Massachusetts Community Health and Healthy Aging Funds
Capacity Building Webinar 1
September 4, 2019

Introduction

Hello and good morning and welcome to our capacity building webinar for the Massachusetts Community Health and Health Aging Funds. My name is Nineequa Blanding and it is an honor to join you today as Health Resources in Action's Vice President of Grantmaking and Director of the Funds. In this role I have the pleasure of working with my colleagues Kevin Myers - Program Officer for the Community Health Fund, Abby Atkins - Managing Director of Community Health Assessment and Evaluation Lead for the Funds, and Jennifer Lee - Managing Director for Grantmaking and the Program Officer for the Healthy Aging Fund. Together, we will lead today's session to deliver technical assistance and support relative to applying for the Funds.

Webinar Objectives

Today's objectives are as follows. Our goal is to provide support as you develop your ideas and ultimately your application for submission. My colleagues and I will provide further detail to help build a shared understanding on the focus and intent of the Funds and the theory of change for their importance in advancing population health. We will also offer guidance and describe the ways in which needs can be identified through community engagement and data. And we hope to support you as you think through formulating and implementing your ideas that advance both health and racial equity. And of course, throughout this session we want to hear from you so we will ask you through various points of today's webinar to share your input through polls on the concepts and approaches that are shared today.

Agenda

The agenda for today is as follows: I will spend a little time reviewing background and history of the Massachusetts Community Health and Healthy Aging Funds. My colleague Kevin Myers will then take the lead to share a visual framework for how you might consider formulating your idea through evaluation with health equity at the center. And, as our lead evaluator, my colleague Abby Atkins will share more detail about how data can be used to tell your story. And we will end with my colleague Jennifer Lee who will then discuss upstream approaches as you think about communicating what is your big idea for this funding opportunity. And we will also provide resources at the end of this session.

Housekeeping Notes

A few housekeeping notes before we begin. If you have any questions related to this webinar, please do share them with us. We absolutely want to hear from you so please do so by typing them into the chat box. Any questions that are raised today we will be included in our frequently asked questions webpage on the website and we will be sure to include responses to all questions posed so that everyone has access to those responses as well. Please also note to the webinar recording, slides, and transcripts will also be available shortly after today's session and they will be posted on our website. In our efforts to make this webinar accessible we will be sure to communicate all details on the slides presented today

Section 1: Background

We'll start with a little background and history on the funding opportunities. As a reminder there are two funds and three funding opportunities available. It is important to note that this opportunity has been established via integral partners such as the Massachusetts Department of Public Health who has been leading this effort. The effort is a result of a landmark revision of the Determination of Need regulation which occurred in 2017. It's also important to note that the fiscal agent that is responsible for facilitating the planning and implementation of these funds is the team here at Health Resources in Action.

Two Funds and Three Funding Opportunities

There are two funds as I noted before. There's the Community Health Fund and the Healthy Aging Fund. The Healthy Aging Fund is pictured in green on the right and Community Health in blue on the left. In order to help shape the vision and guide for this fund there was an alignment with the Commissioner Monica Bharel's aims at the State Department of Health. Two advisory committees were brought together through a competitive process and helped to shape the vision for this work. And as a result of these two funds that have been established there are now three funding opportunities. For the Community Health Fund there is a Policy, Systems, and Environmental (PSE) Change Approaches funding opportunity as well as support to the Community Health Improvement Planning (CHIP) Processes. We also have a Healthy Aging Fund that is to support a number of healthy aging domains that we will cover later on in this session. So, the overall vision for these two funds that was established by the advisory committees are as follows. For the Community Health Fund, the vision is: f*or Massachusetts communities to be transformed so that all residents have an equitable opportunity to have the highest quality of life possible*. And for the Healthy Aging Fund the vision is: *that the Healthy Aging Fund be a resource to contribute to equitable systems across sectors affecting community level physical environment and social and economic conditions, ultimately leading to a better quality of life and health outcomes for older adults as they age in Massachusetts.*

Upcoming Deadlines

And there as a reminder there are few upcoming due dates. For Healthy Aging we are inviting you to submit your Inquiry of Idea (IOI) to us by September 18th. The date is September 18th and we hope to receive your applications by 2 p.m. on that day. For the Policy, Systems, Environmental (PSE) Change Approaches, we invite you to submit your idea is to us by October 2, 2019. Again, we are hoping that you submit all your submissions by 2 p.m. that day. Lastly on November 20th, 2019, that is the final due date for all proposals to the Community Health Improvement Planning (CHIP) funding opportunity. So please do keep these dates in mind as you develop your submission

