



**PLACE MATTERS Design Lab One: A Concept Paper**  
June 28-30, 2006 – Reston, Virginia

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**PURPOSE**

Welcome to Reston, Virginia. We are delighted you are joining us for this first PLACE MATTERS Design Lab (DL) meeting. This concept paper provides a brief overview of the PLACE MATTERS initiative and context for this first DL meeting. You will also find included an extensive bibliography (Appendix 3) related to social determinants of health and inequities in health status, along with two articles with great relevance. The extensive research and writing of Drs. Gail Christopher and Kathleen Maloy informed the writing included herein.

In this first DL, we have Community Strategy Teams (hereafter: Team) represented, each in various stages of formation, from different regions the country, and interested in developing and enhancing

**Health Policy Institute Mission**

The mission of the Joint Center Health Policy Institute (HPI) is to ignite a “Fair Health” movement that gives people of color the inalienable right to equal opportunity for healthy lives. Our goal is to help communities of color identify short- and long-term policy objectives and related activities in the following key areas:

- Identifying and addressing the economic, social, environmental and behavioral determinants that can lead to improved health outcomes.
- Increasing resource allocations for prevention and effective treatment of chronic illness.
- Informing the policy and practice of reducing infant mortality and improving child and maternal health.
- Reducing risk factors and supporting healthy behaviors among children and youth.
- Improving mental health and reducing factors that promote violence.
- Optimizing healthcare access and quality.
- Creating conditions for healthy aging and improving the quality of life for seniors.

strategies designed to address inequity and eliminate health disparities. The DL meeting provides a unique opportunity to provide peer networking and collaborative learning across PLACE MATTERS communities through discussion, networking, and strategizing within and among your Teams. Additionally, our agenda includes excellent discussants who will share with us their success stories. These stories provide sound evidence that it is indeed possible to design interventions that successfully impact upstream causes of inequities in health status.

We invite you to leverage your participation in PLACE MATTERS to enhance your efforts and to strengthen your capacity to improve the health and well-being of your community. Our collaborative work will take place over the course of one year, and will involve active participation in four national meetings (including this first meeting in Reston, VA), as well as conference calls and sharing ideas and resources via electronic means (email and an eventual PLACE MATTERS Blog). We

especially encourage you to provide feedback via the evaluation forms in your meeting packet.

**PLACE MATTERS: BRIEF OVERVIEW**

The Joint Center Health Policy Institute (HPI) approach to reducing/eliminating health disparities involves identifying the complex underlying causes of health disparities and defining strategies to address these root causes. A growing body of research clearly supports the notion that interventions targeting the social determinants of health can indeed modify patterns of health, illness, and health disparities. Systematic and evidence-based translation of this knowledge into policy and practice has been limited, particularly at the local level. HPI intends to address this gap with the PLACE MATTERS Initiative in

partnership with the W.K. Kellogg Foundation, The California Endowment, the National Association of Counties, the International City/County Management Association, the National Organization of Black County Officials, the National Association of County and City Health Officials, the Henry J. Kaiser Family Foundation, and other partners that will join us on this important journey.

HPI has established ongoing collaborations with several organizations to advance its goal of assisting communities of color in identifying short- and long-term policy objectives and related activities in HPI's

### **Joint Center Mission and History**

The Joint Center for Political and Economic Studies, a national, nonprofit research and public policy institution, informs and illuminates the nation's major public policy debates through research, analysis, and information dissemination in order to: improve the socioeconomic status of black Americans and other minorities; expand their effective participation in the political and public policy arenas; and promote communications and relationships across racial and ethnic lines to strengthen the nation's pluralistic society. Founded in 1970 by black intellectuals and professionals to provide training and technical assistance to newly elected black officials, the Joint Center is recognized today as one of the nation's premier think tanks on a broad range of public policy issues of concern to African Americans and other communities of color.

The history of the Joint Center has not only mirrored the progress African Americans have made since the passage of the 1965 Voting Rights Act, but has also mirrored the nation's political and socio-economic progress over the last three decades. When the Joint Center first opened its doors, there were 1,469 black elected officials (BEOs). There are now over 9,000 BEOs in the United States.

seven focus areas. HPI has created PLACE MATTERS to advance its work in these seven areas (for additional resources on each area, visit [www.jointcenter.org](http://www.jointcenter.org)). HPI contracts with CommonHealth ACTION to provide technical assistance to PLACE MATTERS participants. CommonHealth ACTION is a national, nonprofit organization whose mission is to help people and organizations maximize their potential to improve the health of individuals, families, and communities (for additional information, visit [www.commonhealthaction.org](http://www.commonhealthaction.org)).

