Neighborhood and School Environments Support Improved Health and Healthy Behaviors

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Using This Guide: A Note to Building Healthy Communities Coalition Leaders

Purpose/Audience
Each of the Building Healthy Communities Outcome Resource Guides is intended to provide a deeper understanding of the background and context for each outcome, a sampling of promising practices and strategies that will contribute to achieving each outcome, and additional tools and resources that can help local leaders plan for improving the health of their communities. These guides were written specifically to assist local leaders and planners in the 14 communities participating in the Building Healthy Communities program of The California Endowment.

Strategies and Promising Practices
The strategies and practices described in each guide are intended to provide options and spark new ideas for local planners. These lists and examples do not represent all known strategies and policy directions in the field. Rather, they represent an overall direction that, based on the evidence at hand, show promise for contributing to a comprehensive approach to improving health in California communities.

Indicators of Success
These indicators are examples of ways to measure changes in this outcome. The appropriate indicator to use as a part of measuring progress, either as a part of an evaluation or a performance monitoring plan, will depend on the targeted changes and strategies that are selected either as part of a Place’s work plan or part measuring a grantee’s performance.

Contributing to the knowledge base
These guides constitute the beginning of a TCE library of resources that will grow over the next 10 years based on the experiences of BHC communities, as well as on emerging evidence for promising policies and practices in the field as a whole. Community residents, local leaders as well as researchers and scholars are invited to add to this foundation as new tools, strategies, experience and evidence emerge. Please contact TCE at www.calendow.org.

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Outcome Seven: Neighborhood and School Environments Support Improved Health and Healthy Behaviors

I. Background
Health and well-being are influenced by the communities where people live, work, play, and learn through the interplay of a community’s physical, social, and cultural environment. People thrive when they live in neighborhoods with healthy physical environments, safe places for children to play, access to healthy foods and, most important, schools that set strong standards for student achievement, respect, equity, and healthy lifestyles. People need environments that are structured in ways that promote health and support healthy choices. Creating healthy environments cannot be done in isolation by any one organization or institution; it requires coordinated and comprehensive efforts. It requires community involvement and commitment. Without these fundamentals, people are more likely to suffer from multiple chronic diseases, including diabetes, asthma, and heart disease.

Parks and trails, healthy foods, strong schools that promote health and equity, healthy air, and water quality are not equally available across all communities. Some neighborhoods and schools foster health more effectively than others. This inequality contributes to disparities in health outcomes. Low-income individuals and people of color, regardless of income, tend to get ill more frequently, more severely, and at younger ages. Both groups are more likely to live in communities where residents face concerns such as limited access to fresh fruits and vegetables, high concentrations of alcohol outlets, few parks and recreation facilities, close proximity to ports, pesticides, and other toxins, and schools with limited investments in health and healthy lifestyles – all of which are linked to poor health outcomes. Improving the physical and school environments are part of a strategic approach to improving health outcomes for all residents and reducing health disparities in the first place.

Decisions made by government, business, and institutions have an important impact on shaping the conditions in the physical and school environments. For example, schools and communities can enter into joint use agreements to increase access to safe places for children to play; coordinated school health models can provide a framework for incorporating a commitment to health and healthy lifestyles into school programs; and local governments can identify opportunities for new farmers’ markets or local grocery outlets to improve access to nutritious food. Limits on pesticide use, port emissions, or other toxic exposures can provide important protections for residents exposed to these health hazards. Many localities have begun to implement meaningful changes that address concerns about health and the environment. Through their creativity and commitment, neighborhoods are becoming places where all residents have the opportunity for health.

II. Brief Overview of Healthy Neighborhood and School Environments
Advocates for healthy neighborhoods and schools often ask, “What is the best way to participate in changing the environment where I live? Where do I start?” While it is important to take advantage of government-level decision-making opportunities as they arise, community residents, health practitioners, city and school staff, and other advocates can build upon each other’s knowledge and experience to create a long-term, sustainable focus on healthy neighborhood and school environments.
This Resource Guide intends to equip advocates through the process of visualizing specific change, organizing stakeholders around the implementation of a particular change strategy, and measuring its progress. This section of the Resource Guide describes the elements of the neighborhood and school environments that affect the health of children and families. These include air quality and water quality, access to healthy foods, access to health care, and sufficient and convenient opportunities for physical activity. Section III of the Resource Guide provides 13 strategies that offer new ways to address problems and shift thinking toward prevention-oriented solutions. Each strategy or sub-strategy is followed by a list of resources (including example initiatives and toolkits), sample policies, and a list of important stakeholders to consider in taking action. Section IV includes a set of indicators to help advocates and communities visualize and measure progress. Section V provides a list of important organizations that can support advocates as they plan and implement the various strategies listed in this Resource Guide.

Elements of the Neighborhood and School Environments That Affect the Health of Children and Families

What are the elements of the neighborhood environment and how do they impact health?

The neighborhood physical environment consists of various elements that affect residents’ quality of life and public health. Considerations such as access to clean air and water, healthy housing, fresh foods, health care, jobs, schools, safe places to walk and play, and other neighborhood services are often lacking or absent in low-income neighborhoods, and this can have a detrimental effect on the health of neighborhood residents.

Equally important is the neighborhood social environment, such as the attitudes, values, goals, and practices that affect how people interact with each other; and the institutional environment, which along with the physical environment, forms the context that people live in. Like the physical environment, this social and institutional context can have a profound impact on health. In recognizing the importance of the social and institutional environments, these topics, along with the impacts of access to safe streets, public transit, parks, and open space on public health, are treated as a separate outcome and can be found in the Resource Guide for Outcome Four – “Residents Live in Communities with Health-Promoting Land Use, Transportation, and Community Development.”

Additionally, while there are strategies in this Resource Guide that might address school violence and health gaps for boys and young men of color, for a complete set of strategies focused on these topics, please see the Resource Guides for Outcome Five – Children and their Families are Safe from Violence in their Homes and Neighborhoods; Outcome Six – Communities Support Healthy Youth Development; and Outcome Nine – Health Gaps for Boys and Young Men of Color are Narrowed.

Outdoor Air Quality

Every year, millions of pounds of dangerous chemicals, gases, and particles are released into the air by vehicles, power plants, and industrial and agricultural activities. These include ozone emitted by motor vehicles and industrial sources; particulate matter, generated by combustion processes, including diesel-powered engines, power generation, wood burning, and dust from construction, mining, and agricultural activities; nitrogen dioxide produced by fuel emissions from cars, trucks,
and power plants; and sulfur dioxide, which comes from point sources, such as power plants, steel mills, and paper mills.

Outdoor air pollution is a serious problem in most urban areas as well as in many rural areas. Nearly all Californians (about 99%) live in areas that fail to meet the state’s health-based ozone and/or particulate matter standards. Four of the five most ozone-polluted counties in the U.S. are located within California. However, not all Californians are equally affected. Counties in the Central Valley and Los Angeles region are among the worst-polluted in the country. Additionally, across California, poor air quality disproportionately affects low-income communities and communities of color. The inequitable distribution of environmental burdens—also known as environmental injustice—stems from broad inequities linked to institutional racism, land use policies, economic structures, and lack of resources and power in affected communities.

Racial, ethnic, economic, and social inequities are directly correlated with the severity, frequency, and prevalence of asthma in California. Asthma is 30% higher among African Americans than whites. Poor air quality is also linked to cancer and to cardiopulmonary, reproductive, and neurological disorders.

**Indoor Air Quality in Homes**

On average, Californians spend 90% of their time during the week indoors, and most of that time is in the home. The presence of uncontrolled asthma triggers causes irritation to the lungs and can lead to the development and exacerbation of asthma as well as allergies and other health-threatening conditions. While some of these asthma triggers can be controlled by the residents, many of them stem from the pervasive problem of substandard housing. One in eight dwelling units in California is considered substandard, making this a problem for all regions and communities across the state.

**Indoor Air Pollutants**

Sources of indoor air pollutants include tobacco smoke, gas stoves, space heaters, paint, and carpet. There is also growing concern about chemical emissions from common consumer products such as household cleaners and air purifiers.

Numerous sources of indoor air pollutants have been linked to the exacerbation of asthma symptoms, including second-hand smoke; space heaters, furnaces, and gas stoves that emit nitrogen dioxide; volatile organic compounds, which are chemicals found in common household cleaning products, paints, and fuels as well as some building materials, new furniture, and carpets; and air purifiers and cleaning devices that produce ozone. In addition, exposure to second-hand smoke has been linked with the development of asthma in infants and young children.

**Indoor Allergens**

Common indoor allergens include mold, dust mites, cockroaches, cats, and dogs. Exposure to indoor allergens is associated with exacerbation of asthma for sensitized individuals. There is also emerging evidence of a relationship between exposure to mold and the development of asthma in children.
Water Quality
Today, in California, hundreds of thousands of families do not have safe drinking water in their homes, schools, or workplaces. According to the California Department of Public Health, public drinking water systems deliver unsafe levels of contaminants to approximately one million California residents every year. Contamination stems from both human and natural activity. The most common contaminants are nitrates, which can cause immediate adverse health effects. High levels of nitrates frequently come from fertilizers, animal waste, and leaky septic systems. Other common contaminants include pesticides and trihalomethanes, which are byproducts of certain methods of treating drinking water with chlorine. Arsenic is also a common naturally occurring contaminant. Each of these contaminants can cause a variety of negative health effects.

Many of the root causes of drinking water contamination are the result of regional, state, and/or federal agency inaction. The California State Water Resources Quality Control Board and their satellite local water boards are responsible for monitoring the amount of pollutants that end up in community water systems. However, this agency has not sufficiently regulated some of the major sources of contamination, such as pesticide and fertilizer applications, and does not regulate the largest source of drinking water in the state — groundwater. Advocates should work with their local water boards to ensure that their community has access to adequate, clean, safe drinking water.

Access to Healthy Food
Obesity — caused by poor diet and physical inactivity — is arguably the leading public health challenge facing California today. Obesity increases the risk of heart disease, stroke, type-2 diabetes, and some cancers, and the Centers for Disease Control and Prevention (CDC) report that the combined annual costs of obesity-related chronic disease risk factors in California reaches tens of billions of dollars in medical care, lost employee productivity, and workers’ compensation. The current obesity epidemic appears to be attributable, in large part, to environmental conditions that implicitly discourage physical activity, while encouraging the consumption of energy-dense, low-nutrient foods. This is especially prevalent in many low-income neighborhoods throughout California and the nation. Increasing access to healthy foods, while modifying the environment to encourage physical activity, is critical to reducing escalating obesity rates.

What are the elements of the school environment and how do they impact health?
The school environment is made up of various elements that contribute to students’ ability to learn and to their overall health. Some of the elements that are often lacking or absent in schools include indoor air quality, and access to health care, healthy foods, and physical activity. Other issues concerning youth such as school violence, crime, school drop-out, and youth development can be found in Outcome Five — Children and their Families are Safe from Violence in their Homes and Neighborhoods; and Outcome Six — Communities Support Healthy Youth Development, respectively.

Indoor Air Quality in Schools
Asthma is the most common chronic disease among school-aged children and is a leading cause of school absences nationwide. In California, more than 6 million children attend public school. During their time at school, children can be exposed to poor indoor air quality, which can trigger asthma
attacks, cause headaches, irritate their eyes/nose/throat, and reduce their ability to concentrate – leading to missed school days and diminished academic performance. Many schools in California and across the country have been found to have poor indoor air quality related to poor ventilation; moisture and mold; dust; and chemically laden finishes, furnishings, and cleaning and teaching products.

**Access to Health Care**

There is no disputing that the school is a critical environment that impacts children’s health. For many children, healthy foods, physical activity, good indoor air quality, and other environmental improvements will be enough to ensure robust health and development. However, for many children, particularly those from under-resourced communities, additional services and supports are needed. School health centers help improve the lives of these children because they provide a breadth of essential services in exactly the right environment – the schools. Ideally, a school health center combines primary medical services (e.g., screenings, immunizations, physicals, sick care, and chronic disease management); mental health services; reproductive health services (e.g., abstinence counseling, pregnancy prevention, and STD/HIV testing and treatment, as appropriate); oral health services; health promotion and school-wide prevention activities; and youth development and family engagement.

In reality, few schools have all of these services. Some school health centers start with part-time medical services and grow from there. Other schools have opted for “wellness centers” that focus on mental health and health promotion and may eventually expand to include medical care. Other schools open dental clinics. There is no one “right” model – the development of a school health center is based on school and community needs, with school boards having the final say as to what services are provided.

**School Food and Physical Activity**

Schools are uniquely positioned to model, promote, and reinforce healthy behaviors for students, staff, and the community at large. Schools play a critical role in feeding students – sometimes up to two meals a day. Restricting access to unhealthy foods and beverages and providing healthy, desirable, and affordable food options is one component of a comprehensive obesity prevention plan. Physical activity also plays a key role in obesity prevention and promoting academic achievement. Research has shown that students who are more physically active and who eat nutritious foods perform better academically. Schools can help by providing breaks that incorporate physical activity and nutrition into the curriculum, and by offering intramural sports.

**III. Promising Strategies and Practices**

Joining the effort to create healthy community environments can be daunting. The physical environment can pose many challenges as well as opportunities for improving the health of children and families. Environmental change – including action on neighborhood land use, transportation, housing, schools, air and water quality, and parks and open space – happens slowly, though the need is usually urgent. When residents are equipped with the relationships, tools, and information they need, they can overcome challenges and engage their communities in broader strategies toward policies to protect and enhance the health of their communities.
A healthy environment cannot be created by any single organization. It requires advocates to forge new partnerships and tap the local wisdom of community organizers, school principals, city planners, business executives, hospital and healthcare workers, parents, and youth. Furthermore, strategies for making change must engage key stakeholders in all steps of the process – from planning to implementation to monitoring and revising policy strategies. For all voices to be heard, a deep commitment is required from a wide range of community members. Many of the strategies aimed at improving the community and school environments are rooted at the local level, which means that developing relationships and building consensus can be some of the most powerful tools for change.

This section identifies 13 strategies, along with lists of useful resources, toolkits, case studies, sample policies, and key stakeholders that advocates can consider, adopt, and/or tailor to the unique circumstances in their communities.

A. The Neighborhood Environment

**STRATEGY 1 – IMPROVE OUTDOOR AIR QUALITY IN NEIGHBORHOODS.**

**Strategy 1A – Create, institutionalize, and enforce diesel emissions reduction policies and procedures.**

The California Air Resources Board regulates diesel emissions statewide, but there is still much to be done at the local level. Community groups can work with local law enforcement as well as the air quality management district to enforce regulations. For example, there is a five-minute restriction on idling, but often drivers are not aware of this and need to be educated. Community members and organizations can significantly contribute to reducing diesel pollution. For example, community groups across the San Francisco Bay Area joined together to create the Ditching Dirty Diesel Collaborative, which aims to reduce the impact of diesel pollution on disproportionately impacted communities through education and policy change.

