



Cumberland District Public Health Council
Full Council Meeting
January 18, 2013
10:00 p.m. — 12:00 p.m.
Rines Auditorium, Portland Public Library
5 Monument Square, Portland

Present: Jim Budway, Steve Fox, Colleen Hilton, Valerie Landry, Jessica Loney, Becca Matusovich, Bernice Mills, Paul Niehoff, Karen O'Rourke, Cathy Patnaude, Toho Soma, Ted Trainer, Anne Tricomi, Carol Zechman; Shane Gallagher; Leslie Brancato, Jim Cloutier, Peter Crichton, Kristen Dow, Nancy Foss, Mark Grover, Caity Hager, Alex Hughes, Donna Levi, Sarah Mayberry, Zoe Miller, Elizabeth Trice, Georgia Wayne, Paul Weiss

Absent: Neal Allen, Faye Daley, Deb Deatruck, Dennis Fitzgibbons, Megan Hannan, Liz Horton, Paul Hunt, Helen Peake-Godin, Emily Rines, Lucie Rioux, Erica Schmitz, Amanda Sears, Pamela Smith, Ashley Soule, Peter Stuckey, Julie Sullivan, Helen Twombly

Topic	Discussion	Actions
Council Business	Toho Soma provided the year-to-date financial report (Appendix A) to the Council. Becca Matusovich provided a written update for Health on the Move pilot project (Appendix B). Toho Soma solicited input from the Council on future meeting locations, including central locations versus varied locations, technological issues, parking issues, and environmental issues.	The Executive Committee will review Council feedback regarding meeting locations at the February meeting and report at the March Council meeting.
Presentation: PHiT	Zoe Miller and Elizabeth Trice provided the Council with a presentation detailing	Zoe Miller and Elizabeth Trice will send the power point and other pdf resources to

Topic	Discussion	Actions
	<p>the transportation/health connection and the Public Health in Transportation (PHiT) group (Appendix C).</p>	<p>Shane Gallagher for distribution to the Council.</p>
<p>District Public Health Improvement Plan Priorities</p>	<p>Becca Matusovich led the Council through a discussion of the list of priorities for the District Public Health Improvement Plan. Three background slides (Appendix D) set the context for the discussion.</p> <p>After setting the stage, Becca Matusovich reviewed the results of the priority survey (Appendix E).</p> <p>Several individuals presented “pitches” detailing why a given priority should be taken up by the Council:</p> <p>Donna Levi—Blood Pressure Anne Tricomi—Tobacco Caity Hager/Jim Budway—Medical Reserve Corps/Emergency Preparedness Toho Soma—Health Equity Cathy Patnaude—Influenza Alex Hughes/Sarah Mayberry—Healthy Homes</p> <p>Finally, several of the highest scoring priorities from the survey did not have a</p>	<p>The Executive Committee will review the feedback of the Council and perform a prioritization process at the February Executive Committee meeting and report back to the Council at the March meeting.</p> <p>Council members can email the Executive Committee or Shane Gallagher if they have any opinions regarding priorities.</p>

Topic	Discussion	Actions
	representative to make a “pitch” to the Council, but the Council did discuss them as a whole. This included Obesity/Physical Activity/Nutrition and Mental Health/Substance Abuse.	
State Coordinating Council for Public Health By-laws Recommendations	Shane Gallagher, Steve Fox, and Becca Matusovich presented the re-drafted by-laws to the Council and explained changes and the purpose of each. The Council held a vote to approve the by-laws.	Motion for Vote: Colleen Hilton Motion Second: Toho Soma Vote: 16 Yea, 0 Nay Result: Unanimous approval
RWJF Cross Jurisdictional Sharing Grant	Toho Soma informed the Council that the City of Portland received the RWJF Cross-Jurisdictional Sharing Grant.	None.
Grant Opportunities	The Council did not discuss any other grants or grant opportunities beyond the RWJF grant.	None.

Next Meeting: Full Council—March 15, 2013 from 10:00 a.m. — 12:00 p.m. at TBD. Executive Committee—February 25, 2013 from 1:00 p.m. — 3:00 p.m. at City Hall, Room 24, 389 Congress Street, Portland.

**FY13 Cumberland District Public Health Council Finances
(as of 1/15/13)**

Code	Line Item	Budget	Spent	Balance
01 10	Salaries	\$32,305	\$15,566	\$16,739
02 10	Fringe	\$9,249	\$4,457	\$4,792
20 20	Travel/training/meetings	\$500	\$380	\$120
20 30	Indirect Costs	\$5,486	\$2,849	\$2,637
35 00	Contractual	\$1,000	\$200	\$800
35 30	Mileage	\$500	\$46	\$454
35 60	Printing and binding	\$100	\$6	\$94
55 20	Supplies all other	\$11,205	\$2,421	\$8,784
	Total	\$60,345	\$25,925	\$34,420

FY13 Contributions to Date

FY12 Carryover	\$15,038
Cumberland County	\$33,307
Healthy Maine Partnerships	\$8,000
CarePartners/MaineHealth	\$4,000
Total	\$60,345

Health on the Move: CDPHC update 1/18/13

“Health on the Move” is a collaborative initiative of the Cumberland District Public Health Council (CDPHC), designed to address the Council’s District Public Health Improvement Plan priorities. It is a mobile health access project that brings health resources into community settings to break down barriers that limit access to preventive health services and screenings for vulnerable populations.

The primary goal of Health on the Move is to reduce health disparities by bringing health resources to the communities where the target population lives. Health on the Move events are planned by a team including Council members, local organizations that know and serve the target population, and members of the community themselves. The team uses tools that draw on emergency preparedness approaches, so that in the process of planning these events we are building the capacity of the district public health system to quickly plan similar events that might be needed to address specific health needs in an emergency situation.

Led by the CDPHC Health Equity Workgroup, Health on the Move was first piloted at Portland Housing Authority’s Riverton Park on Friday October 19, 2012 from 4:00-6:00 pm.

- Planning Team: Trisha Mason (University of New England), Becca Matusovich (Maine CDC), Trevor Nugent (Portland Housing Authority), Christie Gaydos (Portland Housing Authority), Bankole Kolawole (City of Portland Public Health Division), Caity Hager (Portland Public Health/Cities Readiness Initiative), Shonna Ohm (Portland Police Department), Tiffany Panagakos (Riverton Boys & Girls Club), and several Riverton residents
- Additional Partners: Hannaford, Healthy Portland, Maine CDC Breast & Cervical Health Program, Portland Community Health Center, VNA Home Health Hospice/Mercy,
- Stations:
 - Blood Pressure and Diabetes Screening
 - Cancer Screening
 - Flu Shots
 - Nutrition and Exercise
 - Portland Community Health Center (referrals)
 - Behavioral Health
 - General health information table

Evaluation Results:

RIVERTON (10/19/12)	
<p>Does Health on the Move increase access to screenings, preventive services, medical homes, and health promotion services?</p> <ul style="list-style-type: none"> ✓ Gave 64 flu shots ✓ Conducted 33 blood pressure screenings ✓ Provided health information and referral resources to at least 59 adults ✓ 83% of partners stated that the event increased access “very much” and 17% “somewhat” 	<p>Can we create Health on the Move events with the limited resources, time, and funding available?</p> <ul style="list-style-type: none"> ✓ Planning team convened on 9/11/12 and organized the event in less than 6 weeks ✓ The Council sponsored about \$1,200 in direct costs, with about \$1,000 contributed by other partners (plus additional in-kind contributions) ✓ 28 staff participated from partner organizations ✓ 11 student volunteers assisted with stations and about 40 more students organized children’s activities ✓ 78% of partners rated the event “very successful” and 22% rated it “somewhat successful”

<p>Does Health on the Move engage our target audience of vulnerable populations?</p> <ul style="list-style-type: none"> ✓ Riverton Park is home to 139 families, 72% of the heads of households originate from a country other than the United States and 97% earn less than \$30,000 annually¹. ✓ 89% of partners reported that the event was worth their time because it helps address health disparities 	<p>Does Health on the Move result in positive new or enhanced partnerships and collaboration among partners?</p> <ul style="list-style-type: none"> ✓ 94% of partners said that participating in the event was worth their time ✓ 67% of partners reported that one of the reasons it was worth their time was because it helps develop partnerships that will be beneficial in the future ✓ 50% of the partners reported that one of the reasons it was worth their time was because it helps address one or more of their organization's strategic objectives ✓ 100% of partners said they would participate in another Health on the Move event
---	---

The second pilot Health on the Move event took place on Monday December 3rd, 2012 in Casco from 11:00-2:00.

- Planning team: Zoe Miller (Healthy Lakes/Opportunity Alliance), Joanna Moore (Crosswalk Outreach), Becca Matusovich (Maine CDC), and Caity Hager (Portland Public Health/Cities Readiness Initiative).
- Additional Partners: Bridgton Hospital, CarePartners, Crooked River Adult and Community Education Center, Cumberland County Government, From The First Tooth, Maine CDC Breast & Cervical Health Program, Maine Colorectal Cancer Control Program, Maine Families, MaineHealth, St. Joseph's College, Southern Maine Agency on Aging, Tri-County Mental Health Services, University of New England, VNA Home Health & Hospice/Mercy
- Stations:
 - Physical activity, Nutrition education, Weight management
 - Blood pressure screening
 - Diabetes risk assessment
 - Flu shots
 - Children's Oral Health
 - Cancer (breast & cervical, colorectal, skin cancer screening resources)
 - Healthy Homes
 - Referral for primary care and other health care services
 - Living Well & Managing Stress (including referrals for mental health and addictions)
 - Southern Maine Area Agency on Aging
 - Parenting resources
 - General health information resource table, food, and children's activities



¹ Source: Portland Housing Authority, July 2012

Evaluation Results:

LAKES (12/3/12)	
<p>Does Health on the Move increase access to screenings, preventive services, medical homes, and health promotion services?</p> <ul style="list-style-type: none"> ✓ Gave 19 flu shots ✓ Conducted 25 blood pressure screenings ✓ Provided health information and referral resources to at least 18 adults ✓ 43% of partners stated that the event increased access “very much” and 57% “somewhat” 	<p>Can we create Health on the Move events with the limited resources, time, and funding available?</p> <ul style="list-style-type: none"> ✓ Planning team convened on 10/30/12 and organized the event in less than 6 weeks ✓ The Council sponsored about \$600 in direct costs, with about \$250 contributed by other partners (plus additional in-kind contributions) ✓ 32 staff participated from partner organizations ✓ 18 student volunteers assisted with stations and children’s activities ✓ 0% of partners rated the event “very successful” and 52% rated it “somewhat successful”
<p>Does Health on the Move engage our target audience of vulnerable populations?</p> <ul style="list-style-type: none"> ✓ The Lakes Region is an area of the County with higher than average poverty rates and substantial barriers that make accessing preventive health services challenging ✓ Most of the participants who attended were either regular attendees of Crosswalk Community Meals/Food Pantry or Crooked River Adult Education GED students who had classes in the building ✓ 47% of partners reported that addressing health disparities was a reason the event was worth their time 	<p>Does Health on the Move result in positive new or enhanced partnerships and collaboration among partners?</p> <ul style="list-style-type: none"> ✓ 63% of partners said that participating in the event was worth their time (and another 16% said “sort of”) ✓ 68% of partners reported that one of the reasons it was worth their time was because it helped develop partnerships that will be beneficial in the future ✓ 26% of the partners reported that one of the reasons it was worth their time was because it helps address one or more of their organization’s strategic objectives ✓ 75% of partners said they would participate in another Health on the Move event (and another 25% said they would if there was more assurance the event would be well attended by the target audience, and an indication that the target audience is interested in what the partner has to offer

Additional Anecdotal Outcomes:

- A mother and her two daughters, both struggling with drug and alcohol addiction, attended Health on the Move. One of the daughters has three children and spends her days in her room, unable to move or function. Both daughters were screened for depression at Health on the Move and hadn’t realized how serious it was. As a result of attending the event, both will be receiving counseling services. The mother was incredibly relieved that her daughters were open to the event and will be receiving support.
- A retired couple without health insurance with limited resources came to Health on the Move for flu shots and was enthusiastic to leave with a wealth of useful information.
- A seasonal worker and food pantry client that has been experiencing health and mental health issues and does not have insurance was very happy to be able to talk to health professionals and gain health information and resources.