The Health Tree: Connecting Health Outcomes to Root Causes

And here is a visual to provide a guiding framework for what we hope to achieve as part of the Massachusetts Community Health & Healthy Aging funds. The goal of these funds is to create opportunities so that everyone has an equitable opportunity to thrive and to be healthy and here is a visual that helps to contextualize some of the drivers or influencing factors that

increase or decrease one's risk of developing health conditions such as heart disease, obesity, injury, depression, asthma, stroke, cancer, hypertension, and diabetes. Here's a visual of a tree. Imagine the leaves of the tree represent all the health conditions that I previously noted, and the branches of the tree are the next supporting structure of the leaves. These would represent what we would consider individual behaviors that modify one's risk for developing these conditions. These behaviors include falls, lack of exercise, substance use, diet, stress, social connections, and smoking. While the branches do play a role in supporting the leaves and influencing the health and look of the leaves there are still two major components of the tree that we have not covered which are the trunks and roots. For this visual we consider the trunk to be the factors that are in the environment that are influencing one's health. These are the what would be considered the built environment, access to high-quality education, rates of violence and trauma, access to employment and a livable wage, and affordable and safe housing. All the factors within your environment including your social connections play a role in influencing health. Then, in this context, there are still the roots. The roots in this frame represent the structural factors that also play an integral part in one's ability to thrive. They are embedded in social and institutional structures. These are all forms of -isms that can be playing a role in one's ability to thrive. These include: classism, poverty, racism, heterosexism, ableism, and prejudice. All of these can be rolled into structural and institutional barriers through policies and practices that that have an influence on how resources are distributed, and that ultimately impact the prevalence of many of these health conditions in communities.

Defining Health Equity

With that frame, what are we hoping to achieve? We are hoping to advance health equity. Health equity is defined as: everyone has a fair and just opportunity to be as healthy as possible. To achieve this, we believe we must remove obstacles to health such as poverty, discrimination, and deep power imbalances, and their consequences including lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Martin Luther King in his address to the Human Rights Commission in the 1960s made a quote that is quite famous to date. It states that: *of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death*. Today we invite you all to go on a journey with us to identify levers for meaningfully addressing the obstacles that are creating barriers for everyone to have a fair and just opportunity to achieve their highest form of health.

Additional Information

Just as a reminder please note that you can go to our website at www.MaHealthFunds.org/apply for a listing of all the previous webinars that we have hosted. It is important to note that the concepts that I recently shared on health equity, the differences between disparities and inequities, all these concepts and further information to support them are embedded in the materials that are listed here. Now I am going to turn it over to my colleague Kevin Myers who will take us through the concepts of idea formation and centering our work around health equity.

Section 2: From Idea to Evaluation

Thank you all for taking the time to be with us on this Wednesday morning. We're excited that so many of you could be here today. As Nineequa mentioned I will be focusing on this concept of from idea formation to evaluation. For those of you that attended our funding announcement webinars in August we asked, and we wanted to know, in which areas you wanted to receive additional support and the response that we heard the most from you all was this concept around idea formation. On today's webinar we'll discuss some concepts related to idea formation specifically for these funding opportunities and we'd like to start by introducing a visual or a framework on the following slide.

From Idea Formation to Evaluation

This graphic depicts four blue circles each connected to each other with arrows in a clockwise direction. The top circle is *Forming Idea* which leads to *Communicating an Idea* and this is where we're going to focus today and in next week's webinar. The bottom circle is *Implementing an Idea* which leads to *Evaluating*. We see these as future topics for us to dive deeper into as we get further into this grantmaking process. You also see that at the center of this framework is a light blue diamond that's labeled health and racial equity and equity is really a core value of both the Community Health Fund and the Massachusetts Healthy Aging Fund. Our hope is that applicants and awardees will approach each of these four steps with equity guiding thinking, decisions, and actions. Today we'll share some of those concepts and some key questions to assist in that process.

Idea Formation

So here you can see we've highlighted the first circle of forming an idea as this will be the focus of today's webinar. There are four items that are listed under idea formation and they are as follows: engaging community, identifying need, what's your big idea, and engaging other partners. The three that we're going to talk about today are the first three and on next week's webinars we will be discussing engaging other partners in your idea, how to communicate your idea, and specifically how to submit your idea to these funding opportunities. Throughout today's webinar we will pose questions to you to hear your experiences and expertise in these topics as we know that many of you are already steeped in this work and we love to hear from you all.