**Strategy 1 key stakeholders will include a combination of the following:**

- Environmental justice groups
- Environmental health groups
- Residents
- Community-based organizations
- Public health departments
- Medical providers
- Local government/elected leaders
- Air quality management districts
- Lung health organizations
- Faith-based organizations
- Other NGOs
- Unions
- Bus drivers
- Port workers
- Schools
Resources

- *Deluged by Diesel: Healthy Solutions for West County* – Pacific Institute
- *Reducing Diesel Pollution in West Oakland* – Pacific Institute and the Coalition for West Oakland Revitalization
- *West Oakland Toxics Reduction Collaborative* – Community Action for a Renewed Environment
- *Briefing Kit: Asthma and Diesel* – Community Action to Fight Asthma (CAFA)
- *RAMP Diesel Workshop: Diesel Exhaust and Asthma* – Community Action to Fight Asthma (CAFA)
- *Diesel Engines and Public Health* – Union of Concerned Scientists and the Community Action to Fight Asthma (CAFA)

Sample Policies

- *California’s Diesel Risk Reduction Plan* – Air Resources Board (ARB)
- *Los Angeles School District’s Resolution on Diesel-Burning Buses* – Community Action to Fight Asthma (CAFA)

Strategy 1B – Reduce pollution associated with freight transport at ports, in rail yards, at distribution centers, at intermodal facilities, on truck routes, and in communities across the state.

According to the California Air Resources Board (ARB), air pollution (including diesel pollution) from international trade and movement of goods is a major public health concern. Adverse health impacts from pollutants associated with the movement of goods include, but are not limited to, premature death, cancer risk, respiratory illnesses, and increased risk of heart disease. Low-income communities and communities of color are disproportionately impacted as they are more likely to live near ports and rail yards and along high-traffic corridors, where air pollution is highest. In California’s Central Valley, polluting trucks traverse the state on heavily trafficked thoroughfares such as the I-5 corridor. Additionally, distribution centers also bring significant air pollution to the region. Much can be done by local communities to reduce these impacts, beginning with speaking out about them, and joining forces with groups across the state to advocate for solutions that simultaneously support California’s economy and protect the health of its residents.

Resources

- *North Richmond Truck Route Study* – The Contra Costa County Redevelopment Agency
- *Reducing Diesel Pollution in West Oakland* – Pacific Institute and the Coalition for West Oakland Revitalization
- *Measuring What Matters: Neighborhood Research for Economic and Environmental Health and Justice in Richmond, North Richmond, and San Pablo* – Pacific Institute
- *Briefing Kit: Asthma and Diesel* – Community Action to Fight Asthma (CAFA)
- *Paying with Our Health: The Real Cost of Freight Transportation in California* – Pacific Institute
- *Goods Movement Action Plan* – Air Resources Board (ARB)
Strategy 1C – Reduce exposure to harmful particulate matter through the adoption of wood-burning ordinances.

During the winter months, wood burning accounts for a significant amount of particulate matter, which is harmful to the lungs. Many cities and counties have adopted ordinances aimed at reducing such exposure. Included are provisions such as restricting wood burning when air quality is unhealthy and a Spare the Air Advisory is issued, or requiring only cleaner-burning, EPA-certified stoves and inserts to be used in new construction or remodels. The involvement of community groups is essential to instigate the adoption of such ordinances. For example, the Solano Asthma Coalition successfully worked toward the passage of such ordinances in multiple cities and in the county’s unincorporated areas, which then led the Bay Area Air Quality Management District to establish a district-wide rule. In addition to wood burning, agricultural burning contributes to air pollution, particularly in the Central Valley. The San Joaquin Valley Air Quality Management District established a policy to regulate exposure.

Resources
- Check Before You Burn – San Joaquin Valley Air Quality Management District
- Wood Burning – Bay Area Air Quality Management District (BAAQMD)

Sample Policies
- Wood Burning Rule – San Joaquin Valley Air Quality Management District
- Agricultural Burning – San Joaquin Valley Air Quality Management District
- Wood Smoke Ordinance – Bay Area Air Quality Management District (BAAQMD)
- Sample Wood Burning Ordinance – Community Action to Fight Asthma (CAFA)

Strategy 1D – Promote siting of major sources of outdoor air pollution away from locations where people live, learn, work, and play.

The Children’s Health Study, a long-term study of more than 3,000 children in 12 southern California communities, found that traffic-related pollutants contribute to the onset of asthma. Traffic-related pollution worsens quality of life and leads to other health concerns. Therefore, it is important to consider the location of sources of pollution and the proximity to schools, homes, work places, and other places where people spend a significant amount of time. Several years ago, the California legislature passed SB 352, which prohibits a local educational agency from approving the acquisition of a school site within 500 feet of a busy roadway unless the air quality at the site does not pose a health risk to pupils or staff. Local communities can engage in the enforcement of this law and an examination of ways to mitigate exposure to pollution for schools already located near pollution sources. They can also look at policies regulating the location of other polluting sources such as industry, agriculture, etc. – near homes and schools.

Resources
- Air Quality and Land Use Handbook: A Community Health Perspective – Air Resources Board (ARB)
Strategy 1E – Advocate that regional governing bodies adopt and implement pollution reduction policies.

Regional Air Quality Management Districts (AQMDs) are charged with regulating stationary sources of air pollution such as factories. Local advocates can take several approaches to ensure that their AQMD adopts and implements aggressive policies that reduce pollution and protect the public’s health. Examples include: pushing the AQMD to adopt stringent, health-protective standards when developing regulations for stationary sources of pollution; ensuring that the AQMD aggressively reaches out to the public for input into rulemaking, particularly in those communities most burdened with pollution; requesting that the AQMD adopt a “cumulative impact” approach to its regulations, rather than permitting new sources of pollution on a case-by-case basis; advocating for the AQMD to adopt an “indirect source” rule which requires developers to mitigate the impacts of traffic generated by a new development, or to adopt a “magnet rule” which enables AQMD to regulate large industrial facilities that attract a substantial amount of traffic, such as ports; and participating in the development of a region’s air quality plans, such as the relevant portion of a State Implementation Plan (SIP), which spells out how a particular area will meet its pollution control goals under the Federal Clean Air Act.

Another key opportunity is related to California’s Sustainable Communities and Climate Protection Act (SB 375), the first legislation in the country to link transportation and land use planning with global warming. Because it requires the regional governing bodies in each of the state’s major metropolitan areas to adopt, as part of their regional transportation plan, a “sustainable community strategy” that will meet the region’s target for reducing greenhouse gas emissions, there are key opportunities for communities to shape such plans.

Resources

• Our Air, Our Health, Our Communities Toolkit – Bay Area Environmental Health Collaborative (BAEHC)
• Indirect Source Rules: Cleaning Air in California and Beyond (PowerPoint) – Environmental Defense Fund (EDF)
• White Paper on Cumulative Air Pollution in the Bay Area – Environmental Law & Justice Clinic (ELJC)
• Communities Tackle Global Warming: A Guide to California’s SB 375 – National Resources’ Defense Council (NRDC)

Sample Policies

• Indirect Source Rule 9510 – San Joaquin Valley Air Pollution Control District

Strategy 1F – Advocate for the reduction of harmful pesticides.

California leads the U.S. in pesticide use. A significant fraction of pesticides used in California is capable of causing acute poisoning, cancer, birth defects, sterility, neurotoxicity, damage to the developing child, and/or contamination of California groundwater. Of 188 million pounds of pesticides reportedly used in 2000 in California, 70 million (34%) meet one or more of these criteria. Californians for Pesticide Reform brings together 185 public interest groups aimed at protecting human health and the environment from harmful pesticide use.
Policy opportunities include: reducing the use of pesticides that drift into the air; reducing the overall use of pesticides; and affirming the public’s right to know about the use of pesticides.

**Resources**
- Californians for Pesticide Reform

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### A Community Coalition Leads a Study on Air Pollution

The Contra Costa County Redevelopment Agency (RDA) and Contra Costa Health Services (CCHS) are using the tools of redevelopment to improve health outcomes for residents in the unincorporated area of North Richmond. A coalition of non-profit community development, organizing, and social justice organizations, including Neighborhood House of North Richmond, Community Health Initiative, West County Toxics Coalition, and the Pacific Institute, partnered with CCHS in 2004 to lead a study conducted by residents to measure air quality inside their homes. The study revealed high levels of pollutants tied to exhaust from diesel trucks traveling through their neighborhood. They found that the diesel pollution and soot, which are linked to asthma, heart disease, cancer, and other health problems, was released five times more per square mile in West County than in the City of Richmond, and 40 times more than in all of California. The ensuing report, “Deluged by Diesel: Health Solutions for West County,” called for strategies to reduce residents’ exposure to air pollution and to improve community health. Residents presented the findings to the RDA, which became increasingly involved, and applied to CalTrans for an Environmental Justice Grant to partner with the community to develop practical solutions and alternate routes for trucks. They trained the residents to complete traffic counts at priority intersections and worked with them to propose alternate truck routes that would be safer for neighborhood residents. The Board of Supervisors adopted the alternate routes and is securing funding to implement the project.

*Source: Public Health Law & Policy*

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### STRATEGY 2 – IMPROVE INDOOR AIR QUALITY (IAQ) IN HOMES.

**Strategy 2A – Promote and enact policies and practices that reduce indoor pollutants.**

Numerous policies can be developed and enforced at the local level to reduce indoor air pollutants in homes. One approach is to create smoke-free policies for multi-unit housing. For example, a policy might prohibit smoking in common areas or near entrances or outdoor vents. A policy might also create smoke-free units or complexes through requirements or incentives. However, care should be taken to ensure that such policies do not lead to problems of evictions and homelessness, particularly in already vulnerable populations. Other approaches include promoting the use of Integrated Pest Management (IPM), an environmentally sensitive approach to pest management that reduces the use of harmful pesticides, and the use of consumer and cleaning products that are environmentally preferable and less harmful to health. Requirements pertaining to IPM and/or consumer products can target either public housing or rental housing. Another approach is to require or create incentives for green building practices that incorporate IAQ considerations as well as energy savings for any new construction or renovation. Multiple cities and counties have adopted policies that require new government buildings to adhere to existing
standards (e.g., Leadership in Energy and Environmental Design [LEED]) to ensure that environmental health concerns are addressed through building practices and materials. Many cities in California are also looking at requiring the Green Point Rated (GPR) system for new homes as well. The GPR system is much less costly and less process-oriented than going through the LEED for Homes process.

**Resources**
- *Integrated Pest Management Interventions for Healthier Homes* – The Boston Housing Authority (BHA)
- *Integrated Pest Management Principles* – U.S. Environmental Protection Agency (EPA)

**Sample Policies**
- *San Francisco Policy on Green Building for New Residential Buildings* – San Francisco Department of Building Inspection

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**Strategy 2 key stakeholders will include a combination of the following:**

- City Community Development Department
- Redevelopment Agency
- City Attorney
- Police Department
- Tenants
- Tenants’ rights groups
- Legal Aid
- Landlords
- Rental housing associations
- Code inspectors
- Public health departments
- Housing Authority
- Affordable housing developers
- Local affordable housing advocacy groups
- Community health outreach workers
- Local government/elected officials
- Builders / green builders
- Integrated Pest Management service providers
- Healthy Homes Collaboratives (if one exists)
- Lung health organizations
- Medical providers
- Other NGOs

**Strategy 2B – Establish or ensure the health and safety of rental and public housing.**

Code enforcement is often structured so that properties are only inspected in response to complaints. This creates a situation in which problems get severe before they are addressed, and it relies upon tenants knowing their rights and feeling empowered to call code enforcers without fear of retribution. If code enforcers inspect properties proactively, on a regular schedule, they are better equipped to identify problems before they become severe.

Another important consideration in code enforcement is whether or not a healthy housing approach is incorporated. In some localities, code enforcers utilize a checklist of healthy housing criteria. Then, in addition to identifying specific code violations, they are able to work with landlords more comprehensively to create healthy housing.
Local advocates should also be aware of the California Substandard Housing program, which assists state and local agencies that are responsible for abating living conditions that violate California Health and Safety Codes. Under this program, the State Franchise Tax Board disallows interest, tax, amortization, and depreciation deductions on substandard property. Community advocates can encourage cities to notify the Franchise Tax Board of substandard housing. Revenues generated by the disallowed income tax deductions go to the Local Code Enforcement Rehabilitation Fund. These funds are disbursed to the cities and counties that generate notifications.

Advocates can also encourage cities to develop training programs to educate landlords about decay that might be happening on their properties. In Los Angeles, groups have filed lawsuits against the worst offending slumlords. In San Francisco, advocates and policy makers succeeded in changing the city code by adding mold to its list of public nuisances.

**Resources**
- **Systematic Code Enforcement in Los Angeles** – Los Angeles Housing Department
- **California Substandard Housing Program** – State of California Franchise Tax Board
- **City Resources Against Substandard Housing (C.R.A.S.H.)** – The City of Pasadena

**Sample Policies**
- **Sacramento Housing Code Enforcement Policy**
- **Los Angeles Code Enforcement Policy**
- **Pasadena Code Enforcement Policy**
- **Concord Code Enforcement Policy**
- **San Francisco Health Code (Nuisances Article 11, Section 581)**
- **San Francisco Building Code (Search “mold”)**

**Strategy 2C – Advocate for cities and counties to fulfill their obligation to provide sufficient safe, quality affordable housing.**

Healthy housing needs to be safe, affordable, and sufficiently available. All California cities and counties are required to plan for a sufficient supply of affordable housing in the Housing Element of their General Plans. Local groups can play an important role in advocating for cities and counties to fulfill the requirements of the Housing Element. The California Community and Housing Department, which oversees and approves housing elements, requires cities to analyze code enforcement, compliance with the state's health and safety code, and the jurisdiction's efforts to link code enforcement activities to housing rehabilitation programs. Community advocates should take part in the public participation process during updates to the Housing Element to ensure that these issues are being addressed.

Additionally, local advocates should be aware that California redevelopment law requires that no less than 20% of tax increment revenue derived from a redevelopment project area must be used to increase, improve, and preserve the supply of housing for very low-, low-, and moderate-income households. Several communities have successfully convinced their local redevelopment agency to invest more than the minimum.
Local inclusionary housing ordinances are another way to help make affordable housing available. Local groups can advocate for these ordinances, which require that a given share of new construction is affordable to people with low-to-moderate incomes. Many cities’ inclusionary housing ordinances require that up to 20% of the units in every new housing development are affordable to lower-income families.

**Resources**
- *Codes and Enforcement and On Off-Site Improvement Standards* – California Department of Housing and Community Development
- *California Redevelopment Association*

**Sample Policies**
- *Inclusionary Housing Database* – California Coalition for Rural Housing

**Strategy 2D – Establish working partnerships to address IAQ problems in housing.**
A promising way to address IAQ problems in housing is to create partnerships between medical and legal entities. For example, in Medical-Legal Partnerships, lawyers help patients navigate complex government and community systems that can provide services such as income supports for food-insecure families, utility shut-off protection during cold winter months, and mold removal from the homes of asthmatics. Boston has a Breathe Easy at Home (BEAH) Program, which is a web-based referral system that enables doctors, nurses, and other health professionals to refer their Boston patients with asthma for a home inspection, conducted by the Boston Inspectional Services Department (ISD).

