

¹⁸⁶ Miller HD. "How to Create Accountable Care Organizations." *Center for Healthcare Quality and Payment Reform*. (September 2009). Print.

¹⁸⁷ Goroll AH and Schoenbaum SC, "Payment reform for primary care within the Accountable Care Organization." *Journal of the American Medical Association* 308.6 (Aug 2012):577-8. Print.

¹⁸⁸ Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program. Center for Medicaid and Medicare Services. Web. Accessed 8/18/12 via: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/>

¹⁸⁹ U.S. Department of Health and Human Services. "HHS Strategic Plan FY 2010-2015." Web. Accessed 5/17/12 via: <http://www.hhs.gov/secretary/about/priorities/priorities.html>

¹⁹⁰ U.S. Department of Health and Human Services. "National Strategy for Quality Improvement in Health Care, 2011." Web. Accessed 5/17/12 via: <http://www.healthcare.gov/center/reports/quality03212011a.html>

¹⁹¹ Food and Drug Administration. "FDA Strategic Action Plan, 2007." Web. Accessed 5/17/12 via: <http://www.fda.gov/AboutFDA/ReportsManualsForms/Reports/StrategicActionPlan/default.htm>

¹⁹² National Prevention, Health Promotion and Public Health Council. "National Prevention Strategy: America's Plan for Health and Wellness." (2011). Web. Accessed 8/23/12 via: <http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf>

Potential for Inequities

The evidence that health inequities are patterned by both race and socio-economic status is irrefutable.¹⁹³ In this section, we look more closely at the kind of interventions often used to address chronic disease rates for low income and racial/ethnic groups. To do this we examine explanations used to describe why these two groups make-up the higher rates of chronic disease that are seen in the U.S. In the end we consider why an over emphasis on and singular use of behavioral interventions might prove to be unsuccessful in lowering the incidence of certain chronic diseases when working with these groups.

Within the last decade, other theories (beyond behavioral explanations) have been advanced to account for the disproportionate number of low income and racial/ethnic groups with certain chronic diseases. Most of these newer theories look to the effects of the external environment on the internal landscape of a person. What these new approaches have in common is a willingness to consider a multiplicity of factors outside those characteristics that we have come to automatically rely on when we are considering interventions for groups

that are poor or a member of a racial/ethnic group. Research that examines the SDOH repeatedly emphasizes that various social inequalities do not act independently but interact in ways that can transform and alter behavior, processes, and outcomes of inequality from one setting or context to another.

For example, an intersectional approach emphasizes the importance of intersecting inequalities, multiple vulnerabilities, and the need to examine how multiple dimensions of social statuses combine to facilitate or restrict exposure and response to risk factors and resources relevant for a



disease and its treatment.¹⁹⁴ Intersectional theory posits that multiple social statuses are experienced simultaneously and dynamic interdependent processes arise when race/ethnicity, SES, and gender (and/or other social statuses) combine to affect patterns of risks and resources, privilege and disadvantage that can affect health risks and health service utilization across different social contexts.¹⁹⁵

Cole (2009) identifies at least three implications from intersectionality to consider.¹⁹⁶ First, differences within social categories should be examined, especially attending to categories that have been neglected to facilitate the identification of how the meaning and consequences of one social category depend on other categories.¹⁹⁷ Second, the intersectionality perspective highlights that being part of a social category is not the result of actions on the part of that group but rather is the result of or often embodies institutional policies and

¹⁹³ Braveman, Cubbin, Egarter, Williams, Pamuk. "Socioeconomic disparities in health in the U.S.: what the patterns tell us." *American Journal of Public Health* 11 (2010): S186-196. Print.

¹⁹⁴ Williams DR, Kontos EZ, Viswanath K, Haas JS, Lathan CS, MacConaill LE, Chen J, and Ayanian JZ. "Integrating Multiple Social Statuses in Health Disparities Research: The Case of Lung Cancer." *Health Services Research* 47 (2010): 1255-1277. Print.

¹⁹⁵ Ibid.

¹⁹⁶ Cole ER. "Intersectionality and Research in Psychology." *American Psychologist* 64.3 (2009): 170-180. Print.

¹⁹⁷ Ibid.

practices that structure social inequalities and stigma in ways that shape opportunity and life chances.¹⁹⁸ Third, intersectionality calls for exploring how macro-level social processes create commonalities across different social categories. Thus, an intersectional lens calls for research on health inequities to unpack the lived experiences of social groups at the convergence of multiple identities.¹⁹⁹

Similar to intersectionality, the field of epigenetics is now being used to discuss how the environment might operate to make groups vulnerable at the genetic level.

A 2010 paper by Wallace and Wallace suggests that epigenetic information sources act as catalyst, directing development into different characteristic pathways according to the structure of external signals.²⁰⁰ The authors show how environmental stressors, in a large sense, can induce a broad spectrum of developmental dysfunctions, and examine a number of pandemic chronic diseases, using U.S. data at different scales on the effects of the legacy of slavery compounded by accelerating industrial and urban decay.

Wallace et al. (2010) goes on to say that developmental disorders, broadly taken, are unlikely to respond to medical interventions in the face of serious, persistent individual and community stress. They conclude that addressing pandemic of chronic disease requires significant large-scale changes in public policy and resource allocation. Finally, other theories have been generated to explain why behavioral theories based on individual uptake and adherence have not worked to decrease health inequities but rather resulted in an increased gap in most cases.

One such theory is based on two assumptions expressing significant ideas. First, that lower socioeconomic position is associated with greater exposure to external, contextual, or situational mortality risks (that is, risks that lie outside the body and cannot be mitigated through behavior). A major pathway through which social inequality affects public health is thought to be through the cumulative effects of advantage and disadvantage on broad population groups. The second assumption is that health behavior competes for people's time and energy against other activities which contribute to their well-being. Examples of this assumption where health behaviors compete for people's time and energy against other activities that protect them is smoking to ease stress versus quitting smoking, or the affordability of housing versus living in a community with high performing schools, parks, and access to healthy food.

Under these two assumptions, the theory shows that the optimal amount of health behavior to perform is indeed less for people of lower socioeconomic position.²⁰¹ This would be so because:

1. The payoff for preventative health behavior is reduced in the face of external risk factors accumulated over a lifetime, and therefore the optimal amount of preventative health behavior to perform is reduced; and
2. Disadvantaged groups use competing interests to protect their wellbeing that outweigh healthy behaviors that are considered a luxury or less helpful. In the end, this theory suggests that the reduced

¹⁹⁸ Ibid.

¹⁹⁹ Ibid.

²⁰⁰ Wallace R, and Wallace D. *Gene Expression and Its Discontents: The Social Production of Chronic Disease*. Springer Publications (2010). Print.

²⁰¹ Nettle D. "Why Are There Social Gradients in Preventative Health Behavior? A Perspective from Behavioral Ecology" *PLOS ONE* 5.10 (2010). Web. Accessed 10/16/12 via: <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0013371>

preventative health behavior of people facing socioeconomic adversity and a marginalized status could be a comprehensible response to the life situations they face, rather than simply being ignorance, laziness, error or incompetence.²⁰²

Another way of viewing this is that the efficacy of behavioral interventions (when used alone) for groups of lower socioeconomic status may be compromised due to the overwhelming burden of adversity that propels their lives day in and day out.

David Williams, a Harvard sociologist, has several suggestions about how to tailor health care interventions for groups of low socioeconomic status.²⁰³ Calling it “care that addresses social context” he provides the following checklist:

- Effective health care delivery must take the socio-economic context of the patient’s life seriously
- The health problems of vulnerable groups must be understood within the larger context of their lives
- The delivery of health services must address the many challenges that they face
- Taking the special characteristics and needs of vulnerable populations into account is crucial to the effective delivery of health care services.
- This will involve consideration of extra-therapeutic change factors: the strengths of the client, the support and barriers in the client’s environment and the non-medical resources that may be mobilized to assist the client.

Policy Recommendations

1. Encourage city and county governments and private employers to select a health insurance plan/provider that uses value-based benefit design (VBBD) principles along with strategies for improving health through chronic disease prevention and control, i.e., VBBD is an approach to designing benefit plans that recognizes that different health services have different levels of value. By reducing barriers to high-value treatments through lower costs to patients, e.g., a \$10 insurance co-payment for a cholesterol-lowering drug or other drugs to manage chronic conditions, or free weight-management and smoking-cessation classes; and discouraging low-value, over used treatments through higher costs to patients, e.g., \$500 extra for an MRI scan or knee surgery; these plans or thought to achieve improved health outcomes at any level of health care expenditure. Studies show that when barriers are reduced, significant increases in patient compliance with recommended treatments and potential cost savings result.²⁰⁴
2. Encourage local Community Health Worker training programs to create and submit for approval to the DSHS Promotor(a) or Community Health Worker Training and Certification Program additions to their

²⁰² Ibid.

²⁰³ Williams DR, and Norma L. “Time For Action: the Enigma of Social Disparities in Health and How to Effectively Address Them.” Harvard University Medical School, Office for Diversity and Community Partnerships, Leadership and Faculty Development Conference. (May 2010). Web. Accessed 8/19/12 via: <http://www.scribd.com/doc/7778732/Dr-David-Williams-on-Health-Disparities>

²⁰⁴ The University of Michigan Center for Value-Based Insurance Design (V-BID Center). Web. Accessed 9/13/12 via: <http://www.sph.umich.edu/vbidcenter/about/index.html>

curricula nationally developed training materials on chronic disease prevention and control, with a particular focus on diabetes and heart disease.

3. Encourage city and county governments to adopt resolutions supporting the recommendations from the study mandated under HB2610 to maximize employment of and access to promotores and community health workers and to provide publicly and privately funded health care services using identified methods of funding and reimbursement.
4. Encourage city and county governments, private employers, and local school districts to undertake a review of food procurement contracts and systems for their adherence to the 2010 Dietary Guidelines for Americans, and the recommendation to reduce daily sodium intake to less than 2300 mg.

Gap Analysis

There are several mechanisms currently available in the Harris County area that could help to establish improved/increased clinical preventive practices.

Use of Worksite Wellness Strategies

Value-Based Benefit Design Principles

A landmark 1982 study showed that consumers spend less on health care as their out-of-pocket costs rise. But they economize not just on care that's ineffective or unnecessary but also on care they need such as treatments that are highly effective at addressing current conditions, preventing the onset of poor health, or reducing risk factors for chronic diseases that tend to encumber the employee and employer with rising health costs over time.²⁰⁵

The use of value-based benefit design (VBBD) principles lowers the costs for needed drugs, surgery, and preventive activities. In fact many companies have used this carrot approach to incentivize employees to take up healthier behavior. However, under a VBBD plan the other side of the equation that includes sticks is added so that health care deemed over used and "preference-sensitive" to patient choice will cost more, e.g., spinal surgery, knee and shoulder arthroscopy, hip and knee replacement, or upper endoscopy exams.²⁰⁶

Worksite Wellness Programs

Houston has two non-profit associations with a focus on supporting businesses in developing low cost employee health plans, the Houston Business Group on Health (HBGH) and the Houston Wellness Association (HWA).²⁰⁷

CDC has established a promising initiative in Harris County with 15 businesses to encourage employers to implement worksite wellness. The CDC National Healthy Worksite Program²⁰⁸ (NHWP) is designed to establish and evaluate comprehensive workplace health programs to improve the health of workers and their families.

²⁰⁵ RAND Health. "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Healthcare Reform Debate." RAND Research Highlights (2006). Web. Accessed 9/14/12 via: http://www.rand.org/pubs/research_briefs/2006/RAND_RB9174.pdf

²⁰⁶ Andrews M. "Value-based insurance design's pros and cons," *Washington Post* (Nov 29, 2010). Web. Accessed 9/14/12 via: <http://www.washingtonpost.com/wp-dyn/content/article/2010/11/29/AR2010112904751.html>

²⁰⁷ Houston Wellness Association. Web. Accessed 9/14/12 via: <http://hwa.memberclicks.net/about-hwa>

NHWP will assist up to 100 small, mid-sized and large employers in establishing comprehensive workplace health programs throughout the nation. Specifically, through a contract with Viridian Health Management (based in Phoenix, Arizona), each program participant will receive intensive support and expertise putting in place a combination of program, policy and environmental interventions to support physical activity, good nutrition and tobacco-use cessation. In addition, community participants will receive training and technical assistance as well as mentoring through peer relationships.²⁰⁹



The programs are to make use of a planned, organized, and coordinated set of programs, policies, benefits, and environmental supports designed to meet the health and safety needs of all employees. Participating worksites are expected put in place a high quality workplace health program and create a work environment that supports a culture of health. Examples of interventions cover policy areas (tobacco-free campus policy or a policy that healthy foods will be made available at all company meetings or functions where food is served) or environmental support interventions (access to onsite or near-by fitness facilities or worksite stairwell enhancement and promotion).

Since passage of the State Employee Health and Fitness Act of 1983 Texas has addressed worksite wellness through the Texas Department of State Health Services (DSHS) Health Promotion and Chronic Disease Prevention, State Agency Worksite Wellness program.²¹⁰

With the passage of House Bill 1297 in 2007, the function of the State Agency Worksite Wellness program was enhanced to include the following:

- A waiver of the requirement for agencies to submit a plan for review and approval to establish a worksite wellness program;
- Permission for agencies to implement a wellness program based on a model program and/or evidence-based components developed by DSHS;
- A request that agencies designate an employee to serve as the wellness liaison between the agency and the DSHS Statewide Wellness Coordinator.

²⁰⁸ National Healthy Worksite Program. Web. Accessed 8/18/12 via: <http://www.cdc.gov/nationalhealthyworksite/docs/nhwp-overview-slides.pdf>

²⁰⁹ Centers for Disease Control and Prevention. "Workplace Health Promotion." Web. Accessed 8/23/12 via: <http://www.cdc.gov/workplacehealthpromotion/nhwp/index.html>

²¹⁰ Building Healthy Texans: Statewide Agency Wellness Program. "Legislative History." Web. Accessed 10/2/12 via: <http://www.wellness.state.tx.us/history.htm>

H.B. 1297 also gave new flexibility to state agencies for administering their wellness program by allowing agencies to:

- Develop an agency wellness council;
- Allow their employees to participate in wellness council activities for two or more hours each month;
- Allow each employee 30 minutes during normal working hours for exercise three times each week;
- Allow all employees time to attend on-site wellness seminars when offered; and
- Provide eight hours of additional leave time each year to any employee who receives an annual physical examination and completes an approved health risk assessment (HRA).

