

A blue-tinted photograph of a market stall. In the foreground, there are several wooden crates filled with produce, including what appears to be apples or oranges. In the background, there are more crates and signs. One sign reads "CURE di BUE" with a price of "1.20". Another sign reads "MELE" with a price of "1.00". The overall scene is a busy market stall.

ADDRESSING HEALTH DISPARITIES IN CITIES: LESSONS FROM THE FIELD

A child's health is a key predictor for his or her future success and well-being. Unfortunately, far too many children face barriers that prevent them from reaching their full potential because of where they live, learn and play.

The inequitable distribution of social, economic and environmental resources across communities — often called the social determinants of health — create challenges for healthy living. Socioeconomic conditions (e.g., concentrated poverty), access to health care and transportation options, educational and employment opportunities, and aesthetic elements (e.g., green spaces and vibrant public spaces) result in differences in opportunities and exposure to health-promoting resources such as child care, high performing schools, affordable housing, access to healthy food and safe spaces for physical activity.

The availability and quality of these neighborhood resources and services have a major impact on the ability of children and families to make choices that support healthy growth and development. When children and families have access to these resources and services, children have more opportunities to thrive. On the contrary, children growing up in communities that lack these often suffer poorer health outcomes than their peers. These differences in health are known as health disparities.

During the past four decades, childhood obesity has emerged as one of the nation's greatest public health challenges. One in three children in the United States is overweight or obese. Childhood obesity has serious health and economic consequences for children, families and communities. The recent progress achieved in some communities and population groups is encouraging, but significant childhood obesity-related health disparities still exist and disproportionately affect low-income communities and communities of color.

As cities confront changing demographics and rising income inequality, eliminating health disparities becomes even more critical. A city's economic vitality and vibrancy depends on the ability of all children to thrive and develop the skills necessary to succeed in the 21st century.

Many municipal leaders are eager to learn more about the underlying causes of childhood obesity-related health disparities as well as potential strategies to reduce these disparities. With generous support from the Robert Wood Johnson Foundation, the National League of Cities' Institute for Youth, Education and Families (YEF Institute) established the Learning Collaborative on Health Disparities in the fall of 2014. The purpose of the Learning Collaborative was to better understand emerging city-level models to address the social determinants of health and reduce childhood obesity-related health disparities. The participating cities included:

Baton Rouge, Louisiana	Oklahoma City, Oklahoma
Cleveland, Ohio	Savannah, Georgia
Kansas City, Kansas	Virginia Beach, Virginia
Lincoln, Nebraska	

In the course of working with these seven cities, the YEF Institute gained new insights and uncovered important lessons about the challenges and opportunities associated with local efforts. These insights have implications for childhood obesity prevention efforts as well as broader efforts to promote a culture of health. This report highlights lessons learned and offers recommendations from the pilot cities for municipal officials interested in reducing health disparities.

At the end of this report are city spotlights that include strategies instrumental to each pilot city's efforts to address the root causes of childhood obesity-related disparities.

Lessons from the Field

1

The scope and complexity of the underlying causes of health disparities can be overwhelming to city leaders, making it important to frame issues into discrete, manageable areas for early action.

2

The challenge of having honest conversations about equity and race can slow local progress, making it critical to empower city leaders to initiate honest and respectful conversations.

3

Cities have a range of existing assets and resources that can be adopted to more intentionally focus on addressing health disparities.

4

Some of the most promising city efforts to reduce health disparities focus on data-driven planning and implementation, meaningful engagement of residents and cross-sector partnerships.

5

Efforts to reduce health disparities can be most effective if they expand access to neighborhood-level data on health outcomes, redefine what “health data” means, and track and evaluate progress.

Lesson 1

The scope and complexity of the underlying causes of health disparities can be overwhelming to city leaders, making it important to frame issues into discrete, manageable areas for early action.