**Resources**
- *Medical-Legal Partnerships* – National Center for Medical-Legal Partnership (MLP)
- *The Breathe Easy at Home Program (BEAH)* – Boston Public Health Commission

**Strategy 2E – Promote training and education on IAQ and housing for tenants, landlords, and inspectors.**
Local groups can work to ensure that code enforcement officers are trained to identify health and safety code violations, with specific focus on mold issues. Additionally, local groups have tailored trainings for landlords and tenants to clearly outline their respective responsibilities for maintaining a healthy home.

**Resources**
- *IAQ and Asthma: Questions and Answers for Landlords and Tenants* – Community Action to Fight Asthma (CAFA)
- *Healthy Homes Training Materials* – National Center for Healthy Housing (NCHH)
How can localities work together to have a greater impact, and to influence state and local policy regarding asthma?

Community Action to Fight Asthma (CAFA) is a network of asthma coalitions in California working to shape local, regional, and state policies to reduce the environmental triggers of asthma for school-aged children where they live, learn, and play. It is widely recognized that environmental factors play a major role in asthma, so CAFA members work to support the creation and implementation of policies that reduce environmental risk factors for school-aged children with asthma. The CAFA Network provides a structure to help safeguard and enact environmental policies at the state, regional, and local levels throughout California. The policies are focused on reducing environmental triggers in schools, homes, and outdoor air, ultimately improving the quality of life for people with asthma. The CAFA Network is comprised of local coalitions that bring together diverse constituents, including health care providers, schools, public health organizations, environmental health and justice groups, and community residents, to work together to address the problem of asthma in their communities. Collectively, these coalitions constitute the CAFA Network, which mobilizes the voice and experience of the local communities to shape asthma policies.

STRATEGY 3 – IMPROVE NEIGHBORHOOD WATER QUALITY.

To know if your community’s water is safe, the first step is to know what is in the water and whether it comes from a private well or a public water system. All public water systems are required under the federal and state Safe Drinking Water Acts to regularly monitor for common drinking water contaminants and provide information to the public about the quality of the water. The public water service provider should provide residents with a “consumer confidence report,” which includes information on where the resident’s water comes from, what contaminants it contains, and how it is treated.

If a resident is served by a private well, there are no requirements or regulations regarding testing, quality, or reporting under the state and federal Safe Drinking Water Acts. All maintenance and repairs are the responsibility of the landowner. However, private well owners face the same water quality concerns that people on public water systems do, so testing is important.

Strategy 3 key stakeholders will include a combination of the following:

- Public water system provider
- Regional Water Quality Control Board (RWQCB)
- CA Department of Public Health
- Local offices
- Local Department of Environmental Health
- County Supervisor
- City Council
- State assembly members
- Local media
- Neighborhood residents
- Community-based organizations
To address long-term solutions for secure, safe, and affordable water, community advocates can take the following actions:

*Attend water board meetings.*

All public water systems generally have a governing board that makes policy decisions and holds regular monthly meetings. All meetings of such local water boards have requirements under the Brown Act to post a public agenda and allow the public to attend their meetings and speak. In general, it is easier to work with a board rather than against it. If a community's water system needs more money to address contamination, advocates should urge the board to apply for state and federal grants.

*Get materials translated.*

If a community's water provider is a governmental agency or receives state or federal funding, the water system has an obligation to provide interpretation and translation of documents. The laws that require this are the Dymally-Alatorre Bilingual Services Act, and the California and Federal Civil Rights Acts. It is the right of community members to ask their water provider for translated documents or interpretation services.

*Take the next step: join the water board.*

Joining the water board enables advocates to play a direct role in addressing water quality concerns. Frequently, small, local water boards have vacancies waiting to be filled. If a community's water system is public, advocates can call their County Elections Office for information on who serves on the board, if there are vacancies, when the terms of the board members are up, and how to get appointed or on the ballot to run for a seat.

*Use the media.*

The press can be an important tool for community drinking water advocacy. Newspaper, radio, and television coverage of a community's struggle can get the message out to a wider audience and put pressure on the local water board to do the right thing. Before talking to the media, advocates will want to create a clear message about the problem; make a list of newspapers and radio and television stations to contact; and develop an event to which they can invite reporters.

*Elevate the issue.*

Many of the water quality issues facing communities require the work of regional, state, or federal agencies. These decision-makers can be helpful in forcing a water board to take action, finding sources of funding for a community's water system, or addressing the root causes of a problem. Local elected officials need to know what is going on in order to take action. This is even more important if the community is “unincorporated,” meaning it is not included in city boundaries and does not have municipal representation. In this case, it is the job of the County Supervisor to work with the community to address its concerns, but advocates must make sure the County Supervisor is informed of the issue. Advocates should call the office of the County Supervisor, City Council, or Assembly members to arrange a meeting, and then organize residents to speak at the meeting.
Join forces.
Often, the root causes of drinking water problems need to be addressed regionally, rather than on a community-by-community basis. By connecting with other communities facing similar problems and advocating together at the regional and state levels, advocates can build significant power and create more lasting change for the whole region.

Resources
The information in this section was based on Community Water Center’s (CWC) “Guide to Community Drinking Water Advocacy.” For more information, go to http://www.communitywatercenter.org/downloads.cfm?content=Tools

There are many state agencies and advocacy organizations that play some role in water management or quality issues. Sometimes they can answer questions or help advocates take action. Often, they can help identify sources of funding for a community’s water system. Important agencies include:

- **Community Water Center (CWC)** – CWC provides organizing, legal, and advocacy assistance with water issues to communities in the Central Valley.
- **California Rural Legal Assistance Foundation (CRLAF)** – CRLAF provides farm-worker communities with technical, legal, and advocacy assistance on issues that impact health and civil rights.
- **Center on Race, Poverty & the Environment** – This organization provides communities with legal and organizing assistance on environmental justice issues.
- **Clean Water Action / Clean Water Fund** – These non-profits provide advocacy and technical assistance to help secure safe and affordable drinking water.
- **Environmental Justice Coalition for Water (EJCW)** – EJCW provides communities throughout the state with a network of support and expertise on environmental justice issues.
- **Self-Help Enterprises (SHE)** – SHE helps secure funding and technical assistance for communities developing water and wastewater systems in the San Joaquin Valley.

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**Organized Community Advocacy for Safe Drinking Water**

Seville is a small, low-income community of about 70-80 homes located northeast of Visalia in Tulare County. The town includes one elementary school and a small store. Residents have struggled with old and leaky pipes, high levels of nitrate contamination, water shortages, and clogged faucets and showers due to excess sand and rocks. The water system has been abandoned for years by a small private water company, which meant that there was no entity to conduct more extensive water quality testing or apply for funds to replace the old dilapidated system with a system that delivers safe drinking water.

With the system’s ownership in question, the Seville water system needed to be temporarily taken over (or placed “in receivership”). Given that no one in the community wanted to see another outsider abandon their system, Seville residents organized and formed El Comite para el Bienestar de Seville, (Committee for a Better Seville), whose mission is to work for better community services in Seville. El Comite elected three spokespeople, who have worked closely with the Community Water Center (CWC) and Self Help Enterprises (SHE) to advocate for community water needs. After much hard work and...
STRATEGY 4 – PROVIDE OPPORTUNITIES FOR HEALTHY FOOD IN NEIGHBORHOODS.

Below are some strategies for increasing access to healthy food in neighborhoods. The Resource Guide for Outcome Four “Residents Live in Communities with Health-Promoting Land Use, Transportation, and Community Development,” discusses expanding access to retail establishments that provide healthy food options; restrictions on sales and marketing of unhealthy foods; incentives for stores to carry healthier foods; ways to expand community gardens and urban agriculture; and preservation of urban-edge farmland.

Strategy 4 key stakeholders will include a combination of the following:

- City Planning Department
- City Redevelopment Agency
- Department of Public Health
- Parks and Recreation Department
- Community-based organizations
- Local food policy council (if one exists)
- Local corner store owners
- Corner store associations
- School districts
- Business Improvement Districts
- Neighborhood associations
- Business technical assistance organizations
- Community food advocates
- Community health clinics
- WIC Local Vendor Liaison (LVL)
- WIC program participants
- Farmers
- Wholesale produce distributors
- Youth centers
- Farmers’ Market Association
- Community foundations
- University Cooperative Extension
- Master Gardener Program
- Farmers’ Market Association
- Community foundations
- University Cooperative Extension
- Master Gardener Program

Strategy 4A – Improve food choices in existing neighborhood stores.

Communities without supermarkets generally contain a base of smaller grocery stores, specialty stores, ethnic markets, convenience stores, or corner stores. These are often the only available nearby food resource for residents with limited or no access to cars, and these stores generally do not provide the same selection, quality, and prices as larger grocery stores. They often lack produce and other nutritious foods, offer low-quality goods and services, are poorly maintained, and charge high prices. Over the past decade, a growing number of advocates have begun partnering with corner store owners and local government in low-income urban and rural communities to improve the availability and marketing of healthy, affordable foods. Some specific policy interventions include:

almost six months of negotiations, El Comite successfully convinced the County of Tulare to temporarily take over the system. Residents and CWC were also able to include language in the official order that would establish a more just and affordable rate for the community. This is a huge victory for the community of Seville! It is the first and most important step for the community to have a chance to have safe drinking water.

Source: Community Water Center
• financing improvements to storefront façades to make them more enticing to shoppers and to display fresh foods
• working with developers and store owners on new store development and changing the layout of existing stores to accommodate and promote fresh foods
• requiring a minimum of square footage in stores to be dedicated to fresh foods
• restricting certain types of food such as alcohol and items containing trans fat
• marketing programs that reward stores for selling healthy foods and limit advertising of unhealthy foods

Resources
• Healthy Corner Stores: The State of the Movement – Public Health Law & Policy (PHLP), 2009
• Healthy Corner Store Network – (full of resources)
• Getting to Grocery, Tools for Attracting Healthy Food Retail to Underserved Neighborhoods – Public Health, Law, & Policy (PHLP)
• Healthy Food Retailing Toolkit: Improving Existing Small Stores – PolicyLink
• Healthy Food For All: Healthy Corner Store Strategies from Across the United States – Institute for Agriculture and Trade Policy, 2009
• Creating Healthy Corner Stores in the District of Columbia – D.C. Hunger Solutions, 2008
• Strategies that Work: Healthy Food Retailers in Hartford’s Neighborhoods – Hartford Food System, 2007
• Apache Healthy Stores: Results of the Main Trial and Future Directions – Apache Healthy Stores Program, 2006
• Snackin’ Fresh – The Food Trust, Social Marketing Campaign
• Market Makeovers – South Los Angeles, Healthy Eating, Active Communities (HEAC)

Sample Policies
• New York City Ban on Trans Fat – New York City Department of Health and Mental Hygiene. The Board of Health approved an amendment to the Health Code to phase out artificial trans fat in all New York City restaurants and other food service establishments.

Strategy 4B – Expand the number of WIC vendors.
In December 2007, the U.S. Department of Agriculture (USDA) changed the selection of foods available through the WIC program, known as the “food packages,” for the first time in 35 years. The new WIC food packages will include fresh fruits and vegetables, whole-grain cereals, and culturally appropriate foods. Along with corner store conversion initiatives, these changes hold potential to transform the retail food landscape in low-income communities across the state. Because all WIC vendors will be required by the new federal rules to stock their shelves with an array of products, anyone shopping at a WIC-authorized store will have access to these healthy foods. This is especially important in neighborhoods where fresh and healthy foods are currently hard to find.

Neighborhood stores may be motivated to become authorized WIC vendors to attract a new customer base of WIC participants, who would also shop for other foods and drive foot traffic to the store – and these retailers would be required to upgrade their offerings
in accordance with the new, healthier WIC food packages. These small neighborhood stores, however, may not have the infrastructure and knowledge to stock and sell affordable, quality fruits and vegetables. These vendors will need technical assistance to navigate the WIC vendor application process, improve their stock, and shift their business model.

**Resources**
- *Changes in the WIC Food Packages: A Toolkit for Partnering with Neighborhood Stores* – Public Health, Law, & Policy (PHLP)
- *Getting to Grocery, Tools for Attracting Healthy Food Retail to Underserved Neighborhoods* – Public Health, Law, & Policy (PHLP), 2009
- *New York State WIC Program: 2006 Vegetable and Fruit Demonstration Project* – New York State Department of Health Division of Nutrition
- *Healthy Cornerstores Initiative* – Institute for Agriculture and Trade Policy (IATP)
- *WIC Learning Center* – U.S. Department of Agriculture (USDA)

**Strategy 4C – Improve fresh and local food distribution.**

Food distribution models that efficiently connect local and regional farms to neighborhood retail stores, schools, and health care facilities can provide residents with healthy fruits and vegetables in neighborhoods with little access to fresh foods. Alternative food distribution models can take several different forms. Like the current models of distribution, no single alternative food distribution model will be broadly appropriate. To develop an alternative model to the existing food distribution infrastructure, the capabilities of producers, the desires of buyers, and geography must all be considered. The Center for Food & Justice (CFJ) has identified several models that represent opportunities for scaling up local, fresh foods. Examples of local food distribution models include:

- farm-to-school programs
- a farmers’ market hub that engages farmers’ market associations and farmers’ market managers in performing key organizing functions to distribute locally grown foods to small neighborhood stores and institutions through farmers’ markets
- a farmers’ collaborative that partners with a third-party organization marketing, distributing, or selling food to small neighborhood stores and institutions
- community-supported agriculture (CSA), an arrangement by which individual households purchase “shares” from local farms in exchange for weekly or biweekly boxes of fresh produce. CSA programs often accept food stamps and some programs reach out to low-income customers by subsidizing their shares.

**Resources**
- *Growers Collaborative* – Community Alliance with Family Farmers (CAFF)
- *Healthy Cornerstores Initiative* – Institute for Agriculture and Trade Policy (IATP)
- *Eastern Market, Detroit* (page 24) – PolicyLink
- *Outer Aisle Foods*
- *Grub Boxes* – People’s Grocery
- *Uprising Farm* – LocalHarvest’s Community Supported Agriculture (CSA) projects for low-income households
- *Red Tomato*
Fresh Food Distribution Models for the Greater Los Angeles Region – Center for Food & Justice (CFJ), a division of the Urban & Environmental Policy Institute at Occidental College

Sample Policies
- Woodbury County, Iowa, Local Food Purchase Policy
- City of Davis MOU for Parcel Tax to Fund Farm-to-School Lunch Program

Strategy 4D – Expand farmers’ markets and mobile produce stands.
Weekly outdoor farmers’ markets offer an inexpensive way to make high-quality fresh, local, often organic produce available in just about any neighborhood. Farmers’ markets do not need special buildings, and they do not have difficult site requirements; they can be organized in a parking lot or even on a street that is closed to auto traffic during market hours. Partnering with parks, schools, or other organizations is one way to find available space that would otherwise be underutilized during farmers’ market hours. Advocates can also engage their local planning department in a broad conversation about how a community could maximize the benefits of farmers’ markets. This can lead to adoption of zoning and General Plan language to support markets. For example, zoning provisions can require farmers’ markets to accept various forms of food assistance, such as an Electronic Benefit Transfer system (EBT) to redeem food stamps, WIC, and Senior Farmers Market Nutrition Programs. The community can also encourage local governments to take other actions, such as streamlining permitting processes, sponsoring markets, and partnering with other local agencies.