- Several children at Riverton had missed their school flu clinic and they came to the Health on the Move event to get their flu shot, unaccompanied by a parent (we had to send them back to their apartment to come back with parental permission!)
- After staffing a station at Health on the Move, Tri County Mental Health has begun planning to set up a resource table as an ongoing feature at the bi-weekly Crosswalk Community Outreach community meals. This has helped to nurture a trusting relationship with the 80-130 community members who attend those meals on a regular basis.
- After seeing the health resources available in the community, the local senior center asked whether they could host a Health on the Move event in the future.
- Collaborating on transportation options for the Lakes event helped foster new relationships between local partners which are now expediting transportation access projects that have been on the “wishlist” for a long time

The Connection Between Transportation and Health



You Can Help With...

- Political Support
- Local Data
- Prioritizing Funding

Work is Underway!

Public Health and Transport Survey (PHTS)
 An initiative of the Maine Public Health and Transportation Strategy and Cumberland County.

The survey is a first step in the process of better understanding design and policy needs to improve transportation in a region that's not only...

Getting there in Maine

- Changes in State & Local Policy
- Education & Social Marketing
- Changes in Built Environment

The Missing Link...

Health impacts and costs NEED to be factored into transportation policy, planning, and funding decisions.

?

Transportation systems and infrastructure are designed to move people and goods from one place to another. But what if we could design them to also improve our health and well-being?

Safety

Traffic crashes cause over 42,000 deaths per year. If you're in a car, you're at risk. If you're walking, you're at risk. If you're cycling, you're at risk. If you're driving, you're at risk.

Pollution

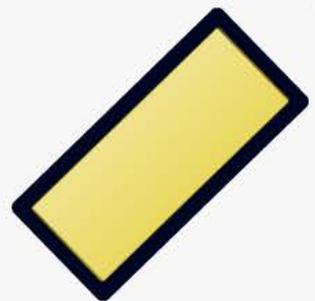
10 million people live with air pollution that's so bad it can cause asthma, heart disease, and other respiratory diseases.

Equity

Most people don't have a car. They rely on public transit, walking, or biking to get to work, school, or the grocery store. If you don't have a car, you're at a disadvantage.

Active Health Equity

There are many ways to stay healthy - at work, at school, at home, and everywhere else. But if you don't have a car, you're at a disadvantage. It's time to think about transportation options that can help everyone stay healthy and active.



The Solution

Transportation systems and community design that engineers, physical activity, safety and transportation options into peoples' daily lives.

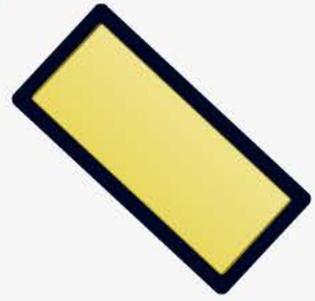
A "healthier" transportation system would include...

- ...Connections between different modes of transport
- ...Connectivity and social interaction

Health Benefits of Active Transportation

Regular physical activity, lower blood pressure, and reduced risk of heart disease and obesity.

If you don't have a car, you're at a disadvantage. It's time to think about transportation options that can help everyone stay healthy and active.





The Connection Between Transportation and Health

**What does
transportation
have to do with
people's health**



Transportation investments, and the systems that emerge from them, shape our lives and communities. Land use patterns and the "built" environment play a major role in:

Safety

Levels of Pollution

Opportunities for Physical Activity

Access & Health Equity



Sadly, our current transportation system's focus on the private car and road building, has profound negative impacts on our health.

Safety:

Traffic crashes cause over 40,000 deaths per year. Pedestrians and bicyclists account for more than one out of 10 deaths. Injuries result in pain and lost quality of life.

Pollution

35 million people live within 300 feet of a major roadway, and are at higher risk of lung cancer, asthma and other respiratory illnesses.

Inactivity

About one-third of adults are estimated to be obese, and another third are overweight, leading to high rates of chronic diseases including high blood pressure, heart disease, cancer, stroke and diabetes.

Access & Health Equity

Those who are most vulnerable - elderly, children, new Americans, and people living in poverty - have worse health outcomes and suffer more from lack of access to active environments, healthy foods and services.

TABLE 1

HOW TRANSPORTATION IMPACTS HEALTH AND EQUITY COSTS

TRANSPORTATION INVESTMENTS



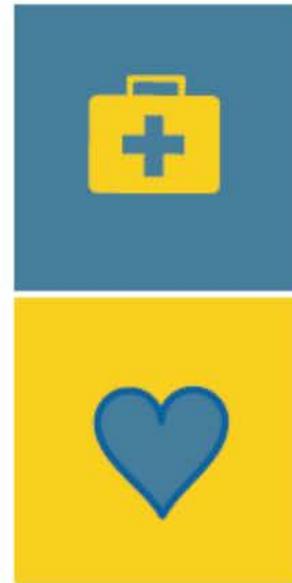
LAND USE PATTERNS



TRAVEL BEHAVIOR



HEALTH



COSTS



The National Health Costs of...	\$\$ (Billions)	Estimate Includes	Source
Obesity and overweight	\$142	<ul style="list-style-type: none"> Healthcare costs Lost wages due to illness & disability Future earnings lost by premature death 	<p>National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases. Statistics Related to Overweight and Obesity: The Economic Costs.</p> <p>Available at: http://win.niddk.nih.gov/statistics/index.htm</p>
Air pollution from traffic	\$50-80	<ul style="list-style-type: none"> Health care costs Premature death 	<p>Federal Highway Administration. 2000. Addendum to the 1997 Federal Highway Cost Allocation Study Final Report, May 2000.</p> <p>Available at: www.fhwa.dot.gov/policy/hcas/addendum.htm</p>
Traffic crashes	\$180	<ul style="list-style-type: none"> Healthcare costs Lost wages Property damage Travel delay Legal/administrative costs Pain & suffering Lost quality of life 	<p>AAA. Crashes vs. Congestion? What's the Cost to Society? Cambridge, MD: Cambridge Systematics, Inc.; 2008.</p> <p>Available at: www.aaanewsroom.net/assets/files/20083591910.crashesVscongestionfullreport2.28.08.pdf</p>

All cost estimates adjusted to 2008 dollars.

The Solution

Transportation systems and community design that engineers physical activity, safety and transportation options into peoples' daily lives.

A “healthier” transportation system would include ...

- Convenient alternatives
- Opportunities for active modes of transport
- Connectivity and social interaction



THE ROLE OF Transportation

IN PROMOTING PHYSICAL ACTIVITY

SIDEWALKS

People who live in neighborhoods with sidewalks on most streets are

47%
more likely to be active at least 30 minutes a day.

TRAFFIC CALMING

Medians, speed bumps and other traffic-calming efforts can reduce the number of automobile crashes with pedestrian injuries by up to

15%

PUBLIC TRANSPORTATION

Public transit users take
30%
more steps per day than people who rely on cars.

BIKE FACILITIES

In Portland, Ore., bicycle commuters ride

49% of their miles

on roads with bike facilities, even though these are only 8% of road miles.

Active Living Research

www.activelivingresearch.org

Sources: SIDEWALKS: Sallis J, Bowles H, Bauman A, et al. "Neighborhood Environments and Physical Activity among Adults in 11 Countries." *American Journal of Preventive Medicine*, 36(6): 484-490, June 2009. BIKE LANES: Dill J et al. Bicycling for Transportation and Health: The Role of Infrastructure. *Journal of Public Health Policy* (2009) 30, 595-5110. doi:10.1057/jphp.2008.56). TRAFFIC CALMING: Bunn F, Collier T, Frost C, et al. "Area-Wide Traffic Calming for Preventing Traffic Related Injuries." *Cochrane Database of Systematic Reviews* (1), January 2003; Elvik R. "Area-Wide Urban Traffic Calming Schemes: A Meta-Analysis of Safety Effects." *Accident Analysis and Prevention*, 33(3): 327-336, May 2001. PUBLIC TRANSPORTATION: Edwards R. "Public Transit, Obesity, and Medical Costs: Assessing the Magnitudes." *Preventive Medicine*, 46(1): 14-21, January 2008.

SIDEWALKS

People who live in neighborhoods with sidewalks on most streets are

47%

more likely to be active at least 30 minutes a day.



15%



BIKE FACILITIES

In Portland, Ore., bicycle commuters ride

49% of their miles

on roads with bike facilities, even though these are only 8% of road miles.



rtation

TIVITY



TRAFFIC CALMING

Medians, speed bumps and other traffic-calming efforts can reduce the number of automobile crashes with pedestrian injuries by up to

15%



PUBLIC TRANSPORTATION

Public transit users take

30%

more steps per day than people who rely on cars.



Health Benefits of Active Transportation

Reduced risk of heart disease, lower blood pressure, and reduced risk of overweight and obesity.

A Bay Area study found that a 15% active transportation mode share would reduce the burden of heart disease by 14%, dementia and depression by 6-7%, and breast and colon cancer by 5%.

The Missing Link...

Health impacts and costs NEED to be factored into transportation policy, planning, and funding decisions.

Getting there in Maine

- **Changes in State & Local Policy**
- **Education & Social Marketing**
- **Changes in Built Environment**

Work is Underway!

Public Health and Transportation (PHiT):

An ad-hoc coalition of HMPs, Portland Trails, Bike Coalition of Maine, PACTS (Portland Area Comprehensive Transportation Strategy) and Cumberland County.

Our mission: to build awareness of the relationship between transportation design and health; and to stimulate actions that result in improved health and safety.

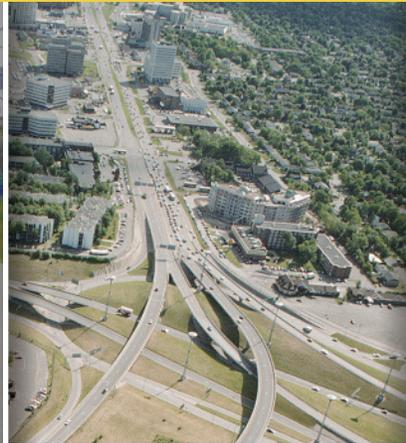
You Can Help With ...

**Political
Support**

**Local
Data**

**Prioritizing
Funding**

The Hidden Health Costs of Transportation



EXECUTIVE SUMMARY

Transportation investments and the systems that are developed from them shape lives and communities. The transportation system is a complex web of highways, sidewalks, bike paths, trains and bus services that connect people to each other as well as to places of work, play, prayer, medical care, and shopping. Transportation policies and decisions influence land use and how communities and neighborhoods are designed and built—whether sprawling and disconnected, or central and connected.