EFFECTIVE FRAMING

Health disparities are more than just differences in health; they are a direct outgrowth of social, economic and environmental factors that shape the environments in which children are raised. Each of the cities selected to participate in the Learning Collaborative expressed a strong interest in better understanding the impact of these disparities on their communities. This interest inspired city leaders (e.g., mayors, councilmembers, health department directors, nonprofit leaders) to make addressing health equity a higher priority and sparked additional action.

Learning Collaborative topics of discussion helped the cities advance their health equity goals by focusing on uncovering the “story behind the differences.” Municipal leaders participated in conversations on how policies, practices and programs in core city areas such as transportation, public safety and economic development positively or negatively affect the ability of children to make healthy choices that lower their risk of childhood obesity.

Although local governments provide essential services in each of these areas every day, the complex ways in which they influence health outcomes may not be familiar to local elected officials, their staff and community partners. In some cases, a lack of data or a clear process to evaluate health impacts makes it even more challenging to understand how separate policy decisions interact to create health disparities in communities. For example, some city leaders shared stories of encountering resistance when attempting to engage other stakeholders who felt that healthy living initiatives were not connected to their department’s mission.

Effective framing can break down some of the complexities of health disparities and spur local action.

All of the pilot cities emphasized that city leaders have competing priorities, and that it is essential to “connect the dots” by framing health disparities in ways that highlights root causes as well as specific areas for action that align with the mayor’s and/or city council’s top priorities and the priorities of the city department they are trying to engage. Five of the seven pilot cities expressed the need for the creation of a health disparities framework to illustrate the connections between the core functions of municipal governments and health disparities. Such a framework could help city leaders distill the underlying causes of health disparities into discrete, manageable areas and highlight how multiple sectors can reduce health disparities both independently and collectively.

Other cities suggested that it is sometimes better not to start the conversation with health but to begin with an exploration of topics such as:

- Priorities of different city departments;
- Strategies each department uses to achieve desired outcomes;
- Indicators each department uses to measure progress; and
- Current interconnections between city departments.

This shared understanding can provide the foundation for future conversations about the health impact of the goals, strategies and outcomes of various city departments, policies and initiatives.

Lesson 2

The challenge of having honest conversations about equity and race can slow local progress, making it critical to empower city leaders to initiate honest and respectful conversations.

HONEST CONVERSATIONS

Low-income communities and communities of color typically experience higher rates of childhood obesity than more affluent and/or white communities. These communities have systematically experienced greater social, economic and physical/environmental barriers to healthy living as a result of discrimination and social exclusion. In this context, municipal leaders may find it impossible to understand health disparities without examining how historical, systemic and structural racism has shaped their communities and influenced current policies and institutional practices.

Topics such as race, individual bias and historical patterns of racism and segregation can make for difficult and uncomfortable conversations for municipal leaders and their community partners. The level of readiness to engage in these sensitive conversations varied widely among Learning Collaborative participants. Furthermore, the level of readiness influenced the terminology that representatives from each city used. For example:

- Some of the pilot cities used racial and ethnic terms to describe the communities most impacted by health disparities, such as African American and Hispanic/Latino populations, whereas other cities preferred to describe disparities using geographic terminology (e.g. by neighborhoods or ZIP codes).
- A few cities preferred to use the term “health equity” over “health disparities,” whereas others preferred not to use the term “equity.”
- In some communities the word “equity” is often misunderstood to mean “equality” and is negatively associated with phrases such as “redistribution of wealth” or “lack of personal responsibility.” This misunderstanding is difficult to correct and may hinder progress.

In some of the pilot cities, local elected officials, city staff and community partners felt they lacked the skills, resources and capacity to discuss these sensitive and complex issues. One city leader shared that his fear of “saying the wrong thing” prevented him from actively engaging in these types of conversations. Another participant expressed his frustration that his colleagues too often “skirt around” the issues rather than “calling out racism,” but did not feel he was the right person to initiate that conversation.

Having honest conversations is challenging, precisely because they are so often difficult or uncomfortable. Existing tools, resources and opportunities for professional development can help cities advance racial equity, but success frequently requires meeting municipal leaders and their community partners where they are and finding ways to empower city leaders to speak candidly about the challenges of race and inequity in their communities.

