

HEALTH IN ALL POLICIES

OCTOBER 2015



Community Engagement Report



Summit County

Health in All Policies

Partnering for better policies and better health



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EXECUTIVE SUMMARY

Summit County leaders, agencies and organizations have a decades-long history of collaborating to address the health needs of the community. In 2011, the Centers for Disease Control and Prevention (CDC) awarded a capacity-building Community Transformation Grant (CTG) to the Summit Partners for Accountable Care Community Transformation (Summit PACCT) in Summit County, Ohio. As a part of this work, a policy scan was completed that began to examine what types of policies already existed in Summit County with the goal of addressing health. While the CTG funding was terminated in 2014, the work continued.

Utilizing the information and partner momentum from that initial policy scan, and in collaboration with long-standing work from the Healthy Connections Network and the Minority Health Roundtable Policy Advocacy Committee, a work group continued to explore the viability of a Health in All Policies (HiAP) approach and development of a health charter for Summit County. The HiAP Workgroup sought broad representation of members to help ensure the many voices of the community were represented at the table. A Community Engagement Plan was developed to further seek input directly from individuals who live, work and play in Summit County.

This report provides a review of the history, process and outcomes of these efforts through the summer of 2015, and outlines our vision of next steps towards development of a health charter for our community.

background

The health status of Summit County, Ohio residents has been on the minds of many local health care organizations over the past seventy years. Activities to measure and institute interventions to improve outcomes have also been ongoing since at least the 1940s, including the response to epidemic polio in the 1940s and 1950s, the development of regional burn care in the 1970s, the development of regionalized neonatal care in the 1970s and a county-wide maternal and child health program in the 1980s. And in the 1990s, the hospitals and the health departments came together to develop the Healthy Connections Network (HCN), a public-private partnership to improve preventive services, expand access to care, and begin to address health disparities.

HCN has continued to advocate on behalf of individuals and population subgroups that experience social, economic, political and health disparities. These disparities are “the causes of the causes” of poor health. Infant mortality and birth outcomes are just one area of obvious and troubling health disparity. For example, the Summit County Infant Mortality Rate (an estimate of the number of infant deaths for every 1,000 live births; CDC, 2014) for 2012 was 6.67 overall, 5.58 for White babies, and 10.84 for Black babies.¹ In context, the infant mortality rate in Ohio in 2012 was 7.57 overall, compared to the 2012 national average of 5.97.² And Ohio’s rate of black infant mortality at 13.8 in 2013, is among the worst in the country, where the 2013 overall black IMR rate was 11.2.³

In 2011, the Centers for Disease Control and Prevention (CDC) awarded a capacity-building Community Transformation Grant (CTG) to the Summit Partners for Accountable Care Community Transformation (Summit PACCT) in Summit County, Ohio. This heightened the amount of collaboration within the county focusing on health and the health of all county residents. The CTG grants were meant to concentrate on population level health and to address inequities between groups. While the CTG grant was terminated by Congress in 2014, the work of HCN and many of the organizations and individuals that were involved with the CTG grant has continued to push forward with the goal of improving the health of all Summit County residents.

The HiAP Workgroup, a holdover from the CTG grant, continued to explore the viability of a Health in All Policies approach. At the same time HCN continued its work with the ultimate goal of creating a Health Charter for the county. A Health Charter would require policy-makers to consider the health implications of their decisions, in an effort to elevate the health status of all members of the community and thereby work toward eliminating health disparities.

project summary

By mid-2014, both the HiAP Workgroup and HCN had come to the same conclusion: the community needed to be included in the conversation. The public needed to be given a voice, especially those residents whose health status was most at risk. Until this point, both groups consisted of representatives from organizations (public, private, businesses, non-profits, etc.) that, either directly or indirectly, work with people in the community to help solve problems or who serve the public in other ways (i.e., professionals in the field). The groups and individuals who live, work and play every day while experiencing disparities were only incidentally part of the conversation. Both groups believed that until the community had an opportunity to “speak”, neither the HiAP Workgroup nor HCN could speak with authority about what the community wanted or needed. Therefore, these two entities came together to create and implement a community engagement plan.

Process

The Community Engagement Plan (CEP) was built on four types of activities: focus groups, paper surveys, a web-based survey distributed through social media, and a community forum. The goal of all of these activities was to engage individuals living in the community and give them an opportunity to be heard. All together, these efforts were considered successful with a total of 595 individuals participating.

What We Learned

From those who were engaged in the CEP efforts we learned, for example, that interpersonal connections (family, friends, a sense of community), community infrastructure (parks, services, arts and cultural events), a sense of meaning and purpose (e.g. church, spirituality) and the ability to meet basic needs were the most important conditions that support health and wellness. Impediments to living life to its fullest included some of the opposite factors --namely, broken connections, lack of infrastructure, racism and basic needs not being met. In addition, one message that is perhaps the single most important takeaway from participants is that they feel disconnected from policy-makers.

A diverse group of smiling people of various ages and ethnicities, including young men, women, and children, all looking towards the camera with positive expressions. The background is a soft, out-of-focus light blue.

next steps

Planning for the future

This report to the community is the beginning of the next steps with the eventual goal of having City and County Councils approve a Health Charter. A series of activities are expected to be undertaken that support the goal of educating policymakers about the HiAP approach and recommending provisions to incorporate into a Health Charter for Summit County. These activities began in August 2015.

COMMUNITY ENGAGEMENT REPORT

Introduction

Government, both city and county, hospital, public health and community leaders in Summit County Ohio have a long history of coming together to identify needs, design interventions, and implement programs to improve the health of Summit County residents. In the past several years, the institutions that those leaders direct have turned their focus from interventions that target individual behavior (e.g., counseling a patient to eat more fruits and vegetables) to those that target the population through changes to policies, systems or environment (e.g., imposing a tax on cigarettes).⁴

Summit County leaders identified the Health in All Policies approach to decision-making as a potentially effective tool in moving the needle on the health of residents. In particular, leaders conceived of a Health in All Policies approach coupled with a health charter adopted by city and county governments as means to improve population health in Summit County. These leaders see the prospect of addressing what have come to be called “the social determinants of health” through population-level interventions as a way to get to the causes of the causes of poor health and health disparities. As this concept began to take shape, these leaders turned to Healthy Connections Network, a Summit County collaborative, to lead the effort to bring a health charter into existence.

This report describes the progress to date of the Health in All Policies Initiative. The subject of this report is the crux of the work over the last eighteen months, i.e., designing and executing a community engagement plan to solicit meaningful input from Summit County residents about their primary concerns on the matter of health and wellness. This detailed account of the process of community engagement can be used as a framework for other communities as they act on similar objectives.

In order to properly place this work in context, it is necessary to review the relationships built on years of collaboration that were essential to being ready to move forward on this specific effort. Therefore, this report begins with the history of the initiative. Moreover, community engagement, the core of this report, occurs in the middle of a process that has yet to yield a health charter. As described at the end of this report, the next major step for the Health in All Policies Initiative is the drafting of a health charter based on recommendations gleaned from the work described.

History of Initiative

Healthy Connections Network

Summit County Healthy Connections Network began in 1996 - 1997, when representatives from Akron City Hospital, Akron General Medical Center and Akron Children's Hospital met with C. William Keck, MD, director of the Akron Health Department. The three hospitals and the county's three health departments (Akron, Barberton and Summit County) were long-time collaborators in the development and operation of the federal and state-funded Summit County Child and Family Health Services project. Dr. Keck, Martha Nelson, MD, and Mr. Joseph Harrison were interested in collaborating more deeply with the hospitals to strengthen prevention efforts that could improve the health of the community. The group chose to start with development of an intervention to reduce the rate and number of women entering prenatal care late in pregnancy, which correlates to less advantageous outcomes including premature birth and low-birth weight newborns.

This intervention eventually took shape in Akron in a partnership with East Akron Community House and

others. The group established a strategy of recruiting from local community informal leaders whose most salient credentials were community credibility and influence. They were asked to identify pregnancies within their own sphere of activity and then bring those women into prenatal care as early as possible. Although this project had some success and demonstrated a modest proof of concept, it unfortunately did not have sustainable funding and eventually dwindled.

Around 1999, the US Department of Health and Human Services (DHHS) Health Research and Services Administration (HRSA) was creating a new grant program to support the development of community-based interventions to improve access to and to reduce disparities in access to health care. This new program was aptly called "100% Access and Zero Disparities." The original group decided to present this as an opportunity for Akron and Summit County based organizations and individuals to come together in a new form, eventually creating an organization that came to be the Healthy Connections Network of Summit County (HCN).

“Healthy Connections Network defines its mission as,
To have a healthy community
with accessible health care for
all in Summit County.”

“The goal of the network is,
To improve the overall health
status of all residents of the
community.”

After several attempts to gain funding from the “100% Access and Zero Disparities” program, and other federal and state programs, in 2003 HCN received a HRSA grant of \$1.8 million over three years, which enabled it to create Summit County’s own Access to Care (ATC) program. The program was based on a voluntary care provider model, which was fully operational for about two and one-half years. At its most robust, the program had about 325 primary and specialty physician volunteers, and provided access to health care to some 6,000 Summit County residents over a span of four years.

Unfortunately, the federal grant program was eliminated by the Bush Administration roughly 18 months into the grant period. The program was able to continue with minimal federal and considerable local support for another few years, until it was absorbed by the Austen BioInnovation Institute in Akron (ABIA). ABIA was interested in the ATC program for its potential to create a replicable model for improving access to healthcare in communities around the country, but the model proved difficult to package and market. Summit County Public Health (SCPH) then adopted the program and continued it with limited support from ABIA. The program continued in limited form over the next several years and still operates under SCPH’s sponsorship.

Current Healthy Connections Network Efforts

At the time that Healthy Connections Network was transitioning the Access to Care program to ABIA, the group decided to focus considerably more emphasis on the “Zero Disparities” effort. Disparities in access to health care are highly significant, but are only part of the picture. Equitable access to the conditions that promote health is essential for all segments of the population.

What are Health Disparities?

According to the Health Resources and Services Administration, health disparities are defined as “population-specific differences in the presence of disease, health outcomes, or access to healthcare.” In the United States, health disparities are a well known problem among ethnic minorities such as African Americans, Asian Americans, Native Americans, and Latinos. Studies have shown that these groups have a higher prevalence of chronic conditions along with higher rates of mortality and poorer health outcomes, when compared with the white population.⁵

Informed by research and widely-shared experience related to health inequalities, HCN shifted its focus to health disparities. Health disparities arise when different groups of people experience divergent social and economic conditions. The effect of these inequities on people’s lives and the overall health of the community contributes to the risk of illness, the actions taken to prevent illness, and the access to treatment of illness when it occurs. HCN’s new focus allowed it to continue advocacy on behalf of individuals and population subgroups that experience social, economic, political and cultural disparities.

These disparities would not exist but for the social inequities that exist. The poorest of the poor around the world have the worst health. In general, the lower an individual’s or community’s socioeconomic position, the worse their health. This is true along the social gradient from top to bottom, where one’s position on the socioeconomic ladder is highly correlated with one’s health status, as true for CEOs, as for homeless persons, and similarly from highly affluent to deeply disadvantaged communities.

