

500 Cities: Local data for better health

RESEARCH REPORT

500 Cities Project

Local Data for Better Health

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Executive Summary

To launch the 500 Cities Project data release, on December 6 and 7, 2016, the Robert Wood Johnson Foundation (RWJF) funded and organized an evening reception and day-long conference in Dallas, Texas, cohosted along with the Centers for Disease Control and Prevention (CDC) and the CDC Foundation.¹ The purpose of the meeting was to introduce the new dataset, explore potential uses, and foster cross-sector collaboration. The 500 Cities data contain estimates for 27 indicators of adult chronic disease, unhealthy behaviors, and preventive care available for the first time at the census-tract level for 500 of the largest cities in United States—at least one per state. The data provide a groundbreaking resource for establishing baseline conditions, advocating for investments in health, and targeting program resources where they are needed most. Over 300 people attended the event in person or online via webcast, representing diverse sectors engaged in health and communities.

National Perspective

Two keynote speakers with experience as local, state, and national public health officials launched the conversation on the value of the 500 Cities data: Dr. Joshua M. Sharfstein of the Johns Hopkins Bloomberg School of Health, and Dr. Jewel Mullen of the US Department of Health and Human Services. In addition, a panel of representatives from national and regional health-related organizations—the National Association of County and City Health Officials, the YMCA of the USA, and CHRISTUS Health—discussed how they could use the 500 Cities data to advance their missions and achieve their goals of healthier communities. The speakers shared how the 500 Cities data will enable a common understanding of health conditions and reveal neighborhood health disparities. They explored the role of data in bringing together a variety of partners to assess neighborhood health and take action, including public health departments, health care providers, community service organizations, and neighborhood groups. Organizations can also use the 500 Cities data to engage neighborhood residents and stakeholders about their local experiences and challenges around critical health issues.

Local Partnerships

A second panel featured three ongoing local partnerships as examples of how cross-sector partnerships are using neighborhood data to target interventions for improving community health: South Carolina

Healthy Insights; Manchester, New Hampshire Public Health Department and Granite United Way; and the Mariposa District in Denver, Colorado. All partnerships used local data to identify health risks and develop and implement plans to address them. Panelists described the value of pulling together data to discover new patterns, the challenges to accessing and using neighborhood-level data to highlight needs and assets, and the empowerment of neighborhood stakeholders to advocate for themselves and lead comprehensive health solutions.

Leveraging the Data

To encourage deeper discussion of how the 500 Cities data can motivate community health partnerships, participants joined nine roundtable discussions co-led by experienced individuals in the field of health and community collaborations. Topics focused on issues such as navigating a variety of health data along with other data on social determinants of health, the health of older adults and of adults with heart-related health issues, and cross-sector partnerships using data as leverage for health and housing interventions. Several roundtable discussions touched on how to reach out to new partners and funders as well as how to proactively engage neighborhood residents and stakeholders. Roundtable participants discussed a variety of uses for the new 500 Cities data, including crafting stories for advocacy, developing plans such as community health needs assessments, anticipating the effects of proposed development through health impact assessments, and improving local data literacy.

Resources and Next Steps

The CDC has published the 500 Cities data in a variety of formats via the CDC website (www.cdc.gov/500cities/). Users can download sets of static maps or visualize, filter, and download data through an interactive mapping tool. In addition, the raw data are available for download from an open data portal. As more organizations and other users become more aware of the data, RWJF is collecting stories of how local groups are using the new estimates and how other organizations are incorporating the data into independent local and national online tools. A companion workshop guide to this report, “[How to Engage Your Community with Health Data: Hosting a 500 Cities Event](#),” provides guidance on using the data, suggestions for organizing local events to explore the data, and resources for accessing complementary data and related policy and program responses.

Chapter 1. Introduction

The 500 Cities Conference

To launch the 500 Cities Project data release, on December 6 and 7, 2016, the Robert Wood Johnson Foundation (RWJF) funded and organized an evening reception and day-long conference in Dallas, Texas, cohosted along with the Centers for Disease Control and Prevention (CDC) and the CDC Foundation.² The data contain new health estimates for census tracts in 500 of the largest cities in the United States. The data release, available on the CDC's website (www.cdc.gov/500cities), represented a milestone in expanding the accessibility of consistent small-area health indicators. Before this project, chronic disease indicators could not be compared across the country below the county or city level. Details of the 500 Cities Project can be found in the appendices to this report, including a brief overview of the project (appendix A), a list of the health indicators estimated (appendix B), and a list of the 500 cities for which the health estimates are available (appendix C).

The purpose of the convening was to introduce the participants to the new dataset and ways that it can be used. The conference sponsors also sought to foster cross-sector collaboration by bringing together participants from various focus areas and disciplines to think about how to use the data to reach out to strategic partners, particularly partners that might not be traditional for them.

The Urban Institute was brought on to provide thought leadership on organizing the conference, including reaching a diverse cross-sectional audience with interest in these data and planning the program's plenary speakers, panels, and roundtable discussions to highlight potential uses of the new data to this broad audience. Appendix D presents the final conference agenda. Urban Institute staff, with help from RWJF, CDC, and CDC Foundation staff, captured speaker comments and roundtable discussions in a comprehensive set of notes for each plenary, panel, and roundtable.³ A workshop guide is also available for groups wanting to host their own event featuring the 500 Cities data.

Structure of Report

This report synthesizes presentation themes from materials, observations, and notes taken during the conference. It is not intended to be a comprehensive summary of the conference and does not

represent the views of the conference sponsors or organizers. It follows the structure of the conference agenda available in appendix D:

- Chapter 2 presents the goals of the convening in detail and who attended the conference.
- Chapter 3 summarizes the presentation from the CDC that gave an overview of the 500 Cities data, the methodology used to develop the estimates, and a comparison to several other common health indicator datasets.
- Chapter 4 highlights the national perspective on the value of local data and uses for the 500 Cities data as offered by two plenary speakers and a panel of national health services organizations.
- Chapter 5 shows the power of data through several local cross-sector partnerships to improve health by addressing social determinants of health, such as housing, education, and nutrition.
- Chapter 6 highlights key themes discussed in a series of roundtables around topics such as crafting stories for advocacy, developing plans for health improvement, prioritizing action, and broadening the table to include new partners, funders, and expanded community engagement around health needs and solutions.

Chapter 2. Conference Goals and Attendees

Introducing the Data and Generating Uses

RWJF, the CDC, and the CDC Foundation recognized the value of drawing a large group of interested users together in concert with the data release to better understand and to discuss the value of these data to their cities. Conference attendees were invited to represent private, public, and nonprofit groups working on health, housing, community development, and a variety of other issues. Some attendees had participated in an earlier webinar in June 2016, but for many the conference was their first time learning how the indicators were developed and discussing how the new indicators could be used to target and improve community health. The data were released just before the conference, along with static map books of the 27 indicators for each city.

In addition to providing an overview of the 500 Cities data, the conference fostered discussion between practitioners of ways to use the data to identify health needs and improve population health. Specifically, attendees were able to discuss how the data could be used to

- understand baseline health conditions to identify local priorities for taking action and targeting solutions;
- explore specific health disparities among census tracts and identify areas of concentrated health problems; and
- advocate for action to address extreme health problems and geographically concentrated health inequities.

The program also cautioned the audience on inappropriate uses of the data. Because of the methodology used to generate the 500 Cities small-area estimates, they are not appropriate to measure change or to evaluate outcomes of program or policy implementation.

The 500 Cities data had only become available during the conference, but the examples the presenters and panelists shared provided models for how participants could use the new health

indicators. They also helped to demonstrate the power of layering multiple data sources to better understand community conditions.

Fostering Cross-Sector Collaboration

A primary motivation for the 500 Cities conference was to highlight how the data may be useful to a broad cross section of practitioners throughout the United States. Conference speakers and attendees were recruited from across the country to represent a variety of perspectives on health and its social determinants. The speakers recruited for the conference (see appendix E for speaker biographies) brought diverse perspectives from national, state, and local levels representing multiple sectors: government, commercial, and nonprofits (including health systems). Many speakers and roundtable leaders worked in the health industry, but others came from housing and community development agencies and nonprofit organizations. There were also a variety of local data users, and advocates, researchers, and funders of various health interventions.

Conference organizers first identified individuals to invite from national health and community improvement organizations; federal, state and local government agencies; and connections through networks like the National Alliance of Community and Economic Development Associations and the National Neighborhood Indicators Partnership. The foundation also invited individuals who attended a June 2016 webinar. Over 300 people participated in the conference, about 220 in person and another 100 online via a live webcast. In-person attendees (appendix F) represented nonprofit (45 percent), local and state government (25 percent), higher education (15 percent), and other organizational types (table 1). Though the majority of the attendees came from the public health sphere (55 percent), nearly one-fifth came from the community development and housing sector and a smaller number came from other sectors (table 2).

TABLE 1

Attendees by Organization Type

Type of organization	Number of attendees	Percent
Nonprofit	98	45
Local or state government	57	25
Higher education	32	15
Other type	9	4
Federal government	9	4
Private sector	8	4
Foundation or funder	6	3
Total	219	100

Source: Urban Institute tabulations.

Note: Excludes staff from conference sponsors and the Urban Institute.

TABLE 2

Attendees by Area of Practice

Area of practice	Number of attendees	Percent
Public health	120	55
Community development and housing	38	17
Health care	17	8
Community data and metrics	8	4
Planning and governance	7	3
Education	5	2
Environment	5	2
Food and nutrition	3	1
Transportation	3	1
Finance	1	1
Safety and justice	1	1
Other areas	11	5
Total	219	100

Source: Urban Institute tabulations.

Note: Excludes staff from conference sponsors and the Urban Institute.

