

California Wellness Plan Implementation

Health in Planning within California's Local Health Departments, 2015

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HEALTH IN PLANNING WITHIN CALIFORNIA'S LOCAL HEALTH DEPARTMENTS

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1. EXECUTIVE SUMMARY

This report summarizes the results of an environmental scan conducted to assess local health department (LHD) involvement in creating healthy built environments through community design and land use planning in California. This report and its findings will inform work to expand LHD capacity to engage in these efforts to create healthy communities in alignment with Let's Get Healthy California priorities and California Wellness Plan goals. It was undertaken by the California Conference of Local Health Officers and the County Health Executives Association of California Chronic Disease Prevention Leadership Project (CCLHO-CHEAC CDPLP or CDPLP) in partnership with the California Department of Public Health (CDPH). Data were collected through an electronic survey, key informant interviews, and a review of publications.

At least forty-six LHDs responded to the electronic survey. Half of the LHDs reported having a person/program to work on health and planning. Multiple funding streams were reported to support efforts, nevertheless 17 percent of LHD respondents reported having no funding for this work. LHD respondents reported useful mechanisms in developing partnerships with planners, including convening stakeholders and providing comments to plans/project development. LHD challenges to working with planners included lack of dedicated staff time and funding (68 percent of respondents) and no mandate/ authorization for LHD to participate in planning (55 percent). Key needs of LHDs identified in order to interact more effectively with planners included: knowledge of funding/collaborative opportunities (85 percent of respondents), how to create opportunities to come together with planners to identify partnerships (72 percent), and models/approaches for incorporating health into planning (72 percent). The most important areas at the local level for public health to join planners in community design and built environment included food systems/access to healthy food retail (71 percent of respondents) and active transportation planning (56 percent). Emerging issues for LHDs (i.e., LHDs not yet involved, but issue locally relevant) included school districts planning/siting, climate change, and affordable housing.

Key informant interviews were conducted with nine LHDs representative of the diversity of California. The following elements for successful and effective engagement with planners were shared: foster partnerships with non-traditional public health sectors; develop internal infrastructures and capacity; adopt a comprehensive, integrated approach that addresses the social and community factors that impact chronic disease and health inequities; blend and leverage internal and external funding; incorporate planning into community health indicator projects and public health accreditation efforts; collaborate with partners to address the challenges of data, monitoring, and evaluation;

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promote shared community values in communications and solutions to achieve mutual benefit among partners; and tailor approaches to respond to the local context. Concrete and detailed LHD experiences are provided in this report to encourage collaboration and innovation.

While advances are being made to engage planners around healthy community designs and land use planning, major gaps in LHD capacity need to be addressed. LHD skills building to consider include: increase understanding of planner language, processes, responsibilities, authority/mandates, data metrics, and measures; communicate and frame the need for healthy built environments in ways that will promote shared values and concerns; engage in more regular discussions with planners to identify new partnership prospects and possible collaborative funding; and share evidence-based LHD models/approaches for incorporating health into planning.

To sustain this work and build capacity, CDPH, in partnership with LHDs, can: support LHD efforts to leverage and blend funding streams at the local level; continue to develop and share tools in areas where the State has expertise (see www.casaferoutestoschool.org); support LHDs around their local data needs, including access to local community health data and non-traditional data that has relevance for public health; promote cross-sector communication, collaboration and partnerships with other State entities; and share information about opportunities to give input into state-level efforts that have local implications. The state Office of Health Equity and the Health in all Policies (HiAP) program staff can play a critical role, for example, in housing policies and equity issues. CDPLP will develop and conduct training and offer technical support and networking opportunities based on the findings in this report to work with LHDs to support their unique needs and concerns.