Idea Formation Guiding Questions

Okay so as we think about idea formation, we created guiding questions to ask yourself, to ask your organization, as well as your partners as you're preparing an idea or proposal for submission. We sort those questions into three buckets, those being: Who will you serve? What will you do? and How will you do it? These can be used to start conversations with your partners as well as to revisit these questions as you keep making decisions about your idea.

To start with the first bucket of questions and that is: Who will you serve? The questions are:

- What is the population with the greatest disparities?
- Where did those disparities come from?
- What is the need?

- What are the health and racial inequities and what describes or defines the need?

My colleague Abby Atkins will be answering some of those questions and providing a little bit more detail and context in just a few moments.

Then we have questions about What will you do?

- What is your big idea?
- How do you address the populations need?
- Why are you the best organization to lead this as compared to others?
- And how does what you plan to do directly connect to the goals of the fund?

So, my colleague Jen Lee will also be reviewing some of these questions in a little bit more detail and providing some additional context around forming your ideas and ways that we hope that you'll connect to the goals of the fund specifically around the ideas of health and racial equity

Finally: How will you do it? The questions here are:

- What partners will you engage to achieve your goals?
- Who else do you need?
- How will you engage members of the community that's affected by these issues?

Addressing Inequities Guiding Questions

When considering a particular idea to address an inequity we continually ask ourselves these four questions - especially considering people who are actually experiencing those inequities. So those four questions are listed in boxes on this slide and they are: Who benefits? Who is harmed? And that can be an unintended consequence of your idea. Who influences? Who decides? So, we ask that you think about the populations and groups of people in the first two boxes who may benefit or who may be harmed by a proposed idea or an initiative and think about what ways are they can influence the idea and think about if they make decisions around the idea. We'll be talking about those concepts on the next slides which are all about engaging the community.

Section 3: Engaging Community and Identifying Need

One of the core concepts of idea formation is engaging the community as well as identifying needs. We want to hear from you. We'd like to learn from you as there are multiple ways that community is defined, and we'd like to understand how you are approaching the concept. We want to know specifically how you define the word community. So please take a few moments to think about your response and type that into the chat box. And we're not expecting a clear-cut definition that's grammatically correct so anything around core concepts of community are fine as well. If you want to type that into the chat box, fantastic. We'll give you about 30 seconds or so to get those responses in.

We're getting responses in here now. We're seeing: *We use the word community to talk about the folks who are affected by or experiencing a challenge or disparity*. Love to hear from some

other folks even if anything just comes to mind when you think of the word community. *People in the cities and towns supported.* Thank you. And we have some more here. *The relationships and the health of relationships. All sectors that have a role to play in reaching community goals. Community is a diverse group of folks living with similar circumstances possibly geography and education. All families living within a geographic area. A group of people living in the same area that have a common experience. Community is the entire town residence and nearby small towns. People who share a place, a passion, a belief or challenge. People on the cities and towns supported. The people and places that come in contact with daily*.

Great so there's a lot of really good responses here. I think two of the main things I'm seeing are the idea of people, groups of people and the second theme is having some sort of shared identity or context. Those are things that we thought of as well, so thank you for sharing those ideas.

A community can be defined by place where people live, work, or play. Community can also be defined by identity which could be externally assigned, like race, or internally defined like religion. Sometimes a community is defined by affinity or something that people like to do, and they do together. Or a community can be defined by affiliation, so it's the people that you know, experiences you've shared, and the values you hold in common. And another example of community is once applicants are selected for awards and become awardees, we look forward to forming a community among them and forming a learning community so we can have a group of organizations that are working towards change that we can also learn from each other.

Community Engagement Spectrum

So now that we've talked a little bit about community, we wanted to talk about community engagement. Specifically, the spectrum of community engagement which ranges from a low level of community engagements on the left side of the screen to a high level of public engagement on the right-hand side of the screen. This is a visual framework that was developed by the Tompkins County in New York, and it is just one way of characterizing different levels of community engagement. Some of you have probably seen this version of the spectrum maybe in a different format or with different colors but wanted to share this version with you as just a way to start a discussion.

The model depicts five levels of engagement. The first being **inform**. That's the one in yellow and that's the lowest level of engagement and includes providing the public with information on the project or decision. The next highest level is **consult** which means to obtain and consider public input at set points in the process. **Involve** is the mid-level step of engagements, and it is to work directly with the public and consider their input throughout the process. Moving on we have **collaborate**. That's the second highest level of engagement and that's to engage the public in key activities and decisions during the process. Finally, we have **empower** which is the highest level of engagement which means to implement what the public decides. An example of that would be a referendum.

