

Denver Healthy People 2010: Analysis of Perceived Progress

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Executive Summary

As the number of preventable deaths in America continues to rise, there has been a growing rate of community health initiatives across the country. In 2001, the Denver Department of Environmental Health created a program called Denver Healthy People (DHP) to encourage community health promotion. Over 100 organizations in the Denver area collaborated to create a set of six DHP 2010 recommendations for improving the health of the residents of Denver. Eight years have passed since the recommendations were created and DHP needs to evaluate the perceived progress of the recommendations by health leaders in the community. This analysis of perceived progress will be used to revise the recommendations for the next decade.

To gather input on the perceived progress, data were collected by a survey administered to approximately 250 individuals on the DHP mailing list, with a total of 48 respondents. This survey evaluated the importance and progress of the recommendations over the past eight years and collected suggestions for revisions. Overall, the majorities of respondents view the recommendations as being very important to the community and indicate the recommendations as having made some progress. However, many participants expressed the need for improvement. As the recommendations are revised for the next decade, the focus must shift from creating awareness in the community to creating behavior changes. The health leaders in the community are ready to focus on implementation. The revised recommendations should include measurable and clear cut objectives, provide strategies, and be more specific. Furthermore, the new recommendations should include analysis to evaluate current efforts.

In the United States, we spend \$2.4 trillion a year in medical care expenses, yet we continue to have much higher rates of preventable deaths than other industrialized countries that spend far less on medical care (Connolly, 2009). Researchers at the Harvard School of Public Health (2009) found that smoking is responsible for 467,000 premature deaths each year, high blood pressure for 395,000, and being overweight for 216,000. As the number of preventable deaths in the United States continues to rise, the field of community health has emerged, shifting from a focus on individual lifestyle changes to the social and environmental determinants of health. Over the past decade, state and local governments across the nation have started a movement towards building healthy communities using system approaches. By using a systems approach to public health, we can use techniques from a range of sources while generating a flexible and responsive approach (Midgley, 2006).

Initially, leaders in public health focused on changes in individual behaviors to improve the health of the community, but identifying a single threat was no longer sufficient to address the complex factors underlying the rise in chronic disease burden and deaths (Navarro et. al, 2007). The social and environmental determinants of health are wide ranging and involve numerous stakeholders in the community. To name a few examples, the Denver City Departments influence health by determining where to develop and sustain parks, green spaces, and sidewalks. Access to these resources increases an individual's opportunity for physical activity. The location of grocery stores or markets determines an individual's access to fresh produce, while the location of convenience stores and fast food often determine an individual's access to junk food. The safety of a neighborhood may influence an individual's decision to walk or ride their bike as opposed to driving. The school district children attend may influence the amount of health and sex education they receive which will impact their decisions lifelong.

Income disparities strongly prevent individuals from seeking health care and healthy food.

Employers play a role in the occupational health and safety of their employees. The list could go on and on. The challenges leaders in community health face are how to effectively involve all of these stakeholders, how to implement community wide initiatives, and how to measure the progress of these initiatives.

In 2001, an effort to unite leaders in community health promotion locally began in Denver with the development of Denver Healthy People (DHP). The organization started as an effort to recognize methods that would make the city a healthier place for all. Working with over 100 other organizations interested in health promotion, a set of key recommendations for creating a system to support community well-being were developed. In short, these recommendations included collaborating, data collecting, educating leaders and the public, increasing financial resources, using multi-dimensional health promotion efforts, and addressing root causes (see Appendix B). The recommendations were created as part of the Denver Healthy People 2010 Strategic Plan that established a model to successfully implement health promotion. Now that we have entered 2010, the client needs to evaluate where these recommendations stand with those familiar with DHP 2010. In other words, the client wants to learn how people think the revisions should be revised, updated, or expanded for the next decade. Currently, no data exist on the progress of the recommendations.

Statement of Purpose

The purpose of this project is to conduct an analysis of the perceived progress in using these recommendations to impact community health during the past eight years by individuals familiar with the DHP 2010 initiative. The goal is to learn to what extent individuals feel

progress has been made or where progress is lacking in regard to the recommended ways of creating a system to support community well-being. This information will be collected through a survey and follow-up questions with key informants. The survey is designed to identify the strengths and weaknesses of each recommendation. The results of this survey and information collected through follow-up questions will be used to inform how the recommendations need to be revised for Denver Healthy People 2020. The project will also be helpful to DHP by drawing individuals back to the earlier health promotion efforts emphasized in 2002 and refocusing the community's attention again to the recommendations. This analysis of perceived progress of DHP 2010 recommendations intends to answer the following key questions:

- ❖ **According to key informants, how much progress has been made on each recommendation?**
- ❖ **To what extent have the recommendations resulted in creating a system to support and improve community well being over the past eight years?**
- ❖ **Should the recommendations stay the same? How should the recommendations be revised?**

Denver Healthy People (DHP)

DHP was created in response to the State of The City Address by Mayor Webb in 2000. In that address, Mayor Webb stated he wanted Denver to be the healthiest city in America. In order to advance this goal, shared by the community, the Denver Department of Environmental Health, the Board of Environmental Health, and Councilwoman Debbie Ortega, chair of the City Council's health committee, launched the DHP 2010 initiative (McConlogue, 2002). DHP 2010 was inspired by the national Healthy People 2010 planning process which sets the health promotion and disease prevention agenda for the nation by providing health promotion goals, objectives, and benchmarks each decade. In 2003, DHP joined with community partners to

develop a Strategic Action Plan and to guide coalition activities. These partners included nonprofits, schools, libraries, hospitals, businesses, local government agencies, media, faith-based charities, and a variety of other organizations. Currently, DHP has two full time employees and one part time employee. The full time employees include a Program Manager for DHP2010 and a Healthy Eating Active Living Program Administrator. The part time employee is an Education Assistant. The employees are primarily funded through grants, with a .5FTE as the portion contributed from the Denver City general fund.

Review of Literature

For the first time in history, the children of Generation Y are expected to live shorter lives than their parents (National Institute of Medicine, 2009). An alarming epidemiological transition is occurring in developing countries leading to the modern rise in obesity, heart disease, type 2 diabetes, autoimmune disorders, and certain types of cancers, which is anticipated to decrease the life expectancy for future generations (Gohlke & Portier, 2007). Treating the symptoms of these diseases is no longer sufficient, as leaders in community health must begin to address the root causes of these frightening statistics. We must start a movement now to move beyond a focus on access, quality, and cost of healthcare to a broader vision of building healthy communities (McBeth & Weydt, 2006). Over the past decade, the concept and importance of community health promotion has gained support in cities and states across the nation. As this new movement develops, research on system wide approaches to promoting community health is emerging. Currently, a number of methods for creating healthy communities at both the state and local level are being discussed in the academic world. In this section, discussion will consist of the reoccurring themes in the literature on system approaches to community health which

include training, collaboration, citizen participation, boundaries, and funding. In addition, tools and strategies for building healthy communities will be identified and evaluated.

Training

Currently, a large proportion of the public health workforce lacks the knowledge, skills, and tools necessary to implement community health promotion approaches. The task of creating healthy communities entails people in agencies, organizations, and communities working and relating in new ways (Lee, Fuccillo, & Wolff, 2000). Additionally, the non-public health workforce lacks the knowledge, skills and tools for collaborative action for health promotion at the community level. For this reason, the National Expert Panel on Community Health Promotion recommends supporting proper training and capacity building (Navarro, Voetsch, Liburd, Giles, & Collins, 2007).

Attention must be paid to the new skills that are required of citizens, while making the training easily accessible to people who want to receive it (Lee et al, 2000). Lee and colleagues (2000) advise training programs which develop efforts to sustain local leaders and develop new leadership, build capacity to work effectively with the media, to organize and mobilize grassroots, and to identify measureable benchmarks.

Collaboration

Best and colleagues (2003) agree with other scholars in the field that partnering is essential for establishing and sustaining a collaborative health promotion community. They recommend three elements for creating partnerships: 1) collaboration among health researchers representing different disciplines; 2) collaboration between health researchers from multiple disciplines and community practitioners representing diverse professional fields, and 3)

collaboration among community health organizations across local, state, national, and international levels (Best, Daniels, Green, Leischow, Holmes, & Beuchholz, 2003).

Although DHP is a local effort to promote health at the community level, several projects are funded by the state. Collaboration at the state level has become increasingly important in creating healthy communities. Over the past five to ten years, many states have begun to develop confederations or networks including partnerships with public health agencies, hospital associations, municipal associations, foundations, Area Health Education Centers (AHECs), citizen coalitions, and conversion foundations. There are many reasons state-level organizations and agencies should be involved such as laws, resources, policies, and modeling. The new movement of healthy communities emphasizes that no one sector alone can or should put forward this movement, making the actions at the state level even more important. States can further the health initiative by supporting and encouraging regional meetings where communities can come together to share data and experiences (Lee et al, 2000).

Citizen Participation

To increase the chances of success in improving wellness, strategies should be included that reach out to people in their homes and communities and support the integration of healthy habits into everyday life (Nolan, 2006). Citizens must engage in outlining community improvements, envisioning the future, setting priorities and creating the political will to drive the movement forward (Lee et al, 2000). According to Lee and colleagues (2000), top-down efforts do not work; bottom-up is where the movement begins. On the contrary, Nolan (2006) believes state governors should play a role in initiating the movement. State governors can influence communities locally by urging businesses to engage in healthy practices (Nolan, 2006). Aside from the public sector, governors can partner with the private sector or faith-based organizations

to expand the target audience and increase public participation, as many underserved populations rely on churches and community groups for lifestyle directions and educational information (Nolan, 2006). When governors work through state agencies, who partner with local organizations and community leaders, they provide consistent health messaging and are able to reach children, teens, adults, and seniors (Nolan, 2006).