Chapter 3. 500 Cities Data

Data Overview

The 500 Cities Project coprincipal investigator from the CDC, James Holt, summarized the 500 Cities data, the methods used to produce it, and how these new data compare with existing health data resources. This dataset is the first to provide indicators of chronic disease, unhealthy behaviors, and preventive care at the census-tract level for a large portion of the United States. As noted, the CDC produced the 500 Cities data in consultation with RWJF and the CDC Foundation. The following are the goals of the project:

1. Provide high-quality estimates on risk factors that influence health status and outcomes and use of preventative health services;
2. Enable identification of emerging health problems; and
3. Inform the development and implementation of effective and targeted health interventions in America's cities.

Table 3 shows the estimates that were generated for 27 measures of adult chronic disease related to unhealthy behaviors (5), health outcomes (13), and use of preventive services (9). The measures and definitions are based on the Chronic Disease Indicators maintained and updated by the CDC. These are based on public health priorities to address the leading causes of morbidity and mortality, as well as national recommendations on critical preventative services. Each indicator definition is provided in appendix B.

The data are available at the census tract level for 500 cities across the United States (figure 1) with at least one in every state. Census tracts are small, relatively stable statistical geographic areas that are updated before each decennial census. The tracts generally have a population size between 1,200 and 8,000 people, with an optimum size of 4,000 people. The 500 Cities census tracts cover about one-third of the 300 million people in the United States as of 2010. Census tracts often are used as proxies for neighborhoods, so the remainder of the report will refer to data for small, subcity areas as neighborhood data.

TABLE 3

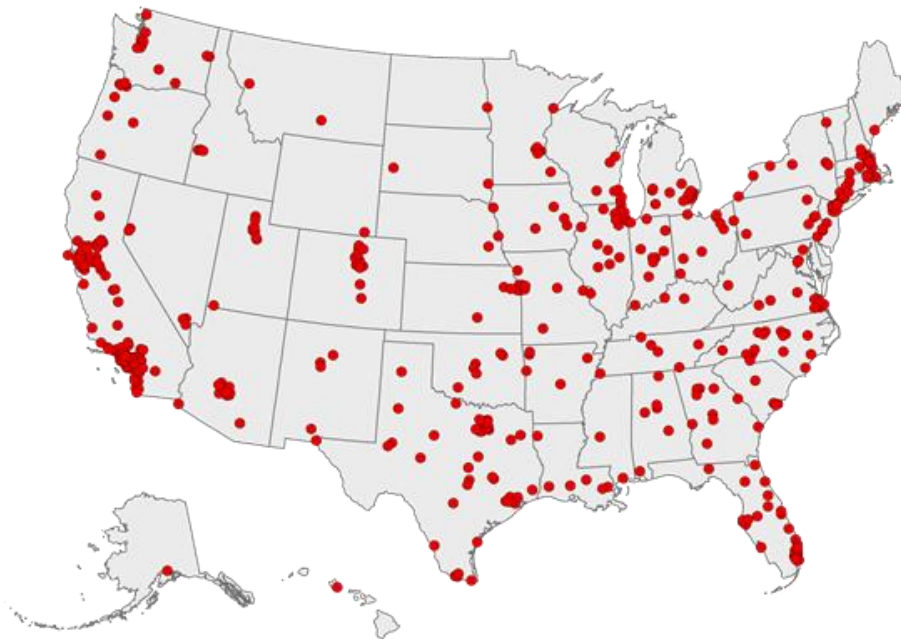
500 Cities Indicators by Category

Unhealthy behavior	Health outcomes	Prevention measures
<ul style="list-style-type: none"> ▪ Binge drinking ▪ Smoking ▪ No leisure-time physical activity ▪ Obesity ▪ Sleeping less than 7 hours 	<ul style="list-style-type: none"> ▪ Arthritis ▪ Asthma ▪ High blood pressure ▪ Cancer ▪ High cholesterol ▪ Chronic kidney disease ▪ Chronic obstructive pulmonary disease ▪ Coronary heart disease ▪ Diabetes ▪ Mental health not good ▪ Physical health not good ▪ All teeth lost ▪ Stroke 	<ul style="list-style-type: none"> ▪ Lack of health insurance ▪ Routine checkup ▪ Dental visit ▪ High blood pressure medication ▪ Cholesterol screening ▪ Mammography use (women) ▪ Papanicolaou smear (women) ▪ Fecal occult blood test, sigmoidoscopy, or colonoscopy ▪ Core prevention services: <i>Men:</i> flu shot, PPV shot, colorectal cancer screening; <i>Women:</i> same as men plus mammogram)

Source: "Measure Definitions," 500 Cities, CDC, last modified December 7, 2016, www.cdc.gov/500cities/measure-definitions.htm.

FIGURE 1

Map of 500 Cities with Health Indicator Estimates



Source: 500 Cities Project website, <https://www.cdc.gov/500cities/index.htm>.

Methodology

The 500 cities were selected based on 2010 Census population counts. These include incorporated places that are within a state, but may cross county boundaries. In general, the data include cities, towns, villages, and boroughs. Since Hawaii has no incorporated places, the City and County of Honolulu are used. Finally, to ensure that all states have at least one city represented, the most populous city from Vermont, West Virginia, and Wyoming are also included in the data. In general, one-third of US residents lived in one of these 500 cities in 2010. City populations ranged from 42,417 (Burlington, Vermont) to 8,175,133 (New York City).

Estimates for each census tract were developed from 2013 and 2014 Behavioral Risk Factor Surveillance System data—a state-level telephone survey that collects behavioral health data from adults age 18 or older. These data were then used to predict the expected risk of health behaviors or conditions for 208 demographic groups (defined by age, gender, and race and ethnicity) using data from the US Census Bureau’s American Community Survey. These estimates were further adjusted by geographic location, such as state, county, and neighborhood. The resulting estimates combine individual-level data with area-level data to predict the probability of each of the indicators.

This approach allows for the ability to generate estimates for areas with small or no samples, a high level of precision, and flexibility in combining relevant individual and area-specific data at multiple geographic scales. It is limited in that the model estimates are based on the expected prevalence rather than on actual sample or administrative data. Thus, although the estimates have narrow ranges, they may underestimate small areas with high prevalence and overestimate areas with low prevalence. This also means that the estimates cannot detect effects of local interventions and therefore cannot be used for program or policy evaluation.

How the 500 Cities Data Compare with Other Data

The 500 Cities data complement existing public health data collections that include well-accepted measures of health conditions, behaviors, and preventive services. Many of these use the same underlying sources of data to create the indicators at the state or county level, but only the 500 Cities data provides estimates down to the city and census tract level. Complementary indicator collections include those listed below (for more, see in appendix G).

- **County Health Rankings and Roadmaps** (www.countyhealthrankings.org/): Funded by RWJF, the County Health Rankings and Roadmaps use indicators of health outcomes (length of life and quality of life) and health factors (behaviors, clinical care, social and economic factors, and physical environment) to create weighted rankings of county health within each state. They provide indicators in a greater range of domains than the 500 Cities data, but they are only available at the county level. Rankings are available beginning in 2010.
- **America's Health Rankings** (www.americashealthrankings.org/): A partnership between United Health Foundation, American Public Health Association, and the Partnership for Prevention, America's Health Rankings began in 1990 to highlight health trends at the state level. It uses 34 measures of behavior, community and environment, state policy, clinical care, and health outcomes. Rankings are weighted.
- **Chronic Disease Indicators** (www.cdc.gov/cdi/): Produced by the CDC, the Council of State and Territorial Epidemiologists, and the National Association of Chronic Disease Directors, the Chronic Disease Indicators include 124 measures on chronic disease, health behaviors, and health outcomes, tracked at the state level as well as some larger metropolitan areas. It was originally published in 1998 with 93 indicators.

Chapter 4. The National Perspective

To launch the conversation on the value of the 500 Cities data, two plenary speakers set the stage for the convening: Dr. Joshua M. Sharfstein of the Johns Hopkins Bloomberg School of Health and Dr. Jewel Mullen, principal deputy assistant secretary for health in the US Department of Health and Human Services. They set the stage by drawing on their experiences as local, state, and national health officials. In addition, a moderated panel of representatives from national and regional health-related organizations discussed how the 500 Cities data would help them advance their mission and achieve their goals of healthier communities. The panelists were from the following organizations:

- **The National Association of County and City Health Officials:** A nonprofit member-based association that is the voice of 3,000 local health departments across the United States.
- **The YMCA of the USA:** A nonprofit working in 10,000 communities across the country to deliver programming around youth development, healthy living, and social responsibility.
- **CHRISTUS Health:** A Catholic health system including more than 40 hospitals and facilities in the United States, Chile, and Mexico. The CHRISTUS Health Department of Community Health focuses on engaging communities in efforts to expand access to health care and improve overall public health.

The following section presents a summary of the themes these national experts discussed.

We need both the best clinical care for people when they are sick and the best environment for people to thrive outside the hospital.

-Dr. Joshua M. Sharfstein, Johns Hopkins Bloomberg School of Health

The Value of Neighborhood Data

The 500 Cities data have the potential to reinvigorate local health discussions and interventions by providing detailed information, revealing community health disparities and motivating action targeted toward improving population health. A variety of health partners, including public health departments,

health care providers, community service organizations, and neighborhood groups, can use these new data to assess the current health status of the places they live and serve and develop action plans.

For the public health sector, which values preventing disease, promoting health, and prolonging a healthy life among the population, these data reveal health disparities among neighborhoods that are often masked when looking at county- or state-level data. Without such data, interventions may fail to target areas where the need is most critical or may fail to address a significant need altogether. For example, if you know that the prevalence of smoking has decreased overall for your county but cannot see that rates are still high within a couple of neighborhoods, you might assume that current interventions are adequately addressing this health crisis. Having neighborhood-level data available gives practitioners the information they need to focus on improving health equity for residents in all areas of the city. In effect, as Dr. Mullen stated, they potentially allow public health officials to screen communities via early detection to catch preventable health issues. This can significantly improve the effectiveness of an intervention, with the potential of producing positive health outcomes for the entire community overall.

[The 500 Cities data provide] community-level screening..., a new way to screen and intervene before we see conditions worsen.