Introducing mobile produce carts into neighborhoods is another strategy that can bring fresh fruits and vegetables into communities where healthy food can be difficult to find. Cart permits can be issued for designated areas around schools, in neighborhoods with limited healthy food retail, and in parks.

Resources
- Establishing Land Use Protections for Farmers’ Markets – Public Health, Law, & Policy (PHLP), 2009
- Del Paso Heights Community Farmers’ Market Sacramento, California – Economic Development and Redevelopment: A Toolkit on Land Use and Health, Planning for Healthy Places in partnership with the California Department of Health Services through the California Nutrition Network for Healthy, Active Families (page 31)

Sample Policies
- Green Carts Program, New York – New York City Department of Health and Mental Hygiene. This local law established 1,000 permits for Green Carts.
Strategy 4E – Expand frontyard and backyard gardens.

Backyard gardens can be an excellent way to increase healthy and fresh foods in neighborhoods as well as a way to encourage daily physical activity. Backyard gardens are an especially valuable resource to low-income residents who can inexpensively grow produce to feed their families. A backyard garden program can be administered through a local community-based organization or a university cooperative extension that helps build the gardens, offers ongoing assistance, and provides necessary supplies and materials.

Backyard gardens can be surprisingly productive and can contribute to backyard garden markets or to regular farmers’ markets. Partnering with city parks and recreation departments, schools, or other organizations is one way to find available space that would otherwise be underutilized. A city and other agencies and organizations might partner to sponsor a series of workshops to help backyard gardeners understand the permitting process and grow produce for public consumption. Advocates should talk with city and county public health departments to waive or reduce permit fees for low-income residents.

Community gardens are equally an excellent way to increase residents’ access to fresh produce while providing an opportunity for physical activity. Please refer to Outcome Four, “Residents Live in Communities with Health-Promoting Land Use, Transportation, and Community Development,” for strategies on how to expand community gardens.

Resources

- City Slicker Farms Backyard Garden Program – Roots of Change
- Victory Gardens, San Francisco
- Winchester, Nevada Backyard Farmers’ Market – Clark County, Nevada Parks & Recreation

Sample Policies

- Sacramento Front Yard Landscape Ordinance – Sustainable Urban Gardens. Enables sustainable diverse landscapes, without restricting fruits and vegetables.
NEIGHBORHOODS AND SCHOOLS SUPPORT HEALTH

Strategy 5 – Provide Opportunities for Physical Activity in Neighborhoods through a Collaborative Process.

There are a number of strategies that can help build more opportunities for physical activity in neighborhoods, including adopting complete street policies, implementing a Safe Routes to School program, connecting roadways to complementary bicycle and pedestrian paths, adopting bicycle and pedestrian master plans, using joint use agreements to provide more access to existing facilities, maintaining existing parks and playgrounds, and requiring new residential development to incorporate outdoor spaces for physical activity. Some of these strategies are discussed in this Resource Guide, and most are discussed in the Resource Guide for Outcome Four, “Residents Live in Communities with Health-Promoting Land Use, Transportation, and Community Development.”

Community, Redevelopment, Public Health, and Economic Development Partner to Improve Access to Healthy Food

The Bayview community in southeast San Francisco has lacked a high-quality, full-service grocery store for decades. Residents’ only options have included the discount and substandard Foods Co. and an underutilized 7,000-square foot SuperSave grocery store in the heart of the neighborhood’s commercial district that functioned more like a liquor store than a grocery store with an internal/external appearance that was not desirable to shoppers. Multiple efforts have been attempted to improve the SuperSave to serve the needs of local residents and the store’s owner has also invested his own funds on improvements.

SuperSave was the first to join the Good Neighbor Program – a partnership between community-based organizations and the Mayor’s Office of Economic and Workforce Development (MOEWD), to increase the sale of fresh produce in the neighborhood. In exchange for the removal of liquor ads and cigarette advertisements, MOEWD provided new energy-efficient produce refrigerators to help the SuperSave improve its produce offerings. The owners invested in a façade improvement in early 2006 and began to work with MOEWD and the Redevelopment Agency to secure funds for a more extensive interior and exterior transformation. From the inception of the façade program in 2005, city and community representatives targeted the SuperSave as a priority for a facelift. Throughout this process, MOEWD, which had committed to the community to improve grocery options in Bayview, helped advocate for this project and make it an institutional priority.

In 2009, when the Redevelopment Agency learned that the opening of a Fresh and Easy grocery store in the neighborhood was delayed, they directed their attention to the SuperSave to help it better serve the neighborhood’s fresh food needs. A member of the Southeast Food Action coalition (SEFA) and also director of the wholesale produce market brought in a pro-bono merchandising consultant to help improve the store’s layout and appeal to shoppers. The owners installed a deli counter within the store that sells sandwiches, pizzas, and salads – foods that had been identified by the Third Street Corridor Project, SEFA, and Bayview PAC as priorities for the community. The Bayview Business Resource Center, a business technical assistance organization that receives funds from redevelopment, CDBG, and other local sources to support business development in the neighborhood, held a press event to publicize the new features and design of the store. SEFA recently submitted a funding application to the redevelopment agency requesting additional funds to implement more far-reaching improvements to the store.

Source: Public Health Law, & Policy
The following strategies describe ways of engaging in a collaborative process with city staff and other stakeholders to create opportunities for physical activity in neighborhoods. Though these strategies are listed in a suggested sequence, they are not mutually exclusive or strictly linear. Communities are unique, and it is important to evaluate strategies and design a process that makes sense within a local context.

**Strategy 5A — Informally disseminate information on the connections between health and built environments.**

Sharing information about the connection between land use and health is a great first step for building a relationship with planners and other built environment practitioners. Fact sheets, studies, and online resources will help planners connect health outcomes to their work. In particular, visual illustrations (such as maps that connect disease rates, demographic characteristics, and neighborhood features or conditions) can be an effective way to convey important concepts to residents, officials, and staff alike. This is a fairly low-cost and minimally time-consuming way to get the ball rolling. Among California communities that have been “early adopters” in inserting health language into their General Plans, proactive health advocates and practitioners took opportunities to share these resources with staff and elected officials. The research summaries in *Create and Implement Healthy General Plans* provide an introduction to the issues for planners, health officials, and residents who are not ready to dig into more detailed and nuanced literature.

**Resources**

- *Center for Civic Partnerships* — Provides technical assistance and consulting to cities and communities to help groups develop, implement, and sustain community improvements.

**Sample Policies**

- *A Resolution of the City Council of the City of Santa Clarita, California, In Support of a Healthy City Initiative*
Strategy 5B – Start a discussion and begin to form personal relationships.
In jurisdictions that have taken steps to plan healthy built environments, planners and health officials have first established personal and professional relationships. This can happen in formal or informal ways. For example, health departments can sponsor a series of lunch meetings to introduce planners to different topics related to health and the built environment, inviting outside experts or those working on these issues within their own communities. Health and planning departments can co-sponsor a public summit on the connection between the built environment and health, where staff, community members, and elected officials can learn about these links and establish common working goals. Relationship-building is an ongoing process; building trust between individuals and institutionalizing partnerships and participation will evolve over time and through continued commitment.

Another way to foster successful partnerships is to involve local elected officials in the process to champion and support increased participation and coordination. Without the political capital (i.e., leadership and direction from an elected official) to motivate health, planning, and other departments to work together, it may be extremely difficult to engage with reluctant partners.

Such political capital has clearly created opportunities for relationship building in California. In Contra Costa County, for instance, the board of supervisors unanimously agreed to direct the Community Development, Public Works, and Health Services departments to work together through an ad hoc committee on smart growth. In San Bernardino County, the board of supervisors convened and sponsored a summit on the built environment and health, sending out invitations to the event. Civic organizations are also important partners in this effort, especially for engaging community residents in a discussion about locally important health issues and the built environment factors that contribute to them.

Resources
Please refer to Strategy 5A.

Sample Policies
Please refer to Strategy 5A.

Strategy 5C – Organize a presentation or training.
Workshops or trainings that focus on the connection between the built environment and health can encourage interdisciplinary approaches to addressing locally relevant health issues. Several California counties and regions are using this strategy to build relationships and institutionalize professional partnerships. Such trainings have often proved to be an important catalyst for change, especially when they engage different departments of government, including health departments, planning departments, transportation engineers, and elected officials. While they require an upfront investment, these trainings and workshops can ultimately save a lot of time and money. They allow a county health department to reach key built environment stakeholders in multiple jurisdictions at once,
as opposed to connecting to each one at a time. They also offer a platform for dealing with the built environment components of health issues that transcend local boundaries, such as water quality, transportation issues, and air quality.

**Resources**
Please refer to Strategy 5A.

**Sample Policies**
Please refer to Strategy 5A.

**Strategy 5D — Form a healthy community coalition.**
Because public health overlaps with many aspects of community life, a number of jurisdictions have convened Healthy Community coalitions. In many cases, these coalitions have emerged from existing projects, including the Center for Civic Partnerships’ California Healthy Cities and Communities Network, The California Endowment’s Healthy Eating Active Communities (HEAC) initiative, Kaiser Permanente’s Healthy Eating Active Living initiative, the Network for a Healthy California, and Safe Routes to School coalitions. In addition to funded initiatives that have focused on health issues, planning processes themselves can prompt the formation of local coalitions. In San Francisco, the proposed rezoning of industrial areas into residential areas prompted the formation of the Eastern Neighborhoods Community Health Impact Assessment coalition, and in Riverside County the anticipation of several new city-scale developments spurred efforts to develop healthy design guidelines. These coalitions frequently involve a range of participants such as government employees, elected officials, representatives of local businesses and organizations, and community members, including low-income residents. By meeting regularly and developing an action plan, such coalitions have often been primarily responsible for initiating local change. Typically, they have focused on public education around healthy food choices, weight loss contests, community walks, and health fairs. But they have also pushed for Healthy City/County resolutions, health-oriented specific plans, and general plan language. Healthy Community coalitions also offer an opportunity for health departments to maximize scarce resources and work with multiple cities within a county, or with cities and counties at a regional level.

**Resources**
Please refer to Strategy 5A.

**Sample Policies**
Please refer to Strategy 5A.

**Strategy 5E — Propose a healthy city resolution.**
As one of the first steps in the process of addressing health in planning, some cities and counties have drafted and passed a Healthy City resolution. While such a resolution is not generally binding, it can be a good way to build political capital for other policies that support healthy built environments. This strategy can help cultivate the support of elected officials who can champion ongoing efforts. A Healthy City resolution typically states that the council desires a healthy and active community, shows that there is a relationship
between planning decisions and public health outcomes, and requests that the planning department work with the health department to improve community health through changes to the built environment. Some city councils have passed a resolution endorsing the Healthy City concept and formal participation in the California Healthy Cities and Communities (CHCC) program. Numerous California cities have been declared a California Healthy City through the CHCC, which is administered by the Public Health Institute under contract with the California Department of Public Health.

Resources
Please refer to Strategy 5A.

Sample Policies
Please refer to Strategy 5A.

Chula Vista Residents Advocate for a New Park

Inspired by John P. Kretzmann’s book, “Building Communities from the Inside Out,” Chula Vista residents embarked on asset-based community mapping of their neighborhood. Their efforts led to the development of the first park built in their community in the last 25 years. The southwest section of Chula Vista is a low-income, predominantly Latino neighborhood. Residents there lack access to parks and open space, and as a result, their quality of life is diminished. According to the 2004 California Physical Fitness Test conducted by the California Department of Education, 33.4% of children in this area are overweight.

Responding to these circumstances, the South Bay Partnership formed the Chula Vista Neighborhood Council Initiative (NCI), a grassroots group of community residents motivated to create changes in their community by addressing them in a culturally appropriate manner. NCI identified an empty lot as a potential park where members of the community could gather and children could participate in recreational activities. What followed was a process of prioritization, community advocacy, meetings with city officials and city staff, and a community dialogue where children and adults expressed their preference for a park design which included basketball courts, a skate ramp, and walking trails. Ultimately, Harborside Park opened in May 2006.

Today Harborside Park hosts a multitude of residents across the age spectrum engaged in various activities: children and adolescents take advantage of the only skate park in their community; fathers and sons spend countless hours after work playing basketball; and the Health and Human Services Agency promotes walking breaks and walking meetings for staff in the park - which is adjacent to their building. Most important, an ongoing relationship between the South Bay Partnership and the City of Chula Vista Parks and Recreation Department was developed and resulted in their active participation in the Healthy Eating, Active Communities (HEAC) program. Among HEAC’s most recent accomplishments is the incorporation of health language into the draft of the parks master plan, which will guide the development of parks in Chula Vista for decades to come.

Source: Healthy Eating, Active Communities Roadmap, 2008. Tanya Rovira-Osterwalder, M.S., South Bay Partnership.
B. The School Environment

A key way to improve the health of students and enhance learning is for school districts to organize around a coordinated school health (CSH) model that builds on eight components: physical education; health education; nutrition services; health services; healthy school environment; staff health promotion; counseling, psychological, and social services; and family and community involvement. Strategies 6 – 13 below address many of the CSH components.

**STRATEGY 6 – ADOPT THE COORDINATED SCHOOL HEALTH (CSH) MODEL TO IMPROVE THE OVERALL SCHOOL ENVIRONMENT.**

**Strategy 6 key stakeholders will include a combination of the following:**

- Students
- Parents
- Teachers
- Nurses
- Community members
- Community-based organizations
- School board members
- District and school administrators
- Food service directors
- Teacher union representatives
- Associated student body directors
- Public health department staff

*See additional stakeholders in Strategies 6-13.*

**Strategy 6A – Implement the CSH model to guide the process for improving the school environment.**

CSH cuts across and manages multiple strategies to help assure positive results. CSH unites efforts of local school and public health staff, students, parents, community partners, and state leadership.

**Resources**

- *Coordinated School Health* – California Department of Education
- *School Health Connections* – California Department of Public Health
- *Coordinated School Health* – Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health

**Strategy 6B – Create (or enhance), adopt, and implement a school wellness policy that supports a healthy school environment.**

A comprehensive and effective wellness policy should address the eight CSH components and additional health topics identified as school district or school site wellness priorities. The policy should specify individuals or subcommittees to oversee policy implementation and evaluation. The policy should also require that each health component receive representation by at least one individual placed on the school’s or district’s health or wellness council. A quality policy will encourage the development of community partnerships to help provide comprehensive services to students and staff. Finally, a complete policy will likely specify fundraising ideas consistent with health principles.
Resources
- California Project LEAN (CPL)
- Local Wellness Policies Tools & Resources – Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health

Strategy 6C – Establish and maintain a school health or wellness council and designate a school health coordinator.