The combustion engine and the creation of the highway system increased mobility and access to goods and services. However, investments in highways have come at the expense of other transportation modes. Over the years this has led to a heavier reliance on vehicles and roadways and less on walking, bicycling and transit use. Further, suburban development has resulted in communities that are away from town centers and public transit and require a near-total reliance on the automobile for transport and access.

Our dependence on automobiles and roadways has profound negative impacts on human health: decreased opportunities for physical activity, and increased exposure to air pollution, and the number of traffic crashes. The health costs associated with these impacts, including costs associated with loss of work days and wages, pain and suffering, and premature death, may be as high as several hundred billion dollars.

An investment in a “healthier” transportation system is critical. Providing convenient alternatives, encouraging active modes of transport, and establishing a transportation system that fosters connectivity and social interaction can not only offset health impacts and costs, but generate health benefits.

Health impacts and costs have typically not been considered in the transportation policy, planning, and funding decision-making process. There are few standards or models for estimating health costs. However, existing research can be used to estimate the population at risk, the magnitude of the health impact, and the health costs associated with those impacts. Growing recognition of the connection between transportation, land development and health has resulted in some studies and examples where health impacts and costs have been considered and assessed. These examples not only demonstrate that health costs should be a significant factor in decision-making, but also show that calculating such costs is indeed possible.

Much more work is needed in the area of health evaluation and cost assessment in transportation policy. Investments in healthier transportation are also critically needed. A few key policy changes can help realize both of these objectives.

Policies that

- Encourage federal planning, funding practices, and decision making to include health impacts, costs and benefits
- Support development of healthy communities, active transport and incentives for transportation investments that support health
- Promote measurement and evaluation of health, safety and equity in planning and development processes
- Fund research to evaluate health impacts and costs of transportation and land use actions

Such policies must be integrated into transportation policy—especially national transportation policy. The upcoming reauthorization of the federal highway transportation bill provides an important opportunity to advocate for healthier and more active transportation systems.

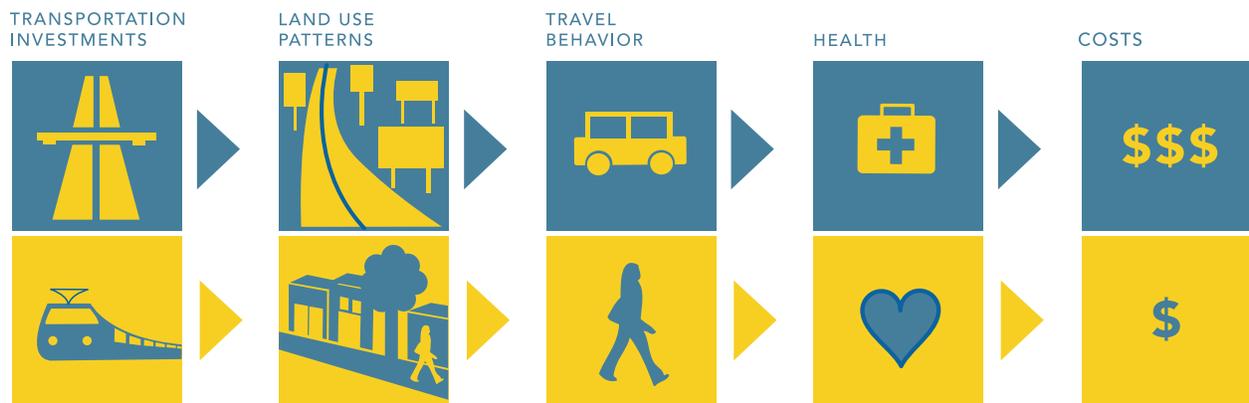
A report prepared by
Urban Design 4 Health,
Inc. and the American
Public Health Association,
February 2010.

1

Overview: Health Costs Associated with Transportation

Transportation investments, and the transportation systems that emerge from them, shape lives and communities. Highways, sidewalks, bike paths, trains and bus service connect people to friends and family, jobs, shopping, school, and countless other activities. These transportation systems also shape the design of the buildings and neighborhoods that they link together. Transportation systems and neighborhood design together determine the out of pocket cost, convenience, and comfort of different travel options.^{1,2} The travel choices we make on a daily basis—whether we get around via active or sedentary, polluting or non-polluting modes of travel—are a product of these investment and development decisions (see Table 1).

TABLE 1 HOW TRANSPORTATION IMPACTS HEALTH AND EQUITY COSTS



Since the 1950s our country has prioritized road building and the private auto when funding transportation, with proportionately little investment in transit, bicycle and pedestrian infrastructure.³ The U.S. is, therefore, a country of drivers – despite recent downward trends in driving, over 80 percent of the country’s workers drove or rode in a car to work in 2007,⁴ and in 2008 the average American drove nearly 10,000 miles. Investments in highways and roads have clearly provided the U.S. and its residents with benefits – convenience and comfort, economic opportunities, access and mobility – and a high degree of independence. However, our auto dependent lifestyles have also impacted our health and our environment in many ways. Traffic crashes cause over 40,000 deaths a year. Thirty-five million people live within 300 feet of a major roadway, and are at higher risk of respiratory illness due to exposure to traffic-related air pollution.⁵ About one-third of adults are estimated to be obese, and another third are overweight,⁶ due in part to sedentary lifestyles and the lack of opportunity for everyday physical activity. The mobility benefits of our current investment paradigm have also been inequitably dispersed—low-income, non-driving and ethnic minority populations are less likely to realize the benefits from road investment, and often suffer more of the adverse impacts.⁷

Total health care spending in the U.S. is already astronomical, and increasing rapidly, with estimated spending of \$2.4 trillion in 2008, \$3.1 trillion in 2012, and \$4.3 trillion by 2016.⁸ The health impacts of traffic crashes, air pollution, and physical inactivity alone add hundreds of billions of dollars in costs—costs of health care, lost

TABLE 2 THE COST OF TRANSPORTATION-RELATED HEALTH OUTCOMES

The consequences of inactivity, obesity, exposure to air pollution, and traffic crashes in the U.S. are staggering when viewed in terms of cost. Fortunately, with certain policy changes, these costs are largely preventable.

The National Health Costs of...	\$\$ (Billions)	Estimate Includes	Source
Obesity and overweight	\$142	<ul style="list-style-type: none"> Healthcare costs Lost wages due to illness & disability Future earnings lost by premature death 	National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases. Statistics Related to Overweight and Obesity: The Economic Costs. Available at: http://win.niddk.nih.gov/statistics/index.htm
Air pollution from traffic	\$50-80	<ul style="list-style-type: none"> Health care costs Premature death 	Federal Highway Administration. 2000. Addendum to the 1997 Federal Highway Cost Allocation Study Final Report, May 2000. Available at: www.fhwa.dot.gov/policy/hcas/addendum.htm
Traffic crashes	\$180	<ul style="list-style-type: none"> Healthcare costs Lost wages Property damage Travel delay Legal/administrative costs Pain & suffering Lost quality of life 	AAA. Crashes vs. Congestion? What's the Cost to Society? Cambridge, MD: Cambridge Systematics, Inc.; 2008. Available at: www.aaanewsroom.net/assets/files/20083591910_crashesVscongestionfullreport2.28.08.pdf

All cost estimates adjusted to 2008 dollars.

work days and productivity, and pain, suffering and premature death. The costs of obesity account for approximately nine percent of total U.S. health care spending,⁹ and add an estimated additional \$395 per year to per-person health care expenses.¹⁰ A portion of these costs are attributable to auto-oriented transportation and land use development that inadvertently limit opportunities for physical activity and access to healthy food. Traffic crashes cost us \$180 billion yearly,¹¹ and the health costs of transportation-related air pollution are between \$50 and \$80 billion.¹² Most often, these potential health costs are not included in the transportation decision-making process and policy framework. These “hidden” health costs of transportation decisions are stacking up to a level that can no longer be ignored. If they are not factored into the decision-making process, these costs will continue to grow and undermine the country’s economic health and our quality of life.



Transportation Policy and Planning is at a Crossroads with Health

Our current system of federal transportation policy, planning and funding is a holdover from the initial structure set up to implement the U.S. interstate highway system in the Eisenhower era. Although the federal highway system is by most accounts complete, the planning and funding structure remains largely the same—with little accountability and few funding programs that tie into to broader national policy goals. The majority of highway

and transit funding is distributed to transit agencies and state Departments of Transportation (DOTs) through formula grants regardless of the anticipated performance or cost-effectiveness of the project.¹³ The federal government does not require a consistent methodology for environmental impact analysis, transportation modeling, or cost-benefit analysis for agencies seeking federal highway funding—and while this approach allows agencies to tailor analyses to fit their needs, it makes it impossible to compare potential project effectiveness at a national level. It also means that health impacts, costs and benefits are often left off the table when projects are being considered.

The methods used to select transportation projects typically provide, at best, an incomplete accounting of a project's potential health costs and benefits. A Government Accountability Office survey of state DOTs and transit agencies found that although assessments of costs and benefits often play some role in the decision-making process, formal cost-benefit analysis is rare, and “not necessarily the most important factor” in project selection.¹³ Although there are no data on how frequently health costs and benefits are included in cost-benefit analyses, these results indicate that more thorough accounting systems are needed to bring health into the decision-making process.¹³

The scope and process for project evaluation will vary widely depending on the project and its location. Typically any cost-benefit analysis for transportation will include the costs of construction, right of way acquisition, operation and maintenance, travel time savings, and any revenues generated such as tolls. The monetary costs and benefits to health are rarely included. The decision to leave out any single impact area may be made because of budget and time constraints, because the impacts are perceived as difficult to measure, or because evidence is perceived as new or limited. However, such decisions have the result of inflating the benefits of roadway projects and underestimating the benefits of transit, bicycle and pedestrian projects. It is safe to assume that if even some of the costs listed below were to be considered in the transportation planning process, the decisions made would be very different.

- **INDIRECT IMPACTS AND INDUCED TRAFFIC.** The indirect impacts of transportation investment on land development (for example, a new road that fuels development on the fringes of an urban area) and transportation (“induced traffic”) are typically externalized (not included). This also means the exclusion of a number of other costs: the impacts of indirect land development on physical activity and obesity, the cost of the additional infrastructure (local roads, water and sewers, schools, fire, police services) necessary to serve indirect land development, and the impact of induced traffic on health and the environment (incremental air pollution, noise, climate change and water pollution costs).
- **SCOPE OF COSTS ESTIMATED.** The scope of costs that are included in estimates may be limited. For example, the costs of pain and suffering and other intangible costs are frequently left out of cost-benefit analyses due to the desire for a more “conservative” approach. However, an approach that uses the precautionary principle to avoid harmful action—and therefore accounts for all potential costs of an action—may actually be the most conservative and health-protective approach.^{14,15}
- **OBESITY AND PHYSICAL ACTIVITY IMPACTS, COSTS AND BENEFITS.** Because research on the link between transportation, the built environment and physical activity/obesity is relatively new, there have been limited opportunities to integrate it into current transportation planning processes, and there are no requirements within the planning process to do so. However, there is a large and growing body of available evidence linking transportation and land use patterns to physical activity and obesity, and physical activity and obesity to costs.

