

Minority Health Council
New York State Department of Health
Ad Hoc Committee Report
On
Obesity Prevention Policy Recommendations

March, 2013

EXECUTIVE SUMMARY

The Office of Minority Health and Health Disparities Prevention (OMH HDP) and the Minority Health Council (MHC) coordinated a strategic planning process involving a broad array of stakeholders and experts to examine the impact of obesity on residents in New York State (NYS).

The discussions centered on the following questions posed to the three ad hoc workgroup committee members:

- (1) How do we best address the social determinants of obesity such as access, socially/physically safe environments, food deserts¹ and individual/collective behaviors, using either existing or new policies or initiatives that respond to these social determinants?
- (2) How do we use available state resources to identify those groups at highest risk of obesity and start within those groups to address their needs in ways that, without stigma or discrimination, provide culturally acceptable health promotion/educational information?
- (3) How do we contribute to existing healthcare by leveraging the resources of community health workers?

This report summarizes the deliberations of this working collaborative group; outlines recommendations which are all supported by or related to, obesity prevention targets established by the Healthy People 2020 Initiative and strategic solutions proposed by NYSDOH's Prevention Agenda 2013-2017; and highlights strategies and action steps critical to addressing this epidemic as well as focuses on the role of the State Department of Health in improving health outcomes for racial-ethnic minorities as part of its mission to promote and protect population health in New York State.

This report was unanimously approved by the Minority Health Council with a recommendation for sending it forward to the Commissioner of Health, Dr. Nirav Shah.

¹ Food deserts are defined as parts of the country void of fresh fruit, vegetables, and other healthful whole foods, usually found in impoverished areas. This is largely due to a lack of grocery stores, farmers' markets, and healthy food providers. Accessed from www.AmericanNutritionAssociation.org.

PROJECT ABSTRACT

In response to the obesity epidemic in the United States that has impacted some of New York State's (NYS) most vulnerable communities, the New York State Department of Health (NYSDOH) developed a cutting-edge program of obesity prevention activities as a component of its Prevention Agenda 2013-2017. Concomitantly, NYSDOH Minority Health Council (MHC) also focused its attention on the problem of obesity from the perspective of the social determinants of health which tend to have greater impact on special populations who are immigrant, LGBT, low income, elderly, youth, people with disabilities, rural residents and others from vulnerable and underserved communities. In this regard, MHC invited its members and external stakeholders to join one of three workgroups: Policy, Special Populations/Community Engagement and Workforce Diversity.

Charge to the Workgroups:

- 1. Policy Workgroup:** This workgroup focused on addressing the problem of the social determinants of obesity such as access, safety, food deserts, and made recommendations for policy that considered these determinants. They also considered existing policies and looked at ways to ensure they address the social determinants of health.
- 2. Special Populations/Community Engagement Workgroup:** This workgroup focused on the problem of addressing the needs and considerations of special populations such as rural residents, immigrants, individuals with disabilities, LGBT community, prisoners, elderly, youth and other vulnerable and underserved populations. The workgroup made recommendations for policies that address obesity in these populations through the lens of the social determinants of health, taking into consideration the many barriers they encounter such as discrimination, stigma, cultural and language barriers and culturally accessible health promotional or educational materials.
- 3. Workforce Diversity Workgroup:** This workgroup focused on the underrepresentation of racial and ethnic minorities in the health care workforce emphasizing the role and importance of community health workers. This included making recommendations in areas of policy and advocacy in support of community health workers as vital members to the public health workforce.

Methods:

Ideas and suggestions collected in the breakout session of the October 19, 2012 MHC meeting were developed through individual and group conference calls; cross-checked with the State's existing obesity prevention initiatives to avoid duplication; and conducted electronic searches to compare ideas to similar programs around the country. These methods were used to determine whether any ideas had the potential for replication in NYS. After this process, the distilled ideas were formulated to inform new policy recommendations.

Findings:

The process described above yielded a total of 12 recommendations: four from the Policy workgroup, five from Special Populations/Community Engagement, and three from Workforce Diversity. These recommendations are all supported by or related to obesity prevention targets established by the federal Healthy People 2020 Initiative, strategic solutions proposed by NYSDOH's Prevention Agenda 2013-2017 and the Designing a Strong and Healthy New York (DASH-NY) policy objectives established by the NY Academy of Medicine.

Recommendations:

1. **Policy Workgroup Recommendations** - How do we best address the social determinants of obesity such as access, socially/physically safe environments, food deserts and individual/collective behaviors, using either existing or new policies and initiatives that respond to these social determinants?
 - Improve access to and utilization of healthy foods by creating systems to obtain community buy-in, feedback and collaboration.
 - Develop coordinated collaborations across multiple sectors, through the establishment of community, academia, schools, hospitals, churches and business partnerships.
 - Enhance community in-reach of existing DOH initiatives through use of technology and media.
 - Conduct rigorous evaluation.

2. **Special Populations/Community Engagement Workgroup Recommendations** – How do we use available state resources to identify those groups at highest risk of obesity and start within those groups to address their needs in ways that, without stigma or discrimination, provide culturally acceptable health promotion/educational information?
 - Community engagement using multiple sector partnerships
 - Increased physical activity/education opportunities
 - Heightened focus on children
 - New funding approaches
 - Community-wide obesity prevention evaluation

3. **Workforce Diversity/Development Workgroup Recommendations** – How do we contribute to existing health care by leveraging the resources of community health workers?
 - How do we identify and train a workforce of community health workers (CHWs) to educate, organize, mobilize and drive the change needed in their communities to reduce obesity?
 - Development of CHW workforce in NYS to assist in community engagement and community health education.

- Establish a formal state-level infrastructure for CHWs.
- Provide funding for enhanced use of CHWs.

AD Hoc Committee on Obesity Prevention

Project Report

Introduction

The obesity epidemic in the United States has unavoidably also impacted NYS (Flegal, Carrol, Ogden, et al., 2010). However, it must be acknowledged that NYS is healthier than many other states, with a 2011 adult obesity rate of 24.5 percent, which is the 11th lowest in the country (Centers for Disease Control and Prevention, 2012). Recent improvements have been noted since the Prevention Agenda was announced in 2009. The Department’s report, “Progress to Date on 2008-2012 Prevention Agenda: Toward the Healthiest State,” showed that of the five indicators for the priority areas of Physical Activity and Nutrition, two improved to narrow the differences between the Prevention Agenda objective and the 2012 rates, and indicators of another priority are improved over time. It was also reported in the 2012 progress report that one indicator remained challenging, adult obesity prevalence rate was significantly higher than the 2013 Prevention Agenda objective derived from the 2011 obesity prevalence of 24.5% compared to the 2013 objective of 15%. ²

Consequently, there is a primary emphasis on obesity in the new Prevention Agenda, which includes in its Preventing Chronic Diseases Action Plan, Focus Area 1: to Reduce Obesity in children and adults. The focus on obesity reduction in the 2013-2017 Prevention Agenda is in response to persistent disparities in obesity prevention for children and adults and within special populations, which tend to also be impacted by specific aspects of their social and physical environments (NYSDOH - BRFSS, 2008; and Emdunds, Woelfel, Dennison, Stratton, Pruzek, & Abusabha, 2006). For example, data from the 2008 Behavioral Risk Factor Surveillance Survey suggests that obesity prevention actions such as consumption of healthy foods and levels of physical activity are known to be lowest among those who also have less education and who are Black and Hispanic (NYSDOH - BRFSS, 2008), and those who live in low-income neighborhoods (Black & Macinko, 2010).

The NYSDOH’s Minority Health Council (MHC) recognizes that obesity in general, and in low-income and special population communities in particular, is tied to factors associated with the social determinants of health. Given that, the MHC decided in spring 2012 to add its own work to augment the Prevention Agenda, using a comprehensive, community-focused approach as recommended in the literature:

² http://www.health.ny.gov/prevention/prevention_agenda/indicators_matrix.htm

“Researchers at Stanford indicate that large scale social change requires broad cross-sector coordination, yet the social sector remains focused on the isolated intervention of individual organizations (Kania & Kramer, 2011).”