PLACE MATTERS will provide a venue for state and local/tribal public officials/administrators and community leaders to engage in innovative initiatives aimed at reducing disparities and to benchmark their activities in a coordinated effort. Working with these county officials and

community leaders and informed by the relevant literature, PLACE MATTERS will help participants establish a set of performance indicators specific to each county or jurisdiction and designed to identify and monitor progress toward health disparities reduction/elimination. Targeting upstream causes of health, and measuring the indicators associated with social determinants of health are at the heart of our PLACE MATTERS work. PLACE MATTERS will help counties determine (1) the best approach to tracking/measuring their interventions, (2) which interventions are associated with the desired outcomes, and (3) why certain interventions seem to be working. This last item is essential for sharing and replicating the most effective ways to design, administer, and sustain programs at the state and local levels.

A benchmarking approach will build the capacity of county health officials and community leaders to identify, assess, and share the most effective disparities reduction strategies. The premise of PLACE MATTERS is that comprehensive and integrated data-based indicators can inform effective local interventions and provide the basis for building on success, making corrections, allocating public resources, and sustaining progress. ***Over a period of three to five years, PLACE MATTERS participants should be able to demonstrate and document progress, as well as the reasons for progress, toward redressing the social conditions associated with health inequities—and thereby toward reducing health disparities.***

PLACE MATTERS will help participants to (1) participate in accountability and learning laboratories designed to highlight more effective strategies to reduce health disparities through data collection/integration and analysis, and (2) understand benchmarking as a process for identifying,

understanding, and adapting outstanding practices that support institutional and systemic changes necessary to sustain these strategies.

PLACE MATTERS will also help county/tribal officials/administrators and community leaders further develop their ability to access, analyze, and integrate data. The capacity to integrate various state, county, and local databases will enable counties to develop more effective interventions because integrated data will provide a more comprehensive analysis and ‘diagnostic picture’ of their particular problems. This focus on data integration will be particularly beneficial for county administrators and staff because their work is often compartmentalized. ‘Connecting the dots’ with integrated data analyses will show the relationships among interventions designed to address the social determinants of health, provide much-needed context for their work, and reveal unexpected

### **Design Lab One: Meeting Goals**

1. Meet and network with colleagues participating in “PLACE MATTERS” counties and inform the national community building process
2. Share Joint Center Health Policy Institute’s vision for “PLACE MATTERS” and expectations for participation
3. Learn about progress and active work to address social determinants of health in participating counties
4. Explore current social determinants of health frameworks
5. Describe Joint Center Health Policy Institute’s technical assistance capacity regarding data/indicators
6. Provide a safe place for brainstorming and testing new approaches
7. Identify primary areas each county plans to address

but crucial insights about reasons for progress or the lack thereof.

The Joint Center has already established a PLACE MATTERS technical assistance team to provide you and your Team members with technical assistance throughout the course of the twelve-month initiative. In many cases, you may already be engaged in activities that address health disparities within your community. We believe that there is great value in convening leaders from different regions to work collaboratively on identifying and testing approaches to addressing health disparities. PLACE MATTERS will provide a safe place for you to share with and learn from others. We will share our collective work and lessons learned with all communities of color working toward improved health status. As a participating community, you can expect technical assistance from a national resource team of experts actively engaged in addressing health disparities from various vantage points.

1. Identify your Community Strategy Team, which will consist of four experts who will participate in four PLACE MATTERS Design Lab meetings and serve as catalysts for strategic action to improve the health of your community (Teams are in the formation process).
2. Identify your community’s priorities that relate to HPI’s seven health issue areas listed above (Teams began identification in the DL registration survey).
3. Design and implement an actionable strategy (or set of strategies) to address one or more of the issues that your Team identifies (we recognize that this may be work with which Teams are already engaged).

### **HPI PERSPECTIVES ON THE SOCIAL DETERMINANTS OF HEALTH**

Social determinants of health refer to conditions of society that reflect *root causes* of community and individual health and well-being<sup>1</sup>. Such causes include but are not limited to quality and affordability of housing, level of employment and job security, standard of living, availability of mass transportation, quality of education, forms of clean economic development, racism, poverty, distribution of goods and services, chronic stress, and workplace conditions.