- **OTHER HEALTH IMPACTS, COSTS AND BENEFITS.** Other health impacts of transportation investment can include noise, water quality, mental health and/or stress, equity and social capital or social cohesion. Noise and water quality impacts are typically documented in a project's environmental impact assessment, but impacts on health in particular, and the costs/benefits of those impacts, are not usually calculated. The link between transportation investment and mental health, stress and social cohesion impacts is less established, with little research on which to base cost estimates. It may be reasonable to recognize and discuss potential impacts qualitatively while continuing to perform research and develop best practices on which impacts and costs can be based. In terms of equity impacts, analytical and accounting methods should examine the population directly affected by the investment, as well as the potential for differential impacts on different vulnerable subgroups within the larger study area population. Evaluation should consider impacts, costs and benefits with respect to not only low-income and ethnic minority groups, but to young, elderly and disabled people, who are typically left out of impact assessments.
- **TRAFFIC CRASHES AND AIR POLLUTION EXPOSURE.** Although the analytical methods and tools exist to measure the impacts and costs of traffic crashes and air pollution exposure, these factors are frequently not accounted for in cost-benefit analysis.

Transportation investments are inevitably a political endeavor, and decisions are often made for reasons other than objective and technical evidence. However, the stronger the evidence over the need and the benefits/costs of a particular investment, and the more that planners are able to conceive, articulate, and promote investments that address an array of established health concerns, the greater the chance that health-promoting projects will be funded.



3 Calculating the Health Costs of Transportation

More work is needed to develop “health cost analysis” and to ensure that health is considered in the cost-benefit analysis of transportation planning, policy and decision making. Several models have been developed and are being used, and a large amount of data and research exists that can be used as the basis for the analysis. However, there are no standard methods, models or specific guidelines for these calculations, although federal agencies frequently have standards for impacts (for example, the Clean Air Act standards are health based) and costs that can be applied to a cost analysis. With any assessment, a number of assumptions will need to be made.

Calculating health costs of changes in investment or policy decisions will require different sets of data, models and considerations for each scenario. There are three basic steps in a cost analysis: determining the affected population, the health impacts on that population, and the cost of those health impacts.

The following examples are conceptual and show how health costs or benefits can be calculated for changes in pedestrian safety, air pollution and physical activity. These examples are drawn from the work of other researchers, and detail the methods and approaches they used to arrive at the estimates.

Traffic Safety Case Study

The San Francisco Department of Public Health estimated how plans for growth in five San Francisco neighborhoods would impact pedestrian injuries from motor vehicle collisions.^{16,17}

- 1 DETERMINING AFFECTED POPULATION:** The population in five San Francisco neighborhoods that were being studied for increased residential development.
- 2 DETERMINING HEALTH IMPACTS:** A citywide analysis was used to determine which factors were most highly correlated with pedestrian – vehicle injury collisions.¹⁸ These factors included traffic volume, proportion of arterial streets without public transit service, land area, proportion of households without cars, proportion of residents commuting via walking or public transit, and total number of residents. These results were applied to projected increases in population and traffic in each of the neighborhood plans in order to estimate the change in pedestrian injury collisions, resulting in a projected increase of 17 percent, or 32 additional collisions in those five neighborhoods each year.

To estimate the health impacts of these pedestrian injury crashes, the distribution of pedestrian crashes by severity for the City of San Francisco over a five-year period was applied to the additional projected crashes (see first column in Table 3).¹⁹

- 3 DETERMINING HEALTH COSTS:** California Highway Patrol estimates of traffic injury costs were the basis of the health costs calculation, as shown in the table's second column. The cost factors include cost of property damage, lost earnings, medical and legal expenses, and costs of pain and lost quality of life, and were adjusted for inflation.²⁰ These estimates are also conservative, in that they assume only one pedestrian is injured per vehicle collision.

TABLE 3 THE COST OF TRAFFIC CRASHES IN FIVE SAN FRANCISCO NEIGHBORHOODS

	Citywide Crash Distribution (5-year average)	CHP value per accident	Estimated existing crashes	Estimated cost of existing crashes	Projected additional crashes with new development	Estimated cost of additional crashes with new development
Fatalities	3%	\$ 2,709,000	28.3	\$ 76,664,700	0.96	\$ 2,600,640
Severe injuries	10%	\$ 180,000	94.2	\$ 16,956,000	3.2	\$ 576,000
Visible injuries	36%	\$ 38,000	339.1	\$ 12,885,800	11.52	\$ 437,760
Pain complaints	51%	\$ 20,000	480.4	\$ 9,608,000	16.32	\$ 326,400
Total	100%	--	942	\$ 116,114,500	32	\$ 3,422,400

Air Pollution Case Study

Researchers from California State University-Fullerton calculated the health cost savings of meeting federal standards for fine particulates and ozone in California's South Coast and San Joaquin Valley regions.²¹

- 1 DETERMINING AFFECTED POPULATION:** Researchers used a computer model to estimate the population currently exposed to unsafe levels of air pollution in both regions.
- 2 DETERMINING HEALTH IMPACTS:** Research results from the scientific literature on air pollution were used to estimate the health impacts on the affected population. The researchers calculated impacts both for current conditions and for a scenario in which air quality standards were met.
- 3 DETERMINING HEALTH COSTS:** In the cost estimating step, other research findings and federal standards were used to calculate the cost of premature death, medical expenses due to illness and hospitalization and lost wages, and the value of avoided illness (where possible, these rates were adjusted for California income levels and current year [2007] dollars). These rates were applied to each of the health impacts that would be avoided by meeting the standards.

The study did not separate out the impacts of motor vehicle air pollution from other sources of air pollution – however, we know vehicles contribute significantly to air pollution. In the San Joaquin Valley, on-road motor vehicles make up 58 percent of oxides of nitrogen (NOx) emissions, one of the major contributors to ozone, and 11 percent of fine particulates.²² In the South Coast region, on-road motor vehicles make up 53 percent of NOx emissions and about 15 percent of fine particulates.

TABLE 4 HEALTH SAVINGS FROM MEETING AIR QUALITY STANDARDS

	San Joaquin	South Coast (Los Angeles, Orange, Riverside and San Bernardino counties)
Costs of air pollution (per year)	\$1,600 per person	\$1,250 per person
Savings if air quality standards were met (per year)	\$6 billion regionwide	\$22 billion regionwide

Physical Activity Case Study

Researchers from the University of California-Irvine, University of Wisconsin-Milwaukee and University of Texas-Austin calculated cost savings from reductions in coronary heart disease deaths and overall mortality due to increases in walking inspired by more walkable urban design.

- 1 DETERMINING AFFECTED POPULATION:** Portland, Oregon metro region
- 2 DETERMINING HEALTH IMPACTS:** Using travel diary data for the Portland, Oregon region, researchers first determined which of the following urban design characteristics were significantly correlated with

physical activity: street connectivity, retail employment density, total employment density, population density and proximity to downtown Portland. The results of the analysis were applied to two scenarios: a “low change” scenario that increased each urban design value from the regional median to the 75th percentile, and a “high change” scenario that increased each to the 95th percentile. To calculate health benefits, researchers assumed that a change in urban design would impact 5,000 people—a significant, but not unusual change roughly the size of a transit station area or a neighborhood. Existing research on the impact of physical activity on mortality rates²³ was used to calculate the number of lives saved per year for each scenario and each urban form characteristic.

3 DETERMINING HEALTH COSTS: To estimate health cost savings, monetized values of human life from previously published sources were applied. The lower value of human life (\$2.47m²⁴) was applied to the “low change” scenario, whereas the higher value (\$7.98m²⁵) was applied to the “high change” scenario. The final values therefore had a wide distribution because they reflected both the differing assumptions for value of life, and the differences in lives saved for each scenario.

In addition to demonstrating that there are substantial monetary benefits due to additional physical activity associated with more walkable urban design, the results show the potential value of changing a single urban design characteristic (for instance, a regulation that increases allowable development densities) or making a combination of changes (for example, by adding the benefits of increasing street connectivity and retail development together). These results can therefore be useful for policy analysis by incorporating the potential benefit from reduced mortality into existing methods for benefit/cost analysis.

TABLE 5 ESTIMATED COST SAVINGS FROM WALKABLE URBAN DESIGN

Land Use/Urban Design Characteristics	Change in Amount of Walking (Miles, Over a Two-Day Period)		Number of Persons Who Will Move from First to Second Tertile of Physical Activity		Annual Lives Saved		Present Discounted Value (in Dollars)	
	Low (median-75th percentile)	High (median-95th percentile)	Low	High	Low	High	Low	High
Street connectivity (intersection density)	0.3816	1.1844	22.79	78.59	0.0456	0.1572	\$2,255,107	\$23,205,007
Retail employment density (retail jobs/0.0652 square mile)	0.0652	0.9734	4.72	62.09	0.0094	0.1242	\$466,574	\$18,331,955
Total employment density (jobs/1.0648 square mile)	0.0019	1.0648	1.57	66.02	0.0031	0.1320	\$155,525	\$19,492,206
Population density (persons/square mile)	0.2581	0.549	15.72	28.29	0.0314	0.0566	\$1,555,247	\$8,353,802
Distance to central business district (miles)	-0.8108	-2.5054	45.58	209.05	0.0912	0.4181	\$4,510,215	\$61,725,318



Factoring Health Costs into Future Transportation Policy Is Critical

The current process by which transportation funding decisions are made generally does little to consider the long-term costs and benefits to health, safety and equity. Our system of transportation investment has resulted in many benefits for the U.S. and its residents, but today's growing, aging and urbanizing population has different needs and expectations for a transportation system. Negotiations over the federal transportation bill will shape transportation spending from top to bottom, and every indication is that the bill is a key opportunity not just to get more funding for health and safety programs, but to totally re-think the transportation funding process. Investment should shift toward transit, pedestrian and bicycling infrastructure in order to facilitate healthy, equitable and environmentally sound mobility. Evaluative methods and project selection practices should reflect goals of accountability and tractability as well as national policy objectives.

Recommendations for Future Transportation Policy and Investment

- 1 A considerable increase in transportation investments is needed to offer more balanced and affordable modes of transport including biking, walking and public transit. Currently 80% of federal transportation funding goes toward building highways and improving road infrastructures, and approximately 20% goes toward public transit and motor vehicle safety programs.
- 2 Federal planning and funding practices need to more fully account for impacts, costs and benefits to health, throughout the planning and decision-making processes. It may be necessary to develop new methods and approaches for health cost accounting, or to fund new areas of research on the health impacts of transportation investments. By internalizing potential health costs, decisions can be made based on a full understanding of the cost tradeoffs to the public, rather than ignoring or trying to guess at what the costs might be.
- 3 A national set of health-related policy objectives needs to be part of the criteria for federal transportation funding decisions. Performance-based transportation funding would allocate more funds to projects and efforts that support healthy communities and active transportation, and give transportation planning agencies an incentive to put forth more health-promoting transportation investments.
- 4 Research funding should be allocated to document the health costs of transportation investments and develop and apply evidence-based tools that account for the health impacts of such investments. These tools can range from the simple and qualitative to more robust quantitative approaches. Existing tools for modeling or scenario planning can be modified to include health outcomes. Such efforts, which use evidence-based feedback to inform project development, are critical. Funding should be made available to test these tools across a range of geographic settings, study area sizes, demographic populations, and project types.

HIA **Health Impact Assessment** :: HIA is a "combination of procedures, methods, and tools by which a policy, program, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population."