In the interest of obtaining broad community change, the MHC used its July 2012 meeting to create seven workgroups – Community, Collaboration/Partnerships, Policy, Seniors/Elders, Psychosocial Determinants of Health, Workforce Diversity and Media – which were later condensed into three smaller workgroups. Subsequently, the MHC contracted with a consultant to facilitate and lead a team of interns in obtaining input from MHC members and external stakeholders, all of whom were invited to join one of the three different workgroups: Policy, Workforce Diversity and Special Populations/Community Engagement. In the interim, an intern was assigned to each of the workgroups and during a breakout session at the general MHC meeting in October 2012, workgroup members and invited stakeholders provided ideas, suggestions and recommendations to address obesity. The facilitator and interns formed the MHC Ad Hoc Committee on Obesity Prevention Policy. That team prepared a preliminary as well as this final report.

Methods

Minutes of the October 2012 MHC meeting, which included ideas and suggestions obtained from the workgroups’ breakout sessions, were sent to workgroup members the first week in December by their assigned intern. The facilitator was introduced to workgroup members via e-mail, and each workgroup member was asked to examine those early ideas and join other workgroup members in telephone conference meetings or individual calls if needed, all of which took place in mid-December. Some of the most fruitful sessions involved arranging for a time when the workgroup member could discuss ideas while simultaneously reviewing onscreen minutes of an earlier meeting, containing comments, ideas and suggestions about the policy being discussed. This process of offering multiple methods facilitated the work of the Ad Hoc Committee which was to:

- Flesh out initial ideas and suggestions from workgroup members;
- Clarify areas of disagreement about the priority level, desirability or effectiveness of some categories of policy recommendation;
- Fully distill this enhanced information;
- Ensure that ideas or suggestions would not duplicate the state’s obesity prevention programs; and
- Provide evidence, if any, that either a specific or similar recommendation in the report had been implemented elsewhere and if so, to what degree of success.

Electronic investigations were conducted to prepare a grid of obesity-related prevention programs across the country and within State agencies.

The team created workgroup-specific logic and social determinants of health models with metrics that were created by adapting a template provided by Dr. Bernice Rumala, a member of the Workforce Diversity workgroup. A logic model is a systematic and visual way to present and share your understanding of the relationships among the resources you have to operate your program, the activities you plan to do, and the changes or results you hope to achieve. (W.K.

Kellogg Foundation Evaluation Handbook (1998)). The template of this logic model is in the “Tools” section of this report on Page 4.

As the work provided recommendations, the Ad Hoc Committee researched them electronically to determine their viability from evidence from the literature and evaluate their efficacy.

The Ad Hoc Committee’s preliminary report, was shared at the January 2013 MHC meeting. DOH reviewed and comments were discussed at the meeting with members, joined by Deputy Commissioner Guthrie S. Birkhead, M.D., M.P.H., of the Office of Public Health, and Sylvia Pirani, M.P.H., Director of the Office of Public Health Practice. Comments were incorporated into this document.

This report reflects strategies from the Prevention Agenda 2013-2017, and speaks to targets developed by DOH’s Pediatric Obesity Prevention Workgroup and the Designing a Strong and Healthy New York (DASH-NY) Policy Center and Coalition, based at the New York Academy of Medicine. DASH-NY offers policy analysis, training, technical assistance and support for sustainable policy changes that increase access to healthy food and safe places to play and exercise for all New Yorkers.

Results

I. Policy Workgroup

This workgroup made recommendations for policy that considered social determinants of obesity such as access to healthy foods, safety, and food deserts, which are neighborhoods with few if any options for residents to buy healthier foods. They also considered policies and looked at ways of making sure those policies address the social determinants of health.

During their breakout session at the October 2012 MHC meeting, the Policy Workgroup discussed:

- Food access
- Availability of programming and grants
- Communication methods
- Health Impact Assessments across other publicly funded areas

This meeting and ensuing discussions contributed to the development of the Policy Workgroup Logic Model, which also includes metrics for evaluating policy efforts. The result is a stronger set of policy formulations to address concerns with issues of access and improved utilization of healthy food in low-income communities and among diverse and special populations of inner-city neighborhoods. This workgroup also wanted to ensure that effective communication tools were used so that differing populations would be informed of program availability. At the same time, the workgroup thought it was critical to recommend that NYSDOH increase opportunities for cross-agency funding to fuel multi-sector community-wide change.

For example the following is a list of NYSDOH obesity prevention initiatives that, with few exceptions, are funded by a single division. A few are jointly funded programs across several agencies. All these programs serve to increase access to healthy foods, including fruits and vegetables, in the State.

Division of Nutrition Initiatives

These six initiatives are funded by the NYSDOH Division of Nutrition and increase access to healthy foods for low-income and other populations in New York State, especially the WIC programs for pregnant women and parenting families, including educational support for breastfeeding mothers.

- 1. Hunger Prevention (HPNAP) Healthy Foods:** Implements policies to ensure that healthy foods, such as fresh produce, low-fat milk, whole grains and lean protein items, are available through eight regional food banks and 2,500 food pantries, soup kitchens and shelters supported through HPNAP.
Reach: Approximately 5 million low-income NY residents
Timeframe: Ongoing
- 2. WIC Healthy Lifestyles Initiative** - WIC local agencies assess, develop, implement and evaluate strategies to encourage participants and their families to adopt healthier lifestyles through physical activity and improved nutrition, including breastfeeding support.
Reach: 510,000 low-income women, infants and children monthly through a network of 100 local agency contractors.
Timeframe: Ongoing
- 3. WIC Breastfeeding Support: Peer Counselors** - All WIC agencies have established peer counselors. Local agencies have designated breastfeeding coordinators with Certified Lactation Counselor (CLC) training. Many have International Board of Certified Lactation Consultants (IBCLC) credentials. Dedicated funds are provided to support the breastfeeding coordinator.
Reach: 50,000 women reached monthly by 400 peer counselors statewide.
Timeframe: Ongoing
- 4. Just Say Yes to Fruits and Vegetables Project** - Project increases access to and consumption of fruits and vegetables by individuals and families receiving food stamps and WIC benefits. New pilot planned for 2013 to expand Stellar Farmers Market model to the Rochester Public Market.
Reach: 25,000 low-income New Yorkers (out of 5 million eligible)
Timeframe: Ongoing
- 5. WIC Farmers Market Nutrition Program** - Designed to encourage low-income families at nutritional risk to increase their consumption of fresh fruits and vegetables through the issuance of checks that may be redeemed at participating farmers markets throughout the state.

Reach: 271,000 low-income families
Timeframe: Ongoing July-November annually

- 6. Eat Well Play Hard in Child Care Settings** - The Child and Adult Care Food Program (CACFP) funds nine Child Care Resource and Referral Agencies and the NYC Department of Health and Mental Hygiene to implement a nutrition education and obesity prevention intervention in low-income CACFP-participating child care centers.
Reach: 241 child care centers were reached during FFY2012.
Timeframe: October 2006-present

Division of Chronic Disease Prevention Initiatives

In the Division of Chronic Disease Prevention, Healthy Eating and Active Living by Design also addresses the issue of food access while the two other programs focus on school-age children and infants. However, DASH-NY is different as it engages multiple sectors in an effort to attack the epidemic by approaching it through policy, systems and environmental changes:

- 1. Healthy Eating and Active Living by Design** – 12 contractors are funded to implement policy, environmental and systems changes in communities to increase access to healthful foods and opportunities for physical activity to reduce risks for heart disease and obesity.
Reach: 12 communities in NYS
Timeframe: April 1, 1999-March 31, 2014
- 2. Healthy Schools New York** – Eighteen contract organizations are working with school districts to develop policies that will create healthier environments for students and adults. Policy efforts focus on increasing the quantity and quality of physical education instruction, physical activity and healthful eating opportunities in schools.
Reach: 90 school districts
Timeframe: July 1, 2010-March 31, 2015
- 3. Breastfeeding Quality Improvement in Hospitals (BQIH)** – In collaboration with the National Initiative for Children's Healthcare Quality (NICHQ), NYSDOH used a learning collaborative to make policy, systems and environmental changes to better support new mothers to exclusively breastfeed their infants in the hospital and beyond.
Reach: 12 out of 135 hospitals that provide maternity care services.
Timeframe: April 1, 2013-March 31, 2018
- 4. Obesity Prevention in Pediatric Health Care Settings** – This five-year initiative aims to decrease obesity among children aged 2-18 years through the promotion of guideline-concordant care in primary pediatric care settings. The initiative focuses on implementation of the AMA's 2007 *Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity*, with an emphasis on assessment and prevention, and reaching primary care practices and health care provider organizations that serve low-income populations, racial and ethnic minorities, and children and teens with disabilities. Nine organizations across the

state are being funded to work with up to 400 pediatric primary care practices to provide clinical expertise and technical assistance through clinician and office staff training, health care systems change, and quality improvement monitoring and reporting.
Reach: PCPs serving high-risk populations in 36 out of 62 counties.
Timeframe: October 1, 2011-September 30, 2016

- 5. Designing a Strong and Healthy New York (DASH-NY)** – Engages multiple sectors in creating policy, systems and environmental changes to end the epidemic of obesity among New Yorkers. Offers policy analysis, training, technical assistance and support for sustainable changes that increase access to healthy food and safe places to play and exercise.
Reach: Statewide
Timeframe: April 1, 2010-March 31, 2015

In addition, these initiatives can be found on various websites:

- 1. Green Cart Program** – Increases availability of fresh fruits and vegetables via loans for operators; encourages residents to purchase fresh produce.
<http://www.nyc.gov/html/doh/html/diseases/green-carts.shtml>
- 2. Food Retail Expansion to Support Health (FRESH)**: Provides zoning and financial incentives to promote neighborhood grocery stores in underserved areas.
<http://www.nyc.gov/html/misc/html/2009/fresh.shtml>
- 3. Farm to School Program** – Resulting from legislation which charged NY State’s departments of Education and Agriculture and Markets to facilitate purchase of local farm products by NY schools. <http://www.farmtoschool.org/NY/>
- 4. “Omnibus Obesity and respiratory illness reduction act”**: establishes a community gardens task force and provides for direct marketing of fresh vegetables and fruits in areas with a high incidence of adult and child obesity; provides for screening for childhood obesity. <http://legiscan.com/NY/bill/A05322/2013>

Most of these NYSDOH programs tend to have an extensive reach to large numbers of New Yorkers (as many as 5 million low-income NYS residents in HPNAP). However, concerns remain regarding access to and utilization of healthy foods:

- a. To what extent are these programs working in silos as opposed to agency-wide, across divisions and bureaus? And to what extent are NYSDOH obesity prevention initiatives, especially those in hospitals and health departments, moving forward without involvement of community partners or cross-agency involvement? This might limit the programs’ target populations and scope, especially in low-income communities. To address these concerns, Commissioner Shah created and chairs an internal workgroup that consists of all Departmental programs addressing the myriad issues pertaining to childhood obesity.

- b. Are there concurrent program components to increase community awareness, provide education about nutrition and cooking, and how to otherwise incorporate healthy change into their lifestyles? The Workgroup suggested coordinating programs between farmers markets, community organizations, schools or libraries, local businesses, and WIC to penetrate communities more deeply to increase access to and use of fresh produce.

These concerns stem from the need for non-traditional approaches, such as reaching out to local businesses, police departments and parks departments. To reduce or prevent obesity effectively in some communities, a broad community change effort will be required that will consider and implement health activities in multiple areas of policy, instead of focusing only on areas specifically related to health care (Kania & Kramer, 2011).

The Policy Workgroup's efforts analysis of these obesity prevention programs resulted in four recommendations:

- 1. Improve access to and utilization of healthy foods by creating systems to obtain community engagement, feedback and collaboration** (preferably before or during implementation of program initiatives, especially in new neighborhoods). Efforts to increase access to and utilization of healthy foods will involve changing the dynamics of the community, which can be difficult without adequate preparation, education and opportunities for feedback about the community's concerns.
- 2. Develop coordinated collaborations across multiple sectors through the establishment of partnerships of communities, academia, schools, hospitals, churches and businesses** that will enable multiple changes to occur at the same time. For example, there is a need to simultaneously conduct outreach and education about healthy eating and lifestyles, marketing and effective communication methods to ensure awareness of obesity prevention programs, and to establish and enhance methods to increase or guarantee safe access to parks, streets and areas where people can be physically active. Coordination of these disparate elements would be critical to success, especially in low-income communities.
- 3. Enhance community use of NYSDOH programs** such as the Stellar Farmers Markets into areas such as Central Brooklyn, the South Bronx, etc. Through culturally relevant technology and media, this program will help produce vendors and farmers markets create new relationships and foster existing ones. New partnerships with Community Based Organizations (CBOs), especially with faith-based organizations (FBOs) and other groups, are needed to deliver culturally tailored messages on healthy eating. New forms of communication with diverse groups will facilitate delivery of fresh produce to new sites in these low-income neighborhoods, which will increase sales and availability of fresh produce to new community partners.
- 4. Conduct evaluation.** NYSDOH has new data management systems to provide county baseline health data on obesity levels to CBOs, FBOs, and other special population groups. In addition to baseline data, NYSDOH would need to guide partners in the establishment of

those key pre-to-post measurements that must be put in place for community partners and grantees to measure their progress in moving their communities toward achievement of obesity prevention recommendations.

Each recommendation calls for additional input from NYSDOH in the form of either RFPs, funding or re-focusing of program goals. The Policy Workgroup's logic model provides a framework for planning, implementation and evaluation of the recommendations.

MINORITY HEALTH COUNCIL
Policy Workgroup

**Logic Model and Social Determinants of Health Template for
New York State Department of Health**

Purpose includes the social determinants of health: access, social and physical environments, biology, individual and behavioral factors.

Purpose	Input	Output (Metrics)	Outcomes (Evaluation) - Short Term - Intermediate - Long Term
1. Improve access to and utilization of healthy food by creating systems to obtain community “buy-In,” feedback and collaboration	1. NYSDOH to provide baseline data on obesity levels in specific communities.	1.1. # of new agreements between farmers and communities re: fresh seasonal produce sales and purchases.	1.1. # of new sites in special population communities where fresh produce was not previously available.
	1.2 NYSDOH would issue RFP to CBOs, FBOs, etc., to obtain community & stakeholder “buy-In” by providing education and obtaining feedback from community re obesity knowledge, concerns about utilization of fresh foods, fruits and vegetables with goals of changing community dynamics related to consumption of healthy foods and creation of collaborations between farmers and urban communities.	1.2. # of new opportunities, sites offered and attended by community to learn and provide feedback about food access and physical activity in their community and to collaborate re: food access and fitness programs.	1.2. # of new and ongoing participants in nutrition education classes and physical activity programs.
	1.3 NYSDOH to assess barriers to vendors serving certain neighborhoods.	1.3 Enhancement of WIC policy changes on access to produce and healthy foods from farmers markets.	1.3. Provide results to community of ongoing monitoring of increase in: sales, availability and costs of fresh produce over time.
		1.3.1. Increase # of WIC participants in education and providing feedback on using WIC vouchers to purchase fresh produce & other healthful items	1.3.1. # of new farmers market sites (minimum 1 x year x community) in schools, parking lots, storage locations, etc.

