TAKOMA PARK HEALTH INDICATORS

February 22, 2010

The Health Indicators Selection Group
Community Health and Empowerment through Education and Research
(CHEER)
A Sponsored Program Fund of the Community Foundation of Montgomery County

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Executive Summary

In the summer and fall of 2009, Community Health and Empowerment through Education and Research (CHEER) convened a representative group of residents, health care providers and other stakeholders from Takoma Park and Long Branch. The purpose of the meeting was to formulate a shared vision and common goals for a community of healthy individuals. On the basis of the vision and goals selected, the group defined measures that would indicate improvement in the quality of life and health care outcomes for all of the residents of Takoma Park and Long Branch.

The shared vision includes four key elements:

- Multiple sources of health information and education are provided in the community
- Equal access for all people to all necessary health services
- Availability to healthy food choices, healthy homes, and a clean and healthy environment
- A community design that accommodates and encourages physical activity.

From this vision, five goals were selected that enable the community to achieve the primary goal of good health outcomes for all individuals. The indicators selection group decided upon measurement tools for each goal. The goals and primary measurement tools are:

1. Health information is available from a variety of sources within the community and readily accessible to all. This is measured by the residents' satisfaction with health information and an inventory and assessment of the availability of health information.
2. All people have equal access to health services and disparities are reduced. This is measured by hospital emergency room data on the number of preventable and unnecessary emergency room visits, and surveys on the availability of health insurance.
3. A diversity of health services are available and patients have influence over how they receive health care. This is measured by the availability of a variety of health practitioners and health specialties.
4. Individuals take action to promote their own wellness and manage their health. This is measured by the frequency of health related behaviors, such as physical activity, tobacco use, obesity prevalence, prenatal care for pregnant women, and risky sexual behavior.
5. Social networks and community institutions that support people's health. This is measured by tools that assess social capital, as well as a list and assessment of the facilities, physical fitness and health and wellness opportunities available to community members.

CHEER is convening a process to implement the selected indicators in partnership with key local health institutions, such as the Primary Care Coalition, the Montgomery County Department of Health and Human Services, and other partners.

Introduction

This report details the process and results for the selection of indicators of health for the Takoma Park and Long Branch communities. It is the second of three indicators selection processes convened by Community Health and Empowerment through Education and Research (CHEER). This effort was funded by the City of Takoma Park, along with private donations, to establish measures of the quality of life in the Takoma Park and Long Branch neighborhoods. The first indicators selection process focused on indicators for housing and was completed in January 2009. The third set of Takoma Park/Long Branch indicators will focus on measuring the Takoma Park and Long Branch local economy. It is scheduled to start in March 2010. A community report card based on the selected indicators is planned for June 2010

Why Community Indicators?

Developing community indicators is a way to inform and empower residents to take ownership in creating their ideal community. This approach has been used in dozens of communities around the country and is widely regarded as a best practice for engaging the public, informing policy makers, and allocating and leveraging resources. This kind of results based accountability has wide spread currency among policy makers and funders.[1] Indicators provide the basis for measuring program impacts in the community, which are key to attracting and sustaining nonprofit, for profit and public investment.

The indicators themselves are statistical measures of the health and well being of the community, as defined by the community. But the benefits go far beyond the statistics they produce. Benefits of the indicators process include:

- Creation of a core group of informed residents committed to improving the community.
- More community engagement and cooperation and broader resident participation in community affairs.
- Improved policy discussions focused on data and facts about the community.
- Improved policy choices based on better information and expanded resident participation.
- Improved budget and resource allocations.
- Increased resources for the community based on better information and focused advocacy from residents.
- Better information on program performance for programs where the indicators measure outcomes in the community.

Background

Community Health and Empowerment through Education and Research (CHEER) began as the Silver Spring/Takoma Park Community Indicators Project, a sponsored program funded by the Montgomery County Community Foundation in 2008. It began at the

[1] Forum on Key National Indicators: Assessing the Nation's Position and Progress. U.S. Government Accountability Office in Cooperation with the National Academies (GAO-03-672SP, May 2003).

initiative of Takoma Park and Long Branch residents. Preliminary funding was provided by the City of Takoma Park and private donations. CHEER has also had benefited from a great deal of volunteer support from dozens of Takoma Park and Long Branch residents. It has also had substantial in-kind support from partnering organizations, such as IMPACT Silver Spring, Casa de Maryland, Adventist Community Services, the Somali American Community Association, Washington Adventist University, and others.