A key element to building healthy communities is creating explicit opportunities for individual communities, especially neighborhoods, to come together in forums where they can develop community values and plan for the future (Lee et al, 2000). A major advantage of engaging in a healthy community initiative is the civic infrastructure that is created and used to establish communication between policy makers and the community (Adams, 2000). Research suggests districts that have successfully implemented initiatives to improve the health of their communities have used strategies that include a broad definition of health, broad public participation, consensus building, and open dialogue among parties to encourage policy change (Adams, 2000).

Although getting the community to participate can be a difficult, slow, and messy process, the problem does not lie in a lack of interest, but rather how communities are engaged (Lee et al, 2000). Community-building is not self-initiating and it must be intentional (Lee et al, 2000).

Boundaries

Best and colleagues (2003) recommend creating common ground among key stakeholders through the identification of the boundaries of the problem, making sure the boundaries are broad enough to incorporate certain dimensions of the problem but narrow enough to allow effective intervention. Midgely (2006) is concerned about initiatives with over

extending boundaries that are set as wide as possible to include a large number of stakeholder values and concerns. The goal may then become impossible to achieve and people will become disillusioned. Rational boundaries are set when all parties involved and affected by an intervention agree upon the boundaries verbally and stakeholders are included in decision making (Midgley, 2006).

Aside from establishing the boundaries of the problem, stakeholders must also establish the boundaries of the target population. The current focus on public health is particularly concerned with addressing disadvantaged and socially excluded populations; in order to properly serve these populations, we must challenge marginalization (Midgley, 2006). Marginalization occurs when a group is excluded from decision making processes within society and their needs or desires are ignored. Both stakeholders and issues can easily become marginalized and a conscious effort must be made to combat this problem.

Funding

For a community or state to implement a systems approach to health, funding is a necessity and often times can prove to be the biggest barrier. In order to obtain funding, people want to see results. For this reason, funding and measuring impacts of community health initiatives are very closely related. In a world that demands evidence of health impact and return on investment, the challenge leaders in public health are facing is to prove the significant role of long-term community health promotion in addressing social and environmental determinants of health (Navarro et al, 2007). Progress must be measured through community health indicators rather than merely rates or statistics to create confidence in the system. Community health indicators provide a more accurate description of the community's health status, raise awareness about the way departments' interactions determine the quality of life, and encourage cross-

departmental collaboration (Mischkovsky, 2010). Examples of community health indicators include: per capita consumption of tobacco products, pregnancy rate for females age 15-19, number of alcohol or drug related emergency room episodes, etc. It is important for community health initiatives to have specified targets or priority populations in which they intend to measure the impacts and surveillance mechanisms in place to monitor those impacts (Best et al, 2003). By enhancing the surveillance of social indicators, public health leaders can facilitate the development, implementation, and evaluation of health policies and public health interventions (Navarro et al, 2007).

Stakeholders must stop separating health issues from governance and begin to address health holistically by identifying policy gaps and opportunities for collaboration-- and cost savings-- among departments (Mischkovsky, 2010). Overall, funding can be increased through collaboration at all levels-local, state, and national. To fully address the complexity of public health and to prevent wasteful spending, local governments must tackle the problems directly, with a comprehensive, multidisciplinary, and prevention-oriented approach (Mischkovsky, 2010). The state funding streams must be remodeled to encourage, support, and reinforce collaboration, in addition to mandating collaboration at the local level (Lee et al, 2000). At the federal level, the National Expert Panel on Community Health Promotion recommended the Centers for Disease Control and Prevention facilitate greater collaboration and coordination among federal agencies to maximize the impact of federal resources dedicated to community health promotion (Navarro et al, 2007). Funding must be tailored to the realities of community health to combat the burdens that prevent health improvements in the community like short time frames to demonstrate impact, limited funding, and restrictions on flexibility needed to address changing circumstances (Navarro et al, 2007).

Funding also plays a significant role in guiding research and must be redirected to focus on community health promotion and prevention. Gohlke and Portier (2007) give several reasons why the research community is very productive in medical areas focused on therapeutic solutions for individuals rather than research identifying preventative measures. First of all, the National Institutes of Health (NIH) awards over 50% of their grants to principle investigators at medical schools, compared to only 2% of grants awarded to principle investigators at schools of public health (Gohlke & Portier, 2007). Additionally, financial incentives from industries drive the most cited medical research which is largely impacted by market forces (Gohlke & Portier, 2007). According to Best and colleagues (2003), many health promotion programs neglect environmental underpinnings of health behavior because they are based on a narrowly conceived conceptual model or lack any kind of theoretical foundation. The gap between health promotion research and practice can be attributed to a number of factors, including the initial increase in work and time needed for researchers and health professionals to collaborate, and the tendency for both parties to remain in their comfort zone of the same workplace, clients, and strategies (Best et al, 2003).

Tools and Strategies for Building Healthy Communities

When designing an intervention to improve public health, Midgely (2006) advocates for drawing from a number of methods by learning from other initiatives and combining methodologies because no one method can meet all the needs of the community. If stakeholders can look to others when developing strategies, they will begin to view methodology as dynamic and evolving. The more methods being used, the more flexible and responsive systems practices will become (Midgley, 2006).

An easy and effective strategy for building healthy communities is recognition. Statewide healthy communities are built through recognizing, honoring, rewarding, and celebrating exemplary local and regional efforts that encourage and sustain efforts (Lee et al, 2000). Many states hold conferences to reinforce efforts and these conferences also act as vehicles for networking among communities and disseminating best practices (Lee et al, 2000). Award programs for individuals, communities, and projects are another good source of positive energy, motivation, and encouragement.

A tool that is being used more and more all the time in creating community health initiatives is Health Impact Assessments (HIA). HIAs are used in communities to devise an initial projection of the public health impacts new policies or projects will create (Mischkovsky, 2010). HIAs have other benefits including the ability to identify long-term health impacts on socially excluded populations and the ability to increase public participation in the land use planning process. In the past two decades, 56 HIAs have been completed across the country, according to the Centers for Disease Control and Prevention. HIAs allow organizations to identify which areas of health are most important to the public because the public participation is broad based (Mischkovsky, 2010).

The final tool for creating healthy communities to be discussed is web-based tools. In order to achieve community goals, strategies must be developed to manage change, network with community builders, prepare leaders for new roles, and to use the latest innovations in information technology (McBeth & Weydt, 2006). To further community health promotion, web-based platforms should be developed to share expertise and knowledge through data, communication tools, evidence-based research, training, and an open forum (Navarro et. al, 2007). Six attributes are necessary for web-based tools to be a resource for community work:

comprehensive content, information readily available on demand, information the reader can apply in practice, the tone of the content must be friendly and supportive, forums or exchange mechanisms must be included, and the resource should help reduce inequalities (Fawcett, Francisco, Schultz, Berkowitz, Wolff, & Nagy, 2000). Additionally, Fawcett and colleagues (2000) believe six phases should guide the framework for the core content in a web-based resource: understanding the community context, collaborative planning, developing leadership and enhancing participation, community action and intervention, evaluation community initiatives, and promoting and sustaining the initiative.

Methodology

The quantitative data was collected by a survey, created online using Survey Monkey (www.surveymonkey.com), consisting of 25 questions divided into three sections. The initial section of the survey is described as background questions that will identify the participants' familiarity with the recommendations. The second section of the survey asks questions that pertain to each recommendation individually. The participant will answer three identical questions for each of the recommendations, in addition, to an optional open-ended question. The final section of the survey gathers additional information on the participant (i.e. career field, sector in which they are employed, residency) and their opinion on the recommendations as a whole in an open-ended manner. To develop the survey questions, concepts and materials from PAD 5003, "Research and Analytic Methods", were utilized. A pilot test of the survey was administered to fellow graduate students with background knowledge in designing surveys to ensure feasibility.

One week prior to administering the survey, a brief announcement was administered via email to survey participants to let them know, in advance, the purpose and importance of the survey. The email also included the recommendations made by DHP 2010 and a link to more in-depth report of the findings by DHP 2010, which was published at the time the recommendations were made in 2002. The purpose of forewarning the participants of the survey was to refresh their memories and get them thinking about the recommendations, while familiarizing them with the project.

The following week, the survey was administered via email to approximately 250 participants, with a goal of obtaining 50 responses. The participants consist of individuals who were initially involved in 2002 when the recommendations were made, individuals who have become involved over the past eight years, and others who have become interested in the work DHP is doing and have asked to be on the emailing list. The participants were given 10 days to complete the survey. Two reminders were sent electronically prior to the deadline to remind and encourage participation. Once the deadline had passed, an analysis of the data was conducted.

The client has looked over the emailing list to identify 23 key informants. These individuals are very involved with the organization or are very familiar with the recommendations. An additional email to the survey containing only two open-ended questions was sent to these key informants in an attempt to obtain more detailed feedback on the recommendations.

Results

Out of the 248 contacts on the healthy people mailing list, emails were returned as undeliverable from 7. So, the survey was received by 241 contacts. 48 people responded to the

survey, for a response rate of 20%. The goal was to obtain 50 responses, so the number of respondents is about what my client expected.

The question regarding the residency of the respondents resulted in a response rate of 75%, with 12 people failing to answer or skipping the question. Two-thirds of the respondents indicated they were residents of the City and County of Denver and one-third of the respondents indicated they were not residents of the City and County of Denver.