Purpose	Input	Output (Metrics)	Outcomes (Evaluation) - Short Term - Intermediate - Long Term
			1.3.2. Measure percentage change over baseline at Year I in community levels of obesity, chronic disease status, achievement of childhood obesity targets, health services and health costs.
2. Coordination of collaborations across multiple sectors, using community with academia, schools, hospital, churches and business partnerships	2.1. NYSDOH would issue RFP to establish community-academic and business partnerships that focus on multiple community changes simultaneously	2. 1. # of new obesity prevention coordinating partners and collaborations	2.1. # and types of multiple programs being managed by each new coordinating partnership.
		2.1.2. # of new partnerships working on multi-level community changes simultaneously, providing community education, new messages, social media apps to monitor physical fitness activities and healthier food consumption.	2.1.2 Each partnership must add at least one CBO, church, school, hospital, clinic or business to the partnership per community per year.
	2.2 NYS would provide incentives, i.e. tax abatements, to businesses that offer healthy food/exercise equipment at affordable costs	2.2 # of coordinating agencies working w/partners who provide healthy food, exercise equipment and other opportunities to prevent, decrease obesity	2.2. Measure increases in # of : a) local CBOs offering multiple obesity prevention programs, b) residents using parks, public spaces, attending classes on cooking, etc.
			2.2.1. Measurement of community change in Yr I in at least 4 areas: a) knowledge/utilization of healthy foods b) new farmers markets sites c) # of residents attending one cooking class monthly d) # of residents who consistently attend a 3-month fitness program
3. Enhance the reach of NYSDOH programs into special populations communities through use	3.1. NYSDOH RFPs would be needed to establish expansions of initiatives	3.1. # of new pilots of programs i.e.: Stellar Farmers Markets & HNAP food pantries, in rural and	3.1. Increased program reach to higher #s of program participants across NYS.

Purpose	Input	Output (Metrics)	Outcomes (Evaluation) - Short Term - Intermediate - Long Term
of technology/media	into new communities	urban low-income communities of special populations.	
		3.2 Use of technology and media to extend deeper into the community to educate and motivate.	3.2. Develop one new obesity prevention education technology tool per year: Create a video or hip-hop song for special populations to: - educate, teach, introduce new vegetables or fruits - give cooking classes, - home-based family fitness programs - fitness programs using local parks
4. Conduct evaluations	4.1. NYSDOH would collect and provide to RFP awardees all available baseline/follow-up health and obesity-related data at the neighborhood level	4.1 Stakeholders and awardees: collaborate on development of pre-to-post measures on which to evaluate program activities and determine pre-set intervals (3, 6 or 12 months) for monitoring and evaluation of obesity prevention activities.	4.1. Grantees to provide periodic reports at pre-set intervals of progress made on obesity prevention activities.
	4.2 NYSDOH would establish/provide: a) guidelines for evaluation b) measurements to be taken for project evaluation, i.e. performance on social determinants c) provide templates to ensure uniformity of reporting activities d) training to grantees on use of GIS or Google neighborhood mapping of changes resulting from obesity prevention activities e) train grantees and stakeholders to populate templates/ databases.	4.2. # of grantees, stakeholders trained in evaluation guidelines and use of measurements and templates to collect data and to generate periodic reports to NYSDOH at specified intervals.	4.2 # of grantees participating in NYSDOH evaluation system through: a) submission of timely reports b) level of report details.

Purpose	Input	Output (Metrics)	Outcomes (Evaluation) - Short Term - Intermediate - Long Term
	4.3. NYSDOH training to increase local capacity to manage data/conduct analysis, to assess and compare their prevention activities	4.3 # of communities involved in analysis of local activities i.e. #s of residents: a) involved in obesity prevention education, b) provide feedback re: prevention efforts, c) residents now eating healthy foods, and d) new farmers markets and new healthy food locations	4.3. Prepare and disseminate reports on community specific differences in progress toward obesity prevention

Discussion

The majority of NYSDOH initiatives to address the primary Policy workgroup concern – access to healthy foods – have extensive reach into the community, such as HPNAP and the WIC programs. Others promote the availability and choice of affordable healthy food and beverages in child care programs and schools, encourage and support breastfeeding, physical activity and limited screen time for youth. Taken together, these individual programs funded by separate agencies demonstrate NYSDOH’s comprehensive effort.

The Policy Workgroup recommends development of community, academic, school, hospital, church and business partnerships – which would be different from existing partnerships between large academic medical centers and community-based organizations. The Policy Workgroup is recommending creation of community-driven partnerships with multiple community sectors that will include academic institutions, businesses, schools, hospitals, informal community leaders and other entities who will come together to collaborate on:

- a) Increasing health literacy levels in low-income and other special populations communities
- b) Using technology, social media and social marketing to create new communication tools that encourage and foster individual and broad change in obesity prevention behaviors.

Most “community based partnerships” since 1980 have been interventions in which a community is the target of change, a resource, or a setting for broad multi-level change. Our literature review suggests that strengthening community-based efforts to become resources of change is important to improving the health of the U.S. population (McElroy, Norton, Kegler, et al., 2003).

However, research into “community-driven partnerships” yielded several studies indicating that such partnerships must create local programs that benefit the community and address unmet need; foster mutually beneficial relationships among community agencies, public health agencies and residents; create new models for community participation in health promotion activities (Eisinger & Senturia, 2001; and Poole, 1997); and help communities acquire skills and

resources to plan, implement, and evaluate health-related actions and policies (Lavery, Smith, Esparza, et al., 2005).

Literature review supports the Policy Workgroup's recommendation to enhance NYSDOH programs to ensure that they are deeply penetrating the most underserved communities, where cultures and behaviors differ from the mainstream, and obesity levels and other health disparities tend to be the highest. To reverse unhealthy obesity rates that are part of the cultures and behaviors in some communities will require community members to become involved in planning programs to change and develop new behaviors in ways that are more culturally relevant for them. In this manner, once residents are engaged, they are more able to recognize the need to learn and educate, encourage and motivate individual and family changes as well as community-wide change. Kania and Kramer (2011) suggest that broad, deep community change is best facilitated by cross-agency funding, and community collaborations that simultaneously deliver multiple services can approach unhealthy behaviors from different angles.

There is ample evidence of movement toward multi-sector efforts in some NYSDOH programs. Creating Healthy Places to Live, Work and Play (CHPLWP) was developed to address type 2 diabetes, and CHPLWP Worksite: The Business Case for Breastfeeding provides support in the workplace for employees who breastfeed. These programs are jointly funded by NYSDOH's divisions of Nutrition and Chronic Disease Prevention, and thus are able to support multiple approaches to change. DASH-NY is designed to engage multiple sectors in working concurrently toward policy, environmental and systems changes. While these three programs stand out, almost all NYSDOH programs can be enhanced with minor goal revisions to allow for greater levels of community involvement as well as increased partnerships and collaborations across CBOs and state agencies.

In that regard, the Policy Workgroup suggests the following strategies to re-direct program goals and enhance program initiatives:

- Increase marketing and education to improve awareness, using creative and interactive methods including music, the arts, web pages, and social media.
- Create live workshops to teach nutrition and demonstrate cooking techniques at grocery stores or farmers markets. Participants could learn to incorporate healthy options and make their purchases in the same place.
- Use GIS mapping and community feedback to identify the most pressing local needs, so that funding can be directed to the most critical areas in that community. For example, where a food desert exists, enhance the use of FRESH, Green Carts and farmers markets. If those programs are already in place, identify opportunities for health and nutrition education, marketing, and ways to engage community partners.
- Enlist community partners to create culturally relevant messages and programs, and create avenues for feedback, to increase community engagement and buy-in.

- Increase awareness of funding opportunities for local community organizations to address the needs of their community, including programs such as FRESH, Green Carts and Health Bucks.
- Increase coordination between nutrition programs and local gardens and parks, as well as the local police departments to provide safe venues for physical activity and community events.
- Create new collective and joint funding models that will support cross sector-program operations to address more comprehensive and effective change in obesity prevention behaviors.

Finally, the Policy Workgroup strongly suggests that its policy recommendations be implemented only with rigorous evaluation and analysis to determine effectiveness, and thus inform decisions regarding program sustainability or termination. Implementation of these recommendations calls for a coordinated simultaneous approach that will require resources for capacity development of community partners that will help them build skills and tools for taking ownership and becoming active participants in creating obesity prevention programs in their communities.

The Policy Workgroup developed the following four recommendations:

1. Improve access to and utilization of healthy foods by creating systems to engage community support, garner feedback and foster collaboration.
2. Develop coordinated collaborations across multiple sectors through partnerships of community, academic, schools, hospitals, churches and business.
3. Enhance community use of NYSDOH initiatives through use of technology and media.
4. Conduct rigorous evaluation.