REFERENCES

- 1 Frank, LD. 2004. Economic Determinants of Urban Form: Resulting Trade-offs Between Active and Sedentary Forms of Travel. *American Journal of Preventive Medicine* 27(3S):146-153.
- 2 Boarnet M, Greenwald M and McMillan T. 2008. Walking, Urban Design, and Health: Toward a Cost-Benefit Analysis Framework. *Journal of Planning Education and Research* 27:341-358.
- 3 Homburger, W. *Fundamentals of traffic engineering*. Berkeley, CA: Institute of Transportation Studies, University of California, Berkeley, 1996. Available at: http://www.bts.gov/publications/transportation_statistics_annual_report/2008/html/chapter_04/table_04_04.html
- 4 Puentes R, Tomer A. 2008. *The Road...Less Traveled: An Analysis of Vehicle Miles Traveled Trends in the U.S.* Washington, DC: Brookings Institution. p. 8.
- 5 Environmental Protection Agency. Available at: <http://epa.gov/airscience/quick-finder/hear-roadway.htm>; accessed June 30, 2009.
- 6 Ogden, C.L., M.D. Carroll, L.R. Curtin, M.A. McDowell, C.J. Tabak, and K.M. Flegal. 2006. Prevalence of Overweight and Obesity in the United States. *Journal of the American Medical Association* 295(13):1549-1555.
- 7 Robert D. Bullard and Glenn S. Johnson. *Just Transportation: Dismantling Race and Class Barriers to Mobility*. Gabriola Islands, British Columbia, Canada: New Society Publishers, 1997.
- 8 Keehan, S. et al. 2008. Health spending projection through 2017. *Health Affairs*. Web Exclusive W146:21. February 28.
- 9 Finkelstein, EA, Fiebelkorn, IC, Wang, G. 2003. National medical spending attributable to overweight and obesity: How much, and who's paying? *Health Affairs* W3: 219-226.
- 10 Sturm R. 2002. The Effects Of Obesity, Smoking, And Drinking On Medical Problems And Costs. *Health Affairs*, March/April: 245-253.
- 11 AAA. *Crashes vs. Congestion Report. What's the Cost to Society?* Cambridge, MD: Cambridge Systematics, Inc.; 2008. Available at: www.aaanewsroom.net/assets/files/20083591910.crashesVscongestionfullreport2.28.08.pdf. Adjusted to 2008 dollars.
- 12 Federal Highway Administration. 2000. Addendum to the 1997 Federal Highway Cost Allocation Study Final Report, May 2000. Available at: www.fhwa.dot.gov/policy/hcas/addendum.htm; Adjusted to 2008 dollars.
- 13 United States Government Accountability Office. 2008. *Surface Transportation. Restructured Federal Approach Needed for Focused, Performance-Based, and Sustainable Programs*. GAO-08-400.
- 14 Frank LD, Kavage S. 2008. Urban Planning and Public Health: A Story of Separation and Reconnection, *Journal of Public Health Management & Practice* 14(3): 214-220.
- 15 Litman, Todd. *Transportation Cost and Benefit Analysis II*. Victoria, British Columbia, Canada: Victoria Transport Policy Institute 2009. Available at: <http://www.vtppi.org/tca/tca08.pdf>
- 16 Wier M, Bhatia R, Weintraub J. 2007. *Predicting Pedestrian Injury Collisions in San Francisco, California: An Area-level Model*. San Francisco, CA: San Francisco Department of Public Health. Available at: www.sfpbes.org
- 17 Bhatia R, Wier M, Weintraub J. 2007. *Impacts of Urban Land Use Development on Pedestrian-Motor Vehicle Collisions: An Application of the San Francisco Pedestrian Injury Model to Five Neighborhood Plans*. San Francisco, CA: San Francisco Department of Public Health. Available at: www.sfpbes.org
- 18 This model has since been refined as detailed in: Wier M, Weintraub J, Humphreys E, Seto E, Bhatia R. 2009. An area-level model of vehicle-pedestrian injury collisions with implications for land use and transportation planning. *Accident Analysis & Prevention* 41:137-145.
- 19 Ragland DR, Markowitz F, MacLeod KE. 2003. *An Intensive Pedestrian Safety Engineering Study Using Computerized Crash Analysis*. Berkeley, CA: Institute of Transportation Studies: UC Berkeley Traffic Safety Center publication UCB-TSC-RR-2003-12. Available at: <http://repositories.cdlib.org/cjiv/viewcontent.cgi?article=1010&context=its/tsc>; accessed on June 25, 2009.
- 20 U.S. Department of Transportation, Federal Highway Administration. *Motor Vehicle Accident Costs*. Technical Advisory T 7570.2. October 31, 1994. Available at: <http://www.fhwa.dot.gov/legisregs/directives/techadvts/t75702.htm>
- 21 Hall J, Brajer V. 2008. *The Benefits of Meeting Clean Air Standards in the South Coast and San Joaquin Valley Air Basins*. Fullerton, CA: California State University Fullerton Institute for Economic and Environmental Studies. November 2008. For more information on the health impacts of air pollution. Available at: <http://www.arb.ca.gov/research/health/health.htm>
- 22 California Air Resources Board. 2006. *Emissions Inventory for the San Joaquin Valley Air District - California Emissions Forecasting System (CEFS) Emissions by Summary Category*. Available at: <http://www.arb.ca.gov/app/emsmv/fcemsumcat2007.php>. Web query accessed on May 15, 2009.
- 23 Leon, A. S., J. Connett, D. R. Jacobs, and R. Rauramaa. 1987. Leisure-time physical activity levels and risk of coronary heart disease and death: The Multiple Risk Factor Intervention Trial. *Journal of the American Medical Association* 258 (17): 2388-2395.
- 24 Mrozek, Janusz R., and Laura O. Taylor. 2002. What determines the value of life? A meta-analysis. *Journal of Policy Analysis and Management* 21(2): 253-270.
- 25 U.S. Environmental Protection Agency. 2000. *Guidelines for preparing economics analyses*. Washington, DC: U.S. Environmental Protection Agency.

ACKNOWLEDGEMENTS

The following are recognized for the development of this report.

URBAN DESIGN 4 HEALTH, INC :: Sarah Kavage, Special Projects Manager; Lawrence Frank, President; and Heidi Smets, Graphics www.urbandesign4health.com

AMERICAN PUBLIC HEALTH ASSOCIATION :: Tracy Kolian, Senior Policy Analyst www.apha.org

ZEIGLER/DACUS :: Ben Dacus, Director of Creative Services www.zeiglerdacus.com

The development of this report was supported through a grant provided by the **Convergence Partnership Fund**.

About APHA

The American Public Health Association is the oldest and most diverse organization of public health professionals in the world and has been working to improve public health since 1872. The Association aims to protect all Americans and their communities from preventable, serious health threats and strives to assure community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States. APHA is committed to health equity and a healthy global society. The Association's broad array of public health professionals are champions of and advocate for healthy people and communities.



800 I Street NW
Washington, DC 20001
(202) 777-APHA (2742)
www.apha.org

Protect, Prevent, Live Well



Getting Involved in Transportation Planning

An Overview for Public Health Advocates



Photo courtesy of Flickr

Why should public health professionals be involved in transportation planning?

Because the way our roads and public transit systems are designed has a lot to do with our health: it influences how much exercise we get, our exposure to noise and air pollution, our risk of getting into traffic accidents, and more. This fact sheet discusses the important link between transportation planning and health, describes the key players and processes of local and regional transportation planning, and suggests steps you can take to advocate effectively for healthier transportation policies.



Making the Connection: Public Health and Transportation



PHYSICAL ACTIVITY

In this country about 92% of all trips are made by automobile, and the average person spends 443 hours in a car each year.³ These findings are directly linked to rising rates of obesity and other chronic illnesses: a study found that for every hour spent each day in a car, a person's risk of being obese increased 6%, while obesity risk decreased 5% for every hour walked each day.⁴



ACCESS TO SERVICES

The need to travel a long distance from home to essential goods and services is an especially dire problem in low-income and people-of-color communities, where people are more likely to be dependent on public transportation. Residents of low-income communities are less likely than their more affluent counterparts to own a car but also three times less likely to live within walking distance of a grocery store.⁵



TRAFFIC INJURIES & FATALITIES

In 2006, automobile crashes in the United States caused more than 37,000 fatalities and 3.4 million nonfatal injuries. For children and young adults, automobile crashes are the leading cause of death.^{6,7}

What Is Transportation Planning?

Transportation planning involves creating safe, efficient, and sustainable ways to move pedestrians, bicyclists, transit riders, and drivers from one area to another.

While transportation planning has long centered around the concept of “mobility” (moving people from place to place), recent focus has begun shifting to “access,” or ensuring that people can easily reach jobs, education, and other daily needs.

Transportation planners design our streets and sidewalks, highways, and public transit networks. Agency decisions are made at all levels, from the city to the federal government. Their choices have a significant impact on chronic disease rates, air quality, and equitable access to services and economic opportunities. Transportation planning decisions can help improve residents' health by promoting bicycling and walking, focusing on access to food shopping and other daily needs (especially for vulnerable populations such as low-income, elderly, and disabled), and conceiving of neighborhoods as destinations rather than funnels for cars and other vehicles.

Transportation planning funds come from the federal government and state, regional, and local agencies. During the 1950s and '60s, when the majority of our interstate highway system was built, state and federal gasoline taxes were sufficient to cover the full costs of road construction. But gas taxes have not kept pace with inflation, forcing local and regional governments to seek other sources of funding, such as bonds or local taxes, to maintain and expand transportation systems.

In more urbanized areas, local governments have been able to create more funding sources to meet transportation goals. Only a third of the Bay Area's transportation budget, for example, comes from the federal and state government combined.¹ By contrast, in rural communities, where local and regional agencies issue fewer taxes and bonds, federal and state government funding may account for as much as two-thirds of the budget for transportation spending.²

Who Makes Transportation Planning Happen?

Transportation planning works at three different levels: local (city), county, and regional.

Local Government

Local governments control what happens on neighborhood streets, set standards for how local land can be used, and secure funding for transportation projects and programs.

Key Players

The **Department of Public Works** (or occasionally **Department of Transportation**) designs, builds, and maintains roadways and sidewalks, pedestrian plazas, bicycle facilities, and traffic signals on locally owned roads.

The **Department of Parks and Recreation** designs, builds, and maintains pedestrian and bicycle facilities, and parks and open spaces within its jurisdiction.

The **Planning Department** develops zoning codes for land uses and policies on access to buildings and properties, sets parking minimums for developments, and approves site plans for housing developments.

Local elected officials champion and secure funding for projects and help set local policies on transportation performance standards and environmental initiatives.

Process

The two most important types of process to track are: **the city's own transportation policies**, and the **funding requests** submitted to higher levels of government. Transportation policies are often reflected in a local general plan (and, if available, in bicycle and pedestrian plans), which shows how much priority the city places on providing space and access for cars, bicyclists, and pedestrians. Available funding sources also drive decisions on which projects are ultimately built. In addition to projects they complete with funds they control, cities also submit lists of projects to higher levels of government to be included in transportation funding plans.

County Congestion Management Agencies (CMAs)

In 1990, California voters passed Proposition 111, doubling the state gas tax, directing the funds to the state Congestion Management Program, and shifting the responsibility for much transportation decision-making from the state to the regional level. This law required urban counties to create a Congestion Management Agency (CMA) to coordinate transportation planning, land use, and air quality measures to reduce traffic congestion and reliance on motor vehicle use. The funding priorities CMAs set through their countywide plans have a significant effect on local decisions.