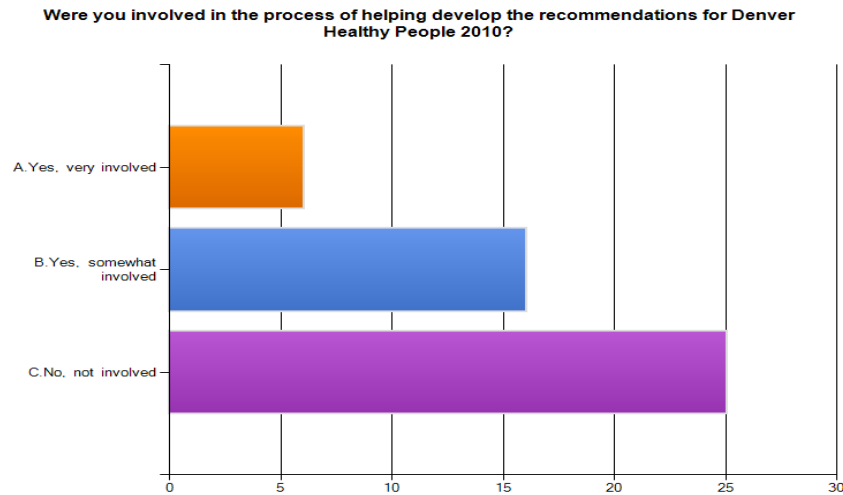
The 48 respondents came from a variety of sectors and career fields. The majority of participants work for the government, followed by the non-profit sector, other, and for-profit sector. A little more than half of the respondents work in public health or health services. About one-third of the respondents selected “other” as their career field which included the following responses: business, policy analysis, advocacy, transportation, urban agriculture and education, consulting, public health communications, legislative government, library, and early childhood system building. The remaining participants selected education and human services as their career field. Table 1 displays the characteristics of the sample.

Table 1: Characteristics of Sample (n=48)		
Work	Percentage	Number
Public Health/Health Services	55.6%	20
Education	13.9%	5
Human Services	2.8%	1
Philanthropy	5.6%	2
Other	30.6%	1
Missing or failed to respond	33.3%	12
Sector of Employment	Percentage	Number
Government	52.9%	18
For-Profit Sector	8.8%	3
Private Non-Profit Sector	26.5%	9
Other	20.6%	7
Missing or failed to respond	41.2%	14

Involvement and Familiarity with DHP

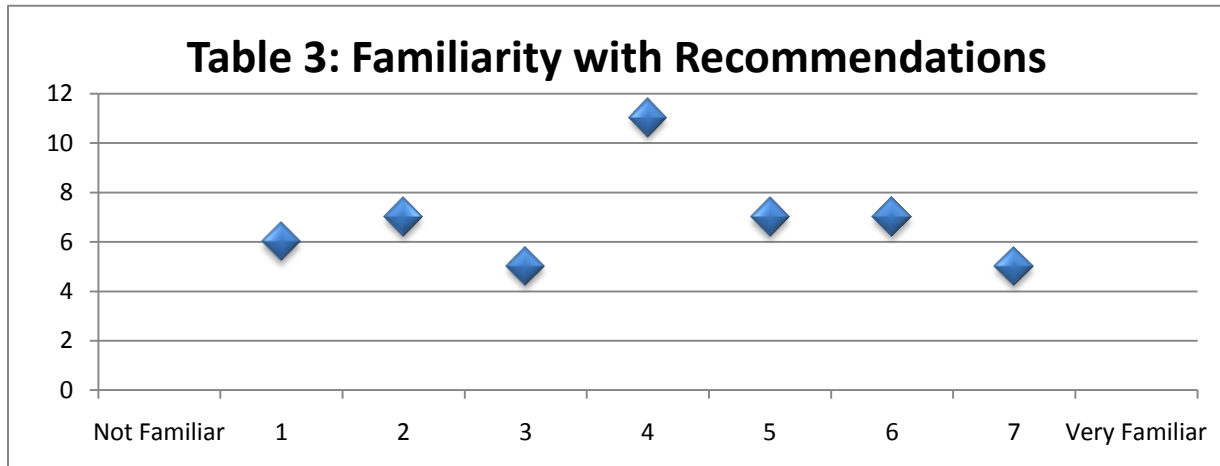
When the respondents were asked about their involvement in the process of developing the recommendations, the majority indicated they were not involved, some indicated they were somewhat involved, and few said they were very involved. Overall, most of the respondents were not knowledgeable on the process of the development of the recommendations. See Table 2 below.

Table 2



The participants were then asked about their familiarity of the DHP recommendations. The question asked them to indicate their familiarity with the recommendations on a Likert scale with 1 being not familiar and 7 being very familiar. The results can be found below in Table 3. The majority of respondents fell in the middle of the Likert scale, but only a few respondents

considered themselves to be very familiar with the recommendations.

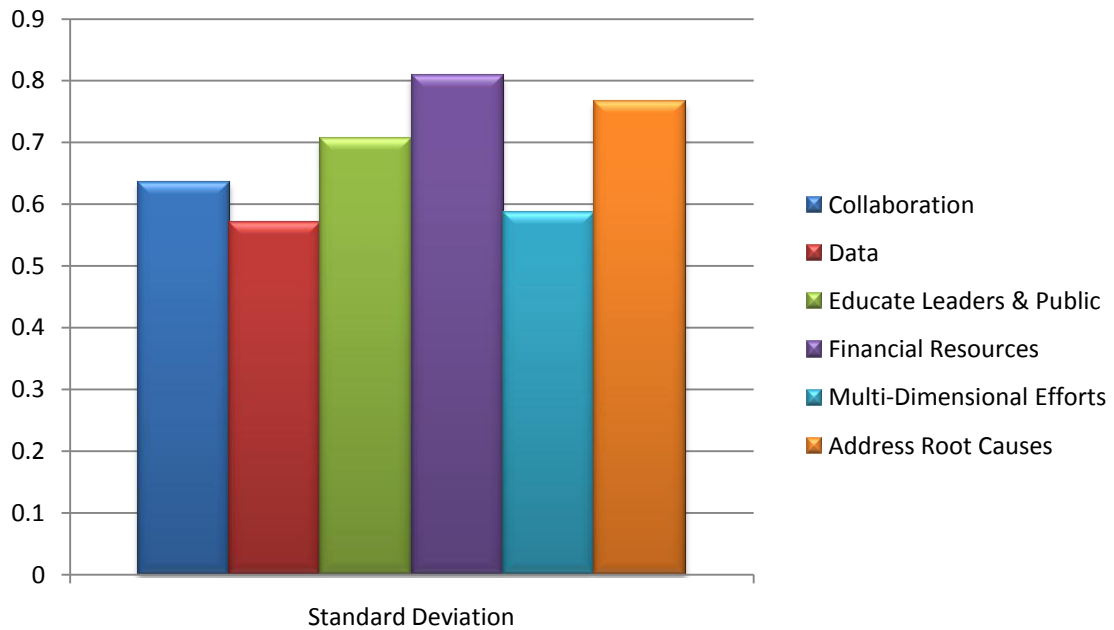
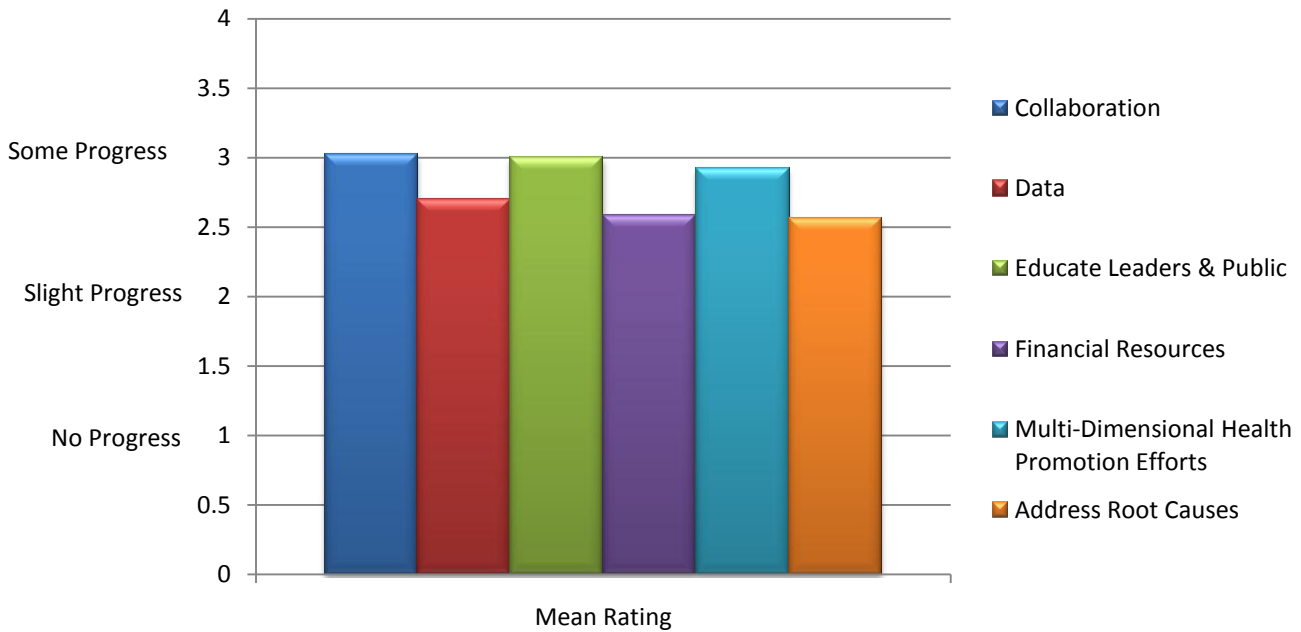


Progress

The first question answered in the survey by participants is, “How much progress has been made on each recommendation?” Each recommendation was evaluated individually in the survey. Table 4 compiles the results to compare the mean rating and standard deviation of the respondents’ perception of progress on recommendations against one another. The means of the recommendations are very similar, with a consensus that all recommendations made more than “slight progress”. The means of *Collaboration* and *Educating Leaders and the Public* made the most progress while the rest of the recommendations fell shortly below the mark for “some progress” but well above “slight progress”. The standard deviation shows how much variation there is from the average of the data set. The standard deviations imply respondents had more differing opinions on *Financial Resources* and *Addressing Root Causes* than they did with *Data* and *Multi-Dimensional Efforts*.

