Claremont Colleges

Scholarship @ Claremont

CGU Theses & Dissertations

CGU Student Scholarship

Spring 2021

An Exploratory Case Study Utilizing a Health in All Policies Approach to Improve Health in the City of Montclair

Alyssa Colunga

Claremont Graduate University

Follow this and additional works at: https://scholarship.claremont.edu/cgu_etd

Recommended Citation

Colunga, Alyssa. (2021). *An Exploratory Case Study Utilizing a Health in All Policies Approach to Improve Health in the City of Montclair*. CGU Theses & Dissertations, 205. https://scholarship.claremont.edu/cgu_etd/205. doi: 10.5642/cguetd/205

This Open Access Dissertation is brought to you for free and open access by the CGU Student Scholarship at Scholarship @ Claremont. It has been accepted for inclusion in CGU Theses & Dissertations by an authorized administrator of Scholarship @ Claremont. For more information, please contact scholarship@cuc.claremont.edu.

An Exploratory Case Study Utilizing a Health in All Policies Approach to Improve Health in the
City of Montclair

By
Alyssa Colunga

CLAREMONT GRADUATE UNIVERSITY
2021

APPROVAL OF THE DISSERTATION COMMITTEE

This dissertation has been duly read, reviewed, and critiqued by the Committee listed below, which hereby approves the manuscript of Alyssa Colunga as fulfilling the scope and quality requirements for meriting the degree of Doctor of Public Health.

Paula H. Palmer, Chair
Claremont Graduate University
Associate Professor

Jay Orr
Claremont Graduate University
Clinical Full Professor and Dean

Jessica Clague DeHart
Claremont Graduate University
Assistant Professor

ABSTRACT

An Exploratory Case Study Utilizing A Health in All Policies Approach to Improve Health in the City of Montclair

By
Alyssa Colunga

Claremont Graduate University: 2021

Rates of chronic disease are a long-term problem in the City of Montclair, a predominately high minority community with low socioeconomic status and limited resources. There is a need for leadership in small local jurisdictions, such as Montclair, to champion sustainable and effective health promotion strategies that meet the needs of its citizens and is accessible and tailored to the population.

The purpose of this case study is to utilize a cross-sector social ecological lens to develop strategies for the City of Montclair to improve health through a collaborative health in all policies (HiAP) approach. This analysis of HiAP as a means to improve health, includes the incidence of chronic disease, uses document review and semi-structured interviews to adapt a logic model meant to guide a HiAP initiative for the City of Montclair. It also identifies the next steps in guiding a future HiAP initiative.

Stakeholders within the City of Montclair were recruited to provide feedback on utilizing a HiAP approach to improve health. Five stakeholders participated in semi-structured interviews and were asked about barriers to creating a HiAP initiative in Montclair, how messaging can be better tailored for multiple sectors to buy-in, the feasibility of engaging high-level stakeholders and community leaders, and the potential benefits of HiAP in Montclair.

This study fills a major need for investigation of how local municipalities might begin a HiAP initiative. Five critical themes were derived from the document review and from the six interviews conducted with Montclair city staff and community leaders provide perspective and insight into plans for a HiAP initiative. The five overall themes mentioned by both include: (1) communications and messaging, (2) incorporating health into decision making, (3) assessments and data collection, (4) building awareness and political support, and (5) formalizing HiAP.

HiAP is an approach to improve chronic disease rates and ensure that future decisions are cross-sectoral and made only after serious consideration of their impacts on health. Other small cities can use this as an example of how to examine their specific environments and determine what they need to do and how to employ the existing literature as they tailor a foundational logic model for their own use.

DEDICATION

To my Grandmother, Connie, your strength, determination, and love
inspire me to achieve my dreams.

To my daughter, Harlow Sylvee, you are my reason why.

ACKNOWLEDGEMENTS

I express my sincere gratitude to my dissertation committee. My chair, Paula Palmer, and committee members, Jay Orr and Jessica Clague DeHart, thank you for the countless hours of support and guidance. I am so grateful for your patience and encouragement throughout this process. I am also thankful to my colleagues and key informants for their willingness to speak and provide their opinions on how we can achieve a healthier future.

This journey would not be complete without the greatest support system. My parents, Patty and Robert, thank you for always believing in me and pushing me to achieve more than I ever thought I could. I appreciate everything you sacrificed so that we can have a better future. My sister, Breann, thank you for the hours you spent reviewing my paper, hearing out my ideas, and encouraging me to get this done. Grandma Connie and my godmother Kathy, thank you for your endless love and support. My colleague, Jovita, having a supportive friend going through this process at the same time was so helpful; thank you for our time spent strategizing, reviewing, and supporting each other, it helped to get me to the end.

I am eternally grateful to my husband and partner in life, Eric. Thank you for taking on more than your fair share to help me achieve my goal. I am thankful for your positivity, words of encouragement, patience, and unwavering support. Thank you to my daughter Harlow, you inspire me to make this world a better place.

TABLE OF CONTENTS

CHAPTER 1. INTRODUCTION.....	1
BACKGROUND	1
THE PROBLEM.....	4
<i>SOCIAL DETERMINANTS OF HEALTH</i>	5
SIGNIFICANCE AND PURPOSE OF THE STUDY	7
RESEARCH QUESTION.....	11
DEFINITIONS OF TERMS	12
<i>HEALTH DISPARITIES.</i>	12
<i>HEALTH INEQUITIES</i>	12
<i>SOCIAL DETERMINANTS OF HEALTH</i>	12
ASSUMPTION AND PROPOSITION.....	12
LIMITATIONS.....	13
SUMMARY	13
CHAPTER 2. BACKGROUND	15
CITY OF MONTCLAIR’S HISTORY OF ATTEMPTS TO IMPROVE HEALTH.....	16
<i>COUNSELING AND EDUCATION</i>	16
<i>CLINICAL INTERVENTIONS</i>	20
<i>LONG-LASTING PROTECTIVE INTERVENTIONS</i>	21
<i>CHANGING CONTEXT TO MAKE INDIVIDUALS DEFAULT DECISIONS HEALTHY</i>	21
<i>SOCIOECONOMIC FACTORS</i>	23
SOCIAL DETERMINANTS OF HEALTH.	24
<i>OVERALL HEALTH AND DEMOGRAPHICS</i>	24
<i>EDUCATIONAL ATTAINMENT AND POVERTY</i>	28

<i>BUILT ENVIRONMENT</i>	33
HEALTHCARE AND MENTAL HEALTH.....	38
SOCIAL CONNECTEDNESS.	40
SUMMARY.....	42
CHAPTER 3. METHODS	43
RESEARCH FRAMEWORK.....	43
<i>HEALTH IN ALL POLICIES</i>	43
<i>LOGIC MODEL</i>	46
STUDY DESIGN AND METHODOLOGY.	48
DATA COLLECTION METHODS	49
<i>DOCUMENT REVIEW</i>	49
<i>KEY INFORMANT INTERVIEWS</i>	52
ETHICAL CONSIDERATIONS.....	55
PLANS FOR PRESENTING THE RESULTS.	56
SUMMARY.....	56
CHAPTER 4. RESULTS AND DISCUSSION	58
THEME 1. COMMUNICATION AND MESSAGING	61
THEME 2. INCORPORATING HEALTH INTO DECISION MAKING	63
THEME 3. EVALUATION: ASSESSMENTS AND DATA COLLECTION	65
THEME 5. FORMALIZING HIAP	69
LOGIC MODEL	70
<i>INPUTS</i>	70
<i>ACTIVITIES</i>	71
<i>OUTPUTS</i>	73
<i>OUTCOMES</i>	74
SUMMARY.....	75

CHAPTER 5. CONCLUSION.....	77
DOCTOR OF PUBLIC HEALTH STUDENT COMPENTENCIES.....	79
APPENDIX A. CITY OF MONTCLAIR MAP WITH CENSUS TRACTS	80
APPENDIX B. DOCUMENT ANALYSIS PROTOCOL	81
APPENDIX C. SEMI-STRUCTURED INTERVIEW GUIDE.....	82
APPENDIX D. IRB REVIEW	83
REFERENCES	84

LIST OF FIGURES

Figure 1. Action Model to Achieve Healthy People 2020 Overarching Goal.....	9
Figure 2. Health Impact Pyramid.....	10
Figure 3. Top Causes of Death in Montclair.....	26
Figure 4. Percentage of obesity and overweight.....	27
Figure 5. Educational Attainment.....	29
Figure 6. Population with high school education or higher.....	29
Figure 7. Montclair high school students college going rate by year	31
Figure 8. Families with children below the federal poverty level.....	33
Figure 9. Retail Food Environment Index.....	36
Figure 10. Potential logic model for HiAP initiatives.....	47
Figure 11. City of Montclair HiAP Logic Model.....	76

LIST OF TABLES

Table 1. Montclair Health Data.....	15
Table 2. City of Montclair Case Study Layout.....	16
Table 3. Median Age.....	25
Table 4. Percent of Population over 25 years, with Less than a High School Diploma.....	30
Table 5. Rates of Montclair high school graduates attending college by school year and ethnicity.....	31
Table 6. Modified Retail Food Environment Index.....	36
Table 7. Documents Reviewed.....	51
Table 8. Key Informants.....	52
Table 9. Sources for interview questions.....	54
Table 10. Interview questions and corresponding logic model area.....	55
Table 11. Key Informant Interview Themes.....	59
Table 12. Document Analysis Themes.....	60

CHAPTER 1. INTRODUCTION

Chronic disease (CD) is a long-standing problem in Montclair, a predominately minority community of low socioeconomic status and limited resources. This is not an unaddressable problem, however, and Montclair's leaders could champion strategies to promote the health of the city's residents, policies tailored to the specific needs of its population. These strategies must be supported by a collaborative group of stakeholders including local government, private and public entities, and community leaders. Treating the City of Montclair as a case study, this dissertation identifies root causes of poor health and recommends actions to adopt a Health in All Policies (HiAP) approach, tailored with feedback from Montclair stakeholders. Chapter One introduces the City of Montclair, the social determinants of health there, and the problem, purpose, and research questions that shape this study.

BACKGROUND

Montclair, a very small city of approximately 5.5 square miles and 38,000 residents, is located in western San Bernardino County along the eastern border of Los Angeles County in Southern California.¹ It is surrounded by much larger cities, such as Ontario, at 50 square miles and a population of 180,000.¹ The population of Montclair is 51% male, 70% Hispanic/Latino, and 14% White.¹ Approximately 25.6% of the population is under 18-years old, compared to 27% of the San Bernardino County overall.¹ The proportion of people in the city over 65 (10.7%) is very similar to the county's 10.6%.¹

Montclair was incorporated in 1956, nine years after the end of World War II.² During the first year, it created a master street-lighting plan, established zoning ordinances, collected engineering data, and instituted the city's recreation program.² In north Montclair, less than ten years after incorporation, planning began for a regional shopping center, Montclair Plaza, which opened in 1968.²

Prior to its incorporation, Montclair, known as the Monte Vista land tract, consisted of citrus groves, as seen in the advertisement replicated here.³ The land had been owned by the Reeder family since 1900 and developed into a fifty-acre citrus ranch on Holt Boulevard.³ Seven years later, 1,000 acres of land in the Monte Vista Land tract were sold to a Los Angeles developer,³ who marketed the land as a place to enjoy a “free, healthy, and independent suburban life” given that its already paved roads were not then common in the area.³

The population included a large immigrant labor force maintained the citrus ranches in south Montclair.⁴ The 1910 census notes a Japanese labor camp in south Montclair along Holt Boulevard, and the 1930 census indicates the presence of a Filipino labor camp on Kingsley Street, just north of Holt Boulevard.⁴ These labor camps had been created for the many immigrants who came to America for the promise of well-paying jobs but who were forced to live in camps with others of their ethnicity.⁵

The city layout included much residential zoning and two major highways, Holt Boulevard and Mission Boulevard, in south Montclair.³ Non-residential zoning was clustered around these roads, which ran by such conveniences for drivers and their passengers as gas stations, service mechanics, fast food restaurants, and strip malls.³ In 1958, interstate 10 was

built through the city. Although it offered residential neighborhood, South Montclair intended to serve those who drove through town on the major highways.³

About 40 years later, in the late 1990s, the city of Montclair and its community partners came created the Montclair Community Collaborative (MCC) to address the growing needs of its residents.⁶ At that time, the rates of chronic disease (CD) were very high, and the MCC recognized that Montclair residents faced many barriers to achieving good health. Alarmed by the problem, the group convened regularly to discuss ways in which it could improve health in Montclair. Those involved included the local government, police department, school district, community college, social service agencies, community members, hospitals, state legislators, and other stakeholders. Since then, the regular MCC meetings have been discontinued, but the MCC's legacy of partnerships continues through the many longstanding community programs that still existed over twenty years later.⁷

Despite the work of the MCC and the programs that survived it, the health of the people of Montclair in the second decade of the 21st century remained much what it had been in the late 1990s. As measured by CalEnviroScreen 3.0¹, the population Montclair's census tracts have been consistently poorer than most other areas in the state.⁸ CalEnviroScreen ranks census tracts in California based on national and state data such as measures of poverty, educational attainment, housing burden, linguistic isolation, low birth weight, cardiovascular disease (CVD), and unemployment. ⁸⁻⁹ Although Montclair fairs more poorly overall than most other areas in the state and country, there is variation among census tracts within the city.⁸ Seven of the eight

¹ CalEnviroScreen, a tool developed by the California Office of Environmental Health Hazard Assessment, assesses the impact of pollution on communities throughout the state⁹

census tracts in Montclair scored above the 70th percentile for overall population characteristics, which means their populations fare better than only 30% of those elsewhere in the state. Two are in the 84th percentile, and another is in the 87th percentile.⁸ .

Chronic health disease is the leading cause of death worldwide and in the United States, and the majority of Americans over 18 have at least one such condition.¹⁰⁻¹¹ Healthcare expenses are the major reason chronic diseases are too-often mortal.¹²⁻¹³ Over 75% of deaths in California in 2016 were attributed to CDs.¹⁴ CDs have been the leading cause of death in Montclair since 1989.¹⁵ Yet chronic conditions are not only treatable in many cases, they are generally preventable.¹⁴ Many threats to good health are attributed to environmental conditions to which people are often exposed early in life.¹⁴⁻¹⁷ Making changes to the physical and policy environment are more effective ways to improve CD rates than implementing treatment programs and services alone.¹⁸

THE PROBLEM

The City of Montclair and its partners have collaborated on programs to improve health in Montclair for over twenty years, yet poor health, including high rates of chronic disease and ensuing mortality have remained persistent. When determining the root cause of poor health in Montclair, policymakers need to take into account the natural and built environments and social, historical, and political contexts, including those of race and ethnicity.¹⁹ Where one lives may be more important to health than genetics.²⁰ Studies have acknowledged the link between health and neighborhood conditions after taking other characteristics into account.²¹⁻²² There is a clear difference in how south Montclair and north Montclair developed since the early 1900s, and environmental development started even earlier than that. Minorities in labor camps lived in

south Montclair in the early 1900s and that portion of the city was developed early on to fit the needs of the car culture rather than of the residents. North Montclair included a major regional retail development meant to attract patrons from across the Inland Empire and San Gabriel Valley; it needed to be enticing and attractive to bring in more customers. Conditions established in the early 1900s influence the lives of residents in Montclair every day.

Historically, policies and programs in Montclair have focused on the individual and interpersonal level; very little has been done to effect sustainable change at affecting the larger population. CD will remain persistent until we see strategic population-level changes focused on the social determinants of health.

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are “the conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. The social determinates of health are mostly responsible for health inequities—the avoidable differences in health status seen within and between countries.”²³

Although moderns society relies on the health care sector to deal with issues regarding health and illness,²³

“the healthcare sector comes in contact with the population after they have experienced and have been affected by many social and environmental factors that influence health. Although healthcare is one social determinant of health, there are many other factors that influence health that healthcare cannot address alone. Categories of SDOH vary; however, the National Expert

Panel on Social Determinants of Health Equity define the SDOH as the conditions needed for health, including education, housing, employment, living wages, access to health care, healthy foods and green spaces, occupational safety, and hopefulness. Inequitable distribution of these conditions across populations contributes to persistent health inequities. In addition, SDOH include freedom from racism, classism, sexism and other forms of exclusion, marginalization, and discrimination based on social status. ”²⁴

SDOH are the root cause of many health inequities and disparities among different groups, ones defined by race/ethnicity, socioeconomic status, age, gender, disability status, sexual orientation, and geographic location.²⁵ Health disparities that are unnecessary and avoidable are known as health inequities.²⁵ Health inequities are often rooted in social injustices that make some groups more vulnerable to health problems.²⁵

It would be extremely hard for populations to change their behaviors if social determinants are working against transformation. If, for example, a single mother with a high school diploma has a minimum wage job that requires her to take the bus for one hour to and from work, she may not have the time, money, or energy to stop at the grocery store and pay for fruits and vegetables her family needs. Instead, she may decide to stop at her local fast food restaurant and pay ten dollars her children’s dinner. Local jurisdictions have the power to influence some of these social determinants of health including education, poverty, access to health care, access to healthy foods, green spaces, and other environmental factors, both social and physical, via well-constructed policies and programs.

SIGNIFICANCE AND PURPOSE OF THE STUDY

Since the CDs that harm Montclair's residents have complex root causes, they cannot be corrected with a single action. There is not a one-size-fits-all approach that can be easily adopted to improve health in Montclair. Rather, linked programs across the levels of society are necessary to create sustainable change.

Every city has a distinct local context that affects how different policies work in practice in that area, and studies of public health policy suggest much innovation occurs at the local level.²⁹ The Institute of Medicine considers local governments in a unique position to institute policies to shape the environment.³⁰ In addition, the Robert Wood Johnson Foundation awards communities with an award for having a Culture of Health and working toward advancing universal health, opportunity, and equity.³¹

After over twenty years developing and maintaining various collaborative programs, such as those for, after-school activities, case management, senior transportation, scholarships, community health worker training, and a medical clinic, some current stakeholders within Montclair are troubled that these have not brought an improvement in the health of the community. The overall guidance and resources that are readily available to larger jurisdictions with powerful stakeholders and access to sizeable funding and other resources do not consider the unique qualities of a small jurisdiction of Montclair's size. Without a framework relevant for use in small cities, many have been left wondering why the tremendous efforts to lead behavior change programs in Montclair have not resulted in a greater improvement in overall health.