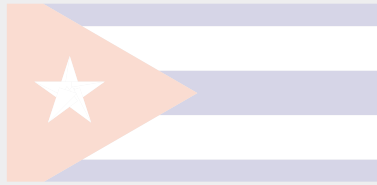
Over the last two years, HCN began a more explicit investigation of the social determinants of health. It has sponsored a series of “Board & Community” meetings, examining various social determinants via expert presentations and panel discussions. Forums addressed housing, transportation, food and nutrition, and access to healthcare under the Accountable Care Act (ACA or ObamaCare). The activities occurred in tandem with various complementary efforts through ABIA and Summit County Public Health.

Community Transformation Grant

In September 2011, the Centers for Disease Control and Prevention (CDC) awarded a capacity-building Community Transformation Grant (CTG) to the Summit Partners for Accountable Care Community Transformation (Summit PACCT) in Summit County, Ohio.⁶ Summit County Public Health (SCPH) and Austen BioInnovation Institute in Akron (ABIA) were the lead organizations on the CTG grant, which focused in part on policies in government, non-profit organizations and businesses that address health and wellness.⁷ At the conclusion of the first year of funding, the Health Policy Scan workgroup, charged with conducting a local policy scan, identified advancement of a “Health in All Policies” approach as a potential avenue to impact population health through policy, systems, and environmental change.⁸

During the second year of funding, September 30, 2012 through September 29, 2013, Summit PACCT partners continued capacity building efforts, digging deeper into the impact of the built environment on health. The Health Policy Scan workgroup conducted several interviews with entities whose decisions directly affect the local built environment. For example, this workgroup met with representatives from the City of Akron Department of Transportation, the Akron Metropolitan Area Transit Study, the Akron Regional Transit Authority, the Akron Metropolitan Housing Authority, the Ohio and Erie Canalway Coalition, and the Cuyahoga Valley National Park.⁹ In addition, as part of CTG-funded technical assistance, Summit PACCT sponsored a three-day summit in June 2013, during which Mark Fenton, an advocate for Active Transportation and Complete Streets,¹⁰ surveyed Summit County and led a community forum on the relationship between healthy physical environments and the health and well-being of residents.¹¹

At the end of this second year of funding, the CDC invited Summit PACCT to proceed from capacity-building to implementation. For the Health Policy component of the CTG, the primary goal was the advancement of a Health in All Policies approach with Summit County public and private decision makers. CTG partners constituted a Health in All Policies (HiAP) Workgroup of interested community members and representatives from local agencies and organizations.¹² The HiAP Workgroup began meeting in March 2014 to develop and implement a plan to advance HiAP in Summit County.



Summit County Delegation Travels to Cuba

At the same time, a third group of Summit County leaders was focusing on improving population health by reviving the development of an Accountable Care Community (ACC). Screening and responding to the social determinants of health is a key component of ACC. To learn about an alternative health care delivery model, a delegation of 15 people traveled to Cuba (the delegation) in February 2014.¹³ The delegation, led by Dr. William Keck,¹⁴ chose to examine the Cuban model of health care delivery because Cuba's health outcomes are comparable (by many measures) to those in the U.S. and the costs are much lower.¹⁵

When the delegation returned from Cuba, they identified several initiatives to explore, one of which was the drafting of a report to identify health-related concerns for Summit County policy makers to use in decision-making. After several internal meetings, in April 2014 the delegation presented the highlights of the Cuban trip and the framework for the initiatives they intended to pursue to other community leaders. Healthy Connections Network was charged with leading the effort to draft the recommendations.

Healthy Connections Network Embraces Concept of Health Charter

Even before the Community Transformation Grant participants began their HiAP work or the Summit County delegation journeyed to Cuba, Healthy Connections Network raised the question of how a health charter could benefit the community. Some among the ranks of HCN were also members of the Summit County Food Policy Coalition, which had successfully brought a Food Charter before Summit County Council, the City of Akron, and several other local municipalities. HCN was a logical organization to lead the drafting of a health charter. In January 2014, the HCN Executive Committee unanimously decided to focus its ongoing efforts on the development of a Health Charter for the Summit County area. This charter would be modeled after the recently adopted Food Charter, with input from the Summit Food Policy Coalition and many of its constituent agencies and individuals.

The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. (Social Determinants of Health Key Concepts, World Health Organization)

In February 2014, Dr. Camara Phyllis Jones, MD, MPH, PhD, from the CDC (Centers for Disease Control and Prevention), came to Akron as an invited presenter on the issue of health equity, hosted by the Akron-Region Interprofessional AHEC and The University of Akron College of Health Professions. Dr. Jones is a family physician and epidemiologist whose work focuses on the impacts of racism on the health and well-being of the nation. She seeks to broaden the national health debate to include not only universal access to high-quality health care, but also attention to the social determinants of health (including poverty) and

the social determinants of equity (including racism). She inspired us to widen our scope by including the social determinants of equity into our overall approach to improving the health of the population.

The social determinants of health are “the causes of the causes of poor health.” They include nutrition, housing, education, transportation and other social realities that shape both the physical environment and the family and community realities that affect our lives and our prospects. These circumstances are impacted by the distribution of money, power and resources, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - unfair and avoidable differences in health status. With all this in mind, HCN was prepared to begin drafting the charter and began its development process.



Initially, it appeared that the Health Charter initiative would proceed more quickly than the HiAP initiative. HCN leaders were prepared in April 2014 to develop a draft to vet with policy makers as early as May 2014. Taking advantage of the support of Summit County leaders and the enthusiasm of the returning Cuba delegation, it seemed like a smooth path from an abstract concept to a concrete document.

The group reasoned that development of a health charter would need two versions: **(1) a formal Charter for public and private organizations; and (2) a plain-language document for the community, describing the Charter’s goals.** To achieve this, HCN leaders realized they needed to be in conversation with a broad representation of people who would not only benefit from a health charter (once instituted), but also would take part in setting the agenda for its development and participate in the drafting of the charter. HCN leaders began to contemplate a broad community effort with residents taking part in an all-day endeavor to discuss the issues and identify those things that should be included in a charter.

In contrast, the HiAP Workgroup, taking a more methodical approach, was still identifying its core values and researching the processes by which other communities had already established a HiAP approach to decision making.

In March 2014, it had convened twice and through vibrant discussion had determined, among other things, that:

- **Current funding opportunities were not a good fit for this project;**
- **The HiAP work was consistent with the top concerns identified by Northeast Ohio residents, consumers, and politicians -- the quality of air, water, and land -- through the Northeast Ohio Community Sustainability Charter;¹⁶**
- **A central concern of those present was the lack of connectedness of communities, neighborhoods and neighbors; and**
- **Workgroup members needed to reach out to additional stakeholders not yet at the table, including representatives from the Akron Metropolitan Area Transportation Study and the City of Akron Engineer.**

The HiAP Workgroup viewed its core questions to be:

- 1. What do we want to do?**
- 2. How are we going to get there?**
- 3. What technical assistance do we need?**
- 4. How do we reach our government/decision makers?**

Workgroup members reviewed and presented information to the Workgroup on topics identified as significant: (1) summary of a publication entitled “Health in All Policies: A Guide for State and Local Governments”;¹⁷ (2) overview of a “Complete Streets” approach to transportation planning;¹⁸ (3) incorporation of “Health Equity” into the HiAP work; and (4) progress in other communities on HiAP initiatives.¹⁹

Complete Streets is defined as transportation infrastructure framework to create a unified system that is appropriate for all users: pedestrians, buses, bicyclists, cars, etc. Complete Streets approaches have been shown to bring economic benefits, as well as health and climate benefits. Over 720 regional and local entities, including several in Ohio, 30 states, the Commonwealth of Puerto Rico, and the District of Columbia have adopted Complete Streets resolutions.²¹



From the publication “Health in All Policies: A Guide for State and Local Governments,”²⁰ the Workgroup learned the five key elements of HiAP, giving it a framework for its efforts. Those five elements are:



PROMOTE HEALTH,
EQUITY &
SUSTAINABILITY.



SUPPORT
INTERSECTORAL
COLLABORATION.



BENEFIT MULTIPLE
PARTNERS.



ENGAGE
STAKEHOLDERS.



CREATE STRUCTURAL
OR PROCEDURAL
CHANGE.

Many members of the workgroup felt that it was essential to embed Health Equity principles in the HiAP work. The following three principles, shared by Dr. Jones, seemed to capture the concepts of health equity.

3 principles to capture the **concepts of healthy equity**:

All individuals and groups must be **valued** equally.

Addressing **health equity** means providing **resources as needed** (equitably) rather than equally.

Health equity **recognizes and responds to historical injustice** by understanding that people start at different levels of social, political, or economic advantage. Some people have been historically burdened by something we may not even remember, while others don't share those same historical burdens and may possess historical advantages. Furthermore, **ignoring historical injustice strengthens institutionalized racism.**

The Workgroup also considered the efforts of other communities, both large (state-wide) and small (cities), that use similar population-level interventions to improve individual and community health. In Washington DC, for example, the purpose of the Sustainable DC Plan is to improve the health of District residents by, among other things, prioritizing sustainability, reducing greenhouse emissions, expanding mass transit, and replacing felled trees.²² “Farm to Fork” programs generally use policies and programs to make it easier for people or communities to purchase produce from local farmers, thereby promoting health by increasing access to affordable and nutritious foods and promoting economic development by supporting local agriculture and food economy.²³ The Nashville Area Metropolitan Planning Organization embraced a goal of financing and building a modern mass transit system, incorporating rapid transit, circulator buses, and extensive pedestrian and bicycle routes to cohesively connect citizens and tourists with live-work-play destinations.²⁴ Finally in a bold and ambitious move, motivated by leaders who showed common interest in climate change, childhood obesity and health, the State of California created a Health in All Policies Task Force.²⁵

California’s task force, envisioning a process which would inform California’s decision makers about the health consequences of policy options during policy development, outlined the following six aspirational goals:

- 1. Provide all residents with active transportation.**
- 2. All residents will live in safe, healthy, and affordable housing.**
- 3. All residents may access places to be active, such as parks, green spaces and a healthy tree canopy.**
- 4. All residents may live and be active in their communities without fear of crime or violence.**
- 5. All residents will have access to healthy, affordable foods at home, work and school.**
- 6. Public decision-makers are informed about the health consequences of various policy options during the policy development process.**

At this point, the HiAP Workgroup assessed its understanding of Health in All Policies and considered next steps. Fortunately the composition of the Workgroup was diverse and included people from a variety of professions. Members ranged from a community organizer to a retired health system executive, to public health professionals, an insurance company representative, and community agency employees, as well as several interested, unaffiliated members of the community. The consensus across these varied participants was that for the outcome to be meaningful, the group could not proceed further without first obtaining community input into the process.