II. Special Populations/Community Engagement Workgroup (SPCE)

The SPCE Workgroup focused on the problem of addressing the needs and considerations of special populations such as rural residents, immigrants, individuals with disabilities, LGBT community, prisoners, elderly, youth and other vulnerable and underserved populations. The Workgroup recommended policies that address obesity in these populations through the lens of social determinants of health, taking into consideration social barriers of discrimination, stigma, cultural and language barriers and culturally accessible health promotion or education materials.

During the Special Populations/Community Engagement (SPCE) Workgroup's breakout session at the October 2012 MHC meeting, several ideas emerged:

- Physical education
- Engagement of specific communities, i.e., Latino, civic/social, faith-based
- Ethnic Media Summit to create culturally relevant obesity prevention messages
- Determine which communities are most affected by obesity
- Health Literacy – Use of non-traditional resources to engage and inform communities

Common threads from that discussion included the need to:

- Conduct community needs and assets assessments, i.e. physically examine geographical locations to assess the culture of special populations such as immigrants, low-income areas, LGBT groups, the elderly, people with disabilities, youth, and others and to determine which communities have greatest need for obesity prevention services;
- Examine strengths and weaknesses of special communities;
- Involve non-traditional organizations, i.e. social clubs, athletic clubs, sports leagues such as basketball, soccer, etc.;
- Develop public/private partnerships with Girl Scouts/Boy Scouts; PTA groups, and
- Identify community organizations and leaders that are trusted by the community and train them to lead obesity prevention efforts.

In subsequent discussions with the SPCE Workgroup, members acknowledged that NYS's population in general, and NYC's population in particular, are culturally diverse and cannot be grouped as one. Engagement efforts must be tailored to the culture and health practices of specific groups. Members of the community must be provided with information about programs and how to enroll or learn more (dial 311). In devising outreach, consider targeting special population and occupational groups: Latinos, taxi and/or truck drivers, disabled, South Asians, elderly, new immigrants, LGBT, rural/urban dwellers, children, adolescents, youth, prisoners, etc. And, just as important, determine whether groups should be engaged from within or among their members, and how to identify these influencers.

The SPCE Workgroup developed the following recommendations:

- 1. Community engagement using multiple sector partnerships.** To create community engagement systems, NYSDOH must seek out collaborators to provide joint funding to non-traditional/informal community groups, trusted by their communities, to develop partnerships with academic institutions, hospitals, churches, schools, businesses and other partners. Informal community leaders should be identified and trained as community health workers³ because they are better positioned to engage and penetrate their communities to increase awareness of resources and help develop new culturally relevant messages that can educate and encourage behavior change to prevent obesity.
- 2. Increase physical activity/education opportunities activities.** NYSDOH should provide the coordination needed to bring disparate sectors together, i.e. communities, parks departments, police departments, schools and related agencies to increase the use of local parks, gyms, and other community facilities and to track and evaluate ongoing park usage.

³ A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. Available at : <http://www.apha.org/membergroups/sections/aphasections/chw/>

- 3. Focus on children.** Establish a statewide and regional system through school-based health centers and community-based clinics (CBCs) to monitor obesity in children. NYSDOH and the State Education Department should seek opportunities to jointly develop tools or systems for use in schools and CHCs to report all activities to improve child health and reduce childhood obesity through: weekly use of local parks and school gyms, classes on healthy eating, demonstrations of preparing healthy foods, availability of healthy foods and snacks, and the use of technology and media to teach students, parents and clinic patients about healthy living.
- 4. Create new approaches to funding community engagement activities.** NYSDOH and related agencies should work with public and private funders to create pooled or collaborative funding of different aspects of obesity-related initiatives. Since 2010, this approach has worked to provide funding from different NYSDOH divisions for CHPLWP and Worksite Breastfeeding.
- 5. Conduct evaluation of community engagement to prevent obesity.** NYSDOH should create systems to foster community engagement by providing special population communities with baseline data to evaluate their progress in changing community-level behaviors, community consumption of healthy foods and ongoing fitness activities. These systems must include a framework (data, training, skills building, funding) to increase community participation in policy development and community change. New funding models will rely on strong data systems and evaluation collaborations among multiple funders as well as effective community capacity to engage in and report on their obesity prevention actions.

The SPCE Workgroup's logic model provides a detailed description of specific input and output steps as well as the outcome measurements for each recommendation.

MINORITY HEALTH COUNCIL
Special Populations/Community Engagement Workgroup

**Logic Model and Social Determinants of Health Template for
New York State Department of Health**

Purpose includes the social determinants of health: Access, social and physical environments, biology, individual and behavioral factors.

Purpose	Input	Output (Metrics)	Outcomes (Evaluation) - Short Term - Intermediate - Long Term
1. Community engagement using multiple sector partnerships.	1. Use NYSDOH data to identify communities of special populations and with the highest obesity rates	1.1. Identify 2-3 non-traditional organizations with roots in special populations communities & provide them w/info re available resources & engage them in working on issue	1. 1. Measurements: Percentage of community entities in multiple sectors that are engaged or informed about obesity prevention: 0= none to 60% = high.
	2. NYSDOH RFP to fund CBOs, FBOs and other entities to assist with community engagement, i.e. training of trusted resident/leaders to spread awareness of prevention programs in their own community	2.1 Identify/Select 2-3 grantees and informal leaders to be trained and become trainers of trainers, the community leadership to become “community health workers” (CHWs) or “neighborhood health messengers,” (NHMs). These people are found in every population; they attend meetings, respond to emails, phone calls, surveys, and requests to join work on an issue	2.1. # or informal leaders trained who are members of non-traditional clubs and organizations. 2.1.1. # of trained CHWs and NHMs working in communities to promote obesity prevention/reduction messages 2.1.2. Measure the impact of CHWs/NHMs on community engagement. 2.1.3. Pre-post CHW/ NHM measures of level of awareness of existing or new prevention programs and services
	3. NYSDOH to develop cross-sector funding program to facilitate broad coordinated community change to prevent obesity through simultaneous engagement of: a) Individuals, groups and systems, children and parents. b) Non-traditional groups and organizations, such as cab drivers, social clubs, sports clubs, or systems such as academic, health care and other institutions	3. 1. Hire coordinating entity to produce specific output by Year 1: a) One entity to do community mapping and create listings of newly identified informal community leaders, individuals, families, etc., as well as potential systems partners (CBOs, FBOs, hospitals, schools, non-traditional groups, social clubs, sports clubs, other). b) One group to identify and select training program to	3.1 Measure each entity’s achievement of projected goals, such as mapping, training, etc. 3.2. Measure levels of community engagement via use of technology: # hits on social media, apps, Twitter, Facebook, etc. 3.3 Track cross-sector funding by establishing benchmarks.

Purpose	Input	Output (Metrics)	Outcomes (Evaluation) - Short Term - Intermediate - Long Term
		train CHWs 1. To become obesity prevention specialists and community resources 2. Have multiple partners host graduation of new CHWs c) One partner to find jobs and deploy trained CHWs into jobs.	
2. Increased physical education opportunities.	2. Parks and NYSDOH should provide community-level data on local parks, any increased use, specific times when use increases, for each local park and contact info for key Parks staff at each park: a) Riverbank Park, Reggie Maywood, Director - 212-694-3606. A few schools in Harlem use Riverbank. b) Karen Phillips, New Regional Director of Parks (212) 866-3100 c) Rose Harvey, State Parks Commissioner. What methods bring people to the parks?	2. 1 Engage a local sports club to coordinate the collaboration between local parks and schools. 2.2 # of new methods implemented to get people into parks. 2.3 Get one group each of young boys, young girls, men and women into parks for one hour of physical activity on a regularly scheduled basis.	2.1 Measure/track ongoing park usage. Engage park officials in communication about and evaluation of park usage and the physical activity programs offered. 2.3 Measure # of groups that entered the park and engaged in one hour of physical activity
3. Heightened Focus on Children	3. HHC, CHCs and local health depts. to partner with local CBOs, FBOs , schools, universities, and other entities to meet the NYSDOH Pediatric Obesity Prev. Workgroup targets. For example, Columbia School of Nursing is in an academic/community partnerships that focuses on obesity prevention in Harlem, using new tools such as hip-hop songs, videos	3.1. Use coordinating agency to work with 1-2 health providers to establish: a) One school-based health centers and/or CHC to be set up in two schools in one community b) One physical fitness program in three schools in Year I that shows increased use of local parks and school gyms (3 x/wk) in one community c) A healthy eating initiative in three schools in one community 3.2 Increase the # of : a) community residents who sit on local health center boards of directors b) # community/academic partnerships that focus on obesity c) # of such partnerships that use culturally sensitive media	3.1 Measurements: Hospitals, school-based health centers, local health departments to: a) Conduct community assessment of specific local pediatric obesity determinants to work on b) Documented evidence of specific programs in hospitals, health centers, health depts. w/results that demonstrate efforts toward obesity reductions in youth 2-17 years old. c) Documented evidence of an implemented effort by a local health entity to address a community-wide obesity- related social determinant. d) Documented evidence of use of culturally relevant media related program outcomes, i.e. hip-hop videos and other items.