-Dr. Jewel Mullen, US Department of Health and Human Services

A representative of CHRISTUS Health explained that for health care providers, data like this can supplement what they already know about their individual patients to strategize more effectively about community prevention and intervention activities. Clinical patient data can be a critical starting point for identifying geographic disparities and trends over time. Providers can use these data to gain a fuller picture of both patient and community health by overlaying their own data with neighborhood-level indicators of health challenges. Though access to health care is not the only determinant of health, identifying hot spots of poor health outcomes and service access can inform neighborhood-level interventions. Layering these with the standardized 500 Cities data can highlight differences between a health care provider's current patients and surrounding community and provide a better understanding of the conditions in the neighborhoods where their patients live.

Health care providers cannot meet all of the health needs of the community, especially when the needs are determined by other social and economic factors outside the control of the providers. As the panelist from the National Association of County and City Health Officials discussed, the new 500 Cities data also provide a common language between health care providers and local public health departments. Understanding the health needs of a community and discussing them with other partners will be important in determining what each partner can contribute to help both patients and communities improve their health outcomes.

We cannot provide all of the services ourselves. The majority of our focus is on the clinical aspects of health... [but] we hope that health care can [increasingly] be done outside of the hospital.

-Corinne Francis, CHRISTUS Health

Finally, data at the neighborhood level allow local health care and health service organizations to better understand the context within which they are operating. For those working in clinical health, like CHRISTUS Health system members, the 500 Cities data allow service providers to compare the characteristics of the population they currently serve with the health of the surrounding community to see how adequately they are meeting community-wide needs. This will allow for better targeting of services and marketing of those services to places where the incidence of health problems are concentrated. Community health service providers like YMCAs may reevaluate service locations as well as the types of services provided to ensure that they are addressing their neighborhood's most critical health needs.

Data Usage and Communication

All stakeholders benefit from clear, compelling communication of health data through stories and visualizations. Community residents can understand their population health status and critical needs to advocate for action. Health departments and providers can mobilize campaigns to increase prevention and reduce disparities. Service providers can tell the story of their mission and highlight the need for

program areas. Telling clear stories with data can also build allies in the public and private sectors. For example, presenting maps of constituent health can help Congressional representatives understand the health challenges facing their districts so that they can advocate for solutions. Showing private-sector employers visualizations of population health where their employees live and work can motivate them to take action around health issues that affect their employee absenteeism and productivity.

We want to take [health data] and think about what kind of story we can tell... We provided Census information...and created visualizations to tell the story of [what looking at health and Census data together] looked like, and compared it to local, on the ground experience.

-Maria-Alicia Serrano, YMCA of the USA

Being able to tell a clear story about critical community health issues with the help of the 500 Cities data can mobilize a variety of cross-sector partners that otherwise may not realize how population health affects their operations and success. Connecting the dots through data and using the social determinants of health as a framework can bring diverse partners together to build partnerships toward more integrated interventions. Panelists specifically mentioned engaging with the public health office, the city planning office, service organizations such as the YMCA, health system partners, neighborhood associations, and local institutions such as businesses and colleges or universities. Public systems, such as schools, child welfare, and public safety can be difficult to bring on board, but they can be extremely effective partners over time as direct influencers of health.

The 500 Cities data can also be a valuable resource for a variety of baseline assessments that identify clustered health needs and develop a plan of action. This includes community health assessments performed by public health departments, community health needs assessments required of tax-exempt hospitals by the Affordable Care Act, and health impact assessments (HIAs) increasingly required for large proposed development projects. (The latter two tools are discussed further in chapter 6.) These participatory processes identify concerns that the community shares on health issues, and they formulate an informed response across health partners to lessen disparities and improve population health.

We need to take a social justice lens to the community, and consider how to change incentives so that folks see the value in investing in these communities.

-Chris Eldridge, National Association of County and City Health Officials

Those seeking to mobilize local action should look beyond the numbers, however. Talking with community residents and stakeholders about their local experiences and challenges is important in developing effective interventions toward the elimination of health disparities. Though quantitative data give valuable information on what is happening at the local level and where issues are concentrated, they do not necessarily provide insight into why things are happening and what action to take in response. When talking with communities, residents may bring to light what they consider to be more pressing issues than what the health data show, including other social and economic issues vital to their well-being and, ultimately, to their health. Though analysis of the 500 Cities data may indeed reveal other issues with which the community needs to engage, the vision for addressing community needs—including health—should be a collective one.

[W]e need to remember how involved and engaged people are in their own lives and issues. We cannot [simply] tell people they have problems that they already know exist.

-Dr. Jewel Mullen, US Department of Health and Human Services

Chapter 5. Local Partnerships

To demonstrate how cross-sector partnerships are using neighborhood health data to target interventions for improving community population health, the 500 Cities Conference included a panel featuring three ongoing local partnerships:

- **South Carolina Healthy Insights** is a partnership between the South Carolina Association of Community Economic Development and the MITRE Corporation to develop a statewide data tool to help South Carolina communities address obesity.
- **Manchester, New Hampshire Culture of Health** is a partnership between the city public health department and the Granite United Way to improve children’s health and educational and economic outcomes through community schools.
- **Denver, Colorado Mariposa Project** is a partnership between the city public health department and the Denver Housing Authority to improve health through physical design and nutritional programming for a redeveloped public housing community.

This section summarizes key themes highlighted by these three diverse partnerships, including forming cross-sector partnerships for improving health and leveraging data to develop plans for action and implement health solutions. The panelists’ strategic efforts to use data to improve community health were practical lessons and inspiration for the conference participants to use the 500 Cities data.

Sharing and Combining Data

After introducing their partnerships, panelists were asked how data informed their partnership. In response, they described seeing new patterns emerge from different data being pulled together for the first time. In South Carolina, places of worship emerged as critical assets and potential partners once notable concentrations of such institutions were found in some neighborhoods with health-related needs. In Manchester, a door-to-door resident survey helped them realize how several social determinants of health could be addressed through neighborhood elementary schools as entry points. The Denver Housing Authority was confronted for the first time with the poor health of their residents facing specific chronic conditions.

Panelists also described a variety of challenges or opportunities in accessing and using neighborhood-level data. Initial challenges included identifying, obtaining, cleaning, and merging the right datasets to produce a reliable and comprehensive picture of neighborhood health needs and assets. This was particularly the case for neighborhood-level health data. Once a partnership initiative was up and running, there were additional challenges to monitoring and tracking change over time, especially in proving that a housing or education intervention, for instance, actually improves health and reduces health costs. When longitudinal tracking is desired, costs to sustain efforts to collect neighborhood-level data can also become an issue.

The holy grail for those of us working on cross-sector collaborations...how do you document and prove that a housing intervention improves health care costs, especially to prove that [the] health care [sector] should get involved?

-Ismael Guerrero, Denver Housing Authority

Though the 500 Cities data cannot help with monitoring and evaluating intervention outcomes, other sources of neighborhood data can be useful. This includes looking for existing neighborhood data sources, such as your local or state public health department, as Denver and Manchester partners did. It can also include emergency room records (Denver), school report card data (Manchester), local crime reports (Denver), and listings of locations of healthy food distribution sites, religious institutions, financial institutions, and YMCAs across the city or state (South Carolina). Negotiating data-sharing agreements with local and state agencies can take time, however, as the Denver team noted. There is also a role for primary data collection. For example, the Denver Housing Authority conducts an annual survey of their residents to collect even more targeted information from the population that their intervention is meant to assist. They are also exploring new ways to crowd source data from the community through the use of online applications.

Mobilizing Data for Planning and Impact

Cross-sector collaborations are critical for conducting comprehensive assessments of community health needs and developing plans to address them. Neighborhood data should be a foundation for understanding community health disparities. The partnerships understood the importance of building a comprehensive picture of local communities with multiple data sources. With the relevant data in place, these innovative partnerships created new initiatives to address some of the greatest needs emerging from the data.

- The South Carolina Association for Community and Economic Development recently allocated grant funding through a competitive award process to four local projects based on how they analyzed a variety of county-level data, such as the County Health Rankings, and point-level data, such as the location of Supplemental Nutrition Assistance Program retailers and churches, using the new online tool. All four projects focus on improving health, but in very different ways: a community kitchen, a new market at a transit station, a nutrition curriculum, and increasing health care access for noncustodial fathers.
- The City of Manchester health department and partners used neighborhood data to explore factors contributing to poor health. They found concentrations of these factors in poor neighborhoods and developed a Neighborhood Health Improvement Strategy to guide public and private investments, including a focus on schools. The Granite United Way leveraged these data through a \$1.5 million investment in the creation of two community schools. These schools offer a variety of tailored programming focused on improving childhood resiliency, building and developing adult capacity, and equipping families to improve health, education, and economic opportunities.
- Working together, the Denver Public Health and Denver Housing Authority conducted an HIA of the Mariposa District, an approximately five square block area surrounding one of the city's public housing communities. After they found high rates of high blood pressure, diabetes, and asthma in the community, they adopted active-living standards for designing the Mariposa District and developed programs to improve access to health care, nutrition, and exercise. They also focused on community programming, such as hiring a health navigator to connect residents with primary care providers, hiring a health living coordination to focus on nutrition and healthy foods, and introducing fitness programs on site.

We recently went to meet with a local community, and the first thing they showed us was data from our tool. It was great to see that there are communities who are [already] using [our] data for their own purposes.

-Sarah Pinson, South Carolina Association of Community Economic Developers

- As Meredith Stidham of Granite United Way pointed out, “...layers of data alone, without community engagement, [are] dangerous.” Data only present a partial picture and often at a single moment in time. Taken alone, these data could be used to stigmatize a neighborhood as a place of only problems, instead of a source of assets and resources. Instead, communities can be empowered to be their own advocates, and solutions can be community generated and led. Data visualizations and workshops can provide training for residents and stakeholders to not just identify pockets of need but also to gather information on local resources to leverage and expand. A workshop guide including a number of examples and suggestions on hosting events to engage with the 500 Cities data is available to help.⁴

We brought our data friends and community together and held the data up as a mirror. Not every mirror is perfect. We said, “This is the data. How true is it to you? How does this look from your lens?” Both the data on the screen and the data that the community holds with them need to be included.