California LHDs have made significant strides in incorporating a public health perspective into planning, but many challenges remain. Lessons they have learned provide a foundation and a direction for integrating public health considerations into planning at the local, regional, and state levels. State and regional leaders need to work with local jurisdictions to create a coherent, cohesive approach statewide that will support local interests and concerns. CDPH can play a critical role in helping to support and disseminate promising approaches that link planning and public health. CDPH programs, such as Safe and Active Communities Branch (SACB) and HiAP, are critical to strengthen communication and partnerships with other State entities, and introduce public health into community design and land use planning processes at the state level.

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2. INTRODUCTION/BACKGROUND

This report summarizes the results of an environmental scan conducted to assess local health department (LHD) involvement in creating healthy built environments through community design and land use planning in California. It builds on priorities outlined in the Let's Get Healthy California Taskforce Report¹ and goals of the California Wellness Plan (CWP),² California's chronic disease prevention and health promotion plan. CWP was created by the California Department of Public Health (CDPH) in collaboration with key stakeholders statewide. CWP's aim is to align common public health approaches to reducing chronic disease in California and create environments in which people can be healthy. The Advancing Prevention in the 21st Century, Commitment to Action 2014 (P21) meeting brought together statewide partners from public- and private-sector organizations to advance its strategies.

The California Conference of Local Health Officers and the County Health Executives Association of California Chronic Disease Prevention Leadership Project (CCLHO-CHEAC CDPLP or CDPLP) was actively involved in planning P21. Subsequently, CDPLP decided to focus its efforts on CWP's Goal Area 1 to "create healthy, safe, built environments that promote active transport, regular daily physical activity, healthy eating and other healthy behaviors, such as by adoption of health considerations into General Plans." This report will inform CDPH and CDPLP's efforts to build LHD capacity in this area.

A Partnership between Local and State Health Departments

CCLHO and CHEAC jointly established CDPLP in 2008.³ CDPLP works to make chronic disease prevention a priority in California's LHDs and promote upstream policy, systems, and environmental changes to reduce chronic disease and related health inequities. The project is directed by a statewide cross-disciplinary leadership team representing twenty-four rural, urban, and suburban LHDs, with support from CDPH via funding from the Centers for Disease Control and Prevention (CDC) Preventive Health and Health Services Block Grant.

3. DATA COLLECTION METHODOLOGY

A work group comprised of CDPLP representatives, Bay Area Regional Health Inequities Initiative (BARHII) staff, and HiAP staff was convened to guide the environmental scan project process (see Appendix B for member list). The work group established the project's focus, helped design, pre-test and reviewed the survey

¹ www.cdph.ca.gov/data/informatics/Documents/Let's_Get_Healthy_California_Task_Force_Final_Report.pdf

² <https://www.cdph.ca.gov/programs/cdcb/Pages/CAwellnessplan.aspx>

³ cclho-cheacchronicdiseaseleadershipproject.com/

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findings, made suggestions for follow-up interviews, and gave input for the report's recommendations. CCLHO Chronic Disease Control Committee received updates at their quarterly meetings, and CHEAC was kept informed through its CDPLP representatives.

CDPLP collected information from California's LHDs about their level of involvement with community design, land use planning and other efforts to create healthy built environments. Information was gathered through an electronic survey, key informant interviews, and a review of pertinent literature and reports. The built environment was defined as the "physical spaces created or modified by humans, where we live, work, study or play, including homes, commercial or public buildings, streets, highways, parks and other open spaces and infrastructures" (adapted from definitions by the Centers for Disease Control and Prevention and National Association of County and City Health Officials⁴).

Electronic Survey

An electronic survey was sent to over two hundred LHD leaders from California's 61 jurisdictions, via CCLHO and CHEAC members and their statewide counterparts in nutrition, public health nursing, health education, data managers/epidemiologists, and Maternal, Child, and Adolescent Health directors (See Appendix C for survey instrument). In addition, a CDPLP member collected information from three of the non-responding jurisdictions.