We ask that you consider where your organization or coalition typically operates and challenge yourself to move closer to the right-hand side of the screen if applicable and appropriate. All levels of the spectrum are important and valid, and different actions or decisions within a particular initiative might operate at different levels within the spectrum. It's not really a static situation. You might move throughout this spectrum even within one initiative, but when you're considering the spectrum and where your organization might fall with a specific decision or action, we ask that you keep asking those addressing inequities guiding questions: *Who benefits? Who is harmed? Who influences? Who decides?*

Key Considerations When Engaging Community
We came up with a few other key considerations when engaging communities, before we hear from you all. The first is engaging community members with lived experience to understand the challenges that they face. By lived experience we mean the experiences of a given person and the knowledge that they gain from those experiences. It's important to note that we all have lived experiences and that we all have some level of expertise, but it's really important to engage those who experience the challenges that we attempt to address instead of formulating an idea within a silo without that really important information. And as you're identifying a population you want to serve, you should ensure that those that are impacted by those decisions are involved in your approach. Two other key considerations when engaging community are to understand who are decision-makers and influencers, and how they might be leveraged, and understand how might other stakeholders offer support in addressing the identified need?

Poll Questions
So now we'd like to hear from you and again you can type in a response into your chat box and we have two questions, the first being: What strategies are effective in engaging your communities? You can feel free to type your response into the chat box. It looks like we have some answers coming in. We have: *Personal relationships. Taking a lot of time and slowly building relationships. Providing stipend, child care, transportation, interpretation*. Fantastic. *Meeting community members and residents where they are at, figuratively and physically. Developing coalitions working towards a common goal. Providing resources such as funding and training. Going to where people are. Hosting community events and using a time to conduct personal interviews. Inviting community members. Live presentations. Personal relationships. Meeting with easy conversations. Meeting community members where they are*. Great. *Connecting with community leaders. Providing resources*. Okay this is fantastic sounds like some of you are really entrenched in this work. That's great to hear.

Our second poll question is: Where does your organization generally operate in a community engagement spectrum? I'll just go back to that slide. We have inform, consult, involve, collaborate, and empower. If you want to think about a response and type that into the chat box, fantastic. I see a *consult, involve, collaborate*. W*ith individuals we aim for collaborate, headed to empower. Mid-level, involve, collaborate. We do them all depending on the project.* Yeah that's a really important point. *Somewhere between involve and collaborate*. Great, it sounds like people are operating in a mid-level of engagement with the caveat that it definitely

depends on the type of project that you're implementing so thank you all for providing those responses.

So now I'd like to turn things over to my colleague Abby Atkins to talk a little bit more about Health Data.

Section 4: Using Data to Define Your Idea

Great, thanks Kevin. Today in this section we're really going to look when communicating your idea to your audience how important is it to use data in the framing and explaining your ideas. Understanding and using data early on in the process will support your later work related to monitoring and evaluation activities that you may be called upon to complete by the Massachusetts Community Health and Health Aging Funds as a funder, or any other funder or key stakeholders. For this part of today's webinar, we're going to take a brief look at some of the data sources and resources that are available to you.

The Health Tree and Data

When going back to the tree that Nineequa shared earlier, the tree slide, we can use data to support the story that you're conveying about the leaves, branches, trunks, and the roots of your tree. While not always an exact match we can look at health outcome data at the leaves, health behavior data at the branches, social determinant of health data at the trunk, and contextual injustices at the roots. I encourage you all to dig into the data that you have to help you to help you see and describe the disparities and the equity in the inequities and plan for strategies to address them.

Types of Health Data

Most of us in public health are used to a typical set of sources for health data. We can look at existing health surveys out there like the behavioral risk factor surveillance system (BRFSS) or the Youth Risk Behavior Survey (YRBS) but those do a great job of telling us what we want to know about all of our citizens or a specific group that's being surveyed, and it's about behaviors, not just about health outcomes. With them, we can get at some specific subpopulations and they're very effective on the state or the county level. If you have access to local school district data for YRBS, they may be helpful for you there, but they don't necessarily cover specific populations or certain geographies. We can also look at disease and injury registries. They do a great job of speaking to every case or every event. They can cover some specific geographies and they can identify disparities within certain subpopulations, but they don't necessarily cover outcomes or behaviors. We can also look at clinical data to get at burden or utilization but it's really when we combine these health data sets with other data, that we get a better sense of what our story is in our communities and what the disparities are within the community.

Health Inequities in Geographies - Life Expectancy

So when can we look at New Bedford and this data came from City Health Dashboard we can see that within the city of New Bedford there appear to be some significant differences in life expectancy in these two census tracts, with one with one life expectancy to be approximately

80 years old while the other is 69 years old so an eleven year difference in what essentially are adjacent neighborhood just pulling the life expectancy data really doesn't tell us much of anything except for that there is a disparity. If we look at this map that came from the Berkshire Regional Planning Commission we can see that even within Pittsfield we're seeing a difference from 71 years in one neighborhood and 83 and a half in the other.