-Meredith Stidham, Granite United Way

Chapter 6. Leveraging the Data

To encourage deeper discussion of how the 500 Cities data can motivate and compliment community partnerships around health, participants joined nine different roundtable discussions co-led by experienced individuals in the field of health and community collaborations. Roundtable leaders and topics of discussion can be found in appendix D. The roundtables were structured around diverse topics, such as the following:

- Harnessing local data to engage with communities about health needs and disparities;
- Navigating health-specific data alternatives, finding complimentary neighborhood data around social determinants of health, and using these data to anticipate and mitigate health impacts of proposed actions within a neighborhood;
- Taking a closer look at the health of older adults and heart-related health issues;
- Partnering across sectors, including examples from Arizona and the city of Philadelphia, specifically with strategic community services organizations; and
- Using data to leverage cross-sector funding for health and housing interventions.

These roundtables followed a flexible format focused on allowing conference participants to debrief on reactions to the plenaries, brainstorm opportunities and challenges to their work the new 500 Cities present, and highlight relevant experiences on the specific topic. Given the diversity of participants and leaders, each discussion took its own direction. Instead of focusing on each widely varying discussion, the following section organizes the roundtable content into two broad themes: broadening the table by working together with new partners or expanding existing partnerships and sharing experiences from the field around data use.

Broadening the Table

A major purpose of the 500 Cities conference was to generate new ideas about how to engage in cross-sector partnerships to improve neighborhood and city health outcomes. A variety of roundtable discussions touched on expanding existing strategies to engage community residents, connecting with new organizational partners, and making the case out to funders.

Expanded Community Engagement

Echoing the messages from the local partnerships plenary, local officials and organizations can use data to create trust with community members and foster community-led and data-driven initiatives. Participants highlighted that when collecting and employing data, there should be intentionality and a stated goal. Organizations gathering data or developing community programming should expressly communicate the purpose and intended use of data. Further, participants discussed the importance of organizations democratizing data and becoming active participants in the communities they represent and serve. Participants vocalized the need to work *with* communities to interpret data, being careful not to stigmatize vulnerable populations. In communities of color especially, organizations need to know how to translate data and communicate with diverse populations.

Gathering qualitative data to combine statistics with community narratives is one way to engage with community members. The stories and voices of community members can help to frame the results from the data. One way of recording and sharing such input, as suggested by participants in the “Navigating the Sea of Data: Finding the Resources You Need” roundtable, is through visual representations of the data overlaid with the lived experiences of community members. By contextualizing public health data in this way, users help communicate a holistic picture of their community’s health status and needs to outside funders, policymakers, and other residents.

New Partners in Health

Participants expressed the need for partnerships around cross-sector health work. Local organizations that leverage funding for housing and community development can be important partners for improving health, such as local United Ways and nonprofit NeighborWorks America affiliates. These organizations, and other like them, can harness neighborhood health data for strategic programming and investment. Specifically, the 500 Cities data can help identify disparities in health-outcomes and establish a starting point for partnerships addressing specific health issues. For example, the Arizona Partnership for Healthy Communities is a working group focused on the intersection of community health and the built environment. By linking public health and community development, they brought together diverse voices, including hospitals, insurers, and members of the transportation, healthy foods, and housing sectors.

Though most know United Way as a fundraising entity that makes local community investments, their interest in aligning these investments with health needs is growing. Representatives spoke of their

shift from being “just a fundraiser with a thermometer in the middle of the town square to becoming a partner and trying to measure outcomes.” At the national and local levels, United Way is developing tools to strategically track local efforts in education, income, and health. The Dallas United Way, which serves roughly 10 million people in four counties, is working across its almost 200 programs to establish a common-measures framework to help its funded partners track health outcomes.

New Funding Opportunities

Data helps connect the dots between community members, organizations, and potential funders. Neighborhood-level data can help pinpoint the need for a given project or intervention to a potential funder concerned about both financial and social returns on their investment. Practitioners can use data, like the 500 Cities data, to justify the need for investment and highlight the scope necessary for public health projects. Combining comprehensive health indicators and visualizations can help flesh out a more robust proposal for funding and create a narrative that appeals to funders.

For many programs, having diverse funding streams— from philanthropic grants to government funding to private investment—is critical to sustainability. Participants agreed that a more comprehensive view of health can open the door to new multidisciplinary funding opportunities. By drawing participation across sectors or fields, practitioners can capitalize on funding that may otherwise be siloed. Some specifically saw nonprofit community-based organizations as emerging nontraditional health partners to leverage more diverse funding streams.

Roundtable participants discussed innovative funding sources that leverage cross-sector work. For example, the Local Initiatives Support Corporation finances cross-sector work through the Healthy Futures Fund which funds colocation of housing and health facilities with other services to address social determinant of health. Successfully funded initiatives include housing with on-site community health centers and family-owned grocery stores with nutrition and cooking classes built into clinics. Community development financial institutions, like the Low-Income Investment Fund, also offer flexible opportunities for integrated investments in housing, schools, and health centers. Overall, participants discussed opportunities to leverage financing through bank investments required by the Community Reinvestment Act or federal tax credits (e.g., new market tax credits and low-income housing tax credits) to generate private-sector investment for mixed-use projects, combining physical construction with supportive services around health.

Taking Action

Roundtable discussions highlighted a variety of ways that conference participants are approaching health data and cross-sector partnerships to meet neighborhood health needs, and how the 500 Cities data may influence their approaches in the future. National partners, such as United Way, the Local Initiatives Support Corporation, the American Heart Association, and the AARP, can create and disseminate partnership models and best practices in data use, and local partners, such as hospitals, data intermediaries, foundations, or universities, can offer more local expertise to craft neighborhood-specific processes, analyses, and implementation. Cross-sector partnerships leverage data and funding opportunities by identifying areas of overlapping needs and reducing duplication of effort by tackling these needs together.

Practitioners can use the 500 Cities data in conjunction with other sources of small-area data to craft stories for advocacy, develop plans for addressing needs, anticipate and mitigate adverse health impacts of proposed actions, prioritize actions, and cultivate data literacy. The following are specific examples of each of these uses from the roundtable leaders and conference participants.

- **Craft stories for advocacy:** Data like the 500 Cities indicators can give community advocacy organizations the information they need to tell powerful stories rooted in data. A representative of the Praxis Project described local data as critical in the passing of the soda tax in Oakland, California. He explained that advocates used public health data from the city to highlight the overlap in diabetes prevalence with soda consumption. Working alongside community members, advocates harnessed local data to substantiate their policy case.⁵
- **Develop plans:** As mentioned in the national plenary panel, nonprofit hospitals must conduct a community health needs assessment (CHNA) every three years, mandated by the Patient Protection and Affordable Care Act. This plan includes data analysis for their service areas and broad community input around health needs and interventions. By combining neighborhood data from a variety of sources of community input, CHNAs can inform targeted neighborhood action plans for improving public health. In developing their CHNA, Thomas Jefferson University Hospital pulled from over 30 diverse data sources, including community interviews to create a more comprehensive picture of community need. They also brought in food access as an integral part of their CHNA, analyzing the role of food as a social determinant of health.⁶
- **Anticipate and mitigate adverse impacts:** HIAs use quantitative, qualitative, and participatory techniques to assess the proposed and actual health impacts of policies, plans, and projects as

part of an iterative process. Data pulled from HIAs can help reframe health as a consequence of multiple factors to create a more comprehensive view beyond just health care. HIAs are an opportunity to use existing data, identify major gaps in information, and collect primary data from neighborhoods working in conjunction with local organizations. The Boston Public Health Commission conducted an HIA to evaluate a proposed wage increase, from \$14 to \$17, for employees of city contractors. Part of the Health Impact Project, the HIA examined the policy's potential effects on the health of low-wage workers who would be affected.⁷ Several roundtable participants pointed out that many of the 500 Cities indicators selected are important to the HIA process and are easily associated with known prevention strategies, making the data useful in identifying needs, assessing potential impacts, and suggesting possible solutions.

- **Prioritize actions:** With accurate neighborhood data from health indicators, both community-based organizations and public health practitioners can reallocate funding or programming to close the gap in unmet needs and prioritize their actions. They can also bring to the forefront health issues that may be less publicly visible but important to address, such as sleep deprivation and tooth loss in older adults.
- **Cultivate data literacy:** Increasing data literacy and interest will support people's additional efforts to complete the picture of community health. Participants in the "Conducting Health Impact Assessments to Promote Public Health" roundtable touched on the importance of capacity building and teaching stakeholder organizations to understand and use data. Pairing local data like 500 Cities with data literacy training can help organizations gauge the effectiveness of their programming and encourage data-driven decisionmaking.

Chapter 7. Resources and Next Steps

As mentioned, the CDC had released the tabular dataset and the map books at the time of the convening. On March 2nd, 2017, they released an interactive website with new tools to explore the data. The site allows users to compare city-level data estimates for all of the 27 chronic disease measures for up to three cities. In addition, users can now retrieve, visualize, and explore the data at the city and census tract levels through an interactive mapping application. Users can choose their own thresholds for measures in the maps. They can also export the underlying data table directly from a map view.

The initial resources for users are also still available:

- map books for each city
- definitions of all the measures
- detailed methodology for small-area estimates used by the CDC to generate the census-tract level estimates
- links to CDC programs and interventions related to the 500 City data indicators
- frequently asked questions
- contact information for any questions of feedback on the data

The CDC plans to release an additional set of estimates based on 2015 data later this year. It is also in the process of validating the 500 Cities data estimates by comparing them with actual local data in several of the included cities that have systems in place for tracking their own data on some of these measures. Future expansion in the number of geographies or indicators is possible if community demand for the data is strong and additional funding becomes available.