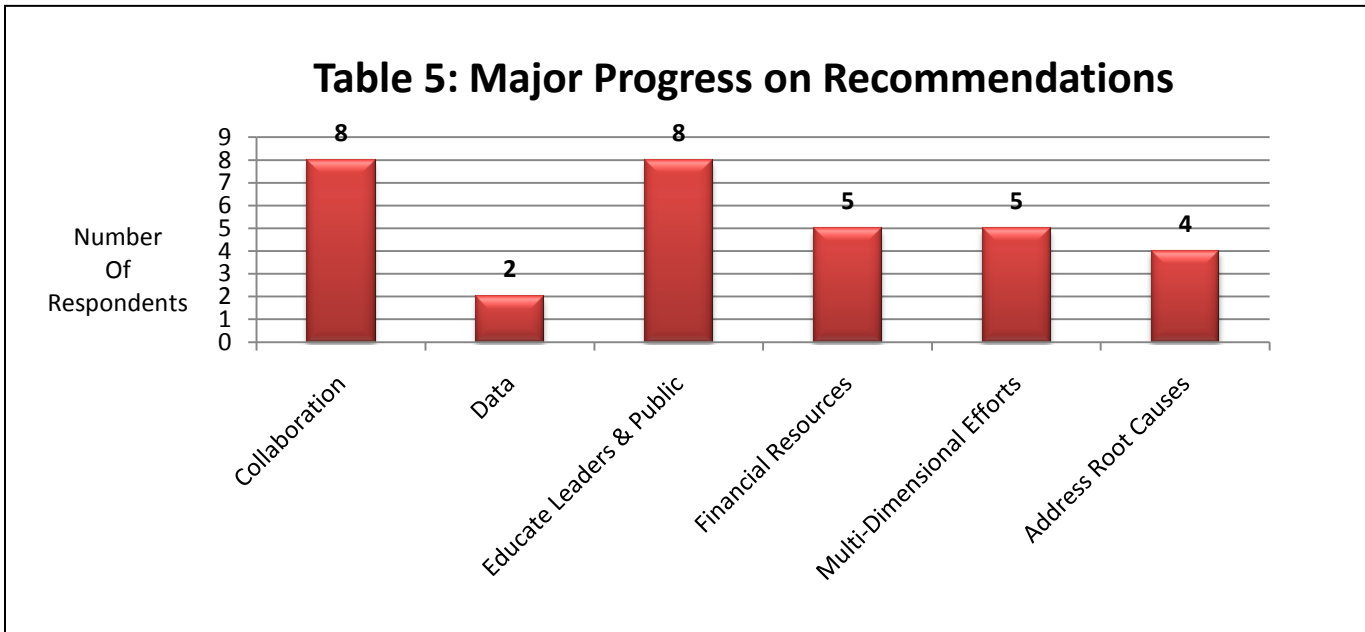
Table 4: How much progress was made from 2002 to 2010?

Major Progress



Overall, most of the participants indicated that “some progress” had been made on the recommendations, except for addressing root causes, where the majority indicated that “slight progress” had been made. Survey respondents indicated the most change had been made over

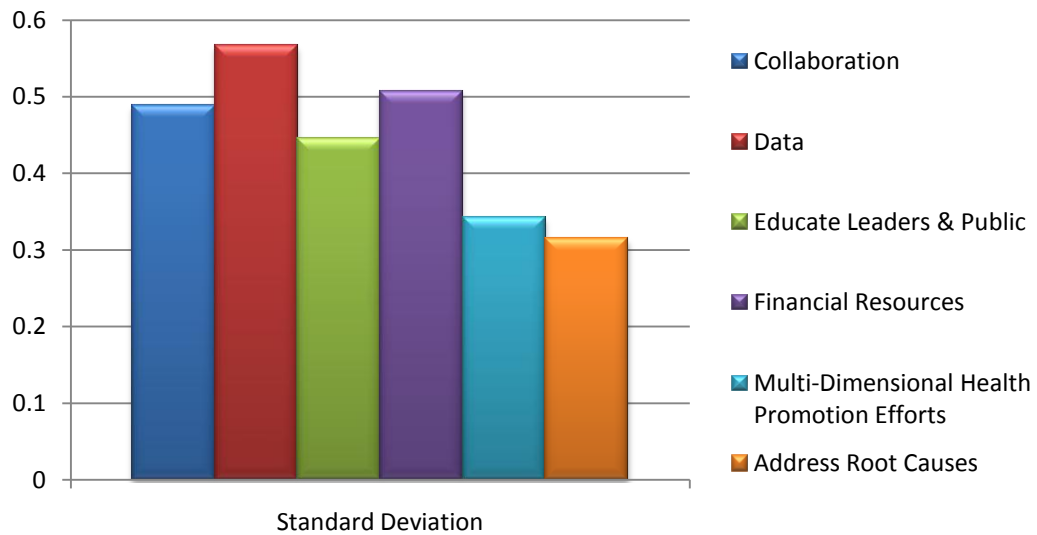
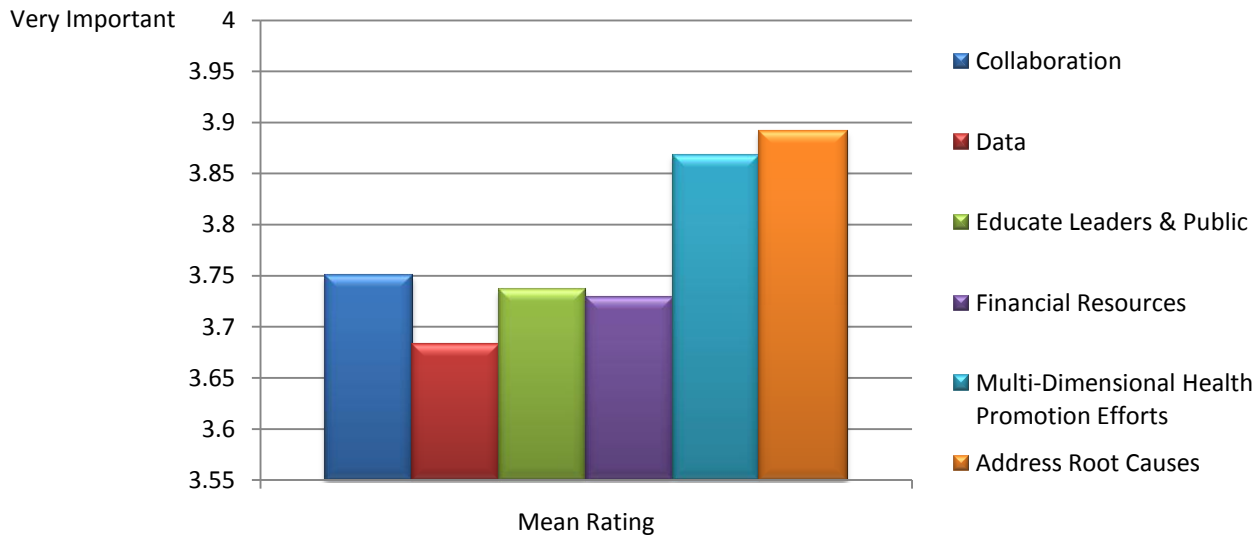
the past eight years in *Educating Leaders & the Public* and *Collaborating*. See the results for the respondents’ perception of major progress on the recommendations below in Table 5.



Importance

The second question answered by the survey is, “How important was this recommendation in moving health promotion forward over the past eight years?” The client wanted to learn how important each recommendation is to those involved with DHP. Table 6 compiles the mean rating and standard deviations of the recommendations in order to compare them in terms of the respondents’ perception of importance. Once again, all of the mean ratings of the recommendations are very similar, indicating the recommendations are perceived as very important. The mean ratings of *Addressing Root Causes* and *Multi-Dimensional Health Promotion Efforts* were the recommendations considered the most important by participants. According to the standard deviation of each of the means, there was more unanimity for *Addressing Root Causes* and *Multi-Dimensional Health Promotion Efforts* while *Data* and *Financial Resources* had more differing opinions.

Table 6: How important was this recommendation in moving health promotion forward over the past eight years?

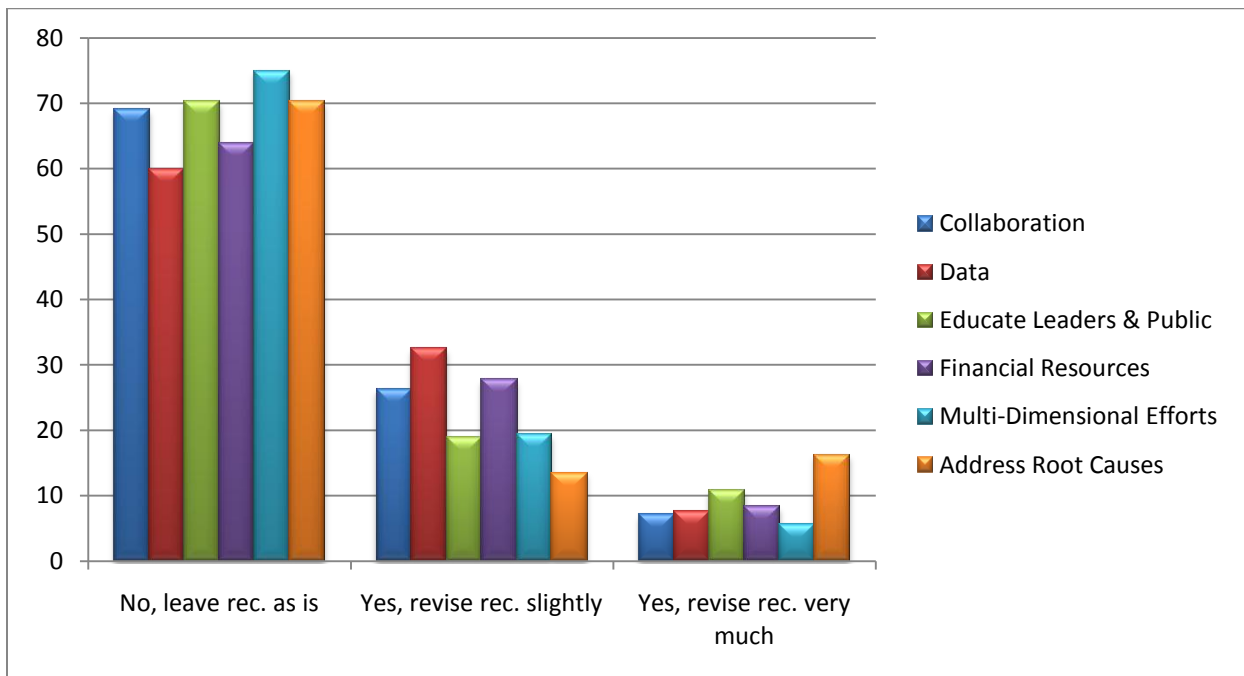


Revising the Recommendations

The final question answered by the survey is, “How should the recommendations be revised or should they stay the same?” The majority of respondents indicated the recommendation should be left as is for all of the recommendations; however, many others indicated the recommendations should be slightly revised. A handful of participants thought the recommendations should be revised very much. No participants selected the choices “yes, drop