Developing a Community Engagement Plan

By the end of April 2014, both the HiAP Workgroup and the HCN core group had independently concluded that neither could proceed until they had brought the community into the conversation. Both groups realized that this step would be essential to the legitimacy of their efforts. Until the community had the opportunity to weigh in on priorities, deficiencies, and goals, how could either initiative speak about what the community wanted or needed? Thus, the two groups came together to develop and implement a community engagement plan. For purposes of this report, the group that came together to develop and implement the community engagement plan will be called the “CEP group.”²⁶

The members of the CEP group collaborated to develop a framework for the planning process and to navigate different styles of communication. Discussions yielded consensus on several concepts. The CEP group identified the need to incorporate education about the social determinants of health into the community engagement efforts. They also felt that people needed to be able to see themselves in any document that was produced as a result of their efforts. Further, the goal of community engagement could not be to mandate that businesses, organizations, or municipalities (e.g., city and county)

always make the healthiest choice. The group recognized that policy-makers (both public and private) would not champion a requirement. However, they would, the CEP group hoped, champion an effort to make health a priority in decision-making.

The CEP group used content from the community engagement segment of “Health in All Policies: A Guide for State and Local Governments.” They also incorporated a new resource, a community engagement workbook entitled “Community Engagement Guide: A tool to advance Equity & Social Justice in King County.”²⁷ (King County includes the City of Seattle, WA.). Both of these tools were helpful in framing the conversation. In addition, Summit County Food Charter served as a case study.

Two factors combined to slow the CEP group’s progress. First, the passion of group members was on the underlying causes of health disparities and the need to include those experiencing difficulties in the discussion, before developing a community engagement plan. Second, the make-up of the group experienced a fair amount of transition for several months. Despite the challenges, the group persevered. Input at each meeting was valuable because the voices at the table were diverse and passionate.

The group articulated the following reasons for engaging the community in the process:

- To educate community members about the social determinants of health;
- To learn from community members what is important to them;
- To build interest in creating a healthier community;
- To build consensus so that the effort to improve health would have more stakeholders;
- To formulate community vision and goals;
- To provide direction in mapping implementation and evaluation strategies;
- To ensure that all voices are heard throughout the process;
- To prioritize important concerns;
- To identify needs and desires; and
- To build bridges between and among community members and groups.

The group then identified those constituencies who were represented by people in the room, and those who were not. Among specific populations served by participants who were already at the table were:

- Residents of the City of Akron;
- Residents of Summit County;
- Low-income residents;
- Residents who are uninsured and underserved;
- Residents with alcohol, substance abuse, and mental health issues;
- Residents with limited education;
- Residents who are busy and tired;
- Residents who are physically, psychologically, and spiritually unhealthy;
- Medically-complex and fragile children;
- Residents with limited English proficiency;
- Health professionals, including students, who serve underserved residents;
- Residents who need access to the tools for good health;
- Residents of various races (Black, White, Asian, and others);
- Senior citizens;
- Veterans;
- Residents experiencing homelessness;
- Survivors of domestic violence; and
- The community as a collective.

The CEP group identified several specific constituencies who were absent, including refugees, Native Americans, undocumented people, individuals with developmental disabilities, members of the LGBTQ community, and policy makers, both public and private. The group then identified point people to make contact with those missing constituencies and invite them to participate in the community engagement effort. In order to structure outreach efforts, several members of the CEP group drafted “elevator speeches” -- two or three sentences to describe the group’s purpose and goals. By September, a core group of 10-14 people continued to attend meetings and help structure next steps.

Implementing The Community Engagement Plan

The Community Engagement Plan (CEP), which had a definite shape by the end of September, was built on four types of activities, classified as:



Focus Groups

Going to community members during existing meetings.



Personal Encounters

Offering individuals paper surveys to complete.



Social Media

Disseminating a web-based survey.



Community Forum

Inviting community members to participate as a group in a structured discussion.

Taking each of these in turn, the group developed an implementation strategy.



Focus Groups

The group first brainstormed a lengthy list of potential community groups from whom to request the opportunity to conduct a focus group. An explicit goal of the group was to hear the voices of those who are most negatively impacted by health disparities. Members of the group volunteered to conduct focus groups in various settings.

The group developed a template²⁸ for a 50-minute and a 25-minute focus group using a learn-teach-do model. To introduce the concept of “social determinants of health, the group selected the video presentation “Making The Connections: Our City, Our Society, Our Health.”²⁹ This video is an upbeat easy-to-follow video presentation that explains the concepts with engaging graphics and narration. The group also incorporated a colorful handout adapted from SAMSHA materials³⁰ and entitled “The Eight Dimensions of Wellness.”³¹ This tool defined eight aspects of wellness -- emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual -- and depicted their interconnectedness using a ring of bright overlapping circles. Taken together, the video and the “Eight Dimensions” handout, both of which present the concepts of intertwined social determinants of health, comprised the “learn” part of the “learn-teach-do” model.

The group had been deliberating over the “teach” part of the model for several months, considering how best to ask participants about the social determinants of health that they experience both positively and negatively in their communities. After much debate and discussion, the group settled on the following three questions.

- What about or in your community gives you joy, happiness, or pleasure in your life?
- What about or in your community keeps you from experiencing joy, happiness, or pleasure in your life?
- Think of how long you would like to live. What about or in your community do you think might get in the way of your living as long as you would like to live?

These three questions became the basis for the second tool, a half-sheet paper survey with the three questions on one side and basic demographic questions on the other side.³² Using these three questions, the participants would teach each other about what was and what was not working in their communities.

Following the template, the facilitator of each focus group was to:

- 1.** Begin with the four-minute video describing the social determinants of health and how each of those determinants impacts the others;
- 2.** Introduce handout “The Eight Dimensions of Wellness” and review the definition of each of the eight aspects of wellness;
- 3.** Divide participants into small groups;
- 4.** Distribute the half-sheet paper with the three survey questions on one side and the demographic questions on the other;
- 5.** Provide time for each participant to answer each question on their paper copy of the survey, share their responses with others in their group, and write their responses on a colored index card using a specific color for each question;
- 6.** Invite participants to identify which of the eight dimensions of wellness best encompassed their response to each question and to tape their index cards on one of the eight sheets of large easel paper on the walls of the room labeled with that dimension;
- 7.** Return the paper copy of the survey with both sides completed;
- 8.** Ask the group to reflect on the visual depiction of each dimension of wellness and the extent to which factors in each were working or not working in their communities; and
- 9.** Promote the upcoming community forum, during which participants would take initial steps toward action in achieving the goals of the Health in All Policies initiative.³³

Personal Encounters

Having developed the paper copy of the survey, the CEP group was ready to distribute it broadly. Group members distributed survey packets to well over a dozen organizations and community groups in the county.³⁴ Several of those organizations actively promoted completion of the survey, with one community partner offering employees an incentive for doing so.

Social Media

The group created an online survey using Google Forms, complete with a link to the form and a scannable QR code³⁵ enabling the use of smartphones to respond. Another group member hung laminated posters of The Eight Dimensions of Wellness handout and the QR code in waiting rooms, encouraging participation. Group members also requested that their organizations and collaborators promote completion of the survey and provide a link to the electronic survey form on their websites.³⁶ The Summit County United Way included a link to the survey in their electronic newsletter, which is sent to every United Way organization in the county.³⁷



In the final quarter of 2014, the CEP group continued to meet regularly, conduct focus groups, distribute and collect hard copy surveys, promote the online survey, and review the information it was receiving. It also sought to obtain greater input from youth, as the mean age of respondents was above 40 in the first month of survey use. To track outreach efforts, the CEP group used a Google Drive spreadsheet identifying location, contact person, and event for each potential focus group and survey location. By November 24, over 100 people had responded to the survey in its various formats. By December 17, that number jumped to 179. The group decided to continue to collect information through January 2015.

* The Eight Dimensions of Wellness
(Adapted from SAMHSA)

Community Forum

The CEP group also began in earnest to plan the Community Forum, envisioned as a culminating event in the Community Engagement Plan. A small subcommittee was formed to plan the Community Forum.³⁸ The group reported its progress to the leadership of Healthy Connections Network (HCN) and elicited HCN input into the Forum structure. HCN approved a general outline and scheduled the culminating event for January 24, 2015.

With four months to plan, the subcommittee began outlining event details, asking:

- **Who is our target audience?**
- **What is our attendance goal?**
- **Who will facilitate the event?**
- **How will we structure the event?**
- **How do we motivate people to attend a gathering at 8:30 am on a January morning?**
- **How do we collect the information from participants?**
- **How much funding will we need?**

The subcommittee worked diligently, seeking input from the CEP group whenever needed. The group set an attendance goal of 50 with a stretch goal of 70 participants. The target audience continued to be Summit County residents most impacted by health disparities. In addition, the CEP group sought input from youth. While these groups were the focus of outreach efforts, any Summit County resident was a stakeholder in the discussion, and the group took several steps to advertise the event broadly. The group made contact with three local newspapers, the Akron Beacon Journal (daily), The Reporter (weekly) and the West Side Leader (weekly) seeking coverage. On January 16, 2015, the Akron Beacon Journal published an article on the Health in All Policies Initiative and the upcoming forum.³⁹

After meeting with Crystal Jones and Susan Vogelsang, co-managers of Project Ujima, the subcommittee recommended to the CEP group that Project Ujima facilitate the event.⁴⁰ The group, many of whom were aware of Project Ujima's community work on the west side of Akron, agreed. Project Ujima's presence, and the many years of community engagement by Jones and Vogelsang in other contexts, would give important credibility to the event. Project Ujima's emphasis -- taking talk to action -- would help make the event meaningful and elicit future engagement.

Working collaboratively, Jones and Vogelsang developed a structure and agenda. The room would be set up with eight circles of 10-12 chairs. Each circle would be assigned to two Project Ujima-trained moderators and designated with one of the eight dimensions of wellness. Upon registration, participants would be randomly assigned to one of the eight circles.

The Forum would open just as the focus groups had started: with the four-minute video on healthy communities and an explanation of the eight dimensions of wellness. Each circle would then discover

which dimension of wellness was to be the focus of its discussion. The moderators would lead the group through a series of three discussion prompts the last two of which were specifically tailored to incorporate the definition of the dimension of wellness assigned to that circle. For example, the circle assigned to “spirituality” would respond to these three prompts:

1. If you want your policy makers to be thinking about one thing when they make decisions in 2015 related to your wellness, what would it be? (This question was the same in every group.)
2. The number one thing that helps me to have purpose and meaning in my life is...
3. The number one thing that gets in the way of helping me to have purpose and meaning in my life is...

After completing discussion on these prompts, the eight circles would designate one person from each circle to report on the focal points of their discussion on the two last prompts. Responses to the first prompt would not be included in the report back, but would be collected and incorporated into the analysis. To wrap up the Forum, facilitators would describe next steps planned by the CEP group and elicit evaluative information regarding the process used for participation at the event.

To encourage attendance, the subcommittee planned to offer a light breakfast upon arrival, a snack midway through the morning, \$500 worth of grocery store gift cards, three day passes to the YMCA for each participant, and door prizes from vendors who were invited to staff information tables in the space just outside the auditorium where the event would be held. In addition, several CEP group members agreed to help call every registrant on Wednesday afternoon and again on Friday afternoon, reminding them about the event, making sure they had transportation and knew where they were going, as well as answering any questions.