Health Inequities in Populations and Geographies - Life Expectancy

We can further look at disparity and inequities if we add even another layer of data. If we look at Fitchburg we can see if that within two census tracts in Fitchburg we can see the life expectancy estimate to be 81, almost 82 in one census tract and much lower less than 75 years old in a different census tract. When we dig a little bit further into what we know about the census tracts, one that has the higher life expectancy estimate is in a census tract where the population is primarily White, and the lower life expectancy is in a census tract in which the population is primarily non-white. When we dig into the information that we have, we can see that there is a little bit more to the story and we see some differences within populations and geographies. With each new piece of information, it prompts us to ask ourselves why we are seeing these differences. What is influencing them? What can be done to create a more equitable space to improve health outcomes? Frequently people look at these maps and say: "That's great Abby. Those maps look wonderful, but I don't have those skills." Well, fortunately a lot of these items can be auto generated for you with a variety of different tools that are available to all of you online.

Resources to Define Community Need

The first tool is the Population Health Information Tool (PHIT) which is a new tool put out and managed by the Massachusetts Health Department that provides a wealth of data within this portal. You can look at a community level report and explore both health outcome and health behavior data and review the impact of social determinants on your health in a specific geographic community. This is just an example I pulled up for folks to see from the PHIT tool and it looks at adults who have ever been diagnosed with pre-diabetes in Massachusetts, and this population is all Hispanic. You can take this data set and export it to excel or .csv file, or you can take multiple data sets and really be able to manipulate them into the visual that you're looking for to tell your story.

Another Massachusetts-based tool is the Massachusetts Healthy Aging data report. This is just a screenshot of their homepage. That data report is just in its third edition and it was just published in December of 2018. It was conducted by the Gerontology Institute of the McCormick Graduate School of Global Studies at UMass Boston. On the Massachusetts Healthy Aging Collaborative website, this report was designed to help residents, agency providers, and government understand the older adults who live in their geographic community. It considers age, living arrangements, health status, strengths, and vulnerabilities. Between the PHIT tool and the Healthy Aging Report you can get a lot of data that's specific to Massachusetts as a whole and community. You can also look at county-wide data relevant to Massachusetts at County Health Rankings, a Robert Wood Johnson Foundation and the University of Wisconsin

collaborative provide state and county level information on health outcomes and behaviors alongside data on where people live, learn, work, and play.

I just pulled up Berkshire County as an example and you can see there are items that were very used to seeing about our County there's health outcomes data and their health behavior data but within County Health Rankings there's also an additional set of data. We can look at clinical care factors along with social and economic factors and physical environment factors. That shows us that between these three sites, some of that data may be duplicative, some of it may be available for different times. But, all three of them are wonderful resources that I can only encourage you to rummage around in so that you can get a better understanding of what data is out there and relevant to the communities that you are working with whether they be a population or a specific geography.

An additional resource that's available is the National Equity Atlas which gives you information to start thinking about: How, with changing demographics in our community, might we impact other measures such as earned wages or housing to change the context in which our neighbors and communities are functioning? It's a wonderful resource to look at changes and trends and the economic impact of equity.

ChangeLab Solutions

We can also go to ChangeLab Solutions. ChangeLab Solutions is a website that has a variety of resources for folks to investigate around strategies to advance equitable laws and policies that ensure healthy lives for all. This is just an example of some of the resources they have related to health and housing. As we move forward with thinking about your ideas for the Massachusetts Community Health Fund, it's important that you think about your policy strategy and environmental change strategies because that's what we're looking to fund and the ChangeLab has a lot of suggestions for some of those policy-related pieces.

Additional Resources

There are several other additional resources including Community Commons which is a collaborative initiative designed to support healthy communities' movement by providing data, tools, and resources to equitable community health and well-being work. The City Health Dashboard focuses on 500 cities in the U.S. and provides data on 37 health measures, and the factors that shape health and the drivers of health equity to guide local solutions. There's also the Opportunity Index which looks at the conditions that can be used to identify and improve access to opportunity. It also provides data and information at the state and county levels. Within Massachusetts there are a regular set of health needs assessments that may have been done that are specific to a geographic community that you serve. The first is the Massachusetts State Health Assessment. The most recent one was published in 2017 that's available at the mass.gov website. Also, hospitals require assessment every three years. I encourage you to go to your local hospital website and review the most recent Community Health Needs Assessment that is there, in addition to looking at other strategies that the hospital and their partners may be engaged in. See how that may influence the work that you were doing to either improve coordination and ultimately impact or to prevent duplication of services. Also,