A functioning school health or wellness council is vital to promoting CSH and a positive school environment. Stakeholders representing each component of the local school wellness policy should comprise the membership of the council. Besides school staff, council membership should include students, parents, and community partners. The council should meet at least bi-monthly and integrate CSH measures into standard school or district operations. Advocates should also ensure that wellness policy requirements are communicated regularly to a range of school stakeholders.

Resources
- Effective School Health Advisory Councils: Moving from Policy to Action – Public Schools of North Carolina
- School Health Advisory Councils – Texas Department of State Health Services

Coordinated School Health in the Los Angeles Unified School District

The Los Angeles Unified School District has over 63,000 students with asthma. The Centers for Disease Control and Prevention, through its Division of Adolescent and School Health, provided financial support for the school district’s nursing program, which worked to help students understand their asthma, use their medications, and avoid environmental triggers.

To achieve these objectives, the program provided a number of services: 1) Asthma education programs were offered to staff, parents, and students; 2) Students learned asthma self-management; 3) Nurses referred students to medical care and insurance; 4) Students with excessive absences received case management; and 5) Education was provided to improve indoor air quality. As a result, school absences, urgent care visits, and hospitalizations have significantly decreased.

Strategy 7 – Improve Indoor Air Quality in Schools.

Strategy 7A – Create and enforce protocols to prevent and address indoor air quality problems.

Many schools across the country and in California have been found to have poor indoor air quality and other conditions that contribute to poor indoor environmental quality, such as inadequate ventilation. For example, one study found significant problems in California’s classrooms, including poor ventilation, poorly regulated temperature and humidity, air pollutants, floor dust contaminants, and excessive moisture and mold.
Strategy 7 key stakeholders will include a combination of the following:

- Schools and school districts
- School staff (principals, teachers, nurses, front office staff, facility staff)
- Parents and students
- Parent Teacher Associations (PTAs)
- California Teachers Association
- California School Nurses Association
- California School Boards Association
- Community-based organizations
- Public health departments
- Medical providers
- Local government/elected leaders
- Lung health organizations
- Other NGOs
- Government agencies (e.g., Department of Education, Department of Public Health, and Environmental Protection Agency)

There are programs to help schools meet standards for ventilation and for the prevention and remediation of moisture intrusion, as well as the reduction of other environmental asthma triggers. The EPA’s IAQ Tools for Schools Program is a comprehensive resource to help schools maintain a healthy environment by identifying, correcting, and preventing IAQ problems. Successful examples show the need for partnerships between school administration and facilities.

Resources
- EPA’s IAQ Tools for Schools Case Studies
- EPA’s IAQ Tools for Schools

Sample Policies
- San Francisco Policy on IAQ Tools for Schools

Strategy 7B – Increase resources for school facility maintenance and repair.
To prevent indoor air quality problems and address problems that do arise, schools need sufficient funds for facility maintenance and repair. Much work can be done at the local and state levels to ensure sufficient resources are devoted to this, and a variety of state funding programs can help. One such program is provided by the Williams Settlement, which among other things provides additional facility funding for low-performing schools (where there are often more facility problems). For example, Regional Asthma Management & Prevention successfully advocated for a portion of funds under the Williams Settlement to be available for underperforming schools to make emergency repairs that will improve indoor air quality.

Resources
- Williams v. California Settlement Overview – Decent Schools for California and Williams v. California Settlement Overview – California Department of Education
- Emergency Repair Program (ERP) – State of California
- The Good Repair Standard and the Facility Inspection Tool – State of California
- Supplemental Facility Inspection Tool Guidebook – California’s Coalition for Adequate School Housing (CASH)
Sample Policies
- San Pedro Clean Air Action Plan – The Ports of Long Beach and Los Angeles

Strategy 7C – Require the use of building materials and furnishings that have zero VOC emissions.
Exposure to volatile organic compounds (VOCs) in classrooms and other indoor environments has been linked to exacerbation of asthma and other respiratory symptoms. Recent studies throughout California have found high concentrations of formaldehyde and other VOCs in the air in a sample of traditional and portable classrooms. Research suggests that using building and interior finishing materials with low VOC emissions can reduce the concentration of VOCs in classrooms. The Collaborative for High Performance Schools' guidelines highlight ways to build new schools or renovate existing ones with healthier building materials.

Resources
- Building Healthy, High Performance Schools: A Review of Selected State and Local Initiatives – Environmental Law Institute (ELI)
- Los Angeles Unified School District's Program – Environmental Law Institute (ELI)
- Collaborative for High Performance Schools (CHPS) Guidelines

Sample Policies
- Collaborative for High Performance Schools (CHPS) Sample Resolutions

Strategy 7D – Establish practices and policies for reducing the presence of environmental triggers in schools by restricting the use of unhealthy cleaning supplies.
Cleaning products used in schools contain a wide variety of hazardous chemicals that can cause asthma, cancer, reproductive harm, and damage to the body’s nervous system and internal organs. Few school districts have switched to less-toxic, environmentally preferable cleaning products (or “green” cleaners). Regional Asthma Management and Prevention (RAMP) is cosponsoring legislation that would significantly improve indoor air quality at schools – AB 821 (Brownley) will require schools to use certified environmentally preferable cleaning products.

Resources
- RAMP's Green Cleaning Case Study Report
- Cleaning for Healthy Schools Toolkit
- Health and Environmental Benefits of Green Cleaning

Sample Policies
- AB 821: Clean and Healthy Schools Act Fact Sheet
- Green Cleaning in Schools: Summary of Selected State and School District Policies – Environmental Law Institute (ELI)

Strategy 7E – Promote the use of integrated pest management to reduce children's exposure to potentially harmful pesticides at school.
Integrated Pest Management (IPM) is an environmentally sensitive approach to pest management that relies on a combination of common-sense approaches and reduces the use of harmful pesticides. Numerous schools and districts, including the Los Angeles
Unified School District (LAUSD), have adopted IPM policies and have been able to successfully manage pests while also reducing the health impacts on students that are commonly associated with the use of chemical pesticides.

**Resources**
- Kids at Risk: Pesticides and Children’s Health — Californians for Pesticide Reform (CPR)
- Safer Schools: Achieving A Healthy Learning Environment Through Integrated Pest Management — School Pesticide Reform Coalition (SPCR)

**Strategy 7F — Reduce exposure to harmful outdoor air quality at schools by providing options for indoor recreation on poor air quality days and by reducing idling near the school.**

In communities with high levels of outdoor air pollution, there are days that it is not safe for children to play outside. The Merced-Mari­posa County Asthma Coalition, among others, has worked with schools to institute an Outdoor Air Quality Flag Program that alerts staff, students, and parents when the air district declares a poor air quality day. On these days, arrangements are made to enable children to get physical activity indoors. The Solano Asthma Coalition and the Ditching Dirty Diesel Collaborative have both developed programs to reduce bus and car idling outside of schools, as idling vehicles can contribute to poor air quality for students.

**Resources**
- The Outdoor Air Quality Flag Program in Central California: A School-Based Educational Intervention to Potentially Help Reduce Children’s Exposure to Environmental Asthma Triggers.
- Additional Central Valley Flag Programs — Valley Air News
- Anti-Idling Educational Materials Developed by the Solano Asthma Coalition — Community Action to Fight Asthma (CAFA)

**Sample Policies**
- Outdoor Air Quality Flag Sample Policy — Community Action to Fight Asthma (CAFA)

**STRATEGY 8 — ESTABLISH COMPREHENSIVE, PREVENTION-ORIENTED SCHOOL HEALTH CLINICS AND LINKAGES TO HEALTH AND HUMAN SERVICE PROVIDERS.**

Some school districts run their own health centers. They employ the nurse practitioners, medical assistants, and clerical staff. Often, these centers work closely with the school nurse. Other school health centers are run by outside agencies such as community health centers, county health departments, hospitals, and other community-based organizations. There is usually one “lead” agency that works with the school and others that collaborate to increase the services offered.

Generally, the school district provides the space, pays for utilities and/or custodial services, and may provide some in-kind personnel. If the health center is run by an outside partner, such as a community clinic, the clinic will bill insurance or public programs for medical and/or mental health services. Some school health centers receive ongoing funding from county or federal programs. Usually, the district and its partners need to work together
to solicit grants from governmental and private funders to keep the health center open. The following set of strategies summarize the key components of establishing a comprehensive school health center. A more detailed discussion of these strategies is included in the Appendix.

**Strategy 8 key stakeholders will include a combination of the following:**

- School principal
- School board member/s, student support, and health staff
- Parents
- Students
- Teachers
- Medical services provider
- Mental health services provider
- Local elected officials
- District student support and health personnel
- Community medical services provider/s
- Community mental health services provider/s
- County public health and mental health departments
- Other community-based organizations delivering services on campus
- District facilities managers
- School site principal
- Health care professionals (health educators and clinicians)
- Physical education and after-school providers
- School nurses and counselors
- Local recreational activities providers
- Health center clients
- Youth leaders
- Student councils
- Youth coordinators
- Medical and dental services provider/s
- Billing staff
- School site staff, health insurance eligibility workers, community outreach workers, and other school health providers or case managers

**Strategy 8A — Getting Started: Engage community and youth in planning.**

All school health centers should provide services that respond to the needs of students, families, and the community. The first step in starting a school health center is to bring together interested parties to assess community needs and map existing resources. This planning stage helps identify concerns about the health center before they become a crisis and gives community members the opportunity to become clear about what they want, so they can deal with opposition if it arises later. The process taps the expertise both of individuals and local groups, draws in key community decision-makers, and should reflect the racial, ethnic, religious, class, and cultural composition of the community, while identifying community priorities. Community planning is not usually an expensive process, but it does require the dedicated time of one or more staff or consultants.

**Resources**

- *Riverbank High School — The Family Resource Center*
- *How to Start a School Health Center Toolkit — California School Health Centers Association (CSHC)*
Strategy 8B — Getting Started: Assemble partners and coordinate their services.

Most school health centers encompass services provided by multiple agencies. For example, medical services are often provided by a community clinic; mental health services may be delivered by a community mental health agency; and a school nurse may perform school-wide health screenings. A critical first step in developing a health center is to identify partner organizations and district staff that will contribute to the effort. Secondly, in order to effectively coordinate services, there must be strong collaboration between agencies, including the school itself. Partners need to determine how they will share information, share space, handle case management, and raise funds, among other issues. One effective strategy is to establish a Coordination of Services Team that brings partners together regularly to make sure the needs of individual students are being met.

Resources

• Health & Enrichment Center at John F. Kennedy High School in Richmond, California
• How to Start a School Health Center Toolkit – California School Health Centers Association (CSHC). See sample agreements on developing a formal memorandum of understanding (MOU) between school district and health services providers, outlining roles/responsibilities, services, hours of operation, and methods of information sharing.

Strategy 8C — Getting Started: Facilities planning.

School health centers can be located in a variety of spaces, ranging from converted classrooms to portables to buildings near the school. Some schools are not able to designate or construct a fixed site, and therefore have services delivered from a mobile van or through telehealth. The health center’s design should be based on the types of services it will provide and should adhere to relevant building codes. School health centers in California have primarily relied on state and local funding to support construction of facilities. These sources include school modernization or new construction grants, local bond measures with school construction project allocations, community development block grants, and facilities grants to community clinics and hospitals.

Resources

• How to Start a School Health Center Toolkit – California School Health Centers Association (CSHC). See sample school clinic floor plans and facilities details for how joint use agreements between cities and school districts can facilitate funding and space allocation for school health center facilities.

Strategy 8D — Program Development: Chronic disease prevention.

School-based interventions have been identified as one of the most efficient means of reducing four main chronic disease risks: tobacco use, unhealthy eating patterns, inadequate physical activity, and obesity. School health centers provide individual, group, and family counseling on preventing health risks, and offer lifestyle-changing programs such as adventure clubs, dance and cooking classes, and healthy snacks. School health centers are uniquely positioned to prevent and manage chronic disease, because they can integrate medical care (such as asthma treatment or blood glucose monitoring) with accessible prevention programs.
Resources
- *Kids Come First (Ontario) and Other Case Studies of School-Based Nutrition and Physical Activity Programs* – California School Health Centers Association (CSHC).
- *California School Health Centers Association (CSHC)* – See web pages on chronic diseases and a school-based obesity prevention policy brief.

Strategy 8E – Program Development: Adolescent health care and youth development.
Adolescents are the most medically underserved population in the U.S. School health centers in middle and high schools not only bring developmentally appropriate health care and counseling directly to teens, but also engage youth as peer educators, outreach workers, advisors, and advocates. This reflects a *youth development* approach, valuing youth’s understanding of health issues, needed services, and how services should be delivered. Peers are often the most effective health promoters because they can model positive behaviors which establish and reinforce healthier norms within their peer group.

Resources
- *Manual Arts Health Center (Los Angeles)* – California School Health Centers Association (CSHC)
- *Adolescent Health Provider Toolkit and a Manual on Confidentiality and Minor Consent Laws In California* – Adolescent Health Working Group (AHWG)
- *Reproductive Health Education and Services at School Health Centers Policy Statement* – California School Health Centers Association’s (CSHC)
- *UCSF Analysis of Youth-Led Participatory Research Programs*

Strategy 8F – Resource Development: Third-party billing.
Multiple revenue streams exist to sustain school medical and mental health services. For medical services, third-party reimbursement sources include the Child Health and Disability Program (CHDP), Medi-Cal, Family PACT, and Healthy Families. Selecting a provider with billing systems in place can be easier than developing new systems. Community clinics designated as Federally Qualified Health Centers receive a higher Medi-Cal reimbursement rate, making it easier for them to sustain their services in a school health center. For mental health programs, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is the primary program for children who qualify for full-scope Medi-Cal. To get EPSDT to cover services in a school health center, the provider must have a contract with the county mental health department. The Mental Health Services Act may also be a source of funding for school-based mental health in some counties.

Resources
- *School Health Clinics of Santa Clara County* – California School Health Centers Association (CSHC)
- *California School Health Centers Association (CSHC)* – See how to integrate health insurance enrollment into operations of a health center, encourage selection of FQHC as primary care provider, and bill for services in CSHC’s *third-party billing manual*. 
STRATEGY 9 – PROVIDE OPPORTUNITIES FOR HEALTHY FOOD IN SCHOOLS.