Jones and Vogelsang asserted the importance of offering transportation to the event, reminding the CEP group that if it were sincerely trying to reach underserved people, then it needed to offer transportation assistance. The group arranged for van transportation for up to 30 people. Jones and Vogelsang also recommended that the group offer some kind of child care, because the four-hour event would be difficult on families with young children. Although the group was not able to overcome liability barriers to offering childcare, it did provide a “soft corner” in the room with games and toys. It also arranged for appropriate adult supervision of the soft corner; however, parents or guardians would retain responsibility for their own children.

In mid-December, the group had not yet procured sufficient revenue to cover the expenses of the Forum, although it had received a \$500 donation to cover the cost of 50 grocery gift cards. Nearing the end of December, the subcommittee met with Summit County Deputy Health Commissioner to identify additional resources. The Health Department, whose leaders are a part of the HCN Executive Committee, is a strong supporter of the Health in All Policies Initiative, as it aligns with several of its current and ongoing programs. As a result, the Health Department was able to provide invaluable in-kind support, as well as financial support to cover the facilitators’ modest fee and the small stipend paid to each moderator. Additional sponsors covered the cost of transportation, giveaway items, and food.⁴¹

With funding secured, the CEP group moved ahead to spread the word about the Forum and encourage registration. Using a Google form and link for registration, as well as paper copies of the registration form, the group targeted many of the organizations that had successfully elicited survey responses earlier in the community engagement process. Many of those entities included information and a link to registration on their websites. The group also handed out flyers and registration forms at community events in the 10 days leading up to the Forum. In addition, Akron Public Schools encouraged attendance among their high school students enrolled in a particular enrichment program. Professors at Kent State and at The University of Akron offered students extra credit for participation.

Despite these numerous outreach efforts, six days before the event registrations were low enough to consider whether to cancel. On the Monday before the Saturday forum, only 28 people were registered. All week, the members of the CEP group all made additional efforts to obtain commitments from their constituencies to attend. Fortunately, the number of registrations slowly climbed: Tuesday, 35; Wednesday, 43; Thursday, 50; Friday morning, 62. By Friday afternoon, much to the excitement of all involved in planning, 76 people were registered. A handful of people had requested transportation. An APS teacher contacted members of the CEP group to indicate that she might have (an additional) 21 students who were interested in attending and who would potentially need transportation. The Project Ujima Facilitators and the CEP group planned for 100 participants. Additional funds were donated to cover more \$10 grocery cards, with the hope of being able to provide one to every participant who stayed until the end.

The logistics on the day of the event went smoothly. A technical problem that surfaced five minutes into the event was resolved quickly. An error in the collection of demographic information was corrected. The facilitators and moderators were able to move through the process, keeping discussions on schedule. A few people arrived late, and a few departed early, but not so many as to be disruptive. Door prizes were awarded at various points in the morning. Everyone present at the mid-morning break received a three day pass to the YMCA. Everyone present at the end of the Forum received a \$10 grocery card. With participation of 72 members of the community, the Forum was an unequivocal success.



Post Forum Debriefing

The CEP group called a post-forum meeting to debrief from the group's extensive community engagement efforts. The group identified 10 community gatherings where CEP group members had conducted focus groups,⁴² 20 locations where paper surveys were handed out or made available to the public,⁴³ and 11 organizations that posted the survey link or directed people to the survey link from their websites.⁴⁴ With these three modes of input, the CEP group collected survey responses from 528 community members. (Demographics of these respondents will be discussed below, with the analysis of the responses.)

In considering what worked with respect to the survey and focus groups, the group identified the following constructive elements:

- **The simplicity of the survey;**
- **The three questions were, for the most part, well-received;**
- **The CEP group had access to a wide array of networks for survey distribution;**
- **The CEP group reached out to a contact person in many of the locations where the survey was distributed; and**
- **The respondents were open to learning and teaching, i.e., they were willing to hear new ideas and to share input.**

The group assessed several elements that did not work as well as they had hoped with regard to the survey and the focus groups. In particular:

- **There were cultural differences regarding people's comfort with the language of the questions;**
- **Some participants thought that institutional racism should have been an explicit part of the discussion;**
- **While the questions were thoughtful, some groups found them to be poorly worded and too vague to elicit specific responses;**
- **Questions 2 and 3 were too similar; and**
- **Question 3, with its two parts, was not well- structured.**

Given the opportunity to do this again, the CEP group would either eliminate question 3 or revise it to ask a third relevant question.

Considering the Community Forum, the following elements worked:

- **Extensive planning;**
- **Breaking into circles for discussion;**
- **Assigning couples, and groups of friends, to different circles;**
- **Offering incentives and giveaways;**
- **Publicizing a start time of 8:30 a.m. but not starting the formal part of the program until 9:00 a.m.;**
- **Solving the initial technical problem quickly;**
- **Using trained moderators who could keep the discussion moving, ensure participation of all members of the circle, and ask for clarification of responses when needed;**
- **Persisting in the five days before the Forum to promote it;**
- **Placing reminder calls to registrants twice in the three days before the Forum;**
- **Providing food and offering transportation;**
- **Offering external incentives for participation, like extra credit from professors and teachers; and**
- **Holding the event in space that was appealing, well lit and thoughtfully laid out.**

The CEP group did identify several elements that it would modify should it ever repeat such a gathering, most significantly:

- **The children's "soft corner" was not well utilized, suggesting that better publicity about its availability might have made that more valuable to participants;**
- **The transportation was expensive and several students who registered on the last day did not use the transportation and did not attend, suggesting arrangements with students and schools needed to be solidified more than 24 hours prior to the event start time;**
- **The flyer promoting the event was vague as to what would occur at the Forum, leaving registrants confused about what would take place; and**
- **The part of the agenda when each circle reported its discussion highlights to the whole room was long and did not sufficiently engage participants, suggesting that this process needed to be modified, perhaps by having each circle give two highlights at a time, until all significant points had been made.**

Who Participated in Community Engagement?

Each component of the Community Engagement Plan was successful. Overall, 595 people participated.⁴⁵ The CEP group gathered paper copies of the surveys from a total of 381 community members, some of whom attended one of the 10 focus groups conducted and the rest of whom completed surveys following a personal encounter of some kind. Another 142 people completed the survey online. The Forum was a success with 72 participants. All but three of the nearly 600 people who participated in some manner provided demographic information. The following tables depict the age, gender, race, and presence of minor children in the home for the entire 592 participants, as well as for each of three groups: (1) Those who participated in the January 24 Forum; (2) Those who completed paper surveys, either in a focus group or following a personal encounter; and (3) Those who completed an online survey. In addition, the zip codes of the residents who participated are also analyzed.

Gender

Overall, and for any given format, roughly three females participated for every male participant. Females comprised 78% of Forum participants, 72% of participants who submitted paper surveys, and 78% of those who submitted online responses. Taken together, females were 74% of the respondents. In comparison, females and males are much more evenly split in Summit County, at 52% and 48% respectively.⁴⁶ Despite the overrepresentation of women, the CEP group was pleased to have reached as many men as it did. Additional efforts are clearly required to encourage men to participate in surveys and discussions.

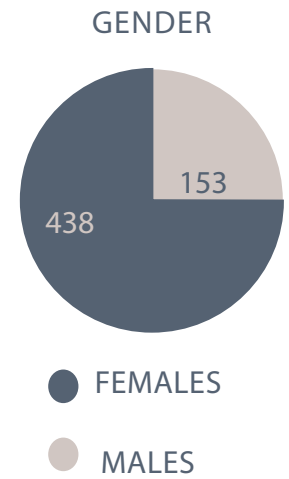


Table 1: Participation in Community Engagement by Type and Gender

	JAN. 24 FORUM		PAPER SURVEY		ONLINE SURVEY		TOTAL	
	NO.	%	NO	%	NO	%	NO.	%
FEMALE	56	78%	272	72%	110	78%	438	74%
MALE	16	22%	106	28%	31	22%	153	26%
NR	0	0%	1		0	0%	1	
TOTAL	72	100%	379	100%	141	100%	592	100%

Age

The CEP group aggressively reached out to youth for input, with some success, particularly using the paper surveys. At the Forum, the mean age of participants was 50.3 years, with a median age of 55 years. Only 22% of participants were under age 35, and 25% were age 65 or older. This older group was somewhat balanced by the age of participants who submitted paper surveys. In the paper survey group, the mean age was 35.5; the median age was 26. A full third of the participants were minors. Another 34% were between the ages of 18 and 44. Because the online survey did not ask for age, but rather asked respondents to choose an age range, the mean and median cannot be calculated. However, almost three-quarters of respondents were over age 45 years, and none were under the age of 18. Likewise, no minors responded using the online survey.

Overall, input was fairly well spread across ages, with 31% under the age of 25 years, and 27% over the age of 55 years. As a point of comparison, median age in Summit County is 40 years.⁴⁷ While the age demographics of the respondents is more representative of county demographics than some of the other categories analyzed, the CEP group was not as successful in achieving an overrepresentation of young people as it had hoped to be. Furthermore, minors almost

exclusively participated using paper copies of the survey, as a result of a very targeted effort towards local high school students. Despite their reputation for being tech-savvy, young people were apparently not enticed by the social media outlets used by the CEP group. Perhaps having high school or college age students at the planning table would have yielded higher participation from this age group. These age demographics are depicted in table 2, below.

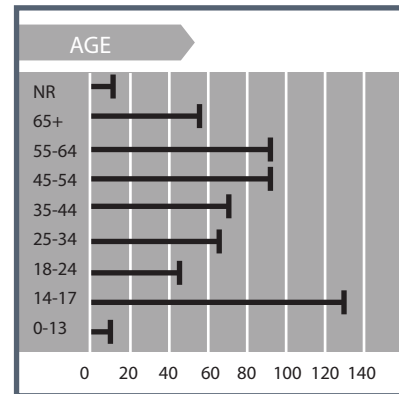


Table 2: Participation in Community Engagement by Type and Age

AGE	JAN. 24 FORUM		PAPER SURVEY		ONLINE SURVEY		TOTAL	
	NO.	%	NO.	%	NO.	%	NO.	%
MEAN AGE	50.3	NA	35.5	NA	NA	NA	NA	NA
MEDIAN AGE	55	NA	26	NA	NA	NA	NA	NA
0-13	0	0%	3	1%	0	0%	3	1%
14-17	5	7%	124	33%	0	0%	129	22%
18-24	3	4%	46	12%	1	1%	50	8%
25-34	8	11%	53	14%	11	8%	72	12%
35-44	6	8%	44	12%	25	18%	75	13%
45-54	13	18%	40	11%	45	32%	98	17%
55-64	17	24%	36	9%	45	32%	98	17%
65+	18	25%	27	7%	13	9%	58	10%
NR	2	3%	6	2%	1	1%	9	2%
TOTAL	72	100%	379	100%	141	100%	592	100%

Race

The CEP group actively sought input from those Summit County residents who disproportionately suffer from negative health disparities. This population is comprised primarily of low-income people and people of color. In contrast, four in five Summit County residents are Caucasian (80%), and only 14% are African American alone.⁴⁸ As is clear from Table 3, below, the CEP group was successful in obtaining an overrepresentation of people of color. This was true overall, where 43% of respondents were African American and 49% were Caucasian. It was also true within two of the three subgroups: Forum participants and respondents to the paper survey. However, respondents to the online survey were 71% Caucasian, a result that is important to consider when planning modes of community engagement where input from people of color is sought.

