

LAW COURT BROWNFIELDS
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REDEVELOPMENT ACTION
COMMUNITY HEALTH
BROWNFIELDS PUBLIC LAW
ENVIRONMENTAL

healthy
people

brownfields

the future of
community health
through
brownfields
redevelopment

september 1, 2004
new bedford, massachusetts

Co-Sponsors

Thank you to all of our co-sponsors for their support of the *Future of Community Health through Brownfields Redevelopment* Workshop!



City of New Bedford



Community Economic Development Center
of Southeastern Massachusetts



Environmental Law Institute

Greater New Bedford
Community Health Center



National Oceanic and
Atmospheric Administration



Old Bedford Village Development Corporation



University of Massachusetts Dartmouth
College of Nursing

The Future of Community Health through Brownfields Redevelopment

Agenda

September 1, 2004

Carney Academy

New Bedford, Massachusetts

welcoming reception

MODERATOR - ROBERT NEELY, NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

5:00PM WELCOME

Mayor Fred Kalisz, *City of New Bedford*

OPENING REMARKS

Congressman Barney Frank (Invited)

5:30PM EXPANDING MOMENTUM THROUGH BROWNFIELDS REDEVELOPMENT

Neighborhood Panelist:

Buddy Andrade, *Old Bedford Village Development Corporation*

Local Government Panelist:

Scott Alfonse, *City of New Bedford*

Community Health Panelist:

Stuart Forman, *Greater New Bedford Community Health Center*

6:15PM MODELING AFTER FLORIDA'S SUCCESS

Community and Health:

Suzi Ruhl, *Environmental Law Institute*

Local Government and Private Sector:

Miles Ballogg, *TBE Group*

6:45PM QUESTIONS AND COMMENTS FROM THE AUDIENCE

forming links

MODERATOR - ROBERT DAVIS, CITY OF NEW BEDFORD

7:00PM CONCURRENT FACILITATED BREAKOUT SESSIONS (*Please see reverse side*)

8:15PM REPORT ON RECOMMENDATIONS FROM BREAKOUT SESSIONS

session 1: prevention and planning

LEADER - JEANNE LEFFERS, UNIVERSITY OF MASSACHUSETTS DARTMOUTH

FACILITATOR: Laurel Miller, *Greater New Bedford Community Health Center*

EXPERT RESOURCES:

David Kennedy, *City of New Bedford*

Carl Alves, *New Bedford Prevention Partnership*

THEME: Brownfield redevelopment reduces exposure to pollution and provides the opportunity for health promotion.

session 2: access to health care through brownfields redevelopment

LEADER - DANNY BERTALDO, GREATER NEW BEDFORD COMMUNITY HEALTH CENTER

FACILITATOR: Paul McMann, *Greater New Bedford Community Health Center*

EXPERT RESOURCES:

Robert Davis, *City of New Bedford*

Ramona Silva, *Member, New Bedford School Committee/Southeastern Cultural Planning Committee*

THEME: Brownfield redevelopment can improve individual and community health.

session 3: disease management within distressed areas

LEADER - KAREN ENRIGHT, GREATER NEW BEDFORD COMMUNITY HEALTH CENTER

FACILITATOR: Ken Ramos, *Neighborhood Association*

EXPERT RESOURCES:

Scott Alfonse, *City of New Bedford*

Dre' Perkins, *Treatment on Demand, Inc.*

THEME: People living in distressed areas suffer high rates of disease. Brownfields redevelopment can produce tangible outcomes that improve the health of these people.

taking the next step

MODERATOR - SUZI RUHL, *Environmental Law Institute*

8:45PM BUILDING COMMUNITY PARTNERSHIPS

Panelists:

Scott Alfonse, *City of New Bedford*

Corinn Williams, *Community Economic Development Center of Southeastern Massachusetts*

Bob Davis, *City of New Bedford*

Jeanne Leffers, *University of Massachusetts Dartmouth*

9:15PM CLOSING

Planning Committee

Thank you to all of our planning committee members for their support of the *Future of Community Health through Brownfields Redevelopment* Workshop!

Scott Alfonse, City of New Bedford

John "Buddy" Andrade, Old Bedford Village Development Corporation

John Calnan, United Way of Greater New Bedford

Robert Davis, City of New Bedford

Stuart Forman, Greater New Bedford Community Health Center

David Kennedy, City of New Bedford

Jeanne Leffers, University of Massachusetts at Dartmouth,
College of Nursing

Robert Neely, National Oceanic and Atmospheric Administration, Convener

Louis Pettine, Southeastern Transit Authority

Suzi Ruhl, Environmental Law Institute, Convener

Corinn Williams, Community Economic Development Center
of Southeastern Massachusetts

Ground Rules & Getting Started

ground rules

1. Start on time.
2. Feel free to contribute.
3. Raise your hand and be recognized before speaking.
4. One speaker at a time.
5. Be brief and to the point.
6. Make your point calmly.
7. NO knives - NO whining.
8. Keep an open mind.
9. Listen without bias.
10. Understand what is said.
11. Avoid side conversations.
12. Respect others opinions.
13. Keep focused.
14. Avoid personal agendas.
15. Come prepared to do what is good for the group.
16. Have FUN.
17. Finish the charge and come out with a plan.
18. Celebrate the efforts and accomplishments of the group.
19. Evaluate the meeting.
20. End on time.

getting started

1. Allow team members to introduce themselves.
2. Ask for a volunteer timekeeper.
3. Ask for a volunteer recorder.
4. Review, change, order the agenda.
5. Establish time limits.
6. Review the charge.

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Public Health

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Section I:
Brownfields

The Basics on Brownfields

what are brownfields?

Brownfields are defined as real property, the expansion, redevelopment, or reuse of which may be complicated by the presence or potential presence of a hazardous substance, pollutant, or contaminant. *Small Business Liability Relief and Brownfields Revitalization Act, 24 USC 9601(39), enacted January 11, 2002.* Brownfields redevelopment seeks to environmentally assess existing brownfield properties, prevent further contamination, safely clean up polluted properties, and design plans for reuse.

how did the term "brownfields" develop?

The term "brownfields" can be traced, in part, to the passage of the Comprehensive Environmental Response, Compensation and Liability Act of 1980 (CERCLA or Superfund). CERCLA addresses the cleanup of sites contaminated with hazardous substances and liability for the costs of remediation. Brownfield sites can be distinguished from greenfield sites. Greenfields describe unused suburban and rural land. As part of the efforts to promote sustainable or "smart" growth, a comparison is made between "brownfields" and "greenfields."

how common are brownfields?

The Government Accounting Office has estimated that there are 400,000 to 600,000 brownfield sites across the United States. In Florida, there are over 50 state-designated brownfields and almost 10,000 confirmed contaminated petroleum sites awaiting clean-up.

why are brownfields important?

Road, sewer, water and other infrastructure lay completely idle on brownfields sites. Abandoned property can attract crime and violence and are an eyesore for the community.

Contaminated sites breed disease and illness.

Brown-fields prevent increases in property value and inhibit job growth.



NeighborWorks' website at www.nw.org is an excellent resource for brownfields materials.

For more information please contact Suzi Ruhl, Director of Environmental Law Institute's Center for Public Health and Law at ruhl@eli.org, or visit www.eli.org.

Environmental Law Institute is an independent, non-profit research and educational organization based in Washington, D.C. The Institute serves the environmental profession in business, government, the private bar, public interest organizations, academia and the press.

laws

brownfields

Federal and state laws substantially influence brownfields and brownfields redevelopment. Certain laws affect funding and location decisions for brownfields redevelopment projects while others concern contamination found on the property. Community health issues at brownfields sites are also among the many factors affected by legislation on brownfields.

massachusetts laws and brownfields

The Commonwealth of Massachusetts is committed to the cleanup and redevelopment of brownfields properties in a manner that promotes environmental protection goals and stimulates the economy. While the Commonwealth of Massachusetts does not “formally” define a brownfields, it recognizes certain common characteristics. Brownfields properties are:

- Abandoned or for sale or lease;
- Have been used for commercial or industrial purposes;
- May have been reported to the Massachusetts Department of Environmental Protection because contamination has been found; and
- May not have been assessed due to fear of unknown contamination conditions.

Massachusetts has laws, which govern the cleanup and redevelopment of contaminated properties. The state’s cleanup law is Chapter 21E, and it addresses parties who conduct site assessment or cleanup at any property. The parties must also follow the cleanup regulations, the Massachusetts Contingency Plan (MCP). The MCP process allows property owners to take planned future reuses into account when performing a cleanup. Parties who undertake site assessments and cleanup activities in Massachusetts must hire a Licensed Site Professional. Massachusetts also passed a brownfields law. This law, known as the Brownfields Act, provides for financial incentives, liability relief, and other measures regarding penalties, audits, and relief for economically distressed areas. The state brownfields program provides incentives to buyers, and sometimes sellers, of contaminated property as long as there is a commitment to cleanup and redevelopment of the property. The Executive Office of Environmental Affairs, through its Environmental Justice Initiative, also works to ensure that environmental justice populations have a strong voice in environmental decision-making, including brownfields redevelopment.

federal laws and brownfields

SUPERFUND

In 1980, Congress passed the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA), commonly known as Superfund. CERCLA provides federal money to clean-up uncontrolled or abandoned hazardous waste sites, as well as accidents, spills, and other emergency releases of pollutants and contaminants into the environment. CERCLA has a comprehensive liability plan that holds owners, operators, and other parties who are responsible for the pollution “jointly and severally” liable for clean-up.

RESOURCE CONSERVATION AND RECOVERY ACT

RCRA regulates the management of hazardous waste from waste production to final disposal. Some brownfield properties contain facilities that have been hazardous waste treatment, storage, or disposal facilities under RCRA. Or, while a brownfield property may not be regulated currently under RCRA, the land may be contaminated with hazardous wastes that may make the site subject to RCRA requirements when cleaned-up.

PETROLEUM LAW

Underground storage tanks (USTs) that contain petroleum or certain hazardous substances may be subject to RCRA’s Subtitle I UST regulations. RCRA’s Subtitle I regulations establish standards for installation, operation, release detection, corrective action, repair, and closure for USTs.

FEDERAL BROWNFIELDS LAW

In January of 2002, Congress passed the Small Business Liability Relief and Brownfields Revitalization Act. The Act provides the U.S. Environmental Protection Program (EPA) with a congressional mandate, increased funding, and meaningful opportunities to advance brownfields reuse across the country. This Act was the first federal law specific to brownfields. It also promotes the inclusion of health effects monitoring as a means of ensuring measurable improvements to health through brownfields redevelopment.

HEALTH CARE SAFETY NET AMENDMENTS ACT

The Health Care Safety Net Amendments Act of 2002 appropriated \$1.34 billion for community health centers in high-need areas, which often include brownfields properties.



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This fact sheet provides a summary of information on state and federal brownfields laws.

The following websites also serve as excellent resources for brownfields law:

<http://www.state.ma.us/dep/bwsc/brownfld.htm>

www.epa.gov/newengland/brownfields

<http://www.epa.gov/brownfields>

<http://www.epa.gov/epaoswer>

<http://www.epa.gov/superfund/>

For more information please contact Suzi Ruhl, Director of the Environmental Law Institute's Center for Public Health and Law at ruhl@eli.org or visit www.eli.org.

risk

assessment

People want to know about the health risks of a contaminated site in their community. A tool that is used to make decisions about how to address contaminated sites is “risk assessment.” It is important for community residents to know about risk assessment. This is because the more they know—the more they can help government make the proper decisions about cleaning up contaminated sites.

the focus of risk assessment

Risk from contaminated sites depends on the chemicals that are present at the site and the ways people may be exposed to them. Risk assessment for human health is used to address four main questions:

- Is a site contaminated, and, if so, what are the contaminants?
- How are people exposed to the contaminants?
- How dangerous could contaminants be to human health?
- What contaminant concentrations are safe?

Risk assessment is not an exact science. It is a method to use the best information available about the site and the manner in which people are exposed to the site. The better the information is, the better the decision. Community residents are an important source of information needed for a risk assessment.

steps of risk assessment

To find out what the current and future health risks are, risk assessments are designed to answer the following questions:

ARE TOXIC COMPOUNDS PRESENT? (*Hazard Identification*)

Depending on a site's history, samples of soil, water, air, fish, waterfowl, and vegetation may be collected to find out what chemicals are present.

WHO IS EXPOSED? HOW OFTEN? (*Exposure Assessment*)

Chemicals may enter the body through breathing (inhalation), eating or drinking (ingestion), or by skin contact (dermal). The Exposure Assessment is an estimate of how people may come into contact with chemicals and how often (for example, the number of times a person eats vegetables grown in contaminated soil). A "reasonable maximum exposure" is used to represent a person who is more highly exposed, and a "central tendency exposure" is used to represent the "average" person.

HOW TOXIC ARE THEY? (*Toxicity Assessment*)

Government agencies such as the Environmental Protection Agency use information from animal and human studies to determine the potential for chemicals to cause cancer or other health effects in people.

ARE THERE POTENTIAL HEALTH RISKS? (*Risk Characterization*)

The Risk Characterization describes the potential health risks and identifies which chemicals are causing the risk.

how community residents can help with risk assessment

Community residents can play an important part in the assessment of risk from a contaminated site. Information from community residents can help answer:

- Where are chemicals located on the site?
- How did the chemicals get there?
- What is the history of the site?
- What do people do on or near the site?
- Who is exposed to the site?
- How are people exposed to the site?
- Are vulnerable populations exposed to the site?



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This fact sheet provides a summary of information on the assessment of risks at contaminated sites.