Purpose	Input	Output (Metrics)	Outcomes (Evaluation) - Short Term - Intermediate - Long Term
4. New funding approaches	4. Collaborative funding for broad partnerships between health entities and CBOs, FBOs and other local groups to reduce obesity.	4.1 Coordinating orgs with multi-sector partners to develop: a) An overarching framework with community input, for community engagement and for creating community change; b) Policy and community capacity to transform their own neighborhoods.	4.1 Pre-to-post measures of the # of residents who increased their health literacy level. 4.2 # of residents trained in methods of obtaining hard data and other info about their community 4.3 # of CBOs, FBOs and other community groups that in Year 1 increase their capacity to participate in obesity prevention initiatives, i.e. cultivate community buy-in, mapping community, teaching/education.
5. Community-wide obesity prevention evaluation	5. Use NYSDOH's technical capacity to a) establish baseline template in low-income communities to collect obesity prevention data (<i>This capability exists at the county level</i>) b) Populate database at the county/community level, beginning with those communities with worst health disparities	5.1 Use coordinating org. to work with multi-sector partners to: a) Establish monitoring and evaluation systems to determine the short-, intermediate and long-term outcomes of these recommendations and strategies. b) Evaluation plan: assess and compare baseline to evidence from outcomes of NYSDOH initiatives to prevent/reduce obesity among special populations in the short, intermediate and long term.	5.1 Provide mid- and end-year reports on: a) Effectiveness of programs and initiatives b) Improvements over baseline of obesity reduction/prevention, c) Changes in policy and programs. d) Evidence at preset intervals of community progress toward targets/goals of obesity reduction

Discussion

In developing its recommendations, the SPCE Workgroup recognized that certain NYSDOH initiatives address some recommendations. For example, the WIC programs, the CHPLWP-Worksite initiative and Healthy Schools New York target women and children, and the Obesity Prevention in Pediatric Health Care Settings Program is designed to train staff and achieve systems change.

Nevertheless, the SPCE Workgroup envisioned its five recommendations implemented as a community-wide multi-sector, collective change effort in communities with the greatest need for intense obesity prevention services. Still, the concept of community engagement remains largely uncharted waters for community leaders/residents and professionals alike (Driscoll, 2009). Community engagement requires carefully managed processes because of the need to engage young people (Pasek, Kenski, Romer, & Jamieson, 2006) as well as multiple other community sectors that are adversely affected by, or contribute, obesity in this instance.

Nevertheless, support for a combination of these recommendations comes from cutting-edge frameworks to address health disparities and related social determinants of health. Community engagement will require the provision of data and capacity building for community organizations to build coordinated comprehensive place-based strategies that mobilize their communities to reduce disparities such as obesity (Kindig & Stoddart, 2003). The use of trusted community leaders and residents is an important aspect of community engagement. The SPEC Workgroup named these community leaders “neighborhood health messengers (NHMs).” These workers are also regularly referred to in the literature as community health workers. They are trusted by residents to not only disseminate health information but also to act as a resource for community members (Fedder, Chang, Curry, & Nicholas, 2008; Christopher & al., 2008).

Many outstanding obesity prevention programs have been implemented around the country, including the Central California Regional Obesity Prevention Program (CCROPP). This joint effort among health care providers, local government, CBOs and community residents addresses obesity in eight counties of the San Joaquin Valley. CCROPP has improved access to healthy foods in some low-income neighborhoods by partnering with markets, local farmers, and community residents. CCROPP has created “Block Leaders” in some neighborhoods, training them in community organizing to help develop more wholesome community activities, such as walking groups that have successfully reclaimed parks. Block Leaders in Fresno transformed a corner store that sold alcohol, tobacco and junk food into a community market where affordable quality produce is now available. CCROPP receives public/private funding from the California Endowment USDA. Early evaluations of CCROPP’s first phase indicate challenges but also show positive results (Samuelson and Associates, 2011).

While interest increases in community-level multi-sector approaches to obesity prevention, these types of programs are difficult to design and challenging to show positive impact. Several studies provide guidelines for evaluating community engagement and community-level change (National Institutes of Health, 2011; Bayne-Smith, et al., 2005; Minkler & Wallerstein, 2009), but there is a lack of empirical evidence. In a recent [Special Issue of the American](#)

[Journal of Public Health](#) devoted to research on obesity prevention, some community-level researchers focused on measuring changes in the community-wide environment and assessing the impact of those changes on residents most directly exposed to the intervention (Cheadle, Samuels, Rauzon, et al., 2010 available at: <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2010.300002>, while others focused on community change regarding one preventive area such as improving the quality of food (Ghirardelli, Quinn & Foerster, 2010 available at: <http://www.ncbi.nlm.nih.gov/pubmed/20864701>).

The SPEC Workgroup acknowledges that the community baseline data will be critical to outcomes evaluation. While NYSDOH has identified baseline data as an ongoing measurement source, these are measures for the state and, in some cases, counties. The SPCE Workgroup has identified baseline measures at the neighborhood or community level as critical to measuring the progress of special population communities in their efforts to reduce obesity. The Workgroup also acknowledges that funding will be needed for special population communities, many of which are also low income, who need to engage multiple partners in a broad effort to achieve collective change. Funders are reluctant to support this kind of work because it is more challenging to monitor partnerships than to fund and monitor one non-profit entity working on a single idea. However, there are now innovative ideas that call for new roles for funders, including the willingness to be part of a group of funders and other stakeholders who are supporting the same issue (Kania & Kramer, 2011). These ideas are slowly evolving among private and for-profit funders, but occur more readily among non-profit or public funders and public private funding arrangements.

Despite the challenges, community-level, cross-agency efforts are recommended for achieving the Healthy People 2020 obesity prevention targets (Wang, Orleans & Gortmaker, 2012). The work of DASH-NY is built upon the concept of enabling policy change at the neighborhood, town, city and higher levels by bringing together a network of leaders into its coalition partner organizations of public and private entities. Further, the Prevention Agenda includes community organizing to create change as a strategic solution to obtain obesity prevention goals (Restina, 2012). In discussions with NYSDOH administrators for this report, they noted that the Prevention Agenda is a guide to local health departments and hospitals as they work on the development of Community Health Assessments, Community Health Improvement Plans and Community Service Plans. Essentially, these new mandates direct health care entities to work with community partners to identify health disparities and plan to address them.

The Special Populations and Community Engagement Workgroup recommendations are:

1. Community engagement using multiple sector partnerships
2. Increased physical activity/education opportunities
3. Heightened focus on children
4. New funding approaches, and
5. Community-wide obesity prevention evaluation

III. Workforce Diversity

This Workgroup focused on the underrepresentation of racial and ethnic minorities in the health care workforce emphasizing the role and importance of community health workers. This included making recommendations in areas of policy and advocacy in support of community health workers as vital members to the public health workforce.

The six members of the Workforce Diversity Work Group consisted of a non-profit community organizer, a private physician, an academic health center representative working in pipeline programming, a medical school faculty member, a health policy fellow, and the NYSDOH Associate Commissioner and director of the Office of Minority Health and Health Disparities Prevention.