Finally, under H.B. 1297 the State Worksite Wellness Program established a web site to serve as the source for agency leaders and wellness planners to find guidance, data and statistics, model programs and policies, templates, forms and other resources to support their wellness initiatives.²¹¹

Physician Focused Programs

The use of physician groups that take an interest in the use of high quality clinical preventive services can also help reduce health care costs. However, an August 2008 Texas Medical Association Quality of Care Survey found that Texas physicians are ripe for education on the benefits of current quality-of-care programs, including the use of patient satisfaction surveys to assess performance and quality.²¹² The survey also found that the vast majority of physicians do not believe that federal or commercial initiatives to measure quality lead to improvements in their patient care.²¹³

The Physician Quality Reporting System (PQRS) is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals. The program provides an incentive payment to practices who satisfactorily report data on quality measures for services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries.²¹⁴ In 2010, Medicare reported that 9,636 physicians in Texas participated in the PQRS.²¹⁵ However, many of those that have participated have found the programs useful in improving their practice.²¹⁶

²¹¹ Ibid.

²¹² Texas Medical Association. "Quality Improvement." Web. Accessed 8/23/12 via: http://www.texmed.org/Quality_Improvement/

²¹³ Ibid.

²¹⁴ Physician Quality Reporting System . Website Accessed August 26, 2012 <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqrs>

²¹⁵ Medicare Physician Quality Reporting System. Web. Accessed 8/26/12 via: <http://www.medicare.gov/find-a-doctor/staticpages/data/pqrs/physician-quality-reporting-system.aspx>. Download the list of eligible professionals who chose to take part in Medicare's Physician Quality Reporting System and reported quality measure information satisfactorily for the year 2010. This provides a downloadable excel sheet of all physicians by state who satisfactorily participated in PQRS for 2010.

²¹⁶ Texas Medical Association. Web. Accessed 8/27/12 via: www.tma.org; and Phone conversations with TMA Quality Improvement Staff 7/20/12.

Harris County Medical Society (HCMS) promotes an incentive program to reward physicians for providing certain kinds of care and meeting established metrics. The program, Bridges to Excellence® (BTE) rewards clinicians who can demonstrate they deliver high quality care as evidenced by their achievement of a BTE



Recognition. BTE is a national program offered in more than 20 states. It is a family of programs to reward recognized physicians and other practitioners who meet certain performance measures for certain conditions including diabetes care. The BTE programs are administered under the parent company of Health Care Incentives Improvement Institute (HCI3). HCI3 is a national non-profit organization, guided by a Board of Directors that includes physicians, employers, health plans, and others. They have created a broad range of programs to measure outcomes, reduce care defects, promote a team approach to patient care, and realign payment incentives around quality. HCI3 has implemented their programs in communities across the country, working collaboratively with clinicians, hospitals, employers, health plans and others.

Blue Cross Blue Shield of Texas (BCBSTX) has also collaborated with BTE to implement the Diabetes Care Recognition program and the Cardiac Care Recognition program. To work with BTE through HCMS, physicians (individually or in a group practice) pay a fee to submit their clinical data through an assessment organization. BCBSTX is licensed as a sponsor of the Bridges to Excellence® Diabetic Care Recognition program and Cardiac Care Recognition programs. After the BTE Recognition program recognizes a physician, BCBSTX will direct members with diabetes or cardiac disease to a BTE recognized physician. BTE recognized physicians are asked to provide clinical biometric information and are eligible for a financial reward of \$100 per patient per year.

As of August 21, 2012, 74 physicians from the Harris County area were recognized for the NCQA Heart and Stroke Recognition Program and 26 were recognized for the Diabetes Recognition Program.²¹⁷ Accordingly, 78 physicians within the Houston/Harris County area received the BTE Cardiac Care Recognition and 126 received the Diabetes Care Recognition.²¹⁸

Regional Healthcare Planning and Coordination

A Southeast Texas Regional Healthcare Planning group is developing a Regional Health Plan (RHP) that can include population based projects for chronic disease prevention and control as part of the Delivery System Reform Incentive Payment projects. This regional healthcare group and the subsequent plan are being formulated under the new Texas Healthcare Transformation and Quality Improvement Program - 1115 Medicaid Waiver.

²¹⁷ National Committee for Quality Assurance. "Heart and Stroke Recognition Program." Web. Accessed 10/16/12 via: <http://recognition.ncqa.org/PSearchResults.aspx?state=TX&rp=3>

²¹⁸ Health Care Incentives Improvement Initiative: Bridges to Excellence. "Find a Recognized Clinician." Web. Accessed 10/16/12 via: http://www.hci3.org/physician_search/results/5456

Starting in 1995 Congress began reexamining the \$131 billion Medicaid program – one of the fastest growing components of both federal and state budgets. In 1993, Medicaid cost almost \$100 billion more and served about 10 million more low-income recipients than it did a decade before. To deal with this cost and enrollment explosion, many states wanted greater flexibility in implementing statewide Medicaid managed care programs. Currently, the degree of flexibility being sought is available only through the waiver authority established by section 1115.²¹⁹

The Southeast Regional Healthcare Planning group is building a Regional Health Plan that covers nine counties. The Harris County Hospital District is the anchoring entity for Harris County as directed by the approved Waiver. Approved by the Centers for Medicare & Medicaid Services (CMS) on December 12, 2011, this new Texas Medicaid section 1115 Waiver has a two-fold purpose: to expand the existing Medicaid managed care programs, STAR and STAR+PLUS, statewide, and to establish two funding pools that will assist providers with uncompensated care costs, and promote health system transformation.

The required RHP plans from each group are due no later than October 31, 2012 to HHSC. An RHP's plan outlines the region's participation in the waiver over the next four years and includes identifying regional healthcare partners, community needs, DSRIP projects and metrics, and related funding estimates. A key goal of the waiver is for local entities to have the opportunity to receive new federal matching funds for projects that transform the Texas health care delivery system while improving the quality of care provided.

Review of food procurement contracts

Clinical preventive services are also being addressed through other structural/systems change focused policies that address dietary issues.

The Texas Department of State Health Services Cardiovascular Disease and Stroke Prevention Partnership created a Texas Salt Reduction Initiative in 2009. A current focus is to work with schools to institute sodium reduction food procurement policies, as well as to promote healthier food options in the school setting. One method of encouraging schools to adopt newly created nutrition recommendations for the National School Lunch Program and National School Breakfast Program is through the promotion of schools to apply for the Healthier U.S. School Challenge.²²⁰

Of these 26 ISDs in Harris County, only 6 have had campuses recognized by the Healthier U.S. Challenge. According to the Healthier U.S. Challenge Award Winners website, Houston/Harris County had the following schools recognized as either Gold, Silver or Bronze: Spring Branch ISD – 25 elementary at Bronze; Aldine ISD – 6 elementary and 3 intermediate schools at Silver and Bronze; Katy ISD – 1 elementary at Gold and 1 elementary at Silver; La Porte ISD – 1 Junior High at Gold and 1 elementary at silver; Cypress Fairbanks ISD – 12 elementary at Bronze and 14 elementary at Gold and Spring ISD – 2 elementary at Gold.²²¹

²¹⁹ Medicaid. "Medicaid, CHIP Program Information-Waivers." Web. Accessed 7/2/12 via: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>

²²⁰ Texas Department of State Health Services. "Texas Salt Reduction Collaborative." Web. Accessed 8/21/12 via: <http://www.dshs.state.tx.us/wellness/Texas-Salt-Reduction-Collaborative.doc>

²²¹ U.S. Department of Agriculture. "Healthier U.S. Challenge Award Winners" Web. Accessed 10/16/12 via: <http://teamnutrition.usda.gov/healthierUS/Texas.html>

The Texas Cardiovascular Disease and Stroke Prevention Partnership (under Texas Department of State Health Services) is a network of partners from across the state representing state and local public and private health care, university, non-profit, business and community sectors. The Partnership works in coordination with the Texas Council on Cardiovascular Disease and Stroke to plan, implement, and evaluate heart disease and stroke prevention programs and policies within the state.

The Texas Cardiovascular Disease and Stroke Partnership has teamed up with the Texas School Health Advisory Committee (TSHAC) to consider policy recommendations for instituting 2010 Dietary Guidelines for Americans. In 2005, the 79th legislature passed SB42, a comprehensive school health education package focused on a number of significant issues, one of which was the establishment of a state-level school health advisory committee at the Department of State Health Services (DSHS). TSHAC provides active leadership in the identification and dissemination of school health best practices and resources for school policy makers.

Increased use of Community Health Workers and enhanced training curriculum

The use of community health workers (CHWs) that have been trained around clinical preventive services is another promising idea that could increase preventive services. In 1999 House Bill 1864 established the Promotor(a) Program Development Committee. The next step was the creation of a training and certification program, which occurred in 2001 under Senate Bill 1051.

Currently the Texas Health and Safety Code – Chapter 48 provides authority to the Texas Department of Health (now DSHS) to establish and operate a certification program for community health workers. Chapter 48 requires certification for Promotores or Community Health Workers receiving compensation for services provided. Chapter 48 also requires certification for instructors and training programs. DSHS has an established Promotor(a) or Community Health Worker Training and Certification Advisory Committee to advise DSHS and the Texas Health and Human Services Commission (HHSC) on the training and certification of persons working as Promotores or Community Health Workers.

All sponsoring Institutions/Training Programs must create and receive approval for curricula based on core competencies, recertify every two years, and submit curriculum changes for approval to DSHS. The DSHS Promotor(a) or Community Health Worker Training and Certification Program provides leadership to enhance the development and implementation of statewide training and certification standards and administrative rules for the Promotor(a) or Community Health Worker (CHW) Training and Certification Program.

The Centers for Disease Control and Prevention created the *Community Health Worker's Heart Disease and Stroke Prevention Sourcebook: A Training Manual for Preventing Heart Disease and Stroke*. The Sourcebook serves as a curriculum for trainers and as a reference for CHWs. It can be used to train CHWs in risk management and the prevention of heart disease and stroke, with a total of 15 chapters on high blood pressure, high cholesterol, depression, heart attack, stroke, heart failure, cardiovascular health in adolescents and children, and other subjects.²²²

According to the Texas 2011 Annual Report Promotor(a) or Community Health Worker (CHW) Training and Certification Advisory Committee, one-hundred-one (101) counties reported that Texas had 1,538 certified

²²² Centers for Disease Control and Prevention. "Addressing Chronic Disease through Community Health Workers: A Policy and Systems Level Approach, Policy Brief on Community Health Workers" Web. Accessed 10/16/12 via: www.cdc.gov

CHWs as of December 31, 2011. Ninety percent of those CHWs were female; 69% and 19% were Hispanic and African American, respectively.

As of December 31, 2011, Harris County had 425 CHWs, three organizations that offered certified CHW courses and six organizations that offered CEU courses. Galveston County reported 1 organization each that offered certification and CEU courses.²²³

The three CHW training institutions in Houston are:

- Gateway to Care
- Houston Community College – Coleman College for Health Sciences
- Dia de la Mujer Latina.²²⁴

Efforts are underway to improve the mechanism to pay CHWs. In December 2011 rules for Community Health Worker Training and Certification Programs under Chapter 48 of the Health and Safety Code, were amended through HB2610. One change recommended a DSHS study, in coordination with the Health and Human Services Commission (HHSC), and recommendations related to: maximizing employment of and access to promotores and community health workers to provide publicly and privately funded health care services; and identifying methods of funding and reimbursement, including outline of costs to the state.

The study is currently being conducted and a report and recommendations will be submitted to the Texas Legislature by December 1, 2012. The study will:

- Study the desirability and feasibility of employing promotores and community health workers to provide publicly and privately funded health care services in this state;
- Assess the impact of promotores and community health workers on increasing the efficiency of, quality of, and access to health care services;
- Explore methods of funding and reimbursing promotores and community health workers for the provision of health care services and outline the costs to this state of the funding and reimbursement; and,
- Develop recommendations to:
 - Maximize the employment of and access to promotores and community health workers; and,
 - Expand the funding of and reimbursement for services provided by promotores and community health workers.

²²³ Texas Department of State Health Services. "2011 Annual Report Promotor(a) or Community Health Worker (CHW) Training and Certification Advisory Committee" Web. Accessed 10/16/12 via: <http://www.dshs.state.tx.us/mch/chw/workforce.aspx>

²²⁴ Department of State Health Services. "Community Health Workers - Training Programs 2012" Web. Accessed 9/17/12 via: <http://www.dshs.state.tx.us/mch/chw/training.aspx>

Case Studies

*Case Study: Pay for Performance (P4P) Incentive Program for Physicians*²²⁵

Study Purpose: To determine the extent to which the size of the available financial incentive influences a physician’s decision to participate in a pay-for performance (P4P) program.

Study Design: Statistical analysis of historical data from Bridges to Excellence (BTE).

Methods: Setting available financial incentives as the independent variable and physician participation rates as the dependent variable, we applied regression analysis to BTE’s data from selected sites to explore the relationship of fixed bonus based incentive programs to physician participation rates in those programs.

Results: The amount of incentives available to physicians strongly affected their rate of participation. Participation rates varied with the type of program, and overall physician participation rates might grow as more purchasers/payers within a community offer similar incentives.

Conclusion: Our analysis suggests that all stakeholders—health plans, physicians, and patients—would benefit from health plans collaborating on their P4P efforts to maximize physician participation.²²⁶

²²⁵ de Brantes FS, D’Andrea BG. “Physicians Respond to Pay-for-Performance Incentives: Larger Incentives Yield Greater Participation.” *American Journal of Managed Care* 15.5 (2009): 305-310. Web. Accessed 8/18/12 via:

http://www.hci3.org/sites/default/files/files/AJMC_09May_deBrantes305to310.pdf

²²⁶ Ibid.