Seventy-five staff from forty-six LHDs responded to the electronic survey between March 30, 2015, and May 4, 2015, (75 percent LHD response rate at minimum), including six respondents that did not identify their agency. The data were initially analyzed for all seventy-five responses, which included multiple surveys from eleven jurisdictions. Because these multiple responses from individual LHDs potentially skewed the results, the survey was re-analyzed using one response per LHD from the most senior-level staff person engaged in the work for those that identified their agency. The latter analysis was used for this report and included a total of 52 respondents (i.e., forty-six respondents who identified their agency and six respondents who did not identify their agency).

Key Informant Interviews

From April 1, 2015, to May 15, 2015, interviews were conducted with nine LHDs representative of California's diverse geographic regions, varying population sizes and demographics, as well as, rural, suburban, and urban communities.

⁴ <http://www.cdc.gov/nceh/publications/factsheets/ImpactoftheBuiltEnvironmentonHealth.pdf>

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The following nine Counties in California were selected for key informant interviews to collectively illustrate the range of involvement (from very little to extensive) in a variety of local planning issues, and to describe innovative LHD approaches, strategies, or models:

Contra Costa	Riverside
Humboldt	Sacramento
Lake	San Diego (only limited pre-approved information provided)
Mendocino	San Francisco
Orange	

Literature Search

CDPLP contacted the staff from the HiAP Task Force, the Center for Climate Change, the Governor's Office of Planning and Research, ChangeLab Solutions, and BARHII to identify materials on LHD involvement in planning. Case studies from CA4Health were reviewed,⁵ as were the American Planning Association's National Planning and Community Health Research report (2012),⁶ and the Metropolitan Area Transportation Planning for Healthy Communities reports.⁷ Documents from the San Diego Health and Human Services Department were reviewed for inclusion.

4. FINDINGS

Key Electronic Survey Findings

Profile of Respondents

The survey responses came from: health officers (25 percent of respondents), public health directors (28 percent), senior agency managers (19 percent), chronic disease managers (18 percent), Data/Epidemiology Managers (6 percent), and Other (17 percent). Thirty-one percent of respondents had been with their LHD for five years or less.

Key findings from the LHDs that responded:

- A. Staff resources:** About half of LHD respondents reported having a point person (58 percent) while 44 percent of respondents reported having a program that works on health and planning (with another 27 percent reported having a program somewhat designated).

⁵ <http://www.ca4health.org/successes-to-date/>

⁶ Healthy Planning: An evaluation of comprehensive and sustainability plans addressing public health, American Planning Association, 2012 <https://www.planning.org/research/publichealth/pdf/evaluationreport.pdf>

⁷ Metropolitan Area Transportation Planning for Healthy Communities, December 2012. http://www.planning.dot.gov/documents/Volpe_FHWA_MPOHealth_12122012.pdf

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- B. Funding sources:** Respondents reported funding their work with planners through various funding streams, including local county funds (64 percent of respondents), Nutritional Education and Obesity Prevention (47 percent), CDC funding (e.g., 1422 Communities in Action 13 percent, Partnership to Improve Community Health 11 percent); and the California Department of Transportation (Caltrans 23 percent). 17 percent of respondents have no funding for this work.
- C. LHD roles:** Respondents reported useful mechanisms in developing partnerships with planners: convene stakeholders (68 percent of respondents); provide comment to plans/project development (66 percent); schedule meetings with planners to give input on health issues in planning (59 percent); and contribute to grant proposals (59 percent).
- D. Challenges:** Staff time/funding (68 percent of respondents); participation is not mandated/authorized (55 percent); not informed about planning processes being undertaken (49 percent); planners do not understand how public health can contribute (44 percent); and, cannot provide geographic-level data to inform planning in a timely manner (38 percent).
- E. Capacity building needs:** Information on available funding/collaborative opportunities (85 percent of respondents); opportunities to come together with planners to identify partnerships (72 percent); models/approaches (72 percent); understanding what data, metrics, and measures planners use (63 percent); and understanding planner language, processes, responsibilities, authority, and legislative mandates (57 percent).
- F. Opportunities to work with planners:** Food systems/access to healthy food retail (71 percent of respondents) and active transportation planning (56 percent).
- G. Emerging issues (i.e., LHDs not yet involved, but issue locally relevant):** School districts planning/siting, climate change, and affordable housing.