Process

In the summer and fall of 2009 CHEER assembled a group of Takoma Park and Long Branch Residents and stakeholders to select health indicators for the Takoma Park and Long Branch communities. The group was selected to reflect the ethnic and racial diversity of the community as a whole, in addition to a variety of health care recipients, health care providers, professionals, and other residents. The group also included three health care "promoters" from Casa de Maryland who received Spanish translation. Participants and attendees included:

- Ron Wylie, Adventist Community Services
- Ahmed Elmi, Somali-American Community Association
- Drew Sommers, Analyst in Public Health & Epidemiology and Takoma Park Health Services Impact Committee
- Joanne Wu, Naturopath and Licensed Acupuncturist
- Mary Carter-Williams, HLC Diabetes Foundation
- Dalila Bounou, Long Branch tenant
- Hatim Bounou Long Branch tenant
- Ed Wilhelm, former Takoma Park resident and health care activist
- Venita George, City of Takoma Park staff
- Ruth Martin, Montgomery County Department of Health and Human Services
- Mercedes Rodriquez, Health Promoter, Casa de Maryland
- Elva Jaldin, Health Promoter, Casa de Maryland
- Bessy Garcia, Health Promoter with Casa de Maryland
- Jim Johnson, Long Branch resident
- Jere Stocks, President Washington Adventist Hospital
- Drew White, Physician and head of Washington Adventist Hospital's Emergency Department
- Karen Green, Healthcare Initiative Foundation

Also contributing to and facilitating the process were CHEER Board Members, Timothy Male, Kathy Porter, Bruce Baker, and Scott Strumburgh (professional facilitator), and Vanessa Landau (note taker) and Norma Lopez (Spanish translator).

The work group held four meetings of two hours each to formulate a vision and set goals with respect to health, and then to select indicators that measure community progress toward these goals. All meetings were open to the public and participation ranged from 13 to 15 people at each meeting. Participants also included individuals who were not

members of the housing indicators work group. One participant, Lois Wessel of MobilMed, was unable to attend meetings but provided contributions online. Meetings were professionally facilitated to maintain fair and balanced involvement from all participants in order to create an open, honest, and understanding discussion from all of the diverse participants.

Additional input was gathered through CHEER staff visits at the Franklin Apartments and the Judy Center. Franklin Apartments is a residence for low-income seniors and disabled people in Takoma Park (12 residents participated). The Judy Center serves many Latino immigrant families with children at Rolling Terrace Elementary School, where approximately 15 Latino women participated through Spanish translation.

The process created a synthesis that incorporates the views and concerns of all participants and constitutes a vision that is representative of the aspirations of the community as a whole. The group agreed upon a definition of health in a community context and articulated a common vision. Goals were selected based on the vision. Indicators were selected based on the goals, with the vision in mind. Ruth Martin, Senior Health Planner with the Montgomery County Department of Health and Human Services, served as data expert to guide the selection of indicators. Criteria used to select the indicators are included in the appendix.

Definition of Community Health

A healthy community is a community of bodily, mentally, and socially healthy individuals. Health is broadly defined to include behavioral health, non-conventional health practices, oral health, and the well being of children in safe and healthy families.

Vision of a Healthy Community

The Takoma Park/Long Branch communities envision a community of strong social networks rich in interactions that empower individuals and families to improve health and fitness, prevent illness, develop a sense of well being, and foster each person's potential for a long, active, and fulfilling life. The community will:

- Offer multiple sources of health information, including community-based health education.
- Offer equal access to all necessary health services including appropriate preventive services regardless of financial means and geographic location, so that health outcome disparities among socio-economic groups are reduced.
- Offer healthy choices in terms of nutritious, locally grown food, healthy homes, and a clean and healthy environment.
- Be designed to accommodate and encourage physical activity.

Goals for Community Health

1. Health information is available from a variety of sources within the community and readily accessible to all.

    A. There is a system of community-based health education.
    B. Individuals can obtain health information from their choice of a variety of sources.
    C. People have the information needed to take a preventative approach to their own health.
    D. People have access to healthy food, healthy housing, and other healthy choices.
    E. The community shares a common definition of health that facilitates interactions with one another that encourage healthy behaviors and facilitates healthy choices.
    F. Parents have information on raising healthy children.

2. All people have equal access to health services and disparities are reduced.

    A. Health care is available to all without regard to their finances.
    B. Medications are affordable.
    C. All individuals feel that they are treated equally and with respect by the health care system.
    D. Translation and other facilitation services are available to those who need them.
    E. School-based health care is available to students and their families.
    F. Children have access to all appropriate services, including oral health care and behavioral health.
    G. 24 hour health care is available nearby for all.
    H. Residents of multi-unit buildings for seniors and the disabled have access to mobile health services on-site.
    I. People with chronic disease have access to continuous care

3. A diversity of health services are available and patients have influence over how they receive health care.

    A. Government regulations permit all health practitioners to fully utilize their training and skills.
    B. Individuals are better informed about the medications they take and how the medications are to be used.
    C. Practitioners put more emphasis on listening to their patients and taking patients concerns and wishes into account.
    D. Individuals and families have information needed to choose doctors and dentists.