Key Players

In many California counties, the CMA also administers the county's transportation sales tax. CMAs have dedicated **staff**, with a **board** usually made up of city/county elected officials and, in some cases, agency staff or representatives of local transit agencies. CMAs frequently have issue-specific **technical advisory committees** (for example, focused on bicycle/pedestrian issues or paratransit).

Process

Every four to six years, each CMA updates its long-range Countywide Transportation Plan (CWTP), outlining a vision and set of investment priorities for the county's long-term future (generally 20 to 30 years). These plans are often the basis of the county's input to a Regional Transportation Plan, a plan that articulates long-term growth patterns for the entire region (often multicounty areas) developed by a Metropolitan Planning Organization (see next section).

More frequently, the CMA also decides on a set of investments, usually drawn from the CWTP, to fund through county fees (for example, a half-cent sales tax), state or federal funding (through inclusion in an RTIP), or a combination of both. In addition to developing plans, CMAs advocate for and deliver regional funds to local governments and transit agencies, and participate in shaping regional transportation policy.

The most crucial time to get involved is when a county plans to ask for voter approval of a new half-cent sales tax for transportation or a renewal of an existing measure. This is a once-in-a-generation opportunity to guide the spending (sometimes of billions of dollars) of

entirely flexible funds. And the projects and programs defined in these plans typically shape how the county – and sometimes the region – will invest other funds for the next 20 to 30 years.⁸

Unfortunately, some observers express concerns that CMAs focus more on highway expansion to manage congestion rather than encouraging multiple transportation modes to provide access. And most CMAs are subject to less public scrutiny than local governments or even regional agencies, which can limit oversight and make it difficult to track how and when decisions are made.

Regional Metropolitan Planning Organizations (MPOs)

A Metropolitan Planning Organization (MPO) is a federally mandated and funded policy-making and planning organization. In California the majority of federal funds are controlled directly by MPOs, with only a small amount retained at the state level. More than 90 percent of Californians live in the jurisdiction of one of the four largest MPOs⁹ (Southern California, San Francisco Bay Area, Sacramento, and San Diego). An MPO has four key functions – long-term planning, short-term allocations of funding, advocacy at state and federal levels, and coordination of activities around the region – plus the overarching responsibility to involve the public in decision-making processes.¹⁰

Key Players

MPO staff (planners and engineers) generally play a significant role in defining the direction of regional policies and priorities. Each MPO has a **board or commission** that guides its work, with members typically representing the counties and cities in the region (sometimes advised by representatives from area transit or state and federal agencies). Most MPOs also have a **citizen advisory committee** and occasionally issue-specific **technical advisory committees** (similar to CMAs).

Process

Every four years, each MPO develops a Regional Transportation Plan (RTP) that outlines a long-term vision (20+ years) and sets investment priorities for transportation projects and programs. California's landmark greenhouse gas reduction law, SB 375, requires the state to set greenhouse gas reduction targets for each region. Each MPO prepares a Sustainable Communities Strategy (SCS) that demonstrates how the region will meet its reduction targets. Once adopted, the SCS will be incorporated into the RTP.

MPOs also use the RTP to guide allocations of specific funding sources, whose revenues originate anywhere from the regional to the federal levels, typically in two-to-three-year cycles.

The MPO planning process provides many opportunities for participation, from hearings and workshops to soliciting public comments on draft RTPs.

Getting Involved

Transportation planners need your input and expertise to help promote biking and walking, reduce traffic injuries, and improve access to grocery stores and other daily needs.

Public health advocates can educate and influence decision-makers at all levels of government – making the connection between transportation and health clear, explaining the impact of transportation investments, and keeping leaders accountable for priorities reflected in local and regional planning processes.



Assess Current Plans

Include healthier transportation goals. Do land use policies support dense, walkable neighborhoods? Do street design standards reflect all users? Can residents access quality public transit to reach jobs and essential services? Regional Transportation Plans and local plans should address the distinct needs of young, elderly, disabled, and low-income residents, who have the fewest transportation options. Discretionary funds should be prioritized for bicycle, pedestrian, and public transit systems rather than new roads. Long-term plans should prioritize improvements to mobility, air quality, land use, and economic objectives.



Build or Support a Coalition

Find like-minded advocates who are interested in advocating for health in transportation. Likely allies include advocates working on climate change, active transportation, public transit, and social justice. **Reach out to potential partners** and draw attention to your advocacy campaign by using the media to amplify your message. Media outreach can include pitching stories to a local journalist, writing letters to the editor, or using social media.



Make a Case for Health

Educate elected officials, planners, and other policymakers about the links between transportation and health. Encourage MPOs to prioritize data collection during the planning process, especially on pedestrians, bicyclists, people with disabilities, and low-income communities. Urge transportation agencies to coordinate their efforts with land use and economic development agencies, public health departments, and social service providers.



Attend Community Planning Meetings

Participate in regional and local community meetings and workshops. At a regional level, the California Department of Transportation has a comprehensive list of MPOs throughout the state; find yours at <http://1.usa.gov/ioc7SJ>. Locally, check the planning department's website or bulletin board for upcoming community meetings (this department is sometimes referred to as "community development").



Work to Improve Standards

Prioritize alternate transportation and walkability through design standards and metrics. Ensure that MPOs' project and funding priorities are consistent with the California Complete Streets Act of 2008 (AB 1358). Both the regional MPOs and county CMAs can adopt stronger safety performance measures that fully consider the needs of pedestrians and bicyclists. Work with your local and regional decision-makers to craft a set of health guidelines that can be used to better evaluate potential projects; Health Impact Assessment, for example, can identify how transportation projects affect a community.



- 1 Metropolitan Transportation Commission. Transportation 2035 Plan. P. 35, 2008.
- 2 Council of Fresno County Governments. 2004 Regional Transportation Plan. 5: 11-14, 2008.
- 3 Frank LD, Sallis JF, Conway T, Chapman J, Saelens B, and Bachman W. "Many Pathways from Land Use to Health: Associations between Neighborhood Walkability and Active Transportation, Body Mass Index, and Air Quality." *Journal of the American Planning Association*, 72(1): 75-87, 2006.
- 4 Ewing R, Frank L, and Kreutzer R. "Understanding the Relationship Between Public Health and the Built Environment: A Report to the LEED-ND Core Committee." 2006.
Available at: www.cnu.org/sites/www.cnu.org/files/leed_public_health.pdf.
- 5 Humpel N, Marshall AL, Leslie E, Bauman A, and Owen N. "Changes in Neighborhood Walking are Related to Changes in Perceptions of Environmental Attributes." *Annals of Behavioral Medicine*, 27(1): 60-67, 2004.
- 6 National Highway Traffic Safety Administration. Fatality Analysis Reporting System. 2006.
- 7 Leyden, KM. "Social Capital and the Built Environment: The Importance of Walkable Neighborhoods." *American Journal of Public Health*, 93(9): 1546-51, 2003.
- 8 TransForm (formerly known as Transportation and Land Use Coalition). *Access Now: A Guide to Winning the Transportation Your Community Needs*. P. 50-56, 2004.
Available at: <http://transformca.org/files/reports/access-now.pdf>.
- 9 The four largest Regional Metropolitan Planning Organizations (MPOs) are (1) Southern California Association of Governments (SCAG), (2) San Francisco Bay Area's Metropolitan Transportation Commission (MTC), (3) Sacramento Area Council of Governments (SACOG), and (4) San Diego Association of Governments (SANDAG).
- 10 TransForm (formerly known as Transportation and Land Use Coalition). *Access Now: A Guide to Winning the Transportation Your Community Needs*. P. 57-66, 2004.
Available at: <http://transformca.org/files/reports/access-now.pdf>.

Who Can Help

For more information about building new partnerships for healthier communities, visit www.phlpnet.org or www.TransformCA.org



public health law & policy

Public Health Law & Policy

PHLP pioneers innovative ways to leverage law and policy to improve public health. We provide a range of practical legal and policy tools – including model laws and policies, fact sheets, FAQs, and toolkits, as well as tailored trainings and one-on-one consultation – to help make healthy communities the norm, not the exception.

Visit www.phlpnet.org to learn more.



TransForm

TransForm works to create world-class public transportation and walkable communities in the Bay Area and beyond. We build diverse coalitions, influence policy, and develop innovative programs to improve the lives of all people and protect the environment.

Visit us at www.TransformCA.org.

You can also contact us at our main office in Oakland, CA (510.740.3150) or at our offices in San Jose (408.406.8074) and Sacramento (916.441.0204).

Public Health Law & Policy (PHLP). PHLP is a nonprofit organization that provides legal information on matters relating to public health. The legal information in this document does not constitute legal advice or legal representation. For legal advice, readers should consult a lawyer in their state.

Support for this document was provided by Kaiser Permanente South and The California Endowment.

Photos by Steve Vance, stevevance.net (cover, p.8) and Lydia Daniller (p.2, p.7).

© 2011 Public Health Law & Policy

What does it mean for something to be a DPHIP (District Public Health Improvement Plan) priority?

Council commitment:

- ✓ Ensure core leadership and backbone support for a workgroup
- ✓ Council members join the workgroup if the priority aligns with your organization's goals/objectives, help engage others
- ✓ Assist with implementation of strategies based on specific requests from workgroup
- ✓ Monitor progress through verbal/written updates at Council meetings

Workgroup commitment:

- ✓ Creates a logic model and workplan to lay out collaborative objectives, strategies, activities
- ✓ Meets regularly/as needed to implement strategies & activities
- ✓ Requests Council assistance with specific strategies/activities
- ✓ Reports back to the Council on a regular basis

Proposed criteria for 2013-14 priorities:

Same criteria as last time, especially:

- Opportunity to build capacity on EPHS 3, 4, & 7
- Good “bang for the buck”, i.e. cost-effective evidence-based strategies exist
- CDPHC is the best vehicle for leveraging collective action

Plus, in order to be selected, a potential priority must demonstrate the 3 pre-conditions for “Collective Impact”:

- Influential champions (core leadership for workgroup)
- Sense of urgency (Data, community/partner concern & energy)
- Adequate resources
 - Workgroup participation
 - Backbone support

Next steps and decision process

- ❑ Today's discussion:
 - ❑ Review of survey input (see handout)
 - ❑ “pitches” on potential priorities
 - ❑ consensus on elimination of any priorities?
- ❑ Executive Committee meeting on Feb 25th – assess/rank the priorities under consideration based on extent to which they meet the criteria
- ❑ Full Council meeting in March:
Exec Committee will propose priorities with rationale for selection, for full Council vote