Key Informant Interviews: Elements for Successful Engagement

Eight elements were identified that need to be in place for LHDs to effectively engage with planners. While some are not new to public health, they are especially critical to address the complex factors that influence chronic disease. The elements are illustrated with real life examples drawn from small, medium, and large LHDs working on a variety of planning-related issues (See Appendix F for complete description).

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A. Foster partnerships with non-traditional public health sectors to support shared agendas/goals for healthy communities.

Community design and land use planning for healthy built environments is a relatively new area for LHDs, requiring an increase in LHD capacity and expertise needed to take the lead. New partnerships are required with city and county government, regional planning bodies, and transportation, community development, housing and economic development planners. LHDs must learn the language of these new partners and how their interests align with community health goals. LHDs can offer public health expertise and support that links planning to health, lending credibility and accountability to plans and proposals. They have a legitimate role in helping planners to use community design to address the built environment elements that contribute to chronic disease and health inequities.

Despite having no dedicated funding, **Sacramento County Public Health Department (SCPHD)** has responded to planners' agendas and supported them with a public health perspective. When the Regional Parks Director launched a campaign to increase park utilization, the Health Officer (HO) produced a customized "parks prescription" included in a brochure sent to all County residents. When the County received an infrastructure grant to increase density around light rail corridor stations, the SCPHD helped engage WALKSacramento, the Local Government Commission, and others to raise awareness of the health benefits of walking to and from transit. The HO and County Planner later applied for and were accepted to participate as a local cross-sector team with the National Leadership Academy for the Public's Health program.⁸ The team developed an easy-to spot icon for the Sacramento County Draft Zoning Code Development Standards that highlighted design guidelines with a health impact.⁹ Judy Robinson, County Planner, observed, "We took planner language, and applied the health lens to it."

Monterey County Health Department (MCHD) works with other sectors to strategically use built environment, land use, and economic development planning opportunities to bring forward a public health

⁸ <http://www.dialogue4health.org/about/projects/national-leadership-academy-for-the-publics-health>

⁹ Sacramento County Adopted Design Guidelines including Active Design -

Zoning Code link:

<http://www.per.saccounty.net/LandUseRegulationDocuments/Documents/ZoningCodes/FINAL%20ADOPTED%20ONING%20CODE%20Sept%2025%202015/Zoning%20Code%20COMPLETE%20Effective%20September%2025,%202015.pdf>

Design Guidelines link:

<http://www.per.saccounty.net/LandUseRegulationDocuments/Documents/ZoningCodes/FINAL%20ADOPTED%20ONING%20CODE%20Sept%2025%202015/Development%20Code%20Design%20Guidelines%20ADOPTEDJuly%202,%202015.pdf>

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approach. When MCHD was asked to review the health impacts of wind turbines for a specific project, they focused on how they could contribute by identifying where a health perspective would be useful. They learned how to work together with planners to supplement the required planning process with a thorough health-focused research review. Prepared with valid science to address potential health impacts during planning commission hearings, the partnership helped get the green energy project approved. Relationships developed through this effort led to consideration of the health impacts of a County-wide ordinance for wind turbines (through a ministerial permit process) to increase green energy, and support the health of all residents.

B. Develop infrastructure capacity to sustain the work with planners.

LHDs need to be proactive in creating broad chronic disease prevention agendas and putting in place the infrastructures and staffing patterns needed to carry them out. By doing this work in advance, LHDs can position themselves to respond quickly to emerging opportunities with staff that can provide support to new community and city-led efforts.

Very small jurisdictions often lack the resources needed to develop and maintain this infrastructure capacity. They rely heavily on the long-term, trusting relationships they have built with partners who can help carry out the work, and don't always have the time or ability to rebuild relationships when staff members leave.