The following websites serve as excellent references:

<http://www.epa.gov/superfund/>

<http://www.naccho.org/project78.cfm>

For more information please contact Suzi Ruhl, Director of the Environmental Law Institute's Center for Public Health and Law at ruhl@eli.org, or visit www.eli.org.

BROWNFIELDS SERVICE
APPROACH HISTORY
FEDERAL FACTS NEEDS
POPULATIONS LAW
CONTAMINATED AGENCIES
GOALS CLEAN UP PRIMARY
FACILITIES AMERICANS
CENTERS HEALTH QUALITY
ACCESS INDUSTRIAL LAW
SAFETY PREVENTITIVE SITES
PUBLIC PEOPLE ACTION
C O M M U N I T Y

cleanup

contaminated sites

Cleanup of contaminated sites can be complicated and expensive. In older, industrial cities, a number of sites may have long histories involving multiple businesses and activities over time. In some cases, a site's history may make it relatively easy to determine the cause of contamination and the cleanup that will be required. In the ideal case, whether the cleanup is complex or straight forward, the responsible party (or parties) steps forward or is forced to pay for the cleanup. In any case, it is both useful and important for residents to understand the process involved in making decisions about cleaning up sites in their community. And, it is important for community residents to have a basic awareness and understanding of the technologies that can be utilized to clean up contaminated sites. Not every approach is suitable for every site, and no approach is perfect.

This fact sheet provides an overview of the steps involved in the restoration and clean up of a contaminated site, including process, technologies, treatment and containment.

process

The process used to respond to a contaminated site includes the following steps:

- Site discovery;
 - Preliminary assessment of the contamination;
 - Investigation of the site;
 - Risk assessment;
 - Cleanup decision;
 - Site cleanup; and
 - Monitoring.
-

technologies

There are many technologies that can be used to cleanup contaminated sites. There are two main categories, treatment and containment. Sometimes a combination of treatment and containment is the best solution.

treatment

Treatment technologies use engineering approaches to reduce the volume, toxicity, or movement of the contaminants. Common treatment technologies include:

- Destroying wastes by burning them at high temperatures while controlling the fumes;
 - Allowing wastes to evaporate into an air stream that is then treated and released;
 - Injecting soils with micro-organisms that digest contaminants and result in less harmful materials; and
 - Treating contaminated groundwater to remove contaminants.
-

containment

Containment approaches build barriers that isolate contamination and keep it from coming into contact with people and the environment. Common containment technologies include:

- Constructing a protective barrier, or cap, over the contaminated area;
- Excavating the waste materials and disposing them in a securely designed landfill; and
- Building an underground barrier that blocks, diverts, or captures contaminated ground water.



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This fact sheet provides an overview of the steps involved in the restoration and cleanup of a contaminated site.

EPA'S website, <http://www.epa.gov/oswer/cleanup/index.html>, serves as an excellent reference and resource for cleanup programs.

For more information please contact Suzi Ruhl, Director of the Environmental Law Institute's Center for Public Health and Law at ruhl@eli.org, or visit www.eli.org.

Section II:
Community Health

health disparities

massachusetts

Racial and ethnic minority populations may be affected by serious diseases and other health conditions at far greater rates than other Americans. These populations include African Americans (Blacks), Hispanics, Native Americans, and Asian Americans/Pacific Islanders. It is said that these populations suffer from “health disparities.” An understanding of health disparities is important so that they can be eliminated.

what are health disparities?

Health disparities are the difference in health status between different groups. The groups can differ because of race, ethnicity, income, religion, immigrant status, and other factors.

Health disparities can be measured in many ways, such as the following:

- New cases of a disease (also know as “incidence”);
- Number of people overall with the disease (also known as “prevalence”);
- Deaths from a disease (also known as “morbidity”);
- Access to prevention, screening and treatment services;
- Increased burdens a disease causes; and
- Other health markers.

Factors such as income, education, and where a person lives can make the health disparities more intense.

what are health disparities in the U.S.?

There are major disparities in the burden of illness and death experienced by people of color in the U.S., as compared to the White population as a whole. Health disparities are seen in diseases such as asthma, cardiovascular disease, diabetes, infant mortality, and birth defects. According to the U.S. Department of Health and Human Services (HHS), the impact of health disparities includes:

- Life expectancy for the White population exceeds that of the African American population by 5.5 years; and
- Death rates for the Hispanic population are greater than for non-Hispanic Whites for four of the leading causes of death (chronic liver disease, diabetes, HIV, and homicide).

what are health disparities in massachusetts?

Differences in health status among racial and ethnic groups in Massachusetts have been identified. According to US Census 2000 data, they include:

- 21% of Blacks and 30% of Hispanics live below poverty;
- Hispanics are 185% more likely to be uninsured than Whites; Blacks are 101% more likely to be uninsured than Whites;
- Because of cost, Hispanics are 106% more likely not to seek health care than Whites, and Blacks are 81% more likely to not seek health care than Whites;
- Compared to Whites, Hispanic mothers are 195% more likely to receive inadequate prenatal care, and Black mothers are 182%; and
- Among youth, Hispanics have a 819% higher mortality rate due to homicide than whites; Black youths are 2156% higher.

why should health disparities be eliminated?

All people, regardless of race, ethnicity, geography, or economic class, deserve the best health status possible. They also deserve the best health and medical care possible. There is a need to increase efforts for prevention and treatment of health problems experienced by those that suffer from health disparities. Society as a whole is improved when all of its members, regardless of race, ethnicity, geography, and economic class, are healthy.



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This fact sheet provides a summary of information on health disparities in the state of Massachusetts.

The following websites also serve as excellent resources:

<http://www.healthgap.omhrc.gov/2004factsheet.htm>

<http://www.enddisparities.org/whatis.html>

For more information please contact Suzi Ruhl, Director of the Environmental Law Institute's Center for Public Health and Law at ruhl@eli.org or visit www.eli.org.

Capacity for Community Health Care

A major barrier to accessing health care is health care provider availability and distribution. In many communities, health care practitioners, such as physicians and dentists, are not available. In other areas, they are available but do not serve the low-income populations. The need for health care capacity in New Bedford, Massachusetts is documented by data and information maintained by the Massachusetts Department of Public Health. This information on health care needs can also be correlated to the availability of funding made available by the federal and state government to increase access to health care. An understanding of the program designations can clarify the need for health care in New Bedford and opportunities for meeting this need.

health professional shortage areas

The U.S. Department of Health and Human Services has programs to address the issue of access to health care. The federal agency works with the Massachusetts Department of Public Health to determine areas of the state that are shortage areas with regard to health care providers (primary care, dental or mental health). These areas are designated as Health Professional Shortage Areas (HPSA). This designation documents a shortage of health care providers as well as the existence of barriers to accessing care. These barriers include:

- Lack of public transportation;
- Travel time;
- Distance to the next source of undesignated care; and
- High poverty.

To be eligible for a designation, a geographic area or population group (e.g. a low income or migrant population) must have a physician to population ratio greater than 3000 to 1. In New Bedford, there are numerous census tract areas that are designated as HPSAs.

medically underserved areas and medically underserved populations

Medically underserved areas or populations (MUAs/MUPs) are measures used by the U.S. Department of Health and Human Services. These designations are determined by the Index of Medical Underservice (IMU). The IMU uses the following variables:

- Percent of the population below 100 percent of the Federal Poverty Level;
- Percent of the population over age 65;
- Infant mortality rate (5 year average); and
- Primary care physician to population ratio.

An IMU score of below 62 is required for designation. The lower the score is, the higher the level of need. In Bristol County and in New Bedford, there are numerous areas that are designated as MUAs or MUPs. Information regarding MUA's and MUPs can be found online at <http://bphc.hrsa.gov/databases/newmua/results.cfm>.

linking health care status to brownfields

It is useful to understand the location of brownfields sites compared to the health care designated areas (i.e. HPSA and MUA/MUPs). On the reverse side is a map, which shows this location. This information can be used to leverage brownfields redevelopment to address the health care needs of the people of New Bedford.



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New Bedford Community Health Status

The following data is from the Massachusetts Department of Public Health MassCHIP website. This data compares the prevalence rate (total cases of a disease in a population) or percent of persons with the condition from the city of New Bedford to the state rate (or percent). The health indicators data retrieved from the MassCHIP website shows that the residents of New Bedford have higher rates of many health problems than do the state residents as a whole. Of particular importance to community redevelopment are the high rates of lead poisoning, asthma discharges from hospitals, cancer deaths, and cardiovascular disease prevalence. All of these factors are important to the overall quality of life and environment.

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Demographic Data	Area Count	Area Percent	State Percent
Per Capita Income *		\$15,602	\$25,952
Population below 100% of poverty level *	18,553	20.2	9.3
Population below 200% of poverty level *	38,803	42.3	21.7
Children less than 18 years of age living below 100% of poverty line *	6,694	29.5	12
Unemployed persons age 16 and over	3,998	9.4	5.3
Persons under 18 years of age	23,327	24.9	23.6
Persons under 20 years of age	25,732	27.4	26.4
Persons age 65 years and over	15,648	16.7	13.6
White non-Hispanic persons *	79,066	84.3	83.9
Black non-Hispanic persons *	3,985	4.3	5.3
Hispanic persons *	9,576	10.2	6.8
Asian persons *	697	0.7	3.9
AFDC Medicaid Recipients	13,850	17.7	7.1
Multiple Assistance Unit Medicaid Recipients	615	1.9	1.2

Injury Indicators: New Bedford	Area Count	Area Age-adjusted Rate **	State Age-adjusted Rate **
Motor vehicle related injury deaths	13	12.9	8.8
Suicide	6	6.8	6.5
Homicide	5	5.7	2.4

Infectious Disease: New Bedford	Area Count	Area Crude Rate	State Crude Rate	Area Age-specific Rate ***	State Age-specific Rate ***
Newly diagnosed AIDS cases	31	33.1	11.1		
Cumulative AIDS cases	560				
Persons alive with AIDS	248	264.5	117.2		
AIDS and HIV-related deaths	15	16	3.9		
Tuberculosis	6	6.4	4.3		
Gonorrhea	50	53.3	50.6		
Chlamydia	160	170.6	163.7		
Gonorrhea, ages 15-19	10			161.6	189.5
Chlamydia, ages 15-19	54			872.8	841.2

Chronic Disease Indicators: New Bedford	Area Count	Area Age-adjusted Rate **	State Age-adjusted Rate **
Total deaths (all causes)	1,182	974.1	815.5
Total cancer deaths	246	213.7	202.4
Lung cancer deaths	67	59.8	54.9
Breast cancer deaths	17	25.1	26.9
Cardiovascular disease deaths	514	393.9	284.2

Hospital Discharges for Primary Care Manageable Conditions: New Bedford	Area Count	Area Age-adjusted Rate **	State Age-adjusted Rate **
Asthma	216	234.1	130.8
Angina	19	16.6	33.8
Bacterial pneumonia	583	530.8	346.6

Morbidity and Mortality Indicators: New Bedford	Area Count	Area Rate	State Rate	Area Age-specific Rate ***	State Age-specific Rate ***
Immediate risk of lead poisoning (blood lead levels 20-24 µg/dL in children ages 6 mos - 5 yrs)	8	1.6	0.7		
Lead poisoning cases (blood lead levels >=25 µg/dL in children ages 6 mos - 5 yrs)	10	2	0.6		
Total deaths, age less than 20	17			66.1	45
Injury-related deaths, age less than 20	3			11.7	12.2

Substance Abuse Indicators: New Bedford	Area Count	Area Crude Rate	State Crude Rate	Area Age-adjusted Rate **	State Age-adjusted Rate **
Admissions to DPH funded treatment programs	3,444	3672.9	1808.4		
Injection drug user admissions to DPH funded treatment program	1,320	1407.7	550.9		
Alcohol and other drug related hospital discharges	405	431.8	364.6		
Alcohol and other drug use deaths	25			27.6	20.4

In addition, The Massachusetts Cancer registry shows that from 1994-1998 New Bedford residents suffered from higher than expected rates of multiple myeloma, non-Hodgkin's lymphoma, cervical cancer, colon and rectal cancer, cancer of the esophagus, Hodgkin's disease, kidney and renal pelvis, larynx, leukemia, pancreas, and stomach cancer.

Notes:

Crude rates are expressed per 100,000 persons.

Lead poisoning rates are expressed per 1,000 children screened.

* The most recent population estimates (2000).

** Age-adjusted rates are expressed per 100,000 persons.

*** Age-specific rates are expressed per 100,000 persons in the specific age group.

Chronic Disease Objectives: New Bedford	Area Count	Area Age-adjusted Rate **	State Age-adjusted Rate **
3-01: Reduce the overall cancer death rate to no more more than 159.9 per 100,000 population. (Cancer: All types - Deaths (ICD 10 based))	246	213.7	202.4
3-02: Slow the rise in lung cancer deaths to achieve a rate of no more than 44.9 per 100,000 population. (Cancer: Lung - Deaths (ICD 10 based))	67	59.8	54.9
5-05: Reduce diabetes death rate to no more than 45 per 100,000 people. (Endocrine: Diabetes Mellitus - Deaths (ICD 10 based))	36	28.4	20.6
12-01: Reduce coronary heart disease deaths to no more than 166 per 100,000 population. (Circulatory Coronary Heart Disease - Deaths (ICD 10 based))	299	230.1	145.7
12-07: Reduce stroke deaths to no more than 48 per 100,000 population. (Circulatory: Cerebrovascular Disease - Deaths (ICD 10 based))	70	53.9	49.4
24-02a: Reduce hospitalizations for asthma among children under age 5 years to no more than 250 hospitalizations per 100,000 population. (Respiratory: Asthma - Hospitalization)	40	638.2	346.1
24-02b: Reduce hospitalizations for asthma among children and adults aged 5 to 64 years to no more than 77 hospitalizations per 100,000 population. (Respiratory: Asthma - Hospitalization)	146	203.3	105.6
24-02c: Reduce hospitalizations for asthma among adults aged 65 years and older to no more than 110 hospitalizations per 100,000 population. (Respiratory: Asthma - Hospitalization)	30	191.8	173.6
24-10: Slow the rise in deaths from chronic obstructive pulmonary diseases (COPD) among adults aged 45 and older to achieve a rate of no more than 60 per 100,000 people. (Respiratory: Chronic Lower Respiratory Diseases (CLRD), All - Deaths (ICD 10 based))	60	173.7	121.7



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community health centers

reducing disparities

Community health centers make important contributions to the health of people and the well-being of the communities they serve. These contributions range from health and medical care to economic revitalization of neighborhoods. An understanding of the role of community health centers is important so that the people and neighborhoods they serve can get the most benefits possible.

WHAT ARE COMMUNITY HEALTH CENTERS?

Community health centers are non-profit community-based organizations. They provide comprehensive primary and preventive health care nationally. This health care may include medical, dental, social and mental health services to anyone in need. They provide these health services regardless of the patient's medical status, ability to pay, or culture or ethnicity. "330" health centers receive federal funds through the Health Resources and Services Administration, Bureau of Primary Health Care.

WHAT MEDICAL SERVICES DO

COMMUNITY HEALTH CENTERS PROVIDE?

Community health centers serve children, families, low-income, uninsured and underinsured, high-risk populations, and the elderly. Community health centers promote good health through prevention, education, outreach, and primary medical/dental care. Types of services include:

- Adult Medicine
- Pediatrics
- Elder Care
- Nutrition/WIC
- Dental Care
- Immunizations
- Gynecology & Family Planning
- Social Services & Case Management
- Urgent Care
- Benefits Counseling
- Laboratory
- Translation Services
- Pharmacy Services
- Radiology
- Infectious Disease Management

role of community health centers in promoting health and reducing disparities

HOW DO COMMUNITY HEALTH CENTERS CONTRIBUTE TO THE HEALTH CARE SYSTEM?

Community health centers provide the “medical/dental” home for patients regardless of their ability to pay, language, race, ethnicity, or any other barrier to care. Community health centers work collaboratively with local hospitals and other medical/dental providers.

CONTRIBUTIONS TO ECONOMIC WELL-BEING OF THE COMMUNITY

In addition to improving the health of the people, community health centers also contribute to the economic vitality of a community. By improving the health of the people, health centers can help stimulate depressed economies of urban neighborhoods. They return millions of dollars to the community in goods, services, and taxes, as well as supporting jobs across all sectors. In New Bedford, this accounts for some \$15 million and support of approximately 270 jobs. The WIC program returns \$2.6 million in food vouchers to the community at large.

Community health centers also help with the shortage of health care professionals. Many health centers provide innovative education and job training. These programs include training for groups such as:

- Nutritionists
- Medical Assistants
- Physicians
- Nurses

Health centers are local businesses. They buy supplies and services from local firms.

National studies show that every dollar invested in community health centers provides an average savings of three dollars to the overall health care system. Much of this saving can be attributed to the active case management of patients, especially those with chronic diseases. Health center patients who participate in disease management programs are less likely to seek care in costly emergency rooms or require hospitalization. Also, because of their expanded urgent care hours and service sites, health care centers have made access easier for patients. This reduces unnecessary utilization of emergency rooms for routine primary care.

Ultimately, community health centers are a major contributor to the health and economic well-being of communities.



Environmental Law Institute is an independent, non-profit research and educational organization based in Washington, D.C. The Institute serves the environmental profession in business, government, the private bar, public interest organizations, academia and the press.

This fact sheet provides a summary of information on community health centers and their benefits.

For more information please contact Suzi Ruhl, Director of the Environmental Law Institute's Center for Public Health and Law at ruhl@eli.org or visit www.eli.org.



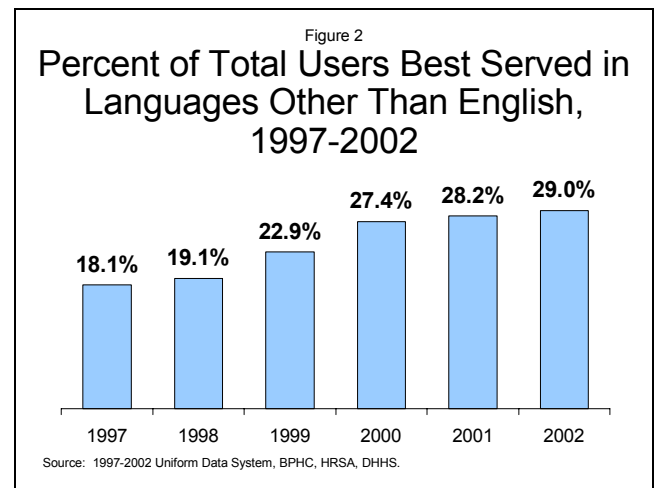
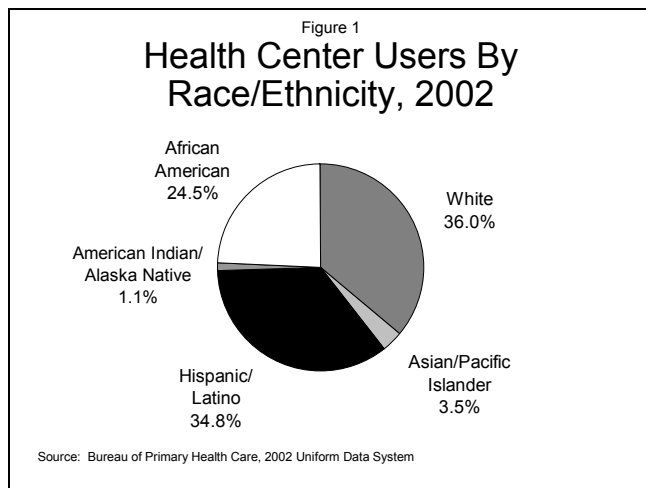
Health Centers' Role in Reducing Racial and Ethnic Health Disparities

HEALTH CENTERS' MISSION

The health centers program is committed to delivering care to the nation's underserved, a large proportion of whom are minorities. Health centers reduce or even eliminate racial and ethnic health disparities among their patients by providing comprehensive, affordable care that is responsive and customized to the low-income racial and ethnic minority communities they serve. In fact, the 2002 Institute of Medicine landmark report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, recognized the importance of health centers in increasing access to care and in improving health outcomes for all patients, especially minorities. Currently, 1000 community, migrant, and homeless health centers serve over 3,500 urban and rural communities in every state and territory.

WHO HEALTH CENTERS SERVE

Health centers are the family doctor and medical home for over 14 million people, 9 million of whom are people of color. Minorities are disproportionately represented among health center users. As Figure 1 shows, two-thirds of health center users in 2002 were members of minority groups, with Latinos making up the largest minority group at 35% of all patients and African Americans making up a quarter of all patients. Nationally, Hispanic/Latinos and African Americans each represent about 12% of the US population. A rising number of health center patients are best served in languages other than English. Figure 2 demonstrates that the number of health center patients who speak a primary language that is not English grew from 18% in 1997 to 29% in 2002 – an increase of 60%.



Under separate Bush Administration and Congressional initiatives to extend health center care to an additional 10 million patients, by 2006 health centers will be the family doctor and health care home for:

- Between 30% and 38% of all low-income Latinos;
- Between 30% and 36% of all low-income African Americans; and
- Between 12% and 15% of all low-income Asian/Pacific Islanders.

HOW HEALTH CENTERS ADDRESS DISPARITIES

All health centers are characterized by five unique federal grant requirements that are central to their mission and success in reducing or eliminating racial and ethnic health disparities. Health centers must be:

1. located in *high-need areas* that have been identified by the federal government as “medically underserved,” improving access for people who traditionally confront geographic barriers to health care.
2. able to provide *comprehensive* health and “enabling” services. They tailor their services to fit the special needs and priorities of their communities, and provide linguistically and culturally appropriate services.
3. *open to all* residents, regardless of income, with sliding scale fee charges for out-of-pocket payments based on an individual's or family's income and ability to pay.

4. governed by *community boards*, the membership of which must consist at least 51% of patients to assure responsiveness to local needs.
5. *follow rigorous performance and accountability requirements* regarding their administrative, clinical, and financial operations. Grantees are required to report to the federal government information each year on utilization, patient demographics, insurance status, managed care, prenatal care and birth outcomes, diagnoses, and financing.

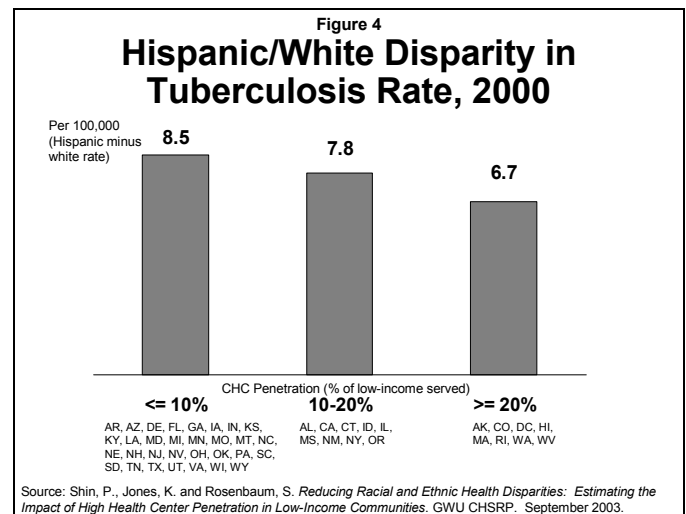
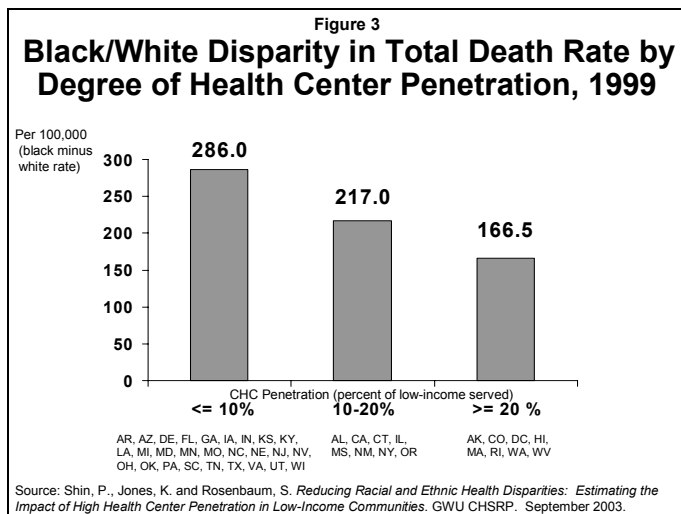
ELIMINATING DISPARITIES FOR CHRONIC CONDITIONS

Over 450 health centers nationwide are participating in an initiative that aims to improve health outcomes for chronic conditions among the medically vulnerable, particularly minorities. Known as the **Health Disparities Collaboratives**, and overseen by the federal Bureau of Primary Health Care, the initiative was designed to improve the skills of clinical staff, strengthen the process of care through the development of extensive patient registries that improve clinicians' ability to monitor the health of individual patients, and effectively educate patients on self-management of their conditions. More than 75,000 health center patients with chronic disease have been enrolled in electronic registries for diabetes, cardiovascular disease, asthma, depression, prevention, cancer, and HIV. By the end of 2003, nearly two-thirds of all health centers are expected to participate, marking significant progress towards meeting the federal goal of 100% participation by 2005.

The Collaboratives have led to improved health outcomes for registered health center users, helping to diminish the health gaps for racial and ethnic minorities as well as the poor in the U.S. As a result of their success, the Institute of Medicine commended health centers in another recent report, and recommended health centers as models for reforming the delivery of primary health care. The General Accounting Office also recently recognized the Collaboratives as a promising federal program targeting health disparities that should be expanded.

ESTIMATING HEALTH CENTERS' IMPACT ON REDUCING DISPARITIES

A recent major report from the George Washington University found that greater levels of health center penetration (defined as the proportion of low-income individuals served) were associated with significant and positive reductions in minority health disparities on the state level along several key health indicators, even after controlling for other factors, such as uninsured rate and per capita income. Figure 3 shows that as health center penetration into states' medically underserved communities increases, the difference in states' black/white disparities in overall mortality decline significantly, from 286 to 166 additional black deaths per 100,000 lives. Figure 4 illustrates that as penetration increases, the difference in states' Hispanic/white disparities in tuberculosis cases decline from 8.5 to 6.7 additional Hispanic tuberculosis cases per 100,000.



THE IMPORTANCE OF MEDICAID

The George Washington University study also found that Medicaid alone has little direct impact on health disparities. However, because Medicaid is essential for health centers' ability to generate revenue required for long-term expansion and stability, as well as important for providing patients with better access to comprehensive services not available through health centers, it is the combination of customized and supported health care and comprehensive health insurance that may most effectively reduce health disparities.

PUBLIC GOAL FEDERAL
MEDICAL CONGRESS FACTS
NEEDS POPULATIONS LAW
TEAM LEGISLATURE GOALS
GOVERNANCE INTEGRATE
UNDERSTANDING CENTERS
LOCATION HEALTH ENGAGE
ACCESS PROGRAMS
HEALTH ENVIRONMENT
INITIATIVES PUBLIC PEOPLE
A C T I O N
C O M M U N I T Y

laws

health care

Hhealth centers have been in existence for over 35 years. They were initially established to provide access to quality preventive and primary health care for the medically under-served people of the United States. These people include the millions of Americans without health insurance, low income working families, members of minority groups, rural residents, homeless persons, and agricultural farm workers. Congressional action with respect to health centers is discussed below.

federal community health laws: an overview

PUBLIC HEALTH SERVICE ACT, SECTION 330

Original statutory authorization for the Community Health Centers Program. The act defines the term “community health center” as meaning under the Public Health Service Act, an entity which provides primary health services and referral to providers of supplemental health services for all residents of the area it serves. The act also authorizes the Secretary to make grants to public and nonprofit private entities for projects to plan and develop community health centers which will serve medically under-served populations. Senator Kennedy sponsored the bill, which became Public Law 94-63 in July of 1975.

health care safety net amendments of 2002

Re-authorizes and amends the Community Health Centers, National Health Service Corps and the Rural Health Outreach and Network Development Grant Programs.

Creates new programs including the Rural Emergency Medical Service Training and Equipment Assistance program, Healthy Communities Access Program, and a program authorizing Mental Health Services via Telehealth.

Authorizes funding for Community Health Centers until 2006 and provides grants to communities to better organize and deliver care to the poor and uninsured.

Retains the four core statutory requirements for all health centers:

- Targeting of resources on high need areas;
- Assurance of openness to all regardless of ability to pay;
- Access to comprehensive primary care services; and
- Governance by the community being served;

Strengthens the Community Health Center program through a variety of approaches, including loan guarantees to acquire, build, lease or modernize clinics. It also makes available mental health and substance abuse treatment at the centers.

Identifies four types of Section 330 Health Centers: Community and Migrant Health Centers; Health Care for the Homeless Programs; Healthy Schools, Healthy Communities Program; and Public Housing Primary Care Programs.

Clarifies the eligibility of certain farm workers and homeless individuals to receive services at 330funded health centers.

Creates a new Healthy Communities Access program (at Section 340 of the PHS Act) to develop community health care delivery systems that coordinate care for uninsured or underinsured individuals. Grants may be made to entities that represent a consortium of local providers (including local health centers, disproportionate share hospitals, public health agencies, and other providers that have traditionally served the uninsured and underserved);

Allows for grants to establish telehealth resource centers, and for expanded delivery of health care services in rural areas.

federal health center regulations (42 CFR Ch I, Part 51c)

Regulates project grants authorized under Section 220 of the Public Health Services Act.

Project funds awarded may be used for any of the following:

- Acquiring and modernizing existing buildings;
- Obtaining technical assistance to develop the management capability of the project;
- Delivering health services;
- Insurance for medical emergency and outofarea coverage; and
- Providing training related to the provision of health services provided or to be provided by the project to the staff and governing board.



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This fact sheet provides a summary of information on federal community health laws.

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SERVICE PHHC FEDERAL
MEDICAL FEDERAL FACTS
NEEDS POPULATIONS LAW
INSURANCE AGENCIES
GOALS CONGRESS PRIMARY
FACILITIES AMERICANS
CENTERS HHS HEALTH
QUALITY ACCESS HRSA LAW
SAFETY PREVENTITIVE CHC
PUBLIC PEOPLE ACTION
C O M M U N I T Y

agencies

Health Care

The primary federal agency governing the Nation's public health is the United States Department of Health and Human Services (HHS). As the guardian of the federal health care system, the mission of the HHS is to "lead Americans to better health, safety, and well-being." Within HHS, there are agencies, bureaus, and programs that address the delivery of health care to the American people.

within HHS is the Health Resources and
Services Administration (HRSA)

MISSION: Improve and expand access to quality health care for all.

GOAL: Move toward one-hundred percent access to health care and zero health disparities for all Americans.

VISION: Assure the availability of quality health care to low income, uninsured, isolated, vulnerable and special needs populations and meet their unique health care needs.

STRATEGY: Eliminate barriers to care; eliminate health disparities; assure quality of care; improve public health and health care systems.

within HRSA is the

Bureau of Primary Health Care (BPHC)

MISSION: To increase access to comprehensive primary and preventive health care and to improve the health status of under-served and vulnerable populations.

GOAL: Continuously improve the quality of patient care, service delivery, the health care workforce, and health outcomes in the delivery systems that BPHC supports through use of quality management systems.

OBJECTIVES: The BPHC strives to achieve the following objectives:

- Continuous Improvement through developing systematic processes that measure and improve performance through team building, data collection, analysis, and feedback;
- Performance Measurement through setting the best practices, guidelines, standards, and benchmarks for the delivery of health care to under-served and vulnerable populations; and,
- Customer Satisfaction through designing systematic evaluations to ensure that customer's expectations of service, performance and results are met.

within BPHC is the

Community Health Center (CHC) Program

HISTORY: CHC's were first funded by the Federal Government as part of the War on Poverty in the mid 1960s. By the early 1970s, about 100 neighborhood health centers had been established under the Economic Opportunity Act (OEO).

MISSION: Continuously improve the quality of patient care, service delivery, the health care workforce, and health outcomes in the delivery systems that BPHC supports through use of quality management systems.

AUTHORITY: Currently, the CHC Federal grant program is authorized under section 330 of the Health Centers Consolidation Act of 1996.

ACTIVITIES: Provide primary and preventive health care, outreach, and dental care; Provide essential ancillary services such as laboratory tests, X ray, environmental health, and pharmacy services; Provide as health education, transportation, translation, and prenatal services; Provide links to welfare, Medicaid, mental health and substance abuse treatment, WIC, and related services; Provide access to a full range of specialty care services.

FUNDING: In Fiscal Year (FY) 1996, the community and migrant health center appropriation was consolidated to include the homeless and public housing programs. Funding for CHCs is approximately 85 percent of the consolidated appropriations, which were \$1.62 billion in FY 2004.



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This fact sheet provides a summary of information on federal health care agencies.

The U.S. Department of Health and Human Services' website, www.hrsa.gov serves as an excellent reference for health care agencies.

For more information please contact Suzi Ruhl, Director of Environmental Law Institute's Center for Public Health and Law at ruhl@eli.org, or visit www.eli.org.

access advocacy
african american
asian american bone
density cancer children
cardiovascular
cholesterol chronic
disease churches
collaboration community
cultural competence
DIABETES diet disability
disparities
diversity education
environment evaluation
ethnicity exposure faith
community financial
need goals grassroots
health insurance
healthcare providers
heart disease higher
rates healthy hispanic
american hypertension
HIV/AIDS insurance
infant mortality
initiative intervention
language barriers LEAD
life expectancy lifestyle
low birthweight
literacy malnutrition
medicare/medicaid men
mental health native
american nutrition
obesity partnership
overweight pollution
prenatal prescription
drugs prevention quality
of care race risk factors
RURAL schools self-
esteem socioeconomics
solutions stereotypes
surveillance technology
teenagers tobacco
tracking transportation
treatment TRUST urban
underutilization
unequal care under-
representation
violence vaccinations
water quality welfare policy
women wellness white
workplace diversity

Health Disparities: A General Overview

What are health disparities?

- Health disparities are differences that occur by gender, race and ethnicity, education level, income level, disability, geographic location and/or sexual orientation.
- Some health disparities are unavoidable, such as health problems that are related to a person's genetic structure.
- However, other health disparities are potentially avoidable, especially when they are related to factors such as living in low-income neighborhoods or having unequal access to medical care and information.

Some examples of health disparities include:

- **Lack of physicians in rural areas.** Residents of rural areas have less contact and fewer visits with physicians.² Although 20 percent of Americans live in rural areas, only 9 percent of the nation's physicians practice in rural areas.¹
- **Unequal treatment for minorities.** Research has shown that even when racial/ethnic minorities are insured at levels comparable to whites, they tend to receive a lower quality of health care for the same health conditions.³
- **Lack of diversity among health care providers.** Lack of diversity among health care providers can be a barrier to communication. Minorities make up 28 percent of the U.S. population but only 3 percent of medical school faculty, 16 percent of public health school faculty and 17 percent of all city and county health officers.⁴
- **Low health literacy.** People with poor health literacy may have problems communicating

with their physician, reading instructions and labels on medicines, completing medical and insurance forms and understanding many other aspects of health care. Over half of the people living in the United States are affected by health literacy.⁵

- **Lack of insurance.** Uninsured women receive fewer prenatal services and needed care than women with insurance.⁶
- **Exposures to environmental risks.** People in low-income communities often have less healthy surroundings than people in other communities. Low-income communities are often located in or near polluting industrial areas and have cheap older housing where lead paint and pests are a threat.⁷
- **Poverty and cancer.** The American Cancer Society estimates that the cancer survival rate of poor individuals is 10 to 15 percent lower than those of other Americans. Low income women are less likely to have mammography and Pap test screening.²

1. "National Healthcare Disparities Report," US Dept Health and Human Services, December 2003, Prepublication Copy.
2. "Rural Poor and the Medically Underserved & Cancer," Intercultural Cancer Council, <http://iccnetwork.org/cancerfacts/ICC-CFS6.pdf>
3. "Closing the Gap 2003: Racial and Ethnic Disparities in Health Care," Alliance for Health Reform, October 2003, www.allhealth.org.
4. <http://www.cfah.org/factsolife/vol8no3.cfm>
5. <http://www.chcs.org/resource/pdf/hl1.pdf>
6. March of Dimes 2003 Data Book for Policy Makers, "Maternal, Infant, and Child Health in the United States."
7. <http://www.ejhu.org/disparities.html>



Racial/Ethnic Disparities

access advocacy
 african american
 asian american bone
 density cancer children
 cardiovascular
 cholesterol chronic
 disease churches
 collaboration community
 cultural competence
 DIABETES diet disability
 disparities
 diversity education
 environment evaluation
 ethnicity exposure faith
 community financial
 need goals grassroots
 health insurance
 healthcare providers
 heart disease higher
 rates healthy hispanic
 american hypertension
 HIV/AIDS insurance
 infant mortality
 initiative intervention
 language barriers LEAD
 life expectancy lifestyle
 low birthweight
 literacy malnutrition
 medicare/medicaid men
 mental health native
 american nutrition
 obesity partnership
 overweight pollution
 prenatal prescription
 drugs prevention quality
 of care race risk factors
 RURAL schools self-
 esteem socioeconomics
 solutions stereotypes
 surveillance technology
 teenagers tobacco
 tracking transportation
 treatment TRUST urban
 underutilization
 unequal care under-
 representation
 violence vaccinations
 water quality welfare policy
 women wellness white
 workplace diversity

Racial and ethnic minorities experience higher rates of a variety of health concerns than other populations. For example:

- **Life expectancy.** African-American men's life expectancy is 68.2 years compared to 74.8 years for white men. African-American women's life expectancy is 74.9 years compared to 80 years for white women.⁴
- **Overall health.** In 2000, nearly 8 percent of whites were considered to be in fair or poor health compared to nearly 13 percent of Hispanics/Latinos, nearly 14 percent of African-Americans and more than 17 percent of Native Americans.¹
- **Infant mortality rates.** Infant death rates among African-Americans are more than double that of whites. Infant death rates among American Indians and Alaska Natives are almost double that of whites.⁵
- **Cancer.** The death rate for all cancers is 30 percent higher for African-Americans than for whites. African-American women have a higher death rate from breast cancer than white women and Vietnamese American women have a cervical cancer rate that is nearly five times the rate for white women.⁵
- **HIV/AIDS.** The death rate from HIV/AIDS for African-Americans is more than seven times that for whites.⁵
- **Violence.** African-Americans' rate of homicide is six times that for whites.⁵ Alaska Native women, ages 20 to 44, are 16 times more likely than white women to be hospitalized for assault injuries.⁶ American Indians have disproportionately high death rates from unintentional injuries.⁵
- **Diabetes.** Hispanics are nearly twice as likely to die from diabetes as whites.⁵ American Indians and Alaska Natives have diabetes rate that is more than twice that for whites.⁵

Some potential reasons for ethnic and/or racial health disparities

- **Unequal treatment.** Research has show that even when racial/ethnic minorities are insured at levels comparable to whites, they tend to receive a lower quality of health care for the same health conditions.¹
- **Poverty.** In 2001, more than half of Hispanics/Latinos, African-Americans, and Native Americans were considered poor or near poor.¹ Low-income patients are more likely to experience difficulties or delays accessing health care due to financial or insurance reasons.¹⁰

- **Insurance.** In 2002, 20.2 percent of African-Americans and 32.4 percent of Hispanics/Latinos were uninsured compared to 11.7 percent of whites.¹ In addition, minorities who have insurance are almost three times as likely as whites to be covered by publicly funded programs such as Medicaid and some health care providers refuse or restrict the number of Medicaid patients they will see.¹
- **Stereotyping.** Research has shown that doctors rated African-Americans patients as less intelligent, less educated, more likely to abuse drugs and alcohol and more likely to fail to comply with medical advice.¹
- **Communication barriers.** Minorities are underrepresented in the health care industry.¹ Thirty-three percent of Hispanics report having difficulty communicating with their doctors compared to 23 percent of African-Americans, 27 percent of Asian Americans and 16 percent of whites.⁹
- **Frequency of care.** Almost half of all Hispanics do not have a regular doctor compared to nearly a third of all African-American and only a fifth of whites.⁹ African-Americans and Hispanics are less likely than whites to make routine office or outpatient visits to health care providers.¹⁰
- **Access to care.** African-Americans are nearly one and a half times more likely to be denied authorization through their managed care system for care after an emergency room visit than whites.¹ Almost 30 percent of African-Americans and Hispanics report having little or no choice in where to seek care compared to 16 percent of whites.¹

1. "Closing the Gap 2003: Racial and Ethnic Disparities in Health Care," Alliance for Health Reform, October 2004, www.allhealth.org.
2. "Fact Sheet: Health Centers Role in Reducing Racial and Ethnic Disparities," National Association of Community Health Centers, September 2003
3. "Tracking Report: The Insurance Gap and Minority Health Care," Center for Studying Health System Change, June 2002
4. "Public Policy & Aging Report: The Landscape of Health Disparities Among Older Adults," Keith E. Whitfield & Mark Hayward, National Academy on an Aging Society, Summer 2003. www.agingociety.org
5. www.healthypeople.gov.
6. http://www.hss.state.ak.us/dph/profiles/injuries/PDFs/ID_overview.pdf
7. "Issue Brief: Unequal Access: African American Medicare Beneficiaries And the Prescription Drug Gap," Center for Studying Health System Change, July 2003
8. <http://www.ahcpr.gov/research/apr02/0402RA15.htm#head5>
9. <http://crchd.nci.nih.gov/chd/barriers.html>
10. "National Healthcare Disparities Report," US Dept Health and Human Services, December 2003, Prepublication Copy.





HEALTHY PEOPLE 2010

Office of Disease Prevention and Health Promotion
 U.S. Department of Health and Human Services
 200 Independence Avenue, SW, Room 738-G
 Washington, DC 20201
 202-205-8611

What Is *Healthy People 2010*?

Healthy People 2010 is a comprehensive set of disease prevention and health promotion objectives for the Nation to achieve over the first decade of the new century. Created by scientists both inside and outside of Government, it identifies a wide range of public health priorities and specific, measurable objectives.

Overarching Goals:

1. Increase quality and years of healthy life
2. Eliminate health disparities

Focus Areas

- | | |
|--|---|
| 1. <i>Access to Quality Health Services</i> | 15. <i>Injury and Violence Prevention</i> |
| 2. <i>Arthritis, Osteoporosis, and Chronic Back Conditions</i> | 16. <i>Maternal, Infant, and Child Health</i> |
| 3. <i>Cancer</i> | 17. <i>Medical Product Safety</i> |
| 4. <i>Chronic Kidney Disease</i> | 18. <i>Mental Health and Mental Disorders</i> |
| 5. <i>Diabetes</i> | 19. <i>Nutrition and Overweight</i> |
| 6. <i>Disability and Secondary Conditions</i> | 20. <i>Occupational Safety and Health</i> |
| 7. <i>Educational and Community-Based Programs</i> | 21. <i>Oral Health</i> |
| 8. <i>Environmental Health</i> | 22. <i>Physical Activity and Fitness</i> |
| 9. <i>Family Planning</i> | 23. <i>Public Health Infrastructure</i> |
| 10. <i>Food Safety</i> | 24. <i>Respiratory Diseases</i> |
| 11. <i>Health Communication</i> | 25. <i>Sexually Transmitted Diseases</i> |
| 12. <i>Heart Disease and Stroke</i> | 26. <i>Substance Abuse</i> |
| 13. <i>HIV</i> | 27. <i>Tobacco Use</i> |
| 14. <i>Immunization and Infectious Diseases</i> | 28. <i>Vision and Hearing</i> |

What Are the Leading Health Indicators (LHIs)?

The Leading Health Indicators are 10 major health issues for the nation.
 The LHIs are:

- | | |
|---------------------------------------|----------------------------------|
| 1. <i>Physical Activity</i> | 6. <i>Mental Health</i> |
| 2. <i>Overweight and Obesity</i> | 7. <i>Injury and Violence</i> |
| 3. <i>Tobacco Use</i> | 8. <i>Environmental Quality</i> |
| 4. <i>Substance Abuse</i> | 9. <i>Immunization</i> |
| 5. <i>Responsible Sexual Behavior</i> | 10. <i>Access to Health Care</i> |

Community Health Survey



Issue	Rating
Quality of educational opportunities	
Availability of health care services	
Responsive Faith community	
Access to volunteer activities	
Quality public safety services	
Ability to join civic organizations	
Access to quality social services	
Availability of jobs/jobs readiness	
Available arts, cultural events	
Access to city and county services	
Quality neighborhoods	
Accessible transportation	
Availability of senior services	
Commitment to positive human/race relations	
Positive community image	
Availability of youth activities	
Accessible programs for persons w/ disabilities	
Accessible quality child care	
Violence	
Crime	
Cancer	
Teen Pregnancy	
Prenatal care access	
Substance abuse	
Heart disease	
Preventive medical care	
HIV/AIDS	
Elder care access	
Overall health care access	
Physician access	
Pollution	
Health Education	
Alcohol misuse	
Sexually transmitted disease	
Mental health	
Nutrition	
Tobacco use	
Weight control	
Sedentary life style	

Section III:
Brownfields Redevelopment
and Public Health

PUBLIC GOAL FEDERAL
MEDICAL CONGRESS FACTS
NEEDS POPULATIONS LAW
TEAM LEGISLATURE GOALS
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ACCESS PROGRAMS
HEALTH ENVIRONMENT
INITIATIVES PUBLIC PEOPLE
A C T I O N
C O M M U N I T Y

community health

redevelopment

The social determinants of health and the social determinants of community vitality are similar. A healthy population requires disease prevention and health promotion. A healthy community requires jobs, education, transportation, affordable housing, a safe environment, and health care. Neither can thrive without the other. Brownfields redevelopment offers an opportunity to revitalize communities that are beleaguered with pollution, poverty, and disease. Connecting health and brownfields offers a new strategy to reduce pollution and disease disparity by leveraging the Nation's commitment to redevelopment of contaminated sites with its commitment to community health.

HEALTH: A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. -*World Health Organization*

PUBLIC HEALTH: Organized community efforts aimed at the prevention of disease and promotion of health. -*National Institute of Medicine*

BROWNFIELDS REDEVELOPMENT: Multi-stakeholder approach to environmentally assess properties, prevent further contamination, safely clean-up polluted sites, and design plans for re-use. -*U.S. Environmental Protection Agency*

the health plight of racial and ethnic minorities

The health status of racial and ethnic minorities is often lower than for other groups, and minorities experience higher rates of morbidity and mortality in many of the leading health conditions. African American, Native American, and Hispanic racial and ethnic groups suffer disparities in major health indicators, such as disease incidence, mental illness, morbidity and mortality. The most striking health disparities result in shorter life expectancy as well as higher rates of most cancers, birth defects, infant mortality, asthma, diabetes, and cardiovascular diseases.

the environmental plight of racial and ethnic minorities living on brownfields

The low_income and minority populations living in brownfields areas often bear the double burden of pollution and disease. They are exposed to contamination from a variety of sources, including abandoned industrial sites and leaking underground storage tanks. People of color and low_income who suffer a disproportionate burden of disease are often exposed to greater levels of contamination than the majority population. This is evidenced by anecdotal data, Toxic Release Inventory Data, and studies performed by environmental justice commissions. This same population coincides with many of the people who live on existing or future brownfields.

access to health care and health education on brownfields sites

According to the American Public Health Association, one of the major causes of these health disparities is the lack of access to quality health care. People living in brownfields areas are often not getting health care from the current system. Even though health care may be available, it is often not accessible. Hurdles include transportation, third party payment opportunities, cultural sensitivities, and racial history. Without access to health care, people living near brownfields are left without the ability to address health issues affecting their community.

revitalizing communities through brownfields redevelopment and public health

Benefits of linking public health with brownfields redevelopment extend to individuals, families, and the community. Benefits include:

- Providing health services to disadvantaged people; maintaining a healthy workforce;
- Attracting health related businesses (e.g., pharmacies) to the brownfields area; and,
- Accessing federal community health resources for medically underserved areas;

Community revitalization can be sustained by integrating public health with brownfields redevelopment. Maximizing the inherent synergy in contaminated site redevelopment and public health, can:

- Increase understanding of the community health issues associated with brownfields redevelopment.
- Increase awareness of opportunities and resources available to promote community health as part of brownfields redevelopment; and
- Strengthen community engagement in brownfields redevelopment.

Environment and health are intimately connected both to each other and to the fabric of communities. Drawing artificial boundaries around them thwarts true community revitalization. Individual, family and community health can be better achieved by engaging diverse stakeholders in addressing the environmental, behavioral, cultural and social determinants of health. Brownfields redevelopment provides the opportunity for this progress toward sustainable communities.



For more information please contact Suzi Ruhl, Director of Environmental Law Institute's Center for Public Health and Law at ruhl@eli.org, or visit www.eli.org.

Environmental Law Institute is an independent, non-profit research and educational organization based in Washington, D.C. The Institute serves the environmental profession in business, government, the private bar, public interest organizations, academia and the press.

PUBLIC GOAL FEDERAL
MEDICAL CONGRESS FACTS
NEEDS POPULATIONS LAW
TEAM LEGISLATURE GOALS
GOVERNANCE INTEGRATE
UNDERSTANDING CENTERS
LOCATION HEALTH ENGAGE
ACCESS PROGRAMS
HEALTH ENVIRONMENT
INITIATIVES PUBLIC PEOPLE
A C T I O N
C O M M U N I T Y

center for public health and law

environmental law institute

The **Brownfields and Public Health Initiative** is the Environmental Law Institute's major new national campaign to integrate public health with economic development, environmental protection and good governance. ELI seeks to improve the well-being of low-income citizens and people of color in communities affected by brownfields by taking advantage of the window of opportunity presented by recent passage by the U.S. Congress of the Small Business Liability Relief and Brownfields Revitalization Act.

the brownfields and public health initiative

PROJECT GOAL : To produce tangible community health benefits for low-income citizens and people of color by leveraging economic opportunities provided by brownfields redevelopment in their communities.

INTEGRATIVE APPROACH : A dynamic, integrative approach is the best way to address the complex web of health and environmental concerns faced by residents of communities eligible for brownfields redevelopment. An integrative approach takes advantage of the inherent synergy between environmental and health issues. ELI's paradigm, now being applied in Massachusetts and Florida, is based on the understanding that intrinsically connected problems are best approached in a coordinated way.

the brownfields and public health initiative

FIVE ACTION STEPS :

1. *Assess Community Environmental Health*

ELI will facilitate a community team to assess environmental health challenges and develop a comprehensive plan to address them with a vision and clear goals. ELI will conduct community workshops and provide leadership, educational materials and technical assistance.

2. *Collaborate with Existing Health Providers*

ELI will identify current health care capacity, assess gaps in the area of the brownfields site, provide models for approaching the problem and identify opportunities.

3. *Engage Local Government and the Private Sector*

ELI will work with its partners to engage local government agencies and private sector leaders to help insure “buy in” at all levels of the community.

4. *Create Future Land Use to Improve Community Health*

ELI will facilitate a community decision about desired future land use, develop a business plan to achieve it and assist with implementation and follow-through.

5. *Identify and Provide for Long-Term Sustainability*

ELI will identify and develop long-term funding mechanisms (e.g. brownfields worker training) and link with environmental health tracking.

PROJECT SUPPORT :

Florida Brownfields Association
Elizabeth Ordway Dunn Foundation
National Oceanic and Atmospheric Administration
U. S. Environmental Protection Agency

ABOUT ELI : ELI, a global leader in protecting the environment through law, policy and management, provides information services, advice, publications, training courses, seminars, research programs and policy recommendations to engage and empower environmental and community leaders. ELI is widely recognized for expertise in state and federal brownfields programs. Its on-line Brownfields Center (www.brownfieldscenter.org) brings together a wide array of resources designed to increase collaboration to ensure tangible benefits to community health and the environment.

PROJECT LEADERSHIP : B. Suzi Ruhl, Director, Public Health and Law Program, ELI; Before joining ELI, Suzi founded and served as President of the Legal Environmental Assistance Foundation (LEAF) a Florida-based organization that protects human health and the environment with impact at local, national and international levels. She holds degrees from the University of Florida (B.A.), Samford University (J.D.) and the University of Alabama at Birmingham (M.P.H.).



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This fact sheet provides a summary of information on ELI's Center for Public Health and Law.

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best management practices for achieving community health and revitalization through brownfields redevelopment

best practices

There is a growing recognition at the national, state and local levels of the complexity of health, economic, and environmental issues faced by neighborhoods eligible for redevelopment of property with perceived or actual contamination. While the focus of such redevelopment has been on economic development, there remains an urgent opportunity to integrate public health into the core mission of community revitalization in order to achieve environmental justice. This opportunity is based on the recognition that the social determinants of health and the social determinants of community revitalization are similar. When the root causes and social determinants of ill health, such as poverty, lack of education and employment, adequate housing, and contamination are addressed, the success of brownfields redevelopment is enhanced.

Despite recent progress in improving public health in the United States, serious problems remain. Minority and low-income populations continue to bear a disproportionate burden of disease and pollution. Further, low-income and minority Americans are often exposed to greater amounts of contamination than the majority population. For example, low-income, African American children have higher than normal levels of lead in their blood. In addition, working class families are more likely than other groups to live near landfills, incinerators, and hazardous waste treatment facilities. The same neighborhoods with high risk for environmental contamination are also severely lacking in health services to treat residents who become sick. Services that are available are often beyond the reach of many low-income residents who lack health insurance, transportation to access existing health capacity, or who suffer from cultural or language barriers.

An unprecedented opportunity for communities bearing the dual burden of disease and pollution is made possible by Congress and the Bush Administration's recognition of the importance of public health in the federal brownfields redevelopment, and the need to expand health care to under-served communities. The *Small Business Liability Relief and Brownfields Revitalization Act* promotes the inclusion of health effects monitoring as a means of ensuring measurable improvements to health through brown FIELDS. At the same time, the *Health Care Safety Net Amendments Act* appropriated \$1.34 billion for community health centers. Promoting the inherent synergy in these two programs presents an important opportunity to achieve tangible benefits for disadvantaged people living in brownfields areas and thereby ensure successful redevelopment.

best management practices

Leveraging the connections between brownfields redevelopment and public health presents an opportunity to engage communities living in contaminated areas. Public health is a priority concern for community members, and provides a positive vehicle to engage diverse stakeholders in complex community problem solving. Efforts to address public health through brownfields also teaches community members how to participate effectively in government decision-making. Several hurdles preclude community members' positive involvement in resolving complex environmental health problems.

COMMUNITY MEMBERS

often lack understanding of the legal, technical, and health issues associated with brownfields and their redevelopment;
are generally unaware of the parameters governing site remediation and the opportunities to address environmental, economic, and health concerns; and
are often limited in their ability to form alliances with other stakeholders from the government and private sector due to their lack of understanding of procedural processes made available through brownfields redevelopment.

To ensure effective participation by community members, the following elements of community participation and community health and revitalization should be considered.

COMMUNITY PARTICIPATION

Provide opportunities for front-end participation by people living in the brownfields area
Provide training and capacity building for community organizations
Ensure access to technical and legal expertise to facilitate participation in decision-making
Present appropriate information to community groups so that they can make informed decisions
Work with many community groups covering a broad range of issues
Utilize a democratic, open process
Initiate public dialogue on the issues

COMMUNITY HEALTH AND REVITALIZATION

Prepare social and community impact statements
Work with others on the root causes and social determinants of community health
Ensure that public health is part of the redevelopment efforts
Provide technical expertise about health effects of redevelopment for communities
Work with the community to find alternative sources of capital investment that can support community opportunities and address local needs



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This fact sheet provides a summary of information on best management practices for achieving community health and revitalization through brownfields redevelopment.



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COMMUNITY ENVIRONMENTAL HEALTH PROGRAM FACT SHEET

LEAF
Legal Environmental
Assistance Foundation



What is the Community Environmental Health Program?

-  A program that promotes public health and reduces disease disparity in blighted low-income, communities of color. It was developed by community advocates to eliminate the disproportionate burden of disease and pollution borne by minority communities.
-  The Florida Legislature established the Community Environmental Health Program in 1998, pursuant to Section 381.1015, Florida Statutes. It includes the Community Environmental Health Advisory Board, pilot projects and community health centers. LEAF prepared the model legislation creating these programs.

Why is Community Environmental Health Important to All Floridians?

-  The Community Environmental Health Program is a nationally recognized model that integrates public health with environmental protection, economic development and governance to ensure healthy communities for all people.
-  Community environmental health improves the delivery of health care to disadvantaged people by bringing attention to their specific needs and cultural sensitivities.
-  Florida's Community Environmental Health Program produces community health surveys, educational materials, health fairs with free screening, among other tools. It promotes linkages among community members, health departments, private medical care professionals and others.

Who is the Community Environmental Health Advisory Board?

-  The Community Environmental Health Advisory Board (CEHAB) oversees the Community Environmental Health Program, identifying community health needs and determining which services and approaches would best meet those needs.
-  Members of the Community Environmental Health Advisory Board, appointed by the Florida Department of Health, and based on recommendations from Florida legislators, are from Belle Glade, Clearwater, Ft. Lauderdale, Miami, Pensacola, Tallahassee, Tampa and West Palm Beach. A majority of the members are low-income, people of color, thus assuring front end participation by those who live with the policies made by government.

<<OVER>>

Where are the Community Environmental Health Projects and Centers?



The Community Environmental Health Program helps Floridians throughout Florida. The CEHABoard has given seed grants to support integrative health efforts in:

- Belle Glade
- Clearwater
- Ft. Lauderdale
- Miami
- Pensacola
- Riviera Beach
- St. Petersburg

In addition to the seed grants sponsored by the CEHABoard, two pilot community health centers in Clearwater and Pensacola have been established.



In Clearwater, the Greenwood Community Health Resource Center, located on the first State of Florida designated brownfield, was formed to provide clinical services directly to low-income people in a contaminated area, who were not being serviced by traditional health care providers. By locating the Center within the neighborhood, itself, a trust was developed between the Center and the local residents, which encouraged residents typically mistrustful of the health care community to actually seek health care services.

Additionally, the Center is beginning to consider the integration of additional related community services, such as job training on related environmental matters, such as lead-based paint.



In Pensacola, the Escambia County Health Department and a local community group, Citizens Against Toxic Exposure (CATE), have formed a cooperative health service effort to bridge cultural and racial fault lines that inhibited the use of traditional health services by minority populations. This effort was established by the Legislature to address studies showing that low income, minority populations are subject to higher rates of cancer and exposure to contaminants.

Services provided through this cooperative effort include:

- health education to citizens
- environmental health education to private health care providers
- preventative health care physicals
- routing for treatment.



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In Pursuit of Environmental Justice through Community Environmental Health

Over the last seven years the Florida Legislature has passed the following laws, which were all based on **LEAF's** model legislation and accomplished through LEAF's partnership with environmental justice communities. This listing shows **LEAF's** strategy of working from the top-down through state level policy anchored by the bottom-up participation of people most affected by pollution.

- 1994** The Environmental Equity and Justice Commission was established; documented environmental justice and health abuses and responsible government policies; and issued a series of recommendations that are being implemented into law.
- 1995** Institute of Public Health at Florida A&M University (FAMU) is designated -- the first at a historically black university, focusing on environmental health and justice. The first graduating class in 1999 sent 18 students trained in public health from a community perspective out into the workforce.
- 1996** Cleanup standard for petroleum underground storage tanks that is 100 times more protective of people's health than the federal standards is set in Florida and requires accountability for the actual circumstances of exposure. This standard has subsequently been extended to apply to dry cleaning facilities and brownfields despite strong, annual industrial lobbying to rescind the standard.
- 1997** Florida Birth Defects Registry is set up within the Department of Health. Florida had been the only large state without such a registry. It begins the building of an official record which can link pollution in the environment to birth defects.

The same year, the Florida Brownfield Redevelopment Act included statutory language on public (community-level) participation and notification, pollution prevention, and proper site remediation.

- 1998** The Environmental Equity and Justice Act established a Community Environmental Health Program within the Florida Department of Health; a Community Environmental Health Advisory Board (made up of a majority of people living in polluted neighborhoods); and a Center for Environmental Equity and Justice at FAMU. All formally acknowledge the linkage between environment and health and the disproportionate burden on people of color.
- 1999** The Florida Community Health Protection Act facilitates community-based health services and education initiatives to prevent disease and promote health. It creates six pilot projects in blighted low-income communities.

Funding to build a model community health clinic in the state's first designated brownfield area is also appropriated.

<<OVER>>

2000 Funding to establish a second model community health clinic is secured. This clinic represents a new model of partnering between the local health department and the community threatened by contaminants.

Requirements for mapping and registering all brownfield sites are imposed.

commhealthlegisum2000

August 5, 2004

Legal Environmental Assistance Foundation, Inc. (LEAF), 1114 Thomasville Road, Suite E, Tallahassee, FL 32303-6290; (850) 681-2591; leaf@leaflaw.org; www.leaflaw.org .

LEAF is membership-based, environmental organization dedicated to protecting people's health from pollution. Founded in 1979, LEAF focuses its efforts in Alabama, Florida, and Georgia.

Health Care Models

People living near brownfields sites often lack access to health care. The people also are faced with diseases and other health problems. They suffer high rates of disease, such as diabetes and cancer, infant mortality and low birth weight babies. The brownfields and public health initiative seeks to increase access to health care for the people living near brownfields by integrating public health with brownfields redevelopment. Several models for accomplishing this have been developed.

These include:

collaboration with federally qualified health centers

E.G. GREATER NEW BEDFORD COMMUNITY HEALTH RESOURCES CENTER (GNBCHC)

The City of New Bedford, Massachusetts, is a national Brownfields Showcase Community. The City's brownfields sites are predominantly located in medically under-served areas. Accordingly, the GNBCHC, the City, community based organizations, academia and the National Oceanic and Atmospheric Administration are working together to expand health care to the populations living near brownfields sites.

independent free health centers

E.G. GREENWOOD COMMUNITY HEALTH RESOURCES CENTER

As part of the City of Clearwater's Brownfields Assessment Demonstration Pilot, a free health center was built on a former gas station site. The Center is located in one of the city's most disadvantaged areas. It provides immunizations, physicals, tests and screenings, flu shots, and counseling to residents of the neighborhood.

multi-party medical facilities

E.G. JOHNNIE RUTH-CLARKE/ MERCY HOSPITAL

The City of St. Petersburg, Florida, redeveloped a six acre site as part of its brownfields redevelopment. Through this effort, a former African American Hospital that is designated a Local Historic Landmark, was converted and combined with a federally qualified health center to create a multi-purpose medical complex that serves low-income, people of color in South St. Petersburg.

diabetes education and research centers

E.G. GILA RIVER INDIAN COMMUNITY

Located near Phoenix, Arizona, the Gila River Indian Community is redeveloping a brownfields site to include a diabetes education, treatment and research center. The prevalence of diabetes in the community is one of the highest in the world. The Center will also employ 40-50 people.



For more information on health care models and related issues, please contact Suzi Ruhl, Director of Environmental Law Institute's Center for Public Health and Law at ruhl@eli.org or visit www.eli.org.

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achieving brownfields and public health in st. petersburg, florida

st. petersburg

The Johnnie Ruth-Clarke/Mercy Hospital Brownfields Project offers the unprecedented accomplishment of integrating public health with economic redevelopment, environmental protection, and good governance through brownfields redevelopment. It represents an expansive effort to improve the health of the community while concurrently producing economic benefits through employment in the health care field.

background on the project

The City of St. Petersburg has redeveloped a six acre site as part of its brownfields redevelopment. Through this redevelopment, a former African American hospital has been converted and combined with a Federally Qualified Health Center to create a multipurpose medical complex that serves low-income, people of color in the City of St. Petersburg.

The Johnnie Ruth-Clarke Center is a Federally Qualified Health Center, which has been operational since 1985 and has received Bureau of Primary Health Care 330(e) support funding since 1984. It was originally a project supported by the Lakeview Presbyterian Church and the African American community, and located in the church. The basement of the church was converted into an adult clinic, and the Fellowship Hall was remodeled and converted into a pediatric and obstetric clinic. The building is in a flood zone, with flooding of the clinic a common occurrence during the rainy season. Additionally, because the building was not originally intended to be a medical clinic, design constrains limited the effectiveness and efficiency of the operation. In the brownfields area is the Mercy Hospital, a former African American hospital, that is now designated a Local Historic Landmark under the City of St. Petersburg Historic Preservation Ordinance.

Through brownfields and City redevelopment, the Johnnie Ruth-Clarke Health Center has been relocated and combined with the Mercy Hospital, which has been restored and renovated to create a modern primary health care facility. The Mercy Hospital is also being used as a community resource and a learning center, and is contiguous to the new Johnnie Ruth-Clarke Medical Center.

improved delivery of health care through brown fields redevelopment

The population in South St. Petersburg, where the Health Center is located, is experiencing a disproportion in health issues in comparison to the County and State. For example, mortality due to diabetes in South St. Petersburg is over double the state and county average. The new primary health care facility is expected to improve health outcomes in the low-income, African American community in a number of ways, including expanded access, modern facilities, and increased services.

With its increased capacity, the health care facility will now address:

Behavioral health (e.g. family therapy, adolescent therapy, crisis therapy);
Community resources (e.g. medicaid services, case management);
Dental care (e.g. preventative, general, emergency); and
Patient education (e.g. nutritional services, health library, screenings, immunizations).

The Health Center has 80 employees and 5 volunteers, and projects the staff level to reach 150 within the next 24 months. The center is serving 125 patients per day and projects future growth to reach 300 per day.

The success of the project is due in large part to the cooperative efforts of multiple parties. Partners in the project include the Johnnie Ruth-Clarke Health Center, Community Health Centers of Pinellas, Inc., the City of St. Petersburg and Bayfront Health System which includes Bayfront Medical Center, Florida A&M University School of Pharmacy, and the University of Florida School of Dentistry. The project provided the vehicle for collaboration between both traditional and unique allies to join forces and leverage resources from multiple areas.

Ultimately, the Johnnie Ruth-Clarke/Mercy Hospital Brownfields Project has increased health care capacity through brownfields redevelopment. In this manner, it continues to provide tangible benefits to the people who bear the dual burden of pollution and disease. As such, it serves as a exemplary brownfields project model.



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This fact sheet provides a summary of information on one city's success with achieving community health and revitalization through brownfields redevelopment.

For more information please contact Suzi Ruhl, Director of Environmental Law Institute's Center for Public Health and Law at ruhl@eli.org or visit www.eli.org.

Specialty Clinic Model

Brownfields redevelopment can produce end uses that provide tangible health benefits to people living near the brownfields sites. The end uses can take a variety of forms. One type is the Specialty Clinic. This type of clinic responds to a particular health concern (e.g. diabetes, asthma) of the neighboring population. To illustrate this model, redevelopment of an UST field site on the Gila River Indian Community is provided.

LOCATION/COMMUNITY PROFILE: The Gila River Indian Community (GRIC) is located near Phoenix, Arizona. It was established in 1859 by Executive Order and covers 640 square miles. The area is home to 14,000 members, mostly from the Akimel O-odham (Pima) and Pee Posh (Maricopa) groups. The site was owned and operated by the Catholic Phoenix Diocese and encompassed a church, convent, monastery, and boarding school. In 1997, most of the property was reverted back to the tribe, and part was turned into a Boys and Girls Club of America. The Roman Catholic Church and Boys and Girls Club continues to operate the ten-acre site.

NATURE OF CONTAMINATION: Located on the site were Underground Storage Tanks (UST) and a former landfill. Both the soil and groundwater were contaminated. The groundwater contains benzene at concentrations exceeding the Safe Drinking Water Act maximum contaminant levels.

SITE ASSESSMENT AND CLEANUP: The groundwater contamination is planned for removal. This will improve the private wells which serve the Gila River Indian Community members. In 1998, two 1,000-gallon underground storage tanks were removed from the site. During removal, a release was found from one of the tanks. A Phase II site assessment was performed. The samples resulted in levels below Arizona DEQ soil remediation levels. A vapor barrier is being installed.

END USE: With the cleanup of the site, the Gila River Indian Community plans to build a Diabetes Education Center (DEC) to benefit the community. The Center will conduct outreach on diabetes as well as research. The prevalence of diabetes in the Community is one of the highest in the world. The Diabetes Education and Research Center is expected to employ 40-50 people full time. The DEC will be crucial for preventing and treating diabetes within the Tribe.

SOURCES OF FUNDING: Funding for the project was obtained from multiple sources. Funding for the site assessment was secured through the UST fields grant program in the amount of over \$170,000. \$6 million was raised for the Diabetes Education and Research Center. Funds were obtained by the Gila River Indian Community's Health and Social Services office from the U.S. Congressional appropriations provided by Speaker of the House Dennis Haskert (Illinois) and the GRIC Tobacco Tax Office.

CONTACTS: Mike Daniel, GRIC, (520)562-2234 and Steven Linder, EPA, (415)972-3369



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November 2003

Partnership Initiative For Reusing Petroleum Brownfields

Background

Over the past several years EPA, along with many state and local leaders, made a commitment to sustainable development and preserving green space by cleaning up and making available for reuse contaminated properties, particularly those in economically distressed communities. EPA is helping to move toward this goal in many ways, such as providing grant money to state and local governments for assessment and cleanup. EPA awarded over 500 brownfields grants to communities to address properties contaminated with hazardous substances and 50 USTfields grants to states to address petroleum contaminated brownfield properties. As a result of the new Brownfields Law, many more petroleum contaminated sites will now be assessed, cleaned up, and available for reuse. The new Brownfields Law requires that 25 percent of the grant money available each year be awarded for petroleum brownfields. These grants provide seed money that will help states and communities more quickly address low risk petroleum contaminated properties with potential for reuse.

Partnership Strategy

EPA's goal is to increase cleanup and reuse opportunities for petroleum contaminated brownfields properties by creating partnerships with public and private entities that will help to prevent the creation of new brownfields and lead to the reuse of existing brownfields. We will build on the successful public/private sector partnerships EPA developed for other programs.

One of the key elements of a successful reuse of a brownfield site is to create a demand for the property. In order to accomplish this, EPA must ultimately bring the public and private property owners together with the public and private end-users who may want to use the property. EPA is reaching out to the public and private sector including: end users; developers; property owners; federal, state and local organizations; tribes; and non-profits who are interested in establishing partnerships to promote the cleanup of brownfield properties and to stimulate the reuse of these properties.

EPA's strategy is to partner with public and private sector organizations who may be interested in reusing petroleum contaminated properties. Our goal is to get large and small public and private entities to incorporate into their every day decision making a greater emphasis on the environment, particularly on ways to promote cleanup and reuse of former petroleum brownfields properties. We envision developing at least one partnership in each of the following four reuse scenarios this year: (1) retail/commercial; (2) residential; (3) ecological/recreational (e.g. parks); or (4) community/public purposes (e.g., fire stations).

The Agency believes there are numerous benefits from such partnerships. Under formal and/or informal agreements between EPA and public and private partners, each partner would offer something different to promote reuse of former petroleum brownfields properties.

For example, EPA could provide some assistance to address obstacles and challenges (e.g., administrative/process, liability, information and funding) to cleaning up and reusing these properties including:

Environmental Information: Property listing of communities with USTfields pilots and brownfields grants as well as available assessment and cleanup information.

Tools to Facilitate Cleanup and Reuse: EPA has developed, and is continuing to develop, enforcement and compliance tools to help clarify liability issues that facilitate cleanup and subsequent redevelopment of a site. These tools may include exploring the potential of Ready for Reuse determinations for property owners who are not eligible for federal brownfields grants but are nevertheless interested in clean up and reuse of petroleum brownfields properties; comfort letters; multi-site cleanup agreements.

Facilitation: Provide federal assistance to promote cleanup and reuse of petroleum contaminated brownfields properties. Often developers and end users identify timing as a crucial factor in siting decisions. EPA can work at the federal, state, and local level to identify process issues and help resolve them quickly. Showcasing models of past success can provide valuable lessons for communities new to reuse/revitalization.

Public Recognition: EPA could provide corporate-wide or site-specific recognition to partners who make a commitment to reusing petroleum contaminated properties. EPA will promote this public recognition to all stakeholders so the award becomes meaningful and desired by other entities as a symbol of their good corporate citizen attitude.

EPA will work with each partner to make a public commitment to cleaning up and reusing formerly contaminated petroleum brownfields properties. For example, a private sector partner could make reuse of petroleum contaminated brownfields properties a significant factor in its market strategy and commit to reusing formerly contaminated properties. Similarly, public or private sector partners could share information on obstacles they faced and solutions they used to clean up and reuse petroleum contaminated brownfields properties.

Through such partnerships, EPA and public and private organizations would work together to help build community good will, promote the organization's commitment to a cleaner environment and the preservation of green spaces for future generations, exemplify public-

private sector cooperation, demonstrate high ethics and nationalism, and represent a demonstrated reinvestment in America.

Retail/Commercial Partnership

EPA is looking for private sector partnerships with companies willing to promote retail/commercial reuses by locating and opening new operations on petroleum contaminated brownfields properties. Through a partnership with EPA, private sector entities could commit to a company-wide goal of locating a certain percentage of its planned new shops/businesses on petroleum contaminated brownfields properties. Alternatively, the company may identify site-specific petroleum contaminated brownfield properties and commit to locate new operations on the specified sites.

EPA could provide public recognition (either corporate-wide or site-specific applauding the commitment to reuse petroleum contaminated brownfields properties and help preserve green space), participate in a grand opening, provide an award such as a plaque that could be displayed in the store, and highlight the success story on EPA's web page. EPA could also help facilitate the cleanup at specific sites identified by our partners to help remove bureaucratic barriers, facilitate quicker cleanup and reuse, and meet the needs of all stakeholders involved.

Residential/Housing Partnership

To promote residential development and housing, EPA is working with Housing and Urban Development (HUD), Habitat for Humanity International, and other associations. EPA is looking to develop an expanded partnership to further promote residential/housing reuse. Under this partnership, EPA and its partners would work together to leverage public and private resources, streamline petroleum contaminated brownfield site cleanups which target abandoned gas stations, and create an opportunity to reuse these properties for public and private housing.

Under this partnership EPA, HUD, and other stakeholders would work together to accelerate the cleanup and revitalization of 15-30 abandoned gas station sites in two or more cities that have been identified as an environmental priority and land use target. This partnership could be completed in phases. In the first phase, EPA, HUD, and other stakeholders would designate certain communities as residential partnership pilots after considering among other things, site characteristics, market conditions, and stakeholder interest and involvement. In the second phase, EPA and HUD would work with other stakeholders to facilitate federal coordination and integrate cleanup and revitalization activities to help ensure timely cleanup and reuse. In the third phase, EPA working with each of the partners, would evaluate the success of the pilot for future application.

Ecological/Recreational Partnership

EPA has an established partnership with the Wildlife Habitat Council (WHC) to promote ecological/recreational reuse at petroleum contaminated brownfields properties. WHC is committed to facilitating the ecological/recreational reuse of petroleum contaminated properties. WHC provides design expertise to maximize the ecological benefit of the reuse and can bring together all the key parties in a community to help reuse petroleum contaminated properties for parks, wetlands, and other ecological and recreational uses.

EPA wants to expand this partnership to other private and public sector entities to focus on abandoned gas stations and other petroleum contaminated lands. Public and private sector partners could invest in communities by reusing abandoned gas stations and other brownfields properties for ecological/recreational purposes.

Public Partnership

Since petroleum brownfields grants are a new source of funding for state and local governments, EPA would like to build broader partnerships with state and local governments as well as site-specific partnerships to assist in the cleanup and reuse of abandoned petroleum contaminated brownfield properties for all four reuse scenarios. Under such partnerships, EPA, states, and local entities would transfer lessons learned from experienced communities to those just beginning to assess their petroleum contaminated brownfields properties, as well as explore opportunities to leverage resources from EPA brownfields grants, state petroleum trust funds, and the private sector.

EPA is also looking to promote the reuse of formerly contaminated petroleum brownfield properties for public purposes, such as police and fire stations, libraries or other public uses by building on EPA's successful USTfields program. For example, at the USTfields pilot in Trenton, New Jersey, EPA, the New Jersey Department of Environmental Protection, the New Jersey Hazardous Discharge Site Remediation Fund, and the City of Trenton worked together to clean up 1.5 acres of petroleum contaminated soil and construct a new fire station at the site. EPA wants to establish partnerships with interested state, local, and private sector partners to replicate this success at other properties addressed under an USTfields pilot and at properties addressed by future petroleum brownfields grant recipients.

For More Information

Contact Steven McNeely at 703-603-7164 or mcneely.steven@epa.gov for more information about partnerships for reusing petroleum brownfields properties.

Section IV:
Resources

EPA Funding Sources

brownfields assessment grants

Assessment grants provide funding for a grant recipient to inventory, characterize, assess, and conduct planning and community involvement related to brownfield sites.

AWARD: An eligible entity may apply for up to \$200,000 to assess a site contaminated by hazardous substances, pollutants, or contaminants (including hazardous substances comingled with petroleum) and up to \$200,000 to address a site contaminated by petroleum. Applicants may seek a waiver of the \$200,000 limit and request up to \$350,000 for a site contaminated by hazardous substances, pollutants, or contaminants and up to \$350,000 to assess a site contaminated by petroleum. Such waivers must be based on the anticipated level of hazardous substances, pollutants, or contaminants (including hazardous substances comingled with petroleum) at a single site. Total grant fund requests should not exceed a total of \$400,000 unless such a waiver is requested. Due to budget limitations, no entity may apply for more than \$700,000.

MATCH : No matching share required.

TIME : The performance period for these grants is two years.

ELIGIBILITY: Local governments, Land clearance authorities, Government entities created by State legislatures, Regional Councils, Redevelopment agencies, and Tribes.

PRIORITIES : Projects that: stimulate availability of other funding, stimulate economic development, facilitate the reuse of exiting infrastructure, preserves space for non-profit use, meets the needs of population and resource deficient communities, reduces threats to the health and welfare of people.

brownfields cleanup revolving loan fund grants

A major component of the Brownfields Economic Redevelopment Initiative is the award of pilot cooperative agreements to States (including U.S. territories), political subdivisions (including cities, towns, and counties), and Indian tribes to capitalize Brownfields Cleanup Revolving Loan Fund (BCRLF). The purpose of the pilots is to enable States, political subdivisions, and Indian tribes to make low interest loans to carryout cleanup activities at brownfields properties.

AWARD : Awards of up to \$1 million per eligible entity.

MATCH : 20% Matching Share required.

ELIGIBILITY : States, political subdivisions, and Tribes that have established and can demonstrate the progress already made in the assessment, cleanup and revitalization of brownfields in the community. Proposals from coalitions, formed among eligible entities, also are permitted to apply, but a single eligible entity must be identified as the legal recipient.

PROPERTIES : Use of BCRLF loan funds is limited to brownfields properties that have been determined to have an actual release or substantial threat of release of a hazardous substance. Loans may also be used at sites with a release or substantial threat of release of a pollutant or contaminant that may present an imminent or substantial danger to public health or welfare. BCRLF loans may not be used for activities at any site: (1) listed (or proposed for listing) on the National Priorities List; (2) at which a removal actions must be taken within six months; or (3) where a federal or state agency is planning or conducting a response enforcement action.

PRIORITIES : Same as in Brownfields Assessment Grants

brownfields cleanup grants

Cleanup grants provide funding for a grant recipient to carry out cleanup activities at brownfield sites.

AWARD : An eligible entity may apply for up to \$200,000 per site. Due to budget limitations, no entity should apply for funding cleanup activities at more than five sites. These funds may be used to address sites contaminated by petroleum and hazardous substances, pollutants, or contaminants (including hazardous substances comingled with petroleum).

MATCH : Cleanup grants require a 20 percent cost share, which may be in the form of a contribution of money, labor, material, or services, and must be for eligible and allowable costs (the match must equal 20 percent of the amount of funding provided by EPA and cannot include administrative costs). A cleanup grant applicant may request a waiver of the 20 percent cost share requirement based on hardship.

ELIGIBILITY : An applicant must own the site for which it is requesting funding at time of application or demonstrate the ability to acquire title. The performance period for these grants is two years.

PRIORITIES : Same as in Brownfields Assessment Grants

job training and workforce development grants

These Grants will bring together community groups, job training organizations, educators, labor groups, investors, lenders, developers, and other affected parties to address the issue of providing environmental employment and training for residents in communities impacted by Brownfields.

AWARD : The Brownfields Job Training Grants will each be funded up to \$200,000 over two years. EPA's Brownfields Program is an organized commitment to help communities revitalize Brownfields properties both environmentally and economically, mitigate potential health risks, and restore economic vitality to areas where Brownfields exist.

MATCH : No matching share required.

ELIGIBILITY : EPA, other federal agencies, local job training organizations, community colleges, labor groups, Tribes, states, cities, and towns.

PRIORITIES : Projects that develop longterm plans for fostering workforce development through environmental training, ensure the recruitment of trainees from socioeconomically disadvantaged communities, provide quality workertraining, and allow local residents an opportunity to qualify for jobs developed as a result of Brownfields efforts.

For more information, please contact Suzi Ruhl, Director of Environmental Law Institute's Center for Public Health and Law at ruhl@eli.org, or visit www.eli.org.



Environmental Law Institute is an independent, non-profit research and educational organization based in Washington, D.C. The Institute serves the environmental profession in business, government, the private bar, public interest organizations, academia and the press.

There are numerous grant opportunities available to leverage other funding to support health care access. A select number of grants are listed according to program area.

HRSA Discretionary Authorities and Programs
BUREAU OF HEALTH PROFESSIONS
Field Experiences In Public Health Nursing In State And Local Health Departments For Baccalaureate Nursing Students (BHNBN)
Training In Primary Care Medicine And Dentistry (DRPC)
Dental Public Health Residency Training Grants (DPHT)
Podiatric Residency Training In Primary Care (PODPC)
Basic Nurse Education And Practice Grants (BNEP)
Nurse Anesthetist Traineeships (NATR)
Advanced Education Nursing Traineeships (AENT)
Nursing Workforce Diversity Grants (NWD)
Advanced Education Nursing Grants (AENP)
Geriatric Nursing Knowledge & Experiences In Long Term Care Facilities For Nursing Students (BNEP)
Health Careers Opportunity Program (HCOP)
Centers Of Excellence (COES)
Basic/Core Area Health Education Centers (BAHEC)
Model State-Supported Area Health Education Centers (MAHEC)
Health Administration Traineeships And Special Projects (HATR)
Public Health Traineeships (PHTR)
Geriatric Education Centers (GECS)
Geriatric Training For Physicians, Dentists, & Behavioral & Mental Health Professionals (GTPD)
Geriatric Academic Career Awards (GACA)
Quentin N. Burdick Program For Rural Interdisciplinary Training (QBRH)
Allied Health Projects (AHPG)
Chiropractic Demonstration Project Grants (CHIRO)
Grants To States For Loan Repayment Programs (SLRP)
Cooperative Agreement For A Regional Center For Health Workforce Studies (RCHWS)
SPECIAL PROGRAMS FOR INDIVIDUALS
NHSC Scholarship Program (NHSCS)
National Health Service Corps Loan Repayment Program (NHSCL)
Faculty Loan Repayment Program (FLRP)
Scholarships For Disadvantaged Students (SDS)
Nursing Education Loan Repayment Program (NELRP)

BUREAU OF PRIMARY HEALTH CARE
Community And Migrant Health Centers (CMHS)
Health Care For The Homeless (HCH)
Public Housing Primary Care (PHPC)
Healthy Schools, Healthy Communities (HSHC)
New Delivery Sites And New Starts In Programs Funded Under The Health Centers Consolidation Act (NDSCS)
Increase In Medical Capacity In Programs Funded Under The Health Care Consolidation Act Of 1996 (IMCHC)
National Health Center Technical Assistance Cooperative Agreement (NAT)
Increase In Mental Health And Substance Abuse, Oral Health, Care Management, And Pharmacy Services In Programs Funded Under The Health Centers Consolidation Act Of 1996 (IMHSA)
Radiation Exposure Screening And Education Program (RESEP)
Community Access Program (CAP)
Integrated Services Development Initiative/Shared Integrated Management Information Systems (IS)
State Primary Care Associations Supplemental Funding For Managing Health Center Growth And Quality (PCO)

HIV/AIDS BUREAU
AIDS Education And Training Centers' National Clinicians' Consultation Center (AETCC)
Grants For Coordinated Services And Access To Research For Children, Youth, Women And Their Families (CSCYW)
Funding For Early Intervention Services Grants: Existing Geographic Service Areas (EIEGS)
HIV Services Planning Grants (SPG)
Ryan White Care Act Capacity Building Grants (RWCBG)
Special Projects Of National Significance - Models Of Comprehensive Care For Caribbeans Living In The United States (SPCCL)
Special Projects Of National Significance - HIV Prevention Initiatives In Primary Care Settings (SPPCS)
Telehealth Grant Program (THGP)

MATERNAL AND CHILD HEALTH BUREAU
Genetic Services - Grants To Support Comprehensive Medical Care For Cooley's Anemia/Thalassemia (GSCAT)
Promoting Integration Of State Health Information Systems And Newborn Screening Service Systems For Monitoring And Ensuring Quality Services To Newborns And Children With Or At Risk For Heritable Disorders-Cooperative Agreement (ISNSS)
National Oral Health PolicyCenter (OHSD)
Integrated Health And Behavioral Health Care For Children, Adolescents And Their Families - Implementation Grants (IHBHC)
State Maternal & Child Health Early Childhood Comprehensive Systems Grants (SECCS)
Transitioning Healthy Child Care America Programs (THCCA)
Leadership Development For Implementation Of Systems Of Care For Children And Youth With Special Health Care Needs (CICS)
Screening For Multiple Behavioral Risk Factors During The Preconception Through Postpartum Period (SMBRF)
SPRANS Community-Based Abstinence Education Project Grants (CBAE)
New Investigators In Maternal & Child Health Research: Dissertation Awards (RDA)
Maternal And Child Health Research Program (MCHR)
Maternal And Child Health Leadership Education In Developmental-Behavioral Pediatrics (BPT)
Maternal And Child Health Centers For Leadership In Communication Disorders Education (CDT)
Leadership Education Excellence In Maternal And Child Health Nursing (NURT)
Leadership Education Excellence In Maternal And Child Health Nutrition (NUTT)
Maternal And Child Health (MCH) Centers For Leadership In Public Health Social Work Education (SWT)
Continuing Education And Development Collaborative Office Rounds (CECOR)
HRSA/MCHB Doctoral Support Training Program: Awards For Enhancement Of Epidemiology Applied To MCH (EPI)
Healthy Tomorrows Partnership For Children Program (HTPC)
State Systems Development Initiative, Maternal And Child Health Services Federal Set-Aside Program (SSDI)
Emergency Medical Services For Children (EMSC) Partnership Demonstration Grants (EMSCP)
Emergency Medical Services For Children (EMSC) Regional Symposium Supplemental Grants (EMSCS)
Traumatic Brain Injury (TBI) State Implementation Grants (TBII)
Traumatic Brain Injury (TBI) State Planning Grants (TBIP)
Traumatic Brain Injury (TBI) Post-Demonstration (TBIPD)
Poison Control Centers Stabilization And Enhancement Grant Program (PCCSE)
Poison Control Centers Stabilization And Enhancement Grant Program, Financial Stabilization Supplemental Grants (PCCFS)



Eliminating Health Disparities
NATIONAL PUBLIC HEALTH WEEK
April 5–11, 2004
www.apha/nphw.org

Racial/Ethnic Health Disparities

Statistics and Solutions



Statistics

Racial and ethnic minorities experience higher rates of a variety of health concerns than other populations. For example, in 2000, nearly 8 percent of Whites were considered to be in fair or poor health compared to nearly 13 percent of Latinos, nearly 14 percent of African-Americans and more than 17 percent of Native Americans. Infant mortality rates among African-Americans are more than double that of Whites and Latinos are nearly twice as likely to die from diabetes as Whites.

Some potential reasons for ethnic and/or racial health disparities include communication barriers, lack of access to care, lower income levels and lack of insurance. In addition, research has shown that even when racial/ethnic minorities are insured at levels comparable to Whites, they tend to receive a lower quality of health care for the same health conditions.

Solutions

Communities across the country are moving from statistics to solutions to eliminate environmental health disparities. Examples of these solutions include:

- **Lumetra: Viva la Vida! (Live Your Life!) ■ San Francisco, CA**

This program's goal is to increase awareness of diabetes among Latino Medicare beneficiaries through educational materials, media campaigns and coordination with community organizations and health care providers. Materials include a bilingual diabetes self-management booklet and a bilingual fact sheet about Medicare coverage of diabetes supplies and services. *For more information, contact Ana Perez at (415) 677-2142.*

- **Inova Health System: Hepatitis Campaign Among Korean Americans ■ Fairfax, VA**

To increase the number of Korean Americans screened and immunized for Hepatitis B, physicians and nurses from participating faith communities join this program to provide screenings and immunizations to Korean American congregants.

- **Centers for Disease Control and Prevention: REACH 2010 Program ■ Atlanta, GA**

REACH 2010 is designed to eliminate racial and ethnic health disparities in the following six priority areas: cardiovascular disease, immunizations, breast and cervical cancer screening and management, diabetes, HIV/AIDS, and infant mortality. The program supports community-based coalitions in building partnerships, training lay individuals to deliver health messages, improving the delivery of health care services and building sustainability within communities, working with faith-based organizations, and influencing state policy to improve the health of the community. *For more information, contact Sakeena Smith at (770) 488-5426 or visit: <http://www.cdc.gov/reach2010>.*

- **La Buena Salud: Idaho Hispanic Wellness Initiative ■ Boise, ID**

This program works to address health issues facing Idaho Hispanics including obesity, tobacco use, injury and violence, access to health care and chronic illnesses. Student teams and a mobile screening unit are driven to three



Communities
Moving from
Statistics to
Solutions

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Continued



rural Hispanic farm worker communities three times per week to provide wellness screening/health promotion services. These teams participate in an interdisciplinary orientation on cultural competency prior to weekly service delivery. *For more information, contact Linda Powell at (208) 336-5533 Ext. 235 or visit: <http://www.mtnstatesgroup.org>.*

- **CDC's National Immunization Program: Racial and Ethnic Adult Disparities Immunization Initiative (READII)**

This project focuses on raising influenza and pneumococcal immunization rates among African-American and Hispanic seniors. READII is a demonstration project with sites in Chicago, Milwaukee, San Antonio, Rochester, New York, and 19 counties in Mississippi. Tactics include supplying vaccines to providers, incorporating Medicare beneficiaries in the immunization registry and placing standing orders in nursing homes and provider offices. *For more information, contact Tamara Kicera at (404) 639-1860 or visit: <http://www.cdc.gov/nip>.*

- **Centers for Healthy Hearts and Souls: Diabetes Support Groups ■ Pittsburgh, PA**

This program works to improve diabetes outcomes through support groups run by doctors and nurses biweekly that include the sharing of experiences, group problem-solving, education about label reading and portion control, stretching sessions, video vignettes for discussion, topical presentations, games, contests and connections to other programs. *For more information, contact Julia Hart, RN, at (412) 371-3282 or visit: <http://www.healthyheartsandsouls.com>.*

For more information about programs addressing racial/ethnic disparities and other solutions to health disparities, please visit www.nphw.org.

Section V:
Glossary

PUBLIC GOAL FEDERAL
BROWNFIELDS TOXICITY
MANAGEMENT EXPOSURE
RISK ASSESSMENT ENGAGE
POPULATIONS LAW TEAM
EXPSOURE GOALS PUBLIC
GOVERNANCE INTEGRATE
REDEVELOPMENT RISK
LHEALTH ENGAGE PUBLIC
DISPARITIES PROGRAMS
HEALTH ENVIRONMENT
TOXICOLOGY ACTION
C O M M U N I T Y

glossary

brownfields and public health

BROWNFIELDS : Real property, the expansion, redevelopment, or reuse of which may be complicated by the presence or potential presence of a hazardous substance, pollutant, or contaminant.

BROWNFIELDS REDEVELOPMENT : Multi-stakeholder approach to environmentally assess properties, prevent further contamination, safely clean-up polluted sites, and design plans for re-use.

ENVIRONMENTAL HEALTH : Environmental health comprises those aspects of human health, including quality of life, that are determined by physical, chemical, biological, social and psychological processes in the environment. It also refers to the theory and practice of assessing, correcting, controlling and preventing those factors in the environment that can potentially affect adversely the health of present and future generations.

EXPOSURE : Actual contact that a person has with a chemical. It can be onetime, short term, or long term.

HEALTH : A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

HEALTH DISPARITIES : Differences that occur by gender, race and ethnicity, education level, income level, disability, geographic location, and/or sexual orientation.

HEALTHY PEOPLE 2010 : Healthy People 2010 is the prevention agenda for the Nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats.

brownfields and public health glossary, continued

HEALTH PROFESSIONAL SHORTAGE AREAS : A geographic area or a population group (e.g., a low income or migrant population) with a physician to population ratio greater than 3000 to 1.

MEDICALLY UNDER-SERVED AREA : These designations are determined by the Index of Medical Underservice (IMU) which uses the following variables: 1) percent of the population below 100 percent of the Federal Poverty Level; 2) percent of the population over age 65; 3) infant mortality rate (5 year average); and 4) primary care physician to population ratio. An IMU score of below 62 is required for designation; the lower the score, the higher the level of need.

PUBLIC HEALTH : Organized community efforts aimed at the prevention of disease and promotion of health.

RISK : The probability of undesirable effects (or health outcomes) arising from exposure to a hazard.

RISK ASSESSMENT : The use of available information to evaluate and estimate exposure to a substance and the resulting adverse health effects. In public health terms, it includes individual and community level assessment.

RISK MANAGEMENT : The process of evaluating alternative strategies for reducing risk and prioritizing or selecting among them.

TOXICITY : Ability of a chemical to damage an organ system to disrupt a biochemical process, or to disturb an enzyme system.

TOXICOLOGY : The study of adverse effects of chemicals or physical agents on living organisms.

This glossary provides a summary of terms relevant to brownfields and public health issues.

For more information please contact Suzi Ruhl, Director of Environmental Law Institute's Center for Public Health and Law at ruhl@eli.org, or visit www.eli.org.



Environmental Law Institute is an independent, non-profit research and educational organization based in Washington, D.C. The Institute serves the environmental profession in business, government, the private bar, public interest organizations, academia and the press.