Strategy 9A – Offer school breakfast.
More than 500 California “severe-need” schools with significant low-income student populations and another 700 California schools with low-income students do not offer breakfast. Eating breakfast is associated with academic achievement, decreased tardiness and absenteeism, improved concentration, and a healthy weight. To start a school breakfast program, school districts can apply to the California Department of Education (CDE) for a $15,000 start-up grant. Advocates can promote innovative strategies to encourage consumption of school breakfasts such as:

- breakfast in the classroom
- second-chance breakfast during a nutrition break or recess
- grab ‘n’ go breakfast (e.g., served as students arrive at school or during passing periods or morning recess)
- promoting school breakfast to make sure that students and their families know it is available for everyone

Resources
- Breakfast First: Healthy Foods for Hungry Minds – California Food Policy Advocates (CFPA)
- Feed More Kids for School Breakfast Success – California Department of Education (CDE)
- School Breakfast – California Department of Education (CDE)

Strategy 9B – Enroll all low-income children in the National School Lunch Program.
While improvements are needed to strengthen the nutritional quality of many school meal programs, students who eat school lunch consume more key nutrients than students who bring their lunches from home or buy a la carte items. However, studies show that school lunch participants have higher fat and sodium intake than nonparticipants. To provide meal benefits to more students, schools can replace paper applications used to determine income eligibility for subsidized school meals and instead use the automated state matching system to directly certify and verify students as eligible for free or reduced-price school meals if they are from families that receive food stamps or services from CalWORKS and other programs. Advocates should find out what system their district is using to determine eligibility for the school meal program and work with key stakeholders to enroll more students.
Resources

• Recess from the Recession: How School Meals Can Do More to Help Struggling Families – California Food Policy Advocates (CFPA), 2008
• School Nutrition...BY DESIGN! – California Department of Education (CDE), 2006

Strategy 9C – Improve the quality of school meals by decreasing high-fat, high-sodium entrées and increasing the number of fresh fruits and raw vegetables served.

Less than one-third of public schools participating in the National School Lunch Program have offered lunches that meet standards for total fat or saturated fat. Foods such as pizza, breaded chicken nuggets, beef patties, and burritos accounted for 40% of the lunch entrées available. These menu items were among the top contributors of calories, fat, and sodium in the lunches. Since school food service finances depend entirely on satisfied customers, students should be involved with the selection of healthier entrée items to ensure continued demand for school breakfast and lunch. Students, parents, and other stakeholders should work with their food service directors to offer more whole grains, fresh produce, fewer processed foods, and more variety in school meals.

Among schools with a higher percentage of low-income students, fresh fruits and raw vegetables are served significantly less often as part of the National School Lunch Program. The U.S. Department of Agriculture’s (USDA) menu planning options provide schools with leeway in offering students a variety of choices (e.g., a district can decide to offer juice instead of a vegetable or fruit). All high schools and most middle and elementary schools utilize “Offer Versus Serve,” which lets students decline certain meal components, including vegetables. Key steps for districts may include:

• using Nutrient Standard Menu Planning, which includes more produce
• purchasing cost-effective, appealing products – ideally from local farmers who may be a good source for in-season items
• marketing fruits and vegetables offered through the meal program (e.g., offering free samples, ensuring the produce appeals to students).

Resources

• Feed More Kids for School Lunch Success: Product and Price – California Department of Education (CDE)
• Folsom Cordova Unified School District: Healthier School Meals – California Project LEAN, 2005 (expected to be available on Project LEAN website, spring 2010)
• California’s Farm to School Program – California Department of Education (CDE)
• Monterey Elementary School, San Bernardino Unified School District – California Project LEAN (expected to be available on Project LEAN website, spring 2010)
• Wake Up to More Fruits and Vegetables – California Department of Education (CDE) and the San Diego County Office of Education
Strategy 9D – Offer low-fat or nonfat milk.
Nationally, 31% of school lunch menus include whole milk and 58% include 2% (reduced fat) milk, which are major sources of saturated fat and extra calories. One cup of whole milk has as much saturated fat as five strips of bacon and 2% milk, which is not low-fat, has as much unhealthy fat as three strips of bacon. A child who drinks one cup of 1% (low-fat) milk instead of 2% milk each day will cut 47,000 calories and 11 pounds from his/her diet during 13 years in school.

In some cultures, whole milk is the milk of choice, so it may be helpful to conduct blind taste tests of the lower-fat milks with parents and students and to educate parents about the health benefits (e.g., low-fat and nonfat milk have just as much Vitamin D and calcium as whole milk). Alternatives such as soy, rice, or lactose-free, low-fat milks also should be made available for lactose-intolerant students and those who do not drink cow’s milk. The USDA has ruled that schools can offer milk with a variety of fat contents as well as lactose-free fluid milks.

Resources

Strategy 9E – Install automated point of sale systems, so students receiving free or reduced-price school meals are not stigmatized.
Some schools still make students who qualify for free or reduced-price meals turn in a slip of paper, while paying students use cash at the point of sale. These methods stigmatize low-income students. Automated payment systems that do not overtly identify which students receive subsidized meals are available. While there is a cost to purchase this type of equipment, school districts that have switched to these systems note that they help track meal participation and inventory.

Resources
• Feed More Kids for School Lunch Success: Product and Price – California Department of Education (CDE)
• Los Angeles Unified School District – California Project LEAN (expected to be available on Project LEAN website, spring 2010)
• School Nutrition...BY DESIGN! – California Department of Education, 2006

Strategy 9F – Market the school meal program and eliminate the marketing of unhealthy foods and beverages on school campuses.
Marketing strategies are essential to the success of a school meal program and can help increase the number of meals sold. Conducting market research, such as surveying students about foods they would like, can help ensure buy-in and support for the program. Making the cafeteria or eating area appealing is also an important marketing strategy. Some school districts have used attractive painting or signage, and/or designed the area as a food court.
It is also important to communicate with parents about the school meal program; some schools promote their food service program during back-to-school nights.

A growing number of health advocates are calling for restrictions on the advertising of unhealthy foods and beverages to children and youth, including in schools, where students are a captive audience. Schools have become a prime location for marketers to gain the undivided attention of children. Marketing in schools can include advertisements on school television, in sponsored curricula, and on school equipment and facilities, including vending machines in high-traffic areas. One way to combat this is to include language in the local school wellness policy that does one of the following:

- bans the use of public school property for all advertising
- bans the use of public school property for all food/beverage advertising
- bans the use of public school property for the advertising of any foods or beverages that are not permitted to be sold on campus

Resources

- Feed More Kids for School Lunch Success: Place and Promotion — California Department of Education (CDE)
- Where We Focus: Marketing to Children – National Policy and Legal Network (NPLAN)

Strategy 9G – Drastically reduce or totally eliminate the sale of competitive foods and beverages.

Most of the foods and beverages sold outside the school meal program (e.g., competitive, a la carte items) in school cafeterias, vending machines, school stores, and through school fundraisers are high in fat, calories, and added sugar, and contain little nutritional value. California’s nutrition standards do not ensure that only healthy foods and beverages are offered on public school campuses; rather, they have merely eliminated the worst of the worst. If a school district drastically reduced or totally eliminated the sale of competitive foods and beverages, not only could the food offerings on campus be healthier, there would also be less staff time required to implement the food and beverage standards. One good place to start is with beverages by eliminating sugar-sweetened sports drinks from middle and high schools. Since this strategy is likely to be controversial, it would require the support of all school stakeholders.

Resources

- To Sell or Not to Sell Competitive Foods and Beverages Case Studies – California Project LEAN (expected to be available on Project LEAN website, spring 2010)
Strategy 9H – Ensure that competitive foods and beverages are compliant with or exceed California nutrition standards.
California high schools have an easier time meeting beverage standards than standards for snacks and entrées sold outside the school meal program. Advocates can encourage the district and school to identify key staff to periodically monitor the foods and beverages sold a la carte in student stores, vending machines, and the school cafeteria to ensure they meet California school food and beverage standards. To determine whether an a la carte food item meets the standards, or to learn more about California standards, visit www.CaliforniaProjectLEAN.org

Advocates can work with their district and schools to encourage the school food service director to oversee all vending on campus. Food service staff is familiar with food and beverage regulations and typically able to assess whether foods and beverages sold outside the school meal program meet California standards. Placing the sale of these products under their direction can improve compliance with the standards and save valuable time for staff that are currently charged with stocking the school store or vending machines. Many school district food service directors have taken over this role and, in turn, share profits with school groups that have traditionally sold food and beverages to earn money.

Resources
- Competitive Foods and Beverages – California Department of Education (CDE)

Strategy 9I – Provide free access to water in eating areas and wherever students are physically active.
Water consumption rather than sugar-sweetened beverages (e.g., soda and sports drinks) and juice can help combat obesity and positively impact academic performance. Research has shown that children who are dehydrated have poor concentration, memory, alertness, and language skills. One way to address this is to provide free water to students during meal times and ensure the availability of water throughout the campus. Challenges to this include drinking fountains that do not work or are in poor repair. Some districts have implemented water stations that allow students to easily fill a reusable water bottle.

Resources
- Improving Water Consumption in Schools: Challenges, Promising Practices, and Next Steps – California Food Policy Advocates (CFPA)

Strategy 9J – Ban school fundraisers that involve the sale of unhealthy foods and beverages.
School groups may be hesitant to support this effort if they make money from the sale of foods and beverages. Advocates must understand the financial needs of these groups and help identify alternative fundraisers. Addressing this issue in the district’s local school wellness policy would be a good first step.
Resources
- Creative School Fund-Raising Ideas – California Project LEAN (expected to be available on Project LEAN website, spring 2010)
- Sweet Deals: School Fundraising Can Be Healthy and Profitable – Center for Science in the Public’s Interest (CSPI), 2007

STRA TEGY 10 – PROVIDE OPPORTUNITIES FOR PHYSICAL ACTIVITY IN SCHOOLS.
In addition to the strategies listed below, the Resource Guide for Outcome Four discusses Safe Routes to School and joint use strategies, which promote physical activity opportunities before, during, and after school. For additional information on after-school programs, please see the Resource Guides for Outcome Five, “Children and Their Families Are Safe from Violence in Their Homes and Neighborhoods,” and Outcome Six, “Communities Support Healthy Youth Development.”

To supplement the strategies listed below, there are several funding streams and fundraising ideas that may support your physical activity work, including:

- Apply for local, state, or federal grants (e.g., the Carol M. White Physical Education Program grant).
- Partner with state and local health jurisdictions receiving stimulus funds.
- Partner with local colleges or health departments to provide professional development opportunities such as in-service days devoted to training teachers on how to incorporate physical activity into the classroom.
- Visit the SPARK Grant-finder at http://www.sparkpe.org/grants/grantfunding-resources/
- Conduct physically active fundraisers (e.g., walk-a-thons, jog-a-thons, dance-a-thons, sports tournaments, and 5Ks).
- Solicit local businesses/corporate sponsors.
- Partner with professional sports teams.
- Apply to community foundations and/or hospitals.

Strategy 10 key stakeholders will include a combination of the following:
- Students
- Parents
- Teachers
- Nurses
- Community members
- Community-based organizations
- District and school administrators
- School board members
- Food service directors
- Teacher union representatives
- Associated student body directors
- Public health department staff

Strategy 10A – Ensure California’s PE-mandated minutes are met or exceeded.
California requires that public school elementary students receive 200 minutes of PE every 10 days and public school middle and high school students receive 400 minutes every 10 school days. These requirements are currently not being met in elementary
Schools. One of the barriers to meeting the mandated PE minutes is that PE is taught by classroom teachers who are not trained in PE. They face pressure to focus on academic subjects such as reading and math and often do not take students out for PE.

To address this problem, advocates should determine whether the school/district is meeting the PE minutes requirement (the state Department of Education conducts compliance reviews of PE programs every four years). Advocates can then meet with district staff to discuss how the district is addressing any deficiencies, determine if more needs to be done, and work with key stakeholders to propose solutions.

**Resources**
- *Active Living Research: Building the Evidence to Prevent Childhood Obesity and Support Active Communities* – Robert Wood Johnson Foundation, 2007

**Strategy 10B – Ensure that PE classes are the same size as classes on other subjects.**
California has the largest PE class sizes in the country. Other subjects have smaller class sizes even though a PE class may be harder to manage than other subjects. Research shows that bigger class sizes result in poorer quality PE and lower physical activity levels. Research also shows that class sizes are higher in low-resource schools. The National Association for Sport and Physical Education recommends a 25-to-1 student-teacher ratio for PE class size, with a maximum of 40 students to 1 teacher. Advocates can educate principals, teachers, other administrators, and school board members on this issue to enhance the value placed on PE and solicit support for reduced PE class size. Advocates should also talk with teachers and their union representatives about this as class sizes are a contractual issue as well.

**Resources**
- *United Teachers Los Angeles (UTLA) PE Campaign*

**Strategy 10C – Require that at least 50% of physical education (PE) class time be spent in moderate-to-vigorous physical activity (MVPA).**
Research shows that only four to six out of 30 minutes are spent in MVPA in PE classes in low-resource California public schools. Research also shows that students in elementary schools are less active. More MVPA during PE can help prevent obesity; students who are more physically active also tend to perform better academically. Studies have shown that 50% MVPA can be realized in PE classes with qualified PE teachers. Increasing MVPA may require more PE teachers, better qualified teachers, and smaller class sizes. Advocates should work with their schools to include language in the school’s wellness policy that addresses MVPA. A first step may be to host a community forum on the importance of PE and MVPA and the link between physical fitness and academic achievement.
Resources

• *Policy Recommendations: Summary of Priorities and Action Steps for Improving PE in California Schools* (draft) – The California Endowment (TCE), 2009
• *School-Based Physical Education: Working with Schools to Increase Physical Activity Among Children and Adolescents in Physical Education Classes* – Partnership for Prevention

Strategy 10D – Ensure that PE is taught by certified and highly qualified PE teachers and offers ongoing PE teacher training/staff development.

Elementary school teachers are not required to take a PE class to receive their teaching credential, yet they are often expected to teach PE. Research shows that certified PE teachers provide better (i.e., more active) PE than classroom teachers. Research also shows that professional development and ongoing support improve elementary school PE classes and that these improvements are maintained for years. Middle and high school PE teachers, though trained in PE, need continuing education to ensure their class activities meet current standards. Advocates should work with their school districts to make continuing education in PE a requirement for all teachers who teach PE. Districts should provide funding and support for training in activity- and standards-based PE programs.

In 2006, California made $40 million available annually to hire PE specialists for grades K-8. However, this funding only pays for one-half of the cost of a full-time PE teacher in each school. Furthermore, schools that received funding were selected by a lottery, which left out many schools that lack access to PE specialists. As a long-term strategy, advocates should begin discussing incremental change with their district and advocate for hiring PE specialists at schools with the greatest need.

Resources


Strategy 10E – Integrate physical activity into the regular school day.