the recommendation because it is not useful” or “yes, drop the recommendation because it has been achieved”. The recommendations participants feel need the most revisions include: *Data*, *Financial Resources*, and *Addressing Root Causes*. Many survey participants commented that the data currently exists, it just needs to be organized and made available online to increase access by leaders in the community. A likely explanation as to why financial resources are a concern for respondents is due to the current state of the economy and the recent recession, although health promotion has always been seriously underfunded. Table 7 displays the compiled results regarding the revision of each recommendation.

Table 7: Should this recommendation be changed for the next ten years by Denver Healthy People?



In addition to specifying the degree to which the recommendations should or should not be revised, survey participants were allowed to make suggestions or comments on how they would specifically revise the recommendation. In Table 8, the responses to the open ended questions are separated by recommendation and sorted by common themes.

Table 8: Suggestions for Recommendation Revision

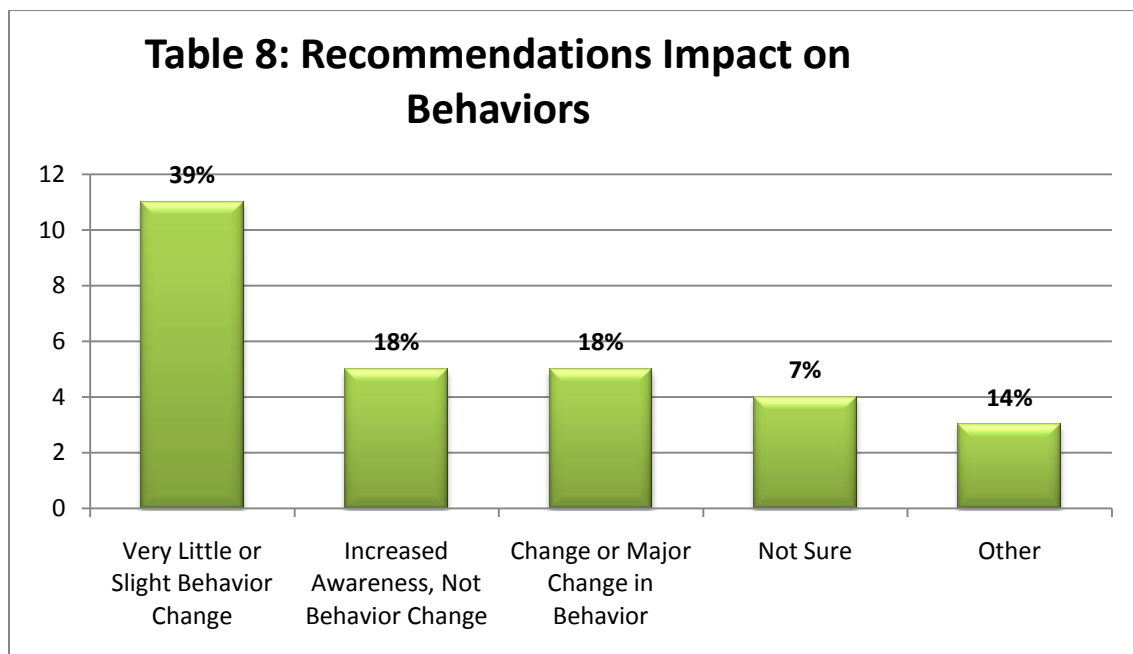
Collaboration		
Suggestion Theme	% of Respondents (n=9)	Narrative Example
Needs to be more specific	33.3%	“Recommendation should lay out some specifics as to how to achieve meaningful collaboration.”
Focus on implementation	33.3%	“Establish actual location and get the program into a tangible state by 2011.”
Change terminology	22.2%	“I would ensure multi-disciplinary in there.”
Other	11.1%	“Get more involvement from the community and have meetings available for working parents either kid friendly or try for a weekend.”
Data		
Suggestion Theme	% of Respondents (n=16)	Narrative Example
Analyze and update data	15.6%	“Recommendation should indicate how often data will be updated/reported (Annual? Bi-annual? Other?) and should clarify how the data will be used to affect city policy/regulations/budgeting.”
Specify sources	15.6%	“List the sources, the contacts at the sources and how you intend to collect the data.”
Set measureable objectives	18.8%	“Tie into work of CORHIO, set measureable objectives.”
Implementation	25.0%	“Much of the data already exists. Instead of building new systems to collect data, more effort should be made towards using existing data, normalizing it, and interpreting it.”
Change terminology	12.5%	“Add “public” before health as people generally think of medical data only when they see “health”.”
Other	12.5%	“I think it is still important to provide more information about where data systems are missing and what information is most important to capture”.
Educate Leaders and the Public		
Suggestion Theme	% of Respondents (n=11)	Narrative Example
Change the focus from “educate” to “engage”	18.2%	“Change the focus from “educate” to “engage leaders in improving public health”. People are often educated, which doesn’t translate into actions or improvement”.

Identify leaders	18.2%	“Identify leaders at various levels relevant for healthy change in Denver (e.g. school district personnel v. teachers).”
Need for clear cut objectives	27.3%	“Add how you intend to educate the public and leaders and define these steps more clearly.”
Need for community meetings	18.2%	“Need for various venues to inform the leaders and the public.”
Include how to direct attention of leaders	18.2%	“Again, there are leaders who aren’t focused on health so how do we include this? Again, quality of life might be a possibility.”
Financial Resources		
Suggestion Theme	% of Respondents (n=12)	Narrative Example
Change terminology	16.7%	“Increase resources, but not limited to financial resources.”
Identify Funding Sources	41.7%	“Identify all existing sources and potential new funding streams in light of changes in health care legislation and new federal dollars.”
Evaluate how funds are being used	16.7%	“Not only increase financial resources, but look at how we are utilizing what we have.”
Other	25.0%	“what are you going to do since increased funding isn’t really a viable option.”
Multi-Dimensional Health Promotion Efforts		
Suggestion Theme	% of Respondents (n=7)	Narrative Example
Change terminology	42.9%	“Possibly change...people’s economic, social and physical environments...to simply people’s environments.”
Evaluate current methods	28.6%	“Identify which kinds of strategies are currently being used to build and what can be expected to improve if strategies are changed”.
Other	28.6%	“Add more focus on ethic requirements, the need changes by racial considerations and especially age, young versus seniors.”
Address Root Causes		
Suggestion Theme	% of Respondents (n=9)	Narrative Examples
Terminology Additions	33.3%	“Add including reducing disparities in income and education.”
Implementation	11.1%	“Healthy People 2010 did a good job raising awareness about issues like HBE, healthy food access, security, disease prevention, etc.

		Healthy People 2020 should retain the existing key topic areas but outline a few specific actions that will be the focus of work for the next 10 years. It is time to move beyond planning to implementation.”
Break down the root causes	33.3%	“Break each root cause into its own recommendation and provide specific ways to address each cause.”
Other	22.2%	“Need to see the grass roots level.”

Looking at the Recommendations as a Whole

When looking at the recommendations as a whole, respondents had a wide range of opinions. Respondents were asked, “Thinking of the recommendations as a whole, how much do you think the recommendations have changed the behaviors and improved the health of people in the community over the past eight years?” The most common response was very little or slight behavior change at 39%. Only 18% indicated the recommendations resulted in change or major change in behavior. The open ended responses to this question have been organized by theme and are found below in Table 8.



Conclusions

The results of the survey revealed there is room for improvement in the DHP recommendations; however, all of the respondents rated the current recommendations to be important to the community. Numerous suggestions have been gathered to take into consideration when revising the recommendations. DHP received a lot of praise from survey participants for their efforts, thus far, in community health promotion.

Most of the participants were not involved or were only somewhat involved in developing the recommendations in 2002. To summarize the opinion of the majority expressed in the survey, they feel “some progress” has been made in all of the recommendations, except for *addressing root causes*. The majority of participants feel the recommendations are “very important” and want the recommendations to stay as they are. A reoccurring theme about the recommendations was that they have increased awareness in the community about health but have not lead to changes in behaviors. Due to the nature of the recommendations, it is more relevant to assess if the behavior of leaders and organizations have changed in terms of the recommendations themselves. There seemed to be confusion regarding health behaviors in the population and the behavior of those the recommendations are designed to influence—the leadership and partners for promoting health. In the future the survey questions should be designed to address this more clearly.