local health departments have community health assessments and I encourage you to look at not only the assessment that they've done but other existing data sets that may be on their website. Finally, there's the data and the resources that your organization or agency has. In the discussion earlier about how do you engage community, there are many opportunities to engage community across the spectrum to inform and influence the selection, design, and implementation of your strategy throughout the community engagement process. These can be created together, both qualitative and quantitative data from community members who might be impacted by your strategies. This data is invaluable in further describing and defining the context in an environment in which individuals and households are making choices.

I can talk a lot about what I think is out there. I'm very curious as to what other data sources folks are aware of or what have you used before that I haven't listed that you would suggest to your peers. I'm going to pause for just a moment and allow you to enter into the chat box any suggestions that you have for additional data collection, additional data resources, or resources for identifying strategies.

This is great. People are pointing out school district profiles and data that's available from the Department of Education. The 500 Largest Cities Project. Additional data that has been intentionally gathered and curated by other funders for use by their applicants or folks in their geography, including the Impact Essex County data program. And people are noting other portals such as Pioneer Valley's data portal that are available for folks to use.

Data Limitations

Finally, I just want to touch base on data limitations - something for folks to keep in mind when they are using other data sets. The first is that the population or number or respondents could be really small and that you should be aware of the size of the population that's being used. You should also go to the data set limitation section of any data that they use to see what that researcher has listed as a limitation. For example, the Behavioral Risk Factor Surveillance Survey and YRBS data sets do have a limitation in a respondent's bias or their own recollection before they answer questions about their own behaviors. Also, data is often generalized and may not be specific or useful or relevant to the population that you are looking to serve. Data is also frequently outdated. I think a perfect example of that is that it takes a long time after data collection for the data to be analyzed and made publicly available. So frequently you'll see data sets that you're fairly sure have been collected again but the publicly-available set is still only 2015 or 2016. And the last piece is to really check your data sources and realize that with growing emphasis on media and social media, that we all take advantage of, to check your sources. See if there is actually an implicit bias in the data being presented and to review what's there to look at whether or not you consider it to be a valid or reliable source.

There are also several other resources that are available to folks in Massachusetts. The first that I encourage you to take a look at is the *Using Data to Tell Your Story* webinar. Go to the Community Health Training Institute website and you can see the recorded webinar that's there to start thinking about how you might use data in both the design and your evaluation. That piece was put together by Dr. Sanouri Ursprung from the Massachusetts Department of

Public Health. I also encourage you to visit the Massachusetts Health Funds website where there will be a regular set of resources posted there and to please email any questions you have to either one of the addresses on the screen. We can also schedule a phone call for you with a with a TA provider. I also see that in the chat box there are numerous questions about how to handle a community where there's not a full dataset or data is few and far between. We can give some tips to that within the FAQ section of the website.

So that's it for the data section and now I'm going to turn it over to my colleague Jennifer Chow Lee to continue to talk about getting to strategies and moving forward.

Section 5: What's Your Big Idea?

Good afternoon everyone and thank you so much Abby. I wanted to echo my colleagues delight in having you all join us for this capacity building webinar. Just to recap what happened in the past hour, we've provided a framework for thinking about idea formation as well as engaging community when identifying need among the population that you plan to serve. We've also heard a host of resources from Abby about how to leverage data. And now in this final portion of the webinar we really want to provide some additional and useful resources as you think about your big idea, especially within the context of upstream approaches that address the root causes of health and racial inequities that Nineequa covered at the beginning of the webinar.

Moving Upstream to Reduce Health Inequities

This next visual is a comprehensive public health framework for reducing health inequities and it was created by the Bay Area Regional Health Inequities Initiative. The visual shows us a spectrum which has approaches to institutional inequities as well as social inequities and ultimately those that comprise policy solutions to represent those that we'll deem as upstream. These particular upstream approaches are positioned farthest to the left of the spectrum on this diagram. Towards the right of the diagram are those that are more downstream approaches and those that, in other words, address health issues more so at the individual level. These include: risk behaviors, disease, injury, and mortality. In the middle are living conditions which are considered positioned in sort of a midstream approach. Just to give you some high-level examples of approaches within each of these areas: social inequities might include class, race, and ethnicity, gender, and sexual orientation. Institutional inequities might include corporations and businesses, schools, and nonprofits are just some examples. Those are the most upstream in this diagram on this slide. Living conditions are bucketed with four types: physical environment - so economic and work environment, and service environment. There are a host of different examples within each of those are considered midstream. Then under risk behaviors, these might include: smoking, nutrition, sexual behavior, disease, and injury which might include communicable disease, injury, chronic disease, and mortality - which would include infant mortality and life expectancy. These last three represent the more downstream approaches on this diagram. It's important to note from this diagram that although downstream approaches have historically and currently represented practice, it's really the upstream approaches reflected on this diagram that represent emerging practice which we hope and encourage when applying to the Massachusetts Community Health and Healthy Aging Funds. We really see this opportunity as a chance to provide financial resources

to communities in addressing upstream approaches reflected on the left-hand side of this diagram.

Health Equity Takes Us Upstream
On the next slide is another diagram that depicts the different tiers of approaches with the emphasis that strategies that really address the root causes of health inequities are those that are framed with an upstream approach so while it's another way to depict the various approaches for upstream strategies we do really want to recognize on this slide that all approaches are important and significant to improve health. To walk you through this particular diagram, starting at the bottom at the most individualized level, downstream approaches would address immediate health and social needs of a population. If we move one tier up from that, a midstream approach would seek to improve physical working or living conditions through promoting healthy environments and which ultimately aim to reduce exposure to health risks. Finally, and importantly, those that create the most opportunity for improving health in our population are those upstream approaches that are really looking to address fundamental structures, be they social or economic in nature, that address the redistribution of wealth, power, opportunities, and decision-making.

Poll Question
Here we want to take another of our pauses, one of the last ones actually in this webinar, to hear from you. As you think about that upstream, midstream, and downstream visual that we just provided in the previous slide, we'd love to hear from you, if you don't mind engaging with us again and with all of your peers on this webinar. Where does your organization typically operate? If you don't mind sharing, we'll pause here for about a minute and you're welcome and encouraged to share via the chat box assigned to all panelists and attendees so your colleagues can see your responses. Let us know: Where do you think your organization may land within that overall framework? Now we know it may not be possible to apply this across the entirety of your organization depending on its size so you can always hone in on a particular department or initiative but we'd love to hear from you at this juncture.

We're fielding some great responses already. *Midstream, upstream. Downstream and midstream.* There are lots of variations on responses which is terrific*. I feel like we're midstream to upstream but we're learning how to communicate it.* That's a very important point. *We operate midstream as an affordable housing and service provider and upstream in our promotion to underserved populations.* So that's an important point as well. Dependent on different lines of work you may find that you're positioned in different parts of that overall diagram. So, let's ask you a second part of that question: What would it look like for your organization to move that work upstream? So now this question is asking you to think of if you responded to that first question, whatever that response was, how would you move it upstream? What would it look like? What would you need? What resources would be helpful?

Let's pause there to get some responses. One response that we received is: policy work in order to move upstream but coordinating with organizations at midstream and downstream levels. So that's a great response thinking about who else you would need at the table. Another response

is providing or receiving operating support to build that evidence-based policy institute. Political advocacy and education of legislators is another really helpful response. Lots coming in. *Focusing on failure of mainstream entities and moving practices upstream. More advocacy with bigger systems. More financial resources and collaboration with relevant decision makers. Political will* is the last comment that we've seen though we know there are many more comments coming in. So that's great. Thank you for taking a moment to share with us where your organization is currently operating and sort of what would you need to get it further upstream.

Working Upstream

Here's another framework to provide to you as you're thinking about how to work upstream or further upstream in your approaches. There are three funding opportunities available through the Funds. One that's specifically focused on policy, systems, and environmental approaches or as we provided the acronym PSE. Although the CHIP and Healthy Aging funding opportunities also seek and welcome approaches that are embedded in PSE approaches. This slide really unpacks some of those PSE approaches and provides a range of types of improvements that fall within each category as you think about your big idea and what levers you might want to mobilize in your approaches. So, under policy improvements examples might include honing in on a law, procedure, administrative action, incentive, or voluntary practice of government or other institutions. If you're considering systems improvement those might include change that impacts all elements including social norms of an organization, institution, or system. Lastly, environmental improvements may include changes in the physical, social, or economic environment.

Policy, Systems, and Environmental (PSE) Change Approaches

This next diagram is a visual that may look familiar to those that participated in our previous webinars where we initially launched the availability of these funds just last month or at least a truncated version was shown in our last series of webinars. What it really provides is a comparison between the different types of public health approaches distinguished by whether they are considered programs approaches or PSE. On this chart programs are listed on the left and PSE changes are listed on the right. And importantly we want to emphasize that all of these approaches are incredibly vital and important in our communities. And what we also want to emphasize simultaneously is that those that are PSE in nature are more so encouraged through these funding opportunities. So less of the one-off individual approaches you see on the left side and pushing towards those that are longer-term and sustainable in nature and really seek to affect the policy, systems, and environmental infrastructures.