Lesson 3

Cities have a range of existing assets and resources that can be adopted to more intentionally focus on addressing health disparities.

EXISTING TOOLS

At the conclusion of the Learning Collaborative, each of the seven pilot cities outlined future steps they could take to address health disparities. The most common next steps leveraged existing assets and infrastructure such as land use/master plans, data collection activities, public engagement and outreach to residents, public-private partnerships.

In many cases, local leaders did not have an explicit focus on health disparities when they initially conceptualized and adopted their land use/master plans, data collection activities or partnerships (prior to the Learning Collaborative). The pilot cities saw a significant opportunity to shift their

approach and embed health and equity considerations into the decision-making to ensure that there is an intentional focus on improving the underlying social, economic and environmental conditions that impact the ability of children and families to make healthy choices.

Examples of next steps include:

- Collecting and synthesizing data to illustrate the connections between health, active transportation, and jobs to encourage the prioritization of infrastructure improvements in high-need, low-income neighborhoods as Baton Rouge implements a Complete Streets Ordinance.
- Inserting language in the Virginia Beach Health District's Community Health Improvement Plan that details how each improvement strategy will improve health outcomes and advance health equity.
- Leveraging appointed positions on commissions or task forces to draw greater attention to connections between their work and the problem of health disparities within the community.

Lesson 4

Some of the most promising city efforts to reduce health disparities focus on data-driven planning and implementation, meaningful engagement of residents and cross-sector partnerships.

DATA-DRIVEN

Assessing community health needs and developing appropriate plans to address these needs is essential to reducing health disparities.

Some of the most noteworthy city efforts to reduce health disparities leverage existing data collection activities at the national, state and local levels.

Pilot cities used health data to identify health outcomes as well as to create evidence-based policies and direct resources to communities with the poorest health outcomes. The most commonly used data sources included:

- U.S. Census;
- Youth Risk Behavioral Surveillance Survey;
- Behavioral Risk Factor Surveillance Survey;
- U.S. Department of Agriculture Food Atlas;
- County Health Rankings & Roadmaps; and
- Community health needs assessments conducted by local hospitals or health departments.

MEANINGFUL ENGAGEMENT OF RESIDENTS

Some of the most promising city-level efforts to reduce health disparities engage residents who are experiencing the poorest health outcomes to inform the policymaking process – from design to implementation. These cities conducted targeted outreach to ensure that low-income residents and communities of color who are most affected by health disparities could share their experiences, clarify their needs and participate in the local decision-making process.

Resident stories about the conditions in their neighborhoods can provide important insight about barriers to healthy living. When combined with other data, this information can create a more comprehensive picture of the current distribution of social determinants of health and the community's health needs, as well as the strategies that the community is most likely to support.

While many cities have systems to collect feedback from residents, the most promising strategies used by the pilot cities were unique in that they focused on resident empowerment versus solely information sharing. These strategies used also included a plan for following up and engaging residents on an ongoing basis with progress updates or information on how they can advocate for their health.

CROSS-SECTOR PARTNERSHIPS

City leaders in all of the pilot cities encouraged participation in their childhood obesity prevention efforts from multiple city departments and community based-organizations. The most successful and robust cross-sector partnerships were broad enough to invite participation from non-traditional sectors, but narrow enough that partners had a clear sense of the city's vision for a healthier city, the purpose of the collaboration and examples of specific actions that their sector can take to improve health outcomes. These partnerships invested time and resources in developing shared goals and establishing indicators and performance metrics to hold partners accountable.

The pilot cities with robust, cross-sector partnerships viewed these relationships as critical assets upon which to build and strengthen future efforts to address health disparities. For example, they suggested using a stakeholder convening to:

- Educate partners about the social determinants of health;
- Collect and share data on community health needs to improve how partners support communities with the highest health disparities;
- Engage residents in data collection and design of solutions;
- Measure the health and equity impact of existing efforts; and
- Better understand the health impact of the sector that each partner represents and identify potential strategies to collaborate in a more intentional manner.