RWJF, CDC, and the CDC Foundation will continue to promote the 500 Cities data as a unique resource to analyze neighborhood-level health conditions and mobilize local action. To inspire other local groups, the foundation will share stories about early uses of the data, such as the Old Colony YMCA in Brockton, Massachusetts, identifying the neighborhood with the greatest health challenges in their city. RWJF and CDC staff would welcome other examples of local use, and encourage users to

submit their stories through the 500 cities website (<https://www.cdc.gov/500cities/contactus.htm>). Spurred on by the conference and other marketing, national networks, like the YMCA and United Way, will assist in spreading awareness about the availability and potential uses for the data. The *500 Cities Communications Toolkit* provides resources that other groups can use to help spread the news about the 500 Cities data, including key messages, social media language suggestions, and press materials (<http://500cities.nptoolkit.org/>). Having the raw data available on the open data portal has also enabled organizations to add the 500 Cities indicators to new or existing online tools. For example, Community Commons has incorporated the indicators into their mapping platform, and DataHaven has created a tool for mapping and visualizing distribution for Connecticut census tracts and cities. These external organizations will continue to amplify the efforts of the CDC, RWJF, and the CDC Foundation to ensure that communities are aware of this valuable new resource for neighborhood health improvement.

Appendix A. 500 Cities Project Overview

In 2015, RWJF and CDC Foundation launched the 500 Cities Project in partnership with the CDC.

Project Purpose

- This project identifies, analyzes, and reports city and census tract-level data, obtained using small-area estimation methods, for 27 chronic disease measures for the 500 largest American cities.
- This project represents a first-of-its kind dataset to release information on a large scale for cities and for small areas within cities. This system complements existing data to more fully understand the health issues affecting the residents of that city or census tract.
- These high-quality, small-area epidemiologic data can be used by individual cities and groups of cities as well as other stakeholders to help develop and implement effective and targeted prevention activities identify emerging health problems, and establish and monitor key health objectives.

Cities

- The project provides estimates for the 497 largest American cities and will include data from the largest cities in Vermont (Burlington, population 42,417), West Virginia (Charleston, population 51,400) and Wyoming (Cheyenne, population 59,466) to ensure inclusion of cities from all the states; bringing the total to 500 cities. The number of cities per state ranges from 1 to 121.
- The cities range in population from 42,417 in Burlington, Vermont, to 8,175,133 in New York City. Among these 500 cities, there are approximately 28,000 census tracts for which data will be provided. The tracts range in population from less than 50 to 28,960, and in size from less than 1 square mile to over 642 square miles. The number of tracts per city ranges from 8 to 2,140.

- The project includes a total population of 103,020,808, which represents 33.4 percent of the total United States population of 308,745,538.

Unique Value of the 500 Cities Project

- The 500 Cities Project reflects innovations in generating valid small-area estimates for population health.
- The project enables, for the first time, retrieval, visualization, and exploration of a uniformly defined selected city and tract-level data for the largest 500 US cities for conditions, behaviors, and risk factors that have a substantial effect on population health.

Appendix B. 500 Cities Project Indicators

Unhealthy Behaviors

- Binge drinking among adults age ≥ 18
- Current smoking among adults age ≥ 18
- No leisure-time physical activity among adults age ≥ 18
- Obesity among adults age ≥ 18
- Sleeping less than seven hours among adults age ≥ 18

Health Outcomes

- Arthritis among adults age ≥ 18
- Current asthma among adults age ≥ 18
- High blood pressure among adults age ≥ 18
- Cancer (excluding skin cancer) among adults age ≥ 18
- High cholesterol among adults age ≥ 18 who have been screened in the past five years
- Chronic kidney disease among adults age ≥ 18
- Chronic obstructive pulmonary disease among adults age ≥ 18
- Coronary heart disease among adults age ≥ 18
- Diagnosed diabetes among adults age ≥ 18
- Mental health not good for ≥ 14 days among adults age ≥ 18
- Physical health not good for ≥ 14 days among adults age ≥ 18

- All teeth lost among adults age ≥ 65
- Stroke among adults age ≥ 18

Prevention

- Current lack of health insurance among adults age 18–64
- Visits to doctor for routine checkup within the past year among adults age ≥ 18
- Visits to dentist or dental clinic among adults age ≥ 18
- Taking medicine for high blood pressure control among adults aged ≥ 18 with high blood pressure
- Cholesterol screening among adults age ≥ 18
- Mammography use among women age 50–74
- Papanicolaou smear use among adult women age 21–65
- Fecal occult blood test, sigmoidoscopy, or colonoscopy among adults age 50–75
- Older adults age ≥ 65 who are up to date on a core set of clinical preventive services (men: flu shot past year, pneumococcal polysaccharides vaccine (PPV) shot ever, colorectal cancer screening; women: same as men and mammogram within the past two years)

Appendix C. List of 500 Cities

Alabama

Birmingham
Montgomery
Mobile
Huntsville
Tuscaloosa
Hoover

Alaska

Anchorage

Arizona

Phoenix
Tucson
Mesa
Chandler
Glendale
Scottsdale
Gilbert
Tempe
Peoria
Surprise
Yuma
Avondale

Arkansas

Little Rock
Fort Smith
Fayetteville
Springdale
Jonesboro

California

Los Angeles
San Diego
San Jose
San Francisco
Fresno
Sacramento
Long Beach
Oakland
Bakersfield
Anaheim
Santa Ana
Riverside
Stockton
Chula Vista
Fremont

Irvine
San Bernardino
Modesto
Oxnard
Fontana
Moreno Valley
Glendale
Huntington Beach
Santa Clarita
Garden Grove
Santa Rosa
Oceanside
Rancho
Cucamonga
Ontario
Lancaster
Elk Grove
Palmdale
Corona
Salinas
Pomona
Torrance
Hayward
Escondido
Sunnyvale
Pasadena
Orange
Fullerton
Thousand Oaks
Visalia
Simi Valley
Concord
Roseville
Santa Clara
Vallejo
Victorville
El Monte
Berkeley
Downey
Costa Mesa
Inglewood
San Buenaventura
West Covina
Norwalk
Carlsbad
Fairfield
Richmond
Murrieta

Burbank
Antioch
Daly City
Temecula
Santa Maria
El Cajon
Rialto
San Mateo
Compton
Clovis
South Gate
Vista
Mission Viejo
Vacaville
Carson
Hesperia
Redding
Santa Monica
Westminster
Santa Barbara
Chico
Whittier
Newport Beach
San Leandro
Hawthorne
San Marcos
Citrus Heights
Alhambra
Tracy
Livermore
Buena Park
Lakewood
Merced
Hemet
Chino
Menifee
Lake Forest
Napa
Redwood City
Bellflower
Indio
Tustin
Baldwin Park
Chino Hills
Mountain View
Alameda
Upland
Folsom

San Ramon
Pleasanton
Lynwood
Union City
Apple Valley
Redlands
Turlock
Perris
Manteca
Milpitas
Redondo Beach

Colorado

Denver
Colorado Springs
Aurora
Fort Collins
Lakewood
Thornton
Pueblo
Arvada
Westminster
Centennial
Boulder
Greeley
Longmont
Loveland

Connecticut

Bridgeport
New Haven
Hartford
Stamford
Waterbury
Norwalk
Danbury
New Britain

Delaware

Wilmington

Washington, DC

Florida

Jacksonville
Miami
Tampa
St. Petersburg

Orlando
Hialeah
Tallahassee
Fort Lauderdale
Port St. Lucie
Pembroke Pines
Cape Coral
Hollywood
Gainesville
Miramar
Coral Springs
Clearwater
Miami Gardens
Palm Bay
West Palm Beach
Pompano Beach
Lakeland
Davie
Miami Beach
Deltona
Plantation
Sunrise
Boca Raton
Largo
Melbourne
Palm Coast
Deerfield Beach
Boynton Beach
Lauderhill

Georgia

Atlanta
Augusta-Richmond
County
Columbus
Savannah
Athens-Clarke
County
Sandy Springs
Macon
Roswell
Albany
Johns Creek
Warner Robins

Hawaii

City and County of
Honolulu

Idaho

Boise City
Nampa

Meridian

Illinois

Chicago
Aurora
Rockford
Joliet
Naperville
Springfield
Peoria
Elgin
Waukegan
Cicero
Champaign
Bloomington
Decatur
Arlington Heights
Evanston
Schaumburg
Bolingbrook
Palatine

Indiana

Indianapolis
Fort Wayne
Evansville
South Bend
Hammond
Bloomington
Gary
Carmel
Fishers
Muncie
Lafayette
Iowa
Des Moines
Cedar Rapids
Davenport
Sioux City
Waterloo
Iowa City

Kansas

Wichita
Overland Park
Kansas City
Topeka
Olathe
Lawrence

Kentucky

Louisville-
Jefferson County
Lexington-Fayette
County

Louisiana

New Orleans
Baton Rouge
Shreveport
Lafayette
Lake Charles
Kenner
Maine
Portland

Maryland

Baltimore

Massachusetts

Boston
Worcester
Springfield
Lowell
Cambridge
New Bedford
Brockton
Quincy
Lynn
Fall River
Newton
Lawrence
Somerville

Michigan

Detroit
Grand Rapids
Warren
Sterling Heights
Lansing
Ann Arbor
Flint
Dearborn
Livonia
Westland
Troy
Farmington Hills
Kalamazoo
Wyoming
Southfield
Rochester Hills

Minnesota

Minneapolis
St. Paul
Rochester
Duluth
Bloomington
Brooklyn Park
Plymouth

Mississippi

Jackson
Gulfport

Missouri

Kansas City
St. Louis
Springfield
Independence
Columbia
Lee's Summit
O'Fallon
St. Joseph

Montana

Billings
Missoula

Nebraska

Omaha
Lincoln

Nevada

Las Vegas
Henderson
Reno
North Las Vegas
Sparks

New Hampshire

Manchester
Nashua

New Jersey

Newark
Jersey City
Paterson
Elizabeth
Trenton
Clifton
Camden
Passaic
Union City

New Mexico

Albuquerque
Las Cruces
Rio Rancho
Santa Fe

New York

New York
Buffalo
Rochester
Yonkers
Syracuse
Albany
New Rochelle
Mount Vernon
Schenectady