4. Individuals take actions to promote their own wellness, and manage their health.

A. Individuals learn to manage their own health, so they need less assistance from medical practitioners.
B. The medical problems of vulnerable people, such as the elderly, are addressed before medical crises occur.
C. People have more opportunities for physical activity, and are physically active.
D. Health and physical fitness are a priority for local government, (beyond the departments of recreation and parks) and are important factors in land use decisions.

5. Social networks and community institutions support people's health.

A. Individuals have access to help outside their immediate social networks.
B. Supportive services are available to all.
C. Schools put more emphasis on children's health and safety.
D. Public schools allow children adequate time for meals and for physical recreation.
E. Residents of multi-unit buildings for seniors and the disabled have supportive social networks and are organized to meet residents' needs.

Primary Goal Individuals experience good health

Community Health Indicators

GOAL 1: Health information is available from a variety of sources within the community and readily accessible to all.

Community representatives felt strongly that 'knowledge is power.' Measuring improvements in the volume and quality of information available and citizens satisfaction with that information is important because a better informed community is expected to be a healthier community.

FIRST INDICATOR: Percent of residents who are satisfied with health information.

A community survey is needed to measure residents' knowledge and understanding of, and satisfaction with health information. The survey could use already-established methods in use in State and County level surveys including the Behavioral Risk Factor Surveillance System (BRFSS) or from the Agency for Healthcare Research and Quality (AHRQ).

> What will it tell us? It will reveal community satisfaction with health information and changes over time in community perception.

SUPPLEMENTARY INFORMATION: Inventory of sources of health information within the community.

The inventory would measure the availability of information. It should include both a list of sources of information, the content provided, and the extent to which that information is accessible to all who may need it. This inventory should include parent education programs and programs promoting healthy lifestyles through good nutrition, physical activity, and avoiding behaviors that put health at risk.

> What will it tell us? It will determine important gaps in information availability, gaps in accessibility of information, and change over time in the quality and quantity of information.

GOAL 2: All people have equal access to health services and disparities are reduced.

FIRST INDICATOR: Percent or number of people with health insurance.

A community survey is needed to determine levels of health insurance coverage. The survey should also include questions on health care access that allow analysis by important race, ethnicity, age, gender, income, education, geographic location and other socioeconomic and demographic categories in the community.

> What will it tell us? This data is fundamental to any understanding of how our community compares to others in the U.S. in basic access to health care and will show changes over time in that access.

SECOND INDICATOR: Use of emergency health services for health conditions that could have been treated by primary care physicians, and the use of emergency health services for conditions that are preventable.

Individuals without adequate health insurance or adequate access to health information are more likely to depend on emergency medical services because they lack or perceive they lack access to non-emergency services. Existing data is available on emergency room use that specifies whether the emergency room visit was for a preventable problem or for a condition that could have been treated in a non-emergency setting. These data should be analyzed by the residents' location within community boundaries and analyzed by socioeconomic and demographic characteristics that may reveal gaps in access among community residents.

> What will it tell us? Use of existing emergency service use data provides an additional way to collect information on health insurance coverage and adequacy of information sought in Goals 1 and 2; decreases in this indicator over time indicate success in providing better health insurance coverage and preventative care.

SUPPLEMENTARY INFORMATION: List and count of health clinics (and providers) in the community and the amount they charge for services.

> What will it tell us? Data on number of service providers and price of services will provide supplementary information indicative of the general accessibility of health care in the community and changes over time.

GOAL 3: A diversity of health services are available and patients have influence over how they receive health care.

FIRST INDICATOR: Availability of a variety of health practitioners and health specialties.

A list of physicians and health practitioners in or near the Takoma Park/Long Branch area will be assembled for each type of practice. From the list, samples for certain types of health practices will be surveyed. The survey will determine whether doctors are accepting new patients, the type of insurance they accept, and how long until the next available appointment.

> What will it tell us? This will demonstrate which types of medical practices are underrepresented in the community and suggest possible gaps in medical services.

SECOND INDICATOR: Percent of Doctors with malpractice judgments or disciplinary actions taken within the last 10 years.