Lesson 5

Efforts to reduce health disparities can be most effective if they expand access to neighborhood-level data on health outcomes, redefine what "health data" means, and track and evaluate progress.

FOCUS ON OUTCOMES

Although national, statewide and county level data sets such as the U.S. Census, Youth Risk Behavioral Surveillance Survey, the Behavioral Risk Factor Surveillance Survey and the County Health Rankings provide extremely useful information on disease prevalence and trends, neighborhood-level data can provide city leaders with more granular detail about the health of certain neighborhoods and population groups in their city. This level of information is critical to identifying the specific barriers children and families face to healthy eating and active living in their community. Neighborhood-level data can play a critical role in grounding difficult conversations in evidence and helping city leaders better understand the underlying causes of health disparities.

A few of the pilot cities established partnerships with their local schools to collect BMI data in order to get childhood obesity data at the neighborhood level. Other cities are exploring data sharing agreements with local hospitals to analyze emergency room admissions and discharge data to better understand in real time the health conditions that different communities are seeking treatment for most frequently.

Cities also collect and store substantial amounts of data on crimes, housing, transportation, education and more. The data collected through the provision of these services is not typically considered "health data," however, it provides information about the factors in communities that hinder or support healthy living.

Some of the most promising efforts to reduce health disparities by pilot cities expanded the definition of health data to take advantage of the wealth of neighborhood-level data that city departments collect on social, economic and environmental factors that influence health. For example, the city of Lincoln uses a broad range of indicators collected through the city's outcome-based budgeting initiative to measure the city's progress towards creating livable neighborhoods and healthy and productive people, including:

- The number of sidewalk repairs completed;
- The number of businesses that plan to expand in the coming year;
- The number of bicycle, pedestrian and vehicle injuries among children;
- Ridership on public transportation; and
- The number of children, teens and adults who attend library-sponsored programs.

Collecting and sharing this data creates opportunities for cities to understand the distribution of the social determinants of health across their city and establish baselines and measure progress toward more equitable health outcomes. Many of the pilot cities were also interested in how data visualization tools, such as maps and dashboards, can help present data in a more manageable way to seed action from local elected officials, their staff and community partners.

CONCLUSION

The National League of Cities’ Learning Collaborative on Health Disparities created an opportunity for local elected officials, city staff and their community partners to reflect on their existing childhood obesity prevention efforts, engage in challenging conversations about inequities in their city and develop next steps for future actions to address health disparities. The discovery and learning process emphasized the need to be intentional and consider health and equity implications throughout the policymaking process – from design to implementation – in order to advance targeted strategies that best serve those communities most in need.

Peer learning was paramount to the success of the Learning Collaborative and the acceleration of action in these cities. According to the seven pilot cities, the experience of participating in the collaborative resulted in a shift in the way they frame and approach these complex issues. Furthermore, this process inspired ideas on how they can build upon existing tools, collaborations and resident engagement tactics to more strategically and deliberately reduce childhood obesity-related disparities.

These conversations are the beginning of an important process that each city is undertaking to examine

underlying issues of race and the unequal distribution of health-promoting resources across communities.

We heard from the pilot city leaders that these conversations served an important role in how they are now examining underlying issues of race. The lessons learned from the collaborative have implications for childhood obesity prevention efforts as well as broader efforts to promote a culture of health and equity in health.

In order to succeed, municipal leaders will have to recognize that all city agencies, community partners and residents have a role to play in addressing disparities. Additionally, as city leaders’ awareness and understanding of a culture of health and equity in health grows, they will need concrete examples of how cities can begin “putting all the pieces together.” Providing city leaders, city staff and community partners with tools, resources and professional development opportunities to understand the complexities of health disparities is essential if we want to make the reduction of health disparities a citywide priority and help all children achieve their full potential.