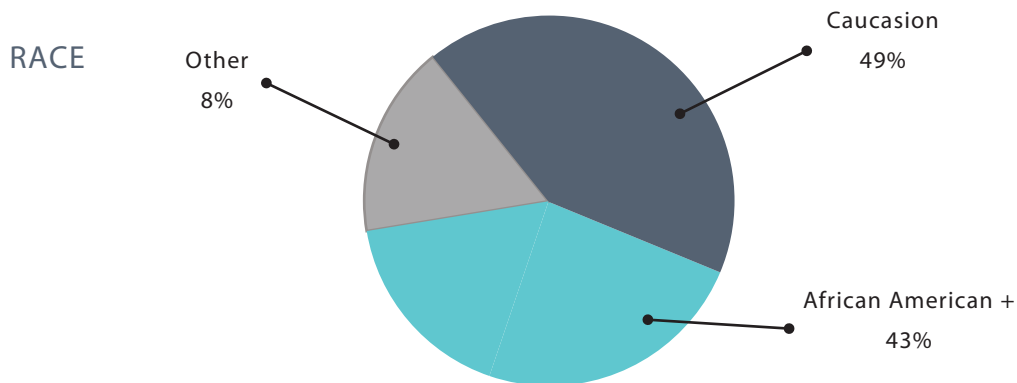


Table 3: Participation in Community Engagement by Type and Race

RACE	JAN. 24 FORUM		PAPER SURVEY		ONLINE SURVEY		TOTAL	
	NO.	%	NO.	%	NO.	%	NO.	%
AFRICAN AMERICAN	34	47%	171	45%	30	21%	235	40%
AFRICAN AMERICAN/ CAUCASION	2	3%	8	2%	0	0%	10	2%
AFRICAN AMERICAN/ AMERICAN INDIAN	1	1%	2	1%	0	0%	3	1%
AFRICAN AMERICAN/ ASIAN/ PACIFIC ISLANDER	0	0%	1	0%	0	0%	1	0%
AFRICAN AMERICAN/ HISPANIC/ LATINO	0	0%	2	1%	0	0%	2	0%
CAUCASION	32	44%	157	41%	100	71%	289	49%
HISPANIC/ LATINO	0	0%	8	2%	2	1%	10	2%
HISPANIC/ LATINO/ CAUCASION	0	0%	1	0%	0	0%	1	0%
ASIAN/ PACIFIC ISLANDER	1	1%	11	3%	2	1%	14	2%
AMERICAN INDIAN	2	3%	2	1%	4	3%	8	1%
OTHER	0	0%	7	2%	1	1%	11	2%
NR	0	0%	9	2%	2	1%	11	2%
TOTAL	72	100%	379	100%	141	100%	592	100%

Minor Children in the Home

This measure was imperfect at best. In several of the early focus groups, the question eliciting this input did not include the word “minor,” i.e., “Do you have children living with you?” As a result, some respondents answered yes when they had adult children sharing their household. So there may be some over counting of the numbers reported for those with minor children in the home. In Summit County, 35% of households have minor children in the home.⁴⁹ By comparison, 42% of the respondents reported living with children. Given the defect, it is important to draw conclusions from this data carefully.

Table 4: Participation in Community Engagement by Type and Minor Children Living in the Home

	JAN. 24 FORUM		PAPER SURVEY		ONLINE SURVEY		TOTAL	
MINOR CHILDREN IN HOME	NO.	%	NO	%	NO	%	NO.	%
YES	20	28%	188	50%	39	28%	247	42%
NO	52	72%	156	41%	101	72%	309	52%
NR	0	0%	35	9%	1	1%	36	6%
TOTAL	72	100%	379	100%	141	100%	592	100%

Zip Code of Residence

The CEP also captured the zip codes of participants, for two reasons. First, the CEP group felt it might be a rough proxy for income, an important social determinant of health. The CEP group considered asking respondents their income, but decided against it as off-putting. Second, the CEP group speculated that policymakers would be interested in knowing which regions of the city and county were represented by the 592 participants.

Eighty-eight percent of respondents were from 33 zip codes (there are a total of 46 zip codes in Summit County). Moreover, each zip code in which 3 or more respondents resided are included in this 88%. The table of zip codes is included below.

Table 5: Top 33 Zip Codes

ZIP CODE	NO.	%	NEIGHBORHOOD	ZIP CODE	NO.	%	NEIGHBORHOOD
44320	61	10%	Akron- Maple Valley	44221	9	2%	Cuyahoga Falls
44305	60	10%	East Akron	44240	9	2%	Kent
44306	58	10%	South Arlington	44278	9	2%	Tallmadge
44313	46	8%	Akron-Fairlawn	44303	9	2%	Northwest Akron
44310	28	5%	Chapel Hill	44321	9	2%	Akron- Copley
44203	26	4%	Barberton	44223	8	1%	Cuyahoga Falls
44307	24	4%	Southwest Akron	44281	8	1%	Wadsworth
44333	17	3%	Fairlawn	44304	6	1%	Akron- City Hospital
44302	16	3%	West Akron	44720	6	1%	Akron- Middlebury
44301	14	2%	Firestone Park	44262	4	1%	Munroe Falls
44312	14	2%	Ellet	44087	3	1%	Twinsburg
44319	14	2%	Akron- New Franklin	44147	3	1%	Broadview Heights
44224	13	2%	Stow	44216	3	1%	Manchester
44311	13	2%	Akron- UA Area	44256	3	1%	Medina
44314	12	2%	Akron- Kenmore Area	44266	3	1%	Ravenna
44236	10	2%	Hudson	44685	3	1%	Uniontown
				TOTAL	426	88%	

What Did We Learn?

The sections below describe the information participants shared about what is working in their communities and what is not. From this information, several themes emerge that can form the basis for policy making. There is a strong foundation on which to build by enhancing what is working and by revisiting what is not.

WHAT ABOUT OR IN YOUR COMMUNITY GIVES YOU JOY, HAPPINESS OR PLEASURE IN YOUR LIFE?

1. Relationships & Purpose

- Having sense of belonging through connections with family, friends, and neighbors; and
- Having purpose, helping others and engaging in spiritual endeavors.

2. Community Infrastructure, Built Environment, and Business Engagement

- Community Infrastructure;
- The Built Environment; and
- Business Engagement.

3. Basic Needs Being Met

WHAT ABOUT OR IN YOUR COMMUNITY KEEPS YOU FROM EXPERIENCING JOY, HAPPINESS, OR PLEASURE IN YOUR LIFE?

1. Connections with Individuals and with Community Institutions that are Broken

2. Basic Needs that are Not Being Met

3. An Inhospitable Built Environment

4. A Lack of Meaning and Purpose

5. Weather-Related Challenges

WHAT ABOUT OR IN YOUR COMMUNITY GIVES YOU JOY,
HAPPINESS OR PLEASURE IN YOUR LIFE?

Relationships & Purpose

Community members mentioned many things in their communities and lives that are working.⁵⁰ First and foremost are the important connections with individuals and with their community. Two prominent themes described by many were:

- 1. Having a sense of belonging through connections with family, friends & neighbors.**
- 2. Having purpose, helping others, and engaging in spiritual endeavors.**

Connections with family is the single most significant, positive element in peoples' lives that was mentioned. Connections with family, friends and neighbors, as well as having a sense of belonging and participating in community events and activities, accounts for more than 35% of the responses that were able to be categorized as the means through which respondents find joy in their lives. The importance of having a sense of belonging cannot be overstated. Respondents described these relationships with such detail as "being able to take my son to school and [do] homework with him after school," "companionship, friends, [and] strong relationships," and "community members working hard to create a thriving community." Being in relationships with people who are special to them is the number one positive element in respondents' lives. A closely related theme is the importance of having purpose and meaning in life, by prioritizing the well-being of others and by having a spiritual relationship. Several people offered context for their response, such as, "giving patients a smile on their faces," "helping others achieve happiness," and "motivating and inspiring youth." Others referenced the pleasure they get through their churches, spirituality, and relationships with God. For example, one person said "working with students in Sunday school." Another offered, "God's willingness to guide me through my trials in life," while a third offered simply, "praying, fellowship."

At the community forum, participants offered some direction as to what helps them create satisfying relationships and connections with a larger community. First, they believe individuals have to be willing to engage, allow themselves to trust and take responsibility for fostering healthy relationships. Second, they reported the need for certain skills, such as listening, communication and social skills. Third, they want more opportunities for making connections, like free or low cost programs to connect youth and seniors and opportunities for neighbors to get to know each other. They also want occasions to get to know others from different racial, ethnic, and economic backgrounds. Fourth, they stated a need for tools to access opportunities for identifying local resources and connecting with new people. One explicitly-identified tool was public transportation, as a means to take advantage of existing opportunities.

It is remarkable that these elements - being connected to family, friends, and neighbors and to the larger community, whether through church, work, or civic outlets - form the foundation of what is working in Summit County. It indicates that the people of Summit County appreciate being part of something beyond their individual lives. It also points to the value people find in such intangibles as family and community.

Community Infrastructure, Built Environment, and Business Engagement.

Three additional closely-related themes that were also widely identified by respondents as contributing to their happiness were:

- 1. Community Infrastructure;**
- 2. Built Environment; and**
- 3. Business Engagement.**

Taken together, these areas that highlight community assets, both public and private, were specified in over a quarter of the categorized responses. People described these positive elements in their lives in a variety of ways. From neighborhood parks to the Summit County Metro Parks, to the Towpath, to the Cuyahoga Valley National Park, respondents made clear that the park system, with its hiking, walking, and biking trails, plays a conspicuous and affirming role in their lives. Many respondents expressed their pleasure in being outdoors, in the fresh air, engaging in outdoor activities, and communing with nature. Others identified access to recreational infrastructure like gyms, fitness centers, or community centers as

instrumental in their lives. Moreover, when describing infrastructure elements that were working, respondents included specific concepts, such as “proximity to downtown,” “city is revitalized,” and “walking to the store.” Among the cultural institutions specifically identified were the Civic Theater, the Public Library, Lock3, and EJ Thomas Hall. In addition, a handful of respondents explicitly identified the business presence as essential to what is good in their communities. “Downtown Partnerships,” “local businesses,” and economic revitalization are part of what is working for residents.

Forum participants enumerated some of the infrastructure that is needed to enable them to take better advantage of their surroundings: safe neighborhoods, clean schools, free community events, and clean drinking water. One forum group expressed the importance of having police officers trained in managing evolving situations, including people with diverse needs.