Several themes emerged from the October 2012 breakout discussion among this Workgroup:

Physical Environment

- Sustainable pipeline programs with a specific focus on health disparities. The discussions referenced SPARC Tri-institutional initiative, a collaborative effort of Rockefeller University, Weill Cornell Medical College and Memorial Sloan Kettering Cancer Center; Albert Einstein Medical College of Yeshiva University's pipeline programs; and the Comprehensive Center for Excellence in Health Disparities Research and Community Engagement at Weill Cornell).
- *Social Environment*
 - Partnership building to get health goals achieved
 - Engaging food services, churches, and CBOs
 - Looking at programs for health professions as a reference point
 - Increase high school graduation rates
 - Increase accountability for institutions
 - Capacity building, empowerment, self-efficacy
 - Funded Training for CHWs and peer health educators
- *Access*
 - Increase dietitians, nutritionists, CHWs and peer health educators as part of multidisciplinary team.
 - Access for individuals reflected in URMs and disadvantaged backgrounds to enter leadership roles to affect change within institutions
- *Policy*
 - Advocating for nutritional consultation reimbursement
 - Increasing URMs and individuals from disadvantaged backgrounds in leadership roles for institutions and health centers

Focus on CHW Workforce

The Workgroup narrowed its focus to CHWs as a vital component of workforce diversity and community engagement. The U.S. Department of Health and Human Services defines CHWs:

Community health workers are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socio-economic status and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, “promotores(as),” outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening (USDHHS, 2007).

Several studies point to the value of CHWs as members of the health care team because they are viewed as trusted community members who tend to have an unusually in-depth understanding of the community served (Jaskiewicz & Tulenko, 2012; Babamoto, Sey, et al., 2009). Commenting on the value of community via community health educator input (CHE), one Workforce Diversity Workgroup member, also a community organizer, commented: “I want to see more Community Health Educators (CHE) provide input into this process based on the diversity of their community, i.e., faith-based and other groups, and I believe that all of our work needs to take into account the use and workability of those whose primary responsibility is to provide or create health materials for the public.”

Some government policies identified in terms of workforce diversity are as follows:

Federal Level

Executive Order 13583 of 2008 is called “Establishing a Coordinated Government wide initiative to provide diversity and inclusion in the federal workforce.” <http://www.whitehouse.gov/the-press-office/2011/08/18/executive-order-establishing-coordinated-government-wide-initiative-prom>

By law, federal recruitment policies should "endeavor to achieve a workforce from all segments of society." (5 U.S.C. 2301(b)(1)). As the nation's largest employer, the federal Government has a special obligation to lead by example. Attaining a diverse, qualified workforce is one of the cornerstones of the merit-based civil service.”

The Patient Protection and Affordable Care Act of 2010 highlights community health workers as an important component in the health care and health improvement system.

State and Local Government Level

At the state and local level, workforce diversity policies are outlined by the Department of Civil Service (<http://www.cs.ny.gov/pio/diversity.pdf>), which promulgates testing regulations (<http://www.cs.ny.gov/pio/diversity.pdf>) and recruitment services selection (<http://www.cs.ny.gov/pio/diversity.pdf>).

cs.ny.gov/pio/diversity.pdf) (This is aimed at raising profiles of state careers in minority communities.)

An Overview of Community Health Workers

A 2007 Community Health Worker National Workforce study (USDHHS, 2007) describes what this workforce looked like across the nation:

Race/Ethnicity

A large percentage of CHWs come from underrepresented minorities (URMs), African American and non-white Hispanic. Based on self-identification, the CHWs in this study were 35 percent Hispanic (non-White), 15.5 percent African American, 5 percent Native American, 4.6 percent Asian/Pacific Islander and 39 percent White.

Gender

Women made up 82 percent of CHWs in this study, which said, “The predominance of women in this workforce was partly due to the focus of many programs on underserved children and their mothers as well as to clients’ greater acceptance of female caregivers in their homes.”

Educational Level of CHWs, Volunteer and Paid

Approximately one-third (35 percent) have a high school education; 20 percent have some college, and one-third (31 percent) have at least four years of college. Volunteers CHWs were more likely to have less than a high school education; most paid CHWs had completed some college.

This study indicated that CHWs tend to provide services for underserved populations and that a majority of their clients included special populations such as the uninsured (as reported by 71 percent of respondents), followed by immigrants (49 percent), the homeless (41 percent), isolated rural residents and migrant workers (31 percent each). Significantly, the services of CHWs provided largely in racial/ethnic minority communities and to special populations were more likely to be delivered by volunteer and not paid CHWs.

The literature also provided information on the infrastructure around select state and private organizations’ CHWs. Massachusetts has an established Office of Community Health Workers, stating that CHWs are a vital component to increase access to health care and eliminate racial, ethnic and socioeconomic health disparities among vulnerable and underserved communities. That state has conducted capacity-building initiatives to strengthen CHW workforce development as part of Massachusetts’ 2006 health reform legislation. A state Association of Community Health Workers also exists.

The American Public Health Association, one of the oldest and largest public health organizations in the United States, has also established a CHW section to support the role of these workers in addressing health equity issues.

Global Efforts on Use of CHWS: Lessons for the Local Level

Anecdotal evidence is growing as supported by the following statement. Globally, CHW programs have emerged as one of the most effective strategies to address human resources for health shortages while improving access to and quality of primary health care. Many developing countries have successfully deployed CHWs in recognition of their potential to identify, refer and, in some cases, treat illnesses at the household level. One New York Times column about two programs in India that train relatively uneducated women as their villages' health workers prompted readers to provide an avalanche of information about other CHW programs around the world. After training periods of as brief as one week, these workers can create significant improvements in health outcomes. For example, one program reduced child deaths by 30 percent. Program leaders often find that lack of education is not a hindrance but an advantage for village health workers, because they know how their neighbors live and think.

Status of CHW Workforce Development in New York State.

Educational development and employment of CHWs in NYS is important. Professional, health and education organizations, as well as policymakers, planners and other stakeholders need to understand how they work so the state can become prepared to meet the supply, demand, distribution and use of CHWs as one component of the health care workforce.

A 2011 report from the Albany-based Center for Health Workforce Studies (CHWS) examined the supply of appropriately trained health workers employed at CHCs, who usually work in underserved communities and tend to serve high-need populations (CHWS, 2011). CHCs face many challenges in the recruitment and retention of qualified staff in all functions.

While CHWs were much less difficult to recruit than nutritionist and nutrition educators, CHCs found that CHWs were the most difficult employees to retain. The recruitment/retention difficulties of CHCs depended on their size and location. Small CHCs had the most difficulty with recruitment of all staff levels, but medium-sized CHCs had the greatest difficulty with recruitment and retention of CHWs. This study defined "small" as fewer than 30 full-time employees (FTEs) in 28 health workforce categories including community health workers; "medium" as 30-49 FTEs, and "large" as CHCs with 50 or more FTEs.

In addition to FTEs, other studies included in their size determination factors such as number of clients and size of annual budgets (Bayne-Smith, et al., 2005). In terms of location, recruitment of CHWs was most difficult in New York City and rural upstate, and retention was most difficult in NYC. The size of CHCs also influenced CHW vacancy rates, which was 25 percent in medium CHCs, but 0 percent in both small and large health centers (CHWS, 2011).