Monterey County Health Department (MCHD) developed a sustainable infrastructure by establishing a Health Equity Policy Unit and requiring its bureaus to financially support it. This Unit provides backbone staffing to local task forces working on planning. MCHD provides data to help planners prioritize what to fund; shares evidence-based approaches that could be used; conducts assessments to identify gaps and inform future planning; and helps to create a shared language among sectors and disciplines.

The **County of Riverside Department of Public Health (CRDPH)** has worked at multiple levels to build the Agency's capacity to advance its vision for a healthy community. Early on, CRDPH trained all staff on the links between health and built environment, setting the stage for launching the Healthy Riverside County Initiative in 2011,¹⁰ which focuses on environmental factors influencing health and chronic disease. CRDPH then convened transportation and other planners in a cross-sector coalition that developed a Community Transformation Grant proposal. Although it was not funded, the effort developed strong working relationships they capitalized on when The California Endowment (TCE)

¹⁰ <http://www.healthyriversidecounty.org/>

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funded one of their partners for the Building Healthy Communities project. CRDPH successfully negotiated with TCE for funding to hire an urban planner. Housed in CRDPH, the urban planner consults with cities to develop health elements and incorporate a health perspective into other planning efforts. The urban planner was critical in supporting the development of the Healthy Cities Resolution Toolkit, which is helping cities to incorporate health in planning and built environment designs.

C. Adopt a comprehensive, integrated approach to address the social and community factors that influence chronic disease and health inequities.

Chronic diseases cannot be prevented without addressing the economic, environmental, social, and infrastructure conditions that keep communities from being healthy. LHDs in California are integrating models that promote policy, systems, organizational and environmental changes that will positively impact these factors and promote health in all communities.

The **San Francisco Department of Public Health (SFDPH)** spearheaded a comprehensive, integrated approach to address healthy nutrition and food access and reduce unhealthy influences,¹¹ by establishing a healthy retail program that linked economic development and public health. The program's initial pilots supported small independent businesses and corner stores to shift their business models and sell healthy products in two diverse, low-income communities.¹² SFDPH continues to support the coalitions leading the effort, and to staff the County's Healthy Retail San Francisco program in partnership with the Economic Development Department. With its emphasis on community leadership through local food justice advocates and food guardians, the project "is a marriage of economic development, workforce development and public health," observed Susana Hennessey Lavery, Health Educator.

D. Blend and leverage funding for broader impact.

LHDs use various approaches to increase funding to support health and built environment planning. Many blend internal categorical funding sources with common agendas, such as tobacco control programs, Safe Routes to School (SRTS), Supplemental Nutrition Assistance Program Education (SNAP-Ed), and state and federally funded chronic disease prevention programs. Others help their planning partners leverage and compete for external funding. Some larger LHDs use regional approaches to extend their impact more broadly. SRTS and Active Transportation Planning (ATP) grants have provided specific opportunities to join with planners to combine infrastructure and non-infrastructure projects.

¹¹ <http://www.healthyretailsf.org>.

¹² <http://www.southeastfoodaccess.org/>; and <http://www.healthyt1.org/>

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Contra Costa Health Services (CCHS) found that offering staffing support to proposals and grants enhanced public health's credibility, gave cities a strong economic incentive to engage with them, and helped bring significant outside funding into the County. As city improvement plans were adopted, CCHS helped identify opportunities for additional funding and laid the groundwork for cities to successfully compete for these funds. Its work with Richmond, San Pablo, and Concord helped bring in millions of dollars to fund community-identified improvements to built environments.

County of Riverside Department of Public Health (CRDPH) has supported the efforts of its external partners by using the Agency's powerful position to promote more comprehensive approaches to creating healthy built environments. They leveraged partnerships with County Transportation and Land Management Agencies and city Public Works Departments to secure more than \$2.5 million in infrastructure and non-infrastructure funding to expand SRTS scopes of work.