6. Please rank order the following potential priorities from 1 to 12 (1=highest priority, 12 = lowest priority), based on how important you think it is that they be included in the CDPHC's 2013-14 District Public Health Improvement Plan													
Answer Options	1	2	3	4	5	6	7	8	9	10	11	12	Rating Average
Obesity, physical activity, nutrition	6	7	7	6	4	0	3	2	0	1	2	1	4.26
Mental health and substance abuse	3	9	5	2	4	3	6	2	4	1	0	0	4.77
Health Equity (including access to health services)	11	4	2	2	3	3	2	7	2	1	0	2	4.82
Flu vaccination	6	4	3	3	7	1	3	3	5	2	1	1	5.36
Tobacco	7	3	4	0	4	4	4	6	1	3	1	2	5.62
Public Health Preparedness	2	3	2	5	3	2	4	5	4	2	6	1	6.74
Healthy homes	0	3	3	4	2	7	3	1	6	5	3	2	7.00
Infectious disease	1	1	2	7	4	3	1	5	1	2	8	4	7.36
Blood pressure	1	1	2	3	3	6	5	2	2	6	3	5	7.54
Community planning/ housing/transportation	1	0	4	5	1	4	0	4	8	3	5	4	7.67
STDs & reproductive health	0	2	3	1	2	2	4	2	3	12	5	3	8.23
Prenatal care	1	2	2	1	2	4	4	0	3	1	5	14	8.64

Backbone support functions:

- Provide structure through which partners can engage together in collaborative efforts
- Scheduling meetings, facilitating meetings, developing agendas, preparing drafts for review & feedback
- Nurture core leadership, keep influential champions engaged
- Communication:
 - manage email list for workgroup
 - develop logic model & living “workplan”
 - provide meeting summaries/workplan updates to keep workgroup members informed when miss meetings and document next steps
 - reporting back to Council
 - point of contact for new recruits to the workgroup

Core leadership/Influential champions functions:

- Content experts
- Represent organizations with substantial resources devoted to the priority area
- Consistent and active participants in workgroup
- Help with drafting agendas, workplans, and other products
- Help with facilitating meetings
- Recruit other partners in the field to participate in the workgroup
- Champion the workgroup’s strategies within their own organization and with other relevant groups/networks

Backbone support functions:

- Provide structure through which partners can engage together in collaborative efforts
- Scheduling meetings, facilitating meetings, developing agendas, preparing drafts for review & feedback
- Nurture core leadership, keep influential champions engaged
- Communication:
 - manage email list for workgroup
 - develop logic model & living “workplan”
 - provide meeting summaries/workplan updates to keep workgroup members informed when miss meetings and document next steps
 - reporting back to Council
 - point of contact for new recruits to the workgroup

Core leadership/Influential champions functions:

- Content experts
- Represent organizations with substantial resources devoted to the priority area
- Consistent and active participants in workgroup
- Help with drafting agendas, workplans, and other products
- Help with facilitating meetings
- Recruit other partners in the field to participate in the workgroup
- Champion the workgroup’s strategies within their own organization and with other relevant groups/networks

(Note: names with question marks have expressed interest but haven't formally confirmed/accepted Core leadership or Backbone support role)

Potential Priorities DPHIP 2013-14	Urgency	Influential champions/ core leadership	Backbone Support	Workgroup participation	Notes
Flu Vaccination	Ranked 4th overall 29% put in top 4 (7 th) 28% named urgency reasons (6 th)	Cathy Patnaude Cassie Grantham Jim Budway	Cathy Patnaude Becca Matusovich	Existing workgroup with track record of active participation and follow-through to implementation	Current severe flu season predicts stronger demand for vaccine next season
Blood pressure	Ranked 9th overall 12% put in top 4 (12 th) 9% named urgency reasons (12 th)	Donna Levi Jaclyn Morrill Cathy Patnaude	Donna Levi Jaclyn Morrill	Existing workgroup formed after the CHNA forums – has met sporadically, identified some strategies but not an overall cohesive direction yet	Small core group is committed but not clear whether there is sufficient commitment to participating in collaborative strategies more widely? Also intersects with Obesity and Health Equity.
Tobacco	Ranked 5th overall 35% put in top 4 (4 th) 38% named urgency reasons (4 th)	Sarah Mayberry Anne Tricomi Claire Schroeder Fred Wolff	Anne Tricomi Shane Gallagher Claire Schroeder Fred Wolff	Existing workgroup formed in 2012 after CHNA forums –	Core group meeting regularly and some focus areas identified
Public Health Preparedness	Ranked 6th overall 24% put in top 4 (9 th) 22% named urgency reasons (8 th)	Jim Budway Caity Hager Paul Weiss Becca Matusovich	Jim Budway Caity Hager Paul Weiss Ted Trainer	Existing Medical Reserve Corps Planning Committee led by CCEMA is active and making progress **6 new workgroup volunteers from the survey**	Other collaborative efforts involve the same core leaders- Cities Readiness, SMRRC initiatives, PH Hazard Vulnerability Analysis, etc

(Note: names with question marks have expressed interest but haven't formally confirmed/accepted Core leadership or Backbone support role)

<p>Health Equity</p>	<p>Ranked 3rd overall 55% put in top 4 (2nd) 44% named urgency reasons (3rd)</p>	<p>Toho Soma Becca Matusovich Carol Zechman Dennis Fitzgibbons? Megan Hannan? Carol Ewan Whyte? Colleen Hilton? Jim Cloutier?</p>	<p>Toho Soma Shane Gallagher</p>	<p>Strong existing workgroup (and sub-groups), has been meeting consistently and actively and making good progress</p> <p>**4 new WG members volunteered thru the survey</p>	<p>Include access needs/strategies from previous DPHIP under Health Equity as appropriate</p>
<p>Mental Health & Substance Abuse</p>	<p>Ranked 2nd overall 55% put in top 4 (2nd) 59% named urgency reasons (2nd)</p>		<p>Melissa Fochesato? Anita Anderson?</p>	<p>4 survey respondents expressed interest in WG participation (+ 4 others to help recruit)</p>	<p>Previous attempt to sustain workgroup after CHNA lacked consistent participation and ongoing backbone support, and has stopped meeting as a result Substance abuse = CHIP priority for all 4 HMPs</p>
<p>Obesity/physical activity/nutrition</p>	<p>Ranked 1st overall 65% put in top 4 (1st) 72% named urgency reasons (1st)</p>	<p>Karen O'Rourke? Elizabeth Trice Anne Tricomi</p>	<p>Elizabeth Trice Anne Tricomi Shane Gallagher Paul Niehoff? Melissa Fochesato? Ted Trainer?</p>	<p>8 survey respondents expressed interest (+ 3 more offered to help recruit) - Some interest in existing CTG PAN workgroup?</p>	<p>Lots of separate projects with new grant \$ working on pieces of this puzzle – need for coordinated plan and strategic approach</p> <p>CHIP priority across all four HMPs - propose rolling up into DPHIP priority</p>
<p>Healthy Homes</p>	<p>Ranked 7th overall 33% put in top 4 (5th) 28% named urgency reasons (6th)</p>	<p>Sarah Mayberry Emily Jacobs? Anita Anderson?</p>	<p>Alex Hughes Carol Zechman Melissa Fochesato? Georgia Wayne? Anita Anderson?</p>	<p>First meeting of workgroup to explore collaborative opportunities on Jan 9th – lots of ideas & enthusiasm</p>	<p>Feb meeting planned</p> <p>CHIP priority for Healthy Casco Bay & Healthy Portland</p>

(Note: names with question marks have expressed interest but haven't formally confirmed/accepted Core leadership or Backbone support role)

Community planning/ housing/ transportation/ Public Health	Ranked 10th overall 31% put in top 4 (6 th) 16% named urgency reasons (11 th)	Elizabeth Trice Paul Niehoff? Dennis Fitzgibbons?	Elizabeth Trice Carol Zechman Paul Niehoff?	(2 potential volunteers for workgroup in the survey)	CDPHC does not need to be the lead on this priority (Sustain Southern Maine HUD grant) but may need to establish/formalize stronger linkages and connections?
STDs/ reproductive health	Ranked 11th overall 14% put in top 4 (11 th) 19% named urgency reasons (9 th) **Rapid increase in Gonorrhea rates in Cumberland County in last 2 years**	Megan Hannan?	Georgia Wayne? Alex Hughes? (or Rivers Region rep?)	Exploratory Workgroup met for the first time on Jan 4 th – lots of enthusiasm & interest	Grad student project during February will include assessment of criteria and capacity for collaboration, recommendations for strategies CHIP priority for Healthy Rivers and Healthy Lakes
Infectious Disease	Ranked 8th overall 29% put in top 4 (7 th) 34% named urgency reasons (5 th)	(left off of survey list in error)	(left off of survey list in error)	No existing workgroup	Survey responses indicate interest in Lyme especially
Prenatal Care	Ranked 12th overall 18% put in top 4 (10 th) 19% named urgency reasons (9 th)	Carol Ewan Whyte?		Megan Hannan? Nancy Foss?	Data in State Health Assessment indicates Cumberland County is worse than state average on this indicator

Acronyms:

DPHIP = District Public Health Improvement Plan

CDPHC = Cumberland District Public Health Council

CHIP = Community Health Improvement Plan (MAPP)

HMP = Healthy Maine Partnership

CHNA = Community Health Needs Assessment (One Maine Health)



Cumberland District Coordinating Council for Public Health

BY-LAWS

01/18/2013

ARTICLE I. Legislative Purpose, Name, Mission, and Vision

Section 1. Legislative Purpose

The District Coordinating Council for Public Health, established under Title 22 MRS §412, is a representative district body of public health stakeholders for collaborative public health planning and coordination.

The District Coordinating Council for Public Health shall:

- (1) Participate as appropriate in district-level activities to help ensure the state public health system in each district is ready and maintained for accreditation; and
- (2) Ensure that the essential public health services and resources are provided in each district in the most efficient, effective, and evidence-based manner possible.
- (3) Assist the Maine Center for Disease Control and Prevention in planning for the essential public health services and resources to be provided in each district and across the State in the most efficient, effective, and evidence-based manner possible.

Section 2. Name

The name of the organization shall be the Cumberland District Public Health Council (the "Council").

Section 3. Mission

The Council's mission is to promote the health of all our communities by providing information, coordination, collaboration, and advocacy.

Section 4. Vision

The Council's vision is that communities in the Cumberland District are among the healthiest in the state.

ARTICLE II. Role and Structure of the Council

Section 1. Council Role

The Council is responsible for providing overarching guidance and setting policy regarding activities that support the purpose and mission. In addition, the Council:

- a. elects Council Officers
- b. approves the work plan and District Public Health Improvement Plan
- c. votes on adoption of or changes to by-laws as needed
- d. approves creation of ad-hoc and standing committees
- e. Provides advice and feedback to Maine Center for Disease Control and Prevention and Statewide Coordinating Council

Section 2. Council Size

Ideally, the Council is comprised of at least twenty-five (25) but not more than forty (40) voting members.

Section 3. Founding members

The following organizations are founding members of the Council and as such will be considered permanent members, with one member each on the Council on an ongoing basis:

City of Portland, Health and Human Services Dept., Public Health Division
Cumberland County Board of Commissioners
Cumberland County Emergency Management Agency
Mercy Health System of Maine
Maine Medical Center/Maine Health
Maine Center for Disease Control and Prevention
Healthy Cumberland County

Section 4. Regular members

Membership in the Council is sector-based, with an assurance of geographic representation. With the exception of the members listed in Article II, Section 3, and optional members listed below, Council membership shall be drawn from but not limited to the following sectors:

1. Maine Center for Disease Control and Prevention
2. county governments
3. municipal governments
4. tribal governments/health departments (Down East, Penquis and Aroostook)
5. city health departments
6. local health officers
7. hospitals
8. health systems
9. emergency management agencies
10. emergency medical services
11. Healthy Maine Partnerships
12. school districts
13. institutions of higher education
14. physicians and other health care providers
15. clinics and community health centers
16. voluntary health organizations
17. family planning organizations
18. area agencies on aging
19. mental health services
20. substance abuse services
21. organizations seeking to improve environmental health
22. other community-based organizations

Optional

1. Water District
2. home health providers
3. health professions training
4. CAP agency
5. immigrant/refugee organization
6. disability services
7. health policy services
8. other

Members shall demonstrate an interest in and commitment to public health, have the capacity for district-level decision-making, and the ability to share critical information with their sector peers.