Research involving elementary school students shows that regular physical activity breaks during the school day may enhance academic performance and improve classroom behavior. Schools can implement 10-minute physical activity breaks in the classroom and incorporate physical activity into the curriculum. Several programs have been designed to do this, including TAKE 10! and Energizers. It is also important to ensure that all elementary school students have at least 20 minutes of supervised outdoor recess as well as access to adequate space and equipment. Schools should discourage extended periods of inactivity (e.g., periods of two or more hours). Advocates should encourage schools to provide clubs and intramural and interscholastic sports programs that address the needs and interests of all students. Coaches and other leaders of such programs should be well qualified and, where appropriate, certified.
**Resources**

- *Energizers: Classroom-Based Physical Activities* – East Carolina University Activity Promotion Laboratory and Prevention Institute, 2006
- *Playworks* (formerly *Sports4Kids*)

**STRATEGY 11 – CREATE JOINT USE AGREEMENTS BETWEEN LOCAL GOVERNMENT AND SCHOOLS TO EXPAND COMMUNITY USE OF SCHOOL FACILITIES.**

School facilities and grounds are integral components of public infrastructure that provide students with space to learn, socialize, and exercise. However, many school grounds and facilities sit empty during evenings and on weekends. As concerns grow over childhood obesity, lack of recreation/open space, suburban sprawl, and the need to efficiently use limited public resources, joint use of school facilities is seen as one strategic approach to these issues. While it is not simple to develop the partnerships and agreements necessary for additional programs and services on school grounds (and in some cases for constructing new facilities to house them), school districts and local jurisdictions throughout California are working together to accommodate community needs.

A joint use agreement is a document codifying a partnership between a school district and one or more public or private (non-profit) entities for the purpose of allowing public access to school property. The agreement details the respective parties’ responsibilities for maintaining school grounds or facilities. Implicit in the agreement is that public resources will be pooled to expand community access and use public space more efficiently. In recent years, increasing access to recreational facilities that already exist at schools has emerged as one of the most promising strategies for building more opportunities for activity into neighborhoods. This promise is rooted in the realization that even the most poorly designed and underserved neighborhoods include schools.

For more information on joint use agreements, please see the Resource Guide for **Outcome Four**, “Residents Live in Communities with Health-Promoting Land Use, Transportation, and Community Development.”

**STRATEGY 12 – CREATE HEALTH AND SAFETY BUFFER ZONES AROUND SCHOOLS. ENGAGE LOCAL GOVERNMENTS TO ENSURE THAT LOCAL PARKS AND PLAYGROUNDS ARE SAFE, WELL LIGHTED, AND MAINTAINED.**

**Strategy 1D** of this Resource Guide discusses ways to promote siting of major sources of outdoor air pollution away from locations where people live, learn, work, and play. In addition, see the Resource Guide for **Outcome Four** for strategies on creating health and safety buffer zones through zoning restrictions to limit fast food outlets, and for strategies that enable children to safely bike and walk to school.

**Strategy 12A – Crime Prevention Through Environmental Design (CPTED) in schools and neighborhoods**

Crime Prevention Through Environmental Design (CPTED) is popular among both urban designers and crime prevention experts. CPTED relies on the use of lighting and other
physical features, public spaces, and ways of influencing human interaction to diminish appeal to potential offenders. Advocating for city financing to implement design strategies such as CPTED in neighborhoods abutting schools can help improve public safety and encourage students to use neighboring parks, open spaces, and public spaces more often.

Schools are expected to be welcoming and inviting places that foster the perception of belonging and safety. The use of CPTED on school grounds – along with student involvement in crime reduction programs, conflict resolution skills training, and collaborative problem-solving – can reduce the need for a “fortress mentality” approach to school safety in which tall fences, bright lights, and security systems overwhelm the character of the school environment. The following are some environmental design features that CPTED could address for safer schools: landscaping; pedestrian routes; lighting; vehicular routes and parking areas; recreational areas; signage; enclosing storm water retention areas; building design and orientation to ancillary buildings; points of entry into buildings; and placement and structure of walls and windows.

**Resources**

- *Report from the National Summit on School Design, A Resource for Educators and Designers – American Architectural Foundation and KnowledgeWorks Foundation*
- *Safe Schools Design Guidelines – The Florida Center for Community Design & Research*
- *International CPTED Association*

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**Strategy 12**

**Strategy 12B – Financing mechanisms and partnerships for safe parks and playgrounds.**

All California cities are required to have a General Plan that lays out the future of a city’s development through a set of policies. All General Plans are required to include an Open Space element. This element should outline not only goals and policies for the long-term conservation of parks and open space, but also implementation strategies for the development of new parks and the maintenance and operation of existing parks. Community advocates should ensure that they take part in the public participation process during updates to the Open Space element. Additionally, advocates can help cities consider innovative sources of funding as well as partnerships with community organizations to maintain safe and useable
parks and playgrounds. Typically, funding for maintenance and operations of parks and recreation facilities and programs are provided by user fees for recreation programs and facility use and a city’s general fund. However, the following list contains a number of financing mechanisms that can supplement traditional funding sources.

- Sponsorship (Naming Rights)
- Corporate Sponsorship of Events
- Adopt-a-Park Program
- Volunteer Labor
- Public/Private Partnerships (Concessions)
- Benefit Assessment District
- Mello Roos District
- Transient Occupancy Tax
- Real Estate Transfer Tax
- Admissions Tax
- User Group Contributions
- Joint Use with School
- District/Public Agency
- Sale/Lease of Surplus Lands

In addition to sources of financing, advocates should look for organizations in the community that can partner with a city’s parks and recreation department to help maintain parks and playgrounds. In some cases, a parks and recreation department may seek a joint use agreement with a community non-profit organization or school that agrees to maintain the facility. In other cases, a parks and recreation department might simply partner with a local organization that organizes volunteers and “park stewards” to maintain parks and serve as a liaison to the city about maintenance-related issues.

**Resources**
- *Santa Clarita Parks, Recreation, and Open Space Master Plan: Funding and Implementation*
- *Local Park Financing Techniques – The Trust for Public Land*
- *Oakland Parks Coalition*

**Sample Policies**
- *Examples of Local Park Funding – The Trust for Public Land*

**STRATEGY 13 – ENSURE THAT LOCAL YOUTH CENTERS AND FAMILY RESOURCE CENTERS ARE ACCESSIBLE TO ALL YOUTH AND FAMILIES.**

For strategies that address access to community recreational facilities, please refer to information on joint use agreements as described above in **Strategy 11** of this Resource Guide and in the Resource Guide for **Outcome Four**. See the Resource Guide for **Outcome Six** for other strategies to support youth development.

Many schools in low-income neighborhoods are in need of a safe and positive space for students to ask questions and get answers about issues that are important to them, develop healthy decision-making skills, and access confidential low- or no-cost clinical services. Advocates should work with their school district, the school health council if one exists, and other key stakeholders to create an accessible youth health center. The center should be designed to mitigate or eliminate barriers, such as stigma, that might deter students from the health care and health education they need.
City governments can be a strong partner in ensuring the accessibility of youth and family health resource centers because they are responsible for a wide spectrum of issues that touch their citizens—from park maintenance and development to health and human services. However, individual city departments often work in silos and are out of touch with policies and programs that do not explicitly relate to their daily jobs, especially those that relate to youth.

The one policy document that binds most of these issues together is a city’s General Plan. While all California cities are legally required to maintain a General Plan with seven requisite elements, an element relating to youth and families is not required. Community advocates should encourage cities to include such an element in their General Plans. That way, the importance of accessible youth and family centers, schools, and other services would be taken into consideration when cities plan for land uses, transportation, housing, safety, noise, open space, conservation, and other elements. Cities and advocates might also consider developing a master plan in place of a General Plan element, since cities generally wait to make large revisions to the General Plan once every ten years.

**Resources**

- John Marshall High School Health Center (REAL Youth Center) — Los Angeles

**Sample Policies**

- City of Davis General Plan: Youth and Education Element
- Vacaville Youth Master Plan

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**Strategy 13 key stakeholders will include a combination of the following:**

- Students
- Parents
- Teachers
- District and school administrators
- School board members
- Associated student body directors
- Public health advocates
- Public Health Department
- Licensed clinicians
- Community members

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**The REAL Youth Center**

The REAL Youth Center in Los Angeles is an example of a health center where students can discreetly access a variety of services without the stigma of going to a health clinic. Located on the school campus, the center is accessible to those who may otherwise not receive care because of lack of transportation or time. The clinic is designed to address challenges that youth face in many California communities, including language barriers, cultural barriers, generational gaps, and acculturation stress. In addition to the health clinic, the center provides various services and activities for youth, including an after-school program; health education services for local middle schools, high schools, and community centers; and peer leadership and volunteer opportunities.
IV. Measures of Progress
To know whether we are succeeding in building healthy communities, the following indicators of success can be used to measure and demonstrate progress toward healthier neighborhoods and school environments.

The Neighborhood Environment

Air Quality
- Outdoor air quality in neighborhoods is improved and does not contribute to poor health.
- The air that people breathe in their neighborhoods is healthy.
- Residents are not exposed to air pollution from sources such as diesel-powered engines, industrial sources, wood burning, agricultural activities, and power plants.
- Policies ensuring healthy air quality are created and enforced and residents are empowered to advocate for their rights, when necessary.
- Indoor air quality in homes is healthy and does not contribute to poor health.
- The air that families breathe in their homes is healthy.
- There is an absence of environmental asthma triggers, as a result of both healthy behaviors by residents and proactive maintenance and repair by home and building owners.
- Policies ensuring healthy air quality in homes are created and enforced and tenants are empowered to advocate for their rights when necessary.
- Low-income communities and communities of color are not disproportionately exposed to poor air quality in homes, schools, and neighborhoods.
- Low-income communities and communities of color will no longer be disproportionately exposed to air pollution.
- Systematic practices and policies that further environmental injustices will cease to exist and the impact on communities will be considered in the creation of future practices and policies. Residents will be empowered to advocate for their rights, when necessary.

Water Quality
- The community is organized around water quality issues and residents have spoken with each other about water quality concerns and issues.
- The community has organized a group to advocate for better water quality.
- Advocates have established a relationship with their local water provider.
- Advocates have attended regional water board meetings.
- Advocates have urged the water board to seek out funds that will improve the water system.
- An advocate representative is running for a seat or is already on the regional water board.
- Advocates have tested the water quality of private wells.
- Advocates have contacted and discussed the community's water concerns with local City Council members, Assembly members, or County Supervisors.
- Advocates have met with the local Department of Public Health or County Environmental Health to address water quality concerns.
- Advocates have effectively used the media to raise awareness about the community's water concerns.
- Advocates have formed a relationship with at least one other advocacy or technical assistance group.
Advocates have formed a relationship with another community that is facing a similar water issue. Advocates have secured a safe, clean, and affordable water source for their community. Families have regular access to language-appropriate information about quality of drinking water in neighborhoods and homes.

**Physical Activity**
- Children and families have safe options to bike or walk to school, parks, and neighborhood shopping corridors.
- Local parks and playgrounds are safe and offer activities for children, youth, and families.
- School facilities are open evenings and weekends and during summer, and are used for community purposes.

**Healthy Food Access**
- Small neighborhood grocery stores carry a wide variety of fresh fruits and vegetables and other healthy and culturally appropriate food items that are fairly priced, and displayed and advertised in a manner that attracts neighborhood customers.
- Local grocery store owners are improving storefront façades to make them more enticing to shoppers and to display fresh foods.
- Local government staff is working with developers and store owners around new store development and the layout of existing stores to accommodate and promote fresh foods.
- Local policies require a minimum square footage of grocery and convenience stores to be dedicated to fresh foods.
- Policies restrict certain types of food such as alcohol and items containing trans fat in local grocery stores.
- Local government offers marketing programs that reward stores for selling healthy foods and limit advertising of unhealthy foods.
- Land use policies encourage farmers' markets and produce stands in residential neighborhoods and near community gathering places.
- Neighborhood stores increasingly become WIC vendors; upgrade their offerings in accordance with the new, healthier WIC food packages; and improve the infrastructure of their stores to stock and sell affordable, quality fruits and vegetables.
- Fresh fruits and vegetables from nearby sustainable farms are ubiquitous in school meals and in neighborhood grocery stores.
- Neighborhood residents are increasingly growing their own food in backyards and in community gardens.

**The School Environment**

**Coordinated School Health**
- School districts and school sites have adopted a coordinated school health model.
- School districts and school sites have adopted a local school wellness policy that is being implemented.
- School districts and school sites have established a school health or wellness council that meets a minimum of every other month and have designated a school health coordinator.
Air Quality
- Indoor air quality in schools and child care settings is healthy and does not contribute to poor health.
- The air that children, teachers, and staff breathe in schools and childcare settings is healthy.
- There is an absence of environmental asthma triggers, as a result of both healthy practices by staff and proper, proactive maintenance and repair.
- Policies ensuring healthy air quality in schools and child care settings are created and enforced.
- Parents and staff are empowered to advocate for their rights, when necessary.

Health Care
- Local youth centers and family resource centers are used by community residents to access family-strengthening supports and are linked to health and human services.
- Schools are actively partnering with local public and private agencies, public health advocates, students, and parents to solve health challenges facing children and youth.
- All schools offer preventive physical and behavioral health care services.
- Community members, youth, families, and other key stakeholders have been convened to participate in planning efforts.
- A needs and resources assessment has been completed that uses data and input from stakeholders.
- A vision or plan has been created for a health center, including the types of services needed, clients to be served, and the location of the site.
- Partner agencies for medical, mental health, oral health, and other services have been identified as appropriate for the health center plan.
- There is a plan for building, purchasing, or renovating facilities needed to provide the services included in the health center plan.
- A mechanism for coordination of services between different agencies is in place.
- There is a draft budget and staffing plan for the health center.
- There is an evaluation plan with target health and school outcomes.

Healthy Food Access
- Schools offer school breakfast.
- More low-income children are enrolled in the National School Lunch Program.
- Fewer high-fat, high-sodium entrées are offered through the school lunch and breakfast programs.
- More fresh fruits and raw vegetables are offered through the school lunch and breakfast programs.
- The number of competitive foods and beverages sold at school sites is drastically reduced or totally eliminated.
- Schools are 100%-compliant with California food and beverage standards for products sold outside the school meal program.
- Students have access to free water in eating areas and wherever students are physically active.
- School fundraisers that involve the sale of unhealthy foods and beverages are banned.
Physical Activity and Education

• Schools are 100%-compliant with physical education requirements, including mandated minutes.
• PE classes are the same size as classes on other subjects.
• At least 50% of PE class time is spent in moderate-to-vigorous physical activity.
• PE is taught by certified and highly qualified PE teachers that receive ongoing training/staff development.
• Physical activity is integrated into the regular school day.

V. Additional Resources

A. The Neighborhood Environment

Center on Race, Poverty & the Environment – Provides legal and technical assistance to grassroots groups in low-income communities and communities of color fighting environmental hazards.

Community Water Center (CWC) – Seeks to ensure that all communities have access to safe, clean, and affordable water by creating community-driven water solutions through organizing, education, and advocacy in California’s San Joaquin Valley.

Healthy Corner Stores Network – Supports efforts to increase the availability and sales of healthy, affordable foods through small-scale stores in underserved communities by bringing together community members, local government staff, non-profits, funders, and others across the country to share best practices and lessons learned, and to develop effective approaches to common challenges.

National Policy & Legal Analysis Network to Prevent Childhood Obesity (NPLAN) – Provides leaders and advocates in the childhood obesity prevention field with focused legal research, model policies, fact sheets, toolkits, training, and technical assistance to explain legal issues related to public health.

Public Health, Law, and Policy (PHLP) – Works to engage advocates in the land use and economic development decision-making process throughout California. With their hands-on training and consultation, coupled with entry-level training materials, PHLP walks users through the planning process and teaches them – in very practical and real-politic ways – to engage in the process.

Regional Asthma Management and Prevention (RAMP) – Works to expand knowledge about asthma and its triggers, and to increase access to resources, build partnerships, provide technical assistance, and advocate for policy change at the state and local levels. RAMP also coordinates Community Action to Fight Asthma (CAFA), a statewide network of asthma coalitions working to shape local, regional, and state policies to reduce the environmental triggers of asthma for school-aged children where they live, learn, and play.
B. The School Environment

**California Department of Education (CDE): Healthy Eating & Nutrition Education** – Provides information and training announcements about improving nutrition and establishing healthy eating habits in school, child care, adult, and after-school settings.

**California Project LEAN (CPL)** – Focuses on youth empowerment, policy, and environmental change strategies, and community-based solutions. CPL’s mission is to increase healthy eating and physical activity to reduce the prevalence of obesity and chronic diseases.

**California School Health Centers Association (CSHC)** – Promotes the health and academic success of children and youth by increasing access to the high-quality health care and support services provided by *school health centers*. CSHC pursues this by advocating for public policies that support school health centers; building support among policymakers, community leaders, parents and students; and providing technical support to new and existing school health centers.

**Public Health, Law, and Policy (PHLP)** – Works to educate advocates on how to work with local school districts and public health advocates to create joint use agreements in their neighborhoods. Through hands-on training, consultation, technical assistance, and multi-level training materials, PHLP walks users through the process of creating joint use agreements and teaches them – in very practical and real-politic ways – to engage in the process.
Appendix - Overview of School Health Centers

School health centers can contribute to making progress in many of the Building Healthy Communities Outcomes. This Appendix was created to provide more detail and links to additional materials to support those communities interested in starting a new school health center or in making existing centers a more integrated and vital part of the system to improve community health.

1. Why should we work to bring health and support services into our schools?

There is no disputing the importance of the school as a critical environment that impacts children’s health. For many children, healthy foods, physical activity, good indoor air quality, and other environmental improvements will be enough to ensure good health and development. However, for many children, particularly those from under-resourced communities, additional services and supports are needed to ensure that they are healthy and successful in school.

School health centers help improve the lives of California’s children because they place a breadth of essential services in exactly the right environment – our schools. The California School Health Centers Association and our national counterpart, the National Assembly on School-Based Health Care, are dedicated to promoting the growth and sustainability of school health centers, and offer a wealth of tools and information to help you get started.

2. What is a school health center?

School health centers are health clinics located on school campuses. Ideally, a school health center combines:

- Primary medical services (e.g., screenings, immunizations, physicals, sick care, and chronic disease management)
- Mental health services
- Reproductive health (e.g., abstinence counseling, pregnancy prevention, and STD/HIV testing and treatment, as appropriate)
- Oral health
- Health promotion and school-wide prevention activities
- Youth development and family engagement

In reality, few schools have all of these services. Some school health centers start with part-time medical services and grow from there. Other schools have opted for “wellness centers” that focus on mental health and health promotion and may eventually expand to include medical care. Still others open dental clinics. There is no one “right” model – the development of a school health center is based on school and community needs with the school board having the final say over what services are provided. Every community determines the right place to start in bringing health and support services to its schools.
3. What can we expect to achieve with a school health center?
Many of the outcomes associated with school health centers have been documented through research and summarized in fact sheets and presentations. Many school health centers help their communities with outcomes such as:

**Increased access to health care** – School health centers eliminate transportation barriers and offer services in a safe, familiar location at no or low cost. Clinicians can be deployed promptly to evaluate the severity of chronic and acute conditions and provide immediate intervention. Students who use school health centers decrease their use of emergency rooms, while increasing their use of primary care, reproductive health, counseling, and substance abuse services.

**Improved prevention and early detection** – Teachers and other school staff have regular contact with students and are well-positioned to identify risk factors in an individual student, as well as trends and changes across the school population. Many school staff have identified changes in students’ motor skills, affect, class attendance, and behavior that were discovered to be early signs of physical or mental health issues.

**Reduced impact of acute and chronic illness** – At school health centers, services are delivered by providers who have a broad understanding of the environment in which students are living. School-based clinicians have more frequent opportunities to educate students and parents about how to manage health conditions. School-based clinicians can easily call a child back for a brief follow-up to determine if an ear infection has cleared or to ask a diabetic teen to come back every day for a week to see if he or she understands how to count carbohydrates.

**Improved student attendance, learning, and retention** – School health centers can influence academic achievement by improving factors such as mental health, diet, injuries, physical illness, and self-esteem/resiliency. Research also shows a positive impact on graduation rates, absences, grade promotion, withdrawal/dropout rates, disciplinary problems, failing grades, and tardiness.

**More engaged families** – Often, school health centers strengthen the connection between school and the family. Some school health centers, particularly those located in elementary schools, offer services to the entire family. Others deliver parent/caregiver support, resources, and/or education programs. Both families and employers appreciate the fact that school health centers enable kids to get services without their caregivers having to take so much time off work.

**Healthier communities** – Schools often serve as the center of their communities. By providing families with support and educational programs such as health insurance enrollment or cooking classes, school health centers are fulfilling the promise of comprehensive school services building stronger communities.
4. How does it work?
Some school districts run their own health centers. They employ the nurse practitioners, medical assistants, and clerical staff. Often, these centers are closely coordinated with the school nurse. Other school health centers are run by outside agencies that form a partnership with the school. The most common are: community health centers, county health departments, hospitals, and other community-based organizations. There is usually one “lead” agency that works with the school and others that collaborate to increase the services offered.

Generally, the school district provides the space, covers utilities and/or custodial services, and may provide some in-kind personnel. If the health center is run by an outside partner, such as a community clinic, the clinic will bill insurance or public programs for the medical and/or mental health services. Some school health centers receive ongoing funding from county or federal programs. Generally, the district and its partners need to work together to write grants to governmental and private funders to keep the health center open.

5. Promising Strategies and Practices

5A. Getting Started: Engaging community and youth in planning
All school health centers should provide services that respond to the needs of students, families, and the community. The first step in starting a school health center is to bring together interested parties in a community to assess community needs and map existing resources. The planning stage helps identify community concerns about the health center before they become a crisis and enables community members to be clear about what they want so they can deal with opposition if it arises later. This approach draws on expertise from other individuals and groups and facilitates the involvement of key community decision-makers who can become “champions” of this mission. This process should reflect the diverse racial, ethnic, religious, class, and cultural composition of the community and acknowledge community priorities. There are not usually a lot of expenses associated with community planning, but it does require dedicated time of one or more staff or consultants.

- Case Study – The health center at Riverbank High School was spearheaded by both youth and parents who were involved from the very beginning. A social worker at the high school facilitated a group of students who were initially focused on developing peer programs. The idea of a campus/community health center grew out of student organizing and surveying of their peers and community. From that point, youth became the “face” of the initiative and spread the word about the center through their parents and throughout the larger community. The Family Resource Center was also instrumental in engaging parents to discuss health issues; parents were recognized as experts in the health of their children. As a result, parents acted as vocal advocates for the presence of a health center when it came to soliciting support from other key stakeholders in education.
- Key Stakeholders – School principal, school board member/s, student support and health staff, parents, students, medical services provider, mental health services provider, county public and behavioral health departments, other community-based organizations, and local elected officials.
- Policies and Systems – See a school health center toolkit for sample surveys and related guidance.
**5B. Getting Started: Assembling partners and coordinating their services**

Most school health centers encompass services provided by multiple agencies. For example, medical services are often provided by a community clinic; mental health services may be delivered by a community mental health agency; and a school nurse may perform school-wide health screenings. A critical first step in developing a health center is to identify partner organizations and district staff that will contribute to the effort. Secondly, in order to effectively coordinate services, there must be strong collaboration between agencies, including the school itself. Partners need to determine how they will share information, share space, handle case management, and raise funds, among other issues. One effective strategy is to establish a Coordination of Services Team that brings partners together regularly to make sure the needs of individual students are being met.

- **Case Study** – *Health & Enrichment Center at John F. Kennedy High School* (Richmond)
- **Key Stakeholders** – District student support and health personnel, community medical services provider/s, community mental health services provider/s, county public health and mental health departments, and other community-based organizations delivering services on campus.
- **Policies and Systems** – Develop a formal memorandum of understanding (MOU) between school district and health services providers, outlining roles/responsibilities, services, hours of operation, and information-sharing. See the *toolkit* for sample agreements.

**5C. Getting Started: Facilities planning**

School health centers can be constructed in a variety of spaces, ranging from converted classrooms to portables to buildings near the school. Some schools are not able to build a fixed site and have services delivered from a mobile van or through telehealth. The design of the health center should be based upon the type of services it will provide and it should adhere to relevant building codes. School health centers in California have primarily relied on state and local funding to support construction of facilities. These sources include school modernization or new construction grants, local bond measures with school construction project allocations, community development block grants, and facilities grants to community clinics and hospitals.

- **Case Study** – In general, school health center facilities developed across diverse communities benefit from engagement of one or more influential leaders who will fight for allocation of local, state, or federal funding dollars for construction/renovation. These leaders include school board members, school district superintendents/student support administrators, city council members, county supervisors, county public health officers, and community clinic/hospital administrators. Engaging these decision-makers early enables them to claim the school health center success as a political success.
- **Key Stakeholders** – District facilities managers, school board members, medical, dental, and mental health provider agencies, school site principal.
- **Policies and Systems** – Joint use agreements between cities and school districts can facilitate funding and space allocation for school health center facilities. See the *toolkit* for sample school clinic floor plans and facilities details.
5D. Program Development: Chronic disease prevention

School-based intervention has been identified as one of the most efficient means of reducing four main chronic disease risks: tobacco use, unhealthy eating patterns, inadequate physical activity, and obesity. School health centers provide individual, group, and family counseling on preventing health risks, and offer lifestyle-changing programs such as adventure clubs, dance and cooking classes, and healthy snacks. The ability to integrate medical care (such as asthma treatment or blood glucose monitoring) with accessible prevention programs makes school health centers uniquely positioned to prevent and manage chronic disease.

- **Case Study** – *Kids Come First* (Ontario) and other case studies of school-based nutrition and physical activity programs
- **Key Stakeholders** – Health care professionals (health educators and clinicians), educators, student leaders, parent leaders, public health department, physical education and after-school providers, school nurses and counselors, local recreational activities providers.
- **Policies and Systems** – See the California School Health Centers Association's (CSHC) web page on chronic diseases, and a school-based obesity prevention policy brief.

5E. Program Development: Adolescent health care and youth development

Adolescents are the most medically underserved population in the U.S. School health centers in middle and high schools not only bring developmentally appropriate health care and counseling directly to teens, but also engage youth as peer educators, outreach workers, advisors, and advocates. This reflects a youth development approach, valuing youth's understanding of health issues, needed services, and how services should be delivered. Peers are often the most effective health promoters and model positive behaviors which establish and reinforce healthier norms within their peer group.

- **Case Study** – Manual Arts High School’s Youth Health Action Board (YHAB) (Los Angeles)
- **Key Stakeholders** – Health center clients, youth leaders, student councils, youth coordinators, supportive CBOs, teachers, school administrators, and parents.
- **Policies and Systems** – The Adolescent Health Working Group has an adolescent health provider toolkit and a manual on confidentiality and minor consent laws in California. See CSHC’s policy statement on reproductive health education and services at school health centers, and UCSF’s analysis of youth-led participatory research programs.

5F. Resource Development: Third-party billing

There are multiple revenue streams to sustain school medical and mental health services. For medical services, sources of third-party reimbursement include the Child Health and Disability Program (CHDP), Medi-Cal, Family PACT, and Healthy Families. Selecting a provider with billing systems in place can be easier than developing new systems. Community clinics designated as Federally Qualified Health Centers receive a higher Medi-Cal reimbursement rate, which makes it easier for them to sustain their services in a school health center. For mental health programs, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is the primary program for children who qualify for full-scope Medi-Cal. In order to get EPSDT to cover services
in a school health center, the provider must have a contract with the county mental health department. The Mental Health Services Act (MHSA) may also be a source of funding for school-based mental health in some counties.

- **Case Studies** — 1) School Health Clinics of Santa Clara County. 2) Maximizing EPSDT: Alameda County Health Care Services Agency’s Case Study
- **Key Stakeholders** — Medical and dental services provider/s, billing staff, school site staff, health insurance eligibility workers, community outreach workers, and other school health providers or case managers.
- **Policies and Systems** — Integrate health insurance enrollment into operations of a health center, encourage selection of FQHC as a primary care provider, and bill proactively. See CSHC’s third-party billing manual.

6. **Measures of Progress**

**Key indicators from Outcome Seven that relate to school health centers:**
- Schools are actively partnering with local public and private agencies to solve health challenges facing neighborhood children.
- All schools offer preventive services for physical and behavioral health issues.
- School facilities are open evenings and weekends in summer, and are used for community purposes.
- Local youth centers and family resource centers are used by community residents to access family strengthening supports and are linked to health and human services.

**Process indicators related to school health services expansion and health center start-up:**
- Community members, youth, families, and other key stakeholders have been convened to participate in planning efforts.
- A needs and resources assessment has been completed that uses data and input from stakeholders.
- A vision or plan has been created for the health center, including the type of services needed, clients to be served, and location of the site.
- Partner agencies for medical, mental health, oral health, and other services have been identified as appropriate for the plan.
- There is a plan for building, purchasing, or renovating facilities needed to provide the services included in the plan.
- A mechanism for coordination of services between different agencies is in place.
- There is a draft budget and staffing plan for the health center.
- There is an evaluation plan with target health and school outcomes.

7. **Additional Resources**

To learn more about school health centers, visit the California School Health Centers Association. See an overview, brochure, and the Governor’s White Paper on school health centers. The following resources are organized by The California Endowment, Building Healthy Communities’ Four Big Results.
Big Result #1: Reduce youth violence.
- CSHC’s paper on expanding mental health services through school health centers
- Tool to assess and improve the quality of mental health services delivered within schools
- CSHC’s toolkit on parent engagement

Big Result #2: Reverse the childhood obesity epidemic.
- CSHC’s new toolkit: Healthy Eating, Learning, Playing (HELP) at School
- CSHC’s school-based obesity prevention policy brief
- CSHC’s model program paper on school-based nutrition and physical activity programs

Big Result #3: Provide a health home for all children.
- CSHC’s comprehensive toolkit on how to start a school health center: From Vision to Reality: How to Build a School Health Center From the Ground Up
- Web pages with resources for developing or improving school health programs
- Online “road map” to starting a school health center
- A model program paper on how school health centers help enroll students in health insurance
- CSHC guidelines for school health centers
- Brief outlining school-based telehealth programs
- CSHC manual on how school health centers can maximize third-party billing

Big Result #4: Increase school attendance.
- Report on evidence that school health centers support academic outcomes
- A summary of how school health centers support student learning