*Case Study: Spring ISD Scores Gold in Healthier U.S. School Challenge*²²⁷

Ponderosa Elementary and Smith Elementary in Spring ISD were honored in 2011 at a special reception at the White House. They were recognized for achieving the gold level in the HealthierUS School Challenge competition, which is sponsored annually by the U.S. Department of Agriculture.

In 2010, Ponderosa Principal Debbie Graham and Smith Principal Peggy Husky accepted the challenge to create and maintain a healthier learning environment on their campuses. Their decision required their campuses to ensure that students are offered nutritious foods, encouraged and provided opportunities to participate in physical activities daily and taught how to make healthy choices.

The reception was hosted by the First Lady, Michelle Obama, on the South Lawn. Both the principals emphasized the importance of physical activity in their schools, where teachers are committed to honoring students' need for recess, activity and movement during the school day.

Campus cafeteria managers, Jennifer Moulton, Ponderosa, and Sue Hauhan Majano, Smith, and Laura Mason, Spring ISD child nutrition assistant director, also attended the reception. According to Spring ISD, "The cafeteria managers contributed to the success of their campuses through a yearlong effort to teach students healthy food choices and serve foods that were nutritious, appealing and flavorful. They used their cafeterias and kitchens as classrooms and provided opportunities for the students' families to taste the healthier menu items. Mason had worked with the campuses to create the new menus."²²⁸

²²⁷ Spring Independent School District. "School Case Study – Spring Independent School District (2011)" Web. Accessed 8/18/12 via: <http://schools.springisd.org/default.aspx?name=18.home>

²²⁸ Ibid.

Case Study: Values Based Benefit Design - Center Point Energy, Inc.²²⁹

Center Point Energy, Inc., a Houston-based energy delivery company, uses value-based benefit design principles for its employee health care program.

The Center Point employee profile shows a company with approximately 9,000 U.S. employees, including more than 5,500 in Texas; 8,230 employee and their dependents are health plan members along with 4,146 retirees and their dependents. Lastly, a large number of plan members live in rural areas.

Center Point's employees are comprised predominantly of males (75%) with jobs that range from linemen, meter readers, pipeline technicians, administrative personnel and professional and marketing executives with advanced degrees.²³⁰ The company's employees consist of an aging, long-term workforce (average age 45, average tenure 17 years), many in physically demanding jobs. The majority of workforce is located in states with the least healthy populations and highest healthcare costs. There is a high incidence of late-stage diagnosis of cancer, heart disease, diabetes and other conditions, as well as, confusion about different cost-sharing strategies for preventive versus diagnostic care, sometimes resulting in plan members incurring unnecessary expenses or deferring potentially life-saving screenings.²³¹

Center Point's VBBD program included the following strategies:²³²

- First-dollar coverage for preventive procedures, including age-appropriate screenings and immunizations for adults and children;
- First dollar-coverage for one colonoscopy exam annually;
- Four tiers of benefits to Minnesota employees with financial incentives for utilization of tiers that include high quality, cost-efficient providers through Minnesota-based HealthPartners;
- Partnerships with healthcare vendors to encourage use of the most effective and efficient treatment plans for highest-cost disease states including asthma, coronary artery disease, diabetes, heart failure, chronic obstructive pulmonary disease and lower back pain;
- A free initial visit and reduced copayments for subsequent visits for early diagnosis and ongoing treatment of diabetes and related conditions for employees in the Houston metropolitan area; and
- Discount health plan premium contributions for non-smokers.

Outcomes:²³³

- Increased adherence to care management regimens including medication compliance, regular eye exams, nutritional education visits, etc. by plan members enrolled in Diabetes America program (Screening for wellness exams and cholesterol went up from the previous year.)
- Annual rate of medical cost increase below national average and holding steady for last few years.
- Prescription drug trend rate also below national levels.

These VBBD efforts have helped Center Point Energy control health care costs, keeping its annual rate of increase below the national average at 6.7% for medical care and 2.5% for prescription drugs in 2011. Since that time the company has stepped up its efforts to lower costs even further through an increased focus on prevention and early detection.²³⁴

²²⁹ Texas Business Group on Health. "Best Practices in Value Based Benefits (2011)." Web. Accessed 10/16/12 via: http://www.tbgh.org/documents/TBGH_compendium_CPE.pdf

²³⁰ Ibid.

²³¹ Ibid.

²³² Ibid.

²³³ Ibid.

²³⁴ Ibid.

Policy Recommendation Summary Table

Clinical Preventive Services	Focal Point	Policy	Program	Project	Recommended Point of Entry	Recommended Action	Likely to impact inequities
Adopt value-based benefit design	Local	X	X	X	Initiate collaborate with existing groups	Build a case; provide evidence, examples, Educate	Possible Increases
Expanded curricula for CHWs	Local and state	X			Support existing groups		Mitigate inequities
Utilize and fund CHWs	State	X			Support existing groups		Mitigate inequities
Review food procurement contracts	Local	X			Initiate collaborate with existing groups	Build a case; provide evidence, examples, Educate,	Mitigate inequities

Strategic Direction 4: Social and Emotional Wellness

Evidence on Social and Emotional Wellness Policies

Social and emotional wellness (SEW), acquired through social and emotional learning (SEL), is the process through which children and adults gain the knowledge, attitudes, and skills they need to recognize and manage their emotions, demonstrate caring and concern for others, establish positive relationships, make responsible decisions, and handle challenging situations constructively.²³⁵

Our emotions and relationships affect how and what we learn and how we use what we learn in work, family, and community contexts. On the one hand, emotions can enable us to generate an active interest in learning and sustain our engagement in it. On the other hand, unmanaged stress and poor regulation of impulses interfere with attention and memory and contribute to behaviors disruptive to learning.

There are a great deal of data indicating that large numbers of children are contending with significant social, emotional, and mental health barriers to their success in school and life. In addition, many children engage in challenging behaviors that educators must address to provide high quality instruction.

The school should be a safe and positive learning environment for all students. To that end school should be considered an important venue for adolescents to learn and be evaluated for social and emotional wellness skills and the ability to handle issues that include suicide, bullying, dating violence, and depression.

²³⁵ Collaborative for Academic, Social, and Emotional, Learning (CASEL). "What is Social and Emotional Learning" Web. Accessed 8/2/12 via: <http://casel.org/why-it-matters/what-is-sel/>

School-wide discipline has focused mainly on reacting to specific student misbehavior by implementing punishment-based strategies including reprimands, office referrals, suspensions, and expulsions. In the 2009-2010 school years, the Texas Education Agency (TEA) reported over 2.4 million disciplinary actions for the total statewide student population of almost 5 million. Recent research indicates that more than 25% of students nationwide report that they have been bullied.²³⁶

Teachers are on the frontline dealing with social and emotional issues that play out in the school setting. To create an environment for academic and SEL teachers must have the tools, and the discretion to use those tools to keep order and help students be emotionally and academically successful. Policies and programs that support SEL are seen as one response to the social/emotional issues and disciplinary problems that occur in classrooms across the Nation. Policies that support social and emotional learning (SEL) programs have been found to yield multiple benefits in every review/analysis conducted to date.

The reviews indicate that school based SEL programs:²³⁷

- Are most effectively conducted by school staff (e.g., teachers, student support staff) indicating that they can be incorporated into routine educational practice.
- Are effective in both school and after-school settings and for students with and without behavioral and emotional problems.
- Are effective for racially and ethnically diverse students from urban, rural, and suburban settings across the K-12 grade range.
- Improve students' social-emotional skills, attitudes about self and others, connection to school, and positive social behavior; and reduce conduct problems and emotional distress.
- Improve students' achievement test scores by 11 percentile points.

Potential for Inequities

Texas schools are regularly confronted with student behavioral challenges that serve as barriers to teachers teaching and students learning. Nevertheless, as social justice, mental health and education advocates point out, student discipline is increasingly moving from the schoolhouse to the courthouse.

Disrupting class, using profanity, misbehaving on a school bus, student fights, and truancy once meant a trip to the principal's office. Today, such misbehavior results in a Class C misdemeanor ticket, which leads to a trip to court for thousands of Texas students and their families each year. It is conservatively estimated that more than 275,000 non-traffic tickets are issued to juveniles in Texas each year based on information from the Texas Office of Court Administration (TOCA).²³⁸

²³⁶National Center for Education Statistics (2011). "Student reports of bullying and cyber bullying: results from the 2009 school crime supplement to the national crime victimization survey." Web. Accessed 9/16/12 via: <http://nces.ed.gov/pubs2011/2011336.pdf>

²³⁷ Collaborative for Academic, Social, and Emotional Learning (CASEL). "Meta-Analysis." Web. Accessed 6/7/12 via: <http://casel.org/why-it-matters/benefits-of-sel/meta-analysis/>

²³⁸ Fowler D, et al. "Texas' School-to-Prison Pipeline: Ticketing, Arrest & Use of Force in Schools, How the Myth of the "Blackboard Jungle" Reshaped School Disciplinary Policy." *Texas Appleseed* (December 2010). Web. Accessed 8/17/12 via: http://www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=504&Itemid



The debate about how schools should respond to student misconduct is not new, but school discipline and juvenile justice policies have changed over time. Commensurate with the trend to be “tough on crime” in the late 1980s and early 1990s to increase public safety in the community (including a focus on perceived “hardened” juveniles), was a change that took hold to make schools safer as well. Policymakers and practitioners alike, taking a page from the shift toward more stringent adult crime

policy, urged stricter enforcement of disruptive or dangerous actions in schools.²³⁹ Calls for swift and sure punishment for students who misbehaved resulted in the adoption of “zero tolerance” disciplinary policy in districts across the nation.²⁴⁰

In July 2011 the Council of State Government (CSG) Justice Center, in partnership with the Public Policy Research Institute at Texas A&M University, released a statewide study of approximately one million Texas public secondary school students, followed for at least six years.²⁴¹ Among its findings were that the majority of suspensions occurred when students were between the seventh to twelfth grades. Of the nearly one million public secondary school students studied, about 15 percent were suspended or expelled 11 times or more. Only three percent of the disciplinary actions were for conduct in which state law mandated suspensions and expulsions; the rest were made at the discretion of school officials primarily in response to violations of local school conduct codes.

The Breaking School Rules study also found that when students were suspended or expelled, the likelihood that they would repeat a grade, not graduate, and/or become involved in the juvenile justice system increased significantly. The study demonstrated that African-American students were more likely than Hispanic or white students to be suspended or expelled for violating school rules when school officials had discretion as to how to respond. In contrast, white and Hispanic students were more likely to be suspended or expelled than African-American students for offenses in which state law mandated that school officials remove students from the classroom, such as bringing a firearm to campus or selling illegal drugs. These findings resulted from

²³⁹ See Kathy Koch, “Zero Tolerance: Is Mandatory Punishment in Schools Unfair?” *Congressional Quarterly Researcher*, 10 (2000): 185 – 208; the Texas State Board of Education began to call for zero tolerance measures as early as 1992, and the Texas Federation of Teachers endorsed a zero tolerance policy in 1993. Texas Education Agency, *Safe Texas Schools: Policy Initiatives and Programs* (Austin, TX: Author, 1994); “We must adopt one policy for those who terrorize teachers or disrupt classrooms—zero tolerance.” State of the State Address by the Honorable George W. Bush, S.J. of Tex., 74th Leg. R. S. 235 – 40 (1995).

²⁴⁰ Researchers define zero tolerance as a “policy that assigns explicit, predetermined punishments to specific violations of school rules, regardless of the situation or context of the behavior.” (Christopher Boccanfuso and Megan Kuhfield, *Multiple Responses, Promising Results: Evidence-Based Nonpunitive Alternatives to Zero Tolerance* (Washington, DC: Child Trends, 2011), 1). The term also has come to be associated with severe punishment, such as suspension or expulsion from school, for relatively minor misbehavior. (See also, Donna St. George, “More Schools Rethinking Zero-Tolerance Discipline Stand,” *Washington Post*, June 1, 2011, retrieved June 10, 2011, from http://www.washingtonpost.com/local/education/more-schools-are-rethinking-zero-tolerance/2011/05/26/AGSIKMGH_story.html)

²⁴¹ Fabelo T, Carmicheal D, et al. “Breaking Schools’ Rules: A Statewide Study of How School Discipline Relates to Students’ Success and Juvenile Justice Involvement,” *Council of State Governments Justice Center & Public Policy Research Institute of Texas A&M University*. (July 2011). Web. Accessed 8/10/12 via: <http://justicecenter.csg.org/resources/juveniles>

an analysis that controlled for 83 variables to isolate the effect of race on discipline. The Breaking School Rules study found African American students had a 31 percent higher likelihood of being disciplined for a discretionary offense, i.e., when school officials had discretion as to how to respond, compared with whites and Hispanics with similar characteristics.

The study also found that students with particular educational disabilities were disciplined at disproportionately high rates—especially those students coded as “emotionally disturbed.” In 2006, Texas Appleseed²⁴² partnered with the Population Research Center at The University of Texas to conduct a study on the disciplinary data self-reported by school districts to the Texas Education Agency.²⁴³ Then and again in 2009, as part of their research into school expulsion and Juvenile Justice Alternative Education Programs, Texas Appleseed documented the disproportionate impact of school discipline on minority and special education students.

Major findings from the study included the following:

- Class C Misdemeanor Ticketing of students in Texas public schools has increased substantially over a two- to five-year period—consistent with a growing law enforcement presence in schools, but in sharp contrast to a reported overall drop in juvenile crime.
- Twenty-two of the 26 districts or jurisdictions supplying ticketing data reported an increase in the number of tickets issued to students at school.
- Some Texas school districts have more than doubled the number of Class C misdemeanor tickets issued over the two- to five-year period for which we have data.
- African American and (to a lesser extent) Hispanic students are disproportionately represented in Class C misdemeanor ticketing on Texas public school campuses.
- Of the 15 districts that could identify the race and ethnicity of ticketed students, 11 disproportionately ticketed African American students compared to their percentage of the total student population.
- In the most recent year for which ticketing data is available, these districts reported ticketing African American students at a rate double their representation in the student body.
- Special education students are likely overrepresented in Class C ticketing on school campuses. Only two school districts could break ticketing data down by special education status, but both reported ticketing special education students at rates more than double their representation in the student body.