As previously mentioned in the results section, many of the questions regarding information on the participants’ background and career field were skipped over. If I were to design the survey again, I would move these questions to the beginning of the survey. A possible explanation as to why respondents skipped these questions could be the length of the survey, although the survey was intended to be as brief as possible. The additional open-ended

follow-up questions delivered to 23 key informants yielded disappointing results due to the time intensive work needed to follow-up with these informants that was too ambitious for this individual capstone project. Only 3 of the 23 individuals responded, but the information they did provide was helpful. They added that a high priority should be to help facilitate health in all city organizations and policies and that a “collaboration fair” would be helpful so health leaders in the community can develop partnerships with one another. I believe the feedback would have dramatically increased if interviews were arranged with these individuals but unfortunately, the compact timeline was a hindrance. A future capstone project, focusing on qualitative follow-up interviews with key informants, could be designed to expand upon this report. To further study the results of this survey, a chi-square test could be performed to estimate the probability that the associations between variables are a result of random chance or sampling by error.

Most respondents feel the recommendations should stay the same, but I will conclude by summarizing the suggestions for revising the DHP recommendations for the next decade:

- Shift attention from raising awareness to creating strategies
- Include analysis of current health promotion initiatives
- Set clear cut and measurable objectives
- Consider additional recommendations suggested by respondents

When revising the recommendations, attention must be shifted from simply raising awareness in the community about health promotion to creating strategies that will elicit behavioral changes in the community. The revised set of recommendations must transform from broad concepts to include specific, concrete examples. For instance, the recommendation for *educating leaders and the public* must identify both target leaders and strategic methods specifying how to educate. The awareness has been created and people involved with DHP are ready to focus on implementation. The revised recommendations should include strategic planning for the actions being recommended by DHP. Additionally, the new set of recommendations should include

analysis of ongoing health promotion initiatives. People want to know what is currently being done in community health promotion and if the programs are successful in yielding the desired results. Clear cut and measurable objectives should be set for each recommendation. Leaders in health promotion want to see tangible data to evaluate their efforts in the community. Overall, the DHP 2010 recommendations are very well supported by the survey participants and they are identified as important.

In addition to revising the current recommendations, consideration should be given to the suggestions made by respondents for additional recommendations including: increasing the public health workforce, develop partnerships for income and education disparities, increasing program support, provide seed money and training for fledging organizations that have significant potential to positively impact healthy outcomes in the community, develop and support community leaders, and increasing local food systems and urban agriculture. Many of the suggestions from survey participants include the development of an action plan for 2020, but action plans involve many resources that DHP does not possess. Resources must be identified in order to begin working towards implementing an action plan.

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Appendix A: Applicable SPA Courses

Research and Analytic Methods PAD 5003

The concepts and skills I obtained in Research and Analytic Methods, PAD 5003, were crucial to the success of my capstone project. When I designed the survey, I frequently referred back to course materials for guidance. The knowledge I acquired in PAD 5003 allowed me to decipher what kind of questions to ask in the survey, the length and style of the survey, and the appropriate scales to use for each question. Additionally, I applied data analysis techniques used in class to draw conclusions from the data.

Negotiation and Conflict Resolution PAD 5440

The second course information I found beneficial throughout my capstone project was Negotiation and Conflict Resolution, PAD 5440. Throughout the capstone project I worked with a number of people with different backgrounds and ideas. I found it difficult to meet the expectations of both my client and Dr. Fitzpatrick because they both had different needs. The skills I obtained in PAD 5440 allowed me to negotiate with all parties involved to find a balance. For example, the survey was longer than what my client had originally wanted because I used a design Dr. Fitzpatrick recommended. On the other hand, I included some questions in the survey my client insisted on that Dr. Fitzpatrick may have seen as unnecessary. The course material also proved to be beneficial when I was scheduling presentation times with all three readers and another student with the same client who all have very tight schedules.

Appendix B: DHP 2010 Recommendations

- ❖ **Collaboration** – Improve communication, collaboration and synergy among those working to improve the health of Denver, including traditional and nontraditional partners.
- ❖ **Data** – Build better data systems to capture all of Denver’s health data from public and private sources.
- ❖ **Educate Leaders & the Public** – raise awareness among leaders and the public about ways to improve health.
- ❖ **Financial Resources** – Increase financial resources dedicated to health promotion and disease prevention.
- ❖ **Multi-dimensional Health Promotion Efforts** – Use health promotion approaches that address change on multiple fronts including policy, people’s economic, social and physical environments, as well as behavior change.
- ❖ **Address Root Causes** - Address the root causes of poor health, including social, physical, psychological and environmental issues.

Appendix C: Particular Methods for Creating Healthy Communities

The Interactive Planning Method: Creating a systems approach to health involves numerous stakeholders with a variety of interests and backgrounds. A major challenge in collaborating with these stakeholders can be facilitating dialogue. The Interactive Planning method can be great for facilitating dialogue among individuals with different opinions and insights on complex issues (Midgley, 2006). The goal is to involve the stakeholders in creating a vision of the ideal future and developing a plan which is flexible and creative enough to avoid or reconcile any disagreements among participants for the organization to work towards that vision (Midgley, 2006). Interactive Planning focuses on long-term goals for healthy communities in the form of three stages: establishing planning boards, generating desired properties of the organization's products and/or activities, and producing the plan itself (Midgley, 2006).

Soft Systems Methodology: Another major challenge in collaborating with stakeholders is consensus building. Midgley (2006) recommends Soft Systems Methodology for multiagency planning as it provides tools for coming to a consensus when individuals have different perspectives on an issue and it provides useful language to maintain a systemic focus (Midgley, 2006). The Soft Systems Methodology allows individuals to model desirable future human activities by generating issues through ongoing explorations of their perceptions (Midgley, 2006). Participants relate the modeled activities to their perceptions of the current situation to ensure the process is valuable (Midgley, 2006). Through workshops participants go through seven steps: 1) consider the problem situation in an unstructured form, 2) produce a visual representation with pictures and arrows, 3) identify possible "relevant systems" that might be designed to improve the situation and harmonize understandings, 4) produce a map of the interconnected human activities for each relevant system, 5) refer back to the visual representation to check the feasibility of ideas, 6) produce an action plan, and 7) proceed to implementation (Midgley, 2006). These activities may not occur in a linear fashion, as often times participants will have to go back and forward to harmonize the outputs of each step (Midgley, 2006).

Ulrich's Critical Systems Heuristics: Werner Ulrich has devised 12 questions that cover four key areas of concern (motivation, control, expertise, and legitimacy) which he claims can be answered equally proficiently by "ordinary" people with no experience of planning as they can by professionals (Midgley, 2006). The idea is that "ordinary" people with no experience in planning can answer the questions just as well, if not better, than professionals and these questions should be asked prior to implementing a public health initiative to increase the likelihood of success. The questions cut right to the fundamental concerns of people in communities who find themselves on the receiving end of policies and initiatives that they do not support or find irrelevant (Midgley, 2006).

System Dynamics Approach: System Dynamics is a method used by decision makers to foresee scenarios that may occur as a result of a new policy initiative or intervention (Midgley, 2006). The process prepares stakeholders by modeling complex feedback processes and considering possible impacts of changes to the system of concern (Midgley, 2006). System Dynamics can emphasize unanticipated side effects of policy options that may have been overlooked prior to implementation (Midgley, 2006).

Viable Systems Model: In order for an organization to properly address community health issues, it is crucial to have an effective infrastructure in place (Midgley, 2006). The Viable Systems Model focuses on 5 essential functions necessary for an organization to remain viable in a quickly changing and multifaceted environment: operations, coordination, support and control, intelligence, and policymaking (Midgley, 2006). These five functions must establish open lines of communications between one another because each of the functions is equally important (Midgley, 2006). The Viable Systems Model can be used to create a new organization or to diagnose organizational failures within a previously existing organization (Midgley, 2006).

Healthy Development Measurement Tools: Healthy Development Measurement Tools (HDMT) was developed by the city of San Francisco to identify 125 community-level indicators of health to assist local decision makers in evaluating new projects (Mischkovsky, 2010). This tool reflects the priorities of San Francisco but it can be used by other communities who are working towards similar goals.

Alternative HIA: Although, HIAs may be more useful to some communities than others, as they are more important when designing a new or large scale project, rather than routine or smaller projects. Small communities may find it challenging to find the manpower and finances to conduct an HIA, but these small communities often have stronger and more effective communication between departments than large communities, which allows them to address health concerns more easily (Mischkovsky, 2010). Mischkovsky (2010) offers several alternatives for communities that cannot conduct a full HIA, such as updating or expanding health components within environmental impact assessments or conducting “desktop” HIAs which involve a brief investigation of health impacts and incorporate a review of existing knowledge, expertise, and research.

Community Tool Box: Fawcett and colleagues (2000) have developed a web-based resource called the Community Tool Box (CTB) for practical, comprehensive, accessible, and user-friendly information on community building, which both professionals and ordinary citizens can use regularly. The mission of the CTB is to promote community health and development by connecting people, ideas, and resources. The Community Tool Box can be found at <http://ctb.ku.edu/en/>.

Leadership for Healthy Communities Action Strategies Toolkit: Many local governments have turned to the Leadership for Healthy Communities Action Strategies Toolkit for assistance in developing healthy communities. The toolkit provides 10 evidence-based and promising action strategies, numerous policy and program options, tips for getting started, successful local and state examples, and key resources (Mischkovsky, 2010). Additionally, the toolkit acknowledges communities which may be more vulnerable than others and advises policymakers on how to tackle opposition to their efforts (Mischkovsky, 2010).

Appendix D: Examples of Successful Community Health Initiatives

Burlington, Vermont: In Vermont, the city of Burlington has made an effort to mobilize the people in what is known as Burlington's Champlain Initiative (Adams, 2000). The initiative began as an effort to make a positive transition as the city's two major hospitals, the medical school, and a physicians group announced the possibility of a merger. A number of meetings were held to discuss the health of the community among a wide variety of people within the community. The meetings continued and the concerned groups of citizens were very powerful in improving state policies (Adams, 2000).