Hence, collaboration within small cities is much more effective than going it alone. Although general strategies to reduce CVD, for example, have been outlined in many studies,^{12,26-28} these reports do not give small jurisdictions, like Montclair, much guidance about how to implement appropriate changes with their limited resources. Hence, by pooling expertise and resources cities working in collaboration can influence community health in many ways a single city cannot do in isolation.

Montclair has attempted to lower chronic disease rates, but the majority of the city's efforts have not been focused strategically or regularly continuously evaluated. Moreover, many took place only at the interpersonal level. Interpersonal interventions alone discount the importance of *upstream factors* that affect living conditions and also impact social and environmental inequities, all of which heavily impact health outcomes. In addition, there is a lack of practical guidance on systems-based approaches accessible to small jurisdictions.

Illustrated below is the Action Model to Achieve Healthy People 2020 Overarching Goals developed by the U.S. Department of Health and Human Services Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives For 2020.³² This action model represents the impact of various interventions on determinants of health at multiple levels and across the life cycle.³²

The Action Model, Figure 1, adapts the long-existing Social Ecological Model to establish what is needed to improve health. It shows that action is needed at multiple levels to have an impact, and interventions are more likely to be successful when they tackle each level for the full life cycle.³² Montclair's efforts have been focused on programs and information affecting individual behavior, family, community, and society, but the city lacks policies and programs that address such broad environmental concerns as living and working conditions.

Utilizing components of the Action Model would enhance Montclair’s opportunity to create long-term sustainable healthy changes, such as addressing all three types of interventions, policies, programs, and information, for prioritized areas of need and then applying them at multiple levels with measurable outcomes for both short- and long-term evaluation.

Figure 1. Action Model to Achieve Healthy People 2020 Overarching Goals³²

Further, the Health Impact Pyramid³³, illustrated in Figure 2 below, showcases another dimension of making long-lasting sustainable change. Within the five tier pyramid, actions to address socioeconomic factors or social determinants of health sit at the foundation.³³ Social determinants are vital to the health of a society and its members.³³ Being at the bottom of the pyramid indicates a large population impact and little individual effort needed to change. The second tier, *Changing the context to make individuals’ default decisions healthy*,³³ suggests that individuals would have to make substantial efforts not to benefit happening more broadly.³³ An example is smoke-free policies, which would make it difficult for people to smoke in certain

areas and lessen the degree of everyone's exposure exposed to second-hand smoke. If sufficiently comprehensive it could reduce their risk of cancer. Montclair has made very little effort at these two lower levels, both of which carry the greatest impact on the whole population with the least individual effort.

Figure 2. Health Impact Pyramid²⁴

The third tier of the pyramid is *long-lasting protective interventions*.³³ This tier is defined as “1-time or infrequent interventions that do not require ongoing clinical interventions.”³³ It has less of an impact on the population than the bottom tiers because it requires securing individuals buy-in.³³ An example of an intervention at this tier is the provision of home colon-cancer screening kits, which can reduce colon cancer by finding signs of cancer early, when the survival rate is 90%.³⁴ The fourth level includes ongoing *clinical Interventions*, and the fifth level is *counseling and educational* interventions.³³ The fourth and fifth levels require the most

individual effort and have the least population impact. Most of the efforts in the City of Montclair have taken place at the top of the pyramid, which requires great effort to convince individuals to make their own great efforts and has little to no impact at the population level.

This study uses a cross-sector social ecological lens to develop strategies for the City of Montclair, ways to improve rates of chronic disease by focusing on root causes. It proposes that chronic disease has remained persistent in Montclair because focus has only placed on one level and so did not create sustainable change in the City of Montclair. The city has the power to foster a collaborative cross-sectoral approach that influences policies and programs that can make a substantial difference in the quality of education, lessen poverty, provide access to health care, healthy foods, and green spaces, and affect other environmental factors, both social and physical.

RESEARCH QUESTION

The following research question guides this case study: what can be done to improve health, including by lessening chronic disease, in the City of Montclair?

The case study propositions are:

- Montclair's CDs have remained the top causes of death in the City of Montclair because:
 - stakeholders focused only on the individual levels of the social ecological model and health impact pyramid and so had a small impact on the full population.
 - there not enough effort to improve the social determinants of health by working collaboratively with other cities.

DEFINITIONS OF TERMS

HEALTH DISPARITIES.

Health disparities are the differences of different groups' health.²⁵

HEALTH INEQUITIES

Health disparities that can also be described as unnecessary, avoidable, inequalities. These are typically referred to as health inequities.²⁵ They are rooted in social inequalities that allow some groups to be more vulnerable to poorer health than others.²⁵

SOCIAL DETERMINANTS OF HEALTH

“The conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. The social determinates of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries.”²³

ASSUMPTION AND PROPOSITION

This study proposes that focusing comprehensively on changing the policy and environment of Montclair is more likely to effect longer-lasting and widespread changes in the health of the population than focusing on changing individual behavior alone. This assumes that the early development of Montclair did not include comprehensive collaborative efforts across sectors

LIMITATIONS

A limitation of this case study is that it is specific to the City of Montclair and its environmental, social, physical, and cultural conditions. It is not clear, therefore, the degree to which its findings can be extended to other places even of similar size and environmental factors. A further limitation is the lack of comprehensive health data available for small cities in lower socioeconomic counties.² An effort was made to gather historical data, the information documented from past events and activities is limited.

SUMMARY

Montclair is a small community on the west end of San Bernardino County that faces many health disparities and challenges, in part, because of short-sighted city planning created over 100 years ago ongoing focus on individual-level changes instead of trying to affect the broader population. The high rates of CDs that affect Montclair's population have complex root causes that cannot be solved with a single action. Multiple interconnected efforts across the contextual environments, the ecologies in which individuals, policy, and society operate, are necessary to create sustainable change. Montclair has attempted to lessen the prevalence and effects of CD, but health most programs have focused almost entirely on the interpersonal level. In addition, there is a lack of practical guidance on systems-based approaches available to small jurisdictions. This study reviews the city's history in reference to issues of health, considers data, recommends an approach to improve the root causes of poor health, gathers feedback from

² When data was requested from county entities, the lack of capacity in various departments was cited.

Montclair stakeholders, and presents a final step-by-step report that can be utilized to create sustainable change.

CHAPTER 2. BACKGROUND

This chapter will address:

- a) How the Action Model and Health Impact Pyramid might assist Montclair to lower chronic disease rates?
- b) The current health status of the Montclair population and its social determinants and the nature of the data.
 - o The health data are organized as follows in Table 1 below:

Table 1. Montclair Health Data

Montclair Case Study Summary
Overall Health & Demographics
Demographics & Aging Population
Causes of Death
Health Status
Chronic Disease
Educational Attainment & Poverty
Poverty Levels
Educational Attainment
Built Environment
Food Access
Transportation & Physical Activity
Healthcare & Mental Health
Access to healthcare
Mental Health
Social Connections & Community Cohesion
Civic Participation

Potential strategies and policies to improve health, focused especially on reducing chronic disease in the City of Montclair are discussed in this and subsequent chapters.

CITY OF MONTCLAIR’S HISTORY OF ATTEMPTS TO IMPROVE HEALTH

Table 2 lays out past actions (corresponding with the Health Impact Pyramid and the Action Model) taken by the City of Montclair to improve health. Although none of the programs specifically focused on CDs, all were meant to improve the health of the residents of Montclair.

Table 2. City of Montclair Case Study Layout

Health Impact Pyramid Level	Action Model Level	City of Montclair Past Actions
Counseling and Education	Individual behavior Social, family and community networks	<ul style="list-style-type: none"> – Community health workers – Senior lunch program – Monthly food distribution – Case Management Partnership – Montclair to College
Clinical Interventions	Living and working conditions	<ul style="list-style-type: none"> – Medical Clinic
Long Lasting Protective Interventions		<ul style="list-style-type: none"> – None
Changing the Context to Make Individuals’ Default Decisions Healthy	Living and working conditions	<ul style="list-style-type: none"> – Community Garden/Fruit Park – Farmers Market – Senior Transportation Program
Socioeconomic Factors	Social, economic, cultural, health, and environmental conditions and policy	<ul style="list-style-type: none"> – Healthy City Designation – Certified Farmers Market Ordinance – Healthy Eating, Active Living Resolution

COUNSELING AND EDUCATION

Over the past thirty years from 1990–2020, the City of Montclair has focused much of its efforts on counseling and education. Many programs began in the late 1990s, when a group of concerned stakeholders came together to improve conditions for the Montclair community.

Typically, these efforts focused on individual behavior and social, family, and community networks.

One of the first initiatives instituted by the Montclair Community Collaborative in 1998 was the Por La Vida Community Health Worker program. Although it had been developed ten years prior at the San Diego State University, this was the first time the program was established in the San Bernardino County region.³⁵ Its main partners were San Antonio Community Hospital, Pomona Valley Hospital, San Bernardino County Department of Public Health, California Department of Public Health, and members of the Montclair Community Collaborative.³⁵ The primary goal was to promote healthy lifestyles. Secondary goals were to improve the use of health care providers through information and referrals and to develop access to healthy food and opportunities for physical activity.³⁵ The target audience was the Hispanic community in Montclair, which made up 45% of the population.³⁵

As part of the program, Montclair recruited community members to serve as health workers, *consejeras* or *promotoras*. They participated in a sixteen-session training course before recruiting others to participate in a fourteen-week curriculum about health and nutrition.³⁵ This program lasted well beyond the initial funding, in 1998, from the California Endowment, with the original classes continuing through 2013. Since then, the Montclair Por La Vida program has expanded its focus and activities. The Por La Vida Consejeras have assessed the social determinants of health for Montclair Medical Clinic patients, connecting them to needed resources to improve their overall wellbeing. They also created a Safe Routes to School committee.

The network of consejeras built through the Montclair Por La Vida program is a powerful force in the community that can be harnessed to tie more people to policymaking and include more of them in programs that improve their own health.

In 1998, Montclair began a nutrition program that included a congregate meal service to individuals over 60 years of age. Twenty-two years later, this project had drawn crowds from all over the Pomona Valley and Inland Empire and had grown to serve over 24,000 meals annually.³⁶ Still extant at the time of this writing, its meals are reviewed by two dieticians to ensure they meet the needs of balanced nutrition for seniors. The program is not simply a meal service, it is a place where seniors can connect. Although nutrition is the main goal, the overall aim of the senior citizens programs has been to “implement educational, social, recreational, and support programs for older adults, with a focus on those in the greatest economic and social need, so they can successfully age in place.”³⁶ The program runs five days per week, Monday through Friday starting at 11:30am. There is a suggested two-dollar donation for the lunch, but seniors are not turned away if they cannot pay.³⁶ In addition to group meals, the City of Montclair provides a monthly food distribution program for those over thirty-five, distributing a variety of canned and frozen foods for low-income residents of San Bernardino County.

The daily nutrition and monthly food-distribution programs have enhanced access to healthy food for some of the most vulnerable in the Montclair community. The framework used to provide healthy and balanced lunches to the elderly can be replicated in many of the other programs that provide food to their own participants, which touch the lives of people from preschoolers to seniors. Through its programs, the city provides the community with foods that can influence residents to choose healthier options. More health-conscious choices can be implemented at a variety of venues, even city council meetings, which currently provide cookies

to meeting attendees and the Youth Center, which offers participants sugary drinks and snacks with little nutritional value.

Through the Montclair Community Collaborative, the city and the local elementary school district partner to provide case management for the students and families in Montclair. The city pays a portion of the salary for the licensed clinical social worker who not only oversees case management and helps students in crisis, but also provides intensive case management to families in need so as to bridge the gap in safety-net services. For example, when a low-income family cannot afford food or health care, a case manager will work with it to find services that meet its member's needs.³⁷ Without the ability to meet basic needs, it is incredibly hard for families to lead healthy lives and achieve their full potential.

In 1998, Montclair started a program called Online to College, now known as Montclair to College (MTC). At the time, few high school students in the area went on to college, and the Montclair Community Collaborative wanted to increase their numbers; it was the first program of its kind in California.³⁸ Over the first 15 years, beginning in fifth grade, students were exposed to information about college and its benefits, and they were promised a college scholarship when they graduated from Montclair High School. They attended workshops throughout the school year, and during fifth grade they were taken on a field trip to Chaffey College and introduced to various departments and clubs. In 2014, the program shifted its focus on students as they entered high school with more information, including education about the college application process and, once again, the benefits of earning a college degree. Students who complete this program receive a full two-year scholarship, valued at approximately \$4,600 in 2021, that covers books, tuition, parking, and other fees at Chaffey College.

The first MTC cohort of the revised program graduated from high school in 2018, and the program has shown very promising outcomes. MTC students were significantly more likely to go to college (21.3%) than non-MTC students (13.9%).³⁹ There was a statistically significant difference in the cumulative mean GPA of MTC students in their first semester of college (GPA 2.26) than in that of non-MTC students (GPA 1.66).³⁹ Additionally, MTC students registered for more units³⁹ and stayed in school for both semesters of their first year than non-MTC participants.³⁹ Although the Montclair to College program existed for over 20 years, the 2019 version of the program recently had its first full graduating class of students who had gone through the program from ninth grade until they graduated.

CLINICAL INTERVENTIONS

The second level of the Health Impact Pyramid includes clinical interventions. These efforts focus on individual behavior and living and working conditions.³³ The effectiveness of clinical interventions is limited by issues of access and adherence.³³

Many in Montclair are uninsured, as has been the case for a long time. To serve the needs of low-income, uninsured residents, the Montclair Medical Clinic was established in 1978. The clinic's mission is to provide health care services to community members with limited financial means, patients who may not have health care coverage. It provides primary care and related prevention and education services to the working poor and other uninsured populations. The Montclair Medical Clinic, housed in city facilities for over 35 years, and moved one block north as a partner of a new-state-of-the-art community health center in 2017. The clinic operates with a volunteer medical director and volunteer physicians. Doctor of Osteopathic Medicine students from Western University of Health Sciences use the Montclair Medical Clinic site for their

community rotation during their second year of schooling. Since 2018, the Montclair Medical Clinic incurred staffing challenges because of the San Bernardino County's general physician shortage. Because it had to limit operations, the clinic became unable to reach as many individuals as in previous years.

The Montclair Medical Clinic is a unique program that is valued by community members who cannot afford health care. It is a vital lifeline for many residents as well as a much-needed physician training site within a community with a physician shortage.

LONG-LASTING PROTECTIVE INTERVENTIONS

The middle level of the pyramid represents long-term protective interventions meaning single or infrequent interventions, such as colonoscopies.³³ This study has uncovered no history of policies or programs at this level.

Establishing such interventions is a way the city might increase the health of area residents. The city has relationships with local hospitals and medical universities and has partnered with them on workshops and educational events. In 2019, a workshop held by San Antonio Regional Hospital and the Healthy Montclair Initiative reached out to provide education about colon cancer and screening kits to the Hispanic community. The City could use such additional such partnerships to provide to long-term protective interventions in the community.

CHANGING CONTEXT TO MAKE INDIVIDUALS DEFAULT DECISIONS HEALTHY

The fourth level of the Health Impact Pyramid represents changing the environmental context to encourage choices that promote health.³³ Starting in 2014 Montclair made a large effort to change the environmental context to encourage the consumption of healthy foods,

efforts have been made mostly by the Human Services Department, which offers social services like case management and medical services.

The city also took actions to make healthy food more accessible. In October 2013, the City of Montclair planted a community fruit park beside a route many students take on their way to high school. The park is also directly behind an elementary school. Students and families can pick healthy snacks there. In June 2015, Montclair opened the first Community Garden in the city. Created, designed, named, and developed by community residents on land provided through a long-term lease from the Monte Vista Water District, the garden was still running five years later, but since further funding to develop it had not been secured, half the large plot sat vacant at that time.

In 2014, the City of Montclair was awarded funding to develop a program to increase access to healthy food. The city used the funds to create incentives, for which participants receive up to \$25 dollars per week to spend at the Montclair Farmers Market. The city also provided a conditional use permit for a certified farmers' market as long as the city was the sponsor or co-sponsor.⁴² The Montclair Farmers Market was successful as long as the grant supported some of its customers, but once the grant funding was exhausted, very few bought at the market.

In addition to changing the food environment, the City of Montclair has improved the ability of senior citizens to find transportation. In 2001, the city began the Montclair Golden Express Senior Transportation program, which runs Monday through Friday and transports residents 60 and older within Montclair city limits for daily needs and outside of city limits for medical appointments. This makes it easier for seniors to run daily errands, visit family and friends, attend the daily nutrition program and classes at the Montclair Senior Center, and get to

medical appointments outside the City of Montclair.⁴⁰ Without this program, many Montclair seniors would be homebound.

There is an opportunity for the City of Montclair to use cross-sector collaborations to continue its work in changing the context of the environment to encourage individuals to make decisions to improve their own health. Involving staff with different areas of expertise in the conversation about how to accomplish changes would be beneficial.

SOCIOECONOMIC FACTORS

The City of Montclair has taken little action at the social, economic, cultural, health, environment, and policy levels. In 1998, it was designated a Healthy City by the Center for Civic Partnerships because of the work of the Montclair Community Collaborative.⁴¹ This designation was a significant milestone for the city, as many of its future achievements were, in part, due to this designation making new programs possible. Receiving the Healthy City designation made a statement to funders, the city was committed to improving the health and quality of life of the community.

Nearly twenty years after the Healthy City designation, in November 2015, the City of Montclair approved a Healthy Eating Active Living (HEAL) Resolution.⁴³ The HEAL resolution acknowledges more than half of Californians are overweight or obese, which puts them at risk for many CDs, including CVD and cancer. The Montclair City Council acknowledges the problem is even more dire at the local level. For example, the resolution acknowledges that almost double the number of children in 7th grade in the local school district, compared to those in the state overall, are obese and overweight.⁴³ The city council recognizes obesity as a serious

public health threat requiring societal and environmental changes and sees one of its roles as improving access to healthy food and physical activity in Montclair.⁴³

By maintaining the city council commitment to improving public health, there is an opportunity for the city to comprehensively review the health of the population with cross-sector stakeholders in order to prioritize community needs. There is a blank canvas of potential policy options for the City of Montclair. To achieve the highest health impact, the city should focus on adopting policies to improve population health.

SOCIAL DETERMINANTS OF HEALTH.

Examining the health data of the City of Montclair is vital to inform the development of future health initiatives, understand the most significant health issues, and monitor indicators to evaluate efforts in the future. Yet health data are limited for small jurisdictions. To that end, the Centers for Disease Control and Prevention, CDC Foundation, and the Robert Wood Johnson Foundation launched a 500 Cities Project to increase the collection of local data in order to improve health.⁴⁴

OVERALL HEALTH AND DEMOGRAPHICS

A map of the City of Montclair, including census tracts, appears in Appendix A. The following section presents an overall look at health and demographics in Montclair.

Demographics

As illustrated in Table 3, the median age in Montclair is estimated to be 32.7, which is very similar to the median age of the county, 32.¹ The median age varies across the city; census

tract 303, located in the south end, has a median age of 28 years. Tract 203, located in the north end, has the oldest residents, with a median age of 36.6 years.¹

Table 3. Median Age¹

	San Bernardino County	City of Montclair	Census Tracts in Montclair							
			201	203	205	207	208	301	303	304
2010	31.2	30.1	30.0	33.1	35.4	29.6	31.6	25.6	31.3	30.4
2017	32.9	32.7	31.6	36.6	32.8	32.3	34.3	28.2	28.0	36.5

Aging population

According to the US Census Bureau, 20% of the US population will be over 65 by 2035, the first time in the country's history that the elderly outnumber younger people.⁴⁵ The population over 65 is growing slightly faster in Montclair than in the rest of the county.¹

As the population ages, the needs of Montclair residents are changing. In 2009, the number of those over 65 was very similar to that of those under, about 8%. In 2017, the population over 65 grew to 11%, and the population under 5 fell to just 6%.¹⁴⁶ Of the nearly one-third of households in Montclair that have at least one person over 65, the subgroup with those receiving food stamps increased dramatically from 2% in 2009 to 11% in 2017.¹ About 18% of the senior population is still working.¹

Many people 50 and over want to stay in their homes and communities for as long as possible as they age.⁴⁷ Aging in place can have many benefits, including the residents' familiarity with the community and neighborhood environment. It can provide a sense of attachment and identity.⁴⁷ Montclair has a high participation rate in most of its senior programs, and that number will continue to increase. With the larger aging population, it is an important

factor for Montclair to include this growing population in plans to make the community more livable and sustainable.

Causes of death

Overall, chronic diseases have been the primary cause of death in Montclair for the thirty years following 1990.⁴⁸ Heart disease has been the leading cause of death, followed by cancer, chronic lower respiratory disease (CLRD), stroke, pneumonia and influenza, diabetes, and unintentional injuries.⁴⁸ These causes of death are consistent with

Figure 3. Top causes of death in Montclair⁴⁸

those for the entire state of California.⁴⁸ As seen in Figure 3, the percentage of those who have died from heart disease and stroke has decreased since the 1990s. Nonetheless, heart disease has remained the leading cause of death. By contrast, the percentage of those who have died from cancer has increased from 23% in the 1990's to 27% during the years 2010–2016.

Chronic disease

All five leading causes of death between 2010 and 2016 were chronic illnesses, which, although the most preventable of all health challenges, are costly to treat.⁴⁹⁻⁵⁰ Montclair has a higher percentage of adults diagnosed with diabetes, 12.3%, compared with the county, 10.4%, and state, 9.7%.⁵¹ CVD is the leading cause of death in the United States.⁵² The number of adults

in Montclair diagnosed with CVD, 7%, is very similar, although slightly higher than in the county, 7%, and state, 6%.⁵³ From 2012 to 2016, the number of adults diagnosed with CVD rose by 0.5%, which was higher than the statewide figure, which only rose by .01%. Between 2010–20 and 1990–1999, the rates of cancer increased in Montclair from 23% to 27%.⁴⁸

Obesity can be simply described as the result of consuming more calories than the body needs. In truth, the determinants of overweight/obesity are complex and driven by multiple factors such as the built environment play a role in causing it.³⁰ The characteristics of the environment, such as access to healthy food, perception of safety in neighborhoods, and access to opportunities for physical activity all have strong impacts on body weight.³⁰

Montclair has higher levels of obesity/overweight than the county and state.⁵⁴⁻⁵⁶ As illustrated in figure 4, since 2012, obesity in adults 18 and over have slightly decreased from 37% to 35%.⁵⁴ Similarly, the number of overweight children, ages 2–11, has decreased from 20% to 17%.⁵⁶ The number of overweight and obese youth from 12–17 decreased from 40% in 2012 to 24% in 2016.⁵⁵

The intake of sugar-sweetened beverages contributes to obesity, and from 2012 to 2016, similar to the rate at which obesity decreased, the percentage of adults who reported drinking at least one sugary drink per day fell from 27% to 19%.⁵⁷⁻⁵⁹ Even with the decreased consumption

Figure 4. Percentage of obesity and overweight.

of sugary drinks, Montclair residents still drink them at a rate higher than the general population rates in the county, 16%, and state, 11%.⁵⁷ Increasing the availability of healthy options, such as water, can help decrease obesity, installing water fountains in public facilities, for example, has been demonstrated to increase water intake and reduce overweight and obesity.⁵⁹ More than 60% of children in Montclair drink less than two cups of water daily, and 13% drink none at all.⁶⁰

According to the California Wellness Plan, that by eliminating tobacco, poor diet, sedentary behavior, and alcohol use, 80% of CVD, stroke, and type 2 diabetes and 30% of cancers could be prevented.⁶¹ The plan goes on to state that prevention is possible through early diagnosis programs and both quality care and care within a community context.⁶¹ The plan identifies a need to increase the social desire for and the ability of cities to make the healthy choice the default choice by changing environmental conditions.⁶¹

EDUCATIONAL ATTAINMENT AND POVERTY

Education

More education can improve health by leading to better jobs and higher incomes.⁶³ Those with low socioeconomic status have a higher risk of CD. The most common predictor of socioeconomic status is educational attainment.⁶²

Educational attainment is lower in Montclair than in the county (Figure 5). More people in Montclair, 29.4%, have less than a high school diploma, as compared to 20.8% in the county.¹ Fewer people in Montclair, 14.5%, have earned a bachelors degree or higher as compared to 19.8% in the county.

Figure 5. Educational attainment, 2017.¹

Montclair has the lowest percentage of people in western San Bernardino County with a high school education or higher (Figure 6).⁶⁴ All of the cities in the figure have larger populations than Montclair; even the city of the closest size and demographics, Chino, has nearly 11% more people who finished high school education or gone beyond it.^{1,64}

Figure 6. Population with high school education or higher.¹

In almost all areas of Montclair, a higher percentage of Hispanics compared with those of others racial/ethnic groups has less than a high school diploma.¹ In one of the eight census tracts, the Asian population has the highest percentage of residents with less than a high school diploma, as shown in Table 4.¹

Table 4. Percent of Population over 25 years, with Less than a High School Diploma, 2013-2017* ¹										
	San Bernardino County	City of Montclair	Census Tracts in Montclair							
			201	203	205	207	208	301	303	304
Overall Population	20.8	29.4	22.5	28.3	18.5	24.6	27.2	45.8	44.3	44.8
Hispanic	34.1	38.8	32.4	34.9	22.2	30.9	35.2	56.5	54.5	42.6
White	8.6	11.8	8.9	12.2	18.6	4.9	11.1	28.3	6.2	7.8
Asian	10.3	16.6	6.5	29.6	11.7	40.7	13.4	14.2	8.6	19.3
Black	12.0	10.2	6.4	11.1	3.2	36.8	0.0	0.0	0.0	15.4
Native Hawaiian/ Pacific Islander	13.0	55.0	0.0	-	0.0	-	0.0	.	-	-
American Indian	21.4	16.7	65.2	-	0.0	-	0.0	-	-	12.1
*- indicates there was zero population, no percentage was given; whereas 0.0 indicates none of the population counted fell in this category										

Studies have demonstrated children who have received a high-quality early education program have a lower risk of CVD and diabetes as adults.^{65,66} 34.1% of three- and four-year olds in Montclair attend pre-school. In the country as a whole, 37.3% do so, and in the state, 48.7% do.¹ Only 52.6% of 18- and 19-year olds are enrolled in school compared to 67.3% of those in the county and 77% of those in the state.¹ Although the percentage in Montclair is extremely low, it has shown improvement since 2009, when 48.3% of that age group was enrolled in school.

Figure 7. Montclair high school students college going rate by year⁴⁹

Data for the most recent year available, 2017–018, show the rate at which Montclair High School (MHS) graduates go to college is slightly higher than for the county overall. It is, however, lower than for the school district and state overall (Figure 7).⁶⁷ MHS had a significant dip of about 8% in its graduates attending college between the 2016–2017 and 2017–2018.⁶⁷ This decrease is unusual as rates for the high school district, county, and state remained quite consistent, all decreasing only about 1% in the same time period. When looking more closely at the rate in Montclair, as seen in table 5, there is a large ongoing disparity between African-American and Hispanic students, on the one hand and those of other ethnicities on the other.

Table 5. Rates of Montclair high school graduates attending college by school year and ethnicity ⁴⁶

	14-15	15-16	16-17	17-18
African American	59.1%	*	64.7%	52.9%
American Indian or Alaska Native	*	*	*	*
Asian	93.1%	88.2%	87.5%	85.2%
Filipino	*	*	*	*
Hispanic or Latino	67%	65.2%	65.6%	58%
Pacific Islander	*	*	*	*
White	39.6%	53.1%	67.6%	68.8%

**Insufficient data*

Poverty

The strong association between income and health is well documented.⁶⁸ In a study of counties in the United States, social and economic factors had the strongest association with rates of avoidable death from CD.⁶⁹ Another study has shown that an increased risk of CD in low-income participants is consistent even after being adjusted for smoking and alcohol intake.⁷⁰ Higher incomes can provide more opportunity for better health through access to better physical/environmental conditions such as safer homes and neighborhoods.⁶⁸

Households in Montclair have a median annual income of \$54,192, which is lower than the county average of \$57,156.¹ The number of individuals below the poverty level in Montclair, 18.2%, is higher than in the state of California, which is 15.2%.¹ There is a large disparity in the number of families in poverty between those in which the main householder is married and those in which the main householder is a single woman. In families with children under 5 years old, none of the married couples are under the federal poverty level, but 28.4% of families with a female householder are.¹ As seen in Figure 8, the data for individual racial/ethnic groups is similar to that for the city overall, except for African American families, of which 40.2% of female householders live below the poverty level compared to none of the married couples.¹

Figure 8. Families with children below the federal poverty level, 2013–2017¹

A study of US counties shows that social and economic factors, such as educational attainment and poverty, have the strongest association with rates of avoidable death from CVD.⁶⁹ Fewer Montclair students go to college than others in the school district and state. A higher percentage of people in Montclair live in poverty than in the state.^{1 67}

To improve education and ease poverty, Montclair might consider expanding such existing programs and partnerships as case management programs and Montclair to College. There is existing buy-in, within both programs and their targeted residents. Expanding services to reach more students could be one route the city might take. In this regard, Montclair might look at nearby cities for models. The City of Richmond, for example, is working to strengthen its job pathways program by using high school academies to provide educational support, pre-employment training, and life skills.⁷² The City of Fresno included policies in its general plan to “create a program to provide incentives for local businesses to offer internship, mentoring, and apprenticeship programs to high school and college students in partnership with local educational institutions”⁷³ The City of Fresno is a part of a collaborative cross sectoral effort, the Fresno Economic Opportunities Commission (FEOC).⁷⁴ The FEOC board includes elected members from low-income target areas, business and community representatives, and public elected officials.⁷⁴ The FEOC’s workforce connection for young adults, which focuses on education and jobs training, might be a useful model for expanding Montclair to College, which focuses on youth from low-income areas and offers paid- and unpaid-work experience, supportive services, adult mentors, and financial literacy education.⁷⁴

BUILT ENVIRONMENT

Food access

The top risk factors for CD include poor diet, obesity/overweight, elevated blood pressure, and high fasting-glucose levels.⁷⁵⁻⁷⁶ Access to healthy food is recognized by national organizations and agencies as a critical tool for reducing obesity and improving public health.^{30,77-80}

In 2011, only 40% of female high school students and 39% of male students reported eating breakfast in the past day.⁸¹ This number increased slightly in 2015, to 44% of females and 32% of males.⁸¹ In addition, students with parents who have less than a high school education or are Hispanic or African American were less likely to eat breakfast than other students.⁸² Research has demonstrated that children who participate in the school breakfast program are less likely to be obese or overweight. Nationally, children consume about half of their calories while they are at school. Two elementary schools in Montclair received an award for the US Healthier Schools Challenge in 2016 for their work promoting nutrition and physical activity.⁸³

It is important for children to consume healthy and nutritious food while at school, as their families may not have the means to provide it at home. Indeed, about 12% of people in Montclair are food insecure.⁸⁴ That is, they have too little money and limited resources to maintain consistent consumption of sufficient calories and nutrients.⁸⁵ That 12% rate of food insecurity in Montclair is much higher than that of the county's 9% and state's 7%.⁸⁴ The number of students eligible for free or reduced-price meals at school is widely used to determine the number of low-income students and families; the Ontario-Montclair School District has an extremely high 87% poverty rate. The county's is 71% and state's is 60%.⁸⁶

CalFresh, the state's food stamp program, helps those with low incomes to purchase healthy foods.⁸⁷ In the year from 2016 to 2017, the number of families in Montclair reached by

CalFresh, decreased from the 80%-100% range to the 50%-79% range.⁸⁸ Because of high food insecurity and decreasing enrollment in CalFresh, more outreach could be conducted to increase CalFresh enrollment so that more food insecure families can have access to healthy food.

The choices that people make about food is greatly influenced by what they find available to them at stores, restaurants, workplaces, and other immediate locations.^{77,89-91} Many studies have shown an association between easier access to unhealthy food and a higher body mass index (BMI).^{30,92} At the time of this writing, there are only two full-service grocery stores in Montclair, along other food retailers, such as Costco, Target, and the 99 Cents Only Store, all of which are located in north Montclair.

The modified Retail Food Environment index (mRFEI) is used by the state of California and Centers for Disease Control to illustrate how many healthy food outlets there are in a given area.⁹³ The overall mRFEI for Montclair is 13.64, meaning that only 13.64% of food outlets offer healthy food options.⁹⁴ This number is lower than the county's 16.38% and state's 18.2%.⁹⁴ The mRFEIs for census tracts within Montclair range from 7.14 in the southern end of the city to 23.3 in the middle (Table 6).

Table 6. Modified Retail Food Environment Index (mRFEI), 2017⁹⁴

	Census Tracts in Montclair							
	201	203	205	207	208	301	303	304
mRFEI	9.3	14.29	10.81	23.33	12.5	17.5	15	7.14

Communities with less than 16.7% healthy food outlets have been shown to have a 20% higher prevalence of obesity and a 23% higher prevalence of diabetes than communities with 25% healthy food outlets.⁹⁴ The Retail Food Environment Index was mapped in 2013 as part of a community-wide needs assessment (Figure 9).⁹⁵ Although the measure includes only convenience stores and fast food restaurants, it provides another view of the food environment in Montclair.

Figure 9. Retail food environment index.⁷⁰

While access to healthy food is important, there are a complex set of factors that influence food consumption. Transportation, perception of safety, quality of produce, and the cultural appropriateness of food outlets all influence how people eat when healthy food is available.³⁰

Transportation and physical activity

The modern transportation environment, the reliance on automobiles, has led to a decline in physical activity and increase in obesity.⁹⁶ Physical inactivity is a common risk factor for CD.⁷⁶ As noted above, Montclair has high rates of overweight and obese residents compared to the county and state. This situation did improve, however, from 2012 to 2016.⁵⁴ Although the number of obese and overweight children and teens has decreased by 16%, children and teens did not, however, get more exercise outside of physical education in school. The percentage of

children ages 5–17 who engaged in at least 60 minutes of physical activity daily in the previous week decreased from 21% in 2012 to 14% in 2016.⁵⁴ During this period, the number of adults who walked at least 150 minutes for transportation or leisure increased from 28% to 36%.⁵⁴

Although the City of Montclair has limited park space, twelve schools within the city have space for physical activity. Schools are encouraged to share their physical activity spaces with the community by numerous nationwide organizations, such as the American Heart Association,⁹⁹ National Physical Activity Plan,¹⁰⁰ Healthy People 2020,¹⁰¹ and the White House Task Force on Obesity.¹⁰²

People who feel safe are more likely to participate in regular physical activity.¹⁰³⁻¹⁰⁶ Yet when fifth-grade students in the Ontario-Montclair School District were asked if they feel safe on their way to and from school, 23% said never and 17% said only some of the time.⁶⁷ The perception of safety is an important determining factor in levels of physical activity.¹⁰³⁻¹⁰⁵ Creating safe environments for play are associated with more frequent outdoor activity.¹⁰⁶ Among general-plan survey participants, 52% of respondents answered they felt unsafe, or at best responded they felt neither safe nor unsafe.¹⁰⁷ Even more participants felt this way about being in parks, although 65% of respondents felt satisfied with the current quality of parks in Montclair.¹⁰⁷ Montclair might well study why people feel unsafe and make appropriate changes to encourage more of them to feel safe outdoors.

Community design can have a significant impact on levels of physical activity.¹⁰³⁻¹⁰⁶ People who live in places with well-maintained sidewalks, bicycle infrastructure, a perception of safety, and pleasing aesthetic characteristics have higher levels of physical activity.¹⁰³⁻¹⁰⁶ Providing amenities such as public art, benches, and bike racks have been shown to increase physical activity.¹⁰⁸⁻¹¹¹ The Urban Land Institute recommends incorporating amenities that go

beyond traditional swings and slides to include imaginative areas with colorful art and playscapes providing spaces for children of all abilities to have fun.¹⁰⁶

The top risk factors for CD include poor diet, high body mass, elevated blood pressure, and high fasting-glucose levels.⁷⁵ Physical activity can help correct these, but Montclair's initial development was focused on the use of the automobile, which created an environment that did not encourage that. To lower CD rates, Montclair will need to focus on improving the built environment. New York City has used the social ecological model to develop fruit and vegetable access, in part by modifying its licensing structure to allow for mobile vendors to bring fresh produce to underserved areas through its Green Carts Program.¹¹²⁻¹¹³ Philadelphia updated its entire zoning code to incorporate health and sustainability by establishing density bonuses for mixed-income housing and including fresh food markets in mixed-use developments. It also changed parking regulations for cars and added bicycle parking to make shopping easier.¹¹⁴ Similarly, the City of Cleveland also has a zoning requirement for bicycle parking.¹¹⁴ Similar changes could help Montclair transform the environment for a healthier population.

HEALTHCARE AND MENTAL HEALTH

Improving access to healthcare is one of many factors in developing a healthy community, and providing affordable healthcare is difficult given that San Bernardino and Riverside Counties have faced a physician shortage for years, conditions expected to worsen.¹¹⁵ In 2016, the county had 120 physicians per 100,000 residents, whereas California's had 194 per 100,000.¹¹⁵ The proportion of uninsured people in Montclair is significantly higher than in the state and county.¹ Almost half of the Native Hawaiian and Pacific Islander population in

Montclair, 46%, is uninsured. In the county, 15% of that population is uninsured.¹ Further, 18% of Montclair's Hispanic/Latino population is uninsured, compared to 15% at the county level.¹

The World Health Organization holds that “there is no health without mental health,”⁹⁹ which it defines as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”¹¹⁶ A higher percentage of Montclair residents have experienced serious psychological distress in 2016 compared to the county and state.¹¹⁷ From 2012 to 2016, the percentage of adults experiencing serious psychological distress increased disproportionately compared to that of the county and state.¹¹⁷ Programs such as Mental Health First Aid have proven successful in increasing mental health knowledge and reducing stigma.¹¹⁸ Within Mental Health First Aid, participants are trained to assist those with mental health problems or those at risk of such problems as anxiety, depression, and substance abuse.¹¹⁸ Financial strain and food insufficiency are both associated with poor mental health outcomes.¹¹⁶ To improve mental health, a number of issues must be addressed. For example, larger distances to mental health providers can lead to more mental health issues continuing for individuals.¹¹⁶ There are very limited behavioral health providers in Montclair, although Kaiser Permanente has a small behavioral health clinic for its members and Health Service Alliance recently began offering behavioral health services at the Montclair Community Health Center.

The City of Montclair is in a unique position to utilize the extensive network of promotoras built through the Montclair Por La Vida Program. In the past, Montclair utilized the promotoras for nutrition education. Studies show how the community health worker model has led to decreases in risk factors for CD when focused on outreach, enrollment, team-based care,

and patient navigation.¹¹⁹ Montclair might consider expanding the program to cover mental health concerns.

SOCIAL CONNECTEDNESS.

Social connection is vital for a healthy community. Healthy people have more time and money to contribute to healthier behaviors such as socializing, recreation, and entertainment.¹²⁰ Depression, loneliness, and stress can lead to poor health.^{116,121-122} Further, social exclusion, adverse learning environments, and trauma are all risk factors for poor mental health.¹²³⁻¹²⁴ When people experience anxiety, trauma, and chronic stress, they are more likely to develop a variety of unhealthy behaviors, in addition to unhealthy conditions such as heart disease and autoimmune disease.¹²³⁻¹²⁴ As discussed previously, the population is aging at an increased rate and social isolation is a major concern for older adults.¹²⁵⁻¹²⁸ Group activities for older adults, such as art and exercise, can improve cognition, reduce depression and improve their mental health overall.^{126,129-130} Physical activity programs for older adults have demonstrated success in reducing falls and improving strength, balance, and cognitive function.^{127,131-132} The Montclair General Plan Update can contribute to increasing social connections and community cohesion through increasing the investment in community resources that are health promoting such as parks and recreation facilities and community programs that are equitably distributed throughout the city.

Other social determinants of health are connected to social connections and community cohesion. Indeed, social support has been shown to promote mental health and well-being.^{120,128,133-134} People with fewer ties to their community are found to have a higher risk of CVD.¹³⁵⁻¹³⁶ Someone's support system and the community conditions where that person lives

can positively affect recuperation from cancer and living with diabetes.^{121,137} Strong connections have been shown to correspond with increases in academic achievement, along with local economic development, and lower rates of homicide, suicide, and alcohol and drug abuse.¹³⁸ Social connections and community cohesion can be developed in community facilities, places where the people can come together, have their voices heard, be active, and feel safe.¹³⁹ In addition, high levels of support from coworkers and supervisors are predictive of better mental health.¹⁴⁰ Developing and encouraging workplace health programs in the community can lead to positive health outcomes in Montclair.

There is a low level of civic participation in Montclair, which is associated with low income communities with low levels of education.^{25,141} The National Conference on Citizenship released a study on *civic deserts*, describing communities with little opportunity for civic engagement.¹⁴² They found that the level of civic engagement has fallen in America, along with a decline of regular involvement with religious institutions, unions, and reading the daily newspaper.¹⁴² At the same time, social isolation has increased and volunteerism has decreased.¹⁴² The study points to areas of opportunity as millennials have volunteered at higher rates than those of the boomer generation, millennials have a greater belief that their involvement will lead to positive social change.¹⁴² The study goes on to suggest that there is an opportunity to capitalize on the momentum of youth participation to create a stronger civic foundation for the community.

The City of Montclair can expand upon current avenues for youth engagement like the Montclair Youth Center, Montclair After-school Program, or the partnership between the local elementary and high schools with Montclair to College. The National Conference on Citizenship recommends increasing access to civics education, including service-learning courses, expanding

service opportunities, and utilizing technology to increase community engagement and social connectivity. Further, the city might increase civic participation by establishing a youth commission, defined by the Institute for Local Government as a body of young residents from 12–24 years old who offer guidance on issues that affect youth.¹⁴³ The City of Benicia, a small city in northern California, included the importance of a youth task force in their general plan strategies.¹⁴⁴ The city has implemented three youth commissions: the Youth Action Coalition, the Youth Commission, and the Youth Master Plan Steering Committee.¹⁴⁵

SUMMARY.

The City of Montclair's efforts to improve residents' health have been directed more towards having had a greater impact on individuals than the broader population. To date, no efforts have been specifically targeted towards reducing CD or improving the social determinants of health.^{133,146-150} A person of lower socioeconomic status is at higher risk for the development of poor health.^{133,146,150} Montclair has a low-income population with low educational attainment. Features of the neighborhood physical and social environments can influence CD development and outcomes.^{146,149,151} Montclair has high food insecurity, insufficient access to healthy food, high rates of obesity, and children feeling unsafe walking to school. In Montclair, CDs have remained the leading cause of death for over twenty years starting in the 1990s. There has been little action on levels of the health impact pyramid resulting in health improvements for the larger population. The city has not done enough, for example, to influence people's default to healthier food choices. Moreover, more needs to be done at all levels of the social ecological model. Reducing the health disparities that exist in Montclair will require policy solutions.^{149,152-153}

CHAPTER 3. METHODS

Montclair is not the only small city that has struggled with finding ways to improve its residents' quality of life. A common line of thinking when it comes bettering the conditions of those who are disadvantaged is to provide more services.⁵ Although services and other programs may be needed, they alone cannot change the environment in which people live, or alter the social determinants of well-being, or improve health.⁵ Changing quality of life and the problems that can ensue from its deficits will require strategic, measured, collaborative multi-sector actions over the long term. This study uses a document review and semi-structured interviews to inform a logic model that will guide a *Health in All Policies* (HiAP) initiative for the City of Montclair. This case study aims to identify ways to guide future policies and programs intended to lower the prevalence of CD in the City of Montclair.

RESEARCH FRAMEWORK.

HEALTH IN ALL POLICIES.

According to the World Health Organization,¹⁵⁴ a HiAP strategy “is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity.” A HiAP strategy utilizes an ecological approach that emphasizes collaboration to assess health impacts across multiple sectors, providing the opportunity to address the social determinants of well-being in a systematic way.^{152,157-161} Such an approach can respond to complex problems that are intertwined, like the increasing incidence of chronic disease—challenges difficult to address in the traditional siloed way local governments typically operate.¹⁵² In addition, local government and their constituent elements are generally constrained

by very tight budgets in addressing these major health challenges.¹⁵² Collaboration across sectors through a HiAP approach, involving government departments and also nongovernmental community agencies and other groups, even individuals, can help address these complex issues through systems-level policies that improve communication, eliminate duplication, employ shared resources, and decrease costs.¹⁵²

In 2006, this approach began to gain traction. First, the Finnish president highlighted HiAP as a concept designed to improve public health through intersectoral collaboration.^{155,156} Since then, HiAP initiatives have been adopted throughout the world, and in 2010 California created a HiAP task force. HiAP has now been recommended by the State of California, the Institute of Medicine, and the World Health Organization, because policy decisions at all levels of government can affect health.^{152,162-163} The goal of HiAP is to institutionalize the consideration of health and sustainability in the policymaking process and to do so across sectors.¹⁵² This requires that multiple sectors share goals, collaborate, and coordinate on policies development and implementation but does not provide a prescribed sequential process for every HiAP initiative, as health challenges are too complex to solve all in the same way.^{160,165}

A HiAP approach can be extremely useful in a community like Montclair. Because there are many complex health challenges there, a focus on one or two specific areas will not have the wide-ranging effect needed to change the environment in which they exist. CDs have been the leading cause of death in Montclair for over twenty years, and a small change, like adding a farmer's market or implementing health workshops, will not be enough to disrupt the system at the level needed to change the health of the community. Unraveling 100 years of policy decisions with a variety of impacts on health is extremely challenging, and it requires a complete

paradigm shift, such as the HiAP framework, to break down the siloed nature of government decisionmaking.^{152,158,166-167}

HiAP initiatives must be tailored to a particular community, so every HiAP initiative is different.^{159,162,165,168} Research to date has not demonstrated one best-practice in implementing a HiAP initiative.¹⁶⁸ However, there are common characteristics found when utilizing HiAP strategies, which usually follow five principles: 1) promoting health, equity, and sustainability, 2) supporting intersectoral collaboration, 3) benefiting all partners, 4) engaging stakeholders, and 5) creating structural or procedural changes.^{152,165} The main goal of a HiAP strategy is to institutionalize health, equity, and sustainability as considerations within all policy decisions.¹⁵² The three basic components of HiAP are community engagement, cross-sectoral collaboration, and government involvement.¹⁶⁹ HiAP does not require that health be at the center of every policy. Rather, it promotes the recognition and importance of health while also highlighting the need for collaboration across multiple sectors.¹⁷⁰ Nor does HiAP require that all components of the initiative be carried out at once. Instead, policy can be developed and implemented when there is the political will and appropriate resources.¹⁷¹ In that sense, the HiAP strategy is dynamic, malleable, and sensitive to current conditions within a city or other geographical area.

There are numerous examples of what appear to be successful HiAP initiatives in a range of cities. Because HiAP is a relatively new concept, however, there are not yet many scholarly articles evaluating them. The HiAP initiative in the City of Richmond, adopted in 2014, led to dozens of actions focused on improving the social determinants of health.⁷² Montclair can learn from the strategies employed there in developing a HiAP initiative of its own. Richmond not only enacted a HiAP ordinance that included a strategy statement but also documented its efforts with a report that covered both its short- and long-term goals. Chicago adopted a HiAP initiative

in 2016, after five years of developing a comprehensive city-wide plan to do so with input from the community.¹⁷² Montclair can learn from the HiAP initiative in New Orleans, which in 2015, after a comprehensive, collaborative process, created a community health improvement plan to solidify its plan to develop a HiAP initiative.¹⁷² Although HiAP is a newer concept, these examples in larger cities can help pave the way for successful implementation in smaller cities, including Montclair.

LOGIC MODEL.

A logic model illustrates a logical sequence that of the steps in an initiative to bring about change.¹⁷³⁻¹⁷⁴ Logic models are often flow charts or tables that make up a picture to show the connections between the pieces of an initiative or program and how it supposed to work.¹⁷³⁻¹⁷⁴ They are often used to summarize a complex program to a diverse group of stakeholders.¹⁷³ In addition, a logic model is an illustrative way to understand the activities and outcomes of a program to build consensus and focus within a group.¹⁷³⁻¹⁷⁴ A logic model is developed by connecting information on existing resources and required actions and linking them to the intended results.¹⁷⁴ Expert evaluations have concluded that developing a logic model is an effective way to ensure the success of a program or initiative.¹⁷⁴

Gase et al. developed a general logic model for HiAP through a literature review and expert interviews, as illustrated in Figure 10.¹⁷⁵ It will be adapted here to address the needs of the City of Montclair, since HiAP is specific to the context of each jurisdiction, as Gase et al.¹⁷⁵ acknowledge.

Figure 10. Potential logic model for HiAP initiatives¹⁷⁵

The Gase et al. model illustrates inputs, activities, outputs, and short-, intermediate- and long-term outcomes of HiAP initiatives. The W. K. Kellogg Foundation¹⁷⁴ recommends developing a logic model from right to left, so the intended results are determined first and are clearly articulated before determining planned actions and linking them to results.¹⁷⁴ The intended results in Figure 10 include the outputs and outcomes. Outputs indicate whether the activities took place as intended and can describe the nature and characteristics of those activities.¹⁷³⁻¹⁷⁴ Outcomes are defined as changes expected to have been produced over a specified time after the activities are conducted.¹⁷⁴ Outcomes are framed in terms of one of the versions of the SMART methodology: they should be specific, measurable, producible via actions, realistic, and timed.¹⁷⁴ Short-term outcomes may include changes at the individual level, such as awareness, attitudes, and skills, and could take one to three years to achieve after

activities take place.¹⁷³⁻¹⁷⁴ Intermediate outcomes build upon short-term ones and might include behavioral changes, policies, and practices that could take four to six years to achieve.¹⁷³⁻¹⁷⁴ Last, long-term outcomes might take seven to ten years to achieve after activities have taken place and include alterations in social, environmental, and economic conditions, or transformation at the systemic level.¹⁷³⁻¹⁷⁴

The planned work detailed in the logic model includes inputs and activities. Activities are the tools, actions, and techniques used to achieve the results.¹⁷⁴ Inputs include resources that can be contributed to achieve the activities and desired results.¹⁷³⁻¹⁷⁴ They can include staff time, funding, partnerships, supplies, and use of facilities.¹⁷⁴

STUDY DESIGN AND METHODOLOGY.

This project, designed as a case study, uses qualitative methods to generate an in-depth understanding of the factors that have hindered attempts to reduce CDs in Montclair. It is meant to inform a comprehensive strategy the city can employ to lower the incidence of CDs and to lessen their toll. The qualitative methods include a document review and semi-structured key informant interviews. Qualitative methods are critical here because they capture the thoughts and experiences of the Montclair's stakeholders, reactions that cannot be fully captured through quantitative methods. Knowledge acquired in the document review will inform the policy recommendations in a tailored approach to Montclair by distilling the plans and findings of important international, national, state, and local approaches to HiAP. The entirety of the information collect in all these ways will inform a logic model outlining how Montclair can develop systemic improvements to reduce chronic disease.

DATA COLLECTION METHODS

DOCUMENT REVIEW

Using qualitative methods to review and analyze documents often provides a rich bounty of information.¹⁷⁶⁻¹⁷⁷ Such an approach has informed many public health studies investigating policies.¹⁷⁷⁻¹⁸² Here, the analysis of HiAP documentation, including international and national gray literature and peer reviewed articles, identifies themes on the development and implementation of a multiplicity of programs.

This study's document review uses Altheide's framework for analysis, a method¹⁸³⁻¹⁸⁴ applied in multiple public health studies.¹⁸⁵⁻¹⁸⁷ This¹⁸⁴ framework for document analysis includes five stages:

Stage 1) *Documents*. The researcher became familiar with the types of documents to be analyzed.¹⁸⁴

Stage 2) *Protocol development and data collection*. A protocol in this approach is a list of questions about or categories to be applied to the material in the documents and typically includes twelve categories or fewer.¹⁸⁴ The first draft of the protocol is then tested, refined, and revised.¹⁸⁴ The final protocol developed for this study can be found in Appendix B. Documents were collected via a progressive theoretical sampling—that is, the selection of materials is based on emerging knowledge about the topic.¹⁸⁴ The documents included in this analysis can be found in Table 7.

Stage 3) *Data coding and organization*. The documents are coded and organized based on the protocol.¹⁸⁴

Stage 4) *Data analysis*. The goal of this document analysis is to understand the themes and substance in the HiAP documents and a purpose that can be lost through the use of a

coding algorithm. Since a computer may not be able to analyze the meanings of the words used, no computerized coding was used in this study.¹⁸⁴ During data analysis, the reports on each coded document were compared for extreme interpretations and key differences.¹⁸⁴

Stage 5) *Report*. Findings from each protocol category are summarized and included in the results section.¹⁸⁴ Ultimately, the findings from the document review inform the HiAP logic model produced for Montclair.

Table 7. Documents Reviewed

Author	Title	Description	Year of Publication
Gase et al ¹⁷⁵	A Practice-Grounded Approach for Evaluating Health in All Policies Initiatives in the United States.	A basic logic model that can be adapted for use in the City of Montclair	2017
Guglielmin et al ¹⁸⁸	A scoping review of the implementation of health in all policies at the local level.	A review of the literature to analyze published information about the factors facilitating or hindering HiAP implementation at the local level.	2018
Johnson and Wooten ¹⁶⁵	From Start to Finish: How to permanently improve government through health in all policies	A tool kit to help communities institutionalize HiAP through policy	2015
Johnson et al ¹⁷²	A Roadmap for Health in All Policies Collaborating to Win the Policy Marathon	A step-by-step guide for creating a HiAP initiative	2018
Rudolph et al ¹⁵²	Health in All Policies a Guide for State and Local Governments	A step-by-step guide for creating a HiAP initiative focused on state and local governments	2013

KEY INFORMANT INTERVIEWS.

Key informants, those with special knowledge of and/or insight into a particular organization, community, program, or group are interviewed to shed light on the basic issue or research question. These interviews are in-depth, often semi-structured, and conducted with a select (non-random) group of those most knowledgeable about a substantive topic or local organization. Data collected in the interviews are used to inform needs-assessments, program development, and evaluation, as well as to assist with the interpretation of research findings.

For the purpose of the current research, the interviewees provided feedback on the proposed HiAP model recommended for Montclair.

Participants

Key informant interviews were conducted with stakeholders from the Montclair. The stakeholders interviewed are listed in Table 8.

Table 8. Key Informants

<i>City of Montclair Officials</i>
Community Development Director
City Planner
Public Works Director/City Engineer
Senior Management Analyst
<i>City of Montclair Community Members</i>
Two community members

The interviewed Montclair city officials direct programs and assist in the development of policy. Their buy-in is required for a HiAP initiative, and their feedback is vital to the future of this particular project. Stakeholders chosen wield influence in both Montclair's policy development and direction and within the community. Feedback from community members is also vital. Policies and programs to improve health are most effectively developed in isolation

without community input about what might be acceptable and viable to the residents.

Interviewed community members live and work in Montclair and are among the leaders of many community programs.

Interview Procedures.

Each key informant was contacted in person to request their taking part. Interviews were audio recorded and transcribed. Each interview lasted from 19-36 minutes. At the start of the interview, each person was presented with a brief overview of the leading causes of death in Montclair, an overview of the HiAP approach, and the draft of the logic model to acquaint them with recommendations for Montclair. They provided in-depth information on the context in Montclair, the city's readiness to begin a HiAP initiative, and identified barriers and opportunities for HiAP development and implementation. These in-person interviews did not collect any identifiable personal information but only requested feedback on the recommended approach to improve population health in Montclair.

Key Informant Interview Items

The semi-structured interview questionnaire is included in Appendix C. Interview questions were adapted from the various sources listed in the Table 9 below. The questions were selected based on current research and knowledge about what is needed to begin a HiAP initiative. Further, questions were developed based on the research question in order to identify which strategy Montclair might best employ to improve patterns of chronic disease, to add to an understanding of Montclair's context, and to inform the predevelopment of HiAP.

Table 9. Sources for interview questions

Interview Questions	Sources
1) How do you think a HiAP approach to decreasing CD can benefit the City of Montclair?	Gase et al ¹⁷⁵ Rantala, Bortz, and Armada ¹⁸⁹ Rudolph et. al ¹⁵² Stahl et. al ¹⁹⁰
2) What are the assets in Montclair that can help move this HiAP initiative forward? Which community leaders/organizations would you recommend for this multisector HiAP effort?	Gase et al ¹⁷⁵ Leppo et. al ¹⁷¹ Polsky ¹⁵⁹ Rantala, Bortz, and Armada ¹⁸⁹ Rudolph et. al ¹⁵²
3) What do you think the barriers will be to creating a HiAP initiative in Montclair?	McQueen et. al ¹⁹¹ Leppo et. al ¹⁷¹ Rudolph et. al ¹⁵² Stahl et. al ¹⁹⁰
4) How can HiAP messaging be tailored to create buy-in among multiple sectors in Montclair?	Rudolph et. al ¹⁵² Stahl et. al ¹⁹⁰
5) With your expertise on the City of Montclair, is there anything you would add or remove from the logic model to make a HiAP initiative sustainable?	Leppo et. al ¹⁷¹ Mundo et. al ¹⁶⁸ Polsky ¹⁵⁹ Rantala, Bortz, and Armada ¹⁸⁹

Data collected from the interviews is used to inform the Montclair HiAP logic model developed here. Each interview question informed one or more areas of the logic model; the crosswalk can be found in Table 10.

Table 10. Interview questions and corresponding logic model area

Interview Questions	Logic Model Area
1) How do you think a HiAP approach to decreasing CD can benefit the City of Montclair?	Outputs Outcomes
2) What are the assets in Montclair that can help move this HiAP initiative forward? –Which community leaders/organizations would you recommend for this multisector HiAP effort?	Inputs
3) What do you think the barriers will be to creating a HiAP initiative in Montclair?	Inputs Activities Outcomes
4) How can HiAP messaging be tailored to create buy-in among multiple sectors in Montclair?	Activities
5) With your expertise on the City of Montclair, is there anything you would add or remove from the logic model that would make a HiAP initiative sustainable?	All

Key Informant Interview Analysis

Data collected from the interviews were transcribed verbatim from the interview recordings. Interview recordings are stored on a password-protected cloud server that is only available to the researcher. After transcription, the data were analyzed without the use of computer assisted technology. Rather, the researcher used inductive content analysis, which allows the coding to emerge as the data are reviewed.¹⁹²⁻¹⁹³ The themes emerging from the interview will be utilized to form the City of Montclair’s HiAP logic model.

ETHICAL CONSIDERATIONS.

The Claremont Graduate University Office of the Institutional Review Board (IRB) was consulted, and the determination letter can be found in Appendix D. An IRB representative conducted a preliminary review of protocol IRB #3865 Utilizing a health in all policies approach

to improve cardiovascular health in the City of Montclair. Pursuant to federal regulations 45 CFR 46.102(e)/(1), the project is not human-subjects research and does not require further IRB review or oversight. Under these regulations, (a) it is not research because it does not aim to contribute to generalizable knowledge, and (b) use of publicly available data that is not identifiable does not constitute the involvement of human subjects.

PLANS FOR PRESENTING THE RESULTS.

Findings are presented in Chapter 4. The results of this case study will be presented to Montclair stakeholders and are included here. The results will include a logic model to develop a HiAP approach to improve CD health in Montclair as tailored by feedback from Montclair stakeholders.

SUMMARY.

This investigation presents a case study using the qualitative methods of document review and key participant interviews to explore what can be done to improve health, including addressing CD, in the City of Montclair. The research informs the study's goal, to identify the next steps to guide strategies, such as policies and procedures, to improve the health of the city's residents. This study proposes that the reasons for CDs having remained the top causes of death in Montclair are: 1) stakeholders focused only on those levels of the social ecological model and health impact pyramid that have low population impact, and 2) there was no focused effort to work collaboratively to improve the social determinants of health. Qualitative methods are important because they capture in-depth information regarding the thoughts and experiences of the Montclair stakeholders, which cannot be fully captured through quantitative methods. The

information retrieved through document review will inform policy recommendations. The entire corpus of information will inform Montclair's HiAP logic model, which will drive the next steps in developing systems-level improvements to reduce chronic disease.

CHAPTER 4. RESULTS AND DISCUSSION

This case study employs a cross-sectoral social ecological lens to develop strategies for the City of Montclair to lower rates of chronic disease by focusing on root causes. It proposes that chronic disease has remained persistent in Montclair because the city's focus was only on one level of the social ecological model, meaning that many social determinants of health were not altered. Hence, interventions did not create sustainable change in the Montclair. The city has the power to foster a collaborative cross-sectoral approach that influences policies and programs and can substantially improve education, socio-economic status, access to health care, availability of healthy foods, the number of green spaces, and other social and physical environmental factors. This study's primary research question is: What can be done to improve health, including addressing chronic disease, in the City of Montclair? A document analysis and key informant interviews provide information necessary to tailor the approach to be recommended.

The transcribed interviews and the reviewed documents were analyzed to determine key points and major themes. Of the six interviews, three were with managerial staff and three with staff members who are Montclair residents, two of whom are also community leaders. The City Manager's office, Community Development Department, Public Works Department, and Human Services Department were all represented. The key points or themes found for each interview question are listed in Table 11. The themes found in the answers of city staff and community members are listed below, there were no key points that were found solely among community members.

Table 11. Key Informant Interview Themes

Question	Key Points or Themes
1) How do you think a HiAP approach to decreasing CD can benefit the City of Montclair?	Creating a healthier community* HiAP can be utilized with our General Plan
2) What are the assets in Montclair that can help move this HiAP initiative forward? –Which community leaders/organizations would you recommend for this multisector HiAP effort?	Existing programs and partnerships* Promotoras General Plan* Small city
3) What do you think the barriers will be to creating a HiAP initiative in Montclair?	Funding and staffing* Community involvement* resistance to change*
4) How can HiAP messaging be tailored to create buy-in among multiple sectors in Montclair?	Framing HiAP as a win-win* Using understandable wording Using data to demonstrate need*
5) With your expertise on the City of Montclair, is there anything you would add or remove from the logic model that would make a HiAP initiative sustainable?	Existing planning documents Community buy-in Assessment of what has been done*

* indicates theme or key point found among community input and city staff

In addition, five reviewed HiAP documents include international and national gray literature and peer-reviewed articles. The documents reveal five major themes:

(1) communications and messaging, (2) incorporating health into decision making, (3) evaluation: assessments and data collection, (4) building awareness and political support, and (5) formalizing HiAP. Each document included important points within each theme. These are listed in Table 12.

Table 12. Document Analysis Themes

Document Titles	Key Points or Themes
1) A Practice-Grounded Approach for Evaluating Health in All Policies Initiatives in the United States. ¹⁷⁵	Shared values Data sharing Evaluation Training and education Policy language
2) A scoping review of the implementation of health in all policies at the local level. ¹⁸⁸	Creating a win-win message Shared values Health impact assessment Collaboration HiAP formalization Incorporating health into decision making
3) From Start to Finish: How to permanently improve government through health in all policies. ¹⁶⁵	Shared values Cross-sectoral approach to decision making Data sharing Executive level support Creating a win-win message Mandating HiAP
4) A Roadmap for Health in All Policies Collaborating to Win the Policy Marathon. ¹⁷²	Storytelling narrative Shared values Cross-sectoral approach to decision making Data sharing Community-needs assessment Current policy/program assessment
5) Health in All Policies a Guide for State and Local Governments. ¹⁵²	HiAP communications Creating a win-win message Shared values Incorporating health into decision making Cross-sectoral approach to decision making Data sharing Health impact assessment Collaboration Executive-level support Pillars for creating intersectoral relationships

An analysis of the documents and interviews provides five overall themes including:

- (1) communications and messaging, (2) incorporating health into decision making,
- (3) evaluation: assessments and data collection, (4) building awareness and political support, and
- (5) formalizing HiAP. These five themes are then used to adapt the foundational HiAP logic model developed by Gase et al¹⁷⁵ for the City of Montclair so it can begin its HiAP initiative.

The first question asked during the interview was “How do you think a HiAP approach to decreasing CD can benefit the City of Montclair?” All the interviewees, whether managerial staff or community member, listed benefits of HiAP for the City in Montclair. Both groups believe a HiAP approach will create a healthier Montclair and will have a variety of benefits. Only one interviewee had a more cautious response, suggesting that HiAP will be beneficial only if it does not duplicate or conflict with existing policies and regulations. One take-away from the interviews is that there will be managers and community members who would support the initiative.

THEME 1. COMMUNICATION AND MESSAGING

Communication and messaging are treated in four of the five documents as an integral part of the HiAP process.^{152,165,172,188} In general, the interviewees believe that community and other stakeholders may have difficulty accepting change. A common theme mentioned by community members and management staff is the challenge of convincing people to accept new ways of doing things. Similarly, the documents note that how HiAP is discussed is critical to its success.¹⁵² There are key elements in good HiAP messaging. These include: tailoring presentations to their audiences, framing the message for the specific environment, having the appropriate person communicate the message, delivering a description of what contributes to poor health. Also important is tailoring the values and vision motivating the effort to the environment.^{152,188}

Creating win-win messaging is a theme running through the documents and the interviews. The documents indicate that messages tailored to the audience must create a win-win for the targeted partners.^{152,188} One city official suggested using a project that is a “low-hanging

fruit” to demonstrate an easy win that can achieve dual goals. Because Montclair was developed as a carcentric city, for example, many streets are overdeveloped and underutilized. That official said, “we change those streets to have more bike lanes, wider sidewalks, and we create initial operating systems as test models that can show people how much better things are. Then we can start getting people to change their minds.” This will be a win-win in showing that changes can achieve the goals of non-health practitioners and meet HiAP goals at the same time. This can also build trust and buy-in for the HiAP initiative.

The documents argue that framing the problem in terms meaningful in the environment where people live, work, and play, as well as using a storytelling narrative, can help the audience connect with the initiative.^{152,172} Another recommendation is to have a well-respected person present the information and proposal, as more people will likely listen.¹⁵² Communicating shared values and vision to motivate change is also vital and is mentioned in all five documents.^{152,165,172,175,188} Rudolph et al¹⁵² suggest that communication about HiAP describe shared values, such as efficiency, collaboration, and opportunity, in order to make HiAP more understandable for all partners involved. City staff advise that the initiative use wording that is comprehensible to different sectors and also the broader community. One interviewee thought, for example, that the word “sustainable” might not be understood by people not from a health-services background.

Further, the communication and messaging for HiAP must consider the complexity of the problems and the intricacy of government bureaucracy.^{152,165} As discussed in two of the documents, HiAP can be a way to promote efficiency in addressing some of the most complicated issues while reducing duplication and costs and improving outcomes.^{152,165} Through HiAP intersectoral collaboration, duplicative activities can be identified and pared. Having

multiple entities working toward the same goal but without duplication might may also increase community reach.

Communication and messaging to the general community is not detailed in the HiAP literature. It does come up in the interviews, however, where a common theme is barriers to community involvement. One interviewee noted HiAP communication and messaging will need to be available in Spanish and English, as there are many primarily Spanish-speaking residents in Montclair. In addition, the interviewee suggested conducting an assessment to understand what the community wants to help ensure the HiAP initiative is being done with and for the people it is intended to help.

THEME 2. INCORPORATING HEALTH INTO DECISION MAKING

All five documents discuss incorporating health into decision making.^{152,165,172,175,188} Embedding or institutionalizing HiAP increases the chance of long-term structural changes, which is a key element of the approach.¹⁵² Rudolph et al¹⁵² define HiAP as “a collaborative approach to improving health that incorporates health considerations into decision-making in all sectors and policy areas.” Incorporating health into decision making is HiAP.¹⁶⁵ The documents agree that although incorporating health into decision making can at first be informal to obtain buy-in, it is imperative that HiAP become formalized—a process discussed in subsequent sections.^{152,165,172,175,188}

The documents also note that HiAP can be applied to the many decisions made frequently by all government departments. Examples include decisions about access to food, public safety, park placement and programs, economic development, sustainability, housing, and transportation.^{152,165,172} The interviewees agree that by systematically changing the ways

decisions are made, a HiAP approach can improve the health of the community. One person suggested requiring the city's development review committee to consider health. If it were, for example, to consider effects on well-being when asked to permit a new warehouse, the committee might find air quality near the site to be poor, a problem the additional truck traffic to the area would exacerbate. In addition, they might look at the proximity of housing and schools and the number of children regularly walking or biking to school who would need to access the sidewalk or street in front of the warehouse. There could be many more considerations depending on the unique needs of the community, issues that would not even be recognized if health were not a mandated concern.

When determining how to evaluate a HiAP initiative, Gase et al¹⁷⁵ propose using "decision making" as an indicator. The outcome "sustainable systems that support cross-sectoral collaboration"¹⁷⁵ can be mandated via statute or other forms of regulation that necessitate the review of considerations of health and equity.¹⁷⁵ Documenting these actions throughout the initiative will be valuable for evaluation. Those interviewed also consider documentation to be critical for assessments of existing and past actions.

A variety of protocols, whether mandated by legislation or some other form regulatory process, can be included in assessments. Local governments might, for example, require that every contract review consider health.¹⁶⁵ A transportation planning contract, for example, might be assessed by the degree to which potential consultants propose to look at issues of health. Similarly, janitorial bidders might be required to include information about the products used to clean and the chemicals they contain. The contracts themselves might demand that certain chemicals not be allowed at all. When choosing caterers, departments can review the nutrients in their offerings and whether healthier options are available. Cities could also alter where

community meetings are held, requiring they occur at multiple sites around the locality. This could encourage greater political participation, increase the number of people walking to meetings, and collecting more, and more valuable, feedback about how best to create a healthier community. In doing so, it would address the barrier to community involvement that was mentioned in the interviews.

THEME 3. EVALUATION: ASSESSMENTS AND DATA COLLECTION

Another key theme in the HiAP documents is the role of assessments and data collection. Every article mentioned the importance of evaluation. HiAP is a complex effort that demands collaborative assessments. Rudolph et al¹⁵² note that a HiAP initiative is a new opportunity to bring different sectors together, ones traditionally siloed, through data collection. National and international HiAP guides and reviews find that health-impact assessments (HIA) are often used for evaluation.^{152,188} *HIA* is the general term used to describe an evaluation of actions' effects on health and recommends moving to mitigate any negative ramifications.¹⁸⁸ HIAs are used to foster intersectoral collaboration.^{152,188} Their strengths include increased engagement from stakeholders and the community, increased transparency, the ability to use it with multiple sectors, and the use of data to inform decisions.¹⁵² HIA may help non-health sectors focus on the impact their decisions make on health.¹⁵²

The documents did note, however, that municipalities should be cautious about using the term because some may relate it to environmental-impact assessments.¹⁵² The initial reaction to HIA might involve a perception that such data gathering and evaluation will increase development time and costs.¹⁵² Indeed, one city official mentioned this process should not “cross purposes” with other goals and requirements and that “The last thing any planner wants its

another layer of bureaucracy.” With knowledge of this possible misconception, HiAP leaders have the opportunity to tailor the messaging to create buy-in.

Further, the documents highlight the role of data collection in enduring that actions are responding to the needs of the community.^{165,172,175} Collaboration is extremely helpful here, as each sector has access to unique data. Some interviewees noted a barrier in that the city has limited staff and funding; collaboration with non-municipal partners will ensure the city not be the only source of data. Non-profit hospitals can provide their needs assessment data, and other non-profit organizations can provide data on their services to the community. It would be wise to use existing data from partners or public data sets to set baselines and also to denote the initiative’s priorities.^{165,172,175} Interviewees suggested that data be used to document need, a critical baseline by which to evaluate outcomes. For a more robust approach to data collection, Gase et al¹⁷⁵ note a mixed-methods approach provides better assessments. It could include traditional methods, such as interviews and surveys, as well as a social network or a document analysis.

THEME 4. BUILDING AWARENESS AND POLITICAL SUPPORT

Each of the five documents stresses the need for building awareness and political support, foundational needs for a HiAP initiative.^{152,165,172,175,188} How HiAP initiatives build awareness and political support may vary based on a variety of factors, including how and by whom the project was started.¹⁵²

In addition, many local conditions and structures can contribute to a HiAP approach, and every person interviewed mentioned many existing programs and policies that might do so. Interviewees suggested conducting an assessment of existing policies and programs, so HiAP is

not reinventing the wheel. This would also be a way to show stakeholders that this work can be done with current capacity. Using the existing network of promotoras through the Por La Vida program can also show how current work fits into a HiAP approach and help to build community support.

Formalizing HiAP will be extremely challenging without executive support,¹⁵² and the reviewed documents underline that buy-in and support at that level is imperative for HiAP's long-term success.^{152,165} Formalization can include legislation, organizational partnerships, memoranda of understanding, and organizational structure.¹⁵² Johnson and Wooten¹⁶⁵ look at a range of HiAP initiatives. All include top-level executives. These people do not need to be involved in day-to-day operations, but their vocal and visible support of the initiative is critical.¹⁵² The interviewees suggest that garnering such backing may not be all that great a challenge, as there have been incremental steps towards this type of initiative through the development of new city planning documents over the years. Nevertheless, it was noted that political support may face challenges and be harder to win when money is required. Montclair's HiAP initiative can overcome this barrier by securing grants to fund small successes before the request for support is made.

Johnson and Wooten¹⁶⁵ identify steps in the establishment of a HiAP initiative; they list the strategic identification of a lead agency or department to oversee the project, deciding whether to implement a task force using an existing group or a new one, framing HiAP as a win-win for all partners, assessing the partners' understanding of the initiative, educating them as needed, and using the task force to hold partners accountable. Other documents suggest a community assessment can also build support for HiAP by raising awareness of the needs that could be addressed.¹⁷² The documents and interviews believe that training and education,

whether for top-level executives, day-to-day staff, or offered as an intersectoral workshop for multiple partner organizations, will build support among stakeholders.¹⁷⁵

Three means are recommended to create intersectoral relationships, which include the community as a partner.¹⁵² First, the HiAP initiative should focus on building trust.¹⁵² Partners will need to put everything on the table honestly and openly, so they must have faith that others will not use this information to undercut or otherwise hurt them. In addition, HiAP initiatives must model reciprocity for a truly collaborative environment.¹⁵² Success should help every group involved, and this will require a shift in mindset. Organizations are used to competing for funding and programming resources and working together in a true intersectoral collaboration will take time and practice. Last, HiAP initiatives must pursue mutuality,¹⁴⁸ which in this context means aligning goals among intersectoral organizations and across policy areas.¹⁴⁸ Pursuing mutuality also requires a shift in thinking—sharing goals is not common within government organizations; each department is traditionally siloed.¹⁴⁸ The support of top-level executives can be a way to model all three pillars. Moreover, the three pillars should also be part of developing a plan to gain community buy-in, which the interviewees stressed as being a necessity.

Another point that came up was the need to educate all groups, including the community, about the meaning of the word “health.” One of the interviewees said that most think of health as something involving medical care and do not see it as part of planning and community development. Providing examples of the wide variety of its meanings is a necessary part of building awareness and support.

THEME 5. FORMALIZING HIAP

Each of the five documents mentions the importance of formalizing a HiAP initiative.^{148,161,168,171,184} To improve community well-being, intersectoral collaboration is required; but many other types of initiatives would also benefit from intersectoral collaboration, Guglielmin et al¹⁸⁴ argue HiAP is different from other initiatives in requiring some type of formalization.

Although all affect health, transportation, access to sidewalks and healthy foods, quality housing, and safe places to play are only some of the areas beyond the scope of traditional health departments. Although the documents point to possible resistance to formalization, it is possible to combat pushback by detailing extant policies and programs involving intersectoral collaboration.¹⁶⁸ In Montclair, these include the Montclair Community Collaborative and the Safe Routes to School and Active Transportation plans.

Because it should be tailored to the community in which it is implemented, there are many different ways to formalize a HiAP initiative. Some general points are likely to apply, however. Formalizing HiAP may, for example, require mandating that health be considered in all policy decisions long-term, no matter what departments are involved and regardless of staff or leadership changes.¹⁶¹ Formalization might also require a resolution, ordinance, general plan language, memoranda of understanding, or new organizational policies.^{148,161}

Then, too, other general considerations may arise. Certain forms of local policy will be more likely to ensure longer-term sustainability; city ordinances involve actions, unlike resolutions of understanding or intentions.¹⁹⁰ Cities should consider using language that mandates health consideration in day-to-day decision making.¹⁷¹ In addition, policy wording can allow leaders to plan successful implementation at all stages, including training and education.

Wording can also provide for the consideration of health in decision making. Policy language can break down the silos that traditionally exist in government; a HiAP policy will require departments work together and consult one another when needed.

Interviewees also stress the necessity of including health in the city's general plan, a guide for city operations not as strong as an ordinance, in that it that does not include mandates. They see the currently in-progress plan update an asset to the HiAP approach. It has already required many city officials to think of health in a way they have not done before. If adopted by the city council, the update will be the second formal policy to include the consideration of health in Montclair's operations.

LOGIC MODEL

The logic model, as illustrated in Figure 11, was adapted from the one developed by Gase et al.¹⁷¹ by including Montclair-specific details for each item or adding items discovered through the interviews and document analysis. Although each category has been adapted to fit the needs of Montclair, the model should be reviewed and further adapted by the HiAP task force, once formed, to tailor still more and also to create a sense of ownership.

INPUTS

Inputs include resources that can be contributed to activities.^{169,170} The inputs of Montclair's HiAP initiative include promotoras, staff, funding, data, partners, and existing programs and policies. The city has a long-standing commitment to the promotora network built through the Por La Vida program. This network can build community support for HiAP and increase involvement. The promotoras can also provide input on communication and messaging

that will entice others to become involved. Existing city staff will also contribute to the initiative, as will current funding. Funding budgeted for Healthy Montclair meetings, for example, can be used for a joint introductory meeting on HiAP. Existing data collected about the City of Montclair will often be sufficient as baselines. New data can be collected at regular intervals to assess the progress of initiative activities. The City of Montclair has developed strong partnerships with non-profits and businesses in every sector. These partners will be important figures at table and will be able to help disseminate information about HiAP to many organizations. Last, there are a variety of existing programs and policies that can be included within an HiAP initiative. A few examples of current programs and policies that can add to the initiative includes the Montclair to College Scholarship program, the city's General Plan, Active Transportation Plan, and Safe Routes to School Plan.

ACTIVITIES

Activities are the tools, actions or techniques used to achieve the results.¹⁷⁰

All interviewees agreed with the logic model's listed activity categories, which are currently: building support and awareness, communication and messaging, incorporating health into decision making, coordinating resources, implementing accountability structures, and integrating data systems. One suggested adding community buy-in to the category for building-awareness and support, believing it is important not only to reach city staff and executive-level management but also the wider community.

There are a variety of groups in Montclair that can help build awareness about the HiAP initiatives. They include the Chamber of Commerce to reach businesses, the Ontario-Montclair School District's Program Management Team to reach the schools and non-profits, the Montclair

Faith Based Collaborative to reach religious organizations, and Healthy Montclair to reach the community in general. None of the groups have a true collective-impact structure and most are primarily for resource sharing and networking.

All the interviewee's believe HiAP will add to Montclair's efforts to reduce chronic diseases and that it will increase quality of life by creating a healthier community. Specifically, the approach will help improve the socioeconomic status of the community by focusing on the upstream approaches to good health.

Montclair could begin by conducting an assessment of what is currently being implemented and what has been done in the past. At the start, Montclair should conduct the assessment internally, with every department contributing. The evaluation does not need to reinvent the wheel; it can use existing documentation, for example. Yet this exercise is not only meant to add to and improve documentation but to include staff members with doubts about whether they can contribute. An exercise like this will increase the awareness that all areas of the city can make a difference. Once the internal assessment is complete, a second can be conducted with external partners. Creating a visual with all that has been accomplished in the past and everything currently being implemented will provide a powerful communication tool about HiAP.

How quickly all this can be done will vary according to the component being considered. Developing the task force and determining accountability structures depends in part on whether the design relies on existing collaborations or begins with an entirely new group. Data-system integration is a long-term, ongoing activity. Once the taskforce determines the logistics of gathering and reporting the data, each agency will have to consider how to do so, although some wonder how it can be implemented given Montclair's limited funding and staffing.

OUTPUTS

Outputs are the results of the activities.^{169,170} The outputs outlined by Gase et al.¹⁷¹ include collaboration structures, engagement processes, political support, ordinance/plans/protocols, and assessment results. The measurement of the outputs is typically straightforward and numerical. The collaboration structure depend, in part, on the group's form—whether it chooses, for example, for everyone to meet together with small-task forces that report back. One interviewee described the need for HiAP not to be so complex that it becomes hard to accomplish work on a day-to-day basis.

The engagement process output can measure the number of presentations that took place to build awareness, the number of emails sent out to partners to invite them to the initial task force meeting, the number of meetings held to develop the initial HiAP framework, and possibly the social media metrics for promoting HiAP to the Montclair community. Political support in Montclair can be measured though the number of meetings executive level staff attend, the number of council members who publicly support HiAP, and to a City Council meeting for council consideration.

The ordinance/plans/protocols output can simply be measured by counting those that that contribute to HiAP. But the strength of the plans and policy documents can also be included. This and the assessment output are similar in that one of the evaluations can measure the number and types of documents under the ordinance/plans/protocols. Further, other assessments can be conducted. Assessments might include pre- and post-test surveys of HiAP partners or a social-network analysis. Once the final activities have been chosen, the form of the desired outputs can be finalized.

OUTCOMES

Outcomes are defined as changes produced over a specified time, after the activities are conducted.¹⁷⁰ Short-, intermediate-, and long-term outcomes are outlined and suggested as starting points that should be tailored once the taskforce is established. Short-term outcomes are typically changes at the individual and interpersonal level and are measured one to three years after activity completion.^{169,170} The existing collaboratives in Montclair currently focus on resource-sharing and networking; Montclair's HiAP initiative will need to emphasize strengthening partnerships in the short-term to achieve its intermediate- and long-term goals. The interviewees mentioned that many in the community do not understand what health means; one of the short-term outcomes can measure the level of understanding and commitment to well-being. This can be measured organizationally and at the individual level. It is vital to have buy-in throughout for a successful HiAP initiative. Montclair could also try to measure, although this is difficult, any increased consideration of health. This is different from the intermediate outcomes that measure the policy changes that follow and which consider if there have been any initial transformations in the decision-making process.

Intermediate outcomes build upon short-term outcomes and take four to six years to achieve.^{169,170} An example of an intermediate outcome is increasing the partners' capacity and systems for HiAP. A concern was mentioned in the interviews about Montclair's capacity to collect and analyze data. It will take time to bolster the ability of both the city and its partners to do so. The original logic model developed by Gase et al.¹⁷¹ includes policies, practices, and funding as one outcome, but each is separate in Montclair's logic model and requires its own distinct evaluation measures. Organizational and city policies would have to provide

determinations of all of these. Practices are different from policies and programs and can be used to measure the actions and processes that have changed across sectors. Funding will measure the amount of dollars secured for the HiAP initiative.

Long-term outcomes are items that take seven to ten years.^{169,170} The long-term outcomes are general¹⁷¹. Although all HiAP initiatives vary based on the community, the overall goals of HiAP remain consistent to improve the environment in the whole sense of the word and improve population health, which will lead to improvements in the incidence and treatment of CD. The HiAP taskforce can further tailor the logic model by determining the specific measures for these long-term outcomes. For example, they can choose to focus on reducing the number and percentage of deaths for a specific chronic disease, such as CVD or increasing green space in the city. Multiple measures can be chosen to determine if the initiative achieves its outcomes.

SUMMARY.

A document analysis and key informant interviews with City of Montclair staff members and community leaders were conducted. In addition, five health-in-all-policies documents were reviewed. These include international and national gray literature and peer-reviewed articles. Themes found in the documents and interviews contributed to the adaptation of the logic model developed by Gase et al.¹⁷¹ for the City of Montclair's HiAP initiative.

Figure 11. City of Montclair HiAP Logic Model

CHAPTER 5. CONCLUSION

This analysis of Health in All Policies (HiAP) as a means to improve health, including the incidence of chronic disease, uses a document review and semi-structured interviews to adapt a logic model meant to guide a HiAP initiative for the City of Montclair. It also identifies the next steps in guiding a future HiAP initiative.

Five critical themes applied here are derived from the review of gray literature and peer-reviewed articles discussing HiAP and from the six interviews conducted with Montclair city staff and community leaders to provide perspective and insight into plans for a HiAP initiative. The five overall themes mentioned by both include: (1) communications and messaging, (2) incorporating health into decision making, (3) assessments and data collection, (4) building awareness and political support, and (5) formalizing HiAP.

Interviewees include management staff and long-time community members. Their responses were consistent with one another. All were positive about a potential HiAP initiative and provided feedback about how to ensure its future success. Similarly, the documents did not disagree with one another, although some elaborated on implementation, whereas others focused on evaluation. Taken together, the documents see as useful the foundational logic model developed by Gase et al.¹⁷¹ This study explains the logic model and how it has been tailored for use in Montclair.

This study fills a major need for investigation of how local municipalities might begin a HiAP initiative. Most of what is now available for guidance is based on ideas offered to and the experiences of larger cities, but those processes could not be easily applied in a small municipality.

Future work on HiAP in small cities should analyze its implementation and evaluation. It would be beneficial if analyses addressed a number of small cities with similar demographics. Although each HiAP initiative will be unique to its community, it would be good to know if there are common barriers that small cities face and strategies that might be or have successfully been used to overcome them. Futures work can also examine the organizational structure of cities that have implemented HiAP to determine if certain characteristics contribute to initiative success.

This study presents data on the City of Montclair and examines past and current actions to combat chronic disease and create a healthier community. Despite over twenty years of programs, chronic disease still remains the leading cause of death. Applying the health impact pyramid (figure 2) to what the city has already tried makes clear that very little has been done to change the environment in ways to lead individuals' to make default choices that improve health. HiAP is an approach to improve chronic disease rates and ensure that future decisions are cross-sectoral and made only after serious consideration of their impacts on health. Other small cities can use this as an example of how to examine their specific environments and determine what they need to do and how to employ the existing literature as they tailor a foundational logic model for own use.

DOCTOR OF PUBLIC HEALTH STUDENT COMPETENCIES

The following Doctorate in Public Health program student competencies were addressed through this dissertation:

Competency	Competency Outcome
FC-DRPH 4	Propose strategies for health improvement and elimination of health inequities by organizing stakeholders, including researchers, practitioners, community leaders and other partners
FC-DRPH 6	Integrate knowledge, approaches, methods, values and potential contributions from multiple professions and systems in addressing public health problems
FC-DRPH 10	Propose strategies to promote inclusion and equity within public health programs, policies and systems
DRPH-LM 1	Critically analyze an issue in health leadership, management or policy and provide recommendations.
DRPH-LM 2	Utilize knowledge of elements of a comprehensive population health system including ancillary organizations that fill in gaps of care in order to advance practice

Appendix A. City of Montclair Map with Census Tracts

Appendix B. Document Analysis Protocol

1. Title:
2. Citation:
3. Type:
4. Date:
5. Length:
6. Main topic/theme:
7. Relevant figures:
8. Inputs:
9. Activities:
 - a. Building support/awareness:
 - b. Communication/messaging:
 - c. Incorporating health into decision making
 - d. Coordinating resources
 - e. Implementing accountability structures
 - f. Integrating data structures
10. Outputs:
 - a. Collaboration structures
 - b. Engagement process
 - c. Political support
 - d. Ordinance/plans/protocols
 - e. Assessments
11. Outcomes:
 - a. Short-term:
 - i. Strengthened multi-sector partnerships
 - ii. Increased value, understanding and commitment to HiAP
 - iii. Increased consideration of health/equity in decision making
 - iv. Increased capacity and systems for HiAP across sectors
 - b. Mid-term:
 - i. Institutional policies, practices, and funding for health across sectors
 - ii. Sustainable systems supporting cross-sector collaboration
 - c. Long-term:
 - i. Improved social and physical environments that support health
 - ii. Improved population health and equity
12. Miscellaneous:
13. Summary of document:

Appendix C. Semi-structured Interview Guide

Interviewee Name: _____ Interview Date/Time: _____

Interview Location: _____

- a) What do you think the barriers will be to create a HiAP initiative in Montclair?
- b) How can the HiAP messaging be tailored to create buy-in among multiple sectors in Montclair?
- c) Currently, do you think it would be feasible to have high level decision makers (Department Directors) at the table along with community leaders for an HiAP initiative?
If not, what would need to change to make this happen?
- d) Which community leaders would you recommend for a multisector HiAP effort?
- e) How do you think a HiAP approach can benefit the City of Montclair?

APPENDIX D. IRB REVIEW

11/24/2020

Dear Alyssa,

An IRB representative has conducted a preliminary review of protocol **IRB # 3865 Utilizing a health in all policies approach to improve cardiovascular health in the City of Montclair**. Pursuant to federal regulations 45 CFR 46.102(e)/(l), your project is not human subjects research, and does not require further IRB review or oversight. Under these regulations, (a) it is not research because it is not aiming to contribute to generalizable knowledge, and (b) use of publicly available data that is not identifiable does not constitute involving human subjects.

Please note that changes to your protocol may affect this determination. Please contact me directly to discuss any changes you may contemplate.

Respectfully,

James Griffith,
IRB Manager
james.griffith2@cgu.edu

150 East Tenth Street • Claremont, California 91711-6160
Tel: 909.607.9406

REFERENCES

1. U. S. Census Bureau. American Community Survey, 2013-2017 5-Year Estimates. Published 2017. Accessed October 25, 2019. <https://factfinder.census.gov/>
2. About Montclair. City of Montclair. Accessed July 31, 2020. <https://www.cityofmontclair.org/residents/about-montclair>
3. City of Montclair Historic Context Report. Published online October 1, 2018.
4. Citrus History. Published 2010. Accessed August 1, 2020. <https://www.reederranch.org/Citrus%20History/index.asp>
5. Bell J, Lee MM. *Why Place & Race Matter: Impacting Health through a Focus on Race and Place*. PolicyLink; 2011:113. <https://www.policylink.org/resources-tools/why-place-and-race-matter>
6. *History of Montclair Community Collaborative*. City of Montclair; :3.
7. Colunga A. *Agenda Report for Agreement No. 19-60, Consider Approval for Agreement No. 19-60 with Ontario Montclair School District to Provide a Licensed Clinical Social Worker for the Case Management Program*. City of Montclair; 2019:1.
8. CalEnviroScreen FAQs. California Office of Environmental Health Hazard Assessment. Published April 20, 2015. Accessed February 11, 2021. <https://oehha.ca.gov/calenviroscreen/calenviroscreen-faqs>
9. California Office of Environmental Health Hazard Assessment. CalEnviroScreen 3.0. Published December 29, 2016. Accessed October 1, 2018. <https://oehha.ca.gov/calenviroscreen/report/calenviroscreen-30>
10. Machlin S, Cohen JW, Beauregard K. Statistical Brief #203: Health Care Expenses for Adults with Chronic Conditions, 2005. 8.
11. Noncommunicable diseases. Accessed October 12, 2020. <https://www.who.int/westernpacific/health-topics/noncommunicable-diseases>
12. Bauer UE, Briss PA, Goodman RA, Bowman BA. Prevention of chronic disease in the 21st century: elimination of the leading preventable causes of premature death and disability in the USA. *The Lancet*. 2014;384(9937):45-52. doi:10.1016/S0140-6736(14)60648-6
13. National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). Centers for Disease Control and Prevention. Published September 18, 2020. Accessed October 12, 2020. <https://www.cdc.gov/chronicdisease/index.htm>

14. Peck C, Logan J, Maizlish N, Van Court J. *The Burden of Chronic Disease, Injury, and Environmental Exposure*. California Department of Public Health, Center for Healthy Communities; 2020:105.
[https://www.cdph.ca.gov/Programs/CCDCPHP/DCDIC/CDCB/CDPH%20Document%20Library/The%20Burden%20of%20Chronic%20Disease%20Injury2020_%20ADA-nnmarkups%20\(SCOTT_26May2020\).pdf](https://www.cdph.ca.gov/Programs/CCDCPHP/DCDIC/CDCB/CDPH%20Document%20Library/The%20Burden%20of%20Chronic%20Disease%20Injury2020_%20ADA-nnmarkups%20(SCOTT_26May2020).pdf)
15. *Death and Birth Records*. State of California, Department of Public Health; 2012. Accessed August 1, 2019. <https://data.chhs.ca.gov/dataset/leading-causes-of-death-by-zip-code>
16. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health; 1999:494.
<https://www.hsdl.org/?abstract&did=730796>
17. Brownson RC, Haire-Joshu D, Luke DA. Shaping the context of health: A Review of Environmental and Policy Approaches in the Prevention of Chronic Diseases. *Annu Rev Public Health*. 2006;27(1):341-370. doi:10.1146/annurev.publhealth.27.021405.102137
18. Weinstein JN, Geller A, Negussie Y, Baciu A, National Academies of Sciences, Engineering, and Medicine (U.S.), eds. *Communities in Action: Pathways to Health Equity*. The National Academies Press; 2017.
19. Marks JS, president C vice, Group RH. Why Your Zip Code May Be More Important to Your Health Than Your Genetic Code. HuffPost. Published 12:01 400AD. Accessed August 1, 2020. https://www.huffpost.com/entry/why-your-zip-code-may-be_b_190650
20. Diez Roux AV. Investigating Neighborhood and Area Effects on Health. *Am J Public Health*. 2001;91(11):1783-1789. doi:10.2105/AJPH.91.11.1783
21. O'Campo P, Xue X, Wang MC, Caughy M. Neighborhood risk factors for low birthweight in Baltimore: a multilevel analysis. *Am J Public Health*. 1997;87(7):1113-1118. doi:10.2105/AJPH.87.7.1113
22. Marmot M, Friel S, Bell R, Houweling TA, Taylor S, Health C on SD of. Closing the gap in a generation: health equity through action on the social determinants of health. *The lancet*. 2008;372(9650):1661-1669.
23. *Report of the National Expert Panel on Social Determinants of Health Equity: Recommendations for Advancing Efforts to Achieve Health Equity*.; 2009.
24. *The Landscape of Opportunity: Cultivating Health Equity In California*. California Pan Ethnic Health Network; 2016:72. Accessed February 23, 2020.
https://cpehn.org/sites/default/files/resource_files/cpehn.landscape-report2016.pdf

25. Pertschuk M, Pomeranz JL, Aoki JR, Larkin MA, Paloma M. Assessing the Impact of Federal and State Preemption in Public Health: A Framework for Decision Makers. *J Public Health Manag Pract.* 2013;19(3):213-219. doi:10.1097/PHH.0b013e3182582a57
26. *Local Government Actions to Prevent Childhood Obesity.* National Academies Press; 2009.
27. RWJF Culture of Health Prize. RWJF. Accessed September 16, 2020. <https://www.rwjf.org/en/library/features/culture-of-health-prize.html>
28. Centers for Disease Control and Prevention - Division of Community Health. *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease.* US Department of Health and Human Services, National Cancer Institute.; 2013:132. Accessed July 1, 2015. <http://www.cdc.gov/healthycommunitiesprogram/overview/healthequity.htm>
29. Labarthe D, Grover B, Galloway J, et al. The Public Health Action Plan to Prevent Heart Disease and Stroke:
30. Grundy Scott M., Balady Gary J., Criqui Michael H., et al. Guide to Primary Prevention of Cardiovascular Diseases. *Circulation.* 1997;95(9):2329-2331. doi:10.1161/01.CIR.95.9.2329
31. *The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I Report: Recommendations for the Framework and Format of Healthy People 2020.* U.S. Department of Health and Human Services; 2008:92. Accessed October 30, 2019. https://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf
32. Frieden TR. A Framework for Public Health Action: The Health Impact Pyramid. *Am J Public Health.* 2010;100(4):590-595. doi:10.2105/AJPH.2009.185652
33. Can Colorectal Polyps and Cancer Be Found Early? Accessed July 5, 2020. <https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/detection.html>
34. Por La Vida Montclair, Community Health Investment Grant Proposal to The California Endowment. Published online November 5, 1997.
35. City of Montclair Nutrition Program Application for The San Bernardino County Department of Aging and Adult Services. Published online March 19, 2019.
36. Montclair Community Collaborative, Request for CAC funding.
37. John Rice Award Nomination Form, Online to College. Published online 2014.
38. *Montclair to College (MTC) Program 2018-19 Chaffey College First Year Performance Outcome Data of 2017-18 Montclair High School Graduates.* Chaffey College, Office of Institutional Research; 2019:7.

39. *An Ordinance of the City Council of the City of Montclair Amending Chapter 11.02 (“Definitions”) and Chapter 11.78 (“Conditional Use Permits”) of the Montclair Municipal Code to Allow Certified Farmers’ Markets*. The City of Montclair City Council; 2014.
40. Montclair Golden Express Brochure. Published online November 2014.
41. Ramos-Ingold T. Montclair named as a healthy city. *Inland Valley Daily Bulletin*. September 25, 1998.
42. *A Resolution of the City Council of the City Of Montclair Supporting the Healthy Eating, Active Living (Heal) Cities Campaign and Strengthening the City’s Commitment to Promote Healthy Living*. The City of Montclair City Council; 2015.
43. The 500 Cities Project: Local Data for Better Health. Published online 2018. Accessed September 16, 2020. <https://www.cdc.gov/500cities>
44. Bureau UC. Older People Projected to Outnumber Children. The United States Census Bureau. Accessed March 6, 2020. <https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html>
45. U. S. Census Bureau. American Community Survey, 2005-2009 5-Year Estimates. Accessed October 25, 2019. <https://factfinder.census.gov/>
46. *Livable Community Indicators for Sustainable Aging in Place*. MetLife Mature Market Institute & Stanford Center on Longevity; 2013:39. Accessed March 6, 2020. <http://longevity3.stanford.edu/wp-content/uploads/2013/03/mmi-livable-communities-study.pdf>
47. *Leading Causes of Death by ZIP Code, 1989-2016*. State of California, Department of Public Health, Death and Birth Records Accessed March 6, 2020. <https://data.chhs.ca.gov/dataset/leading-causes-of-death-by-zip-code>
48. Mensah GA, Brown DW. An Overview Of Cardiovascular Disease Burden In The United States. *Health Aff (Millwood)*. 2007;26(1):38-48. doi:10.1377/hlthaff.26.1.38
49. National Council of La Raza., JSI, Inc. *An Inside Look at Chronic Disease and Health Care among Hispanics in the United States.*; 2014:34. http://www.lchc.org/wp-content/uploads/Chronic_Disease_Report_2014.pdf
50. *AskCHIS Neighborhood Edition. Ever Diagnosed with Diabetes*. UCLA Center for Health Policy Research Accessed October 1, 2019. <http://askchisne.ucla.edu/>
51. Weir HK, Anderson RN, Coleman King SM, et al. Heart Disease and Cancer Deaths — Trends and Projections in the United States, 1969–2020. *Prev Chronic Dis*. 2016;13. doi:10.5888/pcd13.160211
52. *AskCHIS Neighborhood Edition. Ever Diagnosed with Heart Disease*. UCLA Center for Health Policy Research Accessed October 1, 2019. <http://askchisne.ucla.edu/>

53. *AskCHIS Neighborhood Edition. Obese (BMI $\geq$ 30) (18+)*. UCLA Center for Health Policy Research Accessed October 1, 2019. <http://askchisne.ucla.edu/>
54. *AskCHIS Neighborhood Edition. Overweight or Obese (BMI $\geq$ 85th Percentile) (12-17)*. UCLA Center for Health Policy Research Accessed October 1, 2019. <http://askchisne.ucla.edu/>
55. *AskCHIS Neighborhood Edition. Overweight for Age (Weight $\geq$ 95th Percentile) (2-11)*. UCLA Center for Health Policy Research Accessed October 1, 2019. <http://askchisne.ucla.edu/>
56. Keener D, Goodman K, Lowry A, Zaro S, Kettel Khan L. *Recommended Community Strategies and Measurements to Prevent Obesity in the United States*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2009:90.
57. *Increasing Access to Safe Drinking Water in Schools and Communities: Policy Statement*. American Heart Association.; 2015:10. Accessed July 1, 2019. https://www.heart.org/-/media/files/about-us/policy-research/policy-positions/healthy-schools-and-childhood-obesity/increasing-access-to-safe-drinking-water-ucm_475974.pdf?la=en&hash=020C152B5B78EA29F1D4FF526AFEB0D21DE27FC4
58. *AskCHIS Neighborhood Edition. Sugar Drink Consumption 1+ Times per Day (18+)*. UCLA Center for Health Policy Research Accessed October 1, 2019. <http://askchisne.ucla.edu/>
59. Leung CW, DiMatteo SG, Gosliner WA, Ritchie LD. Sugar-sweetened Beverage and Water Intake in Relation to Diet Quality in U.S. Children. *Am J Prev Med*. 2018;54(3):394-402. doi:10.1016/j.amepre.2017.11.005
60. Nuñez de Ybarra J, Weiss R, Pendelton L, et al. *The California Wellness Plan 2014*. California Department of Public Health; 2014:131. Accessed September 29, 2019. https://www.cdph.ca.gov/Programs/CCDCPHP/DCDIC/CDCB/CDPH%20Document%20Library/CDPH-CAWellnessPlan2014_FINAL%202-27-14_PDF%204.3%20MB.pdf
61. *Why Education Matters to Health: Exploring the Causes*. Virginia Commonwealth University, Center on Society and Health; 2014:9. Accessed October 16, 2020. <https://societyhealth.vcu.edu/media/society-health/pdf/test-folder/CSH-EHI-Issue-Brief-2.pdf>
62. Schultz WM, Kelli HM, Lisko JC, et al. Socioeconomic Status and Cardiovascular Outcomes: Challenges and Interventions. *Circulation*. 2018;137(20):2166-2178. doi:10.1161/CIRCULATIONAHA.117.029652
63. Porter K. *2019 Regional Community Health Needs Assessment*. San Antonio Regional Hospital & Hospital Association of Southern California; :147.
64. Campbell F, Conti G, Heckman JJ, et al. Early Childhood Investments Substantially boost adult health. *Science*. 2014;343(6178):1478-1485. doi:10.1126/science.1248429

65. Fisher B, Hanson A, Raden T. *Start Early to Build a Healthy Future: The Research Linking Early Learning and Health*. Ounce of Prevention Fund; 2014:31.
<https://files.eric.ed.gov/fulltext/ED570103.pdf>
66. California Department of Education. DataQuest. Published 2018. Accessed August 1, 2019.
<https://data1.cde.ca.gov/dataquest/>
67. Braveman P, Acker J, Arkin E, et al. *Wealth Matters for Health Equity*. Robert Wood Johnson Foundation; 2018:28.
68. Greer S, Schieb LJ, Ritchey M, George M, Casper M. County Health Factors Associated with Avoidable Deaths from Cardiovascular Disease in the United States, 2006–2010. *Public Health Rep*. 2016;131(3):438-448. doi:10.1177/003335491613100310
69. Kucharska-Newton AM, Harald K, Rosamond WD, Rose KM, Rea TD, Salomaa V. Socioeconomic Indicators and the Risk of Acute Coronary Heart Disease Events: Comparison of Population-Based Data from the United States and Finland. *Ann Epidemiol*. 2011;21(8):572-579. doi:10.1016/j.annepidem.2011.04.006
70. *Health in All Policies Report City of Richmond, California.*; 2015. www.richmondhealth.org
71. *Fresno General Plan*. City of Fresno; 2014:523.
72. Fresno Economic Opportunities Commission. <https://fresnoeoc.org/>
73. Benjamin EJ, Muntner P, Alonso A, et al. Heart Disease and Stroke Statistics—2019 Update: A Report From the American Heart Association. *Circulation*. 2019;139(10). doi:10.1161/CIR.0000000000000659
74. *Chronic Diseases and Their Common Risk Factors*. World Health Organization; :3. Accessed October 16, 2020.
https://www.who.int/chp/chronic_disease_report/media/Factsheet1.pdf
75. *Bringing Healthy Foods Home- Examining Inequalities in Access to Food Stores*. Robert Wood Johnson Foundation; 2008:8.
76. Forsyth A, Salomon E, Smead L. *Creating Healthy Neighborhoods: Evidence-Based Planning and Design Strategies*. APA Planners Press; 2017.
77. Kelli HM, Hammadah M, Ahmed H, et al. Association Between Living in Food Deserts and Cardiovascular Risk. *Circ Cardiovasc Qual Outcomes*. 2017;10(9). doi:10.1161/CIRCOUTCOMES.116.003532
78. Glanz K, Lankenau B, Foerster S, Temple S, Mullis R, Schmid T. Environmental and Policy Approaches to Cardiovascular Disease Prevention Through Nutrition: Opportunities for State and Local Action. *Health Educ Q*. 1995;22(4):512-527. doi:10.1177/109019819502200408

79. Students Who Ate Breakfast in the Past Day, by Gender and Grade Level. Kidsdata.org. Accessed March 13, 2020. <https://www.kidsdata.org/topic/304/breakfast-gender/table#fmt=330&loc=1188&tf=122&ch=78,77,69,305,306,431,1177,1176&sortColumnId=0&sortType=asc>
80. Students Who Ate Breakfast in the Past Day, by Parent Education Level. Kidsdata.org. Accessed March 13, 2020. <https://www.kidsdata.org/topic/2137/breakfast-parent-education/table#fmt=2649&loc=1188&tf=122&ch=1177,1176,1316,1317,1318,1319&sortColumnId=0&sortType=asc>
81. Healthier US Schools Challenge. Ontario-Montclair School District. Accessed March 13, 2020. <http://www.omsd.net/site/default.aspx?PageID%3D319>
82. *AskCHIS Neighborhood Edition. Low-Income Food Insecurity (18+)*. UCLA Center for Health Policy Research Accessed October 1, 2019. <http://askchisne.ucla.edu/>
83. Food Insecurity. Healthy People 2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/food-insecurity>
84. Student Eligibility to Receive Free or Reduced Price School Meals. Kidsdata.org. Accessed March 13, 2020. <https://www.kidsdata.org/topic/518/free-school-meals-eligible/table#fmt=675&loc=1188&tf=124&sortColumnId=0&sortType=asc>
85. CalFresh. Accessed July 5, 2020. <https://www.cdss.ca.gov/calfresh>
86. CalFresh Reach Index. Published online February 1, 2020.
87. Bodor JN, Rose D, Farley TA, Swalm C, Scott SK. Neighbourhood fruit and vegetable availability and consumption: the role of small food stores in an urban environment. *Public Health Nutr.* 2008;11(4):413-420. doi:10.1017/S1368980007000493
88. Laraia B. Proximity of supermarkets is positively associated with diet quality index for pregnancy. *Prev Med.* 2004;39(5):869-875. doi:10.1016/j.ypmed.2004.03.018
89. Rose D, Richards R. Food store access and household fruit and vegetable use among participants in the US Food Stamp Program. *Public Health Nutr.* 2004;7(8):1081-1088. doi:10.1079/PHN2004648
90. Barnhill A, Palmer A, Weston CM, et al. Grappling With Complex Food Systems to Reduce Obesity: A US Public Health Challenge. *Public Health Rep.* 2018;133(1_suppl):44S-53S. doi:10.1177/0033354918802793
91. *Modified Retail Food Environment Index*. Office of Health Equity Healthy Communities Data and Indicators Project; 2017:4. <https://www.cdph.ca.gov/Programs/OHE/Pages/HCI-Search.aspx>

92. *Healthy Communities Data and Indicators Project: Retail Food Environment Index*. California Department of Public Health, Office of Health Equity; 2017.
<https://www.cdph.ca.gov/Programs/OHE/Pages/HCI-Search.aspx>
93. Hoffman M, De Santiago A. Using Healthography to Define a Healthy Montclair. Presented at the: Southern California Public Health Association; November 7, 2014; Los Angeles, CA.
94. Matson-Koffman DM, Brownstein JN, Neiner JA, Greaney ML. A Site-Specific Literature Review of Policy and Environmental Interventions That Promote Physical Activity and Nutrition for Cardiovascular Health: What Works? *Am J Health Promot*. 2005;19(3):167-193. doi:10.4278/0890-1171-19.3.167
95. Herrman H, Saxena S, Moodie R, World Health Organization, Victorian Health Promotion Foundation, University of Melbourne, eds. *Promoting Mental Health: Concepts, Emerging Evidence, Practice*. World Health Organization; 2005.
96. *National Physical Activity Plan*. National Physical Activity Plan Alliance; 2016:75.
physicalactivityplan.org/
97. Healthy People 2020: An Opportunity to Address Societal Determinants of Health in the U.S. Published online 2020:16.
98. *Solving the Problem of Childhood Obesity within a Generation*. Executive Office of the President of the United States; 2010:124.
https://letsmove.obamawhitehouse.archives.gov/sites/letsmove.gov/files/TaskForce_on_Childhood_Obesity_May2010_FullReport.pdf
99. Centers for Disease Control and Prevention. *Health Equity Resource Toolkit for State Practitioners Addressing Obesity Disparities*. National Center for Chronic Disease Prevention and Health Promotion. Division of Population Health, Centers for Disease Control and Prevention; 2013:83. <https://www.cdc.gov/nccdphp/dnpao/state-local-programs/health-equity/index.html>
100. Loukaitou-Sideris A, Eck JE. Crime Prevention and Active Living. *Am J Health Promot*. 2007;21(4_suppl):380-389. doi:10.4278/0890-1171-21.4s.380
101. de Leeuw E, Simos J, eds. *Healthy Cities: The Theory, Policy, and Practice of Value-Based Urban Planning*. Springer; 2017.
102. Urban Land Institute, Frank J, MacCleery R, et al., eds. *Building Healthy Places Toolkit: Strategies for Enhancing Health in the Built Environment*. Urban Land Institute; 2015.
103. City of Montclair General Plan Survey. Published online 2019.
104. Zaccaro H. *Blind Spots: How Unhealthy Corridors Harm Communities and How to Fix Them.*; 2019.