²⁴² Texas Appleseed is part of a national nonprofit network of 17 public interest justice centers in the United States and Mexico. Mission Statement: Appleseed is dedicated to building a society in which opportunities are genuine, access to the law is universal and equal, and government advances the public interest. Appleseed uncovers and corrects injustices and barriers to opportunity through legal, legislative and market-based structural reform.

²⁴³ For purposes of this study, Texas Appleseed submitted an Open Records Request to the Texas school districts that have established their own school police departments and to municipal and justice courts, requesting Class C ticketing and arrest data for a five-year period (2001-02 through 2006-07)—broken down by race or ethnicity, the student’s age, the nature of the offense, and special education status of the student receiving the ticket. Only 26 school districts and eight municipal courts could provide any part of the requested information from a searchable database. Regarding Class C ticketing of students, only 22 school districts and four municipal court districts could provide any data for a two- to five-year-period.. Only 15 of these school districts could provide ticketing data that identified the race or ethnicity of the student, and age- or grade-range of the student. Only two districts kept ticketing data by special education status. Texas Appleseed noted the Texas Education Agency does not require school districts to report student ticketing or arrest data, and very few school districts submit school-based crime data to the Texas Department of Public Safety for inclusion in the department’s annual Uniform Crime Report.

Policy Recommendations for Social and Emotional Wellness

1. Municipalities should support and encourage legislative efforts to sustain school districts efforts to provide a comprehensive and coordinated approach to address the positive development and social and emotional needs of students by using a continuum of evidence-based practices aimed at promoting student success. Local and national advocates and researchers recommend School-wide Positive Behavioral Interventions and Supports (SW-PBIS), a proactive discipline approach which uses a three tiered framework for schools to provide universal, targeted, and indicated interventions.^{244, 245}
2. Municipalities should support and encourage legislative efforts that address the need to increase the capacity of school personnel to appropriately recognize, respond to, and make community based referrals for students with suspected mental health concerns through training and professional development.
3. To better address social and emotional wellness of students municipalities should support a resolution that facilitates, develops, or strengthens partnerships with available community resources including the following options:
 - a. Supporting Local School Health Advisory Councils (SHACs) – SHACs are appointed by the school district to provide the district advice on coordinated school health programming and its impact on student health and learning.²⁴⁶ SHACs provide a structure for creating and implementing age-appropriate, sequential health education programs, and early intervention and prevention strategies.
 - b. Supporting the Region 4 Education Resource Center (ESC) School wide PBIS project. ESC specialists assist schools in implementing a school-wide positive behavioral intervention and supports (PBIS) approach that supports the success of all students.
 - c. Supporting Harris County Systems of Hope - Systems of Hope meet the needs of Harris County children and youth with serious mental health needs and their families by creating a collaborative network of community-based services and supports using an approach to services that recognizes the importance of family, school and community.
 - d. Supporting the Texans Care for children SW-PBIS Implementation Plan.

²⁴⁴ Bazelon Center for Mental Health Law. (2006). *Way to Go: School Success for Children with Mental Health Needs*.

²⁴⁵ Positive behavior support (PBS) is: the application of behavior analysis to achieve socially important behavior change; used for a wide range of students as opposed to in the past when it was an alternative to aversive interventions that were used with students with severe disabilities who engaged in extreme forms of self-injury and aggression; not a new intervention package, nor a new theory of behavior but an application of a behaviorally-based systems approach to enhance the capacity of schools, families, and communities to design effective environments that improve the fit or link between research-validated practices and the environments in which teaching and learning occurs. Attention is focused on creating and sustaining school environments that improve lifestyle results for all children and youth by making problem behavior less effective, efficient, and relevant, and desired behavior more functional. In addition, the use of culturally appropriate interventions is emphasized. PBS is an effective method for increasing school safety, enhancing students' social-behavioral skills, and creating a more positive school climate. See FAQs- Florida's Positive Behavior support Project at USF 11.18.05 Website Accessed August 17, 2012
<http://flpbs.fmhi.usf.edu/pdfs/FAQs%20final%20revision%2011%2018%2005.pdf>

²⁴⁶ [Chapter 28.004 of the Texas Education Code](#) requires every independent school district to have a School Health Advisory Council (SHAC).

Gap Analysis

Initially we began by looking at each Harris County school districts to see if they had policies on bullying, suicide prevention, and teen dating violence (results from a gap analysis in Harris County School Districts are displayed in Appendix F). Findings indicate that each of the twenty-six school districts examined feature a policy related to bullying and suicide prevention. No school districts had firm policies on teen dating violence. Their online policy manuals indicated that it was a work in progress.



Finally, our findings suggest the need for schools to implement a comprehensive and coordinated approach that proactively addresses social and emotional wellness and behavioral issues using a continuum of effective strategies and interventions.

Bullying

Each of the online school board policy sets studied include a policy on bullying from Texas' anti-bullying law (House Bill 1942):

- Establishes a new bullying definition that includes bullying through electronic means (e.g. "cyberbullying");
- Integrates awareness, prevention, identification, and resolution of and intervention in bullying into health curriculum;
- Provides local school boards with discretion to transfer a student found to have bullied to another classroom or to another campus in consultation with the parent or guardian (previously, only the victim could be transferred); and
- Requires local school districts to adopt and implement a bullying policy that recognizes minimum guidelines such as prohibition of bullying, providing counseling options, and establishes procedures for reporting, investigating and responding to an incidence of bullying. Further, each program must consist of professional assistance for students and a bully-free zone complete with rules and regulations posted on campuses grounds. Additionally, there must be information available for both parents and students regarding these policy changes on campus including steps for reporting bullying properly.

Suicide Prevention

In order to enhance suicide prevention efforts, all Texas school districts have policies focused on the issue using Texas' youth suicide prevention law [HB 1386]:

- Provides for the Texas Department of State Health Services, in coordination with the Texas Education Agency, to provide a list of best practice-based early mental health intervention and

suicide prevention programs for implementation in public elementary, junior high, middle, and high schools;

- Provides that each school district may select from the list a program or programs appropriate for implementation in the district;
- Provides that the board of trustees of each school district may adopt a policy concerning early mental health intervention and suicide prevention that:
 - establishes a procedure for providing notice of a recommendation for early mental health intervention regarding a student to a parent or guardian of the student within a reasonable amount of time after the identification of early warning signs;
 - establishes a procedure for providing notice of a student identified as at risk of committing suicide to a parent or guardian of the student; and
 - sets out available counseling alternatives for a parent or guardian to consider.

The suicide prevention bill states that nothing in the law is intended to interfere with the rights of parents or guardians and the decision-making regarding the best interest of the child. Policy and procedures are intended to notify a parent or guardian of a need for mental health intervention so that a parent or guardian may take appropriate action. At no time is the school to take action without first contacting parents.

*Interviews with policy advocates*²⁴⁷

The reaction to the suicide prevention bill from state level policy advocates provides a picture of the benefits and disadvantages shortcomings of the legislation for suicide prevention. Comments reveal a sense that the suicide prevention law lacks teeth. On the positive side the law established a clearinghouse of effective suicide prevention programs available to schools and encourages districts to establish policies relating to early identification of mental health concerns, suicide risk, and parental notification. However, the law is permissive and does not require districts to develop suicide prevention policies. Nor does it hold districts accountable to suicide prevention policies they develop. To strengthen the law, advocates believe districts should be required to develop policies related to early identification of mental health concerns and suicide prevention policies and to provide school personnel with training on how to recognize and respond to early warning signs.

Advocates also expressed concerns with recent bullying legislation. Having schools develop a bullying policy is a positive step, however the law does not include accountability measures to ensure districts adhere to their bullying policies. Some advocates express concerns over the law's provision which allows a district to transfer a student who engaged in bullying behavior to another campus, believing this will lead to students being pushed out of their natural school environment instead of receiving appropriate interventions to prevent further bullying behavior from occurring or becoming worse. An accountability mechanism is needed to ensure school districts comply with their bullying policies and that before a student's removal from a classroom or campus, a graduated continuum of effective interventions to help students change inappropriate behaviors have been employed.

Advocates reported that schools are hesitant to actually identify and label students with mental health issues and/or signs of mental illness because federal laws would then require them to provide services. Multiple schools reported being unable to refer students for targeted services due to a lack of resources for adolescent

²⁴⁷ Phone interviews and emails with Key SEL Informants conducted from July 26 – August 1, 2012.

mental health. This outcome is related to the reimbursement rate for mental health services to providers that take Medicaid patients.

Last, advocates overwhelmingly support efforts to provide schools with the tools to build a comprehensive and coordinated approach to address the positive development and social and emotional needs of students by using a continuum of evidence-based practices aimed at promoting student success.

With the support of several large statewide advocacy groups in the last state legislative session in April 2011 a bill (H.B.1340) was introduced to help schools build this evidence based coordinated approach to developing social and emotional needs. H.B. 1340 would have established a Statewide Positive Behavioral Interventions and Supports (PBIS) Leadership Team.

H.B. 1340, which ultimately failed, directed the Statewide PBIS Team to assess, develop, implement, manage and evaluate a statewide school-wide system of positive behavioral interventions and supports for students, to align policies and resources of appropriate state agencies, to develop and implement a statewide plan for PBIS. Further, the Bill provided a framework for school districts to adopt the plan, and to identify funding available for school districts to implement the plan.

Despite the bills failure advocates and agencies continue their pursuit of policies, programs, and projects that assist schools in the application of evidence-based strategies and systems aimed at creating school wide frameworks and practices that increase academic performance, ensure safety, decrease problem behavior, provide alternative disciplinary practices, and establish positive school cultures. The primary initiatives currently pursued include: SHACS, Region 4 Education Resource Center SW-PBIS Project; the Harris County Systems of Hope program; and the Texans Care for Children SW-PBIS Texas Implementation Plan.

Texas School Health Advisory Councils (SHACs)

Chapter 28.004 of the Texas Education Code requires every independent school district to have a School Health Advisory Council (SHAC). A SHAC must be composed of a group of representatives from the community within the school district they serve. More than half of the SHAC members must be parents of students enrolled in the district and who are not employed by the district. Additionally, SHACs must meet at least four times per year, contain a minimum of five members, report directly to the school board at least once annually, and appoint a parent as a chair or co-chair.

For the 2010-2011 school year the TEA awarded grants for *Characteristics of an Effective School Health Advisory Council* in an effort to highlight district SHACs that go above and beyond the minimum requirements of the law. During that award period each grantee school district received \$4,500 from the Centers for Disease Control and Prevention to improve the health of all students and families within their community through a coordinated school health approach.

Texans Care for Children and the Region 4 ESC continued to work towards statewide support and programming for SW-PBIS.

During summer 2012, Texans Care for Children, with support from the Hogg Foundation for Mental Health, launched a SW-PBIS Texas Summit.²⁴⁸ The Summit was meant to create a synergy around the issue of how Texas can help schools continue to push forward with School-Wide Positive Behavioral Interventions and

²⁴⁸ Saxon J. MSSW Mental Health Policy Associate, Texans Care for Children. (July 26, 2012). Email.

Supports (SW-PBIS). The purpose of the Summit was to bring together key stakeholders to inform the development of a state plan that would lay out a roadmap of how to promote the use of SW-PBIS in schools across the state and support schools choosing to implement the approach.

As a result of the Summit an advisory group was established to assist Texans Care in the development of the SW-PBIS Texas Implementation Plan. Texans Care will work with the advisory group to compile data and findings and publish a SW-PBIS report and implementation plan. The report and implementation plan will help to inform legislators and administrative bodies about the need for broader use of this evidence based practice in schools across the state and recommend policy actions for this to be achieved.

By fall of 2013, Texans Care will publish a summary of progress made in addressing policy barriers to statewide SW-PBIS implementation. The advisory group will reconvene stakeholders to update the implementation plan based on policy changes and will identify next steps.

The Region 4 Education Service Center²⁴⁹ supports the implementation of School-wide Positive Behavioral Interventions and Supports in schools and districts through the PBIS Project.²⁵⁰

The Region 4 Education Service Center is one of twenty such entities in the State of Texas. Regional education service centers are public entities created by state statute, to provide educational support programs and services to local schools and school districts within a given geographic area. Each education service center has different programs unique to its region. Currently there are 620 regional education service centers in 42 states.

As the largest Texas educational service center, Region 4 Education Service Center provides services to 51 school districts (including Harris County School Districts), representing more than 1,000,000 students, and 79,000 professional educators. The purpose of the Region 4 SW-PBIS Project is to work with schools (initially in 2003 -2004) to provide team training, technical assistance, and resources in implementing SW-PBIS. For the 2011-2012 school year, the project began a period of transition in modifying its current operation. Instead of enrolling individual schools, district wide participation is now required in order to provide the administrative support necessary when implementing PBIS.

The transition is moving forward and districts have been selected for entrance into the project. For the 2011-2012 school year, 39 campuses across 7 districts participated in the Region 4 PBIS Project. Fourteen of these campuses were in Harris County.²⁵¹ It takes approximately 2-3 years per campus for school to complete training. To evaluate schools data collection and analysis is a strong component of the project. Outcomes data is derived from three main areas; PEIMS discipline data, staff surveys, and fidelity evaluation tools such as the Benchmarks Of Quality or School-wide Evaluation Tool.

²⁴⁹ Texas Region 4 Education Service Center. "About Region 4." Web. Accessed 8/16/12 via:

<http://www.theansweris4.net/default.aspx?name=pi.aboutus>

²⁵⁰ Grafenreed CJ. Education Specialist, Special Education Solutions, Region 4 Education Service Center. (July 2012). Email.

²⁵¹ We were unable to find out which school districts and schools in Harris County were part of the Region 4 Education SW-PBIS Project. While not exactly clear, the reason for the hesitation to list schools may have been related to a reluctance to imply that schools and school districts were bad or good (or better than another) based on their willingness to take part in the PBIS Project.