State of California: One of the most successful and well-known examples of communities influencing policy occurred in the state of California by the California Smoke-Free Cities (CSFC) initiative. The CSFC successfully used funds generated by the tobacco tax to fight the health hazard of second hand smoke and create a movement within the public to demand change (Adams, 2000). CSFC used education and public participation as tools to getting smoke-free city ordinances to pass, in addition to providing training and consultation to local officials (Adams, 2000). The project led to tobacco regulation by getting citizens involved at the local level and encouraging citizens to take control of their own health and quality of life (Adams, 2000). This example proves the profound effects citizen participation can have on a community health initiative.

Lancaster County Pennsylvania: Across the country, the Healthy Communities movement has had important effects on policy development. The success in Lancaster county Pennsylvania can be attributed to the partnership created with the county's five hospitals to involve citizens in improving the healthy and quality of life (Adams, 2000). Prior to the Healthy Communities movement Lancaster County used a Comprehensive Plan which focused on open space, land use issues, and natural resources but the transition to healthy communities began to include societal issues such as education, housing, and cultural opportunities (Adams, 2000). The county has made citizen participation the cornerstone of every planning process to influence public policy in meaningful ways (Adams, 2000).

Mankato, Minnesota: In 1993, the Open Door Health Center (ODHC) was founding in Mankato, Minnesota, as a low-cost health center providing preventative services to uninsured and underserved clients. ODHC is vital to the community health in the region by acting as a safety net for the underserved and providing culturally competent care to the region's diverse population (McBeth and Weydt, 2006). Some of the most frequent barriers to receiving health care for this population include language barriers, costs, facility hours, and transportation (McBeth and Weydt, 2006). If this population of uninsured and underinsured individuals does not receive services, they are likely to seek costly treatment in the emergency departments and it is estimated that ODHC saved local emergency departments \$200,077,067 from September 1, 2003 to August 31, 2004 (McBeth and Weydt, 2006). The ODHC believes relationship-based care reflecting an understanding of the values and beliefs of the client is the key to serving everyone (McBeth and Weydt, 2006). This community based system approach to health care for the underinsured and uninsured takes a proactive approach to preventative care and includes health education and promotion in all of its services (McBeth and Weydt, 2006).

Appendix E: Survey Results: Suggestions for Revising Recommendations

Collaboration- Improve communication, collaboration and synergy among those working to improve the health of Denver, including traditional and nontraditional partners.

- “The recommendation is really broad, which can be good as vision but hard to identify whether and how it was implemented.”
- “Recommendation should lay out some specifics as to how to achieve meaningful collaboration.”
- “Using the term "health" seems too narrow even with specifying traditional and nontraditional partners. Could quality of life capture a broader scope?”
- “Get more involvement from the community and have meetings available to working parents either kid friendly or try for a weekend.”
- “Include strategies that encourage organizational support/guidelines to support collaboration.”
- “The recommendation is fine; it's implementation is what needs to change. There is so much duplication of effort that no organization's left hand knows what another organization's right hand is doing.”
- “Establish actual locations and get the program into a tangible state by 2011”
- “I would ensure multi-disciplinary in there.”
- “The goal needs to be more measurable. It would be great to revise it to include specifics like: identifying specific areas where communication and synergy are not present currently; ways to increase communication; what is hoped to be gained from increasing the collaboration and synergy.”

Data- Build better data systems to capture all of Denver’s health data from public and private sources.

- “This one is really important. I would revise to say something like "Capture and analyze Denver's health data from public and private sources, through better systems and processes." The data capture is just one step, if you don't analyze the data, they are meaningless. And, I don't think we have a prayer of capturing all data, nor do I think we want do. There's a limit beyond which more data are not useful.”
- “Recommendation should indicate how often data will be updated/reported (annual? bi-annual? other?) and should clarify how the data will be used to affect city policy/regulations/budgeting. Data needs to be made available online and it should be reflected in the Plan 2000 Annual Report so that it can impact the City's budget recommendations.”
- “List the sources, the contacts at the sources and how you intend to collate the data.”
- “Tie into work of CORHIO, set measurable objectives”
- “It is a big job to maintain, but an important one. Who is able to dedicate the time and energy? Be sure this is maintained and that the public / health leaders are aware of where to find the great sources, many listed at the Denver Healthy People 2010 website.”
- “Revisions on how data is utilized and translated for community utilization.”

- “Would include in this data systems to evaluate outcomes for various interventions.”
- “Track the impact of Health Care Reform legislation on our indicators.”
- “Again, the implementation is key. Too many organizations believe their vision is the only correct way and disparate systems and software applications result in data chaos.”
- “Much of the data already exists. Instead of building new systems to collect data, more effort should be made towards using existing data, normalizing it, and interpreting it.”
- “add "public" before health as people generally think of medical data only when they see "health"”
- “forget data, look out the window, walk the streets, the demand is there.... not implement it soon”
- “Add some detail regarding exactly what sources/programs etc. data should ideally be gathered from.”
- “define health promotion in terms that are more meaningful to the non-public health person. (often misinterpreted as health education!)”
- “I think it is still important to provide more information about where data systems are missing and what information is most important to capture.”
- “We have relied heavily on data collected by the state through the BRFSS, it would be good to develop other technical capabilities that would allow DEH or both DE/DPH further develop data capabilities to get it down to the the neighborhood level or zip code level capturing not only DPH's patient population but all of the city.”

Educate Leaders & the Public- Raise awareness among leaders and the public about ways to improve health.

- “Change the focus from "educate" to "engage leaders in improving public health". People are often educated, which doesn't translate into actions or improvement.”
- “Add how you intend to educate the public and leaders and define these steps more clearly.”
- “Move beyond raising awareness to identify vocal champions of public health who will spearhead reform and change at the local level. I would also compile a list of all the health advocacy groups and assess their roles/responsibilities. From this assessment, make recommendations about how to improve the effectiveness of these groups and leverage their support for a\various initiatives.”
- “Again, there are leaders who aren't focused on health so how do we include this? Again, quality of life might be a possibility.”
- “Need more community meetings maybe block meetings”
- “I wonder how we could expand on "ways" to improve health on top of the usual activity/nutrition messages. It is time to dig deeper. Many in the general public know what they are "supposed" to do. We need to look at Public Health efforts that actually motivate what people know.”
- “stop spending resources on education, if they are truly leaders in their neighborhoods, they should know the needs of the residents and this is an obvious one”
- “Identify leaders at various levels relevant for healthy change in Denver (e.g., school district personnel v. teachers)”

- “This recommendation needs to have clear-cut objectives in order for it to ever be achieved. As it stands, it is too broad.”
- “Need for various venues to inform leaders and public”
- “This is just a comment, but there needs to be buy-in from the administration so that health becomes a priority.”

Financial Resources- Increase financial resources dedicated to health promotion and disease prevention.

- “Health promotion is a term of art that some sees as a tool to reach the desired end of improving public health. I'd reword to make clear that the goal is to improve public health, rather than increase use of the tool of health promotion.”
- “ID sustainable funding sources for public health projects - especially general fund sources, bond initiatives or special taxing districts.”
- “identify all existing sources and potential new funding streams in light of changes in health care legislation and new federal dollars”
- “Add foundations serving the community and providing in areas of improvement to disburse money to instead of the city trying to take on more”
- “Not only increase financial resources, but look at how we are utilizing what we have.”
- “Recreate health promotion and disease prevention activities in light of shifting resources, e.g. National Health Reform shifts and Expansion via Hosp Provider Fee match.”
- “Do we even know if the current money being spent is having an effect? Very little data analysis is done, therefore, how can we justify increasing money? The key is spending money in the right way, not necessarily spending "more" money -- which sometimes isn't even worth it if it takes more time/effort/money to spend the money than it would if one didn't even have it. Better focus on data analysis is needed.”
- “the only change would be to get more major funders. A program like this could benefit many companies and even save them money in the long run”
- “What are you going to do since increased funding isn't really a viable option?”
- “Need for more business involvement as well as health insurance industry”
- “Increase resources, but not limited to financial resources”
- “Again a comment, the last nine years have been difficult in the city due to budget constraints but even internally in DEH there's been some slight progress in maintaining .50 FTE and allocating a little bit of a budget to health promotion.”

Multi-Dimensional Health Promotion Efforts- Use the health promotion approaches that address change on multiple fronts including policy, people's economic, social and physical environments, as well as behavior change.

- “Again, use plain language rather than the public health practitioner term "health promotion".”
- “Get specific.”

- “When having any type of the classes that promote health - remember the working class - and offer classes in the evening or on the weekend.”
- “Possibly change: .."people’s economic, social and physical environments.." to simply ... "people's environments..."”
- “Don't shy away from system and policy change to improve people health and wellness”
- “add more focus on ethic requirements, the need changes by racial considerations and especially age, young versus seniors”
- “Identify which kinds of strategies are currently being used to build and what can be expected to improve if strategies are changed.”

Address Root Causes- Address the root causes of poor health, including social, physical, psychological and environmental issues.

- “Add the action steps to address these root causes.”
- “Educational (as Colorado tries to overhaul its education system)”
- “Need to see the grass roots level”
- “Healthy People 2010 did a good job raising awareness about issues like HBE, healthy food access/security, disease prevention, etc. Healthy People 2020 should retain the existing key topic areas but outline a few specific actions that will be the focus of the work for the next 10 years. It is time to moving beyond planning to implementation.”
- “I think we have to ask what it means to "address" root causes. I would consider breaking off a smaller segment of root causes and focus on that one thing rather than having such a large overarching goal that will be difficult to see any improvements on.”
- “Reframe health and wellness as social and environmental concern versus just a personal responsibility issue. Reframe poverty as a health issue.”
- “Define some of the root causes that have been identified and opportunities to fix”
- “Add "including reducing disparities in income and education"”
- “Break each root cause into its own recommendation and provide specific ways to address each cause.”