Development and Preparation of the CHW Workforce

The Center for Health Workforce Studies' report highlights the need to develop and prepare a CHW workforce across the State in view of recruitment and retention difficulties, as well as high vacancy rates for CHWs in upstate and NYC CHCs. In response to that need, a list of preparation programs at New York's public colleges is provided:

State University of New York Schools with Programs that Include CHW Training

1. **College at Brockport:** Community Health Education Program offers a bachelor's degree for health educators
2. **College at Cortland:** bachelor's degree program
3. **College at Potsdam:** bachelor's degree program

City University of New York Schools with Programs that Include CHW Training

- **Bureau of Manhattan Community College:** Department of Health Education has several courses, such as Consumer Health Surveys and Nutrition for health
<http://www.bmcc.cuny.edu/healtheducation/courses.jsp>
- **Kingsborough Community College:** An associate's degree program in community health. Courses explore the role of environmental, genetic and lifestyle factors in the control, development or prevention of public health problems such as diabetes, cardiovascular disease, and cancer. A three-credit, 100-hour fieldwork course gives health education students experience in a community health-related job setting:
<http://www.kbcc.cuny.edu/academicdepartments/hper/pages/com.aspx>
- **Hostos Community College:** An associate's degree program in community health. Graduates can provide culturally and linguistically appropriate services to the most vulnerable populations in New York City. Program goal: increase diversity in health-related fields. http://www.hostos.cuny.edu/oaa/pdf/Community_health.pdf.
Hostos also offers a Community Health Worker Program Certificate
<http://www.hostos.cuny.edu/news/press/First-CUNY-CareerPATH-Community-Health-Worker-Certificate-Program.html>
- **LaGuardia Community College:** Associate's degree in community health worker program. <http://www.encore.org/find/resources/laguardia-community>

The Workforce Diversity Workgroup distilled its research into three recommendations:

1. **Develop and train CHW workforce in NYS to assist in community engagement and community health education.** NYSDOH and the State Education Department must lead this effort by providing standards for training, self-efficacy, empowerment, capacity to increase health literacy, and the ability to organize and mobilize their communities to advocate for access to healthy food and fitness opportunities that will reduce obesity and overall health disparities.
2. **Establish a state-level infrastructure for CHWs.** Development of the CHW workforce will require establishment of a state-level office to monitor CHW training/preparation and deployment in communities with high obesity disparities. These workers can fill the gaps in services through community engagement and community education, but the process for doing so must be managed at the state level. Guidelines for this process could be modeled from states such as Massachusetts and from recent studies on how best to advance the CHW workforce.
3. **Provide funding for enhanced use of CHWs.** NYSDOH should create a funding mechanism that will build capacity and equip CHWs to fill the gaps in health services to effectively reduce obesity in low-income communities of special populations.

The details of Workforce Diversity development are captured in this logic model with specific input, output and outcome measures:

MINORITY HEALTH COUNCIL
Workforce Diversity Workgroup

**Logic Model and Social Determinants of Health Template for
New York State Department of Health**

Purpose includes the social determinants of health: access, social/physical environments, biology, individual and behavioral factors

Purpose	Input	Output	Outcomes Evaluation - Short Term - Intermediate - Long Term
1. Develop and train CHWs workforce for community engagement and community health education.	1. NYSDOH should require local health departments, hospitals and CHCs to select, train and hire paid CHWs in communities of special populations and low income to help meet requirements to develop the new Community Health Assessments, Community Health Improvement Plans and Community Service Plans.	1.1 # of CHWs outreach efforts by emails, phone calls, surveys, meeting attendance and in-person requests for help vs. # of responses in each category from community 1.2 CHWs to maintain accurate, computerized records of a) services accessed by community b) attendance at all education sessions, and c) pre-to-post evidence of increased health literacy	1.1 Measure community engagement: from none to high. 1.2 Determine level of increase in community awareness of resources and increased access to needed services re healthy eating and fitness over baseline
2. Establish a formal state level infrastructure for CHWs.	2. NYSDOH – State level infrastructure for Community Health Workers (i.e. Office of Community Health Workers)	2.1. Establish an office within NYSDOH as: b) point of contact for CHWs. c) to provide resources for training and development	2.1. # of services provided and # of CHWs who benefit from resources and support infrastructure
3. Fund enhanced use of CHWs.	3. NYSDOH RFP to non-traditional CBOs; FBOs, CHCs that can: a) identify potential neighborhood CHWs b) train CHWs, refer for employment.	3.1. CBOs, CHCs, FBOs provided funding to: a) Identify/select/train CHWs and refer them for employment	Measurement of: a) # of new CHWs in specific communities b) # of individuals, families, schools, & other entities served by CHWs.

Discussion

More research is needed regarding policies and programs, especially for paid community health workers. CHWs are a diverse workforce that can be identified, trained and deployed to fill gaps in providing obesity prevention services in communities of special populations and underserved low-income neighborhoods. Their use would increase services in these communities while also building the capacity and skill level of this workforce.

There is great variation in the training of CHWs across NYS. The majority of volunteer CHWs had less than a high school diploma, vs. paid CHWs who had some college. A significant

percentage of CHWs were from underrepresented racial/ethnic groups and were providing services to underserved, vulnerable and predominantly racial/ethnic minorities. NYS has a unique opportunity to assess and establish protocols through a formal office within NYSDOH charged with determining ascending levels of training and preparation to allow CHWs to advance in their careers.

For example, local CBOs, FBOs and other community entities could prepare entry-level CHWs through a training program focused on building the self-efficacy, knowledge capacity and personal empowerment of this workforce. However, upward movement, with CHWs asked to deliver more demanding levels of assignments, would also require increased levels of formal education from accredited schools.

While CHW training programs exist in certain New York State and City public colleges, further research is needed to establish state guidelines for CHW training. That research should also explore the availability of private or state funding for further training at all educational levels, from certificate to associate's and bachelor's degree programs at NY's extensive network of state and citywide community colleges.

Even as higher education requirements are developed, it is important not to lose sight of the efficacy of limited training for local women to become effective community health workers. These limited CHW training programs have proven vital in improving global public health outcomes in areas that lack access to or have experienced shortages of physicians, nurses and other health workers.

Workforce development at a variety of levels is not a new undertaking for NYS. In 2006, a study found that NYS's public health workforce has been steadily increasing since 2003. Much of that growth is fueled by federal bioterrorism grants for states and large cities. Past approaches relied largely on a pipeline model, which emphasized production of future workers in various disciplines and occupations. The report cautioned that an end to federal funding could reverse growth trends, and that pipeline strategies, though necessary, are insufficient to meet the needs of a diverse public health workforce. This report pointed out that an adequately prepared workforce does not simply materialize. Instead, sustaining high performance and improved health outcomes requires long-term workforce development, with new approaches to move in the desired direction.⁴

There appears to be a similar need now to expand the roles and competencies of the CHW to improve health outcomes. A 2011 study by the Mailman School of Public Health at Columbia University provided guidelines and recommendations for advancing the CHW workforce in NYS (Matos, Findley, Hicks, Legendre, & Do Canto, 2011), with a clear policy and programmatic path for training, funding and deployment of the State's CHW workforce. Another model for filling the CHW gap is provided by the Office of Community Health Workers in Massachusetts, established to develop, support, train and fund this vital workforce.

⁴ http://www.health.NY.gov/press/reports/docs/strengthening_the_public_health_workforce.pdf.

The Workforce Diversity Workgroup strongly supports including community representatives to provide input on the development of the CHW workforce. The research and discussion culled from involvement of community members, groups and community organizations around the important issue of CHW workforce development should yield valuable input.

The Workforce Diversity Workgroup makes these recommendations:

1. Develop CHW workforce to increase health literacy and engage their communities in planning and implementation of obesity reduction activities.
2. Create a state-level formal infrastructure for CHWs.
3. Create and fund more paid positions for trained CHWs.

Conclusion

This report's recommendations reflect the need for using a broad community change approach to obesity prevention in high-disparity communities and in the use of rigorous metrics for evaluation. The Ad Hoc Committee's efforts were facilitated and guided by critical questions that provided the contextual framework for discussions, analysis and distillation of ideas, suggestions, data and information:

- How do we change systems and behavior in our different communities through policy intervention, community engagement and advocacy, so that the construct and everything within it changes in a sustainable way?
- What are the policy targets, policy asks and systems change that will sustain obesity prevention in high-risk communities over time?

The substantive answer is to ensure that implementation of any of these recommendations rely on real data and the necessary resources to build community capacity to collect, manage and analyze that data. Evaluation must be based on measurable results as an integral component of policy solutions and resulting program implementation designs.

TOOLS

Following is the logic and social determinants model of health framework developed by Bernice Rumala, Ph.D. This tool is useful for contextualizing process through outcome recommendations and metrics through the lens of the social determinants of health.

Social Determinants of Health and Logic Model Template

(October, 2012)

Purpose and Social Determinants (Access, social / physical environments, policies & interventions
biology, individual & behavioral factors)

Purpose	Input	Output	Outcomes <i>Evaluation</i> <ul style="list-style-type: none">- Short Term- Intermediate- Long Term

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