The Systems of Hope

The Systems of Hope came about as a result of funding received by The Harris County Alliance for Families and Children. The 2005 award, from the Substance Abuse and Mental Health Services Administration (SAMHSA), provided a six-year grant totaling \$9,500,000. The funds were allocated to address the mental health needs of children and their families by creating a system of care. Harris County Protective Services serves as the fiduciary agent for the grant.

The Systems of Hope model utilizes the Wraparound process, which follows a series of steps to help children and their families plan a course of action. Care Teams (Care Coordinator paired with a Parent Partner) meet with families and their children to assess strengths and challenges that serves as the basis for a plan of care. Working with the entire family, Systems of Hope uses both traditional (e.g. traditional therapy) and non-traditional (e.g. Equestrian Therapy) methods of service.

Case Studies

Requests to advocates and supporters for local examples of SW-PBIS were met with referrals to other states and national websites for schools with PBIS. An Internet search²⁵² turned up the fact that Aldine and Spring ISD have been part of the part of the Region 4 ESC PBIS Project.

Case Study: Aldine Independent School District Safe and Secure Schools, Positive Behavioral Interventions & Supports

The Aldine school district labels their program “Aldine Independent School District Safe and Secure Schools, Positive Behavioral Interventions and Support (PBIS)”. Spring ISD uses the name “Improving School-Wide discipline and Climate through implementing CHAMPs/Safe and Civil Schools”.

Aldine ISD started in 2008 while spring began its program with an elementary school in 2010. As of yet there is little or no outcome data for these projects.

²⁵² The Texas Behavior Support (TBS) State Conference. sponsored by the [Texas Behavior Support \(TBS\) Network](#) and the [Texas Education Agency \(TEA\)](#). June 26–27, 2012. Region 4 Education Service Center. Houston, Texas.

Case Study: Florida's Positive Behavior Support: Response to Intervention for Behavior Project

The State of Florida PBIS program has been underway since 2001. It has been evaluated and assessed with very positive outcomes. As of 2009, seven hundred nine (709) Florida schools located in 52 of Florida's 67 districts had implemented PBIS. Essentially, 78% of Florida school districts have actively collaborated with *Florida's Positive Behavior Support: Response to Intervention for Behavior (FLPBS: RTIB) Project*.

In 2005 researchers finalized the development of the Benchmarks of Quality (BoQ) to measure the level of implementation fidelity for PBIS in schools. The BoQ became instrumental in matching PBIS training and technical assistance efforts to the unique implementation challenges encountered by schools.

The BoQ also captures the extent to which student behaviors are positively impacted by the quality of PBIS implementation. Measures focus on office discipline referrals (ODRs), in-school suspension (ISS) and out-of-school suspension (OSS).

Data reported for the Florida PBIS project demonstrates significant gains in the effort to decrease school disciplinary actions.²⁵³

For the 2008-2009 school year the FLPBS:RTIB Project high implementing schools reported 37% fewer ODRs per 100 students compared to low implementing schools, representing the greatest difference reported over a five year span. For the past three school years, higher implementing schools reported fewer ODRs. The average number of ODRs for lower implementing schools increased slightly in the last two years. In general, high implementing schools reported a lower rate of OSS days for each of the five school years from 2004-2005 through 2008-2009. In addition, both lower and higher implementing schools are on a general trend of fewer OSS days, during each subsequent year.

²⁵³ Positive Outlook; volume 20 spring 2010. University of South Florida . Website site accessed August 17, 2012
http://www.pbis.org/common/pbisresources/publications/PBS_Newsletter_Jan%202010.pdf

Policy Recommendation Summary Table

Social & Emotional Wellness	Focal Point	Policy	Program	Project	Recommended Point of Entry	Recommended Action	Likely to impact inequities
Support efforts to implement SW-PBIS	State	X		X	Support existing groups	Support efforts; Provide evidence	Mitigate inequities
Support efforts to train school personnel on mental health issues	State	X	X		Support existing groups	Support efforts; Provide evidence	Mitigate inequities
Support partnerships between community resources and schools	State and local		X	X	Support existing groups	Collaborate; Provide evidence	Mitigate inequities

Challenges to Dealing with Inequity through Policy

There are several challenges to the use of public policies and systemic and structural changes to tackle health inequities. This section examines some of these issues including the idea of causation where inequities result from long causal chains that in most cases begin at birth and work over the life course. In an effort to study group differences in health that play out over the course of a lifetime one can hardly establish random control studies that purposefully distribute the resources needed to survive (educational opportunities, jobs, income, and housing) among study and control groups.

While we do not yet have longitudinal experimental data or exact models that disentangle the myriad factors that interact to cause health inequities, the good news is that research is beginning to demonstrate the kinds of interventions that work for health inequities versus those that actually increase group differences in health. Nonetheless, researchers still acknowledge the challenges in documenting independent and interdependent effects, determining applicability to different populations and settings, assessing implementation fidelity and feasibility, identifying cumulative benefits and costs, ascertaining impacts on health equity, and tracking sustainability.²⁵⁴

²⁵⁴ Brennan L, Castro S, Brownson RC, Claus J, Orleans CT. "Accelerating evidence reviews and broadening evidence standards to identify effective, promising, and emerging policy and environmental strategies for prevention of childhood obesity." *Annual Review of Public Health* 32(2011):199-223. Print.

Specificity and Generalizability

We know that policies and programs ‘work’ in different ways for different groups.²⁵⁵ In other words, a policy or program can trigger different change mechanisms and responses for dissimilar groups because those groups are distinctive.

Accordingly, while knowing whether a policy or program works is essential, it is also imperative to know ‘what works for whom in what circumstances and in what respects, and how?’²⁵⁶ This addresses the important issue of heterogeneity of effect, in other words, that programs have different effects for different people, potentially even exacerbating inequities and worsening the situation of marginalized groups. But in addition, and essentially, it is important to realize that a policy/program may not only have a greater or lesser effect, but even for the same effect, it may work by way of a different mechanism, about which we must theorize, for different groups.

We know now that the contexts in which people live and policies/programs operate make a difference to the outcomes they achieve. Contexts include features such as social, economic and political structures, neighbourhood/environmental context, group characteristics, geographical and historical context, and so on. Because contexts differ along with the impacts to groups we find that policies/programs work differently in different contexts and through different change mechanisms. This means that policies/ programs cannot simply be replicated from one context to another and automatically achieve the same outcomes. An excellent example is the use of high-risk screening and educational, individualist strategies for cardiovascular disease (CVD). There is evidence that CVD prevention strategies for screening and treating high-risk individuals may represent a relatively ineffective approach that typically widens social inequities.²⁵⁷ An exploration of screening strategies for CVD demonstrates that it cannot decrease group differences in health because it cannot reach all groups effectively.



Let us recall that the primary prevention of cardiovascular disease (CVD) is dependent on the effective reduction of the major risk factors for CVD, particularly reductions in the use of tobacco and a healthier diet. The approach to reduce risk factors thus preventing CVD typically involves population screening and the assignment of lifestyle advice and/or drugs to reduce blood cholesterol and blood pressure.

There is research to support the notion that this approach to reducing risk factors for CVD typically widens socioeconomic inequities with inequities reported in screening, healthy diet advice, smoking cessation, statin and anti-

²⁵⁵ Pawson R. and Tilley N. *Realistic Evaluation*. Sage Publications Limited: London (1997). Print.

²⁵⁶ Ibid.

²⁵⁷ Capewell S, Graham H. “Will Cardiovascular Disease Prevention Widen Health Inequalities?” *PLOS Med* 7.8(2010) PLoS Med 7(8.) Print.

hypertensive prescribing, and adherence.²⁵⁸

Some evidence demonstrates that groups with inequities have a harder time adopting the advice, accessing smoking cessation interventions, and securing and maintaining prescription drugs. The alternative approach seeming to work more effectively to decrease inequities in CVD focuses on population-wide CVD prevention such as legislating for smoke-free public spaces, banning dietary trans-fats, or decreasing daily dietary salt intake. In this case we have an example of an intervention that does not apply to all groups and could actually increase health inequities when it is used alone without other kinds of efforts put into place. Policies and programs cannot simply be replicated from one context to another and automatically achieve the same outcomes.

Long Causal Chains - Social Determinants of Health

The SDOH approach uses the language of causation. This is entirely appropriate especially in the context of taking action to reverse the health-damaging effects of these broader determinants of health. Much is both known and unknown about the precise ways in which SDOH operate. It is clear that at the population and individual level poor health is linked to social and economic disadvantage. The unequal distribution of the social and economic determinants of health such as income, employment, education, housing, and environment produce inequities in health.²⁵⁹ However, while the general relationship between social factors and health is well established²⁶⁰ the relationship is not precisely understood in terms of mechanisms and causal pathways.²⁶¹ Consequently the policy imperatives necessary to reduce inequities in health are not easily deduced from the known data. Nevertheless, while the precise causal pathways are not yet fully understood, enough is known in many areas, and the evidence is good enough, for us to take effective action.²⁶²

²⁵⁸ Ibid.

²⁵⁹ Graham H. *Understanding Health Inequalities*. Open University Press: New York (2009). Print.

²⁶⁰ Solar O and Irwin A. "A Conceptual Framework for Action on the Social Determinants of Health," *Commission On Social Determinants Of Health* (2007). Web. Accessed 9/14/12 via:

http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

²⁶¹ Shaw M, Gordon, D, Dorling, D, and Smith DG. *The Widening Gap: Health Inequalities and Policy in Britain*. The Policy Press: Bristol (1999). Print.

²⁶² Bonnefoy J, Morgan A, Kelly MP, Butt J, Bergman V, et al. "Constructing the evidence base on the social determinants of health: A guide" *World Health Organization, Measurement and Evidence Knowledge Network* (November 2007). Web. Accessed 6/21/12 via:

http://www.who.int/social_determinants/knowledge_networks/add_documents/mekn_final_guide_112007.pdf

Next Steps

Recommendations for next steps are offered for each strategic area. However, we will first cover actions that apply to all strategic areas generally.

- Identify the kind of action you plan to pursue and the locus of control and decision-making: regulatory activities working with governmental agencies; voluntary efforts working with the private or nonprofit sector; and/or public policy strategies working with state and/or local policymakers.
- Review the literature and available evidence on the potential inequities that may result from policy and program recommendations in each strategic area. Consider how policies/programs might impact vulnerable populations, e.g., children, seniors, the disabled, LGBT communities, low income groups, racial/ethnic groups etc. Judge the policies potential to close the gap between groups, widen the gap or possibly move everyone up on the health gradient.
- Review the appendix of key informants consulted for the policy scan. These individuals are familiar with the CTI initiative and have expressed an interest in continuing to collaborate with HDHHS.

Next Steps: Tobacco Free Living

- This strategic area has a sizeable number of groups that have been working plus a rich history of legislative activity at the national, state, and local levels that must be considered. Conduct a series of discussions with key informants to assess the direction of tobacco policy in Texas and the interests of other local governments in Harris County in strengthening local laws on second hand smoke.
- Actively participate in existing advocacy networks or groups working on this issue.
- Provide briefings and information on the concept of health equity and review the potential inequities related to tobacco control policies.

Next Steps: Active Living and Health Eating

- This strategic area has gained recognition nationally and here in Texas. Several large organizations in Harris County have undertaken initiatives that have the potential to improve the built environment in communities. These initiatives are not necessarily tied to health. There is room for HDHHS to both join and lead initiatives. There should be a period of reflection to determine where HDHHS will focus its efforts based on an assessment of issues external and internal to the department.
- Where appropriate assemble one or several work groups for this strategic area. The group should include policy or issue experts, stakeholders, impacted community members, advocates, and members from other sectors outside health but related to this strategic area.
- Educate the work group on the concept of health equity and review the potential inequities related to each strategic area. Other educational topics might also include: a review of any related data for Harris County; research and studies on best practices; and results from the community focus groups.

Next Steps: Clinical Preventive Services

- As described in the gap analysis, Harris County has many well established private and public sector initiatives around decreasing the rate of chronic diseases through clinical preventive services.
- Once again, there is room for HDHHS to both join and lead initiatives. There should be a period of reflection to determine where HDHHS will focus its efforts based on an assessment of issues external and internal to the department.
- The low hanging fruit in clinical preventive services in Harris County appears to be in the review of contracts for health provider services and food procurement contracts for local governments. For example, using existing programs and key informants the CTI could work with local governments to create strategies to heighten the use of values based benefit polices in their employee health programs.

Next Steps: Social and Emotional Wellness

- Advocates in this area are very well organized with a policy agenda and set of initiatives that they are pursuing. As in other strategic areas, there should be a period of assessment to determine where HDHHS will focus its efforts based on a review of issues external and internal to the department.
- It is advisable to review the list of key informants from the policy scan. Joining an existing working group such as the Houston National Association of Mental Illness (NAMI) or Texans Care for Children is advised.
- Provide briefings and information on the concept of health equity.