The survey of doctors will also be checked in the Maryland Board of Physicians Practitioner Profile System to see if they have any record of malpractice or disciplinary actions.

> What will it tell us? This will provide a measure of medical care quality. An increase in the percentage of physicians with malpractice judgments, settlements or disciplinary actions would indicate a decrease in the quality of physicians providing services in the area.

GOAL 4: Individuals take actions to promote their own wellness and manage their health.

FIRST INDICATOR: The percent of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.

SECOND INDICATOR: The proportion of people who are using any forms of tobacco products.

Both of these indicators are monitored down to the County level by the Behavioral Risk Factor Surveillance System. Obtaining this data at the community level will require purchasing an oversample of the BRFSS for the community level or including these items as questions in a separate community wide survey.

> What will they tell us? This will demonstrate residents' participation in two activities that have been demonstrated to be significant factors in personal health and suggest areas where modification of individual behaviors and practices may be encouraged.

THIRD INDICATOR: The proportion of children and adolescents who are overweight or obese.

FOURTH INDICATOR: The proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.

Indicators three and four are monitored to the State level by the Youth Risk Behavior Survey. An oversample of the YRBS at the community level may be possible. It may be possible to apply the YRBS to targeted populations of youth within the community.

> What will they tell us? Indicator three will demonstrate the degree to which youths balance their diet and physical activities. Obesity among youth is a major factor contributing to the incidence of future cardiovascular disease and Type 2 diabetes. This may suggest a need to increase opportunities and encouragement for physical activities, and improved nutrition. Indicator 4 measures youth behaviors that endanger health and raise the risk of underage pregnancy.

FIFTH INDICATOR: Percent of births to women receiving prenatal care in the first trimester.

Vital statistics data for these indicators may be available at the local level through the state or through the CDC.

> What will they tell us? This will demonstrate whether mothers in the community are getting early prenatal care, which has been demonstrated to be a significant factor in determining whether babies are born healthy. A decrease in this measure would suggest a need to address barriers to early prenatal care.

GOAL 5: Social structures, networks and community institutions support people's health.

FIRST INDICATOR: Measure of neighborhood connectedness.

Social networks can influence and support individuals in their health choices and behaviors. Survey instruments for measuring the strength of social networks have been developed. One, Measurement of Markers of Social Capital (MSC), has been used in efforts to improve public health. Another more general instrument, the Social Capital Benchmarking Survey, may also be helpful. A methodology for measuring social integration and civic participation should be selected and implemented.

> What will this tell us? This will provide a measure the level of trust, reciprocity, and participation within the community. This is referred to as social capital and it has been associated with improved health outcomes, such as improved health status, lower infant mortality, and longer life expectancy. Increases in social capital would suggest improvements in social structures that would allow social networks and community institutions to provide more support for people's health.

SUPPLEMENTARY INFORMATION: List of physical fitness opportunities and facilities available to community members.

Physical fitness facilities and opportunities are seen as important to promoting health. Information on the availability of facilities is available from the City and County Recreation Departments and the Maryland National Capitol Park and Planning Commission. Information on private facilities such as gyms, martial arts classes, yoga and dance classes are also available through mapping software and business directories. It may be possible to measure increases or decreases in the availability of various types of opportunities from year to year.

PRIMARY GOAL: Individuals experience good health.

The goals and indicators above reflect the belief that a well-informed population with health insurance and equitable and adequate access to services will be healthier. However, it is also important to directly measure that health - which is our ultimate goal. The following indicators measure the health of individuals in the community. Together with Indicators from Goals 1-5, we believe these indicators will paint a comprehensive picture of where the community has been and where it is going in improving the health of all residents.

FIRST INDICATOR: Prevalence of chronic diseases, especially those that are preventable.

The most common and deadly preventable chronic diseases are cardiovascular disease and Type 2 diabetes. The CDC has data on prevalence down to the County level. Getting prevalence data for the local level will require more effort.

> What will it tell us? Decreases in the prevalence of heart disease and Type 2 diabetes would demonstrate improvement in the health of the population.

SECOND INDICATOR: Number of people whose self-reported health status as Good or Excellent.

THIRD INDICATOR: Number of 'healthy' days.

The BRFSS asks individuals their health status and the number of days, out of the last 30, for which their health status was not good, resulting in missed activities. The healthy days questions in the BRFSS ask about mental as well as physical health. This data may be obtained by an oversample of the BRFSS at the community level, or by using the health status and healthy days questions in a separate community survey.

> What will it tell us? Increases in health status would demonstrate improvement in the health of the population. It would also include a measure of mental health in the community.

FOURTH INDICATOR: Percent of babies born with low birth weight.