Humboldt County Department of Health and Human Services, Public Health (HCDHHS-PH) built on its partnership with local Safe Routes to School task forces to bring public health into the County's ATP process. When ATP Round Two funding was announced, the HCDHHS-PH was invited to help the Humboldt County Association of Governments think about engaging them in the application process. The resulting funded proposals focus on a combination of infrastructure, encouragement, and education activities (e.g., traffic slow-down, bike safety education). With the two strong SRTS coalitions as co-collaborators, the HCDHHS-PH will work more extensively with planners and engineers to incorporate a public health perspective into the development of these strategies.

E. Legitimize public health involvement by incorporating planning into public health accreditation efforts and community health indicator projects.

LHDs are not specifically mandated by regulation or code to engage in work with planners. Some engage in the work despite this, on the assumption that community design for healthy built environments is implicit in their charge to protect the public's health. Others face significant challenges to making that case with local decision makers. Some LHDs have legitimized their role by incorporating planning in categorically funded grant work or agency strategic plans, or through community health assessments and national public health accreditation efforts.

Humboldt County Department of Health and Human Services, Public Health (HCDHHS-PH) is incorporating a healthy community's perspective and goals into its Community Health Improvement Plan (CHIP), which will inform the HCDHHS-PH's accreditation efforts. The CHIP outlines

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community-identified concerns that lend themselves naturally to built environment objectives, including issues such as food access and placement of healthy stores, safety and walkable communities, and the need for increased sense of social cohesion. HCDHHS-PH is connecting these community health issues to community design interventions, establishing a legitimate role for public health to participate in local planning.

Monterey Public Health Department (MPHD) is imbedding built environment principles and a HiAP approach into its accreditation process. Prior to the onset of accreditation planning, the Health Director solicited more community engagement in developing the Agency's strategic plan. MPHD wove identified community priorities, such as transportation, affordable housing, and better jobs, into the plan. Presenting HiAP as a potentially unifying approach, staff created policy-specific actions, and proposed the creation of a policy unit within MPHD. With Board of Supervisors' approval, the strategic plan legitimized the Agency's role in working in this new area. MPHD has incorporated those issues into its accreditation process.

F. Work with partners to address data, monitoring, and evaluation challenges.

Data on the links between community health and the built environment is critical to determine where to focus planning, prioritize interventions, and evaluate their impact on health. LHDs often do not have access to current community health data at the level needed for planning. They are not well informed about non-traditional public health data that may be pertinent to incorporating a health perspective into planning, such as local transportation use. Rural counties are challenged in a different way, with small population numbers making it challenging to use epidemiology to monitor statistically significant trends, identify and justify areas of need, and evaluate program impacts. LHDs must collaborate with the planning sector, academic institutions, and CDPH to identify new data sources and develop relevant tools for collecting and analyzing local data.

County of San Diego Health and Human Services Agency (SD-HHSA) partnered with San Diego State University (SDSU) and the San Diego Association of Governments (SANDAG), to sponsor the Bikes Count Project¹³ to inform decisions on future bicycle-related improvements throughout the County. SDSU initially installed 28 bicycle-counter locations in 14 cities, and now has expanded to include 54 bike and pedestrian counters in 15 municipalities. Tracking bicycling and pedestrian trips has offered essential information leading to a more

¹³ Healthy Works Grant Summary: Communities Putting Prevention to Work, December 2014.

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balanced and healthy transportation system that supports active living, and helped justify critical investments to improve active transportation infrastructures. SDSU recently provided Bikes Count data to the City of San Diego as it prepared to approve the San Diego Bicycle Master Plan update. That plan - which will double the city's bicycle network during the next 20 years - was approved by the City Council.

G. Frame public health messages and healthy built environment solutions in ways that promote shared community values and achieve mutual benefit among partners.