Section 5. Interested Parties and Stakeholders

Stakeholders and interested parties are encouraged to attend and participate in all Council meetings, but do not have voting privileges.

Section 6. Selection of Members

A Membership Committee shall be established with the responsibility of developing nominees for regular membership of the Council. Nominees should be geographically representative of Cumberland County. Nominees shall be approved at the annual meeting by a simple majority vote. The Council may vote on vacancies that occur between annual meetings based on a proposal from the Membership Committee.

Section 7. Council Terms

The term of office of each member is three (3) years. A member may serve an unlimited number of terms. All vacancies must be filled for the balance of the unexpired term in the same manner as the original appointment.

A Council member may resign from the Council by written notice to the Executive Committee.

A Council member may be removed at the discretion of a two-thirds (2/3) of the Council members.

Section 8. Council Member Responsibilities:

Members shall regularly attend meetings of the Council and meetings of the Executive Committee or committees to which they are appointed. As the sector representative to the Council, to the extent possible each Council member shall routinely communicate decisions, discussions, and business of the Council to the member's sector/geography, and likewise communicate sector/geography information back to the Council.

Council members absent three (3) or more consecutive meetings may be asked to resign.

The Executive Committee, in certain circumstances, on a case-by-case basis, may waive this requirement. In order to be considered, members shall send written notification—in advance, when possible—to the Executive Committee for consideration. The Executive Committee shall consider the member's circumstance and respond within two weeks of receiving written notification with a decision.

ARTICLE III. Executive Committee

Section 1. Executive Committee Role

The Executive Committee will provide leadership for the Council, provide continuity and make decisions on Council activities, appoint committee chairs, and investigate complaints regarding activities of the Council or its members in the course of their role on the Council.

Section 2. Executive Committee Members

The Executive Committee is composed of officers elected to this body from the full Council, chairs of all standing committees, and the Maine Center for Disease Control and Prevention District Liaison.

Section 3. Officers

At a minimum, the Council shall elect a Chair, Vice Chair, and Representative to the State Coordinating Council for Public Health. Additional officer positions may be created at the discretion of the Council. The Executive Committee, through the Chair, will convene regularly schedule Council meetings.

The Chair shall preside at Council meetings. The Chair shall provide leadership in preparing agendas for Council meetings and provide guidance and support to appointed committees. The Chair shall also designate another member of the Executive Committee as the Alternate Representative to the State Coordinating Council for Public Health.

The Vice Chair shall convene regularly scheduled Council meetings and preside at Council meetings in the absence, or at the request, of the Chair. The Vice Chair shall also chair special ad hoc committees as designated by the Chair.

The Representative to the State Coordinating Council shall ensure the District is represented at the State Coordinating Council, report to the State Coordinating Council on District matters, and report back to the Executive Committee and Council on State Coordinating Council proceedings.

In addition, the Council will elect two additional officers, a Treasurer and Secretary.

The Treasurer shall issue a finance report to the Council at each regular meeting, and shall work with the Council's fiscal agent to remain abreast of financial activities.

The Secretary shall ensure that accurate records are maintained of Council actions, adequate notice is sent regarding Council meetings, and maintain records of active membership for purposes of establishing quorum.

Section 4. Executive Committee Size

The size of the Executive Committee is comprised of a minimum of five (5) members and described in in Article III, Sections 2 and 3 above.

Section 5. Election of Officers

The Membership Committee established in Article II, Section 6, shall be responsible for developing a list of nominees for Council officers. Nominees shall be approved at the annual meeting by a simple majority vote. The Council, based on a proposal from the Membership Committee, may vote on vacancies that occur between annual meetings.

Section 6. Executive Committee Terms

Council Officer terms shall be two (2) years and may be renewed by Council vote; however, no Council Officer shall serve more than three (3) consecutive terms, with the exception of the Maine Center for Disease Control and Prevention District Public Health Liaison.

During the first year, Council terms will be staggered by one and two years. The Council Chair and Secretary shall be the odd terms (1 year). The Vice Chair, Treasurer, and Representative to the State Coordinating Council shall be the even terms (2 years). If in the event an officer is no longer associated with the member organization they represent, the officer shall be removed from the office and the Council and a new officer shall be elected by the Council.

Section 7. Executive Committee Responsibilities

Executive Committee Members will regularly attend meetings of the Council and meetings of the Executive Committee.

In cooperation with the Council Chair, the Maine Center for Disease Control and Prevention District Liaison shall be responsible for Council internal communications. Any public comment shall be coordinated with the Executive Committee with respect for the potential conflicts

Section 8. Executive Committee Meetings

The Executive Committee shall meet on a regular schedule that it deems necessary and appropriate in order to fulfill its responsibilities as set forth in the Bylaws. Notice of all regular Executive Committee meetings shall be communicated via electronic mail to all members of the Committee at least five days prior to the meeting.

Special or emergency meeting of the Executive Committee may be called as needed by the Executive Committee leadership. Notice of special or emergency meeting shall be sent via electronic mail with as much notice as possible.

ARTICLE IV. Council Meetings

Section 1. Time and Place of Meetings

The Council will meet, at a minimum, quarterly. The Executive Committee shall determine meeting times and locations of all Council meetings.

Section 2. Agenda

The Chair or his/her designee shall prepare an agenda of items requiring Council action, and shall add items of business as may be requested by Council members and/or the Executive Committee.

Section 3. Notice

Council members shall be sent electronic mail notice of the time and date of the meetings at least twenty (20) business days before a regular Council meeting. In the event of an emergency, the Executive Committee may call a meeting with a simple majority vote of the Executive Board and shall give as much notice as possible.

Section 4. Rules of Order

Robert's Rules of Order shall govern regular Council meetings unless the Council adopts other rules of order. Council meetings are open to all interested parties.

Section 5. Council Meeting Minutes

The responsibility of Council minutes rest with the Executive Committee. Minutes recording all motions and subsequent action including the number of yeas, nays or abstentions shall be recorded. Minutes of all meetings shall be maintained by the Secretary or his/her designee and made available on the Council website.

Section 6. Quorum

A simple majority of the current Council membership shall constitute a quorum. In the absence of a quorum, a Council meeting may continue discussion; however, no formal actions shall be taken, except a vote to adjourn the meeting to a subsequent date.

Section 7. Voting

Each Council member shall have one vote, once quorum is established. As the district-wide representative body for collaborative planning and decision-making for public health, the Council will seek consensus through well-structured and staged processes. If a consensus decision cannot be reached, all business conducted with a simple majority vote of the quorum shall stand as official action of the Council. By formal agreement of the Council, voting may be conducted electronically.

ARTICLE V. Committees

Section 1. Creation of Committees

The Council or its Executive Committee shall have the power to create standing and ad-hoc committees and work groups. Committees created by the Executive Committee between Council meetings shall be voted upon at the next scheduled meeting of the Council. The Council Chair, in coordination with the Executive Committee, shall appoint and charge each committee with its responsibilities and shall appoint the chair of the committee.

Section 2. Membership

Membership on a committee or work group, with the exception of the Executive Committee, is not limited to (voting) members of the Council. The Council, Executive Committee and other committees may call on non-Council members as advisors to provide information and guidance.

At least one member of the Executive Committee will serve on each of the Council's committees and work groups.

Committee Chairs shall bring proposed activities to the Council for discussion and approval. The Council may accept recommendations of committees/work groups as part of a consent agenda; however, if any Council member finds that he/she has a significant issue with a committee/work group recommendation, he/she shall say so at the Council meeting and bring it for further discussion and separate vote at the Council level.

Section 3. Standing Committees

Standing Committees and work groups may be established by the Council or its Executive Committee. Standing committees shall be recorded in the Council By-Laws. The current standing committees are the following:

- Advocacy
- Communications
- Finance & Fundraising
- Health Data
- Healthy Cumberland
- Membership

Section 4. Committee Chairs

The Committee Chair shall be responsible for scheduling meetings, assigning specific tasks within the mandate of the committee, and reporting to the Executive Committee and the Council concerning the work of the committee. In addition, standing committee chairs shall be members of the Council.

ARTICLE VI. Non-Partisan Activities

The Council shall be non-partisan. No part of the activities of the Council shall consist of the publication or distribution of materials or statements with the purposes of attempting to influence or intervene in any political campaign on behalf of or in opposition to any candidate for public office.

ARTICLE VII. Conflict of Interest

A conflict of interest is defined as any personal or organizational financial or other interest which prevents or appears to prevent an impartial action or decision on the part of a Council member or member of any Council committee. A conflict occurs when a financial or other interest could:

- a. Significantly impair the individual's objectivity.
- b. Create an unfair competitive advantage for any person or organization.
- c. Provide a direct or indirect fiduciary interest of financial gain for that individual or organization.

Should a matter before the Council present a known, or a potential conflict of interest, Council members are required to disclose such potential conflict to the Executive Committee at the earliest point possible. Once a conflict or potential conflict is disclosed, the Chair shall lead the rest of the members in deciding how the member with the conflict or potential conflict may participate in discussions or voting.

ARTICLE VIII. Fiscal Agent

The Council shall designate a fiscal agent or agents as necessary. The Council and fiscal agent shall enter into an agreement that is documented and designates the roles and responsibilities of both organizations.

ARTICLE IX. Fiscal Calendar

The fiscal year of the Council will be July 1 to June 30. The fiscal year of the Council may additionally follow the fiscal calendar designated in any funding program the Council receives.

ARTICLE X. Reporting

The Council will submit quarterly progress reports to the State Coordinating Council for Public Health according to the State Coordinating Council’s format. The quarterly reports will be sent to the Council membership and interested parties, and posted on the State Coordinating Council for Public Health website.

ARTICLE XI. By-Law Amendments

The District Coordinating Council for Public Health bylaw document serves as uniform guidance in all Public Health Districts. To address specific district needs, districts may draft additional addendums in the following areas:

- a. Council mission and vision
- b. Additional membership requirements to:
 - i. have at least one member who is a recognized content expert in each of the essential public health services
 - ii. have representation from populations in the State facing health disparities
- c. Council Standing Committee structure
- d. Policies that help instruct the function of the Council

The Council may amend these by-laws. Before consideration, the amendment must be submitted in writing to the Council and posted on the Council agenda according to the guidelines in Article IV., Section 3 (Notice). Prior to an amendment of the by-laws, the Council may request a recommendation from the Executive Committee. Votes to approve by-law amendments follow the guidelines set forth in Article IV., Section 6 (Quorum), and Section 7 (Voting).

Any bylaw amendments will be submitted to the State Coordinating Council for Public Health within sixty (60) days after Council approval.

Adopted this ____ day of _____, 20__.

Signed this ____ day of _____, 20__.

Council Chair, acting on behalf of
Cumberland District Public Health Council:

State Coordinating Council Chair, acting on behalf of
State Coordinating Council For Public Health:

Director, Maine Center for Disease Control and Prevention, acting on behalf of the
Maine Center for Disease Control and Prevention:
