Oregon
Theodore R. Kulongoski, Governor

Department of Human Services
Public Health Division
800 NE Oregon Street
Portland, OR 97232-2162
(971) 673-0977
(971) 673-0979 - FAX
(971) 673-0372 - TTY-Nonvoice

December 30, 2009

Kerry Williams, MEM
Senior Analyst, Environmental Health
Association of State and Territorial Health Officials (ASTHO)
2231 Crystal Drive, Suite 450
Arlington, Virginia 22202

Dear Ms Williams,

Please accept this final report of activities associated with Oregon's Health Impact Initiative funded under contract number 16005-OREGON001-2092. If you have any questions or comments, please direct them to myself or Nancy Goff, Program Coordinator, Health Impact Assessment Program, at (971)-673-0024 or e-mail nancy.m.goff@state.or.us.

Sincerely,

Jae P. Douglas

Jae P. Douglas, M.S.W, PhD
Section Manager, Research & Education Services
Office of Environmental Public Health
(971) 673-1139

Table of Contents

Introduction 1

Progress Report 1

Goal One - Further develop internal HIA capacity in the Oregon Public Health Division (OPHD). 1

Goal Two – Become an HIA resource for local partners..... 4

Goal Three – Design and Implement a Comprehensive Evaluation Plan 6

Challenges 7

Successes 8

Recommendations for Best Practices..... 9

Future Recommendations 10

Appendix A - Agenda April 22-23, 2009 Training..... A-1

Appendix B - HIA Training Attendees, April 22 – 23, 2009..... B-2

Appendix C - Outcome of Discussion of moving HIA forward in Oregon, April 23, 2009..... C-3

Appendix D - Summary of Evaluations, HIA Training April 22 – 23, 2009..... D-4

Appendix E - HIA Practitioner Roles Assessment..... E-12

Appendix F - HIA Workshop, April 29, 2009, Eugene, Oregon F-24

Appendix G - HIA Training Attendees, September 10 – 11, 2009..... G-30

Appendix H - Agenda from September 10 – 11, 2009 Training H-31

Appendix I - Discussion of Next Steps for HIA, September 11, 2009..... I-32

ASTHO Capacity Building for Built Environment Projects and Health Impact Assessments within State and Territorial Health Agencies

Final Report
Oregon's Health Impact Assessment Initative
Contract Number : 16005-OREGON001-2092
December 2009

Introduction

In January 2009, the Oregon Public Health Division (OPHD), Office of Environmental Public Health (OEPH) Research & Education (R&E) Services was funded through contract16005-OREGON001-2092 to begin building capacity for Health Impact Assessment (HIA) principles and practices at the state and local level. This report details the activities conducted to meet the goals outlined in the proposed work plan, as well as successes, challenges and best practices recommendations.

Progress Report

Goal 1: *Further develop internal HIA capacity in the Oregon Public Health Division (OPHD)*

Objective 1: Educate engaged internal OPHD staff on HIA and related tools that can be used to inform partners about the health impacts of projects and policies

In April 2009, R&E, in collaboration with Human Impact Partners (HIP), hosted HIA training (see *Appendix A* for agenda). The goal of the training was to build internal OPHD capacity on HIA and built environment initiatives. A large proportion of the attendees were internal OPHD staff representing R&E and the Health Promotion and Chronic Disease (HPCDP) Section of the Office of Family Health. HPCDP have been our main partners throughout this project, dedicating staff time to assist in the planning, coordination and implementation. Also in attendance were representatives of various public agencies, two local universities and one nonprofit (see *Appendix B* for list of trainees' titles and agencies). This diversity of the group contributed to the richness of the discussions and group exercises. Only five trainees had prior experience with HIA, either on the Columbia River Crossing HIA or the Vehicle Miles Traveled HIA, but all trainees currently work for programs that have some relevancy to HIA, either in methods or topic area.

The training introduced the stages of HIA, including case studies, as well as incorporated time for completing Screening, Scoping and Assessment exercises based on the real world case study of congestion pricing. The trainers also facilitated a group discussion on moving HIA forward in Oregon, including barriers, perceived opportunities, and upcoming projects suitable for HIA. The discussion gave participants an opportunity to contribute to the local HIA dialogue and process the information presented. The themes that emerged from the large group discussion centered on time, funding, politics and agency/administrative support as well as the role of various agencies in the HIA process. Participants also saw opportunities to start working on HIA in Oregon, including building on existing initiatives and collaborations, building capacity, raising awareness with partners and decision makers, and conducting demonstration projects. The individual contributions stated by participants varied from data provision, analysis and technical support to training and outreach to local health departments (LHDs) and communities. Some participants were interested in moving the conversation forward with leadership in their agencies.

In order to build the capacity of OPHD to continue to provide training in the future, four OPHD staff worked closely with HIP to plan the curriculum and case studies, and lead small group exercises. By employing this "Training-of-Trainers" model, we began the process of developing HIA leadership within the OPHD. The four individuals who participated in this process continued to work closely with HIP throughout the duration of the project to plan a subsequent workshop and training, and provide technical assistance to local health departments conducting HIA. These activities are described in detail later in this report.

At the end of both days of training, participants completed an evaluation of their understanding of the material, satisfaction with the training format and topics, and plans to integrate new information into existing work. Overall, participants were satisfied with the training and materials. Most agreed or strongly agreed with positive statements about the usefulness and format of the training, and most rated the content and modules as good or excellent (see *Appendix D* for the full evaluation questions and summary). In November 2009, we began working with HIP to interview trainees about their experiences with HIA in the 6 months following the training. These interviews are ongoing and results will be communicated as they become available.

Host presentations to raise awareness about connections between the built environment and health

With the goal of raising awareness about HIA among OPHD staff, R&E staff organized three brown bag presentations in April, July and September of 2009. Each presentation was announced to a distribution list of over 1000 public health practitioners and colleagues. The first was a panel presentation that was integrated into Oregon's public health week activities. Six panelists from diverse organizations to discussed their involvement with HIA, as well as other successes in integrating health into decision making. The presentation attracted approximately 40-50 public health professionals from the OPHD and elsewhere. Following the hour of panelist presentations, attendees asked questions on topics such as measuring cost effectiveness in HIA, community participation, and how to ensure the quality of data. The audience was generally engaged and satisfied with the presentation, although there may have been too many presenters for the amount of time allotted.

The second brown bag held in July 2009 focused on the connections between transportation and health. Leslie Perdue, a Research Associate from Oregon Health and Sciences University discussed her recent work completing the analysis for the Vehicle Miles Traveled HIA which examined the health impacts of policies aimed at reducing driving in Oregon. John MacArthur, the Sustainable Transportation Program Manager from the Oregon Transportation Research and Education Consortium, then presented ways for the public health community to get involved in transportation decision making processes in Oregon. The presentations were well received by the 30-40 attendees. In particular, attendees were excited to have a transportation professional presenting the material, and used to opportunity to ask him detailed questions about the different systems and processes in place in Oregon.

The third brown bag was held in September 2009 and was given by Jonathan Heller from HIP. The presentation focused on HIP's Paid Sick Leave Policy HIA. We selected this topic to demonstrate that HIA can be applied to a broad range of projects and policies beyond the transportation and land use sectors. We anticipated a large turnout due to the interest we received beforehand, but due to a canceled flight the presentation time moved from noon to 3pm. This reduced the crowd to about 10 people as it is more difficult to attend during working hours. We followed up and sent the presentation slides to those who had expressed interest and were unable to attend.

Interview key partners within the OPHD engaged in healthy built environment work

A large focus of this project is building the capacity of state OPHD staff to conduct HIA. In order to gauge success, R&E staff established a baseline by identifying existing resources and programs currently addressing

HIA-related topics and approaches, as well as the interest of colleagues in integrating HIA into their existing work. This goal was accomplished in two ways. First, the April training described above targeted key staff in OPHD to ensure that those with a stake in HIA were included. As part of the training attendees were asked to describe what kind of contribution they were interested in making to a long term HIA initiative within the OPHD. The full list of responses is found in *Appendix C*. We have used these responses to target individuals for specific contributions throughout the course of this project. For example, those interested in statewide training and outreach were invited to participate in the training for LHDs, while those interested in data analysis have been contacted for topic-specific data needs. In addition, many of the trainees have been invited to participate in an advisory group for the statewide HIA we will conduct as part of our Year 2 activities. This targeting of activities to trainees ensures continued connection with HIA and integration of built environment initiatives into the broader work of OPHD.

In addition to bringing together programs and departments with a stake in HIA, R&E staff interview partners with prior HIA experience to gain insight into their views on HIA, relationship to current work, roles that different organizations would play in a coordinated HIA initiative, approaches to HIA and potential barriers. In-depth interviews were conducted with 10 public health professionals, five of which were state OPHD employees. The remaining five respondents were from the Multnomah County Health Department and other nonprofits in Oregon that have been actively integrating HIA into their work. All interviews were conducted in July and August of 2009, and subsequently transcribed and analyzed by John Dougherty, PhD, an independent program evaluator. After the interviews were completed, the respondents were invited to meet and discuss the results and provide additional feedback on the findings. In order to disseminate the findings, we will post them on the OPHD HIA website, distribute them via listserv to the Oregon HIA Network, and prepare the report for submission to a peer reviewed journal. The list of interview questions, executive summary, and full report are included in *Appendix E.*

Distribute information about existing resources internally and externally to staff

Over the past year, we have built and maintained an OPHD HIA website (http://www.oregon.gov/DHS/ph/hia/). The website is intended to supplement the information provided at trainings, and encourage ongoing engagement with HIA. The site is also designed to act as a resource to local health departments in getting started with HIA. Links include HIA initiatives in the US and worldwide, upcoming HIA and related events (including conferences and HIA Network meetings), useful online data sources, online training modules and worksheets, local contacts for different topic areas, and a list of completed HIAs. The analytical tools developed in San Francisco and presented at our trainings are also included on the site. We continue to update this website as we become aware of new resources.

The website address has been distributed to our list of HIA stakeholders, including state and local public health practitioners, or members of the Oregon HIA Network listserv. The Oregon HIA Network is an informal group from diverse organizations interested in HIA. The listserv is maintained by the Coalition for a Livable Future, a local nonprofit with whom we work closely on HIA-related activities. To date, the outreach conducted by OPHD as a part of this project is responsible for recruiting a significant portion of the members. More detail about our work with this group is provided under Goal 3 below. We have worked through our partners to distribute HIA resources and announcements, including HPCDP's Healthy Communities initiative (chronic disease staff and their community partners in most counties around the state), Portland State University (students and faculty in the School of Community Health and the School of Urban Studies and Planning), and the Oregon Environmental Council (environmental health stakeholders statewide).

Objective 2: Identify resources within agency that could be utilized by local partners.

Create an inventory of resources that exist internally and externally with regard to healthy built environments
Through our work with partners and the HIA Network, mentorship from HIP, interviews with those engaged in HIA in Oregon, and post-training conversations, we have identified resources both within and outside the OPHD that would be useful in HIA. We have used these resources to shape our program, as well as create an HIA website. The website address has been distributed to hundreds of stakeholders through our outreach and other existing channels.

Modify national HIA and related tools for use in Oregon
Many of the tools developed in San Francisco and elsewhere are particularly relevant for urban environments, but nationally, there is a dearth of information about the links between the built environment and health in rural communities. This became clear when working with LHDs, who found many of the completed HIAs irrelevant due to their urban focus. To address this need, we partnered with the Oregon Environmental Public Health Tracking Program (EPHT) to create a modified version of the San Francisco Department of Public Health's Healthy Development Measurement Tool (HDMT). The HDMT is a list of over 100 social and built environment indicators that have health significance that allows planners to evaluate whether projects or policies meet health-based standards. In Oregon, built environment data is collected by a variety of agencies at the local level, and is not easily accessible to LHDs. Beginning in March 2009, R&E staff worked with the EPHT to narrow the list of HDMT indicators to a core set relevant to Oregon's six Metropolitan Service Areas (MSAs). Although the MSAs are technically categorized as urban, many also incorporate distinct rural areas. Selected indicators incorporate transportation, housing, healthy and affordable food access, parks and recreation, and social cohesion. Currently, the EPHT program has finalized the list and is calculating the indicators for each MSA. When completed, the data and maps produced will provide a useful resource for HIA practitioners and other stakeholders interested in the links between the built environment and health. Since 78% of Oregon's population lives within the six MSAs, this project will be relevant to a significant proportion of the population.

Objective 3: Track the activities of the HIA initiative and state and community responsiveness.

Develop internal screening, tracking and other processes in order to effectively deal with requests for technical assistance and data
The HIA Program Coordinator has dedicated a significant portion of time (approximately 20 hours per week) to implementing this project over the past year. The EHAP Epidemiologist, CDC Prevention Specialist, HPCDP Workforce Capacity Manager and R&E Health Assessment Program Manager have also been contributing several hours a week to this initiative. Most recently, staff have provided individualized technical assistance to LHDs pursuing HIA and tracking the requests. So far, sharing this responsibility for mentorship has not created significant time burdens for R&E staff. Due to the overlap in activities with other programs in our office, we anticipate that we will be able to leverage existing program activities to continue providing technical assistance to local health departments into the future.

Goal 2: *Become an HIA resource for local partners*

Objective 1: Build relationships with potential partners across the State and assess capacity, interest, and needs of potential local partners

HPCDP has been working with 12 Oregon communities for several years as part of the Healthy Communities Institute (formerly TROCD). As part of this initiative, LHDs form community advisory committees who work to identify policy and program approaches to improve public health and complete a series of training institutes to

learn about strategies. Built environment approaches to combating chronic disease are one topic highlighted in these trainings.

Healthy Communities Institute members were invited to an OPHD facilitated HIA workshop that introduced the concept of HIA, and gathered feedback about how a future HIA initiatives could work best for communities. 75 people from 22 different counties and one tribal organization attended.

The agenda included an introduction to the ASTHO project, an overview of HIA, a description of a few case studies, a screening and scoping activity, and small and large group discussions. For the activity, participants were asked to work in small groups to review a real case study (provided by trainers) and decide if it was a good candidate for HIA. They were then asked to draw a pathway diagram that visually linked all of the project or policy components to health outcomes.

Time was also allotted to discuss the benefits and barriers of HIA, existing programs that overlap with HIA, role of the state health department and potential projects and policies in their local area that would be good candidates for HIA. The themes of the discussion are presented in *Appendix F.* Generally, participants saw opportunity for new partnerships and non-traditional public health topic areas, the potential acquisition of new tools and skill sets, the ability to be action oriented, and the opportunity to raise the profile of public health as the benefits of conducting HIA. The major barriers to HIA identified included time, funding, agency buy-in, analysis skills and geographic differences. Programs that have overlap with different pieces of HIA include chronic disease programs, community health assessments, advocacy, and city and county planning processes. Participants felt that they could bring local knowledge, potential project ideas, stakeholders, local data, community organizing skills, and links to local planning departments to an HIA initiative. They felt the state health department could assist in providing funding or identifying potential sources, initiating pilot projects, training, technical assistance and data, outreach to policy makers, networking opportunities, best practices, and integration and coordination with existing programs. There was also much frustration expressed over continually lacking resources and capacity to support new and existing programs.

Objective 2: Provide training to local partners

Using the feedback generated at the HIA workshop described above, we worked with HIP to plan an HIA training for local health departments in September 2009.

Counties were recruited through the list of workshop attendees, as well as other existing networks of local health department staff. We received interest in participating from seven local health departments representing 9 counties. Prior to the training, LHDs were required to select a local project or policy to use as a case study with the intention of making the training more hands-on and relevant, and increase learning opportunities and interest. Staff worked with LHDs to identify and screen potential case studies through phone calls in the months preceding the training. This process was time consuming and often difficult for several reasons: 1) LHD staff were being asked to select a project suitable for HIA while having little knowledge of HIA, 2) Finding suitable projects often required researching ongoing activities in totally unfamiliar sectors (i.e. transportation, land use), and 3) Many rural communities do not have many (if any) ongoing projects or policies at any one time. Suitable case studies were identified for all LHDs before they arrived at the training. Despite the challenges, we felt this greatly enhanced the experience for all participants in the end. OPHD staff that worked with individual counties to select case studies also attended the training and facilitated activities and small group discussions regarding these studies. In total, there were seven OPHD facilitators (one per county), three trainers from HIP, and 32 participants (list of attendees can be found in *Appendix G*). Participants were mostly from local health departments, but a significant number of planners from local

agencies also attended. Materials from the training can be found on our website (http://www.oregon.gov/DHS/ph/hia/training.shtml#Materials_from_previous_trainings_in_Oregon), and the agenda can be found in *Appendix H*.
As in the April training, participants learned the stages of HIA and worked in groups to complete Screening, Scoping and Assessment exercises. Attendees spent significantly more time working in small groups than in the April training because they had a real case study and an OPHD staff person to facilitate. The large group discussion at the end of Day 2 was focused on next steps for HIA in Oregon. The suggestions that emerged generally fell into five categories: outreach, training, technical assistance, funding and policy, with most participants focused on strategies for outreach. The discussion points are summarized in *Appendix I*.

Overall, satisfaction with the training was high. Training evaluations asked about satisfaction with content, pace, presentation, and facilitation of training. A summary of responses can be found in *Appendix J*. Participants were asked to rate their level of knowledge before and after the training. On a scale of 1 to 10, where 1 means no knowledge and 10 means expert, on average participants rated their knowledge before the training at 3, and after at 7. Two additional questions asked if participants have enough information to get started on HIA, and if not, what else they would need. The answers to these questions correspond to what we learned in the workshop in April; time, funding and agency buy-in are the top barriers to initiating HIA.

Objective 3: Provide ongoing technical assistance to trainees to assist them in sustaining their efforts

Following the LHD training in September, three counties decided to pursue HIA and built environment related pilot projects. The mini-grants from the OPHD (part of Year 2 funding) provided the incentive to initiate these projects. OPHD HIA initiative staff and HIP have been providing mentorship to these three counties to screen projects, create project plans and provide general information and resources for HIA. As the projects progress, we expect that the technical assistance focus will shift to data and assessment.

In addition to providing technical assistance to LHDs pursuing HIA pilot projects, we are working with LHDs interested in conducting HIA in the future but do not currently have resources or support from agency leadership. TWe have requests for assistance with outreach to local planners and decision makers, public health conference presentations, grant writing, and providing specific HIA resources and data. For example, Marion County Health Department is raising awareness with their local planning staff through a “Take a Planner to Lunch” Day. OPHD will assist in organizing, presenting and leading group activities.

Providing technical assistance, resources, and mentorship is a natural role for the state health department, and we expect to continue providing this service for HIA beyond the scope of this grant. Since we have several people trained in HIA in R&E and HPCDP, we anticipate staff will be available for technical assistance in the future.

Goal 3: Formalize an interdepartmental HIA initiative within the OPHD

Objective 1: Build partnerships within OPHD to define roles for assistance in HIA.

Activities described above fulfill this objective, including the in-depth interviews with HIA practitioners about their roles, discussions during the April training, and the contributions that trainees have offered to make as part of a coordinated HIA initiative. We have also been meeting regularly with staff from HPCDP, and the HIA initiative has provided a great opportunity to forge a partnership between the two offices.

Despite our successes in building relationships over the past year, we feel the most optimal way to build capacity for HIA within the OPHD and formalize an interdepartmental initiative is to conduct a statewide HIA. We have started the screening process as a part of our Year 2 activities. We have invited LHD staff, former trainees, and staff from other OPHD offices to participate. This project will provide the opportunity for programs to make unique contributions to a larger project. We will report on this project at the end of Year 2.

Objective 2: Define a role for the EHAP, EPHT, HPCDP and other OPHD programs with regard to HIA in order to enhance and support the current HIA work of community partners in Oregon.

OPHD has leveraged staff time from numerous but related projects in order to conduct HIA related activities. This model has allowed for the integration of HIA into the work of these other projects in a way that the traditional programmatic model would not have accomplished. Members from each of the OPHD programs have defined their role in the process. Both EHAP and EPHT provided technical expertise and data support while staff from HPCDP provided expertise in LHD relations and policy development. These roles support the work of our community partners while distributing the work across OPHD programs.

The HIA Program Coordinator has defined the role of OPHD to external partners through participation in the Oregon HIA Network. The Network is a diverse group of over 150 individuals from different organizations, agencies and sectors that are interested in HIA. The OPHD HIA Program Coordinator has been the Chair of the HIA Steering Committee since August 2009. During that time, the group began organizing the activities of the Network, creating a collaborative Oregon HIA website, and finding ways to increase communication among partners engaged in HIA. The HIA Program Coordinator has also been involved with participating on advisory boards for three local HIAs, grant writing for partner nonprofits, and manuscript preparation for the Vehicle Miles Traveled HIA.

Challenges

One challenge we encountered while implementing this project is a common theme in public health initiatives—shortage of time and resources. We were able to leverage the staff time and resources from existing programs in the OPHD, including the EPHT, EHAP, and the Healthy Communities Initiative. Due to the overlap between the scope of the HIA initiative and these programs, the resultant initiative is more robust and integrated into existing processes than if it had been implemented without collaboration at the state level. However, our LHD partners face continual time and resource constraints that essentially prohibit them from implementing new initiatives without additional funding. Some LHDs expressed to us that an HIA project was not even a consideration without additional resources in the face of competing demands (i.e. the H1N1 response). Many of Oregon's rural LHDs have one or two staff managing all public health programs for their county.

We also faced other challenges common to starting *new* initiatives. As this was the first state level HIA project in the country, we were creating a new model as we implemented the program. Part of the scope of work became continual outreach and education about what HIA is, and would be ideal to do this before recruiting partners to participate in a project or training. However, the short timeline of the project made it necessary to raise awareness and engage partners concurrently. We had the most success engaging partners who had previously learned about the connections between the built environment and health. For this reason, our decision to work through the existing Healthy Communities Initiative was crucial. Many of the OPHD and LHD staff who agreed to participate in training did so because they already had a prior understanding of HIA related processes and topics. Providing funding to attend the training and holding it at a more central location than Portland was also necessary to ensure participation.

Outside of public health, we were able to engage the Department of Environmental Quality and local planning departments due to existing relationships, but we were not successful in engaging transportation professionals. We have started exploring a longer term strategy for building relationships with the Oregon Department of Transportation in the hope that this will lead to partnerships on future HIAs.

Once we secured stakeholder interest in the concept of HIA, it was necessary to provide training, resources and case studies *relevant* to Oregon's communities. This was a challenge due to the relative newness of the field in the United States. Many of the examples come from urban areas, which may not apply in Oregon's more rural communities. Oregon's rural areas also lack the abundance of projects or policies suitable for HIA, so selecting case studies for the training was especially difficult. In addition, data does not exist at a small enough geographic scale to provide meaningful analysis of some of the questions raised by an HIA. Because this is a common problem in the United States, many of the HIAs completed do not have a rigorous assessment component.

One final challenge was responding to the demand that we created through raising awareness about HIA. We receive continual requests from diverse stakeholders that want to be involved with the initiative. It would be ideal to have strategies to keep these partners engaged before their enthusiasm wanes. We refer people to the HIA Network listserv to receive updates on the HIA work of various partners, but unfortunately the Network is also grappling with the same difficult questions. We have also considered ways to keep trainees involved with HIA post-training. Until the HIA process and capacity building is institutionalized in various organizations, we will continue to face these challenges. So far, we have dealt with this by creating a website where partners can receive information and current updates about opportunities to get involved, and inviting interested partners to participate on the advisory board for a statewide HIA. Dependent on continued resources, we are also interested in providing ongoing HIA training once or twice a year. We have learned from our mentors at HIP that completing an HIA is the best way to build capacity. We will continue to look for opportunities to engage partners in projects and provide resources for them to take initiative their own.

Successes

One of the biggest successes of this initiative was working through existing programs and relationships at the OPHD. Since we were able to leverage both for HIA, we bypassed some of the relationship building necessary for any new initiative. Our resultant program is interdepartmental and collaborative, and while it borrows elements from other programs, it does not duplicate and existing activities. At a minimum, this structure will allow us to sustain some elements of the program into the future.

While both HIA trainings accomplished their goals of building capacity, we felt that the LHD training was particularly successful for several reasons. First, the requirement to bring a real, locally relevant case study to the training allowed participants to deeply engage with the material, thinking through all the steps of HIA in an applied way. This greatly contributed to learning, retention post-training, and interest in pursuing future projects. We will attempt to incorporate this element into the curriculum at any future training we provide.

Inviting local planners to the LHD training was also a major success. Planners intuitively understand the connections between the built environment and health, although they may use the terms "quality of life" or "livability" in place of "public health." They also have technical expertise in data collection, analysis and GIS that is necessary for HIA on built environment related topics. Finally, they are aware of the projects that would be suitable for HIA, and can share these with their local public health partners. A frequent complaint of those new to HIA is that it is difficult to find projects suitable for HIA before the public comment period is

announced, which is often too late to conduct an assessment. By merely introducing local public health staff to their local planning counterparts, we have addressed this issue.

We have also had success in continuing to stay involved with the HIA partners outside of the OPHD. This initiative was originally built on the success of the HIA workgroup in collectively completing the Columbia River Crossing HIA in June 2008. Since then, partners have continued to explore different roles for their organizations in a long term, collaborative HIA initiative. By defining some roles for the state OPHD early on, we have avoided duplicating the work of partners or competing for projects or resources. Currently, we find building capacity LHDs to be a natural role that state agencies play, while many of our HIA Network partners are focused on the Portland Metro area. We have also established a role for ourselves in HIA training, technical assistance and providing resources, all of which contribute to the work of our partners. Conversely, we can rely on the HIA Network for connections to communities and public health advocacy. Listening to community priorities and having partners to advocate for their needs is crucial to the success of any HIA.

Finally, our brown bag series was extremely successful in raising awareness about HIA to a large group of stakeholders with minimal planning involved. The presentations served to make public health practitioners and partners familiar with HIA and related efforts. This will build the groundwork for engaging partners in projects in the future.

Recommendations for Best Practices:

The narrative above provides descriptions of the activities we engaged in over the past year, along with some successes and barriers. Below is a summary of the key lessons learned which can be considered recommendations for best practices when building a state level HIA initiative.

1) A successful state HIA initiative should build off of the resources and relationships of existing programs and community partners. This is especially important in the field of HIA, since maintaining an ongoing program in the absence of a specific HIA project can be challenging. At the same time, it is necessary to have HIA practitioners available to be responsive to projects or policies with short timelines.
2) Building capacity cannot be accomplished through training alone; it also involves post-training engagement in projects and initiatives, raising awareness, building support and securing resources.
3) Participants in HIA training should be required to bring a real project or policy from their community to the training for use in the exercises, and the training should be as hands on as possible.
4) HIA training experiences are enhanced when transportation and land use planners, environmental professionals or other colleagues from various sectors are invited to attend with their local public health counterparts.
5) Engagement in HIA principles and practices is optimized when participants have a basic understanding of the links between the social and built environments and health. Efforts to raise awareness about these topics or incorporate them into the training are particularly valuable.
6) Two major barriers to implementing HIA at the local level are obtaining support of leadership and securing appropriate resources. A successful capacity building initiative should address these realities and incorporate strategies into the plan. Some strategies we have worked into our Year 2 plans include outreach to state and local leadership in partnership with LHDs and

providing resources in the form of data, literature, an accessible and comprehensive website, technical assistance, mini-grants and links to other funding opportunities.

7) Opportunities to stay engaged should be available to public health practitioners after they complete an HIA training to maintain interest and momentum. Aside from initiating an HIA, this could include participating on the advisory board for a new project, conducting outreach to local planners or providing information to decision makers about health without conducting a full assessment. This would reinforce the knowledge and skills gained in the training, and bring practitioners closer to initiating their own projects.
8) State health departments may have limited capacity to get involved with conducting HIAs due to limited knowledge of local issues surrounding projects, scope of work, timelines and political concerns. However, there are several natural roles that state health departments can play, including providing resources (technical assistance, funding, online toolkits), raising awareness, training and mentorship, health consultation for decision makers, and conducting HIA on projects or policies with a statewide scope.

Future Recommendations

We have highlighted some activities that we are currently engaged in as part of our Year 2 funding. These activities build off the lessons we have learned in the current year and include providing continued technical assistance and resources to local health departments, working with community partners, outreach to agency and local leadership, and conducting a statewide HIA to build internal capacity. In the future, we are most interested in exploring strategies for long term sustainability of this program (i.e. statewide HIA policies or fee-based health consultation from partner agencies). We will also continue to find ways to integrate HIA into existing programs and processes, including the Healthy Communities initiative, EHAP and EPHT. To sustain our current level of programmatic support, a heath assessor (epidemiologist or research analyst) is needed for technical assistance and assessment, and a health educator is needed for training, outreach and partnership building. To date, we have been able to leverage resources from other programs to support these functions, but additional dedicated staff time could help grow a more robust program.

Appendix A Agenda April 22-23, 2009 Training

Health Impact Assessment Training

Day 1 Objectives:

- Demonstrate connections between land use/policy planning and community health issues
- Understand the value and purpose of HIA
- Review HIA case studies
- Understand the collaborative nature of HIA, and the roles for diverse stakeholders in the HIA process
- Learn about the "screening" and "scoping" steps of HIA, and practice using tools for each
- Gain familiarity with practical HIA tools and methodologies for assessment
- Discuss opportunities for community based participatory research in HIA

Day 2 Objectives:

- Explore a variety of analytical tools used for HIA assessment, and consider how these tools could apply to an HIA on a proposed congestion pricing pilot program
- Discuss intervention points in land use planning and policy making processes where HIA can be used to bring health to the forefront of decision making
- Understand how HIA can add value to existing regulatory processes
- Examine types of HIA reporting and strategies for communicating HIA results to target audiences
- Discuss how and when monitoring and evaluation have been used in HIA
- Discuss strategies to use HIA to effectively influence decision makers and decision making processes
- Understand how all of the steps of an HIA fit together, and how to collaborate with various partners to achieve an HIA
- Engage in a strategizing exercise to explore ways that an HIA on the proposed congestion pricing pilot program, or other HIA projects, could effectively be moved forward

Agenda – Day 1

9:30 Welcome and Introductions
10:00 Making the connection between land use, policy and health
10:15 Introduction to Health Impact Assessment
10:30 BREAK
10:40 HIA Case Study Examples
11:15 HIA as a Collaborative Process: stakeholders, partners and roles
11:35 Case Study Project Description
12:00 LUNCH
12:45 Step 1: Screening
1:40 Step 2: Scoping
2:50 BREAK
3:00 Step 3: Assessment
4:00 Wrap-up
4:30 Adjourn

Agenda – Day 2

9:00 Check-in / Introduction to Day 2
9:15 Report Back/ Review of Data Sources for Assessment from Day 1
9:30 Analytic Tools for HIA Assessment
11:00 BREAK
11:15 Intervention points in land use planning and regulatory processes
12:00 LUNCH
1:00 Step 4: Reporting
1:15 Step 5: Monitoring, and Evaluation
1:35 Report Back from Upstream Public Health HIA Training
2:00 BREAK
2:15 Using HIA to influence Decision-Making
2:35 HIA Next Steps
3:30 Reflections and Evaluation

Appendix B HIA Training Attendees, April 22-23, 2009

Organization	*Title*	*Program*
City of Portland	City Planner	Bureau of Planning and Sustainability
Clark County Public Health	Research Analyst	Clark County Public Health
Community Health Partnership	Program Director	Healthy Eating Active Living
Metro	Senior Transportation Planner	Regional Travel Options Program
Metro	Transportation Planner	Regional Travel Options Program
Multnomah County Health Dept	Manager	Health Assessment and Evaluation
OPHD[1]	Research Analyst	Health Systems Planning
OPHD[1] /Multnomah County Health Dept	Principal Investigator	Program Design and Evaluation Services
OPHD[1] /Multnomah County Health Dept	Epidemiologist	Program Design and Evaluation Services
OPHD, ODPE[1]	Workforce Capacity Manager	HPCDP
OPHD, ODPE[1]	Systems, Policy and Self Management Coordinator	HPCDP
OPHD, ODPE[1]	Community Programs Coordinator for Cancer	HPCDP
OPHD, ODPE[1]	Health Promotion Manager	HPCDP
OPHD, ODPE[1]	Research Analyst	HPCDP
OPHD, ODPE[1]	Chronic Disease Manager	HPCDP
OPHD, ODPE[1]	Evaluation Manager	HPCDP
OPHD, ODPE[1]	Community Programs Coordinator for Arthritis	HPCDP
OPHD, ODPE[1]	Community Programs Coordinator for Heart Disease and Stroke	HPCDP
OPHD, OEPH[1]	Program Coordinator	HPCDP
OPHD, OEPH[1]	Program Manager	Health Assessment and Consultation
OPHD, OEPH[1]	Graduate Student and Intern	Environmental Public Health Tracking
OPHD, OEPH[1]	Research Analyst	Environmental Public Health Tracking
OPHD, OEPH[1]	Toxicologist	Environmental Hlth Assessment Prgrm
OPHD, OEPH[1]	CDC Fellow	Office of Environmental Public Health
OPHD, OEPH[1]	Program Coordinator	Health Impact Assessment
OPHD, OEPH[1]	Epidemiologist	Environmental Hlth Assessment Prgrm
OPHD, OEPH[1]	Senior Research Analyst	Environmental Public Health Tracking
OPHD, OEPH[1]	Administrator	N/A
OPHD[1], Office of Family Health	Nutrition Consultant	Office of Family Health
OPHD[1], Office of Multicultural Health	Administrator	N/A
Oregon Dept of Environmental Quality	Northwest Region Administrator	N/A
Oregon Hlth and Sciences University	Family Physician	Preventive Medicine
Oregon Hlth and Sciences University	Assistant Professor	Public Health and Preventive Medicine
Oregon Hlth and Sciences University	Research Associate	Public Health and Preventive Medicine
Portland State University	Sustainable Transportation Program Manager	Oregon Transportation Research and Education Consortium

OPHD=Oregon Public Health Division; OEPH=Office of Environmental Public Health, ODPE=Office of Disease Prevention and Epidemiology HPCDP= Health Promotion and Chronic Disease Prevention.

Appendix C Outcome of Discussion of moving HIA forward in Oregon, April 23, 2009.

Perceived Barriers:

Funding
Resources
Competing demands/lack of time
Short timelines for policy decisions
Agency and administrative support
Lack of clarity about roles for initiation and components of HIA
Need to build capacity in local health departments
Challenges in community involvement
Government agencies cannot get involved with some political situations
Involving the right partner agencies
Need for more rigorous research and quality information
Determining scope of project
Determining impact of HIA
Public agencies lack skills in collaboration
Reaching decision makers with HIA findin

Opportunities:

Engage the Oregon HIA Network
Build capacity upfront
Start a strategic planning process
Hold an HIA conference to share strategies
Use the resources and expertise of state and local public health
Obtain support for HIA from elected officials
Develop strong partnerships with advocacy groups
Raise awareness through media and presentations
Work through existing programs/channels/collaborations to reach out to potential stakeholders
Incorporate health into existing planning or decision making processes
Explore a statewide HIA policy
Conduct small pilot projects to build capacity
Improve communication with other agencies about upcoming project

Upcoming ideas for HIAs:

Portland Comprehensive Plan
East Portland Action Plan
Discarding of cell phones and other electronic devices
Taxing pornography to fund women's health issues
Water flouridation
Rose Garden district redevelopment
Flexible funding process (related to transportation)

How would you like to participate in a future HIA initiative?

Examples:

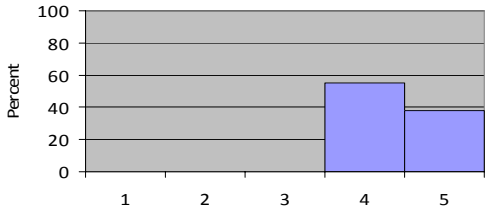
Data and GIS skills: land use, transportation, parks, trails open spaces, trash, recycling, chronic disease, tobacco
Policy, planning, implementation, and measurement of transportation demand management
Linkages to county public health departments and tribes through training, technical assistance and outreach
Building interstate collaboration and political support on regional initiatives/HIA projects.
Education on links between health and transportation
Incorporating health into existing planning processes

Appendix D Summary of Evaluations, HIA Training April 22-23, 2009.

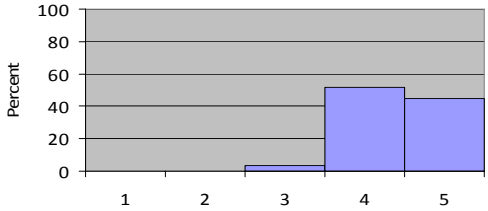
Day 1 Evaluation

1. Please rate the following statements listed below by circling the appropriate rating
(1-strongly disagree; 2-disagree; 3-neutral; 4-agree; 5-strongly agree)

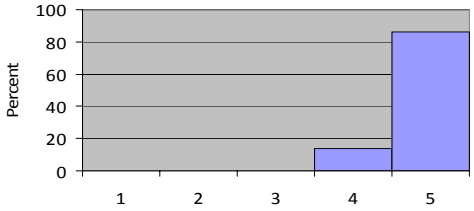
The content presented today deepened my understanding of the subject and HIA



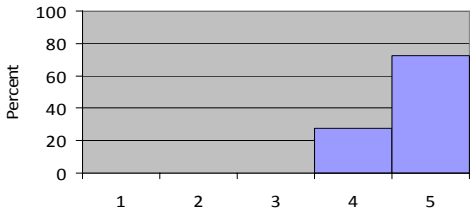
Today's pace was appropriate for participants, not too fast or too slow



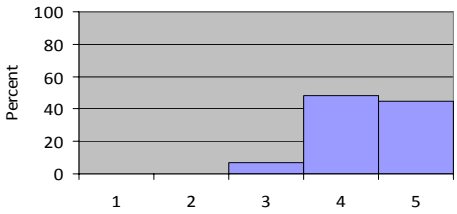
Today's facilitator encouraged participation



Today's agenda had a good balance between speaker presentations, small group exercises and discussion



I will use the knowledge/skills gained from today's session in my future work



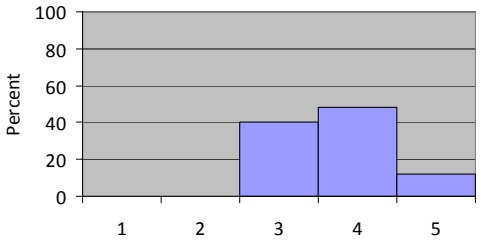
Additional comments on Question 1:

length of group exercises could be shortened
well presented, clear easy to understand; hope to use in the future
already know the basics; would like more time for hands on learning
pace was somewhat too fast - time for reflection would have been helpful
use of knowledge and skills is unknown because my future work is currently undetermined
thank you for giving time for people to ask questions, and for encouraging participation

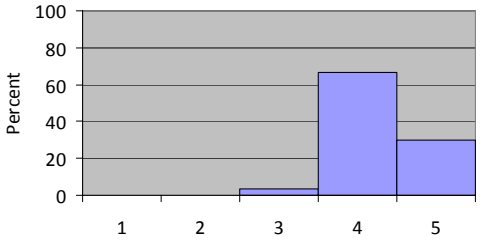
2. Please rate the different sections of the training on a scale of 1 to 5.

(1-very poor; 2-poor; 3-neutral; 4-good; 5-excellent)

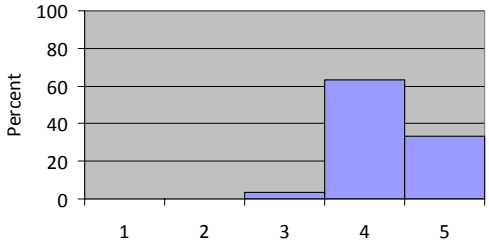
Trees, Leaves and Roots, making the connection between land-use policy and health activity



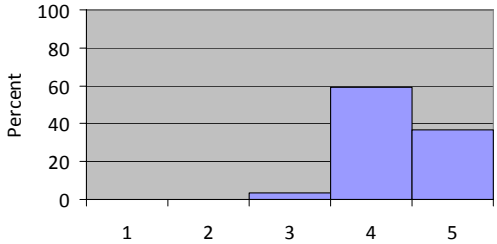
Introduction to HIA



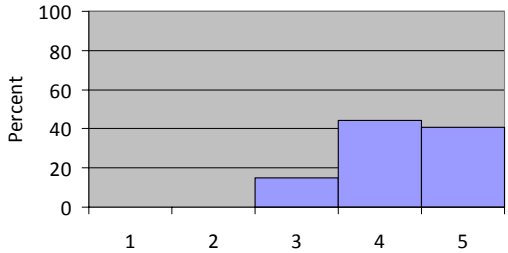
HIA as a collaborative process



Step 1: Screening



Step 2: Scoping



Step 3: Analysis

Additional comments on Question 2:

need more depth on scoping and analysis

concerns about weakness of data in analysis

I think it's hard to know how to scope w/o all of the rec. info.

more info on limiting the scope; would like more on assessment
I think if we had a more focused topic [for the case study] it would not be so overwhelming. The concepts being presented are great as is the presentation of the material.
tree leaves - good as a train the trainer; analysis - particularly good w/ this diverse group & focused on a specific geographic area.
collaborative process should be stressed, screening was overwhelming and should be linked to process & organizing principles

like the pathway diagrams in scoping

more time needed on analysis

great case studies; many details to track in screening, scoping and assessment

3. What did you particularly like about the content of today's training?

Common themes:

- data source ideas
- case examples
- pace of the training
- handouts and materials
- well organized and facilitated
- group exercises
- time for discussion

4. What changes would you propose in content, structure or emphasis of today's training?

shorten exercises

focus on subjects and research in addition to curriculum

put numbers on the pages in the notebooks
I would prefer to have a concrete radius of the definition/scope of the problem [case study] in order to apply the questions/ thought process more efficiently
suggest using one example, and using it to model/guide the small group exercises - which means diminishing the role of participant generated projects
maybe start the conversation with what is currently happening in Oregon - or recognize that people have been involved in HIA work - and it may make the task not so daunting

a little more case studies analysis

Many of the slides hard to read - could simplify

more definition early on for group work
maybe talk about potential roles of different stakeholders (e.g. if planning agency doesn't have data, but can offer TA)

5. Are there things that we should have covered today but did not?

what should you have in place before undertaking HIA

networking opportunities

more data resources would be helpful

Look at the protocols & process docs in more depth to get at the tangible ways the work is done

it would be great to see the tools and indicator lists rather than just hear about them

Coverage was extensive - thanks!

data sources - more examples

perhaps more time on thinking through decision-making to narrow scope and audience

Is there any more guidance about procedures & flow chart about how HIA should be done?

Would have liked more non-California examples - there is other work going on that may more closely align with Oregon (demographics, priorities, etc.)

I think it would have been interesting to hear more about the background/training of the HIP staff

Talk about resources needed for different levels of HIA (e.g. staff time, IT, etc.)

6. Are there things that we should have spent less time on today?

I don't think we needed the small group report backs

narrow the number of examples

small group discussions may not have required the large group report back

7. Should we include all of today's material in future HIA Trainings?

also common challenges and how to avoid them

I think it is all helpful

so far so good

yes

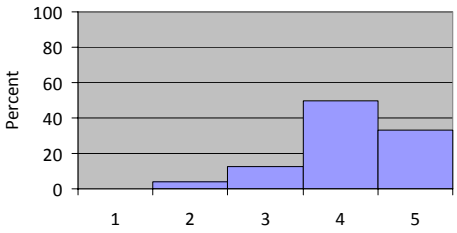
suggest using one example, and using it to model/guide the small group exercises - which means diminishing the role of participant generated projects - then at end of training could address generalization of HIA to other health issues

Day 2 Evaluation(April)

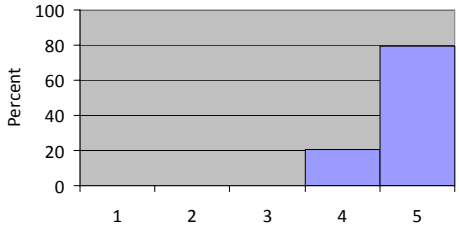
1. Please rate the following statements listed below by circling the appropriate rating *(1-strongly disagree; 2-disagree; 3-neutral; 4-agree; 5-strongly agree)*

The content presented today deepened my understanding of the subject and HIA

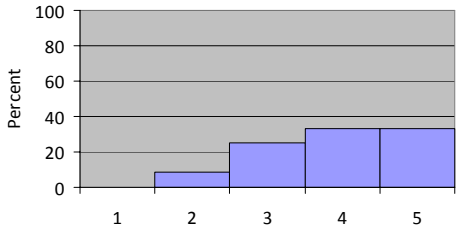
Today's pace was appropriate for participants, not too fast or too slow



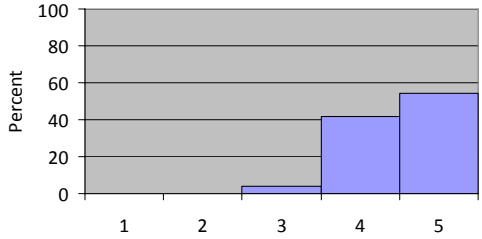
Today's facilitator encouraged participation



Today's agenda had a good balance between speaker presentations, small group exercises and discussion



I will use the knowledge/skills gained from today's session in my future work



Additional comments on Question 1:

low energy after lunch - today was a lot less interactive

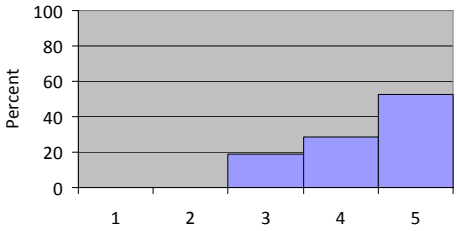
pace was too slow, needed more interaction/group work

a.m. was a little slow

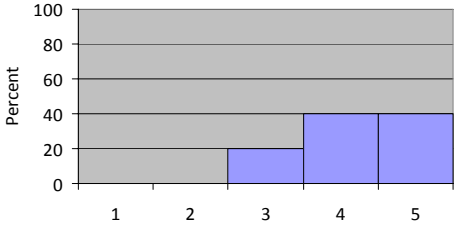
pace too slow; group comfortable in lg. group discussion so fine not to break out into small groups; will use assessment tools in future

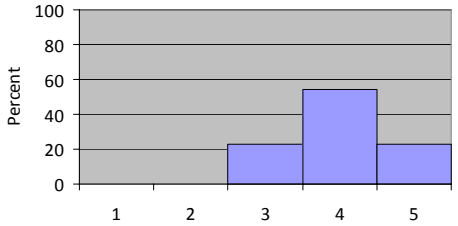
2. Please rate the different sections of the training on a scale of 1 to 5.
(1-very poor; 2-poor; 3-neutral; 4-good; 5-excellent)

Analytical tools for HIA Assessment

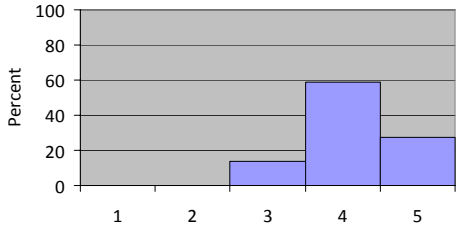


Intervention points in the HIA process

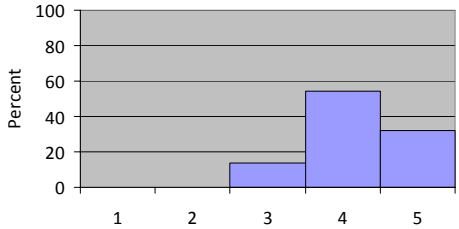




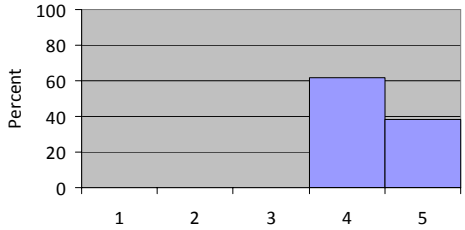
Step 4: Reporting



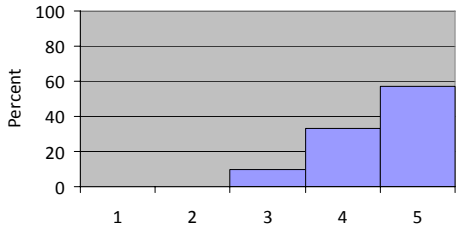
Step 5: Monitoring



HIA Evaluation



Using HIA to influence decision making



HIA next steps

Additional comments on Question 2:

reporting - maybe more on to how/when to best disseminate

some of the analytic tools sections could have been better presented, noise, air etc. Inc. knowledge of the subject and simplify

intervention points - too much new info., would have benefited professionally from more conversation about reporting

we are the choir, but others may not see the benefit - need strong advocacy; not sure how will move forward, lots of discussion but perhaps need concrete ideas, no overwhelming consensus

more time on analytic tools

tools section was too quick to learn much

tools might have been better is shorter or not done since author was not here

intervention points not needed with slow moving planning processes; good discussion about next

steps

intervention points - highly relevant; reporting most relevant to me in my work

3. What did you particularly like about the content of today's training?

explanation of NEPA/CEQA process, data tools, discussion of barriers/ strategies; report back from community training

discussion focused on local issues and possible future process

review of data sources

afternoon session was interesting

discussion about barriers and next steps

liked going through barriers/opportunities & getting to think about HIA locally

tools learning about peqi and others; discussing specific next steps

opportunities to discuss strategies and challenges with participants

more frequent breaks

quantitative tools

analysis

great range - nitty-gritty technical stuff so techies weren't bored, but emphasis on community work so policy types stayed engaged

brainstorming discussion

brainstorming next steps

great analysis info. demo projects were interesting; good networking opps.

provided practical next steps

looking forward to list of participants, discussion of opportunities

modeling tools

assessment

I really enjoyed the brainstorming session at the end

4. What changes would you propose in content, structure or emphasis of today's training?

short break out session after data tools on ID'ing data sources locally

greater focus on the presentation of tools, that is, more to the point

some slides in 2nd half of day were out of order

create more time for dialogue among participants about opportunities and challenges

describe the specific roles of each participating party of HIA projects

more variety in presentation styles

earlier break in a.m.

diagrams to help discuss balance of grass roots vs. public policy/ gov't regulation

would like a break out session on reporting

5. Are there things that we should have covered today but did not?

maybe focus on political, fiscal challenges encountered in the Bay Area

describing or discussion different types of policy decision-making venues would have been good background info

local data resources, maybe more about recommendations

whistle blowing?

professional skills to develop in this work? diplomacy? mediation?

6. Are there things that we should have spent less time on today?

maybe EIA
why is congestion pricing a big topic, instead I think developing comprehensive public transportation would be more helpful
HIA seemed a little broad which is a strength, but I think a mental map of when to think of specific applications vs. broad subjects would help

7. Should we include all of today's material in future HIA Trainings?

I particularly liked the tools for noise, collisions, etc- what about light?
Connect each to an example health outcome

more on community engagement, possibly skill building

yes (6 responses)

Appendix E HIA Practitioner Roles Assessment

E.1 Interview Questions

1. From your perspective, what is a Health Impact Assessment? [We're interested in understanding how you define health impact assessment.]
2. In what ways are HIAs potentially useful in Oregon?
3. What to you see as the skills your organization could bring to an HIA and what roles would you like to play in the process?

[Yes, No, Maybe, Not Applicable]

List of Skills and Roles:	Skills Can Bring	Roles Like to Play
a. Identifying suitable HIA projects ("screening")		
b. Soliciting community input		
c. Convening and managing the HIA process		
d. Planning the HIA process ("scoping")		
e. Data gathering		
f. GIS mapping		
g. Modeling of exposures		
h. Risk assessment		
i. Expertise in a specific area of health or environment (if so, what)		
j. Engaging and coordinating input from diverse partners and stakeholders		
k. Conducting the assessment – using multiple data sources to identify potential health impacts		
l. Providing data for the assessment		
m. Providing expertise on a particular piece of the assessment (e.g., air quality)		
n. Providing input on recommendations and mitigations that could address the health impacts revealed in the assessment		
o. Framing the results of the HIA for various audiences		
p. Presenting the findings to decision makers and other target audiences		
q. Proposing policy alternatives that support health		
r. Monitoring the impacts of decisions on health		
s. Evaluating the influence of the HIA on the decision-making process		
t. Advocating for public health (e.g., inclusion of health outcomes in policies & plans)		
u. Educating others about HIAs or how to use HIA findings		

4. In what ways, if any, does your current work overlap with the activities that usually are a part of doing an HIA?
5. a. What other agencies or organizations do you see as your collaborators in working on HIAs?
   b. What do you see as your agency's / organization's role in an HIA collaboration?
   c. Some proponents of HIAs recommend that HIA selection should be primarily driven by community stakeholder interests and by health advocates. Do you have any thoughts about that recommendation?

6. If you were thinking about initiating an HIA in your organization, how would you go about planning what HIAs to do and what not to do?
7. What kinds of policy processes [decision-making] do you see HIAs contributing to?
8. How would you decide if an HIA had achieved what you wanted it to?

9. What, if any, barriers do you foresee in successfully participating in an HIA and what would be helpful in overcoming those barriers?

E.2 Executive Summary

Draft Executive Summary: Health Impact Assessment Interviews

John A. Dougherty, PhD
Program Design and Evaluation Services (PDES)
Multnomah County Health Dept. &
Office of Disease Prevention and Epidemiology/DHS

I. Introduction and Background

In June 2009 interviews were held with 10 key informants from the Oregon Department of Health Services, the Multnomah County Health Dept., and community-based organizations, all of whom had received HIA training or had participated in an HIA. The purpose of the interviews was to develop an understanding of the issues, views, and needs surrounding the development of Health Impact Assessment (HIA) capacity in Oregon. The interviews were about 30-45 minutes in length and consisted entirely of open-ended questions necessitating narrative responses.

The interviews were conducted as part of grant funded by ASTHO to provide HIA training to government and non-government public health professionals. The interviews were intended to expand understanding about existing HIA capacitates and training needs.

HIAs are intended to provide systematic input on the potential health consequences of proposed project and policy decisions. HIAs "seek to predict the future consequences for health of possible decisions, and that it seeks to inform decision-making." (Kemm, 2003). In that sense, HIAs join environmental impact statements, budgetary impact statements for proposed legislation or regulations, and other attempts to predict the 'impacts' of social, fiscal, sustainability, risk, environmental, educational, demographic, housing, climate, and other aspects of proposed projects or broader policy decisions. Without considering the potential health impacts of decisions, the potential health 'costs' of projects and policies remain invisible and externalized, potentially leading to increased health burdens on communities, and resulting in disproportionately negative impacts on vulnerable populations.

Impact assessment has been a recognized field of practice for 10-15 years, and the International Association for Impact Assessment, established in 1981, serves as a forum for impact assessment practitioners and has established definitions and professional guidelines. The introduction of health and public health considerations into project planning and broader policy decisions over the past 5-8 years, through HIAs and other means, has been an important development.

The field of 'policy analysis' is a related field that seeks to understand how policies are developed, adopted, and implemented. Understanding the impact of existing policies and the potential consequences of changes in policy (especially fiscal consequences) are also routine components of policy analyses conducted by legislative and executive branches of government world-wide.

The recent training and emphasis on HIAs in Oregon has come at a time when some public health programs are placing less emphasis on individual behavior change as a means for improving the health of populations and more emphasis on changing 'environmental' and 'contextual' variables that influence health behavior more broadly. That many HIAs seek to protect health by changing the physical and social environment (e.g., transportation), and by changing broader policy, is supportive of the transition of public health programs to community-level interventions (e.g., social marketing).

Summary of Major Findings

- **HIA Definition:** From your perspective, what is a Health Impact Assessment? Interviewees were asked to define HIAs in their own words. The major characteristics of HIAs that they identified include:
  - A formal systematic 5- 8-step process useful for built-environment planning projects, and
  - A flexible process that could be used in multiple policy venues.

  Also, HIAs were conceptualized in three general ways:
  - As a process of gathering and interpreting data,
  - As a set of recommendations for supporting health, and
  - As a tool for including health considerations in policy making.

- **Use of HIAs in Oregon:** In what ways are HIAs potentially useful in Oregon? Informants said that that HIAs would be useful for:
    - Making the built environment healthier,
    - Incorporating health considerations into policy process and decision-making, and
    - Understanding how changes in the environment may affect health in the future ("future casting").
- **HIA Skills and Roles:** What to you see as the skills your organization could bring to an HIA and what roles would you like to play in the process?
    - There was considerable overlap in skills and desired roles among government and non-government respondents.
    - Individuals reported gaps between desired roles and existing skills for their organizations.
    - HIA training needs were identified.
    - The full report describes skills and desired roles for 21 different aspects of HIAs.
- **Overlap with Existing Activities:** In what ways, if any, does your current work overlap with the activities that usually are a part of doing an HIA?
    - Respondents reported that multiple existing activities within their respective organizations significantly overlapped those of many HIAs, including:
        - Gathering and analyzing data,
        - Creating geographic data displays,
        - Developing partnerships with diverse organizations & communities,
        - Facilitating collaborative work,
        - Addressing built environment issues,
        - Conducting policy analyses,
        - Presenting findings,
        - Evaluating policy process and HIA outcomes, and
        - Community engagement and advocacy.
    - In addition, the current of many HIAs on the built environment reinforces their shift from individual to community-level interventions.
- **Collaboration:**

Respondents said that:

- The number and kinds of collaborators depends on the topic, scope, and likely process of the HIA.
- Many potential partners could be involved.
- Their respective organizations could take lead in doing an HIA, be an active partner in an HIA, or support others in doing an HIA, depending on topic of HIA and whether the proposed HIA activities were consistent with the organization's skills.
- Community involvement in HIA planning and implementation is important, especially when community interests are relevant and they have the capacity to participate.
- Many thought that community interests should guide HIA selection. However, government organizations pointed out that they have a responsibility to conduct health assessments and HIAs whether or not a specific community group is interested in the issue.

- **HIA Planning:** If you were thinking about initiating an HIA in your organization, how would you go about planning what HIAs to do and what not to do?
    - Several informants said that they preferred a collaborative process with partners.
    - Others said that the planning would have to be consistent with organization mission, skills, and capacities.
    - Planning would be informed by the impact on health of the proposed policy and/or the potential health benefits of HIA recommendations.
- **Policy Processes:** Informants were asked about the kinds of policy processes [decision-making] to which HIAs might contribute. They reported that:
    - HIAs were very well suited for built-environment planning projects.
    - Also, they could contribute to less formal policy making (e.g., "strategic" policy decisions)
    - There would need to be a fit between the timeframe available for giving input, the kinds of health data that were available, and the needs of the policy process.

- The fluidity of some policy processes may be a problem for planning and implementing systematic HIAs.
- Having a flexible HIA process is important.

- **Assessment of HIA Impact:** How would you decide if an HIA had achieved what you wanted it to? Respondents said that examples of success would include:
  - That HIA-based health information was incorporated into policy.
  - The number of HIA recommendations incorporated into policy.
  - The HIA had an impact on the policy-making process.
  - The policy informed by the HIA had an impact on the health of communities (a much longer term outcome).
- **Barriers:** What, if any, barriers do you foresee in successfully participating in an HIA and what would be helpful in overcoming those barriers? Informants identified the following barriers:
  - Relatively incomplete knowledge & experience with conducting HIAs.
  - Availability of sufficient funding, skills, and time.
  - The complexities of collaboration with other organizations.
  - Limits to city/environmental planner and decision-maker knowledge of potential health impacts of their decisions.
  - Lack of experience in knowing how to make the health information and/or data useful to decision makers.

E.3 Full Report

Draft Report: Health Impact Assessment Interview Narratives

August 24, 2009
John A. Dougherty, PhD
Program Design and Evaluation Services (PDES)
Multnomah County Health Dept. &
Office of Disease Prevention and Epidemiology/DHS

II. Purpose:

The purpose of the interviews was to develop an understanding of the issues, views, and needs surrounding the development of Health Impact Assessment (HIA) capacity in Oregon. The letter introducing the survey questions stated that the objective was to: " . . understand the perceptions of state public health professionals about their potential roles in HIA work. In addition, the views of non-state partners will be important for obtaining a view of how collaborative HIA work might proceed." Information was therefore sought from a list of DHS, LHD, and CBO persons who had received training or had participated in and HIA.

III. Methods:

As part of an evaluation contract with Toxicology, Assessment, and Tracking Section (TATS)* of the Office of Environmental Public Health/DHS, the interviewer developed a draft plan and interview topics in the Spring of 2009 in collaboration with staff. In May and June, prospective key informants were invited to provide comments and suggestions on the topics, interview methods, and uses of the information in a participative process. Interview questions were was finalized in June 2009 and copies of questions were forwarded to 5 DHS staff and managers, one person from a local health department, and 4 persons from community-based organizations working on health and/or HIA issues. The interviews were about 30-45 minutes in length and consisted entirely of open-ended questions necessitating narrative responses. Some interviews were conducted face-to-face, while others were conducted over the phone for convenience. The first interview was conducted on June 5th and the 10th on June 24th, 2009. A copy of the interview questions is attached to this report.

The narrative responses were analyzed qualitatively by identifying topics and keywords. Issues and themes were developed from the topics by examining the responses within respondents and then refined by re-examining each domain across respondents (Patton, M. Qualitative Research & Evaluation Methods (3rd Ed.), Thousand Oaks, CA: Sage Publications, 2002).

Organization of the Report: For each question in the interview, the report summarizes the narrative or quantitative responses, and then discusses the issues and themes identified in the narratives. The issues and themes contained in the Discussion section of each question are necessarily related and overlapping; similar issues may arise in several related questions. The discussion is based on respondent narratives, but the interpretations are influenced by

the interviewer's background in environmental science, environmental health, and experience and knowledge of policy analysis and evaluation. Therefore, the issues and themes described in the Discussions below represent only one way the qualitative data could be organized and interpreted. While they are faithful to the comments of the respondents and have been systematically developed, they do not represent a single truth about the interview narratives. The interpretations, especially those that are discordant with the reader's experience, may best viewed as topics for discussion and clarification than as a valid assessment that stands alone.

III. Context of the Interviews and HIAs:

The interviews were conducted as part of grant funded by ASTHO to provide HIA training to government and non-government public health professionals. The interviews were intended to expand understanding about existing HIA capacitates and training needs. The interviews were conducted approximately 2 months after an initial 2-day HIA training provided by Human Impact Partners to community members and to health professionals. Of the ten interviewees, seven had attended the HIA training and five had previously participated in an HIA.

HIAs are intended to provide systematic input on the potential health consequences of proposed project and policy decisions. HIAs "seek to predict the future consequences for health of possible decisions, and that it seeks to inform decision-making." (Kemm, 2003). In that sense, HIAs join environmental impact statements, budgetary impact statements for proposed legislation or regulations, and other attempts to predict the 'impacts' of social, fiscal, sustainability, risk, environmental, educational, demographic, housing, climate, and other aspects of proposed projects or broader policy decisions. Without considering the potential health impacts of decisions, the potential health 'costs' of projects and policies remain invisible and externalized, potentially leading to increased health burdens on communities, and resulting in disproportionately negative impacts on vulnerable populations. When these externalized health costs (and benefits) are not considered during the planning process, the health care and public health systems also may become burdened with the task of addressing the increased health and prevention needs of affected communities.

Impact assessment has been a recognized field of practice for 10-15 years, and the International Association for Impact Assessment, established in 1981, serves as a forum for impact assessment practitioners and has established definitions and professional guidelines. The US Government Accountability Office (GAO), in their Prospective Evaluation Synthesis program, develop impact statements that address a number of variables as part of their policy analyses for legislative and other policy-making customers, as do other federal and state agencies. The introduction of health and public health considerations into project planning and broader policy decisions over the past 5-8 years, through HIAs and other means, has been an important development. Great Britain, the EU, Australia, and New Zealand early-on established procedures for including health information in project and policy planning.

The field of 'policy analysis' is a related field which seeks to understand how policies are developed, adopted, and implemented. Understanding the impact of existing policies and the potential consequences of changes in policy (especially fiscal consequences) are also routine components of policy analyses conducted by legislative and executive branches of government world-wide. A recent emphasis in the United States (and in Oregon) of advancing health and public health goals through policy change (in addition to educating individuals and communities) is important to note. An emphasis on policy change will increase the need of public health organizations to become more familiar with policy analyses, different policy venues, and the various ways in which policies are made.

The recent training and emphasis on HIAs in Oregon has come at a time when some public health programs are placing less emphasis on individual behavior change as a means for improving the health of populations and more emphasis on changing 'environmental' and 'contextual' variables that influence health behavior more broadly. For example, increasing opportunities in neighborhoods for safe exercise through modifications of the physical or social environment may have an important positive impacts on physical activity, cardiovascular health, and obesity of residents over and above that achieved by health education directed towards individuals. That many contemporary HIAs seek to protect health by changing the physical and social environment (e.g., transportation), and by changing broader policy, is consistent with and supportive of the transition of public health programs to community-level (e.g., social marketing) and 'structural' interventions.

IV. Level of participation

All 10 persons who were identified participated in the interviews. All questions were answered by all participants except for some parts of Question 3 where the interviewee did not feel they had sufficient familiarity with the topic.

V. Narrative and Quantitative Findings

Question 1: What is an HIA?

Government respondents offered more formalized conceptualizations of HIAs (i.e., the 5- or 8- step process as described in recent HIA trainings and the published literature) relative to community-based organization interviewees who saw HIAs as a more flexible process. Individual respondents emphasized different aspects of the HIA in their definitions. Some saw HIAs primarily as a systematic process of data gathering, assessment, and recommendations. Others focused instead on the provision of the health recommendations themselves (the 'product' of an HIA), and some described the HIA primarily as a 'tool' for advancing health interests in policy decisions (the target audience for the HIA).

There also were differences in how respondents conceptualized the level of effort or intensity of HIAs. Some thought of HIAs in terms of a set of practices and procedures by which a literature review and systematic analysis results in health-based recommendations for policy decisions (e.g., the 5- or 8-step HIA processes). In contrast, others provided a more flexible view of an HIA in which the needs and timelines of the policy process and policy advocates had a large impact on the kinds and scope of health information and recommendations that were provided. Several indicated that an important goal was the incorporation of health information as an integral part of various policy and decision-making processes. Finally, some emphasized the importance of HIAs for reducing the negative health impacts of policy decisions, while others viewed it at a means for increasing health benefits.

Discussion: There were significant differences in how respondents conceptualized HIAs – some pointing primarily to characteristics of the HIA process, others to the incorporation of health information into policy deliberations, and still others on the impact of adopted HIA recommendations on the health of target populations. Clarification and discussion of these three ways of viewing HIAs may be useful among HIA collaborators.

There may be an inherent conflict between the idea of an HIA as a means for reviewing the literature and finding some relevant 'truth' about potential health impacts of policy decisions, and the needs of many policy processes [outside formal transportation planning processes] for health information provided in a timely manner that advances an advocacy policy position. Those respondents committed to carefully reasoned health evidence based on a review of the literature and assessment of data quality may be limited to long-range planning and transportation policy processes that have similar timelines and data-review practices to HIAs. The systematic 5- or 8-step HIA process taking 2-weeks to 6 months to develop may not be fast or definitive enough for many less formal policy processes; policymakers may find the HIA process ill-suited to their (often fluid) policy deliberation process or find health data less compelling than other drivers of policy decisions. Having a flexible set of definitions for what constitutes an HIA may be of benefit in serving a wide variety of structured and more fluid policy processes (but may complicate HIA training or establishing a scope of practice guidelines for HIAs).

Finally, the context of HIAs was seen as future-orientated by some respondents (what the HIA could influence) but others focused on learning from past efforts (how well did the HIA work?).

Question 2: In what ways are HIAs potentially useful in Oregon?

Most respondents mentioned health topics that were mostly related to the built environment (transportation, land use, obesity, reduction in energy use and pollution, pubic and private investment, family leave act, etc.). However, others were less specific and suggested that HIAs could fill [knowledge] 'gaps.'

Incorporating health considerations into the policy process also was mentioned, and several suggested that HIAs were not just useful in Oregon, but also elsewhere. Training planners and policy makers to incorporate and use health information in their decision making was thought important. HIAs also were said to be a means for 'future casting' the impact of climate or population changes in the Metro area to assist adaptation [of policy and organizations]..

Discussion: Training policy makers to consider health information is one aspect of incorporating health information into the policy process. One potentially could sensitize policymakers to the health impacts of decisions with or without a formal HIA process; the formal HIA process may be only one way to increase the use of health considerations in decision making (see also Question 7, below). The use of HIAs for 'future casting' or filling knowledge gaps also is a somewhat more general goal for HIAs, independent of its application to a specific planning or policy process.

Question 3: What do you see as the skills your organization could bring to an HIA and what roles would you like to play in the process?

Interviewees were presented with a series of HIA-related activities and asked about the "skills" their organizations could bring to an HIA and also about the "roles" they would be interested in playing in the HIA process. Endorsement of a "role" did not necessarily mean that they had the corresponding skill – differences between skills and roles could reflect a skill the organization would like to develop or roles the organization would like to play in the future. Their responses to the activities were scored as a Yes, No, Maybe, or Not Applicable. **Figures 1 and 2**, show that as a group, 6 government (state and county) respondents reported skills in more areas than did a group of 4 that represented non-government organizations, despite the considerable overlap. The ordinate of the graphs represents the percent of interviewees who responded 'Yes' to the item. These are averaged data, and therefore one should not conclude that all non-government organizations have fewer skills in conducting HIAs than do government ones.

Comparison of skills and roles for government and non-government respondents, respectively, are shown in **Figures 3 and 4**. Differences between skills and roles in most cases reflects a desire for HIA training that will enable organizations to participate more fully. Because of averaging, some desired roles were lower than skills – the difference is not meaningful for any given organization. Average gaps between skills and desired roles appear larger for government than for non-government organizations; the meaning of this difference is not clear.

Discussion: As shown in **Figure 1**, there is overlap in skills related to HIAs, and some areas where government or non-government organizations both have strengths, and areas where both report fewer skills. The areas where both report relatively fewer skills would normally suggest areas for future training opportunities. However, lower interest in playing a role in many of the lower skill areas (**Figure 2**) could indicate that organizations are relatively satisfied with their current skills and roles. Differences between skills and desired roles within each of the two groups (**Figures 3-4**) may be a better indicator of training needs – but important individual organizational needs may be obscured by presenting averaged data. The data presented in these Figures therefore should not be viewed as a definitive assessment of training needs.

Figure 1

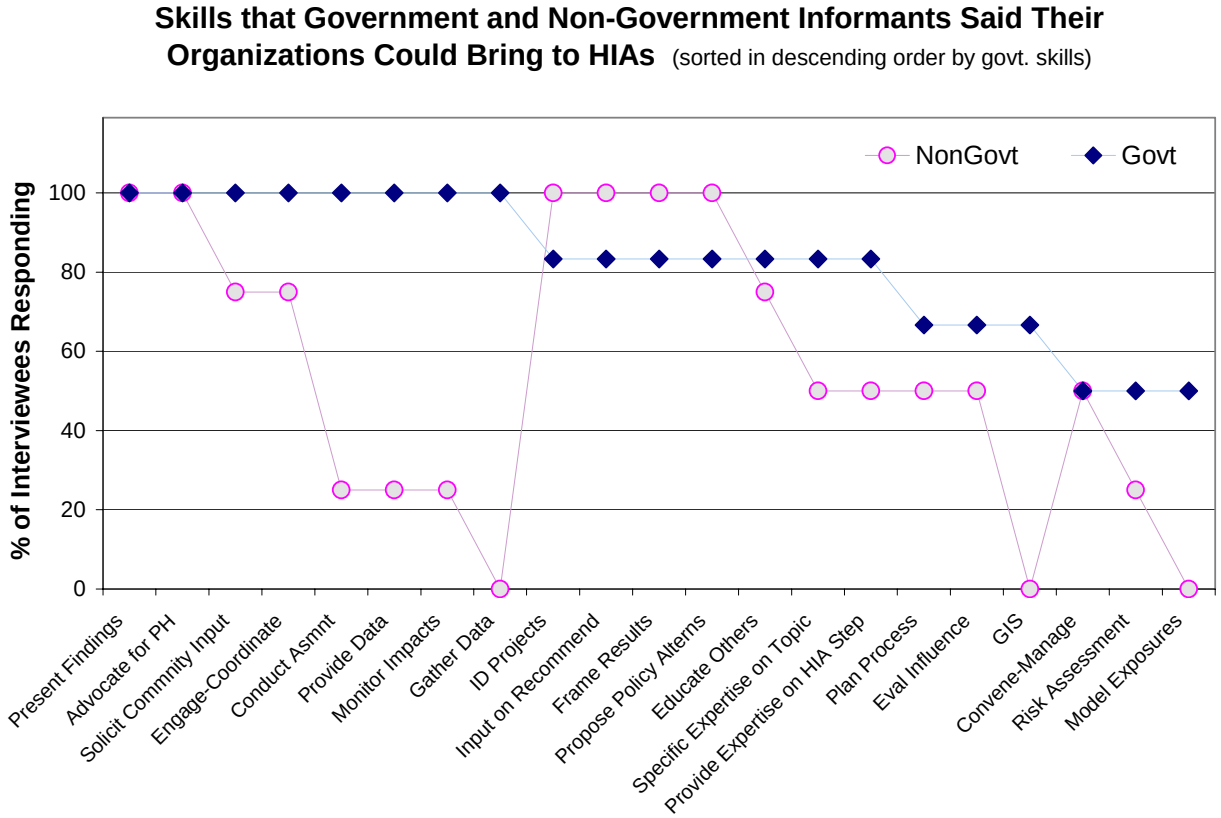


Figure 2

Roles that Government and Non-Government Informants Said Their Organizations Would Like to Play (sorted in descending order by government skills)

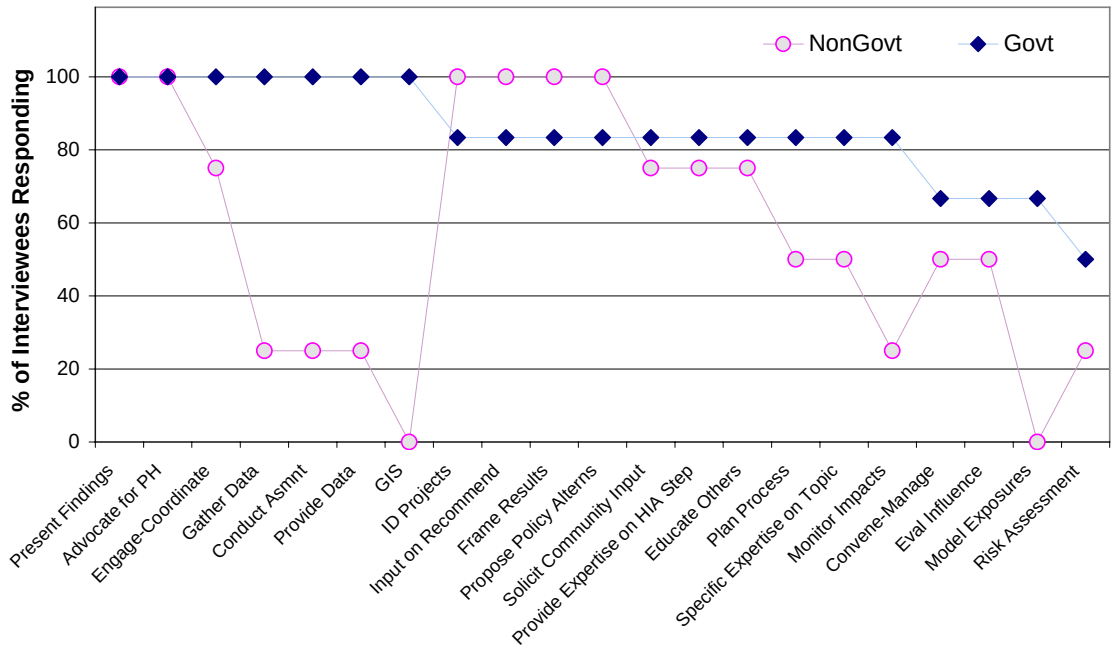


Figure 3

State and Local Government Respondents: Correspondence between HIA Skills and Roles the Organization Would like to Play

(Correlation 0.792)

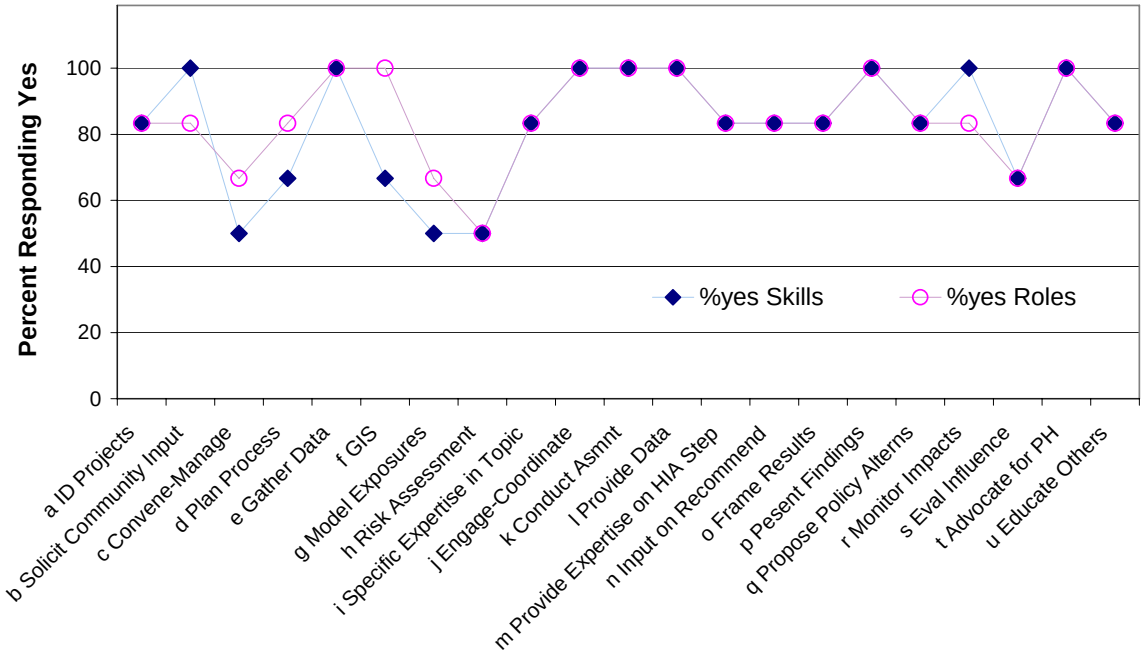
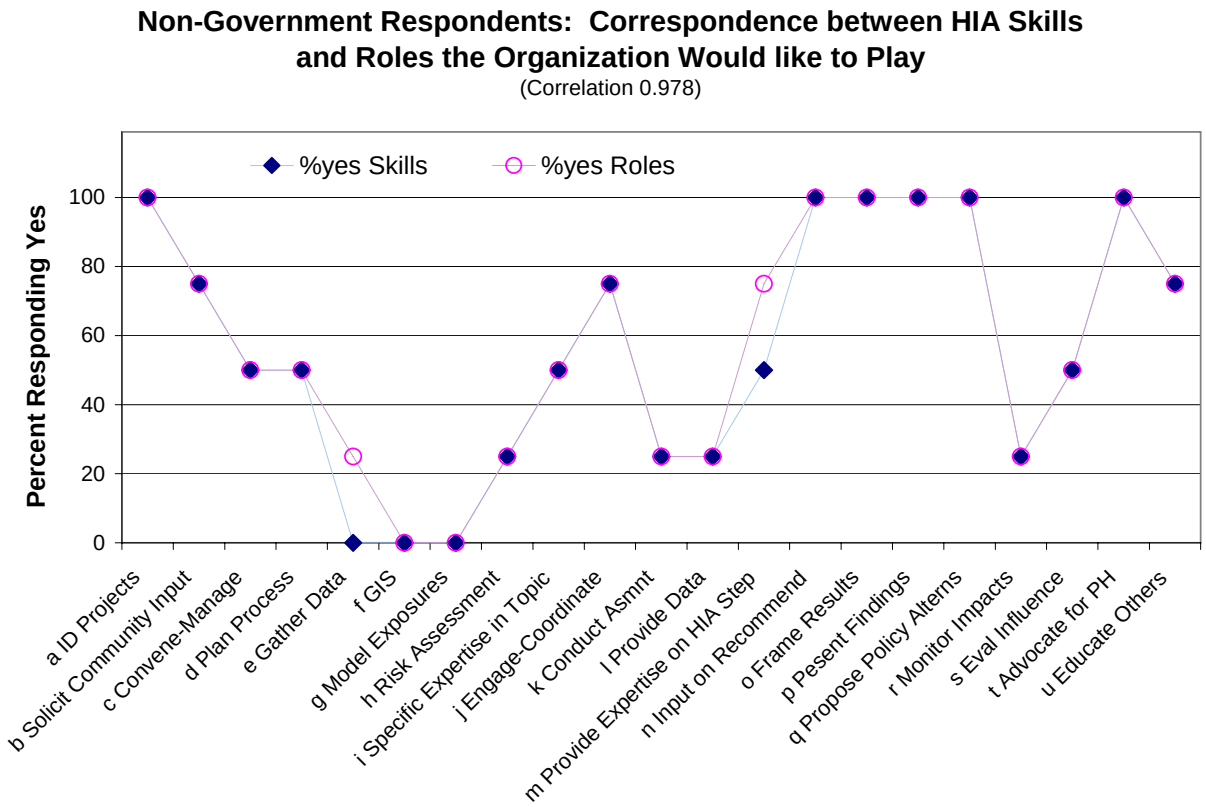


Figure 4



Question 4: In what ways does your current work overlap with the activities that are usually part of doing an HIA?