105. Edmonds A, Braveman P, Arkin E, Jutte D. *Making the Case for Linking Community Development and Health.Pdf*. University of San Francisco, Center on Social Disparities in Health, Build Healthy Places Network, Robert Wood Johnson Foundation; 2015:60.
<https://www.buildhealthyplaces.org/resources/making-the-case-for-linking-community-development-and-health/>
106. Braunstein S, Lavizzo-Mourey R. How The Health And Community Development Sectors Are Combining Forces To Improve Health And Well-Being. *Health Aff (Millwood)*. 2011;30(11):2042-2051. doi:10.1377/hlthaff.2011.0838
107. *Healthy Development Checklist*. Riverside University Health System, Public Health; 2017.
108. *Healthy Mobile Vending Policies*. ChangeLab Solutions; 2013. Accessed August 28, 2020.
https://www.changelabsolutions.org/sites/default/files/MobileVending_FactSht_FINAL_20130425.pdf
109. M Farley S, Sacks R, Dannefer R, et al. Evaluation of the New York City Green Carts program. *AIMS Public Health*. 2015;2(4):906-918. doi:10.3934/publichealth.2015.4.906
110. ChangeLab Solutions. *Licensing & Zoning: Tools for Public Health.*; 9.
<https://www.changelabsolutions.org/product/licensing-zoning>
111. Steinberg J. Physician shortages continue to plague Inland Empire. *San Bernardino Sun*.
<https://www.sbsun.com/2016/03/14/physician-shortages-continue-to-plague-inland-empire/>.
Published March 14, 2016.
112. *Mental Health and Community Development*. Federal Reserve Bank of San Francisco; 2018:87. <https://www.frbsf.org/community-development/publications/community-development-investment-review/2018/october/mental-health-and-community-development/>
113. *AskCHIS Neighborhood Edition. Serious Psychological Distress (18+)*. UCLA Center for Health Policy Research Accessed October 1, 2019. <http://askchisne.ucla.edu/>
114. Wong E, Collins R, Cerully J. *Reviewing the Evidence Base for Mental Health First Aid: Is There Support for Its Use with Key Target Populations in California?* RAND Corporation; 2015. doi:10.7249/RR972
115. Community Preventative Services Task Force. *Cardiovascular Disease Prevention and Control: Interventions Engaging Community Health Workers*. The Community Guide; 2017:11. Accessed August 29, 2020.
<https://www.thecommunityguide.org/findings/cardiovascular-disease-prevention-and-control-interventions-engaging-community-health>
116. Calloway E. *Long-Range Planning Primer*. ChangeLab Solutions; 2019:75.
117. *Back to Our Roots: Catalyzing Community Action for Mental Health and Wellbeing*. Prevention Institute; 2017:69.

118. Egerter S, Braveman P, Barclay C. *Stress and Health*. Robert Wood Johnson Foundation; 2011:14. <https://www.rwjf.org/en/library/research/2011/03/how-social-factors-shape-health.html>
119. Compton MT, Shim RS. The Social Determinants of Mental Health. *FOCUS*. 2015;13(4):419-425. doi:10.1176/appi.focus.20150017
120. Yoshikawa H, Aber JL, Beardslee WR. The effects of poverty on the mental, emotional, and behavioral health of children and youth: Implications for prevention. *Am Psychol*. 2012;67(4):272-284. doi:10.1037/a0028015
121. De Biasi A, Wolfe M, Carmody J, Fulmer T, Auerbach J. Creating an Age-Friendly Public Health System. Albert SM, ed. *Innov Aging*. 2020;4(1):igz044. doi:10.1093/geroni/igz044
122. World Health Organization, ed. *World Report on Ageing and Health*. World Health Organization; 2015.
123. Healthy Aging in Action.
124. World Health Organization, ed. *Global Age-Friendly Cities: A Guide*. World Health Organization; 2007.
125. Williams K, Kemper S. Exploring Interventions to Reduce Cognitive Decline in Aging. *J Psychosoc Nurs Ment Health Serv*. 2010;48(5):42-51. doi:10.3928/02793695-20100331-03
126. Williams P, Lord SR. Effects of group exercise on cognitive functioning and mood in older women. *Aust N Z J Public Health*. 1997;21(1):45-52. doi:10.1111/j.1467-842X.1997.tb01653.x
127. Northey JM, Cherbuin N, Pumpa KL, Smee DJ, Rattray B. Exercise interventions for cognitive function in adults older than 50: a systematic review with meta-analysis. *Br J Sports Med*. 2018;52(3):154-160. doi:10.1136/bjsports-2016-096587
128. Weuve J, Kang JH, Manson JE, Breteler MMB, Ware JH, Grodstein F. Physical Activity, Including Walking, and Cognitive Function in Older Women. *JAMA*. 2004;292(12):1454-1461. doi:10.1001/jama.292.12.1454
129. Braveman P, Gottlieb L. The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Rep*. 2014;129(1_suppl2):19-31. doi:10.1177/00333549141291S206
130. Dailey C, Elias RR, Moore A. *Summarizing the Landscape of Healthy Communities: Executive Summary and Environmental Scan*. Build Healthy Places Network; 2016. <https://www.buildhealthyplaces.org/whats-new/summarizing-landscape-healthy-communities-review-demonstration-programs-working-towards-health-equity/>
131. McKnight J, Block P. *The Abundant Community: Awakening the Power of Families and Neighborhoods*. 1st ed. Berrett-Koehler Publishers; 2010.

132. Bowling Alone. Accessed August 29, 2020. <http://bowlingalone.com/>
133. Rugulies R. Depression as a predictor for coronary heart disease. *Am J Prev Med.* 2002;23(1):51-61. doi:10.1016/S0749-3797(02)00439-7
134. Coehn L, Iton A, Davis R, Rodriguez S. *A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety.* Prevention Institute, Alameda County Public Health Department; 2009:55. Accessed February 25, 2018. <https://www.preventioninstitute.org/publications/a-time-of-opportunity-local-solutions-to-reduce-inequities-in-health-and-safety>
135. Governor's Office of Planning and Research. *State of California General Plan Guidelines 2003.* Governor's Office of Planning and Research; 2003:290.
136. Baron SL, Beard S, Davis LK, et al. Promoting integrated approaches to reducing health inequities among low-income workers: Applying a social ecological framework. *Am J Ind Med.* 2014;57(5):539-556. doi:10.1002/ajim.22174
137. *Office of Health Equity Healthy Communities Data and Indicators Project: Voter Registration and Participation.* California Department of Public Health, Office of Health Equity; 2014:3. https://www.cdph.ca.gov/Programs/OHE/CDPH%20Document%20Library/HCI/ADA%20Compliant%20Documents/HCI_RegisteredVoters_653_Narrative_and_examples_6-2-14-ADA.pdf
138. Atwell MN, Bridgeland J, Levine P. *Civic Deserts: America's Civic Health Challenge.* National Conference on Citizenship; 2017:36. Accessed August 29, 2020. <https://www.ncoc.org/wp-content/uploads/2017/10/2017CHIUpdate-FINAL-small.pdf>
139. CA Youth Commissions and Councils. Institute for Local Government. Accessed August 29, 2020. <https://www.ca-ilg.org/post/ca-youth-commissions-councils-and-advisory-boards>
140. Feldstein LM. *General Plans and Zoning: A Toolkit for Building Healthy, Vibrant Communities.* Public Health Law & Policy; 2007:254.
141. Boards and Commissions - Benicia, California. Accessed August 29, 2020. <https://www.ci.benicia.ca.us/cbc>
142. Havranek EP, Mujahid MS, Barr DA, et al. Social Determinants of Risk and Outcomes for Cardiovascular Disease: A Scientific Statement from the American Heart Association. *Circulation.* 2015;132(9):873-898. doi:10.1161/CIR.0000000000000228
143. What are the social determinants of health? Canadian Public Health Association. Accessed October 18, 2020. <https://www.cpha.ca/what-are-social-determinants-health>
144. Bharmal N, Derose KP, Felician M, Weden MM. *Understanding the Upstream Social Determinants of Health.* Rand Corporation; 2015:20. Accessed October 1, 2019. https://www.rand.org/pubs/working_papers/WR1096.html

145. Artiga S, Hinton E. *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*. Henry J Kaiser Family Foundation; 2018:13.
<https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>
146. World Health Organization, WHO Commission on Social Determinants of Health, eds. *Addressing the Social Determinants of Health: The Urban Dimension and the Role of Local Government*. World Health Organization Regional Office for Europe; 2012.
147. Braveman P, Egerter S, Williams DR. The Social Determinants of Health: Coming of Age. *Annu Rev Public Health*. 2011;32(1):381-398. doi:10.1146/annurev-publhealth-031210-101218
148. Rudolph L, Caplan J, Ben-Moshe K, Dillon L. *Health in All Policies a Guide for State and Local Governments*. American Public Health Association and Public Health Institute; 2013.
<http://www.phi.org/resources/?resource=hiapgguide>
149. Braveman PA, Egerter SA, Mockenhaupt RE. Broadening the Focus the Need to Address the Social Determinants of Health. *Am J Prev Med*. 2011;40(1):S4-S18.
doi:10.1016/j.amepre.2010.10.002
150. The Helsinki Statement on Health in All Policies. In: *Proceedings of the 8th Global Conference on Health Promotion, 2013*. World Health Organization; 2013. Accessed November 8, 2020.
https://www.who.int/healthpromotion/conferences/8gchp/8gchp_helsinki_statement.pdf
151. Gingrich M. *Incorporating Health into Policymaking across Sectors: The California Health in All Policies Initiative*. Center for Health Care Strategies, Inc.; 2018:5.
152. Kickbusch I, Buckett K, South Australia, Department of Health, Health in All Policies Unit. *Implementing Health in All Policies: Adelaide 2010*; 2010.
153. Polsky C, Stagg K, Gakh M, Bozlak CT. The Health in All Policies (HiAP) Approach and the Law: Preliminary Lessons from California and Chicago. *J Law Med Ethics*. 2015;43(s1):52-55. doi:10.1111/jlme.12216
154. Kickbusch I, Williams C, Lawless A. Making the Most of Open Windows: Establishing Health in All Policies in South Australia. *Int J Health Serv*. 2014;44(1):185-194.
doi:10.2190/HS.44.1.k
155. Pepin D, Winig BD, Carr D, Jacobson PD. Collaborating for Health: Health in All Policies and the Law. *J Law Med Ethics J Am Soc Law Med Ethics*. 2017;45(1 Suppl):60-64.
doi:10.1177/1073110517703327
156. Puska P. *Editorials Health in All Policies—from What to How*.

157. Van Vliet-Brown CE, Shahram S, Oelke ND. Health in All Policies utilization by municipal governments: scoping review. *Health Promot Int.* 2018;33(4):713-722. doi:10.1093/heapro/dax008
158. Stone V, ed. *Health in All Policies: Training Manual*. World Health Organization; 2015. Accessed September 29, 2019. http://who.int/social_determinants/publications/health-policies-manual/en/
159. *For the Public's Health: Revitalizing Law and Policy to Meet New Challenges*. National Academies Press; 2011:13093. doi:10.17226/13093
160. Institute of Medicine (U.S.), ed. *For the Public's Health. Investing in a Healthier Future*. National Academies Press; 2012.
161. Johnson R, Wooten H. *From Start to Finish: How to Permanently Improve Government through Health in All Policies*. Changelab Solutions; 2015:42. changelabsolutions.org
162. *Health in All Policies: Summary of the Experiences of the Americas*. Pan American Health Organizations; 2013. Accessed August 7, 2020. <https://www.paho.org/hq/dmdocuments/2013/health-promotion-2013-8th-global-conference-summary-of-experiences-from-the-americas.pdf>
163. Corburn J, Bhatia R. Health impact assessment in San Francisco: Incorporating the social determinants of health into environmental planning. *J Environ Plan Manag.* 2007;50(3):323-341. doi:10.1080/09640560701260283
164. Mundo W, Manetta P, Fort MP, Sauaia A. A Qualitative Study of Health in All Policies at the Local Level. *Inq J Health Care Organ Provis Financ.* 2019;56:004695801987415. doi:10.1177/0046958019874153
165. Wernham A, Teutsch SM. Health in All Policies for Big Cities: *J Public Health Manag Pract.* 2015;21:S56-S65. doi:10.1097/PHH.0000000000000130
166. Gase LN, Pennotti R, Smith KD. "Health in All Policies": Taking Stock of Emerging Practices to Incorporate Health in Decision Making in the United States. *J Public Health Manag Pract.* 2013;19(6):529-540. doi:10.1097/PHH.0b013e3182980c6e
167. Leppo K, ed. *Health in All Policies: Seizing Opportunities, Implementing Policies*. Ministry of Social Affairs and Health, Finland; 2013.
168. Johnson R, Yuen T, Wooten H. *A Roadmap for Health in All Policies Collaborating to Win the Policy Marathon*. ChangeLab Solutions; 2018.
169. Goldman KD, Schmalz KJ. Logic Models: The Picture Worth Ten Thousand Words. *Health Promot Pract.* 2006;7(1):8-12. doi:10.1177/1524839905283230
170. *Using Logic Models to Bring Together Planning, Evaluation, and Action Logic Model Development Guide*. W.K. Kellogg Foundation; 2004:71.

171. Gase L, Schooley T, Lee M, Rotakhina S, Vick J, Caplan J. A Practice-Grounded Approach for Evaluating Health in All Policies Initiatives in the United States. *J Public Health Manag Pract JPHMP*. 2017;23(4):339-347. doi:10.1097/PHH.0000000000000427
172. Bowen GA. Document Analysis as a Qualitative Research Method. *Qual Res J*. 2009;9(2):27-40. doi:10.3316/QRJ0902027
173. Fisher M, Baum FE, MacDougall C, Newman L, McDermott D. To what Extent do Australian Health Policy Documents address Social Determinants of Health and Health Equity? *J Soc Policy*. 2016;45(3):545-564. doi:10.1017/S0047279415000756
174. Fisher M, Baum F, MacDougall C, Newman L, McDermott D. A qualitative methodological framework to assess uptake of evidence on social determinants of health in health policy. *Evid Policy J Res Debate Pract*. 2015;11(4):491-507. doi:10.1332/174426414X14170264741073
175. Eklund Karlsson L, Ikonen AL, Alqahtani KM, Tanggaard Andersen P, Thapa S. Health Equity Lens Embedded in the Public Health Policies of Saudi Arabia: A Qualitative Document Analysis. *SAGE Open*. 2020;10(4):215824402096277. doi:10.1177/2158244020962776
176. Söderberg E, Wikström E. The policy process for health promotion. *Scand J Public Health*. 2015;43(6):606-614. doi:10.1177/1403494815586327
177. McLoughlin GM. Addressing Food Insecurity through a Health Equity Lens: a Case Study of Large Urban School Districts during the COVID-19 Pandemic. 17.
178. Borrell C, Morrison J, Burstrom B, et al. Comparison of health policy documents of European cities: Are they oriented to reduce inequalities in health? *J Public Health Policy*. 2013;34(1):100-120. doi:10.1057/jphp.2012.57
179. Altheide DL. Process of Qualitative Document Analysis. In: *Qualitative Media Analysis*. Qualitative research methods. Sage Publications; 1996:24-44. <https://hdl.handle.net/2027/uc1.32106019545513>
180. Altheide DL, Schneider CJ. Process of Qualitative Document Analysis. In: *Qualitative Media Analysis*. SAGE Publications, Ltd; 2013:38-74. Accessed November 30, 2020. <http://methods.sagepub.com/Book/qualitative-media-analysis-2e>
181. Esbati A, Barnes M, Henderson A, Taylor J. Legislation, policies and guidelines related to breastfeeding and the Baby Friendly Health Initiative in Australia: a document analysis. 11.
182. Gollust SE, Kite HA, Benning SJ, Callanan RA, Weisman SR, Nanney MS. Use of Research Evidence in State Policymaking for Childhood Obesity Prevention in Minnesota. *Am J Public Health*. 2014;104(10):1894-1900. doi:10.2105/AJPH.2014.302137

183. Ramirez RL, Jernigan DH. Increasing Alcohol Taxes: Analysis of Case Studies From Illinois, Maryland, and Massachusetts. *J Stud Alcohol Drugs*. 2017;78(5):763-769. doi:10.15288/jsad.2017.78.763
184. Guglielmin M, Muntaner C, O'Campo P, Shankardass K. A scoping review of the implementation of health in all policies at the local level. *Health Policy*. 2018;122(3):284-292. doi:10.1016/j.healthpol.2017.12.005
185. Rantala R, Bortz M, Armada F. Intersectoral action: local governments promoting health. *Health Promot Int*. 2014;29(suppl 1):i92-i102. doi:10.1093/heapro/dau047
186. Ståhl T, ed. *Health in All Policies: Prospects and Potentials*. Ministry of Social Affairs and Health; 2006.
187. Nutbeam D. Inter-sectoral Action for Health- Making it Work. *Health Promot Int*. 1994;9(3):2.
188. Crano WD, Brewer MB, Lac A. *Principles and Methods of Social Research*. Third edition. Routledge; 2014.
189. Patton MQ. *Qualitative Research and Evaluation Methods*. 3 ed. Sage Publications; 2002.
190. Foley ML. Ordinances and Resolutions: Practice Tips for Effective Legislation. Presented at the: League of California Cities Annual Conference. <https://www.cacities.org/Resources-Documents/Member-Engagement/Professional-Departments/City-Attorneys/Library/2002/LR-Foley>