Basic Needs Being Met

A third important theme people identified was the joy they feel when their basic needs are met. Living in a safe, peaceful environment, accessing healthy food and health care, experiencing financial security by virtue of income and jobs, and appreciating the strong pre-K-grade 12 educational system was uppermost in the minds of 145 respondents, over 15% of those whose responses were categorized. Of these, the joy that comes from feeling safe stands out as the basic need offered the most by respondents. Forum participants also emphasized the need for support to maintain physical and mental wellbeing. People specifically referenced needing access to safe and affordable food, and being both motivated and having time to be physically active and spend time outdoors. To encourage school-aged children and youth to be physically active, they need physical activities both during and after the school day, transportation to and from school, and safe affordable opportunities to be outside. These responses serve as a reminder that meeting the basic needs of the individual members of the community should not be taken for granted. When it occurs, it is one of the most important positive elements in people’s lives.

Table 6: What about or in your community gives you joy?
(Survey Responses)

CONNECTIONS	No.	COMMUNITY INFRASTRUCTURE	No.
Family	122	Parks including Metro & CVNP	75
Friends	75	Arts & cultural events	39
Belonging/community	57	Places for physical activity	30
Community events & activities	47	Library	12
Neighbors	17	Restaurants	7
Gathering places	12	Services	4
Pets	9	Sports teams	2
Community Support	8	Zoo	1
Work-related connections	2	TOTAL	170
TOTAL	349	MEANING & PURPOSE	No.
BASIC NEEDS	No.	Well-being of others	34
Safety, including peace	52	Church/religion	22
Food access	30	God/spiritual being	17
Health, including medical care	29	Work-related	17
Income/work	18	Generally	15
Education	16	Volunteering	9
Housing	4	Service	8
Transportation	3	TOTAL	122
Generally	2	OTHER	No.
Water	1	Leisure time	17
TOTAL	155	Arts & cultural events	8
BUILT ENVIRONMENT	No.	Places for physical activity	7
Open spaces/green spaces	20	Library	3
Shopping	20	TOTAL	35
Infrastructure	19	Total of all categories	17
Other	8	Nothing mentioned	8
TOTAL	67	Unable to categorize	7
		GRAND TOTAL	958

The people who engaged in this process have identified five essential themes that capture those elements in the community that are working for them. These elements provide a place of strength from which to view any policy considerations that come from the Health in All Policies Initiative. Policy makers, whether public or private, considering a change in policy, or one policy over another, should evaluate how that policy will either enhance or undermine these elements. To the extent feasible, policy makers should strive to enhance, at best, and not undermine, at least, these positive elements in recognition of the health implications.



WHAT ABOUT OR IN YOUR COMMUNITY KEEPS YOU FROM EXPERIENCING JOY, HAPPINESS OR PLEASURE IN YOUR LIFE?

Respondents also provided valuable information about what is not working in their communities and in their lives.⁵¹ Five themes emerged as the most significant barriers people face in their communities. Although each of these themes is described in a myriad of ways, they are essentially:

Broken Connections with Individuals and Communities.

The most significant barriers people face in their lives are the inverse of what they found to be working. Where connections are the most significant positive element, broken connections, whether with people or institutions, are the most significant people face. First and foremost among these barriers to happiness is living in the midst of unlawful activities, including shootings and killings. Over 10% of survey respondents identified this single condition as a problem. Combining this response with the similar and potentially related responses of drug activity, gangs, noise, and sirens brings this set of circumstances to the very top of the list of barriers. These circumstances reflect a broken connection between and among those with whom respondents live, work and play.

If “the drug dealer next door,” as described by one respondent, is undermining the ability of others to live in a safe and pleasing environment, then that respondent and his neighbor are not enjoying a connection that is enhancing their well being.

Experiencing racism, both personally-mediated and institutional,⁵² is another specific example of circumstances that reflect a broken connection in the community. Respondents described this barrier in various ways, such as “stress of being a person of color and all the negative experiences encountered because of racism;” “intolerance toward and/or disregard for others, especially toward minority populations, refugees, immigrants, non-Judeo-Christians, [and] the poor...;” and “racial profiling.” Respondents also specifically identified a broken relationship between residents in urban neighborhoods and law enforcement, citing conditions of negative police presence as a specific barrier in their lives. Some described these conditions as “the unjust application of laws on the street by police;” “broken windows’ policing,⁵³” and “high target risk due to race [and] criminal record.”

In relation to police presence in communities, respondents named as barriers insufficient cultural competency, representative diversity, connection to communities, and understanding of historical and root causes of poverty.

FORUM PARTICIPANTS FURTHER DESCRIBED RACE CONCERNS AS RACIAL PROFILING, TARGETING OF BLACK PEOPLE WITH FELONY CONVICTIONS, LACK OF TRUST BETWEEN PEOPLE OF COLOR AND LAW ENFORCEMENT, AND SYSTEMIC AND INSTITUTIONAL RACISM.

Broken relationships with community institutions points to a deeper issue, as is evident from the concerns shared by forum participants. The deeper issue is the feelings residents expressed of being voiceless, isolated and a disconnected from decision-makers whose decisions have a significant impact on their daily lives. These feelings are evident from the following statements about barriers people face (paraphrased for readability).

- **Legislation designed to reduce judgments based on our looks, appearance, income, race and community is not enforced.**
- **The police need to be more connected to communities and need additional training that includes education on poverty.**
- **There are not enough block clubs.**
- **Because police are not representative of their community, community members are stigmatized; police lack respect for community members' culture.**
- **We are ineffective in affecting change in unfair policies.**
- **The city government does not address the problems of abandoned houses, slumlords, and issues with zoning regulations.**
- **Administrators adhere to policies and regulations too slavishly without remembering goal of the policy--not just the letter of the policy.**
- **I have responsibility without authority to solve problems.**

In addition to these places of broken connections, respondents also identified:

- **Broken family relationships;**
- **Broken relationships with neighbors and co-workers; and**
- **Broken relationships with other individuals, as evidenced by "bullies," "naysayers," "rudeness," "disrespect," "apathy," and "selfish people."**





Unmet Basic Needs

A counter to the positive theme of having one's basic needs met is the opposite negative theme of having unmet basic needs. Insufficient income and jobs was a critical factor among unmet needs. Sixty-two survey respondents specifically described this barrier, stating "need a job for everyone, this will result in less crime," "low-wage employment," "fewer opportunities," and "difficulty

obtaining gainful employment." Many forum participants also pointed to financial instability, as a result of high health care, medical, education, and childcare costs, among other things, as a significant barrier in their lives. Poverty, living with insufficient resources, and the inability to earn enough money to alleviate the situation are leaving people stressed at a fundamental level.

Survey respondents and forum participants also expressed unmet basic needs in other contexts, for example:

- **Unmet need for a safe living environment, e.g., "rampant violence that prevents people from feeling safe," "knowing crime and violence can occur at any time," and "neighborhood violence";**
- **Unmet physical and mental health needs, e.g., "depression," "stress," and "sleep deprivation";**
- **Unmet transportation needs, e.g., "no car," and "lack of adequate public transportation";**
- **Unmet education needs, e.g., "struggling school systems," and "lack of universal, high-quality preschool";**
- **Unmet need for access to healthy food, e.g., "not enough quality grocery stores," and "corner store with limited healthy food"; and**
- **Unmet housing needs, e.g., "homeless persons" and "dislocation of city residences."**

Inhospitable Built Environment; Gaps in Community Infrastructure

The third negative theme people identified in their responses is dealing with an inhospitable built environment. “Speeding cars,” “traffic,” “not enough sidewalks,” and “abandoned houses” were among some specifics mentioned. In addition, several people articulated dissatisfaction with the need to drive everywhere, stating, e.g., “I wish our community were more walkable,” and “not enough things to do in walking distance.” Closely related to the inhospitable built environment are gaps in community infrastructure. Respondents shared that there are not enough interesting restaurants, cafes, and locally-owned stores. A couple of people also pinpointed difficulties meeting people, suggesting a need for more social opportunities.

Meaning and Purpose Lacking

The absence of meaning and purpose was a fourth theme that emerged from responses. This gap centered primarily on the struggle to have enough time after working long hours to do other things, perhaps spending time with family or having fun. The pressure people feel to find ways to meet their basic need for income likely detracts from their ability to have the relative luxury of having a life filled with meaning and purpose. As forum participants contributed, that luxury is also denied to people struggling with poor health. One person shared: “if you are sick, you cannot think of goals to fulfill.” Another explained: “illness gets in the way; with illness, [you] can’t focus on anything else.” All the joy that people attain by having a meaning-filled and purposeful life, as respondents described in response to the previous question, is unavailable to those who instead are struggling with time and health constraints, and otherwise trying to meet basic needs.

Weather

Finally, the weather in Northeast Ohio, especially in the winter, presents its own set of challenges. This survey was conducted in October – January of 2015, during some very cold months, which may have skewed the responses. But it is undeniable that the cold months take a toll, as specifically mentioned by two people, in terms of fewer free outdoor community events and fewer hours of sunlight.

While the weather remains outside the control of policy-makers, how our local institutions respond is not. For example, if local government would facilitate a better system for clearing sidewalks in the winter so pedestrians, particularly school children, could use them, that system would improve the ability of residents to be more physically active during snowy months. The need for such a system was particularly evident during the 2014-2015 winter months, when a 16 year old student pedestrian was injured in a car accident while walking in the street because the sidewalks were not clear.⁵⁴ In addition to encouraging outdoor winter activity, identifying ways to use indoor venues for free indoor community events from November through March might also be welcomed. In short, rather than creating conditions for further isolation, challenging weather can bring new opportunities for connection.

Table 7: What about or in your community gives you from experiencing joy, happiness or pleasure in your life?
(Survey Responses)

BROKEN CONNECTIONS	No.	BASIC NEEDS- UNMENT	No.
Unlawful behavior, shootings, killings	48	Income, work	62
Drama, negative attitudes	34	Physical & mental health	42
Generally	22	Transportation	10
Racist behavior, institutional racism	16	Housing	8
Drug activity, gangs	12	Food access	7
Work-related	13	Education	6
Family dysfunction	10	Pollution	2
Lack of services	10	TOTAL	159
Lack of curtesy & respect	9	MEANING & PURPOSE	No.
Negative police presence	8	Lack of time, lack of work/life balance	23
Narrow-minded thinking	5	Lack of empathy	6
Lack of effort, apathy	5	Lack of spirituality	3
Neighbors	5	TOTAL	32
Noise, sirens	4	OTHER	No.
TOTAL	201	Weather	16
IN-HOSPITABLE BUILT ENVIRONMENT	No.	TOTAL	16
Traffic, roads	14		
Infrastructure lacking	8		
Generally	6	Total of all categories	456
Sidewalks	5	Nothing mentioned	56
Vacant property	3	Unable to categorize	67
TOTAL	36	GRAND TOTAL	579
COMMUNITY INFRASTRUCTURE LACKING	No.		
To encourage social interaction	4		
Interesting restaurants & shops	4		
Cultural events & live entertainment	4		
TOTAL	12		

IF YOU WANT YOUR POLICY MAKERS TO BE THINKING ABOUT ONE THING WHEN THEY MAKE DECISIONS IN 2015 RELATED TO YOUR WELLNESS, WHAT WOULD IT BE?