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<sup>1</sup> Rhein, M., Lafronza, V., Bhandari, E., Hawes, J., & Hofrichter, R. *Advancing Community Public Health Systems in the 21<sup>st</sup> Century*. National Association of County and City Health Officials, 2001.

Many public/community health practitioners struggle with the notion that their programs should address social issues. How could individual programs tackle deep-rooted injustices related to racial and class discrimination, socioeconomic disadvantage, poor housing stock, and a myriad of other social forces that drive population health status? Shouldn't public health practitioners just focus on their mission to provide everyday public health services such as preventing the spread of West Nile Virus, inspecting restaurants, family planning programs, immunizations, communicable disease surveillance, and so on? Won't inequities in health be addressed by providing access to services to all community residents?

**Text Box 1: The WHO Commission  
Social Determinants of Health Framework**

“Throughout the world, people who are vulnerable and socially disadvantaged have less access to health resources, get sicker, and die earlier than people in more privileged social positions. Health equity gaps are growing today, despite unprecedented global wealth and technological progress. The greatest share of health problems is attributable to the social conditions in which people live and work, referred to as the social determinants of health (SDH). Good medical care is vital to the well-being of populations, but improved clinical care is not enough to meet today's major health challenges and overcome health inequities. Without action on social determinants, those countries in greatest need will neither meet the health-related Millennium Development Goals nor achieve global targets for reducing chronic diseases such as cardiovascular diseases, cancer, and diabetes. Problems are especially urgent in developing countries where the burden of chronic illnesses is growing rapidly on top of the burden of unresolved infectious epidemics. In developing countries—including Brazil, China, India, and Pakistan—death rates from chronic diseases already far exceed the combined death rates from communicable diseases, maternal and perinatal conditions, and nutritional deficiencies. Modifiable risk factors for chronic illness—such as poor diets, alcohol abuse, and smoking—are often seen as individual “lifestyle choices.” But such choices are conditioned by patterns of material deprivation and social exclusion. Health-compromising behaviors are disproportionately concentrated in socially disadvantaged groups, both in developed and in developing countries. Effective policy to tackle health challenges must address the underlying social conditions that make people who are disadvantaged more vulnerable.”

These questions are understandable. History has shown that indeed one agency simply cannot address these issues, nor should one agency attempt to do so. The US is certainly not alone in the need to address persistent population health challenges. Across the globe, many wealthy countries are struggling with increasing health inequity. In March 2005, the World Health Organization established an international body, entitled, *The Commission on Social Determinants of Health: Tackling the Social Roots of Health Inequities*.<sup>2</sup> With WHO Web site permission, we acknowledge the authors and include highlights from this article (Text Box 1).

In the US, despite the admonition from the Institute of Medicine (IOM) Committee on Health and Behavior, the lion's share of public and private investment in health supports the health care industry with minimal resources committed to understanding the role of communities and environments in shaping health outcomes. This persistent reality has triggered the need to improve health status and reduce health disparities with community-focused approaches that involve conditions necessary for healthy living. Consensus among leading researchers, policymakers, and public health officials around the world has been coalescing that eliminating health disparities requires addressing the multiple social determinants of health as well as assuring access to quality medical care.<sup>3</sup> While the IOM report *Unequal*

*Treatment* in 2002 provided an unprecedented focus and a much-needed blueprint for addressing disparities in health care services, the IOM exclusive focus on access to health care services meant that the critical need to recognize, assess, and account for the social determinants of health was again not recognized. Many activists have subsequently articulated the need to use a broader understanding of the origins/underlying causes of health disparities.

<sup>2</sup> Irwin A, Valentine N, Brown C, Loewenson R, Solar O, et al. (2006) The Commission on Social Determinants of Health: Tackling the Social Roots of Health Inequities. *PLoS Med* 3(6): e106.

<sup>3</sup> US Department of Health and Human Services *Call to action: Eliminating Racial and Ethnic Disparities in Health*, 1998. Schulz, A. et al. Racial and Spatial Relations as Fundamental Determinants of Health in Detroit. *The Milbank Quarterly*, 80(4):677-707, 2002. Marmot, M. Social determinants of health inequalities. *Lancet* 2005; 365:1099-1104.

A particularly notable article describes work funded by the Division of Prevention Research of the federal Centers for Disease Control and Prevention (CDC) to synthesize available knowledge about the effectiveness of community-based interventions to improve population health outcomes. This work led to the development of a conceptual model that links social environmental interventions to health outcomes.<sup>4</sup>

#### **Washington State Framework**

Social conditions are major determinants of health. Social forces acting at a collective level shape individual biology, individual risk behaviors, environmental exposures, and access to resources that promote health. There is a graded relationship between social position and health status that affects people at all levels of the social hierarchy. While public health programs alone cannot ameliorate the social forces that are associated with poor health outcomes, developing a better understanding of the social determinants of health is critical to reducing health disparities among Washington State residents of differing socioeconomic position. From *The Health of Washington State: The Social Determinants of Health, 2002*.

Identified as the *Community's Guide*, the premise of this model is that access to societal resources determines community health outcomes. Standard of living, culture and history, social institutions, built environments, political structures, economic systems, and technology are all societal resources that a population draws upon to sustain health. This conceptual model is shown in Appendices 1 and 2 and is notably consistent with the conceptual framework for examining community effect on health outlined in paper developed and published jointly in 2004 by the Joint Center Health Policy Institute and PolicyLink and titled *Building Stronger Communities for Better Health*.<sup>5</sup>

The *Community's Guide* model identifies these specific social environment factors associated with health outcomes: neighborhood living conditions, opportunities for learning and developing capacity, community development and employment opportunities, prevailing community norms, customs, and processes, social cohesion, civic engagement, and collective efficacy, and health promotion, disease and injury prevention and health care opportunities.

#### **RELATIONSHIPS BETWEEN SOCIAL DETERMINANTS OF HEALTH AND HEALTH DISPARITIES**

The need to identify and examine the relationships between the social determinants of health and health disparities is increasingly well-accepted in academic, research and policy circles. The March/April 2005 issue of the leading health policy and health service research journal *Health Affairs* is dedicated to racial and ethnic health disparities.<sup>6</sup> Excerpts from the Foreword authored by Risa Lavizzo-Mourey, President/CEO, The Robert Wood Johnson, William C. Richardson, President/CEO, WK Kellogg Foundation, Robert K. Ross, President/CEO, The California Endowment, and John W. Rowe, Chair/CEO, Aetna, are instructive:

*“At the outset, it must be clear that the strategies for eliminating disparities in health care and health status will, by necessity, be different....it is widely known that less than one-quarter of our health status is attributable to health care; rather, our health—or lack thereof—is primarily determined by social factors such as unhealthy practices, poverty, unemployment and underemployment, racism and discrimination, housing, transportation, and other neighborhood environmental conditions...Further research and study about community-based approaches to advance health promotion and disease prevention in communities wracked by poverty, racism, and other adverse environmental conditions is critical.”*

<sup>4</sup> Anderson, LM et al. The *Community Guide's* Model for Linking the Social Environment to Health, *American Journal of Preventive Medicine*, 2003;24(3S) pp. 12-22. Anderson, LM et al. Methods for Conducting Systematic Reviews of the Evidence of Effectiveness and Economic Efficiency of Interventions to Promote Health Social Environments, *American Journal of Preventive Medicine*, 2003;24(3S) pp.25-31.

<sup>5</sup> <http://www.policylink.org/publications.html>

<sup>6</sup> Racial & Ethnic Disparities *Health Affairs*, 24(2) March/April 2005. It is notable that the March/April 2002 issue of *Health Affairs*, 21(2), was devoted to examining the societal and environmental determinants of health and the dominant influence of non-medical factors on health status.

These authors conclude by noting the need for leadership to ensure that the many ongoing efforts to

**Addressing Social Determinants of Health Necessary to Eliminate Health Inequities**

*“Greater emphasis is needed on public health interventions that involve communities, with the goal of collectively identifying resources, needs and solutions... Individuals and families are embedded within social, political and economic systems that shape behaviors and constrain access to resources necessary to maintain health.”*

*Institute of Medicine, Committee on Health and Behavior 2001*

reduce racial and ethnic disparities move forward in a coordinated and thoughtful fashion and that a broad range of diverse stakeholders gets effectively engaged in the strategies for change. A review of the articles and authors in this issue of *Health Affairs* demonstrates decisively the breadth and depth of the recognition that strategies to reduce health disparities will not be successful unless these strategies are informed by sophisticated knowledge about environmental and social factors affecting health and are dependent upon community-based participation. The increased demand for research focused on strategies for eliminating health disparities and promoting community and broader social change has spurred attention on alternative approaches to inquiries that stress community

partnership, action for social change, and reductions in health inequities.

**SOCIAL DETERMINANTS AS PRIMARY FACTORS AFFECTING HEALTH STATUS & DISPARITIES**

Just as well-regarded scientific evidence establishes that a wide range of social conditions primarily determine health status and health disparities, accumulating evidence also shows that directing enhanced medical/social services or other interventions at the symptoms will not eliminate health disparities because the source of the inequities has not been addressed.<sup>7</sup> Nonetheless, the leading policy debates on health disparities continue to focus almost exclusively on service delivery despite the growing awareness that health care services have a relatively small effect on health status.<sup>8</sup>

Consequently, our efforts to reduce health disparities are based on the need to identify clearly the

**Text Box 2: WHO Five Key Action Areas**

- Improving living and learning conditions in early childhood
- Strengthening social programs to provide fairer employment conditions and access to labor markets, particularly for vulnerable social groups
- Policies and interventions to protect people in informal employment—that is, those who work without formal contracts or social protections, often in sectors outside government regulation, such as subsistence farming, household-based enterprises, and street vending
- Policies across sectors to improve living conditions in urban slums
- Programs to address key determinants of women's health, such as access to education and economic opportunities

underlying causes of health disparities and to develop strategies informed by this knowledge. How we defined a problem inexorably shapes our intervention. HPI's approach to reducing health disparities also presumes that change must begin locally. Identifying and promoting the concept of a *health safety net* emerges as a key component to strategies for eliminating health inequities. The health care safety net is well-recognized as critical to the ability of communities of color and vulnerable underserved populations to access health care services.<sup>9</sup> Recognizing the crucial role played by social determinants in health status, however, means that the health care safety net alone is not sufficient to address health disparities. Beyond the health care safety net, a *health safety net* encompasses all of the conditions

<sup>7</sup> *Health and Social Justice: Politics, Ideology and Inequity in the Distribution of Disease, A Public Health Reader* Ed. Richard Hofrichter Jossey-Bass 2003 Wiley & Sons San Francisco, CA See generally Chapter One The Politics of Health Inequities: Contested Terrain

<sup>8</sup> McGinnis, JM et al The Case for More Active Policy Attention to Health Promotion *Health Affairs* 21(2) 78-85 March/April 2002. "Policymakers need to begin thinking in terms of a health agenda rather than a health care agenda."

<sup>9</sup> AHRQ Billings, J & Weinick, RM, *Monitoring the Health Care Safety Net Book 1: A Data Book for Metropolitan Areas*, AHRQ Publication No. 03-0025 August 2003. Lewin, M.E., Altman S. Ed. *American's Health Care Safety Net: Intact but Endangered*, Institute of Medicine, National Academy Press, 2000.

necessary for achieving healthy lives such as affordable and safe housing, clean environments, safe neighborhoods, and health-promoting community services.

In its landmark 2002 report *The Future of the Public's Health*, the Institute of Medicine acknowledged the traditional role of public health to ensure a basic level of health for the population.<sup>10</sup> Noting that major

**Addressing Social Determinants of Health Necessary to Eliminate Health Inequities**

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*Institute of Medicine, Committee on Health and Behavior 2001*

improvements in health status and health outcomes have come from population-focused intervention involving social conditions such as improved sanitation, clean drinking water, and slum eradication/infection control, the IOM stated that community good health is related to basic infrastructure quality and economic equality. Public health's traditional focus on promoting population health by addressing social, economic and ecological conditions<sup>11</sup> is consistent with the premise of a health safety net. Public Health priorities and principles will assert that policymakers and legislators must have concrete data-based knowledge about how physical and social environments affect health and well-being and how poverty makes choosing healthy behaviors difficult, if not impossible.

**PLACE MATTERS: MOVING FROM ACTION TO DATA**

There are more than adequate data around the world demonstrating the power of social determinants. We share the WHO's approach to illustrate strategies to reducing inequities in health status across participating countries (Text Box 2). In the US, baseline data from 1950 show significant increases in disparities among age-adjusted death rates for blacks and whites.<sup>12</sup> Common examples of inequities in causes of death include homicide (3.6 vs. 20.5 per 100,000), heart disease (253.4 vs. 324.8), and cancers (197.2 vs. 248.5)<sup>13</sup>. While each indicator may vary slightly, we also find inequities in leading causes of death among American Indians/Alaska Native, Hispanic/Latino, and Asian populations. What's more, Williams and Jackson illustrate the lack of disparity in death rates for blacks and whites resulting from influenza and pneumonia.

These types of data clearly illustrate the power of social forces that determine health and well-being. HPI appreciates that each PLACE MATTERS Team will be most knowledgeable of the leading causes of death – and their root causes – at home, and for our US context. Reducing inequities in the distribution of disease and wellness will require each Team to derive strategies to address upstream influences of health status. Noted public health historian Elizabeth Fee in her introduction to George Rosen's *A History of Public Health* wrote:

“When the history of public health is seen as a history of how populations experience health and illness, how social economic and political systems structure the possibilities for health or unhealthy lives, how societies create the preconditions for the production and transmission of disease, and how people, both as individuals and social groups, attempt to promote their own health or avoid illness, we find that public health history is not limited to the study of bureaucratic structures and institutions but pervades every aspect of social and cultural life.”<sup>14</sup>

<sup>10</sup> Institute of Medicine *The Future of the Public's Health in the 21<sup>st</sup> Century* National Academy Press 2003. See also Institute of Medicine *The Future of Public Health* National Academy Press 1988.

<sup>11</sup> HPI has recently partnered with the American Public Health Association in sponsoring a symposium on Medicaid.

<sup>12</sup> D.R. Williams, & P.B. Jackson. Social Sources of Racial Disparities in Health. *Health Affairs* 24, no. 2 (2005): 325-334.

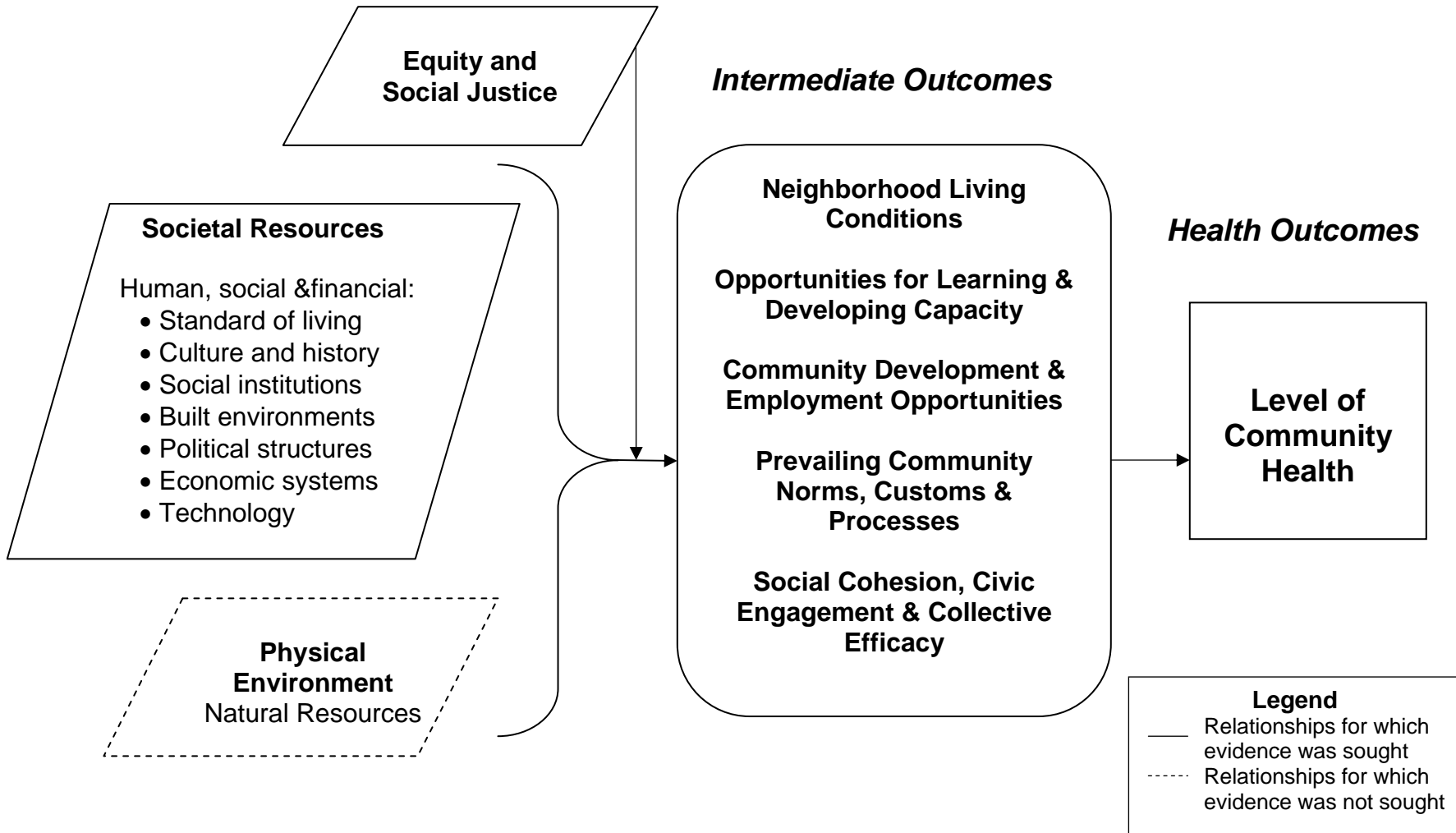
<sup>13</sup> Ibid.

<sup>14</sup> Rosen, G. *A History of Public Health* Baltimore: Johns Hopkins University Press, 1993.

Over time, the HPI believes that it will be possible to measure our collective success through positive changes reflected in the indicators selected by Teams. In this light, PLACE MATTERS activity will help participants *move from action to data*. Such outcomes would provide powerful evidence for dedicating action to address social determinants of health. We thank you for your participation in PLACE MATTERS and look forward to a collaborative learning journey that holds great promise. We must all believe that indeed it is possible to take positive action that impacts the social determinants now and for future generations.

APPENDIX 1

**Health Determinants<sup>1</sup>**



<sup>1</sup>Anderson et al. *The Community Guide's Model for Linking the Social Environment to Health*. *American Journal of Preventive Medicine* 2003; 24(3S) p. 13

## APPENDIX 2

### Measuring Elements from The Community Guide’s Model<sup>1</sup>

An Illustrative Example Involving Neighborhood Living Conditions:

#### Community Interventions to Promote Health Social Environment

	Intermediate Outcome	Intervention(s)
<b>Neighborhood Living Conditions</b>	<b>Making Housing Affordable</b>	Legislative Support for Subsidized Housing Housing or Shelters for Homeless People Increased SROs for low-income single adults Building Codes to require low-cost units for New Development Mixed Income Housing Developments
	<b>Increasing Housing Quality and Safety</b>	Tenant Organizations and Support Public Programs to Abate Housing Hazards Child-Proof Homes Protection Against Climate Extremes Removal of Unsafe/Abandoned Buildings Fire Safety Protections Neighborhood Beautification
	<b>Making Neighborhoods Safer</b>	Neighborhood Watch Programs Rapid access to emergency personnel Home security systems Safe playgrounds Animal Control Neighborhood policing by residents Reduction of neighborhood gang activity Reduction of drug trafficking Increased sidewalks, exercise & recreation paths Reduction of liquor store density
	<b>Building, Improving, &amp; Retaining Neighborhood Assets</b>	Public Libraries, schools, fire depts., parks Public Information Systems Neighborhood Businesses Cultural Orgs & Citizen Assocs. Facilities for Sports and other Clubs Religious Orgs. Family Resource Centers Transportation Systems Supermarkets & Produce Grocers Home-Based Enterprises
	<b>Enhancing Neighborhood Cohesion and Social Support Systems</b>	Informal neighborhood social activities Mentoring programs Involvement in community organizations Senior Citizen Centers After-school programs Accommodations for people with disabilities Elder day care Park recreation & exercise programs Architecture designed to ↑ neighbors’ interaction Neighborhood planning to increase public meeting spaces

<sup>1</sup>Excerpted from Anderson et al. *The Community Guide’s Model for Linking the Social Environment to Health.* *American Journal of Preventive Medicine* 2003: 24(3S) p. 14

## APPENDIX 3

### SOCIAL DETERMINANTS OF HEALTH BIBLIOGRAPHY (IN PROGRESS)

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