North Carolina

Charlotte
Raleigh
Greensboro
Winston-Salem
Durham
Fayetteville
Cary
Wilmington
High Point
Greenville
Asheville
Concord
Gastonia
Jacksonville

North Dakota

Fargo

Ohio

Columbus
Cleveland
Cincinnati
Toledo
Akron
Dayton
Parma
Canton
Youngstown

Oklahoma

Oklahoma City
Tulsa
Norman
Broken Arrow
Lawton

Edmond

Oregon

Portland
Eugene
Salem
Gresham
Hillsboro
Beaverton
Bend
Medford

Pennsylvania

Philadelphia
Pittsburgh
Allentown
Erie
Reading
Scranton
Bethlehem

Rhode Island

Providence
Warwick
Cranston
Pawtucket

South Carolina

Columbia
Charleston
North Charleston
Mount Pleasant
Rock Hill

South Dakota

Sioux Falls
Rapid City

Tennessee

Memphis
Nashville-
Davidson
Knoxville
Chattanooga
Clarksville
Murfreesboro

Texas

Houston
San Antonio
Dallas
Austin

Fort Worth
El Paso
Arlington
Corpus Christi
Plano
Laredo
Lubbock
Garland
Irving
Amarillo
Grand Prairie
Brownsville
Pasadena
Mesquite
McKinney
McAllen
Killeen
Waco
Carrollton
Beaumont
Abilene
Frisco
Denton
Midland
Wichita Falls
Odessa
Round Rock
Richardson
Tyler
Lewisville
College Station
San Angelo
Pearland
Allen
League City
Longview
Sugar Land
Edinburg
Mission
Bryan
Baytown
Pharr
Missouri City

Utah

Salt Lake City
West Valley City
Provo
West Jordan
Orem
Sandy
Ogden

St. George
Layton
Vermont
Burlington

Virginia

Virginia Beach
Norfolk
Chesapeake
Richmond
Newport News
Alexandria
Hampton
Roanoke
Portsmouth
Suffolk
Lynchburg

Washington

Seattle
Spokane
Tacoma
Vancouver
Bellevue
Everett
Kent
Yakima
Renton
Spokane Valley
Federal Way
Bellingham
Kennewick
Auburn

West Virginia

Charleston

Wisconsin

Milwaukee
Madison
Green Bay
Kenosha
Racine
Appleton
Waukesha

Wyoming

Cheyenne

Appendix D. Conference Agenda

Tuesday, December 6

6:00–8:00 p.m.

Networking Reception

Wednesday, December 7

7:00–8:30 a.m.

Breakfast

8:30–8:45 a.m.

Welcome

Dr. Oktawia Wojcik, Robert Wood Johnson Foundation

8:45–9:30 a.m.

Keynote

Sekou Sidibe, CDC Foundation (moderator)

Dr. Joshua M. Sharfstein

Associate Dean, Public Health Practice and Training, Johns Hopkins
Bloomberg School of Public Health

9:30–10:15 a.m.

Introduction to 500 Cities Data

Dr. James Holt, Centers for Disease Control and Prevention

10:15–10:30 a.m.

Break

10:30–11:30 a.m.

Applying Health Data: A National Perspective

Margaret Tait, Robert Wood Johnson Foundation (moderator)

Chris Aldridge, National Association of County and City Health Officials

Maria-Alicia Serrano, YMCA

Corinne Francis, CHRISTUS Health

11:30 a.m.–12:15 p.m.

Keynote

Dr. Wayne Giles, Centers for Disease Control and Prevention (moderator)

Dr. Jewel Mullen

Principal Deputy Assistant Secretary for Health,
US Department of Health and Human Services

12:15–1:15 p.m.

Lunch

1:15–2:30 p.m.

Partnering for Health through Data: Local Successes

Jennifer LeClercq, Centers for Disease Control and Prevention
(moderator)

Sarah Pinson, South Carolina Association for Community Economic
Development

Mike Nosal, The MITRE Corporation

Ismael Guerrero, Denver Housing Authority

Jaime Hoebeke, City of Manchester, NH Health Department

Meredith Stidham, Granite United Way

2:30–2:45 p.m.

Break

2:45–3:45 p.m.

Roundtables

1. Apples and Oranges: Getting Unusual Partners to Collaborate on Healthy Communities

Val Iverson, Arizona Housing Alliance and Serena Unrein, Arizona Partnership for Healthy Communities

2. Establishing Cross-Sector Collaborations to Improve Health – Philadelphia

Garrett O'Dwyer, Philadelphia Association of Community Development Corporations and Dr. Rickie Brawer, Thomas Jefferson University Hospital

3. Financing for Achieving Better Health Outcomes

Cecile Chalifour, Low Income Investment Fund and Amy Gillman, Local Initiatives Support Corporation

4. Using the 500 Cities Data: Focus on Heart-Related Indicators

Dr. Eduardo Sanchez, American Heart Association and Dr. Vincent Fonseca, Population Health Institute of Texas and Intellica Corporation

5. Using the 500 Cities Data: Focus on Older Adult Health

Dr. Doug Shenson, Yale University and Dr. Rodney Harrell, AARP

6. Working with Community Partners to Improve Health

Matthew Aliberti, United Way Worldwide and Galen Smith and Jessica Galleshaw, United Way of Metropolitan Dallas

7. Using Neighborhood Data to Engage Communities

Dr. Katie Pritchard, Data You Can Use and Dr. Susan Millea, Children's Optimal Health

8. Navigating the Sea of Data: Finding the Resources You Need

Dr. Marjory Givens and Amanda Jovaag, University of Wisconsin Population Health Institute and Erin Barbaro, Institute for People, Place & Possibility (IP3)/Community Commons

9. Conducting Health Impact Assessments to Promote Public Health

Abigail Baum, Health Impact Project, a collaboration of the Robert Wood Johnson Foundation and the Pew Charitable Trusts, and Sarah Hartsig, Kansas Health Institute

3:45–4:00 p.m.

Break

4:00–4:30 p.m.

Closing Session

Dr. Donald Schwarz, Vice President of Program, Robert Wood Johnson Foundation

Appendix E. Speaker Biographies

Keynote: Dr. Sekou Sidibe and Dr. Joshua Sharfstein

Sekou Sidibe is a senior program officer at the CDC Foundation, where he currently manages a portfolio of more than 15 diverse projects. Previously, Sidibe worked at the Centers for Disease Control and Prevention (CDC), where he was hired by SciMetrica to implement and manage the field epidemiology training program for the Ebola emergency response for CDC's Division of Global Health Protection in West Africa. Sidibe is a graduate of the University of North Carolina at Chapel Hill. He also attended the Gillings School of Global Public Health at the University of North Carolina and graduated with a master's degree in public health with a focus on health behavior. Following graduation, Sidibe was selected for an Association of Schools and Program of Public Health fellowship at CDC where he was assigned to work in HIV/AIDS and oversaw a randomized controlled study assessing the effectiveness of an evidence-based intervention in Botswana.

Joshua Sharfstein, MD, is associate dean for public health practice and training and faculty in health policy and management at the Johns Hopkins Bloomberg School of Public Health. Previously, Sharfstein served as secretary of the Maryland Department of Health and Mental Hygiene from January 2011 to December 2014. In this position, he led efforts to align Maryland's health care system with improved health outcomes, culminating in the adoption of a revised payment model for all hospital care for Maryland residents. He also oversaw the development of a statewide health improvement process with 18 local public-private coalitions and the reshaping of state's approach to health information exchange, long-term care, and behavioral health. From March 2009 to January 2011, Sharfstein was principal deputy commissioner of the US Food and Drug Administration, where he oversaw the agency's successful performance management and transparency initiatives. From December 2005 to March 2009, as commissioner of health for Baltimore City, he led innovative efforts that contributed to major declines in both overdose deaths and infant mortality rates. From July 2001 to December 2005, as minority professional staff and health policy advisor for Congressman Waxman, Sharfstein was engaged in a wide range of oversight and legislative activities on health care topics, including emergency preparedness, HIV, and the politicization of science. He graduated summa cum laude with an AB in social studies from Harvard College in 1991 and is an elected fellow of the Institute of Medicine (2014) and the National Academy of Public Administration (2013). He serves on the Board of Population

Health and Public Health Practice of the Institute of Medicine and on the editorial board of the *Journal of the American Medical Association*.

Introduction to 500 Cities Data: Dr. James Holt

James Holt is the team leader for analytic methods in the CDC National Center Chronic Disease Prevention and Health Promotion. Jim has been with the CDC in Atlanta since 1992. He earned his PhD in geography from the University of Georgia in 2003. His research focuses on the application of geospatial analysis methods for chronic disease surveillance and epidemiology. He is the CDC co-principal investigator for the 500 Cities project.

Applying Health Data: A National Perspective

Margaret E. Tait joined the Robert Wood Johnson Foundation (RWJF) in 2014 and is a research associate in research-evaluation-learning (REL). In this role, she helps to support REL leadership and staff on an array of projects including the development and implementation of the Culture of Health Action Framework, the RWJF's Sentinel Community project, and exploratory work to better disseminate published research that results from the RWJF's grant making. Before joining RWJF, Tait worked as the program coordinator for Access Health SC at the South Carolina Hospital Association, an initiative of the Duke Endowment. In this role, Tait supported 10 community networks of care, made up of health systems, social service agencies, and community based organizations that coordinate care for the uninsured and underinsured populations throughout South Carolina, with reporting and evaluation. Before that, Tait was an Americorps*VISTA at Access Health Spartanburg, one of the 10 networks she later supported through Access Health SC. Tait has also worked at the University of Pennsylvania Center for Health Equity Research and Temple University's Center for Obesity Research and Education on several National Institute of Health– and US Department of Agriculture–funded projects.