Forum participants had the opportunity to answer an additional question that was designed to be open-ended. To make sure they were able to share the most important issue on their minds, they were asked: If you want your policy makers to be thinking about one thing when they make decisions in 2015 related to your wellness, what would it be?⁵⁵ Many themes similar to those already discussed were raised in response to this question. However, respondents elevated the intensity surrounding some of those areas by giving them greater emphasis. For example, the need for better health care systems was emphasized by many, with specific comments calling for renewal of Medicaid Expansion (and better education about it), provision of dental care, implementation of patient medical homes and reproductive justice. Mental health services in particular were the focus for a number of participants, some of whom pointed out the need for more complete mental health care, better management of chronic mental health issues, greater opportunities for early psychological intervention and reduced stigmatization of individuals with mental illness.

Other areas that received greater treatment in response to this question were youth services and education. Participants signaled the importance of having the voice of youth represented at decision-making tables. Socialization of youth services, like Boys and Girls Clubs for youth and Better Lives for Children, also received greater emphasis. One person commented that students need more chances, guidance, and help when they make mistakes. Educational and environmental influences on children were also identified as needing attention. Participants desire better education on healthy food preparation for youth, health fairs and programming for young children (under age 5), healthy food environments in schools, more physical exercise for students and greater safety for students commuting to school. Participants also called for better financing for education and more educational opportunities. With regard to higher education, participants desire policymakers to address the need for affordable higher education.

Other environmental issues received some attention. Safe drinking water was a prominent theme, as is clear from the numerous comments on water quality, water management, storm water run-off and fracking. Renewable energy also was mentioned.

One final focal point that has received little attention thus far, but that is perhaps the single most significant message from participants, is that they feel disconnected from policy-makers. They seek better connection between policy-makers and the community, including improved communication, particularly with underserved communities. The need to act *with* rather than *for* disenfranchised groups like people of color, children and youth, elderly residents and people who experience health disparities cannot be overemphasized.

What Comes Next?

Between the time of the forum in January 2015 and completion of the drafting of this report in late 2015, several subsequent milestones were achieved. A drafting committee convened to distill the vast amount of information gathered, analyze the community input and draft this report.⁵⁶ At three points, the work of that committee was presented to various groups. First, on March 27, 2015, a preliminary report on the findings of these efforts were presented at the quarterly Board meeting of Healthy Connections Network. Second, on May 12, 2015, another more comprehensive report was given at a community meeting in Akron. Third, on May 18, 2015, Health Connections Network Executive Committee received an update on the progress of the report and discussed the continuation of this work within the Health Equity and Social Determinants Unit at Summit County Public Health.

Next Steps

In addition, the Health in All Policies Workgroup will reconstitute itself⁵⁷ with the charge to develop a strategy for using what we learned from community engagement to inform policy-level decision-making. Steps to accomplish this include:

1.

Determining whether gaps in community engagement effort, for example, the lack of input obtained from the local refugee community and other newcomers to the United States, can be practically remedied.

2. DESIGNING A COMMUNICATION PLAN

to educate and inform Akron and Summit County policy makers about the benefits of a Health in All Policies approach and of adopting a Health Charter.



3. Emphasizing economic development and related implications for long term planning of Health in All Policies approach.

4.

Considering whether or how to incorporate findings from other community engagement efforts, including current Safe Routes to School initiative, Health in Transportation project, Gun Violence as a Public Health Crisis effort and Complete Streets principles.

5. OUTLINING POTENTIAL PROVISIONS OF A HEALTH CHARTER.



Identifying and educating additional decision makers, including other municipalities and private, public, and nonprofit businesses that might also consider adopting a Health in All Policies approach and a Health Charter.

6.



Researching and identifying potential policy-level approaches to address issues raised by community engagement work.⁵⁸



8. CREATING AN IMPLEMENTATION PLAN

that incorporates ongoing community input, monitoring of transparency and adherence to the integrity of the Health in All Policies approach.

Community Leaders anticipate that the September 2015 Healthy Connections Board meeting will be devoted to reviewing the findings of the community engagement work, identifying recommendations and beginning to draft a health charter to be presented to city and county councils in the subsequent 30-60 days.

CONCLUSION

The Community Engagement Plan developed and implemented to ask Summit County residents what they think is important was, for the most part, successful. Neighborhood and community strengths and barriers have been identified. Next steps have been outlined and are already underway. The reconstituted HiAP Workgroup remains committed to the goal of developing recommendations for policy makers to use in fashioning and adopting a Health Charter. But even this accomplishment is only a means to the end of healthier Summit County residents.

Summit County
Health in All Policies



Endnotes

- 1 Ohio Infant Mortality Data: 2007-2012 Infant Mortality by Race, Age, and County Mortality by Race, Age, and County (July 28, 2015) Ohio Department of Health. Retrieved from <http://www.odh.ohio.gov/odhprograms/cfhs/octpim/latestoimd.aspx>. Summit County Health and Health Disparities Report (n.d.). Retrieved from www.scphoh.org/PDFS/PDF-Reports/Health_HealthDisparitiesRept2015.pdf.
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- 3 Ohio Department of Health (n.d.). 2013 Ohio Infant Mortality Data: General Findings. Retrieved from 2013 Ohio Infant Mortality Data Report FINAL <http://www.odh.ohio.gov/odhprograms/cfhs/octpim/latestoimd.aspx>.
- 4 This shift has been informed by, inter alia, the work of Centers for Disease Control and Management Director Tom Frieden, and is illustrated by The Health Impact Pyramid that he describes in his scholarly writings. See, e.g., Frieden, T. R. (2010). A framework for public health action: the health impact pyramid. *American journal of public health*, 100(4), 590-595.
- 5 Mandal, A. (2014). What are Health Disparities? News Medical. Retrieved from <http://www.news-medical.net/health/What-are-Health-Disparities.aspx>.
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- 7 Id.
- 8 For full description of year one see: Description: Summit Partners for Accountable Care Community Transformation (Summit PACCT): Executive Summary Year 1 (p. 3). (2013). Summit PACCT. Retrieved from <http://www.livehealthysummit.com/reports/>. For full description of year two see: Executive Summary. Summit Partners for Accountable Care Community Transformation (Summit PACCT) (p. 1). (n.d.) Summit PACCT. Retrieved from <http://www.livehealthysummit.com/reports/>. For full description of year three see: Executive Summary. In Summit Partners for Accountable Care Community Transformation (Summit PACCT). Summit Partners for Accountable Care Community Transformation (Summit PACCT). (2013). Summit PACCT. Retrieved from <http://www.livehealthysummit.com/reports/>.
- 9 See Description. Summit Partners for Accountable Care Community Transformation (Summit PACCT): Executive Summary Year 1 (p. 3). (2013). Retrieved from <http://www.livehealthysummit.com/reports/>.
- 10 Chattanooga City Ordinance Section 32-340 provides a useful definition of Complete Streets. "Complete Streets" are streets that are designed, built and operated to enable safe access for all users, in that pedestrians, bicyclists, motorists and public transportation users of all ages and abilities are able to safely move along and across the street right-of-way.
- 11 Mark Fenton: Healthy Physical Environments Summit. (2012). Summit Partners for Accountable Care Community Transformation (Summit PACCT), 3. Retrieved from <http://www.livehealthysummit.com/reports/>.
- 12 See Appendix A: HiAP Workgroup Members. Summit Partners for Accountable Care Community Transformation (Summit PACCT): Capacity Building for Community Health Improvement (p. 27). (2013). Retrieved from <http://www.livehealthysummit.com/reports/>.
- 13 See Appendix B: Members of Summit County Delegation who traveled Cuba.
- 14 Dr. C. William Keck is a former director of health for the city of Akron and a past president of the American Public Health Association. Powell, C., & Warsmith, S. (2014, February 25). Akron-area officials travel to Cuba to study community health-care practices. Retrieved from <http://www.ohio.com/business/akron-area-officials-travel-to-cuba-to-study-community-health-care-practices-1.469183>.

- 15 C. William Keck and Gail A. Reed. The Curious Case of Cuba. *American Journal of Public Health*: August 2012, Vol. 102, No. 8, pp. e13-e22. doi: 10.2105/AJPH.2012.300822.
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- 25 The California Health in All Policies Task Force. Retrieved from http://sgc.ca.gov/s_hiap.php.
- 26 See Appendix C: Core Community Engagement Plan Workgroup Members. This list identifies those individual who attended meetings with some regularity. Many others participated in one or two meetings, giving voice to their constituents.
- 27 *Community Engagement Guide: A tool to advance Equity and Social Justice in King County*. (2011). Retrieved from <http://www.kingcounty.gov/elected/executive/equity-social-justice.aspx>.
- 28 See page 21.
- 29 Wellesley Institute, dir. "Making The Connections: Our City, Our Society, Our Health" YouTube. 22 Nov 2012. Web. 15 July 2015: <https://www.youtube.com/watch?v=LMPQEMb0Trc>. The group deliberated over four possible videos to use to introduce the concept of health as more than "healthcare." The remaining three videos considered were: UNNATURALCAUSES: Is Inequality Making Us Sick?, dir. "Unnatural Causes trailer" YouTube. 26 Mar 2008. Web. 9 July 2015: <https://www.youtube.com/watch?v=uE7v5cHIHDQ>; Office of Disease Prevention and Health Promotion, dir. "Preparing for the Next Decade: A 2020 Vision for Healthy People" YouTube. Web. 10 Sep 2012. Web. 9 July 2015: <https://www.youtube.com/watch?v=zZG94c7xQmE>; U.S. Department of Health and Human Services (HHS), dir. "Determinants of Health: A Framework for Reaching Healthy People 2020 Goals" YouTube.
- 30 May 2013. Web. 9 July 2015 : <https://www.youtube.com/watch?v=IXYhKjj-SIE>. 30 Substance Abuse and Mental Health Services Administration. *Eight Dimensions of Wellness*. (2015). Retrieved from <http://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness>.
- 31 See Appendix D: Eight Dimensions of Wellness handout.
- 32 See Appendix E: Copy of ½ sheet survey, front and back.
- 33 The process used in the focus groups evolved as improvements were identified. This report describes the process as it existed for the later focus groups.
- 34 See Appendix F: Places where paper surveys were distributed, or people who distributed surveys.