Public health's commitment to healthy and vibrant communities is shared by planners, who want to design places where communities can thrive. This shared value offers an opportunity to partner together to look at communities holistically. LHDs have found that they also need to consider the impact of built environment interventions on other powerful and influential sectors at the local level if they are to be perceived as a legitimate partner. In many LHDs, the business or development communities are key players.

Orange County Health Care Agency (OCHCA) has become conversant in linking economic benefits that are important to city and county officials with those important to health. OCHCA recognized early on the need to consider the impact on the business community of their recommendations around the built environment. For example, it was important for them to be in sync with Orange County's Metropolitan Planning Organization (MPO) plan priorities, to avoid recommending proposals that might lead to loss of local funds such as Measure M dollars. To avoid potential conflicts such as this, when they are asked to comment on regional planning documents and proposals, OCHCA sends their recommendations first to the County Planning Department for review and inclusion with the County Planning Department's comments. This gives the OCHCA greater credibility as a collaborative partner. Amy Buch, division manager, explained "We had to learn how to craft our messages carefully and knit our recommendations together so we didn't set up cities, the county and communities against each other. We needed to create mutually beneficial opportunities for all."

H. Tailor approaches to respond to local context, particularly in rural jurisdictions.

California's rural communities have very different built environment design issues than more urban or suburban areas. Residents of rural communities value the wilderness settings they live in, and can see the work of public health as a threat to that way of life. Built environment interventions that focus on complete street

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designs, pedestrian sidewalks and bike paths, and plans to eliminate food deserts are not always relevant or desirable in these areas.

Lake County Public Health Department (LCPHD) has found that walkable community and complete street designs are irrelevant in a jurisdiction that is trying to get paved streets wide enough for two-way traffic and where sidewalks are seen as destroying the environment that residents treasure. Parent concerns about mountain lions, bears, and unleashed dogs wandering near where kids wait for buses take precedence over SRTS concerns found elsewhere. Nonetheless, as the Lake County Area Planning Council was developing its Regional Blueprint 2030¹⁴ for planning communities, open spaces, and transportation and population centers, they invited the HO to participate in the early phases. She offered a public health perspective that resulted in a plan that included active transportation elements to help residents get to distant services.

5. DISCUSSION: LHD CAPACITY BUILDING NEEDS

The environmental scan identified current activities, challenges and opportunities for public health to inform planning, and the support needed to help LHDs effectively engage with planners. While advances are being made to engage planners around healthy community designs and land use planning, major gaps in LHD capacity, knowledge, and relationships need to be addressed.

LHD skills building may be considered in the following key areas:

- A. Knowledge:** Gain better understanding of: planner language, processes, responsibilities, and authority/mandates; planner data, metrics, and measures; and, how to use epidemiology more effectively to monitor trends, identify needs, and evaluate programs, particularly in sparsely populated rural communities.
- B. Communication skills:** Learn how to effectively frame the need for healthy built environments in ways that will promote shared values and concerns.
- C. Networking:** Engage in more regular discussions with planners to identify new partnership prospects and possible collaborative funding. Explore non-traditional sources for funding, such as Cap and Trade (see Institute for Local Government site¹⁵) and Active Transportation Planning grants, which LHDs may be able to tap into.

¹⁴ <http://www.lakeapc.org/docs/Final%20Blueprint%202030-Phase%20III.pdf>

¹⁵ <http://www.ca-ilg.org/cap-and-trade-resource-center>

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D. Peer learning exchange: Share concrete examples among LHDs of: evidence-based models/approaches for incorporating health into planning; how LHDs demonstrate the value and contribution of public health; and, how to incorporate health in planning into local community health improvement plans/accreditation efforts.

E. Accessing non-traditional data resources: Learn about and gain access to data collected by other sectors that is relevant to public health.

6. RECOMMENDATIONS FOR ACTION

CDPLP conducted this environmental scan to inform CDPH and CDPLP's decisions about priority areas to work on to increase LHD capacity in the next two years.