Chris Aldridge is the senior director for Infectious Disease Prevention and Control at the National Association of County & City Health Officials. In this role, he oversees programs designed to strengthen the capacity of local health departments to prevent the spread of infectious disease. Previously, he worked as the assistant director for the Office of Infectious Disease Prevention and Care Services, part of the Infectious Disease Bureau, Prevention and Public Health Administration at the Maryland Department of Health and Mental Hygiene. In that role, he led HIV prevention and health services and

the programs for sexually transmitted infection, tuberculosis, and hepatitis for the state of Maryland. Other experience includes work as a case manager at St. Louis Effort for AIDS; managing HIV prevention activities, with a focus on HIV testing and linkage to care, as a senior program manager at the National Alliance of State and Territorial AIDS Directors, and running a grant program to expand access to HIV testing as an associate director of medical affairs at Gilead Sciences. Chris has a bachelor of science in Business Administration from University of Missouri and a master's in Social Work from Washington University in St. Louis.

Maria-Alicia Serrano is senior manager in the Research, Evaluation and Data Sciences Department at YMCA of the USA (Y-USA). Y- USA is the national resource office for the more than 2,700 YMCAs (Ys) across the country serving 22 million people in 10,000 communities. Serrano leads the research analyst team whose primary responsibilities include conducting summative and formative evaluations, analyzing how socioeconomic trends and patterns impact Y programs and operations, and increasing the capacity of local Ys to strategically use data through interactive data visualizations. Before joining Y-USA, Serrano was vice president and director of public sector services for Applied Real Estate Analysis (AREA), Inc., a Chicago-based research and public policy consulting firm. At AREA, Serrano led national evaluations of public housing programs and policies for the US Department of Housing and Urban Development (HUD), developed fair housing analyses and action plans for local governments, and conducted economic impact analyses of public-sector activities. Before joining AREA Inc., she was senior policy analyst manager with the Chicago Housing Authority where she led the development of annual plans and reports for submission to HUD. Serrano holds a master's of public affairs in urban management from the School of Public and Environmental Affairs at Indiana University and bachelor of arts in law, letters and society from the University of Chicago.

Corinne Francis is the system vice president of Mission Integration and Community Benefit at CHRISTUS Health in Irving, Texas. Previously, she was the executive vice president of Mission Integration in the Louisiana Region. The system employs approximately 30,000 associates and has over 9,500 physicians on faculty medical staffs in which care and support are provided for patients. Previously, she served for 11 years as a Mission leader with Catholic Health East, where she held the following positions as vice president of Mission Integration for Saint Michael's Medical Center in Newark, New Jersey; St Anthony' s Health Care in St Petersburg, Florida; and St. James Mercy Health System in Hornell, New York. Francis has coauthored two publications on program outcome measurements with the Health Research and Education Trust of the American Hospitals Association. In 2006, Francis was selected by Modern Healthcare as one of 12 Up and Comers in US health care. She also served two terms as a board member of the Catholic Health Association. Francis is currently part of

a national think tank with the Ministry Leadership Center Hilton Foundation project on leadership formation in all Catholic Ministries: health care, universities, social services, and Catholic Relief Services.

Keynote Presentation: Dr. Wayne Giles and Dr. Jewel Mullen

Wayne H. Giles, MD, MS joined the CDC in July 1992. He is the director of the division of population health within the National Center for Chronic Disease Prevention and Health Promotion at the CDC. He holds a BA in biology from Washington University, an MS in epidemiology from the University of Maryland, and an MD from Washington University, and has completed residencies in both internal medicine (University of Alabama at Birmingham) and preventive medicine (University of Maryland). His past work experience has included studies examining the prevalence of hypertension in Africa, clinical trials evaluating the effectiveness of cholesterol-lowering agents, and studies examining racial differences in the incidence of stroke. Giles directs research and programmatic activities in a number of areas including behavioral risk factor surveillance, arthritis, aging, alcohol, chronic obstructive pulmonary disease, prevention research, school health, and epilepsy. He has over 150 publications in peer reviewed journals and has authored several book chapters. He has been the recipient of numerous awards including the Centers for Disease Control and Prevention's Charles C. Shepard Award in Assessment and Epidemiology and the Jeffrey P Kaplan Award.

Jewel Mullen, MD, MPH, MPA, principal deputy assistant secretary for health in the US Department of Health and Human Services (HHS), is a physician and epidemiologist whose career has spanned clinical, research, teaching, and administrative roles focused on improving the health of all people, especially the underserved. She is recognized nationally and internationally as a leader in building effective community-based chronic disease prevention programs, and for her commitment to improving individual and population health by strengthening coordination between community, public health and health care systems. In her position at HHS, Mullen oversees the offices within of the Office of Assistant Secretary for Health with the goal of fostering collaboration across its programs to advance public health. She is the lead liaison for the HHS regions and advises the acting assistant secretary for health on a variety of priority public health issues, ranging from research integrity to women's health to health promotion and disease prevention. Before joining HHS, Mullen served for five years as commissioner of the Connecticut Department of Public Health. Before that, she was the director of the Bureau of Community Health and Prevention at the Massachusetts Department of Public Health. Over the years,

she has also been on the medical faculty at New York University, the University of Virginia, Yale, and Tufts.

Partnering for Health through Local Successes

Jennifer LeClerc has been in the field of public health for over 15 years at the national and local level working with state and local health agencies, national nongovernmental organizations, and departments of education. She has been with the division of population health's policy team at the CDC for three years. In this capacity, she works on policy issues for the Behavioral Risk Factor Surveillance System and programs in the epidemiology and surveillance branch, including the 500 Cities Project and excessive alcohol use prevention. LeClerc conducts policy and legislative analysis and environmental scanning, programmatic strategic development, issues management, and partnership development. She previously served as public health analyst and project officer in the division of adolescent and school health where she worked on adolescent pregnancy, STD, and HIV prevention. She joined CDC after completing the HHS's Emerging Leaders program, where she completed rotational assignments throughout CDC and the Substance Abuse and Mental Health Services Administration. Before joining CDC, she managed the health and safety services full-service program and the HIV/AIDS prevention education program for the American Red Cross, Prince George's County Chapter (Maryland). She holds a master's in public health from Columbia University's Mailman School of Public Health and is a Certified Health Education Specialist.

Michael Nosal is a lead human factors engineer for the MITRE and the group leader of the Health Experience Design Group within the health transformation technical center. He leads his staff in the health experience design group, focused on user interface design, interaction design, user interface engineering, information architecture and accessibility/Section 508 compliance and testing. Nosal has led the design and user interface engineering efforts on the majority of MITRE's open source health projects. These efforts include all facets of user experience and interface design, with an emphasis on creating interfaces that provide exemplary usability and clarity of data presentation. He is currently working on the Standard Health Record Collaborative, an open-source effort to develop a specification for a single, unified digital health record for every individual in the United States. This effort includes work in semantic interoperability of electronic health record data, generation of synthetic patient records for testing, and spatial analysis for population health modeling. Recent projects include Healthy Insights, a website to provide data visualization of demographic information related to health and healthy lifestyle for the South Carolina Association for Community and Economic Development. Before

joining MITRE in 2005, Nosal worked for the online travel search startup Kayak.com, developed content-management software now owned by Oracle, and designed user interfaces and performed software quality assurance testing for Symantec, IBM, and Lotus. He received his bachelor's of science in computer science from Brown University.

Jaime Hoebeke is the division head of Neighborhood Health at the City of Manchester, NH Health Department. She has been with the department for over 13 years. As a member of the department's senior leadership team, Hoebeke oversees several systems and environmental change efforts to improve the health of residents within the city's most impoverished neighborhoods, including a large collective impact initiative known as the Manchester Community Schools Project. In addition, she has coauthored on many community assessments and reports, including the most recently released publication entitled the Manchester Neighborhood Health Improvement Strategy, and she has successfully secured approximately \$1.6 million in grant funding to support the division's work. She currently serves on several local and state committees and boards, such as the board of directors for the Mental Health Center of Greater Manchester, advisory board for the YMCA Downtown Branch, and the board of directors for the New Hampshire Comprehensive Cancer Collaboration. In 2015, she was honored as a Top 40 Under Forty recipient by the NH Union Leader and the NH Business and Industry Association. Before working at the Manchester Health Department, she was the community benefits coordinator within the community health and benefits department at Brigham and Women's Faulkner Hospital in Boston, MA for three years. In addition to professional certification as a Master Certified Health Education Specialist, she has a bachelor's of science in community health education from the University of Massachusetts Lowell, and a master's of public health degree in social and behavioral sciences from the Boston University School of Public Health.

Meredith Stidham is vice president of Community Impact at Granite United Way, New Hampshire's largest United Way. Meredith oversees the investment of a \$2.5 million annual investment portfolio and has developed specific investment strategies related to improving childhood literacy and implementing community school programs in Manchester. In 2016, Stidham led Granite United Way's investment in Manchester's Neighborhood Health Improvement Strategy, which received honors from United Way Worldwide and was featured in Manchester's Culture of Health Prize through the Robert Wood Johnson Foundation. She completed her bachelor's degrees in English and psychology at the University of Michigan, and she holds a master's degree in social work from the University of New Hampshire, where she is a member of the adjunct faculty. She is a mentor for social work students attending the University of New Hampshire and St. Anselm College. In 2016, Stidham was recognized as a member of New Hampshire's Forty Under 40.

Theresa Mickiewicz has been part of the effort to improve the health of Coloradans for 20 years. She is an evaluator and epidemiologist for Denver Public Health and leads the evaluations of most health promotion division programs while providing evaluation assistance to external partners, such as Denver Housing Authority and the Stapleton Foundation. Adept at qualitative and quantitative methods and project management, skills include evaluation design with a focus on process, intermediate and long-term outcomes, survey design, data analysis, and reporting. Mickiewicz presents regularly at local, state, and national meetings.