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- 36 See Appendix G: Places where electronic link to survey could be accessed.
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- 41 See Appendix I. Sponsors for Community Engagement Forum.
- 42 See Appendix J: Places where focus groups were conducted.
- 43 See Appendix F.
- 44 See Appendix G.
- 45 While it is possible that people participated multiple times, the CEP group has no reason to believe anyone did so other than unintentionally.
- 46 Summit County, Ohio. Retrieved from http://www.city-data.com/county/Summit_County-OH.html.
- 47 Id.
- 48 Id.
- 49 Id.
- 50 For full list of responses to Question 1, visit www.livehealthysummit.com.
- 51 For full list of responses to Question 2, visit www.livehealthysummit.com.
- 52 According to Dr. Jones, the three levels of racism are institutionalized, personally-mediated, and internalized. "Institutionalized racism is defined as the structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by race. Personally mediated racism is defined as prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race. Internalized racism is defined as acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth." Jones, C. (2000). Levels of Racism: A Theoretic Framework and a Gardener's Tale. *American Journal of Public Health*, 90(8), 1212-1213. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446334/pdf/10936998.pdf>.
- 53 According to journalist Jamelle Bouie, "[b]roken windows policy prioritizes cracking down on minor offenses on the theory that doing so can preempt serious crime." Bouie, J. (2014, August 05). Broken Windows Policing Kills People. Retrieved from http://www.slate.com/articles/news_and_politics/politics/2014/08/broken_windows_policing_deaths_racism_in_chokeholds_arrests_and_convictions.html.
- 54 Trexler, Phil. Akron Team Shocked by Hit-and-Run Drives; citation delivered to hospital. Akron Beacon Journal February 24, 2015. Retrieved from <http://www.ohio.com/news/break-news/akron-teen-shocked-by-hit-and-run-driver-citation-delivered-to-hospital-1.569471>
- 55 For full list of responses to from Forum participants, visit www.livehealthysummit.com.
- 56 See Appendix K: Members of Health in All Policies drafting committee.
- 57 At least 20 people have expressed interest in being part of the continuing conversation on this initiative.
- 58 Several such policy-level initiatives, like the raising the minimum wage, maintaining a requirement that contractors for the city hire a certain percentage of local workers, and improving food access have already come to mind.



APPENDIX
Health in all Policies

Community Engagement Report

APPENDIX A

WORKGROUP MEMBERS

Heather Beard, PhD	Summit County Public Health
Anureet Benipal, MPH	Austen BioInnovation Institute in Akron
Alison Capoun, BS, RS	Summit County Public Health
Tracy Carter, MHSA	Summa Health System
Donae Ceja	United Way of Summit County
Billi Copeland-King, JD	Summa Health System
Brenda Cox, MPA	United Way of Summit County and Minority Health Roundtable
Tim Cox, MPA	Austen BioInnovation Institute in Akron
Marie B. Curry, JD, MPH	Community Legal Aid
Sujay Datta, PhD	The University of Akron
Kady Downing	Community Member
Susan Gerberich, RN, PhD, CNS	Healthy Connections Network
Sue Hobson, BA, MA	Akron General Health System
Sharon K. Hull MD, MPA	Northeast Ohio Medical University
Janine Janosky, PhD	Austen BioInnovation Institute in Akron
Ryan Jaskolka, MBA	Child Guidance and Family Solutions
Kerry Kernen, MPA, MSN, RN	Summit County Public Health
Amy Lee, MD, MPH, MBA	Northeast Ohio Medical University
Mary Anne Loftus, RN, BS	Akron General Health System
Richard Marountas, MPA	Summit County Public Health
Sally Missimi, PhD, RN	Summa Health System
Alida J. Moonen, PhD	Summa Health System
Eric J. Mundy, PhD	The University of Akron
Vicki England Patton, MS	Austen BioInnovation Institute in Akron
Melissa Peace, MSSA, LISW-S	Akron Children's Hospital
Annalisa Piccorelli, PhD	The University of Akron
Erik Porfeli, PhD	Northeast Ohio Medical University
Michael Rickles, MA	Austen BioInnovation Institute in Akron
Michael Steiner, MA	Austen BioInnovation Institute in Akron
Mollie Sturm, MPH	Austen BioInnovation Institute in Akron
Annette Sues-Mitzel, RN, DNP,CNS	The University of Akron
Jennifer L.S. Teller, PhD	Austen BioInnovation Institute in Akron
Laura Turner-Essel, MA	Austen BioInnovation Institute in Akron
Terri Underwood, Paralegal	Community Legal Aid
Meredith Watts, JD	Community Legal Aid

APPENDIX B

MEMBERS OF SUMMIT COUNTY DELEGATION WHO TRAVELED TO CUBA

Dr. Norm Christopher	Akron Children's Hospital
Dr. Kris M Drummond	Axess Pointe Community Health Center
Dr. William Keck	Northeast Ohio Medical University
Dr Jeff Kempf	Akron Children's Hospital
Dr. Amy Lee	Northeast Ohio Medical University
Dr. Mark Munetz	Northeast Ohio Medical University
Gene Nixon	Summit County Public Health
Dr. Kim Peer	Kent State University
Don Plusquellic	Mayor of Akron
Russ Pry	Summit County Executive
Ken Slenkovick	Summit County Public Health
Marco Sommerville	Akron City Council President
Dr. Janice Splading	Northeast Ohio Medical University
Tom Strauss	Summa Health System
Dr. Jeff Sussman	Northeast Ohio Medical University

APPENDIX C

CORE COMMUNITY ENGAGEMENT PLAN WORKGROUP MEMBERS

Terry Albanese	City of Akron Mayor's Office
Nichole Ammon	Northeastern Ohio Medical University
Billi Copeland-King	Summa Health System
Marie B. Curry	Community Legal Aid Services, Inc.
Kris Drummond	AxessPointe Community Health Center
Jerry Egan	American Planning Association of Ohio, Akron Chapter
Sylvia Gage	Community Resident
Monique Harris	Summit County Public Health
Bob Hasenyager	Summit County Public Health
Bob Howard	Akron Children's Hospital, Retired
Sue Hobson	Akron General Medical Center
Elizabeth James	Summit County Public Health
Illene Katz Jewel	Austen BioInnovation Institute in Akron
Jeffrey Krauss	Summit County Public Health
Greta Lax	Akron-Region Interprofessional Area Health Education Center
Joshua Morgan	CANAPI
Mary Raitano	International Institute of Akron
Tiffanie Riggs	Paramount
Sam Rubens	Summit County Public Health
Cory St. Esprit	United Way of Summit County
Veronica Sims	Akron Summit Community Action, Inc.
Doug Smith	Alcohol, Drug Addition & Mental Health Board
Hattie Tracy	Child Guidance and Family Solutions
Jennifer Teller	Austen BioInnovation Institute in Akron
Ted Thompson	Community Resident
Minette Wilson	Summit County Public Health

APPENDIX D

THE EIGHT DIMENSIONS OF WELLNESS (ADAPTED FROM SAMHSA)

These are the eight dimensions of Wellness.
These dimensions affect your health and wellbeing.



- Emotional Wellness is creating satisfying relationships.
- Environmental Wellness is being in pleasant, stimulating surroundings.
- Financial Wellness is feeling good about your current and future money-related circumstances.
- Intellectual Wellness is knowing your abilities and finding ways to grow in your knowledge and skills.
- Occupational Wellness is how satisfied or excited you are about your work.
- Physical Wellness is your physical activity, your eating habits, and your sleep.
- Social Wellness is your sense of connection and belonging, and having people around you to help you when you need it.
- Spiritual Wellness is having purpose and meaning in your life.

APPENDIX E

HALF-SHEET SURVEY: FRONT & BACK

Now that you have learned about The Eight Dimensions of Wellness, we'd like to ask you a few short questions. We want to know what is important to you in your effort to be well. Please answer these questions.

1. What ABOUT or IN YOUR COMMUNITY gives you joy, happiness, or pleasure in your life?
2. What ABOUT or IN YOUR COMMUNITY keeps you from experiencing joy, happiness, or pleasure in your life?
3. Think of how long you would like to live. What ABOUT or IN YOUR COMMUNITY do you think might get in the way of your living as long as you would like to live?

Site (location):

Now, please tell us something about yourself.

Are you Male or Female

Age _____

What is your zipcode? _____

Do you have minor children living with you? Yes No

Race:

African American/ Black

American Indian

Asian/ Pacific Islander

Caucasian/ White

Hispanic/ Latino

Other _____

For office use: This survey is part of Health in All Policies community engagement. Please return to M. Curry @ 50 South Main Street, Suite 800, Akron OH 44308-1828 For Q call 330 983 2657

Thank you!

11/17/2014

APPENDIX F

PLACES WHERE PAPER SURVEYS WERE DISTRIBUTED OR PEOPLE WHO DISTRIBUTED SURVEYS

1. Axxess Pointe patients
 2. Summit County Public Health – Accountable Care Community enrollment events
 3. Summit County Public Health - Breast Cancer Awareness Event
 4. Peacemakers
 5. Summa employees
 6. Akron and Vicinity Interdenominational Ministerial Alliance
 7. American Heart Association Nutrition Class
 8. University of Akron Nutrition Class
 9. Faithful Servants
 10. Juvenile Detention
 11. Life Skills
 12. Alcohol, Drug Addiction and Mental Health Services Board - clinical leaders
 13. North High School
 14. East Community Learning Center
 15. Akron City Council
 16. Mike Williams
 17. Russ Neal
 18. Tamara Samples
 19. United Baptist Church
 20. Alpha Phi Alpha
-

APPENDIX G

PLACES WHERE ELECTRONIC LINK TO SURVEY COULD BE ACCESSED

1. Summit County Public Health
 2. Axxess Pointe
 3. Community Legal Aid
 4. United Way list serve
 5. Live Healthy Summit
 6. American Planning Association, Akron chapter
 7. Minority Health Roundtable
 8. Akron City Council
 9. City of Akron
 10. United Baptist Church
 11. Wellness Council
-

APPENDIX H

FORUM PLANNING SUBCOMMITTEE

Marie B. Curry

Managing Attorney
Community Legal Aid Services, Inc.

Jeffrey Krauss

Public Health Specialist
Community Health Division Summit County Public Health

Monique C. Harris

Public Health Coordinator
Office of Minority Health Summit County Public Health

APPENDIX I

SPONSORS COMMUNITY ENGAGEMENT FORUM

1. Akron-Region Interprofessional Area Health Education Center (ARI-AHEC)
 2. Akron Summit Community Action
 3. Alcohol Drug Addiction and Mental Health Services Board (ADM Board)
 4. City of Akron
 5. AxessPointe Community Health Center
 6. Child Guidance and Family Solutions
 7. Community Aids Network Akron Pride Initiative
 8. Community Legal Aid,
 9. Direction Home (Akron Canton Area Agency On Aging)
 10. Northeast Ohio Medical University
 11. Paramount Advantage
 12. Project Ujima
 13. Summa Health System
 14. Summit County Public Health
 15. United Way of Summit County
-

APPENDIX J

PLACES WHERE FOCUS GROUPS WERE CONDUCTED

1. Mental Health Consumer Advisory Group
 2. AxxessPoint Staff Retreat
 3. Health in All Policies workgroup
 4. Minority Health Roundtable
 5. Circles (Bridges out of Poverty)
 6. Project Ujima Wellness Circle
 7. Summit County Office of Minority Health Advisory Council
 8. Ohio Organizing Collaborative
 9. Coalition for a Safe Community
 10. Summit County Wellness Council
-

APPENDIX K

MEMBERS OF HEALTH IN ALL POLICIES DRAFTING COMMITTEE

Nichole Ammon

Marie B. Curry

Meredith Fratantonio

James Hardy

Bob Howard

Greta Lax

Joshua Morgan

Hattie Tracy

Northeast Ohio Medical University

Community Legal Aid

AxessPoint Community Health Center

Summit County Public Health

Akron Children's Hospital, retired

Akron-Region Interprofessional Area Health Education Center

CANAPI

Child Guidance and Family Solutions

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Summit County

Health in All Policies

Partnering for better policies and better health