Appendix F: Survey Results: Thinking of the Recommendations as a Whole

Thinking of the recommendations as a whole, how much do you think the recommendations have changed the behaviors and improved the health of people in the community over the past eight years?

1.	They have given people access to options that foster forethought and provide opportunities for change.	Fri, Jun 18, 2010 7:55 AM
2.	I think internally, within the City, there has been a paradigm shift on how we think about health, as staff in the city, have become more aware of the social determinants of health and what are some ways to affect behaviors through the work they do. I also think there have been some positive policy developments that have encouraged greater communications and collaboration within the city. However, I'm not completely sure how these changes within the city have impacted behaviors when evaluating improved health. This is precisely one of the great challenges in public health in demonstrating effectiveness over time because population-based changes take time.	Thu, Jun 17, 2010 9:36 PM
3.	Very little behavior change has occurred. A much greater awareness has occurred though difficult to capture.	Thu, Jun 17, 2010 3:25 PM
4.	Slightly changed	Thu, Jun 17, 2010 12:01 PM
5.	Slight change with increased awareness	Wed, Jun 16, 2010 2:48 PM
6.	Health promotion is recognized as important to maintaining health as going to the doctor;	Wed, Jun 16, 2010 12:45 PM
7.	Recommendations affecting individual community members - less. Recommendations affecting systems that affect community members - more. These recommendations are very broad and overarching - good concept but difficult for others to understand- may be beneficial to add specific examples. The foundation community has been critical in moving this forward...there needs to be some collective visioning to get it moving forward within Denver itself...	Wed, Jun 16, 2010 12:17 PM
8.	We may not have measurable improvement in the health of people in our community, but	Wed, Jun

	I believe awareness of the need for addressing health behaviors and the broad scope of interconnected influences on health is trending up and getting much more attention in the media, throughout the City and in public conversations.	16, 2010 9:56 AM
9.	only a slight change because the solution recommended are too hard for some population to follow possibly due to location to access and/or age	Wed, Jun 16, 2010 8:44 AM
10.	I have no way of knowing the impact of the recommendations	Wed, Jun 16, 2010 8:31 AM
11.	I believe this is a work in progress. Public awareness is important and over-all, people are aware via media etc., of the importance of health and proper choices,	Wed, Jun 16, 2010 7:48 AM
12.	They are good recommendations, but Denver Healthy People is a very small program. The recommendations need to be picked up and championed by larger organizations to help move them forward.	Wed, Jun 16, 2010 6:42 AM
13.	I can't say very much. Some of the data suggests some improvement, but not necessarily different than what's happening on a national scale. So are our efforts making a difference? More thorough analysis is needed.	Mon, Jun 14, 2010 8:22 AM
14.	Very little. I answered these questions not having heard a word in the media about Denver Healthy People, only on what I've seen change in the last 8 years regarding programs/policies that may have been in response to the recommendations via partnerships Denver Healthy People has cultivated in 8 years. I have seen virtually no real change in the way health issues are treated in Denver, how mechanisms for conducting healthy lifestyles are publicized, how health care disparities are being eradicated, etc., etc., etc.	Sat, Jun 12, 2010 3:10 PM
15.	I think there is beginning awareness...	Tue, Jun 8, 2010 10:43 AM
16.	It's very hard to work out the cause and effect of behavior change. The recommendations have perhaps gotten a few more people involved in advocating specific actions. More people seem to be aware of healthy diet issues although only in the contemplative stage.	Mon, Jun 7, 2010 10:06 PM

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|-------|--|---------------------------------|
| 17. | I believe the recommendations have had a net positive effect on Denver as a whole | Mon, Jun
7, 2010
3:33 PM |
| <hr/> | | |
| 18. | I think the recommendations have penetrated local communities in small amounts and possibly temporarily improved health behaviors. As many strategies were grant funded and as those funds dried up so did the programs. I think we take some of the model communities and share those stories as much as possible to other communities. We can support those community leaders in expanding around the city telling stories of their success and possibly coaching other communities on where to start and overcoming barriers. Promoting leadership from within each community is where it's at! | Mon, Jun
7, 2010
2:44 PM |
| <hr/> | | |
| 19. | Much greater awareness of health issues, some behavior change. Much work yet to be done to really improve health and change conventional behavior and institutional approaches. We still need major policy shifts and better funding for implementation. | Mon, Jun
7, 2010
2:24 PM |
| <hr/> | | |
| 20. | There is a HUGE amount to be accomplished! Improvement may happen for some, and then they move away, with others coming along who need the same support. The awareness of health promotion and wellness has increased, and that alone is a big accomplishment. We still have a long way to go, but we're getting on the right track. | Mon, Jun
7, 2010
1:14 PM |
| <hr/> | | |
| 21. | Not sure because the are needed is the area used to gather information but improved health services are not getting to the people. | Mon, Jun
7, 2010
12:23 PM |
| <hr/> | | |
| 22. | They have changed behaviors substantially-- by bringing together city agencies who now embrace and collaborate on achieving these outcomes, as well as bringing together nonprofits, citizens and others who are engaged in these efforts. In 2002-- Health promotion was hardly known outside "professional circles" now establishing healthy lifestyles and engaging in healthy activities is a widespread priority. many. Raised the level of awareness of They have been an essential component in achieving a wide variety of changes--DHP 2010 has done an outstanding job leveraging resources and engaging partners. | Mon, Jun
7, 2010
11:54 AM |
| <hr/> | | |
| 23. | The data isn't showing much improvement in health status and youth obesity is increasing. The physical environment and policies are changing to support healthy behaviors. | Mon, Jun
7, 2010
11:24 AM |
| <hr/> | | |
| 24. | After the initial planning I was not involved enough to know the answer to this. In my work I only have limited access to data. | Mon, Jun
7, 2010
10:46 AM |

25. Not much
Mon, Jun
7, 2010
10:36 AM

26. Slightly
Mon, Jun
7, 2010
10:04 AM

27. Without a strong federal component to implement these recommendations, little will improve and little has improved.
Mon, Jun
7, 2010
9:57 AM

28. Recommendations have helped to change the focus of public and environmental health professionals, and have helped to increase understanding of priority areas to address.
Mon, Jun
7, 2010
9:51 AM

Appendix G: Survey Results: Suggestions for Additional Recommendations

In addition to the recommendation from 2002 you suggested be continued earlier in the survey, are there any other recommendations that should be added for the next decade?

1.	The current ones are very overarching and just need to keep being worked on.	Fri, Jun 18, 2010 7:55 AM
2.	I don't know yet, but would like to see more of the work that is taking place at the federal level for HP2020.	Thu, Jun 17, 2010 9:36 PM
3.	Work towards increasing public health workforce; in order to reach our healthy people goals, we are going to need more people in the public health workforce to do the work	Thu, Jun 17, 2010 12:01 PM
4.	I think the language is changing around these healthy/sustainable communities concepts, but the recommendations originally adopted still work.	Wed, Jun 16, 2010 9:56 AM
5.	implement, implement, implement.... stop studying it....just do it	Wed, Jun 16, 2010 8:44 AM
6.	NA	Wed, Jun 16, 2010 7:48 AM
7.	Perhaps my suggestion for expanding the 'root causes' one should be made into a new recommendation--"Develop partnerships for addressing income and educational disparities	Wed, Jun 16, 2010 6:42 AM
8.	We have decent health data, but not much high-quality environmental data. We need to boost that sector.	Mon, Jun 14, 2010 8:22 AM
9.	Support programming, not just policy and advertising.	Sat, Jun 12, 2010 5:55 PM

10.	There needs to be more visibility of the collaboration and of the myriad groups active in the neighborhoods. Once a critical mass of groups are in communication perhaps the smaller organizations will be less insular. The neighborhood association meetings are good. Always hard to find warm bodies to commit to volunteering.	Mon, Jun 7, 2010 10:06 PM
11.	Provide seed money and training (capacity building on all levels) for fledgling organizations that have significant potential to positively impact healthy outcomes in the community such as ReFarm; GrowLocal and GrowHaus	Mon, Jun 7, 2010 3:33 PM
12.	Develop and support community leaders.	Mon, Jun 7, 2010 2:44 PM
13.	More focus on developing sustainable, local food systems and urban agriculture.	Mon, Jun 7, 2010 2:24 PM

Appendix H: Follow-Up Questions with Key Informants

Hi Annie,

I think this is still a great package of recommendations.

In practice, early on there was more effort put into the overall synergy/collaboration aspect of implementing these things. I expect that took a great deal of effort, and may have yielded little apparent returns, but I would love for us to gather on occasion - maybe set up a collaboration fair just for us, and have people set up tables / displays, mingle... That sort of thing. Something to facilitate us meeting one another and developing partnerships on our own.

If that sounds interesting, it might be something we could facilitate at one of our larger library locations with parking and a meeting room. We might also be able to host some programs to educate leaders and the public about health promotion.

It seems to me that some great projects have come of the 'addressing root causes' end of things, but more could be done to spread the vision of what DHP2010 is doing and how more people can get involved.

Thanks!
Elaine

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Looks good, I would add that it would be great to have a high priority be: to help facilitate health in all city organizations (health in all policies): i.e. working with various city agencies to review and influence existing policies, systems and funding avenues so they promote rather than deteriorate health

(City public works, city schools, city economic development, city planning, etc)

Thanks for asking for input.

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What are the strengths and weaknesses of the current recommendations?

Strengths

Recommendations get to the "core" of public health strategies that are effective.

Can to opportunities of a program housed within City and County of Denver organizational structure (working for the city)

Weaknesses

Difficult concepts for non-public health folks to understand - need to be simplified to clarified

Not always used as a "filter" for action within DHP 2010

Needs to have a link to work within the community

If you have a suggestion you did not include in the survey, we would like to know how the recommendations should be changed for 2020?

Add clarity to how DHP 2010 is different from Denver Public Healthm - lots of lack of clarity there and - therefore - difficult for organizations to get involved appropriately and use their time efficiently

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