Closing Session

Donald Schwarz, MD, MPH, MBA is the vice president of program for the Robert Wood Johnson Foundation (RWJF), guiding the RWJF's strategies and working closely with colleagues, external partners, and community leaders to build a culture of health in America, enabling everyone to live the healthiest life possible. Schwarz, a nationally recognized leader in public health and children's health care, is formerly deputy mayor for health and opportunity and health commissioner for the City of Philadelphia where he oversaw the departments of human services, behavioral health, and intellectual disability services, and the Office of Supportive Housing. Most recently, he was an RWJF director, leading efforts to catalyze public demand for healthier people and the places in which they live, work, learn, and play. Schwarz currently leads RWJF's efforts to promote healthier, more equitable communities, healthy children and healthy weight. As health commissioner, Schwarz worked to initiate successful antiobesity and smoking cessation programs, introduced electronic health records to the city's eight federally qualified health centers, and established a unique public-private partnership to construct a new health center, recreation center, and library complex to serve the needs of the highly diverse South Philadelphia community. Rates of HIV also declined in Philadelphia, the city has reached its lowest rates of infant mortality, and Philadelphia had the highest rates of childhood immunization of America's large cities. Before entering government service, Schwarz was vice chairman of the department of pediatrics of the University of Pennsylvania School of Medicine and deputy physician-in-chief and Craig-Dalsimer division chief of adolescent medicine at the Children's Hospital of Philadelphia. He was professor of pediatrics in the University of Pennsylvania Schools of Medicine and Nursing and a senior fellow at the Leonard Davis Institute for Health Economics at Penn. Earlier in his career Schwarz was a RWJF Clinical Scholar. A board-certified pediatrician, he holds a master's of business administration in health care administration from The Wharton School, University of

Pennsylvania. He received his MD and MPH from Johns Hopkins University, and earned his BA in biology from Brown University.

Appendix F. Attendee List

<u>Participants</u>		
Sanaa Abedin	Benjamin Faust	Michelle Kirian
Leigh Ann Alderman	Vincent Fonseca	Mia Kirk
James Aldridge	Jaeson Fournier	Korey Klein
Matthew Aliberti	Eric Fox	Sara Knoll
Luis Alvarez Leon	Corinne Francis	Natalie Kotkin
Richard Amory	Lawrence Frank	Deborah Kozick
Leta Anthony	Kirstin Frescoln	Amy Laurent
Adam Atherly	Florence Fulk	Tatiana Lin
Bernadette Austin	Jessica Galleshaw	Danelle Lobdell
Erin Barbaro	Anthony Galvan	Marisel Losa
Kathryn Barker	Gary Gaston	Elizabeth Lutz
Chris Barnett	Vedette Gavin	Zhen-qiang Ma
Zarnaaz Bashir	Elise George	Marcella Maguire
Abigail Baum	Heidi Gerbracht	Bryn Manzella
Kendall Bennett	Amy Gillman	Mehran Massoudi
Chelsea Berg	Jonathan Giuffrida	Meghan McGinty
Albert Blankley	Marjory Givens	Vienna McLeod
Nisha Botchwey	Shannon Godbout	Melissa McPheeters
Timothy Bray	Anna Gonzales	Monica Medina McCurdy
Nicole Brazelton	Marc Gourevitch	Christie Mettenbrink
Dallas Breen	Robert Graff	Aaron Mettey
Deirdre Browner	Alison Green-Parsons	Theresa Mickiewicz
David Broyles	Ismael Guerrero	Susan Millea
JocCole "JC" Burton	Julie Gunter	Aaron Mondada
James Cassell	Karen Hacker	Myeta Moon
Nina Cesare	Erin Hagan	Quentin Moore
Anita Chandra	Leigh Hancock	Melissa Moorehead
David Chang	Rosa Hand	Xavier Morales
Derek Chapman	Rodney Harrell	Elizabeth Morehead
Randal Chenard	Chris Harrison	Jewel Mullen
Dante Chinni	Sarah Hartsig	Edgar Munoz
Young Cho	Khosrow Heidari	Caitlin Murphy
Pedro Cons	Nicki Hellenkamp	Jamie Newman
Naomi Cytron	Craig Helmstetter	Jessica Nguyen
Dajun Dai	Jennifer Hicks	Ruth Ann Norton
Amanda Dave	Katherine Hillenbrand	Mike Nosal
Khatidja Dawood	Robin Hobart	Jessica Nunez
Justin Denney	Jaime Hoebeke	Garrett O'Dwyer
Carl Dillon Jr.	Margaret Ingraham	Chinonye Onwunli
Jimmy Dills	Val Iverson	Cathleen Rickie Orr Brawer
Mei Ding	Marquisha Johns	Kristi Paiva
Daniel Dooley	MaryCatherine Jones	Sharon Peterson
Jodi Dyer	Amanda Jovaag	Janet Phoenix
Thomas Eckstein	Mira Kahn	Sarah Pinson
Becky Eisinger Land	Gelin Kan	Kimberly Porter
Larissa Estes	Barry Keppard	Alan Potter
Dina Faticone	Eric Kessell	Andrea Price
	Marya Khan	Katie Pritchard

Raquel Qualls-Hampton
Kalpana Ramiah
Ela Rausch
Marina Recio
Glenda Redeemer
Chris Reeder
Jordan Riddle
Emily Ridgway
Breece Robertson
Robyn Rontal
Neal Rosenblatt
Alicia Rouault
Victor Rubin
Chris Saleeba
Eduardo Sanchez
Laura Schuch
Richard Schultz
Ellen Schwaller
Camille Seaberry
Neil Sealy
Rachelle Seger
Sarah Seidel
Maria-Alicia Serrano
Snehal Shah
Joshua Sharfstein
Douglas Shenson
Juliet Sheridan
Stephen Sills
Jim Skinner
Heather Skrabak
Nate Smith
Bernita Smith
Galen Smith
Lin Song
Jenelyn Sotto
Tim Soucy
Susan Spiller
Mallory Staskus
Chantal Stevens
John Steware
Meredith Stidham
Emily Suter
Grace Tee Lewis
Kavya Timmireddy
Rickey Tolliver
Kathy Triantafillou-Ashe
Aaron Truchil
Wei-Lun Tsai
Serena Unrein
W.W. Sanouri Ursprung
Vrunda Vaghela
Linda Vail

Janet Viveiros
Tam Vuong
Nicholas Wallace
Elizabeth Walsh
Kristi Wamstad-Evans
Scott Weaver
Dan Weidenbenner
Sarah Weller Pegna
Tara Westman
Ben White
Jason Wilcox
Cathleen Williams
Frank Woodruff
Jim Wooten
Dustin Young
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James Holt
Jen LeClercq
Hua Lu

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Ruthy Gourevitch
Josh Leopold
Kathryn Pettit
Lily Posey
Corianne Scally
Patricia Solleveld

Notes

1. For conference presentations, see “500 Cities Project Meetings,” CDC Foundation, accessed April 16, 2017, <http://www.cdcfoundation.org/500-cities-project-meetings>. For video of the plenary sessions, see “500 Cities Project Convening, December, 2016,” Robert Wood Johnson Foundation, accessed April 13, 2017, <https://www.youtube.com/playlist?list=PLqF-bKPCi6CqL0aT631F48QYcdFOE6edF>.
2. See note 1.
3. For the slides from the conference plenary presentations, see note 1.
4. See Corianne Payton Scally and Kathryn L.S. Pettit, “How to Engage Your Community with Health Data: Hosting a 500 Cities Event” (Washington, DC: Urban Institute, 2017).
5. See also, Xavier Morales, “Sweet Results from Bay Area Elections on Soda Taxes,” Praxis Project (blog) November 10, 2016, <https://www.thepraxisproject.org/sweet-results-from-bay-area-elections-on-soda-taxes/>.
6. See Rickie Brawer, James Plumb, F. Abby Cabrera, Ann D. Clark, Monica Doyle, Heather Prasad, and Jane Elkis Berkowitz, *Community Health Needs Assessment* (Philadelphia, PA: Thomas Jefferson University Hospital, 2016).
7. For additional information on Boston’s Living Wage Ordinance HIA see Lisa Conley, Brandynn Holgate, Randy Albelda, and Shannon O’Malley, *Health and Income: The Impact of Changes to Boston’s Living Wage Ordinance on the Health of Living Wage Workers* (Boston Public Health Commission: 2016).

About the Authors



Corianne Payton Scally is a senior research associate in the Metropolitan Housing and Communities Policy Center at the Urban Institute, where she explores the complexities of interagency and cross-sector state and local implementation of affordable rental housing policy, finance, and development. Her areas of expertise include federal, state, and local affordable housing programs and partners, covering topics from policy development and advocacy to program funding and implementation to on-the-ground development and operations. Through extensive case study research, interviews, and surveys, Scally evaluates how well the affordable rental housing system works to serve vulnerable populations, including low-income households, people with disabilities, and the elderly. Scally received her BA in international affairs and MS in urban planning from Florida State University, and her PhD in urban planning and policy development from Rutgers University.



Kathryn L.S. Pettit is a senior research associate in the Metropolitan Housing and Communities Policy Center at the Urban Institute, where her research focuses on measuring and understanding neighborhood change. Pettit is a recognized expert on several small-area local and national data sources and on the use of neighborhood data in research, policymaking, and program development. She has conducted research on many topics, including student mobility, neighborhood redevelopment, federally assisted housing, and local housing markets and conditions. Pettit directs the National Neighborhood Indicators Partnership, a network of three dozen local organizations that collect, organize, and use neighborhood data to inform local advocacy and decisionmaking. She frequently presents the model and accomplishments of the network and local partners. She has produced two books on the role of data in community change: *Strengthening Communities for Neighborhood Data* and *What Counts: Harnessing Data for America's Communities*.



Olivia Arena is a research assistant in the Metropolitan Housing and Communities Policy Center at the Urban Institute. She has experience in municipal governments, research entities, and community organizations. Arena recently graduated from the University of Texas at Austin with degrees in Plan II honors, urban studies, and international relations with concentrations in Latin American studies and geography. Her senior thesis explored urban interventions as a form of civic engagement in Austin, Texas.

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