Key Informants by Strategic Area

Tobacco-Free Living

Winfred Kang
Oil & Gas, Fuels & Miscellaneous Taxes
Section
Tax Policy Division, Texas Comptroller of
Public Accounts

Lorraine D Walls
Revitalization Specialist
Baytown Housing Authority

Paula Burns
Director of Development
Harris County Housing Authority

Joshua Meehan,
Vice President of Administration
The Houston Housing Authority

Active Living and Healthy Eating

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Environmental Policy & Planning (UEP),
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Godwin Yeboah
School Of The Built & Natural
Environment,
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Second Year Phd Research Focus On An
Integrated Approach To Understanding
Constraints And Enablers For Cycling In
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Adonia Lugo
The Seattle Bike Justice Project
cultural anthropologist and activist
completing anthropology dissertation
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Alison Hill Graves
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Clinical Preventive Services

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Julie Harvill, MPA, MPH
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Texas Medical Association

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Texas Business Group on Health/
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Texas Department of State Health Services
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Texas Medical Foundation Health
Quality Institute

Jennifer Markley,
Director, Quality Improvement
Harris County Medical Society
staff, Katherine Grigsby

Stacy Hodgins
Executive Director,
Houston Wellness Association

Karin Dunn
Navigation Services Manager
Gateway to Care

Ron Cookston
Executive Director
Gateway to Care

Appendices

Appendix A: Harris County Tobacco-Free Policies Table

Municipality Name	Precincts				100% Smoke Free Non-hospitality Workplaces	100% Smoke Free Restaurants	100% Smoke Free Bars	100% Smoke Free Gov't Buildings & Schools	No Tobacco Policy
	1	2	3	4					
Baytown		x			X	X	X	X	
Bellaire	x		x						
Bunker Hill Village									X
Deer Park								X	X
El Lago									
Friendswood								X	
Galena Park									
Hedwig Village									X
Hilshire Village									X
Houston	x	x	x	x	X	X	X	X	
Humble									X
Hunters Creek Village			x	x					X
Jacinto City	x	x							X
Jersey Village								X	
Katy				x					
La Porte		x							X
League City		x						X	X
Missouri City	x				X	X	X	X	
Morgan's Point								X	
Nassau Bay		x			X			X	
Pasadena		x			X	X			
Pearland					X	X	X	X	
Piney Point Village									X
Seabrook		x			X				
Shoreacres									X
South Houston		x						X	
Southside Place									
Spring									
Spring Valley Village									X
Stafford			x					X	X
Taylor Lake Village								X	
Tomball				x	X			X	
Waller									X
Webster		x			X			X	
West University Pl.	x		x					X	

Appendix B: Healthy Houston Food Access Program Food Deserts Report

Healthy Houston Food Access

Bringing nutritious food to Houston neighborhoods -one grocery store at a time

Summary

Healthy Houston Food Access (HHFA) is a program designed to assist food retailers in expanding, relocating, rehabilitating or developing new stores in underserved communities, known as food deserts. This public-private partnership seeks to encourage economic development in order to address a growing public health issue.

The Numbers

Information gathered by The Food Trust, a non-profit advocacy group for increasing food access, reports that Houston has fewer supermarkets per capita than most larger cities in the country¹. Further, an examination of low- and middle-income zip codes reveals that low-income neighborhoods have 25% fewer grocery stores than middle-income neighborhoods.

This “grocery store gap” affects the overall health of our city. An estimated two-thirds of Houstonians are overweight or obese, and of those, high percentages live in food deserts. Without access to fresh food, families are forced to purchase over-processed food from convenience stores or consume fatty foods from local fast food restaurants.

According to the Centers for Disease Control and Prevention, Texas spends \$5.3 billion on treating obesity-related diseases². Increasing the availability of fresh food options is one preventive measure that ultimately will result in a healthier society and lessen the burden on tax payers.

¹ “Food For Every Child.” The Food Trust. December 2010.

² The Burden of Obesity in Texas. 9 Jan. 2012. <http://www.cdc.gov/obesity/stateprograms/fundedstates/texas.html>

The Green Side

Successful projects in underserved communities will ignite development and spur investment. Serving as anchor tenants, supermarkets attract other retail and dining outlets. Additionally, new supermarkets have shown to increase the real estate values of surrounding homes.³

While often overlooked, there is opportunity in Houston's underserved communities. As Houston continues to grow in size, the need in these areas will only increase.

Looking for Solutions

There is not a "one size fits all" solution to eliminating food deserts. Contributing factors vary and are complex. For this reason, a comprehensive approach should be taken when addressing food access. Supermarkets offer a large selection of fresh produce, meat and dairy items. Community gardens and farmers' markets supplement grocery stores with local food items and provide fresh food to areas not yet served by grocery stores.

When considering the complexity of the issue and the effects limited food access have on public health, finding solutions presents the perfect opportunity for the public and private sector to work together toward a common goal. Public-private partnerships enable resources to be leveraged more effectively in order to better serve the community and enhance the quality of life for Houston residents.

Houston is Open for Business

Under Chapter 380 of the Texas Local Government Code, the City of Houston is able to loan or grant public money in exchange for public infrastructure, drainage and/or utility improvements and job creation⁴. Known as a 380 Agreement, HHFA seeks to use this economic development tool to incent food retailers by offsetting the high first costs associated with site acquisition and infrastructure and/or offer assistance with facility rehabilitation to allow operators to expand existing stores.

380 Agreements offer a performance-based rebate to commercial and residential development projects on the city's portion of ad valorem taxes, sales and use taxes. The performance-based rebates will be determined solely upon proven increases in taxes assessed and collected after the projects are operational and taxes can be accurately measured.

³ *"The Economic Impact of Supermarkets on their Surrounding Communities."* Reinvestment Brief. Issue 4.

⁴ Tex. Loc. Gov't Code Ann. § 380.001 (West)

HHFA has identified four priority communities: Fifth Ward, East End, Sunnyside, and Third Ward as pilot areas where the city seeks to increase food access. These neighborhoods extend from the north side of Houston down toward the east and southeast; along I-610 from US 59 to I-45. Companies seeking to participate in a pilot area are encouraged to submit project proposals to HHFA.

Submitted proposals must provide a brief description of project scope including mission statement, site location, and number of jobs expected to be created. There is no fee required for project submittals.

Upon submission, HHFA will work with the applicant to draft a 380 Agreement. State guidelines allow for flexibility in determining criteria on a case by case basis. This enables the city to work with each applicant to determine project goals and rebate incentives. Once a 380 Agreement has been crafted and negotiated, it must be considered by City Council for final approval.

In conclusion

Limited food access has shown to have an effect on diet-related health issues. Closing the grocery gap offers a solution that will not only improve the quality of life for many Houston residents, but also encourage development that will create jobs and revitalize neighborhoods.

Contact Healthy Houston Food Access for more information on the application process and incentives available by emailing Melissa at melissa.arredondo@houstontx.gov or calling 832-393-3014.

Appendix C: Houston, Texas Active Living and Healthy Eating Resolution

MAYOR'S ADVISORY COUNCIL ON HEALTH AND ENVIRONMENT OBESITY TASK FORCE

The Mayor's Advisory Council on Health and Environment convened an Obesity Task Force to address the significant obesity health threat in the City of Houston. The Task Force recommends that the City of Houston adopt the following resolution and establish a continuing Task Force to identify concrete actions that could be taken to address the goals in the resolution and report annually on progress toward reducing obesity in the City of Houston.

INTRODUCTION

In recent years, obesity has emerged as a significant health threat in America. In the United States as a whole, 17% of children aged 2-19 and 34 % of adults are obese (body-mass index ≥ 30).^{1,2} In 2010, Texas became one of 12 states in which 30% or more of the population is obese.³ The situation in the City of Houston/Harris County is no different, where it is estimated that 28% of 4th graders, 16.7% of adolescents 15-18 years of age and 29.1% of adults are obese. This translates into 15,752 children in the 4th grade, 18,116 15-18 year old adolescents and 1,253,941 adults in the City of Houston/Harris County whose health is at risk.⁴ The danger of obesity resides in the fact that it kills over 100,000 Americans each year and increases the risks of type-2 diabetes, heart disease, stroke, certain cancers, high blood pressure, and asthma.³ In addition, obesity is associated with increased depression, anxiety, and low self-esteem.⁵

These conditions cost Texas businesses around \$10B in 2010, a figure projected to rise to \$32.5B by 2030 if the current trend continues.⁶ In the U.S. in 2006, the average health care costs for obese individuals were 41.5% higher than those for non-obese individuals.⁷ Most of these costs are borne by Medicare, Medicaid, private health insurance companies, and ultimately, by area employers and the community at large. Thus, the costs of obesity are likely to thwart any attempts to reduce health care costs in the future, and furthermore, they threaten to shorten the lifespan of Americans for the first time in more than a century.⁸ The costs of obesity-related illnesses include not only direct medical costs, but also the costs of absenteeism, lost productivity, and disability.⁶

It is clear that promoting awareness of the risks of obesity and preventing and reducing obesity are essential for reversing this disastrous trend. However, this is easier said than done. Current evidence suggests that the obesity epidemic results from increased caloric intake, decreased physical activity, and decreased prevalence of infant breast feeding.^{6,9} In addition, anxiety, behavioral problems, and depression in children and adolescents are associated with increased obesity in adulthood.¹⁰ Emerging evidence suggests, in addition, a contributing role for certain environmental chemicals, particularly those with endocrine-disrupting activity.¹¹ Clearly, this is a multi-factorial problem that requires a multi-pronged approach to address it. Reducing caloric intake involves not just reducing food portion sizes, but increasing the availability of

fresh, healthy foods. Studies show that most Americans do not consume enough fresh fruits, vegetables, and whole grains to maintain a healthy weight and consume an excess of food high in calories and sugar.¹² Access to fresh, healthy food and appropriate nutrition is central to any anti-obesity effort. In addition, it has been demonstrated that infants who are breast fed are less likely to become obese children or adults.⁹ Physical activity is also essential for maintaining healthy weight. Less than 50% of adults meet the Center for Disease Control and Prevention's recommendation of at least 30 minutes of moderate physical activity at least five days a week and 24% engage in no leisure time physical activity at all.¹³ Improvements to the "built environment", including bike and pedestrian friendly streets and access to parks, trails, and retail stores offering fresh, healthy foods can increase physical activity and significantly reduce the incidence of obesity.¹⁴

To address this increasing problem, we respectfully request that the City of Houston adopt the following resolution.

HEALTHY HOUSTON RESOLUTION

WHEREAS, obesity is an increasing problem that contributes to heart disease, diabetes, cancer, and mental health issues, leading to increased healthcare costs for individuals and companies, decreased quality of life, lost productivity, and a shortened lifespan of people in our community; and

WHEREAS, factors contributing to obesity include increased calorie intake, lack of access to fresh and local, healthy and nutritious foods, hunger, inadequate physical activity and exercise, lack of breastfeeding of infants, and mental health issues; and

WHEREAS, increasing access to affordable fresh and local, healthy and nutritious foods, enabling opportunities for infant breastfeeding, and providing venues for physical activity and exercise are avenues to reducing obesity; and

WHEREAS, cultural, policy, and environmental changes are needed to address these issues, along with individual efforts; and

WHEREAS, strategic infrastructure changes are needed to improve access to fresh and local foods (e.g., transportation, incentives for retailers), provide places for infant breastfeeding, promote walking destinations in communities (e.g., sidewalks, parks, community centers), and provide safe neighborhoods for outdoor activities in order to effect changes in individual behavior, as well as corporate culture and community practices;

THEREFORE, LET IT BE RESOLVED, that the City of Houston hereby recognizes that obesity is a serious threat to the health and wellbeing of adults, children, and families in Houston; and in light of the foregoing considerations, the City of Houston commits to take steps to decrease the proportion of overweight and obese residents in its communities and to implement the

necessary laws or policies to create work, school, and neighborhood environments conducive to healthier eating and increased physical activity among residents. Specifically, the City of Houston resolves to promote programs, policies, and actions designed to increase

- (1) access to affordable fresh and local, healthy and nutritious foods,
- (2) awareness regarding the benefits of fresh fruits and vegetables, locally grown foods, sustainably produced foods, infant breastfeeding, the provision of healthy meals in our schools, physical activity, and maintaining a healthy weight, and
- (3) opportunities for physical activity and exercise for all ages.

To meet this challenge, the City of Houston shall

Establish an ongoing Healthy Houston Task Force to identify concrete actions that could be taken to address these goals, including infrastructure and policy changes that support modifications in both individual behavior and community culture, recommend changes that would improve access to fresh, affordable foods and safe places for physical activity, and report annually on progress toward reducing obesity in the City of Houston.

Encourage urban agriculture in community, school, backyard, and rooftop gardens, and where feasible, on City property.

Improve access to healthy, affordable, and locally produced food, for all neighborhoods.

Support education regarding the physical and mental health risks of obesity and the benefits of sustainable agriculture, using locally produced food, consuming fresh fruits and vegetables, infant breastfeeding, providing healthy meals in our schools, physical activity and exercise, and maintaining a healthy weight.

Enable programs that increase physical activity and exercise in schools, at work, and in communities, including those that provide safe playgrounds and parks, pedestrian-friendly walkways, bicycle paths, and other recreational opportunities.

Promote infrastructure changes in the City to improve access to fresh and local, healthy and nutritious foods and safe places for physical activity, exercise, and breastfeeding, and promote community awareness of these changes.

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APPENDICES

The appendices were developed by working groups of the Obesity Task Force convened by the Mayor’s Advisory Council on Health and Environment. The first appendix provides guidance for the establishment of an ongoing Healthy Houston Task Force on obesity to continue to address the issue of obesity. Subsequent appendices provide suggestions for specific actions that could be taken by such an ongoing Healthy Houston Task Force on obesity.

- I. Recommendations for establishing a Healthy Houston Task Force on obesity by the Mayor

Chair, Faith Forman; members, Shreela Sharma, William Baun, Susan Fordice, Jessica Schleifer

II. Suggested actions regarding urban agriculture

Chair, Mark Bowen; members, Robert Borja, Scott Howard, Toral Sindha

III. Suggested actions to improve access to healthy foods

Chair, Lynn Henson; members, Melissa Arredondo, Pamela Berger, Claudia Vasquez

IV. Suggested educational initiatives

Chair, Gracie Cavnar; members, R.J. Hazeltine-Shedd, Lisa Whitaker, Brian Giles, Courtney McNamara, Tracey Ledoux

V. Suggested programs to increase physical activity

Chair, Daniel O'Connor; members, Crystal Ford, Joel Romo, Niiobli Armah, Paula McHam

VI. Suggested infrastructure and policy changes aimed at reducing obesity

Chair, Barry Hart; members, Glen Boudreaux, Lauren Santerre, Auturo Jackson

TASK FORCE DEVELOPMENT WORK GROUP RECOMMENDATIONS

Recommendations for establishing a Healthy Houston Task Force on obesity by the Mayor

Section 1. Establishment of Healthy Houston Task Force on Obesity. There is established a Healthy Houston Task Force on obesity (Task Force) to identify and recommend actions that would reduce the incidence and prevalence of obesity and its health and economic impacts on the City of Houston. A person selected by the Mayor shall serve as Chair of the Task Force.

a. Mission and Function of the Task Force. The Task Force shall work across City of Houston departments, multi-sector agencies, and key stakeholder organizations (1) to establish and maintain an inventory of major initiatives in the City of Houston addressing the problem of obesity; (2) identify and recommend to the Mayor concrete actions that could be taken to reduce obesity; and (3) report annually to the Mayor on progress toward reducing obesity within the City of Houston. The functions of the Task Force are advisory only and shall include, but are not limited to, making recommendations to meet the following objectives:

- i. ensuring access to and availability of healthy and affordable food in schools, workplaces and communities;
- ii. increasing opportunities for physical activity in schools, workplaces and communities;
- iii. providing Houstonians with the knowledge, skills and tools it takes to make healthy choices for themselves and their families; and
- iv. improving the built environment to promote active living.

b. Task Force Membership. In addition to the Chair, the Task Force shall consist of not more than 15 members and shall include:

- i. the Director of Health and Human Services;
- ii. the Director of Parks and Recreation;
- iii. the Director of Planning;
- iv. the Director of the Office of Sustainability (or any senior official designated by one of these Directors who is a member of the Director's department);
- v. other Heads of Departments as deemed necessary by the Chair;
- vi. the President of the Metropolitan Transit Authority of Harris County (or any senior official designated by the President);
- vii. community leaders focused on obesity from a variety of stakeholder groups;
- viii. education and public health experts;
- ix. individuals representing the restaurant and grocery store industry; and
- x. other stakeholders that bring unique resources or solutions.

Members shall be recommended by the Chair and appointed by the Mayor. They shall serve one year terms and may be reappointed for up to two additional terms.

c. Administration of the Task Force. The Mayor's Office shall provide funding and administrative support for the Task Force to the extent permitted by law and within existing appropriations.

Section 2. Action Plan.

a. Within eight (8) months of its establishment, the Task Force shall develop and submit to the Mayor an inventory report, summarizing current major initiatives in the City of Houston addressing the obesity problem and identifying gaps and overlaps among programs.

b. The Task Force shall recommend to the Mayor actions that could be taken or facilitated by the City of Houston that can improve the health and well-being of children, families, and communities by reducing obesity. In developing its recommendations, the Task Force shall consider and prioritize suggestions in the following appendices, developed by previous working groups.

c. The Task Force shall report progress and make recommendations to the Mayor at least annually on efforts to reduce obesity.

Section 3. Outreach.

Consistent with the objectives set out in this memorandum, the Task Force, in accordance with applicable law, and in addition to regular meetings, shall conduct outreach with representatives of private and nonprofit organizations, local governmental authorities, and other interested persons that can assist with the Task Force's development of a detailed set of recommendations to reduce the health, economic, and societal impacts of obesity.

Section 4. General Provisions.

The heads of all relevant City of Houston departments and agencies shall assist and provide information to the Task Force, consistent with applicable law, and shall bear its own expense for participating in the Task Force.

I. URBAN AGRICULTURE WORK GROUP RECOMMENDATIONS

Section 1. Expand land access and development opportunities for urban agriculture

- a. Encourage greater use of LARA (Land Assemblage Redevelopment Authority) vacant lots;
- b. Explore the use of other public lands (i.e. Flood Control, Parks, Public Housing, Utility Easements and Right of Ways);
- c. Promote the use of public/private partnerships to develop underutilized private land for urban agriculture; and
- d. Increase the public knowledge of the benefits of urban agriculture and create evidence-based development tool kits for organizations wanting to get involved

Section 2. Review, examine and recommend changes to governmental codes to mitigate barriers to urban agriculture and provide greater opportunities to achieve goals of increased access to land for urban agriculture

- a. Increase the tenure of LARA land leases to five years with a five year option, allow on and off site sales of food grown, expand the universe of applicants to include individuals and for-profits; and
- b. Review and examine utility billing practices and code provisions to accurately reflect urban agriculture utility use

II. FOOD ACCESS WORK GROUP RECOMMENDATIONS

Section 1. Provide Incentives to grocers and food suppliers to entice them to expand into underserved communities.

- a. Property Tax Abatement Programs
 - i. But-for condition – would locate elsewhere
 - ii. Negotiated on a case by case basis
 - iii. Owner must agree to construct a certain type of improvement must invest at least \$1M and create or retain at least 25 jobs
- b. 380 Loan Grant Program
 - i. COH uses sales and property taxes as rebate mechanism
 - ii. Performance based (“post project” incremental increases)
 - iii. Rebate for a specified time and only for public infrastructure
- c. Land Grants – city can grant city owned property to support economic development and negotiate a 380 loan to allow owner to pay for the land
- d. Developer Participation Contract (PWE)
 - i. Program to reimburse a portion of development infrastructure cost
- e. Programs to Facilitate or Subsidize fresh food in local convenience stores
 - i. Corner stores:
 - Already in communities, access for those w/o cars
 - Healthy Corner Store Initiative

- ii. Offer loans/grants to purchase necessary equipment
- iii. Partnership with farmers markets, community gardens or micro gardens
- f. Allow the use of SNAP benefits at farmers markets
- g. Tax Increment Reinvestment Zones (TIRZ) or Tax Increment Financing if not in a TIRZ
 - i. Rebate of city property taxes from incremental revenue within a designated boundary
- h. Texas Enterprise Zone
 - i. Rebate of a portion of state sales and use taxes
 - ii. Refund based on the capital investment and number of jobs created
 - iii. Maximum refund between \$2,500 - \$7500 for each job created
- i. Community Development Block Grants or other state or federal grant program
- j. Grants - Foundations (e.g. Houston Endowment, Inc.)
- k. New Market Tax Credits

Section 2. Other Initiatives

- a. Encourage all eligible individuals/families receive to apply for SNAP, Medicaid, CHIP, etc. (in Houston only 60% of eligible people receive SNAP)
- b. Develop partnerships between corner stores and community gardens
 - i. Assist in connecting urban gardens with willing corner stores
 - ii. Underwrite spoilage early on
 - iii. Consider ordinances requiring a minimum amount and variety of perishable healthy food choices
- c. Provide opportunities for mobile food trucks and food stands
- d. Support development of Farmers' Markets
- e. Support innovative programs to increase food access (e.g. Chicago's Healthy Corner Store Initiative; Minneapolis' Health Corner Store Program, Philadelphia's Food Trust-Fresh Food Financing Initiative)

III. EDUCATION WORK GROUP RECOMMENDATIONS

The ongoing Task Force should establish a working committee that includes communication professionals to develop a comprehensive marketing campaign that infuses the messaging used by every City of Houston department participating in the anti-obesity initiative with the goal of reinforcing a supportive multi-disciplinary, multi-media approach. Branding, promotion and messaging of the campaign should be consistent across all departments and platforms and leveraged for maximum public and media exposure resulting in broad based civic engagement and changed behaviors. The recommended campaign has four legs:

Section 1. Open the Door to Policy

The Task Force should develop a strategic education and outreach campaign directed to members of the City Council and Harris County Commissioners to first make clear the financial and social impact of the obesity epidemic in Houston and secondly guide them to realize the

benefit of establishing a permanent policy commission or committee to advise elected officials and craft legislation.

Section 2. Begin at Home

Establish a proactive campaign for City Employees incorporating many of the initiatives suggested for the public below.

Section 3. Educate Key Community Influencers

Robust outreach to encourage participation, collaboration and support among TIRZ Administrators and Boards, community leaders—pastors, organizers, associations and fraternities, Harris County Commissioners, hospitals, clinics, physicians and medical care providers.

Section 4. Educate Houstonians

Our suggestions for priority public messaging:

- a. Identify the problem—"How to tell if you or your child is obese"- with a TV, billboard and print ad campaign
 - i. To identify specific examples of healthy weight, overweight and obese for children and adults
 - ii. To urge parents to talk to their health care providers (e.g., physicians, dietitians, nurses, etc.) about their child's weight status
- b. Promote simple proactive steps to health undertaken as separate media campaigns such as
 - i. Back to the Table (encourage family dinner time)
 - ii. Get Moving (highlighting cost free movement options throughout the city and simple ways to add movement to your day—such as take the stair, parks & recreation options)
 - iii. Start the Day with Breakfast/or Breakfast is Cool-highlighting the availability of breakfast at school and encouraging kids to be advocates for eating breakfast
 - iv. Eat Local-featuring the Tex Dept of Ag crop of the month tied to easy recipes from area chefs. Call for everyone to eat the same food on the same day- Broccoli Day, recipe contests, harvest contest, etc.
 - v. Color is Cool-Celebrity PSAs for eating veggies
 - vi. Citywide 5-a-Day Contest for a week or a month, led by the Mayor, celebrity testimonies and family, chef, kid interviews on TV, etc. Tracker sheets online for families and schools.
 - vii. Fast Easy Healthy – Affordable recipes for family meals
 - viii. Walk Your Kids to School
 - ix. Grow What You Eat – Campaign to encourage community & private gardens

- x. It's Cool to Breastfeed
- xi. Lets Walk for Lunch
- c. Incorporate all public resources into an engaging interactive website
 - i. Cross blog on the Chronicle and other popular cultural resources
 - ii. Maps, resources, free exercise options, recipes, cultivation tips, nutrition information, farmers markets, community gardens, how to start a L.A.R.A. farm, community supported agriculture (CSA) and coop lists
 - iii. Develop an app with same resources
 - iv. Establish a benchmark and recognition for Houston's Healthiest Schools
 - v. Operate as a clearinghouse for city-wide activities and initiatives

IV. PHYSICAL ACTIVITY WORK GROUP RECOMMENDATIONS

Section 1. Enable programs that increase exercise in schools, at work, and in communities, including those that provide safe playgrounds and parks, pedestrian-friendly walkways, bicycle paths, and other recreational opportunities.

Section 2. Enable programs that decrease sedentary behaviors in schools, at work, and in communities, including those that provide opportunities to minimize or provide breaks from sitting, television and computer time, and passive transportation and commuting.

a. Guiding Principle

- i. Recommended amount of physical activity each day; 60 minutes for children; 30 minutes for adults.

b. Support Physical Activity in the School Environment

- i. Promote comprehensive obesity prevention strategies in early childhood programs.
- ii. Support the creation and/or strengthening of school health councils, Coordinated School Health programs and wellness policies.
- iii. Ensure children receive quality physical education that meets minimum state standards for duration and frequency.
- iv. Maintain strong P.E. programs that engage students in moderate to vigorous physical activity for at least 50% of P.E. class time.
- v. Establish programs that get students walking and/or biking to school such as "Safe Route to Schools" that offer walking/biking options for most students.
- vi. Establish school policies limiting the amount of television or other screen time permitted to be used in the classroom (e.g., movies or video lessons).
- vii. Investigate methods of integrating activity into the school schedule, such as student schedules that require changing classrooms and walking across the campus or short activity sessions (e.g., 10 or 20 repetitions rising to stand from desk chair) at the beginning and end of each class.

- c. Support Physical Activity in the Community Environment
 - i. Promote efforts within the community environment that will lead to increased physical activity.
 - ii. Promote built environments that integrate physical activity into daily life.
 - iii. Establish and promote community-based walking groups.
 - iv. Create more family-oriented special events targeting physical fitness.
 - v. Expand day and after school programs that incorporate physical activity.
 - vi. Offer Employee health incentives for physical activities.
 - vii. Offer employee health incentives for using active transportation, such as bicycling, public transportation modes that require some degree of walking to and from transit stops, and walking or biking whenever possible in place of the use of cars or carts when on the work campus.

- d. Support Physical Activity through the Physical and Built Environment and Resources
 - i. The promotion of more opportunities for physical activity through Joint Use Agreements (JUA)--a formal agreement between two separate government entities--often a school and a city or county- setting forth the terms and conditions for shared use of public property or facilitates; JUAs can range in scope from relatively simple (e.g., opening school playgrounds to the pubic outside of school hours) to complex (allowing community individuals and groups to access all school recreation facilities, and allowing schools to access all city or country recreation facilitates).
 - ii. National Policy and Legal Analysis Network to Prevent Childhood Obesity (These may already exist in some areas, but would benefit other those neighborhoods that don't have access. Requires some leg work on the front-end, but could result in a local policy change promoting more physical activity).
 - iii. The establishment of "health zones", specific locations around the city that receive focused and strategic efforts. These could be piloted through the existing super neighborhood structure. Access to safe opportunities to physical activity, and the built environment could be potential priority areas to address. This would be an innovative method to pilot certain initiatives before rolling out to the entire city.
 - iv. Identify, audit, upgrade/maintain, and promote existing trails, explore development of neighborhood trails.
 - v. Audit parks to target improvements in physical campus, resources, programs, and safety.
 - vi. Audit walkability and bikeability around schools, commercial sites (e.g., shopping centers), and public venues (e.g., parks).

- vii. Identify potential bike paths and shared use roadways and incorporate those features into city planning and new construction areas.
- viii. Investigate the possibility of long-term planning and city code revisions to incorporate aspects of “healthy places” into Houston’s architecture and built structures. <http://www.cdc.gov/healthyplaces>

V. INFRASTRUCTURE WORK GROUP RECOMMENDATIONS

To enhance access for pedestrian residents to providers of fresh and nutritious food choices and to venues for education, community support, and physical activity, the Infrastructure Work Group offers the following recommendations:

Section 1. Pedestrian communities are particularly vulnerable to limited access to the venues described above. Of particular concern in these communities is the safety of the pedestrian population. To minimize the concerns for safety among this population segment, the following are recommended:

- a. Enhanced law enforcement presence in these communities to provide for the safety of the citizenry
- b. The development of Community Watch programs, trained and supervised by local law enforcement precincts, to further efforts toward crime deterrence
- c. Where needed, improvements to sidewalks and crosswalks to provide for safe pedestrian traffic
- d. Improved lighting along pedestrian passageways
- e. Address these issues as appropriate in the permitting process for new or remodel construction

Section 2. In addition to improvements that enhance pedestrian safety, METRO should consider the addition of affordable local transit in high-pedestrian communities. Local transit would be defined as a public transit offering that serves a local community only, not focusing on commuter transit, but on access to local venues such as:

- a. Supermarkets and other operators providing a well-rounded grocery offering
- b. Health-care providers
- c. Community and religious organizations
- d. Post offices
- e. Parks and other recreational facilities
- f. Other retail centers providing non-grocery needs, laundrymats, banks, dry cleaners, etc.

Section 3. The City and other stakeholders should use available channels to incent local faith-based and community organizations to make their facilities available for the needs of the community including:

- a. In-door physical activities such as games, volleyball, basketball, etc.
- b. Support groups such as those supporting breast-feeding, weight control groups, drug and alcohol recovery groups, adult education, etc.

- c. Providing women with breast-fed infants venues for breast-feeding while out in the community
- d. Outdoor recreational venues that further opportunities for physical activity for both children and adults

Section 4. The City and other stakeholders should use available channels to incent a local organization to take on the responsibility of communicating these offerings to residents of the community. These communications might include:

- a. Community maps free to the public in various locations that show local transit and the location of various on-going activities
- b. A community newsletter for the purpose of announcing activities, educational, and support groups open to the public, the times and places of their meetings

Appendix D: El Paso, Texas Active Living and Healthy Eating Resolution

Committing El Paso to Improved Nutrition and Physical Activity

Updated November 16, 2010

WHEREAS, in El Paso, Texas 29% percent of adults reported themselves obese and another 37% reported themselves as overweight according to the Behavioral Risk Factor Surveillance System;

WHEREAS, obesity and overweight are primarily a consequence of poor nutrition and physical inactivity;

WHEREAS, improved nutrition and physical activity have benefits beyond weight control;

WHEREAS, infants who are breastfed are less likely to become obese children or adults;

WHEREAS, individual effort alone is insufficient to combat obesity's rising tide and significant societal and environmental changes are needed to support individual efforts to make healthier choices;

WHEREAS, improvements to the "built environment" – including, bike and pedestrian friendly streets, adequate public transportation, access to healthy food retailers, access to parks, trails and grocery stores, or the lack thereof – have a significant impact on obesity rates;

NOW, THEREFORE, LET IT BE RESOLVED, that the city of El Paso hereby recognizes that poor nutrition and lack of physical activity are serious threats to the health and wellbeing of adults, children, and families in El Paso. And in light of the foregoing considerations, the city of El Paso makes obesity prevention a priority, commits itself to improving nutrition and physical activity, encourages city staff to make policy recommendations for solutions, and directs the City Manager to implement the following Action Plan for five years from the time of passage and report progress annually to City Council.

Action Plan

Built Environment

BE IT FURTHER RESOLVED that the city of El Paso directs the City Manager to review comprehensive plans, zoning ordinances, subdivision regulations, smart growth policies, and

other plans, codes, policies, and regulations, and report to the El Paso City Council proposed action that could increase access to healthy foods, decrease access to unhealthy food retail outlets, and increase opportunities for physical activity.

BE IT FURTHER RESOLVED that the city of El Paso directs the City Manager to procure a Health Impact Assessment from the Director of Public Health for any new large-scale development project. Such an assessment will study the potential effect of a development project on physical activity, availability of nutritious foods, and other potential impacts on population health.

BE IT FURTHER RESOLVED that the city of El Paso directs the City Manager to review and revise all policies that might erect unnecessary barriers to use of local parks, recreation facilities, physical activity programs, or related activities, and shall report findings to the El Paso City Council.

Access to Healthy Food

BE IT FURTHER RESOLVED that the city of El Paso directs the City Manager to review and revise all policies and practices that might erect unnecessary barriers to breastfeeding, community gardening, farmers' markets, or related activities, and shall report findings and recommendations to the El Paso City Council.

BE IT FURTHER RESOLVED that the city of El Paso directs the City Manager to generate recommendations to reduce public consumption of minimally nutritious foods.

BE IT FURTHER RESOLVED that the city of El Paso directs the City Manager to identify any transportation barriers to accessing supermarkets or farmers' markets and determine where there are opportunities to increase access to healthy food through public transportation, and shall report to the El Paso City Council with findings and recommendations. BE IT FURTHER RESOLVED that the city of El Paso hereby directs the City Manager to review existing beverage, snack, and food service contracts, and upon renewal, revise these contracts to reduce access to sugar-sweetened beverages and food high in sugar and fat, and replace them with beverages and food that support good health and nutrition, and shall report findings to the El Paso City Council.

Employee Wellness Program and Policies

BE IT FURTHER RESOLVED that in order to promote employee wellness within the city of El

Paso, and to set an example for other businesses, the city of El Paso hereby directs the City Manager to work with key stakeholders to enhance the municipal employee wellness program emphasizing improved nutrition, physical activity, and safety. In addition to recommending any new wellness policies or practices for employee wellness, the plan shall include estimated program costs and estimated potential savings from improved employee health and wellbeing.

Community Involvement for Improved Nutrition and Physical Activity

BE IT FURTHER RESOLVED that the city of El Paso hereby encourages representation from city departments on the Paso del Norte Healthy Eating and Active Living Coalition. The City Council, City Manager, and Departments will consider policy recommendations from this Coalition.

Implementation

BE IT FURTHER RESOLVED that the City Manager will evaluate and report annually regarding steps taken to implement this Resolution, additional steps planned, and any desired actions that would need to be taken by El Paso City Council or other agencies or departments to promote proper nutrition and physical activity.

Appendix E: Clark County Bicycle and Pedestrian Master Plan: Allocation Assessments Tool

Appendix C. Prioritization Criteria

This appendix provides the revised prioritization used in the existing Clark County sidewalk infill program, and the Plan prioritization.

Project Prioritization Used in the Plan

The Bicycle and Pedestrian Advisory Committee developed evaluation criteria for bicycle and pedestrian projects that are connected to the plan’s vision statement. Additionally, Clark County Public Health suggested that additional criteria on health and equity be included. This recommendation was drafted as part of a Health Impact Assessment of the plan, and will be revisited later in the HIA process. Based on committee input and health concerns, Public Health recommends that the criteria shown in Table 50 be considered for adoption. It should be noted that the purpose of this exercise is to understand the relative priority of the projects so that the County may apportion available funding to the highest priority projects. Medium- and long-term projects are also important, and may be implemented at any point in time as part of a development or public works project. The ranked lists should be considered a “living document” and should be frequently reviewed to ensure they reflect current Clark County priorities.

Table 50. Project Criteria

Criteria	Comments
Closing Gaps	To what degree does the project fill a missing gap or overcome a barrier in the current system? Does it improve significant crossings?
Safety & Comfort	Can the project improve walking and bicycling conditions at locations with perceived or documented safety issues? Does the project make cycling and walking appealing to all users?
Access & Mobility/Land Use	How many user generators does the project connect within a reasonable walking or cycling distance? Are adjacent land uses supportive of walking and bicycling? To what degree will the project generate users?
Multi-modal Connections	To what degree does the project integrate walking and cycling into the existing transit system? Does the project enable the use of multiple active transportation modes?
Implementation	What is the ease of implementation? Is funding available? Is additional right-of-way required? Are negotiations required over parking availability, signage, etc.?
Community Benefit	To what degree does the project offer potential benefits to the regional community by offering opportunities for increased connectivity to parks, natural scenic beauty, and activity centers?
Health Outcomes	To what extent does the project increase physical activity, regardless of travel purpose? To what extent does the project improve other determinants of health?

Criteria Measurement

Each evaluation criterion was assigned a range of points, with the number of potential points reflecting the criterion’s relative importance (based on input from County staff and the public). Objective measurements of each criterion were developed as shown in Table 51.

Table 51. Project Criteria and Scoring

Criteria	Possible Scores	Measurement
Closing Gaps	25	Project within a 1/8 mile of existing bicycle or pedestrian facilities
	18	Project within a 1/4 mile of existing bicycle or pedestrian facilities
	15	Project within a 1/2 mile of existing bicycle or pedestrian facilities
	12	Project provides partial connection where no other facilities exist
	1	Project does not connect to the existing system or provide network coverage
Safety & Comfort	15	Off-street facilities separated from roadways
	10	Off-street facilities within the roadway right-of-way
	12	On-street lower order roadway
	8	On-street, urban collector, rural collector, or state route
	6	On-street, minor or major arterial roadway
Access & Mobility/ Land Use	10	Within 1/8 of retail (city center, community/ neighborhood/ regional commercial, employment campus, mixed-use, or rural centers), a school, or high-density residential (MF 18 units/acre, R1-5, or R1-6) lands.
	7	Project within 1/4 mile of supportive land uses
	4	Project within 1/2 mile of supportive land uses
	1	Project not close to supportive land uses
Multi-modal Connections	15	Project within 1/8 mile of C-TRAN service area and existing trail
	10	Project within 1/4 mile of C-TRAN service area or existing trail
	5	Project within 1/2 mile of C-TRAN service area or existing trail
	1	Project not close to C-TRAN service area or existing trail
Implementation	5	Bike lane inventory identified sufficient space for a bike route
	4	Other on-street facility (additional review required)
	3	Off-street facility, county-owned right-of-way
	1	Other off-street facility
Community Benefit*	10	Project within 1/8 mile of schools, parks and open space
	8	Project within 1/4 mile of schools, parks and open space
	4	Project within 1/2 mile of schools, parks and open space
	1	Project not close to schools, parks and open space
Health Outcomes	20	Project is in block group with unfavorable social determinants of health and high walkability potential, project improves connectivity, and project involves low-speed/low-traffic designs
	Less than 20	See discussion of Health Outcomes criterion scoring following

* Commercial and downtown centers considered in Access & Mobility/Land Use criterion.

Health Outcomes Criterion Scoring

The 20 points allocated for the “Health Outcomes” criteria were distributed using the following methodology, as recommended by Public Health. The methodology assigns point values based on the project’s ability to improve health outcomes, particularly through encouraging physical activity. The strength of evidence supporting the criteria was also considered, with more weight given to strategies that are supported by extensive evidence.

Table 52. Summary of Health Outcomes Points

Factor	Possible Score
Socioeconomic status	10 points
Walkability potential	4 points
Connectivity	5 points
Low-stress facilities	1 point

Socioeconomic Status: 10 points

Description: Project is located in a block group with unfavorable social determinants of health

Measure: Percent of block group population living in poverty based on census data.

Points: See Table 53.

Table 53. Socioeconomic Status Points

Quintile	Points
1 (Lowest poverty block groups)	0
2	2
3	5
4	7
5 (Highest poverty block groups)	10

Evidence: Health outcomes improve as socioeconomic status increases (Commission on Social Determinants of Health, 2008). Availability of physical activity increases with socioeconomic status, while risk of obesity decreases (Powell, Frank, & Chaloupka, 2004).

Walkability Potential: 4 points

Description: Project adds infrastructure in areas with high walkability potential

Measure: The walkability index is based on connectivity, land use mix (destinations), retail FAR, and density. Projects in locations at or above the

60th percentile in county-wide walkability measured at the block group level received a full score.

Points: All 4 points awarded if conditions are met.

Evidence: Walkability is linked with physical activity, independently of income or self-selection (Sallis et al, 2009). Neighborhoods with higher walkability facilitate physical activity (Transportation Research Board and Institute of Medicine, 2005).

Connectivity: 5 points

Description: Project improves connectivity for active transportation modes

Measure: Eligible projects provide a new connection, improving the effective connected node ratio for active transportation modes. Additional points are available for projects in areas at or below the 40th percentile in walkability county-wide.

Points: Two points if a new connection is provided, five points if in an area with poor connectivity (walkability in the lowest two quintiles) or within one mile of a school.

Evidence: Connectivity is a strong predictor of physical activity (Sallis et al. 2009; Dill, 2004).

Low-stress facilities: 1 point

Description: Project involves low-speed/low-traffic designs

Measure: Eligible projects include off-street paths not adjacent to roadways, sidewalks on lower-order streets (collectors or local streets), and on-street projects on local roadways.

Points: Awarded if conditions are met.

Evidence: Cyclists go out of their way to use these facilities, indicating that they have potential to attract new users (Dill, 2009). Low speed designs are safer for users (Pucher and Dijkstra, 2003).

Appendix F: Harris County School Districts' Social and Emotional Wellness Policies Table

District Name	All Harris County ISDs should include a specific policy in the school district conduct and discipline code concerning bullying prevention and education.	All Harris County ISDs should provide for evidence-based suicide prevention screening.	All Harris County ISDs should provide for evidence-based programming around teen dating violence.
Aldine ISD	Planning to adopt (TEA) policy or implement own policy by September 1, 2012.	Future suicide prevention and teacher training procedures are in progress.	No evidence of planning.
Alief ISD	Planning to adopt (TEA) policy or implement own policy by September 1, 2012.	Future suicide prevention and teacher training procedures are in progress.	Working towards a solution.
Channelview ISD	Planning to adopt (TEA) policy or implement own policy by September 1, 2012	Future suicide prevention and teacher training procedures are in progress.	Working towards a solution.
Clear Creek ISD	Planning to adopt (TEA) policy or implement own policy by September 1, 2012	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.
Crosby ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.
Cypress Fairbanks ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	. No evidence of planning.
Dayton ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.
Deer Park ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.
Galena Park ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	No evidence of planning.

Goose Creek ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.
Houston ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	No evidence of planning.
Huffman ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working towards a solution.
Humble ISD	Planning to adopt (TEA) policy or implement own policy by September 1, 2012.	Future suicide prevention and teacher training procedures are in progress.	Working towards a solution.
Katy ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	No evidence of planning.
Klein ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.
La Porte ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.
New Caney ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.
North Forest ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.
Pasadena ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.
Pearland ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working towards a solution.
Sheldon ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working towards a solution.

Spring ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working towards a solution.
Spring Branch ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.
Stafford ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.
Tomball ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.
Waller ISD	Planning to adopt (TEA) policy or implement own policy by September 1	Future suicide prevention and teacher training procedures are in progress.	Working toward a solution.