To quickly go through this chart to give you some tangible examples: what would be considered a programs approach is hosting a one-time community bike-ride. Looking at a PSE change approach for that same concept is more so implementing a complete streets policy to ensure community roads are designed to be safe and accessible for all of its users. A second example is hosting an open gym night at a local school and a PSE approach to that concept would be implementing a town-wide joint use agreement which enables community members to have access to the school's gym on a longer-term basis and field when school is not in session. A third

example is working with a corner store to become a designated healthy market. A more PSE approach towards that contact will be creating a citywide healthy retail program that supports food retailers that it enables them to offer a variety of fresh produce and affordable healthy food. Finally, a fourth example is opening and maintaining a community garden. A more PSE change approach towards that concept would include passing a municipal urban agriculture ordinance or policy that allows residents to use a space for community gardens on a longer-term level.

Addressing Inequities Guiding Questions

On this next slide we want to bring up again for guiding questions that Kevin previously covered in his segment of this webinar. These are seen as really four key guiding questions that are worthwhile for your organizations to ask internally as you're developing your idea. In particular an idea that is seeking to address an inequity in a population.

So those four questions to consider and to really sort of walk through your idea as you're developing it is: *Who benefits? Who is harmed? Who influences? And Who decides?*

Policy, Systems, and Environmental (PSE) Change Resources

Finally, we want to share with you a range of different resources that can help build knowledge and understanding of policy systems and environmental approaches to the first two that are listed here are provided in developed by the Community Health Institute. The first one is targeted at how your community can be prepared for policy change whereas the second one is focused on how local officials can be engaged. The third resource listed here is called the Groundwater Approach and it is a document and resource created by the Racial Equity Institute that provides essentially a metaphor to help understand that we live in a racially structured society which is what really causes racial inequities. These are all really helpful resources and as mentioned before the sides from this webinar will be posted on our website following the session so you can directly link to these resources as well as any others that have been covered so far.

Section 6: Resources

So, in our final section of the webinar we want to recap for you other ways to be in touch with us as well as resources coming up. This is nearing the end of the first of our two capacity-building webinar opportunities that we're making available to all potential applicants prior to idea and proposal submission due this fall. The next webinar, as Kevin mentioned earlier, will be held next week. We will delve deeper into how you can engage other partners, communicating that big idea that you've developed, and the mechanics of how to submit your proposal through the online portal. We welcome you to sign up for that if you haven't already and to designate a colleague or staff person to participate. We've listed here, again, our two email addresses you can contact at any time with any questions or comments. And visit our FAQ webpage so as we collect questions that may come in from you or your colleagues, we will have waves of uploading those questions and responses on our website. And as Abby mentioned you can certainly sign up for an individualized TA session that will range for 15 minutes with our staff to answer any questions for your organization. We encourage you to visit our website if

you haven't already. The URL is listed at the bottom of this slide. It is www.mass.gov/mahealthfunds. It contains all of the information about eligibility criteria and all the materials from the webinars and how to apply.

Upcoming Deadlines
And to bring up the chart that Nineequa introduced at the beginning of this webinar. We want to share with you some upcoming and important deadlines for each of the three funding areas.

We want to pause here because we've received an important question about whether an organization can submit to more than one funding opportunity and the answer to that question is yes. So reflected on this slide are the three funding opportunities available. First is Healthy Aging, second is PSE, and the third is CHIP. You're not limited to submitting a proposal to just one of these three funding streams.

Importantly, please note the key deadlines are all 2:00 PM on the days reflected. So Healthy Aging on September 18, PSE on October 2nd, and CHIP on November 20 for upcoming and impending deadlines.

Contact Information
And then finally our contact information listed here which you can also use as a resource to reach out to us. In addition, so in addition to myself, Kevin Myers, and Nineequa Blanding, our colleagues at the MA DPH Ben Wood who is the director of Community Health Planning and Engagement and Liz Maffei who is a Program Coordinator at DPH.

That concludes the official content of our webinar. Again, we are so pleased that you were able to spend your afternoon with us. We welcome any comments or questions you might have as this application process rolls along. And a reminder that that first and next deadline for Healthy Aging is in about two weeks on September 18th. Thank you all for joining. We hope this has been a helpful webinar and we look forward to receiving your applications. Thank you very much. Have a great day.