Many municipal leaders are concerned about health disparities in their communities. They are eager to understand not only the underlying causes of health disparities, but also how to lead and drive change to reduce these disparities.

Professional development and training are needed to assist local governments, community partners and residents in developing the skills to advance sensitive conversations about race, racism and the inequitable distribution of social, economic and environmental resources across communities.

In partnership with residents who experience the greatest health challenges, create a shared vision, commitment, and metrics for building a healthier city that can be used to hold stakeholders accountable for reducing health disparities.

ADVICE FROM PILOT CITIES

Consider the health and equity implications of decisions made in a broad array of sectors throughout the entire policymaking process — from design to implementation — to ensure that there is an intentional focus on reducing health disparities.

Use data and city success stories to explain how core functions of municipal governments such as public safety and economic development impact the distribution of the social determinants of health as well as specific cross-sector actions that cities can take to address health disparities.

Prioritize the meaningful and authentic engagement of residents from low-income communities and communities of color who are most affected by health disparities. Empower residents to not only share their story but also to inform childhood obesity-prevention policies, practices and programs.

CITY SPOTLIGHTS



Baton Rouge, Louisiana

In 2012, Mayor-President “Kip” Holden used his bully pulpit to convene leadership from the five area hospitals to discuss how the city could leverage the Patient Protection and Affordable Care Act’s (ACA) requirement for nonprofit hospitals to conduct a community health needs assessment (CHNA). That same year, these five hospitals committed to a joint health needs assessment and implementation plan, making Baton Rouge one of the first communities in the nation to develop a CHNA with a unified implementation plan. Using the data in the CHNA as a roadmap, Healthy Baton Rouge – the mayor’s cross-sector healthy city initiative – created various practices, programs and policies to increase healthy food access and physical activity in communities with the poorest health outcomes.

Cleveland, Ohio

In 2011, Mayor Frank G. Jackson and Councilmember Joe Cimperman joined with the CEOs of Cleveland’s four anchor health care institutions to create the Healthy Cleveland Initiative (HCI). To help improve the quality of life of all residents, the Cleveland City Planning Commission (CCPC) conducted a health impact assessment (HIA) of one of the city’s the lowest-income neighborhoods, the Hough neighborhood. Meaningful and authentic engagement of neighborhood residents was a top priority for the CCPC staff. Residents were not only invited to attend meetings but were asked to help develop solutions to create a healthier, safer neighborhood. Their feedback was used to create a Healthy Community Design Checklist that the CCPC is now using as a consideration for new permits and building design guidelines to ensure that new development takes into account community priorities, health and equity considerations.

Kansas City, Kansas

In order to improve health outcomes, the Unified Government of Wyandotte County/Kansas City is removing the barriers that prevent residents in the northeast region of the city — an area with high rates of poverty, unemployment and health disparities — from reaching their full health potential. The city-county is leading a collaborative effort to develop a “healthy campus” in downtown Kansas City. Nearly 300 residents and stakeholders attended the first public forum about the healthy campus and shared their feedback and concerns. The city organized follow-up conversations with residents, businesses, faith leaders, schools, banks, health providers, commercial developers, foundations, city staff and elected officials to better understand barriers to healthy living and the community’s vision for the downtown campus.

Lincoln, Nebraska

In 2008, Mayor Chris Beutler launched an outcome-based budgeting process, the *Taking Charge* initiative, which established performance measures in eight outcome areas identified through a community survey process. These performance measures and indicators are used to hold city departments accountable and encourage cross-sector collaboration. Many of these measures focus on addressing key social determinants of health, such as transportation and economic development. The Lincoln-Lancaster County Health Department intends to use its experience with the Learning Collaborative on Health Disparities to educate other city departments on how improving health and equity can help the city meet and exceed its *Taking Charge* performance measures.