This vital statistic information should be available at the local level from the state or the CDC.

> What will it tell us? Adequate birth weight is used as the best indicator correlated with the birth of a healthy baby. Increases in this percentage would indicate improvements in infant health and prenatal care.

FIFTH INDICATOR: Changes in mortality rates by causes of death in the community.

This vital statistic information should be available at the local level from the state or the CDC. The data should be normalized across age, and other characteristics.

> What will it tell us? Increases in mortality rates for certain causes of death, or unfavorable comparisons with other jurisdictions, would signal threats to health that may be overlooked by other measures.

Next Steps: Research and Action

The Vision, Goals and Indicators set forth above form the basis of a community health research agenda. Participants in the indicators selection process and representatives from organizations that have an interest in measuring community health have been invited to participate in a discussion about how to implement measurement of the indicators. CHEER will convene a meeting in March to begin this part of the process. To date confirmed participants include representatives of the Primary Care Coalition, the Montgomery County Department of Health and Human Services, the University of Maryland's School of Public Health.

Plans will be made to conduct a participatory community based research process that will engage residents, community partners, and academic supporters. This process will reveal and suggest opportunities for change and action.

Appendix A: Criteria for selection of Indicators

PROXY POWER: DOES IT MEASURE THE DESIRED OUTCOME?

1. Does it illustrate an aspect of the well-being of the community?
2. Does it help illustrate what's most important and pertinent about the community?
3. Is the indicator a reasonable measure of progress towards the community's desired results?
4. Would improvements made in the indicator represent progress towards the community's vision and goals?

DATA POWER: IS IT VALID, RELIABLE AND AVAILABLE?

5. Does the indicator accurately and consistently measure what it is intended to measure?
6. Are fluctuations in the indicator data subject to causes unrelated to the desired result?
7. Is the data available for the community or neighborhood?
8. Is it costly or difficult to obtain?
9. Can it be updated in regular meaningful intervals, such as annually?
10. Will the data continue to be available into the future?

COMMUNICATION POWER: DOES IT TELL A COMPELLING STORY?

11. Does the indicator communicate the result simply and directly in a way that suggests action?
12. Is it easily understood?
13. Is it credible and defensible in the eyes of the community?
14. Does it allow for comparisons with other communities?
15. Does it reveal underlying factors that contribute to the problem?

Appendix B: List of Health Goals and Indicators

GOAL 1: Health information is available from a variety of sources within the community and readily accessible to all.

FIRST INDICATOR: Percent of residents who are satisfied with health information.

SUPPLEMENTARY INFORMATION: Inventory of sources of health information within the community.

GOAL 2: All people have equal access to health services and disparities are reduced.

FIRST INDICATOR: Percent or number of people with health insurance.

SECOND INDICATOR: Use of emergency health services for health conditions that could have been treated by primary care physicians and the use of emergency health services for conditions that are preventable.

SUPPLEMENTARY INFORMATION: List and count of health clinics (and providers?) in the community and the amount they charge for services.

GOAL 3: A diversity of health services are available and patients have influence over how they receive health care.

FIRST INDICATOR: Availability of a variety of health practitioners and health specialties.

SECOND INDICATOR: Percent of Doctors with malpractice judgments or disciplinary actions taken within the last 10 years.

GOAL 4: Individuals take actions to promote their own wellness and manage their health.

FIRST INDICATOR: The percent of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.

SECOND INDICATOR: The proportion of people who are using any forms of tobacco products.

THIRD INDICATOR: The proportion of children and adolescents who are overweight or obese.

FOURTH INDICATOR: The proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.

FIFTH INDICATOR: Percent of births to women receiving prenatal care in the first trimester.

GOAL 5: Social structures, networks and community institutions support people's health.

FIRST INDICATOR: Measure of neighborhood connectedness.

SUPPLEMENTARY INFORMATION: List of physical fitness opportunities and facilities available to community members.

PRIMARY GOAL: Individuals experience good health.

FIRST INDICATOR: Prevalence of chronic diseases, especially those that are preventable.

SECOND INDICATOR: Number of people whose self-reported health status is Good or Excellent.

THIRD INDICATOR: Number of 'healthy' days.

FOURTH INDICATOR: Percent of babies born with low birth weight.

FIFTH INDICATOR: Changes in mortality rates by causes of death in the community.

Appendix C: Contact Information

Bruce Baker
Community Health and Empowerment through Education and Research (CHEER)
7724 Maple Avenue, #13
Takoma Park, MD 20912
301-589-3633
Email: bruce@communitycheer.org
Web: www.communitycheer.org