Several respondents reported that their organizations routinely did "health" or "community" assessments that were similar to HIAs and were done either alone or with government or community partners. Similarly, various respondents and their organizations have other overlapping expertise and current practice related to components of HIAs, such as systematic data gathering, analyzing data and creating geographic data displays, developing partnerships with diverse organizations and communities, facilitating collaborative work, addressing the built environment, conducting policy analyses, presenting findings, evaluating policy process and outcomes, community engagement, and policy advocacy. A few respondents reported that they have initiated and completed HIAs. In the context of this question, several respondents mentioned their transition from a focus on individual behavior change (such as smoking or obesity) to a contextual or 'structural' approach in which one tries to alter in positive ways the environmental determinants of health behaviors. Those respondents said that their involvement in HIAs might support that change, and vice versa.

Discussion: Both government and non-government individuals and organizations have multiple skills that could contribute to a formal or informal HIA process. Respondents said that they have much to contribute and much to learn from participating in future HIAs. The HIA focus on the environment is consistent with some organizations considering a contextual approach to changing health behaviors. The relationship between the HIA and the adoption of contextual or community-level interventions might be a useful discussion among HIA partners. These discussions also may be important for community-based health organizations not involved in HIAs, who frequently focus on individual level interventions in their public health work. There may be a need for broader training and learning about environmental / structural and community interventions that would complement HIA-specific training opportunities.

Question 5a: What other agencies or organizations do you see as potential collaborators in working on HIAs?
Question 5b: What do you see as your agency's / organization's role in an HIA collaboration?
Question 5c: Some proponents of HIAs recommend that HIA selection should be primarily driven by community stakeholders interests and by health advocates. Do you have any thoughts about that recommendation?

a. A majority of respondents said that their collaborators would depend upon the topic, scope, and process envisioned for the HIA. State government partners indicated that they would have internal partners within the state and, depending upon the HIA, would also involve community and grassroots organizations. Also, local health departments, academia, and city planning agencies also would be likely collaborators on many of the HIA topics envisioned as important for Oregon. Others informants mentioned EPA, Kaiser, city councils, the Federal Department of Energy, Metro, sustainability organizations, and community-based public health partners.

b. The anticipated roles of state and non-state respondents were similar to their responses to Question 4 – their roles would depend upon the scope, process, and topics of the HIA. Many respondents said that they could take a lead, partnership, or a supportive role in an HIA depending upon the nature of the specific HIA. Some respondents indicated that they could manage the entire process while other respondents said that they could probably take the lead on some components of a 5- or 8-step HIA process, but not others. Specific roles would depend on the HIA topic and whether or not they have any existing expertise in that content area or expertise in some of the steps of an HIA. For example, one respondent said that they could take the lead on data analysis and evaluation, while others said they could take the lead in convening partners, doing advocacy, mentoring, and management of volunteers. Other roles in HIAs mentioned by respondents included capacity building, resource development, training, and advocacy.

c. While there was general agreement that affected communities should be involved in HIAs, several did not see community interests as the only driver for HIA selection. State respondents pointed out that state and local public health agencies have a broad responsibility to conduct assessments and identify potential threats to health, especially for vulnerable populations and communities of color. Having HIA selection most responsive to vocal communities would not be equitable. The interviewees also said that public health benefits of HIAs should be informed by, but somewhat independent, from the interests of organized and vocal communities. The state was said to have a responsibility to act or plan work with or without community input, and input from specific communities may not always inform statewide concerns. Among the non-state respondents, community involvement was seen as somewhat more salient to HIA selection, but in agreement with their state colleagues, several said that some issues HIA selection issues would transcend the interests of specific communities, such as getting health information incorporated into the policymaking process. It was pointed out that there was no reason that HIAs couldn't be initiated by policy makers, legislators, and others ("anyone should be empowered to suggest an HIA"). Some pointed out that when an idea for an HIA is relevant to a particular community, the affected communities should be involved in meaningful ways (not superficially), which may require support for communities to participate.

Discussion: All respondents indicated that they were open to collaboration and various roles in HIAs, depending on the nature of the HIA and how it fit with their interests, skills, and capacities. This strongly suggests that HIA partners would be flexible and work with partners to define suitable roles and responsibilities. All were open to meaningful community influence, but it's obvious that community interest is not the only, or in some situations, the primary or appropriate driver of HIA selection, especially when the HIA topic or the policy process it is intended to influence applies state-wide or to multiple communities, organized or not.

Question 6: If you were thinking about initiating an HIA, how would you go about planning what HIAs to do and what not to do?

Most respondents identified a collaborative planning process as the ideal context in which to plan an HIA. Others identified specific criteria, such as the HIA topic being consistent with the organizations' priorities and mission, the magnitude of the likely impact of the HIA on health [through the policy process], the likelihood that the HIA could influence the decision-making process, the presence of sufficient information about the policy outcomes to allow assessment of HIA impact on health, and initiation at an early stage of the decision-making process. A similar idea was that planning HIA priorities would be informed by potential health outcomes as identified by a policy analysis (but see discussion in Question 7 regarding the fluidity of some policy processes). Others mentioned interest among community partners, relevance to and involvement of vulnerable populations, and the availability of suitable resources. It was also suggested that there should be an 'environmental' or 'policy' scanning process to identify the likely importance of impending policy decisions for health.

Discussion: Setting up clear priorities for HIAs that are consistent with existing organizational capacities and goals is a theme underlying many ideas about HIA planning. This emphasis should not be interpreted as organizations' having a fixed set of interests – several have talked about a transition toward learning about environmental/structural factors that influence health behaviors, and the responses to Question 3 suggest that acquisition of new skills related to HIAs is desired. Estimating the likelihood that involvement in the decision-making or policy process will be productive

(either for participating in the process or for health outcomes) is also important. Conducting an analysis of the likely health consequences of the proposed policy is an important component in the HIA "screening" step, and may necessitate considerable prior knowledge about existing health evidence that bears on the potential impacts of the proposed policies. However, little was said about expertise or other resources needed to conduct a policy impact analysis – this issue may warrant further discussion. Likewise, identifying policy alternatives that would potentially result in better health outcomes is important, although how one would go about assessing likely health payoff is not clear. Most respondents indicated that they would like to be involved in HIAs as part of a multi-partner collaboration. The amount of time and effort necessary to develop a working collaboration should not be underestimated and it would be a significant task to develop a different collaboration for each HIA.

Question 7: What kinds of policy processes do you see HIAs contributing to?

Most respondents provided a list of specific kinds of policy processes in response to this question. Many pertained to built environment policy decisions, land-use (zoning), and transportation planning ('development projects' in HIA parlance). Other suggestions were workplace policies such as smoking and family leave, grocery store location, state-regional-local government decisions, housing and education policy, budgeting, health care decisions, living wage, and microeconomics ('strategic policy processes' in HIA terms). Several also mentioned in a more general way the importance of the social determinants of health. The ideas of health policy scanning for decision-making processes that may influence health and looking for policy processes in the early stages were again mentioned.

Discussion: The policy process to which HIAs can contribute seem solidly envisioned in the built environment and in relatively formalized planning processes (the Columbia River Crossing, the Portland Plan, zoning deliberations, etc.). This is no surprise as the recent HIA training made extensive use of built environment examples, several public health programs focus some of their work on the built environment, and the relatively formal physical environment planning process uses systematically collected data over a relatively long time period similar to that envisioned by many for the HIA process – suggesting that there is a good fit between HIAs and the planning process.

However, several respondents mentioned much less formalized 'policy' or 'practice' processes as being of potential relevance for HIAs. Legislative, special task force, regulatory, and private development, to name several, were identified as policy processes for which health information would be useful. Many of these "non-planning" policy processes have much shorter timelines, may be more fluid, and perhaps are influenced more by advocacy and relationships than by data. They therefore may be less receptive to formal 5- or 8-step HIA processes but may remain responsive to health advocacy presented in other ways. Planning HIAs that fit the needs of fluid and rapidly changing policy options will be an special challenge, as advocates and public health staff with policy experience are likely to point out. A flexible approach to defining the range of health information gathering under the HIA label may allow a wider number of policy process to be influenced.

The focus on the built environment by many respondents somewhat eclipsed importance of the social and cultural determinants of health. Focusing on the built environment as a primary focus of HIAs (or on the social/cultural environment as mediated by the physical environment) is in the long run likely to neglect important determinants of individual health behaviors and community norms.

Question 8: How would you decide if the HIA had achieved what you wanted it to?

Achieving desired health outcomes from HIA input into policy decisions was a central theme of the responses, and included whether the HIA recommendations were considered or discussed by the decision-making group, and whether some or all of the recommendations were incorporated into policy. The impacts of HIAs on the policy decision-making process itself or on organizational practice also were suggested as important endpoints. Some respondents pointed to the importance of assessing the impact of the HIA-influenced policy decisions on the health of the affected communities. Additional suggestions were to evaluate the HIA process and product itself [presumably against some standard for representativeness, data quality, and recommendations supported by the data], assess the dissemination of the HIA findings, and to assess involvement of relevant communities as an evaluation question. Identifying evaluation questions early in the HIA development process, having adequate support for evaluation, and setting up milestones for measuring progress also were mentioned.

Discussion: The evaluation question elicited a diversity of responses and suggestions indicative of the diversity of 'evaluatable' aspects of the HIA process, the inclusion of HIA input into policy discussions, incorporation of HIA recommendations into policy decisions, and the impact of the implemented policies on the health of communities that is attributable to the HIA contribution. The US Government Accountability Office (GAO, 1990) has pointed out the

difficulties in understanding the impacts of proposed policies, as they are subject to multiple influences through the many steps between policy formulation and incorporation into practice. Also, it may take years for expected and unexpected consequences of policy change to become evident.

If HIA work is to become established as a recognized discipline within public health, retrospective comparisons of intended versus actual health consequences of policy recommendations should be made to identify in what ways HIA input into decision-making resulted in better health outcomes. This is a different question than asking did the HIA more or less accurately predict the health consequences of implemented policies.

In the early stages of development of HIA practice, careful attention to evaluating the HIA 'process' may be important (e.g., asking questions such as what worked and didn't work to get health information to be considered by a policy-making body, to what extent were public health professionals invited to join the policy process, what partners and allies were identified and how were those alliances helpful or not in getting health input considered, how many HIA recommendations were translated into policy, etc.). Other interesting evaluation questions might involve seeking policy opportunities for HIAs and about the process by which HIA-influenced policies are translated into regulations, rules, and eventually into practice. One also might be on the lookout for how the engagement with the policy process may have changed the policy making process itself or how HIAs are conducted.

Question 9: What barriers do you foresee in successfully participating in an HIA and what would be helpful in overcoming those barriers?

Potential barriers identified by respondents included uncertainties in identifying the HIA topic, lack of resources (especially funding), nascent mutual understanding of the HIA process and goals among partners and decision makers and the availability of data relevant to the decision-making process. It was suggested that competing evidence and negative findings also should be considered in the HIA development process.

Other barriers included insufficient expertise in built-environment and other topic areas, lack of training in HIAs, shortage of funding for local health departments, complexities of collaboration among state organizations and with other partners, figuring out how to structure community input for each step of the HIA process, and lack of time or specific skills relevant to HIAs (e.g., GIS). The process of selecting collaborating partners also could delay progress and the limited capacity for many community groups to be actively involved (especially vulnerable populations) were also mentioned as potential barriers. Limited understanding on the part of many decision makers and built environment planners of health considerations, and expanding their field of vision in that area was felt important. Ideas for overcoming barriers included getting more funding, more HIA training for health staff and for planners, getting HIAs recognized as an important organizational activity, and getting more involved in and knowledgeable about policy processes.

Discussion: The responses to this question are likely to inform the process by which HIA capacity is increased in Oregon – at the community, local government, and state government levels. The multiple barriers identified by the respondents suggest that the HIA process will have to be flexible in its conceptualization of what constitutes adequate data or health information as the basis for policy recommendations, and the in manner with which those recommendations are developed – i.e., collaboratively or not. Funding for HIAs may to become increasingly difficult to obtain if the benefits of the approach for the health of communities cannot clearly be demonstrated. Finding a range of ways to present and disseminate HIA-based health information and recommendations that are considered valuable by policy makers also will be an important task.

References:

Kemm, J. Editorial: Perspectives on health impact assessment. Bulletin of the World Heath Organization, 81 (6), p 387, 2003

US Government Accountability Office: GAO/PEMD – 10.1.10, Prospective Evaluation Methods: The Prospective Evaluation Synthesis, November 1990.

Appendix F HIA Workshop, April 29, 2009, Eugene, Oregon.

F.1 Workshop agenda

AGENDA
HIA Pre-Training Assessment Workshop
Valley River Inn, Eugene, Oregon
Wednesday, April 29, 2009

Objectives:

- Demonstrate connections between land use/policy planning and community health issues
- Understand the value and purpose of HIA
- Review HIA case studies
- Learn about the "screening" and "scoping" steps of HIA, and practice using tools for each of these steps
- Discuss the challenges and opportunities for local health departments to implement HIA.
- Discuss the best way to tailor the upcoming training in September 2009

Agenda:

12:45 Welcome and Introductions
Introduction to the State HIA Capacity Building project
1:15 Presentations
Introduction to Health Impact Assessment
Case Studies in HIA:

- Columbia River Crossing
- Humboldt County General Plan

1:45 Small group discussions: Screening and Scoping—*Participants will break into small groups of 8-10 and complete screening and scoping, the first two steps of HIA, for a case study.*
2:15 Report back to larger group on Screening and Scoping
2:45 Break
3:00 Small group discussions: HIA in local health departments—*Groups will discuss the opportunities for and barriers to HIA in their agency, and identify ways the state can help provide resources and ways that the upcoming September training can best fit their needs. They will come up with a list of next steps to prepare them for the September training, including stakeholders to engage, project to select, preliminary investigation of available data.*
3:30 Report back to larger group
4:00 Opportunity for participants to ask questions and have a general discussion
4:30 Adjourn

F.2 Workshop questions and discussion

HIA Workshop
April 29, 2009
Valley River Inn, Eugene, OR

1) In what ways would involvement in HIAs benefit or not benefit your health department's work? Would HIA be useful in your county?

- Can document root causes of disparities to where to intervene
- Opportunity to share the work of Public Health with non-Public Health groups
- Opportunity to bring Health Perspective to conversations it hasn't been a part of
- Promotes Public Health discussions among desperate groups of interests
- Gives Public Health the chance to facilitate discussion with stakeholders and develop non-traditional partnerships

- Raises credibility of Public Health
- Creates a concrete service that Public Health could provide other policy conversations
- Give Health Department's additional tools, different framework, tools to think differently, provides template as additional resource, validates "real world" focus, takes ideas to action, draws attention to health issues. Yes this would be useful.
- We don't have the capacity to be the lead in a HIA / We would like to be involved, but not lead
- The HIA could validate health issues
- HIA's could be a jumping off point to start conversation with agencies
- Integrated into something else we already do…would be, yes.
- Informed decision making
- Raising the profile of health issues
- Strengthening partnerships/new partners
- Stronger link between health and economics
- This is all new to Wallowa County. It would help reduce health care costs. Would expand the conversation about health to include other departments. It would raise the visibility of the Public Health department.

2) What if any, barriers do you see in the implementing HIA in your work?

- Time (3)
- Money
- Knowledge/Familiarity of the process
- Analysis skills
- Political will to acceptance with in departments etc.
- Time, resources-staff, agency buy-in, funding geographic, various needs of communities.
- We could be perceived as being not objective, being biased
- Lack of support from administration
- Lack of resources due to economic climate at this point
- Capacity-time, staff, money
- Workforce capacity (what do you not do to conduct an HIA?)
- Introducing new concept to decision makers and stakeholders
- Educating the decision-makers in the county about the process-Chamber of Commerce, etc. We need to bring them on board about this. Making others in the community view Public Health as useful in the approach. We need to be sure that an issue is something that an HIA could be part of, is there a health issue?
- Local politics
- Geographic particularities

3) How is this related to other initiatives or programs in your county?

- A component of chronic disease prevention, environmental health
- Strengthen interagency relationships
- Very similar to "Health Communities" assessment
- Could support/validate public involvement and built environmental/health concerns with planning department
- Related to commission on children and families planning process, 10 year plan to end homelessness, PAN grant, Healthy Communities, ACHIEVE, Community assessments.
- Comparable to other groups advocating their cause
- TROCD Assessment
- City/transportation plan
- CCF annual planning
- TROCD, Map Program
- HACE (Healthy Active Community Environment)
- PACE EH
- Healthy Communities

- Much of this will fall to the environmental people.

4) What can your county contribute to an HIA initiative?
If initiative is local then…

- Expertise
- Potential projects
- Local knowledge
- Creates statewide value that promotes Public Health
- Nail down methodology
- Cross-county collaboration to assist each other and work toward common values
- Provide potential stakeholders
- Can add value to Public Health processes
- Depends on county resources – larger communities can contribute data, disparity information and resources while the smaller communities have a harder time contributing as much. Health also depends on the HIA.
- Data resources, ccf, TROCD, TPEP
- CHLOA
- Health Data
- Overall existing health conditions
- Help Coordinate meetings
- Be liaison between state & agency doing the HIA
- Possibly mobilize community partners and community groups, contribute leadership, momentum
- Data
- Support
- Advocacy
- Community linkages
- Partnership with planning
- We can start by connecting with people in transportation and planning to build relationships, educate them about our skills and visa versa.
- Expertise, potential projects, local knowledge, stakeholders, cross-county collaboration

5) What would help you do HIA in your county? What additional information or training do you need to begin conducting HIA?

- Funding
- Time, resources/funding, data and case studies, mentorship, training in predictive models, GIS, baseline data.
- Give examples of what has been done elsewhere, different examples for urban vs. rest of world
- Documentation that your forecasting actually happened
- What is the cost benefit of implementing the recommendations
- Time, Resources/Funding, Regional training
- Data and Case Studies
- Technical Assistance-mentors from state or counties that have already done it.
- Guidance on how to work on this incrementally/baby steps in order to get decision-makers on board with funding a larger project.
- Current data (GIS) that would provide current situation
- Template, additional training and practice, data sources, funding, imperative stakeholders at the September training.
- Expertise at hand staff
- Political receptivity, realization
- Accessibility to model
- Funding sources-sustainability

- How do you decide what to do an HIA on?
- Support from Commissioners, Administrators
- Training, buy in Director, education to county policy makers, commissioners, enhances what we are already doing.
- Basic training on HIA, technical assistance to make community based to tailor toward our community
- Technical Assist during first couple of assessments
- Additional FTE
- Training-this is all new but seems very useful
- Template on HIA steps / process
- Examples of where data comes from
- State should bring data
- Extended invitations from / conversations with other planning partners
- Clarity in demonstrating how HIA contributes to what policies/projects

6) What can the state bring to an HIA and how?

- Money
- Opportunities for pilot projects
- Training and Technical Assist
- Facilitate connection for federal funding etc…
- Data sources, examples of 35 indicators, template to conduct HIA resources, communication
- Good model demonstrated in Oregon
- State can provide good evidence
- Demonstration projects
- Rural and urban model
- State is the lead, with health departments being a partner
- State to do presentation at state and city, county levels
- Information, training, technical assistance, talking to policy makers, identify opportunities
- Community
- Orientation to HIA
- Technical Assist and training
- Networking with experienced states, counties, universities, etc…
- Training on how to do this, strategizing with other counties, share with others what has worked and not worked.
- Know what is going on-identify issues/projects that the county should look at with an HIA.
- A model that is pertinent to Oregon, evidence-based, rural-urban model, state taking the lead, communicating to county and city levels
- Networking with other states that are experienced with HIA
- Data resources
- Educating policy makers and legislators so they can consider health from the beginning
- County and city level needs to be integral to communication with policy makers
- Conversations with the AOC
- Funding is earmarked for other things
- Guidance on how to work on this incrementally, how to start without
- funding in order to demonstrate capacity
- Training and technical assistance
- TROCD and other funding used for HIA- built into an existing process
- Having the HIA as a conversation builder, collect resources and collaborate, use resources gathered for TROCD
- Put it in the annual plan
- Integrate into existing processes, without prescriptive process
- Get into existing legislative dialogue
- Look at it as a tool or framework, not a separate program

- Add health to EIS, not HIA as a separate process

7) What kinds of policy processes [decision-making] do you see HIAs contributing to?

- Local planning/community development/community growth
- Future planning/built environment
- Showing outcomes/validating Public Health's role
- Bringing awareness to the health aspects of policy/projects, understanding the comprehensive approach to decision making
- Implementation of new policies
- Decision to change or modify current policies
- Start task forces
- Smoke free multi unit housing-tenants/landlords
- Management update
- Community planning and development
- Transportation system (e.g., bus routes)
- $$ spent for roads/transportation needs to involve inclusion of pedestrian and bike facilities.
- Public Health can use HIA to get health in to conversation
- Legislation about field burning
- Community planning and development
- Built environment planning
- Public health's role
- Transportation systems
- HB2013 – Task force for school facilities planning and assessment

8) What kinds of projects can you apply HIA to in your county?

- Community garden, smoke free campus', living well, decreasing negative advertising, smoke free policies, transportation, neighborhood development
- What to do with South Medford High School, when the new building is completed
- Drug treatment center in residential neighborhood
- Klamath River Dam
- Giant burner-Brooks Burner-Marion County
- New school sighting (Benton)
- Bus route (Benton)
- Juniper Ridge Dev (Deschutes)
- Grocery Store location, South Corvallis
- Transportation and Community Sus. (Monroe)
- Hwy 99 (Benton)
- Restoration of Wallowa river project-moving it back to where it was prior to development.
- Decisions to cut services to mental health, made by the legislature, will have a huge negative effect. If we could apply HIA tools to demonstrate the impact it might help minimize the effect.
- Juniper ridge development in Deschutes County. Developing a business park.
- EIS- Trolley from Lake Oswego to Portland
- Northern Douglas County- Mill town hill Dam project
- Proposed annexations
- Residential treatment facility
- School districts budget cuts, closing schools
- School closures, people hanging out there, decreases home values
- Neighborhoods lacking grocery stores
- Burning trees for renewable energy- biomass plant
- Field burning
- Locally-grown community garden (Wasco-County)
- Plans for locations of community amenities

9) What other stakeholders would you need to engage for an HIA to be successful?

- Project specific, park and recreation, city/county government, business owners, schools, medical community, community members-very much depends on specific project
- Oregon association of County Commissioners
- City and County Planners
- Association of Oregon Counties
- Find out who is the stakeholder
- Policy makers, people on all sides of issue
- Schools
- Municipal governments
- City and county planning
- Developers
- Depends on the project
- County Commissioners, Chamber of Commerce.
- We need to learn who we need to involve-who do we talk to?
- Municipal governments
- People you don't normally think of—depending on the project
- State Assoc. of cities and counties—AOC, NACCHO (national)
- Who is involved in any given decision, who do you need to contact?

10) What else would you like to share that we have not asked you about?

- We would like to have a reasonable training time-later arrival, early departure, paid travel and expenses, tribes involved
- Informed/Included in policy making
- Educate Legislators to look at Public Health, look at policies
- Provide examples of issues that would benefit from HIA
- We need to connect with the environmental department so they know that Public Health can be an asset
- We need to learn who has the power to do things. 'Power mapping' to learn who does what.
- HIA is a potentially valuable as an adjustable framework to validate other points that influence health (as well as community livelihoods)

Appendix G HIA Training Attendees, September 10-11, 2009

Organization	*Title*
Benton County Public Health	Chronic Disease Prevention Coordinator
City of Corvallis	Parks Planner
Benton County Public Health	Planner
City of Corvallis	Planner
City of Corvallis	Bicycle and Pedestrian Coordinator
Benton County Public Health	Planner
Benton County	Bicycle and Pedestrian Coordinator
Benton County Public Health	Environmental Health Supervisor
Benton County Public Health	Healthy Eating Active Living Coordinator
Benton County Public Health	Public Health Planner
Benton County Public Health	Intern
Deschutes County Public Health	Chronic Disease Program Coordinator
Commute Options	Program Coordinator
City of Bend	Planner
City of Bend	Senior Planner
City of Sisters	Associate Planner
Jackson County Public Health	Public Health Advisory Board
Jackson County Public Health	Public Health Advisory Board
Lane County Public Health	Tobacco Coordinator
Lane County Public Health	Chronic Disease Coordinator
North Central Public Health District (Wasco Sherman Gilliam)	Public Health Nurse
City of the Dalles	Planner
Wasco County Planning Department	Planner
Yamhill County Public Health	Public Health Manager
Yamhill County Public Health	Tobacco Prevention Coordinator
Yamhill County Public Health	Health Educator
Yamhill County Public Health	Environmental Health
Marion County Public Health	Community Health Development Manager
Marion County Public Health	Public Health Division Director
City of Woodburn	Weed & Seed Coordinator
City of Woodburn	RSVP Director

Appendix H Agenda from September 10-11, 2009 Training

Health Impact Assessment Training:

Day 1 Objectives:

- Demonstrate connections between land use/policy planning and community health issues
- Understand the value and purpose of HIA
- Review examples of past and current HIA projects
- Understand the collaborative nature of HIA, and the roles for diverse stakeholders in the HIA process
- Participants identify projects or policies at the county level that would be appropriate for HIA, and use this project as a "case study" to explore throughout the training
- Learn about the "screening" and "scoping" steps of HIA, and practice using tools for each of these steps
- Gain familiarity with practical HIA tools and methodologies for assessment
- Discuss approaches to both qualitative and quantitative data collection as well as community based participatory research in HIA
- Provide opportunity for participants to share information about data sources and resources that could be used in HIA

Day 2 Objectives:

- Discuss strategies and resources to help inform development of recommendations/mitigation measures in HIA
- Examine various types of HIA reporting and strategies for communicating HIA results to target audiences
- Discuss how and when monitoring and evaluation has been used in HIA
- Discuss intervention points in land use planning and policy making processes where HIA can be used to bring health to the forefront of decision making
- Engage in a strategizing exercise to explore ways in which to effectively initiate an HIA project in an area where HIA has not been done before
- Discuss strategies to use HIA to effectively influence decision makers and decision making processes
- Understand how all of the steps of an HIA fit together, and how to collaborate with various partners to achieve an HIA

Agenda- Day 1

9:15 Welcome and Introductions
9:45 Making the connection between land use, policy and health
10:00 Introduction to Health Impact Assessment
10:20 BREAK
10:30 HIA Case Study Examples
11:20 HIA as a Collaborative Process: stakeholders, partners and roles
11:35 Case Study Project Description
12:00 LUNCH
1:00 Step 1: Screening
1:50 Step 2: Scoping
3:00 BREAK
3:15 Step 3: Assessment
4:15 Wrap-up
4:45 Adjourn

Agenda- Day 2

9:00 Check-in/ Introduction to Day 2
9:15 Report Back/ Review of Outcomes/Exercises from Day 1
9:30 Developing Recommendations/ Mitigation Measures for HIA
9:50 Step 4: Reporting
10:20 BREAK
10:30 Step 5: Monitoring, and Evaluation
11:00 Intervention Points in Land Use Planning and Regulatory Processes
11:40 Preparing to move local HIA Projects Forward
12:00 LUNCH
1:00 Next Steps: Thinking Through Local HIA Projects
2:15 Discussion
3:00 Wrap-up and Reflections
3:30 Training Evaluation
3:45 Adjourn

Appendix I Discussion of Next Steps for HIA, September 11, 2009.

1) Outreach

- Have a summit of State Agency department heads and give an introduction to HIA
- Transportation Options group of Oregon has a conference next week where they are featuring health.
- Conduct presentations for Association of Oregon Counties/League of Oregon Cities/Association of City and County Planning Departments
- Attend the Oregon Planning Association conference in Eugene
- Outreach to MPOs/public advisory councils
- Outreach to developers and architects
- Outreach to neighborhood associations
- Getting leadership on board (and how can the state help with this?)

2) Training

- Booster conference/meeting in 2-3 months, Marion County is interested in hosting.
- HIA training at the American Planning Association conference

3) Technical/other resource

- City/county commissioners would like a list of other places that have done HIA; would like to see some precedents.
- Compile email/phone list of trainees and distribute after training
- Compile information and post on HIA website
- Local health departments can get a list of project notifications from planners
- Counties would like more communication about projects that have been done in Oregon or are going on in their communities (example VMT HIA)

4) Funding

- Apply for a TGM grant from DLCD
- Benton County applied for a joint public health/planning employee

5) Policy

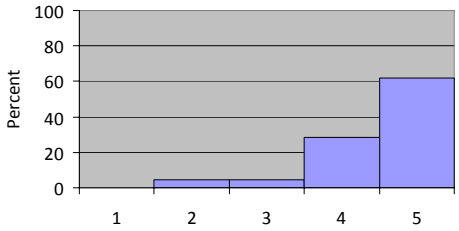
- Explore a policy to require HIA (HB 2229 was mentioned)
- Get involved with TOD projects and DLCD/ODOT decision making processes

Appendix J Summary of Evaluations, HIA Training September 10-11, 2009.

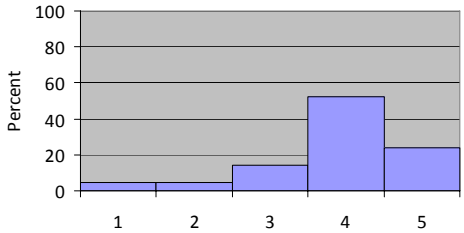
Day 1 Evaluation (September)

1. Please rate the following statements listed below by circling the appropriate rating
(1-strongly disagree; 2-disagree; 3-neutral; 4-agree; 5-strongly agree)

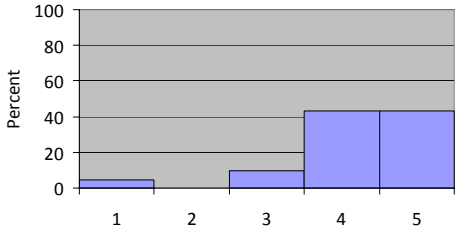
The content presented today deepened my understanding of the subject and HIA



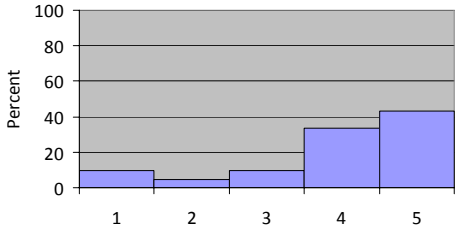
Today's pace was appropriate for participants, not too fast or too slow



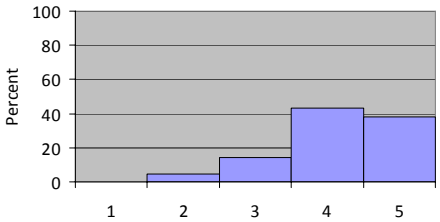
Today's facilitator encouraged participation



Today's agenda had a good balance between speaker presentations, small group exercises and discussion



I will use the knowledge/skills gained from today's session in my future work



Additional comments on Question 1:

Today's facilitator good job, I will use the knowledge if I work.

The content felt I had heard before, Today's pace felt too slow, Today's facilitator very nice & respectful facilitators just need more interaction, Today's agenda please more hands on

I will use the knowledge not always up to me I'd like to...

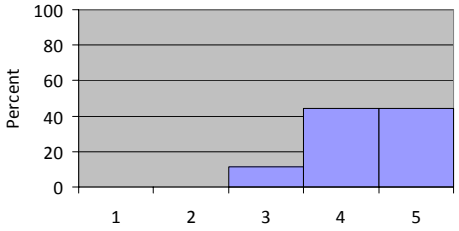
Today's agenda it's hard when there is so much! I wish we had more time for specific group work.

Today's agenda need more time for small group exercises

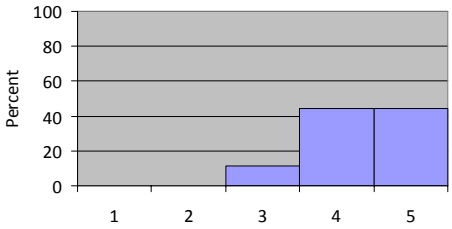
Today's facilitator possible to build in more time for spontaneous discussion? so it doesn't leave you behind.
The content the articles was great, too thanks for emailing them head of time I will use the knowledge
unfortunately the county planning dept is not active in shaping projects/policies and we pretty much have to just accept what is presented, unless it states planning code. but I will try to incorporate these ideas whenever I can, to encourage my boss to shape good policy that would impact projects
today's pace could have spent more time developing group project ideas & presenters , I will use the knowledge I don't know
The content broad application to decision making, Today's pace most could keep up, Today's agenda couldn't see could have been different
Today's pace too echoey, Today's agenda too much group work

2. Please rate the different sections of the training on a scale of 1 to 5.
(1-very poor; 2-poor; 3-neutral; 4-good; 5-excellent)

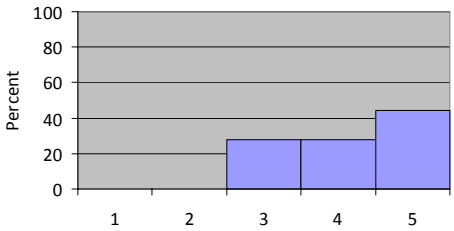
Trees, Leaves and Roots, making the connection between land-use policy and health activity



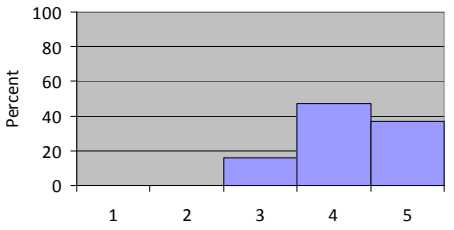
Introduction to HIA & HIA project examples



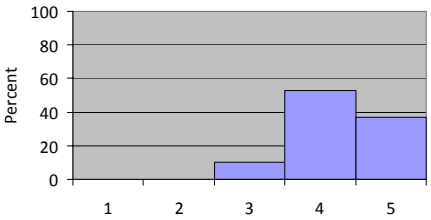
HIA as a collaborative process

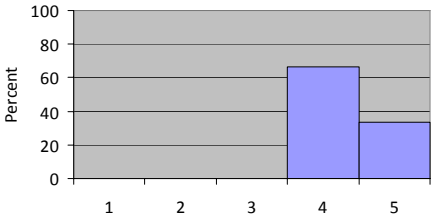


Step 1: Screening



Step 2: Scoping





Step 3: Assessment

Additional comments on Question 2:

Trees was a wonderful analogy

hard to hear presenters + participants

Step 1 and step 2 I wish i had more time for these activities! Thanks! so far, so good!

Tree loved that very inclusive

HIA AS A COLLABORATIVE i CAN'T REMEMBER, NICE JOB THANKS FOR SPEADING THE WORD ABOUT HIA. YOU ARE MAKING THE U.S. A BETTER PLACE!

HIA as a collaborative this is a continually critical important different value, I really think the PEQI TOO FLAWED WITH GEO CULTUSED SUBJECTIVITY

STEP 1. still a little unclear

3. What did you particularly like about the content of today's training?

support for our individual projects

Content of resources available use real example

The tree>root causes exercise

I appreciated the group exercises

The variety of case studies presented

Specific group work on our project. Good HIA examples

The interaction of the presenters. one on one with individual groups was great.

case study application of process

demystifying of HIA - the daunting name worried me a little

I appreciated the time w/ facilitators working on the group exercises & getting feedback.

local case studies, good balance of lecture/ discussion, opportunity to meet + learn about resources

great case study examples, made it easy to understand. nice to have so many different speakers.

THE EXAMPLES APPLICATIONS & RESOURCES OF HIA, NOW IT CAN BE NEED IN MY WORK.

The case study examples of past HIAS

variety of real applications

The mix of speaker and small group discussion

good balance between knowledge base and unanswerable discussion points

4. What changes would you propose in content, structure or emphasis of today's training?

more small group interaction discussion + moving around

more time for group work. it's hard often to get a group like this together, it's be great to have a lot more time for meaningful group work time on our specific projects.

none

Better/clearer description of how to choose a case study (prior to coming to the training)

A little more physical activity breaks organized walking tour or stretching

would've been nice if we had receive more info about the project to choose, as would've not chosen a project ahead "deemed" healthy an apt. complex planned on the edge of town (ugly busy road is only transport connector) would've been better.

POLICY -ORIENTED HIAS

i would spend more time developing group HIAs & sharing back others findings

more concrete examples/case studies

structure-name tags,- for presenters

5. Are there things that we should have covered today but did not?

No (2 responses)

you know that better than I do

nope looking forward to the rest tomorrow

do not think so.

IT MIGHT BE INTERESTING TO PRESENT PREDESTRIAN SAFE GUARDS ..GOOD BAD EXAMPLES It would be prudent to sum up the main point with short examples. PEQI is limited to specific settings, I gather

not sure

more information about how data information was obtained

hard to hear, please repeat participants questions, before you answers

6. Are there things that we should have spent less time on today?

no (3 responses)

Case studies were good but we need to learn thru working on our own case study then have your case studies back up our understanding

examples got a little too specific ...not necessary your fault, the questions were nit-pick at times!

made an emphasis on asking participants easily or added case study specific usually to agenda

would be good to limit comments by folks who are wasting the groups time

7. Should we include all of today's material in future HIA Trainings?

Especially appreciated case studies

yes (11 responses)

if we didn't actually use it today (and won't tomorrow) then it probably shouldn't be in book, as people are so busy they won't take time to read later.

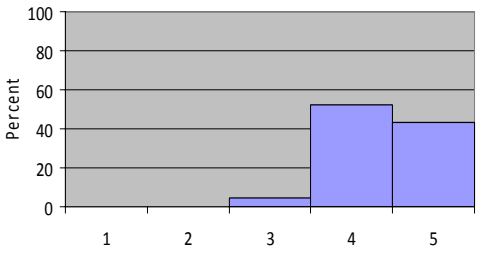
Yes plus issues shared by participants

Day 2 Evaluation (September)

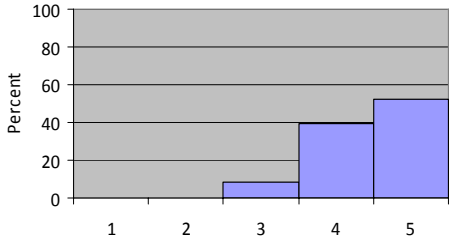
1. Please rate the following statements listed below by circling the appropriate rating

(1-strongly disagree; 2-disagree; 3-neutral; 4-agree; 5-strongly agree)

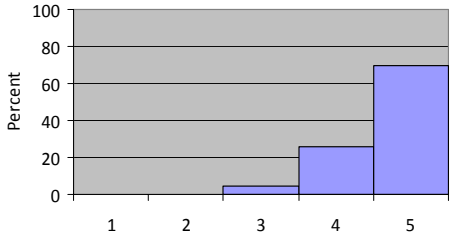
The content presented today deepened my understanding of the subject and HIA



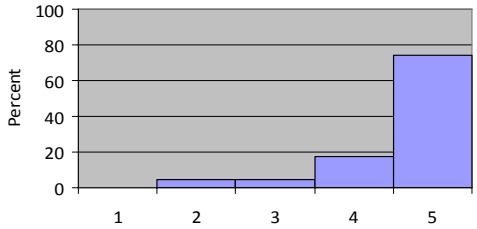
Today's pace was appropriate for participants, not too fast or too slow



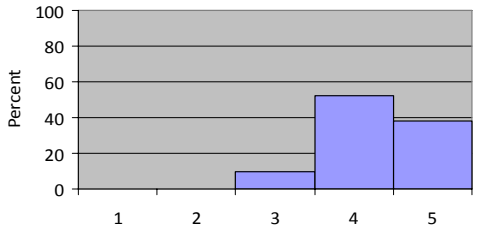
Today's facilitator encouraged participation



Today's agenda had a good balance between speaker presentations, small group exercises and discussion



I will use the knowledge/skills gained from today's session in my future work



Additional comments on Question 1:

I will use the knowledge, gave me some things to think about and I plan to go through the screening process

Today's pace I felt better today's vs. yesterday maybe it was me

I will use the knowledge, hopefully

I will use the knowledge I hope so!

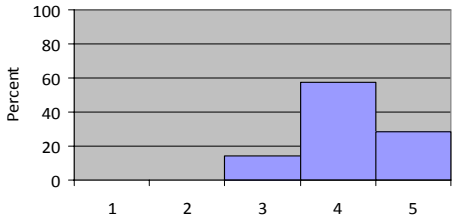
Today's agenda better balance today

today's agenda yeah good job

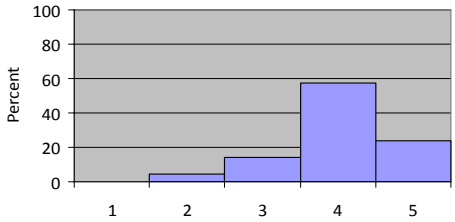
Today's pace a bit slow, today's agenda less small group please

today's facilitators always.

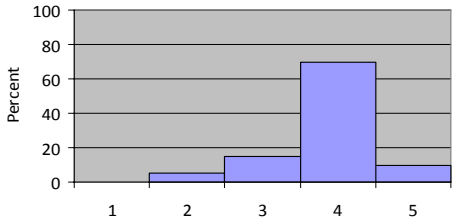
2. Please rate the different sections of the training on a scale of 1 to 5.
(1-very poor; 2-poor; 3-neutral; 4-good; 5-excellent)



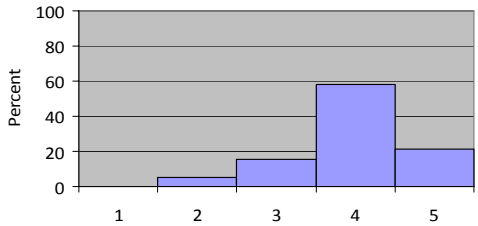
Developing mitigations/recommendations



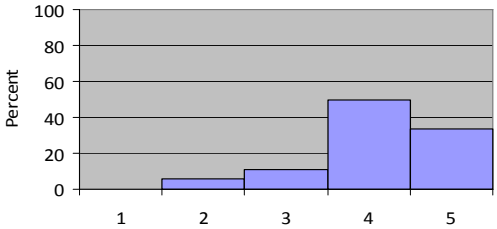
Step 4: Reporting



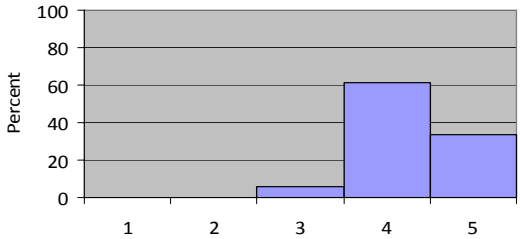
Step 5: Monitoring



HIA Evaluation



Intervention points in the land use planning and regulatory processes



Preparing to move local HIA projects forward

Additional comments on Question 2:

Thanks great training!

I would prefer to spend time learning about all of the specialized tools...

thank you for a great training opportunities!

preparing to move I wish there was a little more structure....experience from people who have done them! A booster session to include everyone who has moved forward on HIA process say in 3-6 weeks would be good

booster session in 6 month to learn where we've been / what's next

let's move this discussion to national forum and link it to the health care crisis

very capable/ competent staff very well organized

in some ways the articles could it both/more thoroughly

intervention points very good discussion, preparing to move glad to have time to discuss
preparing to move good group discussion, I'm real excited about formalizing the links between public health + planning actually its all the same. continued joint discussions would be very useful

3. What did you particularly like about the content of today's training?

staff interaction with attendees.
case study focus, lessons learned, discussion
I appreciated the amount of time given to discuss our individual projects
The time to flesh out our projects further mitigation/recommendation discussion was helpful
excellent exchange of ideas between group members as well as presenters
more time to work in groups thinking about our specific projects.
land use
more talking + brainstorming the groups
discussion time
time to determine next steps
gave me an understanding of HIA
great interaction w/ large group good feeling of "bondedness" in the subject
a lot of idea exchange we will be getting follow up into
mix of speakers. applicability to my projects. hearing about problems/solutions from other areas. getting to know each other professionals in my geographic area
good group discussion
nice balance between + small group work + large group discussion
increase small group discussion compared to yesterday Nancy, our facilitator was great!

4. What changes would you propose in content, structure or emphasis of today's training?
nothing
none (3 responses)
if slides aren't important I would change them/ take them out
work through a full local case study
specific to finding cases
inform planners a bit more of health issues data, inform health professionals
more about the birth of the planning profession it grew out of health concerns in cities
can't think of anything
maybe limit presentation of specific tools to just one do illustrate using tools but provide more time
more discussion of concrete ways planners can bring HIA goals to "current planning"

5. Are there things that we should have covered today but did not?

none

would like more discussion on gathering leadership buy in etc

no (2 responses)

perhaps more info/practice on developing recommendation/ mitigations

man power how to do HIA? so I can tell my boss it cost about 10,000 or about 40000

hard to tell

maybe more examples of when we could tap to help develop mitigations

recommendations

6. Are there things that we should have spent less time on today?

no (3 responses)

random discussion

monitoring

small groups too aimless

no, wish we had more time

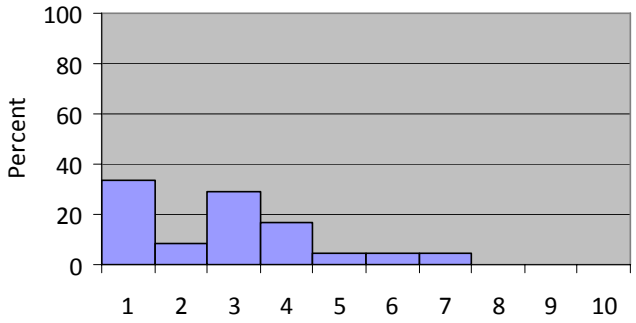
7. Should we include all of today's material in future HIA Trainings?

yes (11 responses)

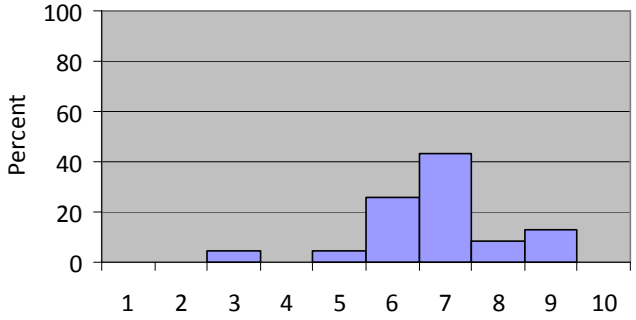
yes suggest following up w/ of forms CD/website

yes, and more, especially on the context of available science

8. On a scale of 1 to 10 (where 1=none and 10=expert) what was your level of knowledge about HIA prior to this training?



8. On a scale of 1 to 10 (where 1=none and 10=expert) what would you rate your level of knowledge about HIA now that you have participated in this training?



9. What are some of the specific things that you think you would need in order to start HIA work at your agency/organization?

Management approval/ support

City benefiting project

open minds

A concrete project!

a lead champion this could appear after more scoping, however

political will

full endorsement & support from my health dept & intimated from county, court to continue spending my time that way.

find a specific project! it seems like it all comes down to timing and ability to affect changes. we need to carefully select a good project to put our efforts into.

community support

administrative support extra funding would be good!

funding

access to scientific journals

partnerships w/ planners

mentor to help plan/ preview each step

funding

support of elected officials

more money to pay the person. I think our county commissions would totally

support HIA if it was free!

identifying the problem specifically/ w detail (data)

funding for time

more knowledge of local players/ experts

time, political support= time + money

I would need a team

10. Did this training provide sufficient information and practice for you to start conducting HIA?

yes (6 responses)

If I could fold in HIA to my current work (funded work) it would help

mmm... possible

I think so it's good to get started & especially knowing there is continuing support when we need it. Its impossible to anticipate everything a person will need up front.

I will need work, but for some I think that the training has help me us chart a good course.

a good start

yes, with the help of my public health colleagues

If we didn't have the $ to hire HIP, then I would feel comfortable after receiving the binder + your web site trying to do the HIA w/ the help of others in my jurisdiction.

I think so...with plenty of expert guidance

it was a good overview it's clear that to do a full fledged HIA requires a lot of time +research + community involvement