Oklahoma City, Oklahoma

The Oklahoma City-County Health Department (OCCHD) created Wellness Now in 2010 to support and improve the well-being of all residents. Every three years, OCCHD conducts a health and wellness assessment that assigns each ZIP code in the county a Wellness Score. This score is calculated using a combination of socioeconomic factors as well as disease-specific indicators. Using the data from the health assessment as a guide, the Wellness Now Coalition develops an action plan to improve the health outcomes of the residents living in areas with the highest health burdens. This data-driven approach enables the OCCHD and its partners to direct resources to areas most in need. For example, in 2013, the Northeast Regional Health and Wellness Campus was built in the ZIP code with the lowest Wellness Score. In addition to addressing health challenges such as obesity, substance abuse and mental health, the wellness campus offers job training and employment services to address the underlying causes of health disparities.

Savannah, Georgia

In 2014, Healthy Savannah—founded by former Mayor Otis Johnson—partnered with the city of Savannah to select 10 public schools to host community listening sessions to identify barriers to active living. Rather than host a traditional town hall or public forum, the listening sessions were designed to facilitate active engagement and empower residents in low-income communities to voice their opinions. Healthy Savannah created GIS maps and gave all attendees the opportunity to identify on the map the barriers to physical activity in their neighborhoods. Children who attended the sessions worked with a local artist to draw their vision of a healthy community. Healthy Savannah compiled resident feedback and is working diligently with its partners to share this information with key city decision-makers in order to influence the implementation of a complete streets ordinance.

Virginia Beach, Virginia

In 2010, Mayor William Sessoms joined over 100 mayors participating in the National League of Cities' Mayors' Action Challenge. As part of this challenge, he established a committee focused on healthy lifestyles and the environment. This committee includes city departments and community partners such as Old Dominion University, Fresh Farm Supermarkets, the Virginia Beach Restaurant Association and Virginia Beach City Schools. A key priority of the committee is childhood obesity. To better address disparities, the public health department is partnering with the Office of Volunteer Services Neighborhood Services Coordinator to provide community engagement training to help the MACC-HLE develop a plan to actively engage residents in creating solutions to address barriers to healthy living.

Project Overview

With generous support from the Robert Wood Johnson Foundation, the YEF Institute established the Learning Collaborative on Health Disparities. The Learning Collaborative on Health Disparities created new opportunities for the YEF Institute to engage in a dialogue with local leaders, city staff and their community partners about local efforts to reduce childhood obesity-related health disparities. It also provided an opportunity for participating cities to share best practices and approaches with their peers. From the outset, the YEF Institute sought to gather information from cities on:

- How they conceptualize health disparities;
- What data/indicators they are using;
- How they are engaging other city agencies, partners and residents; and
- What strategies they are using to increase access to affordable, healthy food and physical activity at the local level.

The YEF Institute selected seven pilot cities to participate in the collaborative based on their documented health disparities, commitment and readiness to preventing childhood obesity-related disparities and ability to form strong and diverse partnerships. YEF Institute staff also considered factors such as city size, region and political affiliation to ensure a diverse composition of cities.

To guide this work, the YEF Institute formed an advisory panel comprised of national and regional experts and city leaders with expertise in various disciplines, including transportation, safety, environmental health, food access, early care and education, family economic success and equity. These experts also provided direct technical support to the participating cities to advance their health disparities work.

Finally, through in-depth interviews, site visits and an in-person convening, the YEF Institute documented new insights and important lessons. These lessons included throughout this report have implications for childhood obesity prevention efforts as well as broader efforts to promote a culture of health and equity in health.

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About the National League of Cities

The National League of Cities (NLC) is dedicated to helping city leaders build better communities. NLC is a resource and advocate for 19,000 cities, towns and villages, representing more than 218 million Americans.

About the Institute for Youth, Education, and Families

The National League of Cities' Institute for Youth, Education, and Families (YEF Institute) helps municipal leaders take action on behalf of the children, youth, and families in their communities. NLC launched the YEF Institute in January 2000 in recognition of the unique and influential roles that mayors, city councilmembers and other local leaders play in strengthening families and improving outcomes for children and youth.



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