CDPH Role in Partnership with LHDs

The state-local health department partnership can continue to be an important resource to support LHDs to effectively engage with local planning. Several examples illustrate the potential for the State to support this work. Efforts by CDPH's HiAP and SACB staff to encourage Caltrans to include language requiring participation with LHDs in Round Two ATP funding led to many city and county agencies engaging their LHDs, lending tremendous legitimacy to their role. In addition, CDPH SACB continues to provide specialized technical assistance to LHDs to help ensure that ATP applicants and awardees have access to public health expertise. The California Tobacco Control Program's Healthy Stores for a Healthy Community (collaboration between tobacco, nutrition and alcohol programs) is giving LHDs flexibility to use that funding to integrate work in these areas.¹⁶ Also, CDPH has produced key tools such as its Healthy Communities Data and Indicators and provided technical assistance to LHDs through programs like the Community Health Indicators Project.¹⁷

CDPH, in partnership with LHDs, can continue to encourage and advance this work in the following ways:

A. Support LHD efforts to leverage and blend funding streams at the local level. CDPH could help convene state funders and LHDs that are experienced with balancing categorical grant requirements with more comprehensive efforts, to discuss how the State can support this approach. California's experience with Emergency Services programs could be a model for how LHDs leveraged emergency preparedness funding to increase overall public health capacity through mass immunization exercises.

¹⁶ County and regional healthy community data is available at <http://www.healthystoreshealthycommunity.com/>

¹⁷ <http://www.cdph.ca.gov/programs/pages/healthycommunityindicators.aspx>

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- B. Continue to develop and share tools in areas where the State has expertise.** LHDs may lack expertise in certain areas, such as epidemiology, and need help to adapt tools and approaches. Rural health departments, in particular, often lack this expertise.
- C. Support LHDs around their data needs.** CDPH can promote improved access to local community health data, help identify what exists in other sectors that could be accessed, and assist rural communities with ways to adapt epidemiology tools to monitor trends, identify needs and evaluate programs in their communities.
- D. Promote cross-sector communication, collaboration and partnerships with other State entities.** CDPH can help to legitimize the role of LHDs in community design and land use planning for healthy built environments
- E. Share information about opportunities to give input into state-level planning that has local implications.** This includes opportunities in the emerging areas of affordable housing, school district master planning, and climate change. The CDPH Office of Health Equity and the HiAP program staff can play a critical role here, especially in identifying opportunities to inform housing and equity issues.

CDPLP Role in Partnership with LHDs

With partial funding from CDPH, CDPLP will host a regional workshop for LHDs in Central California in September 2015 on using upstream, policy, systems, and environmental change approaches to incorporating health in planning and policy work. CDPLP also will organize at least one regional convening of LHDs and their planning counterparts to follow up on the issues identified in this report. It will also seek additional funding to develop and conduct training and offer technical support and networking in the remaining capacity-building areas outlined above, including working with rural LHDs to support their unique needs and concerns.

7. CONCLUSION

California LHDs have made significant strides in working with planners, but many challenges still exist. Lessons learned provide a foundation and a direction for incorporating public health considerations into future planning at the local, regional, and state levels. LHDs need to expand networking opportunities with other sectors and engage in peer-learning exchanges on promising practices. State and regional leaders need to work with local jurisdictions to create a coherent, cohesive approach statewide that will support local interests and concerns. CDPH can play a critical role in helping to

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support and disseminate promising approaches that link planning and public health. CDPH programs such as SACB and HiAP are critical to strengthen communication and partnerships with other State entities, and introduce public health into community design and land use planning processes at the state level.

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8. APPENDICES- available upon request

A. Acknowledgements

B. Contributing Partners

C. Electronic Survey Instrument

D. Electronic Survey Findings

E. Key Informant Interview Protocol

F. Key Informant Interview Findings

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APPENDIX A: ACKNOWLEDGMENTS

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