Boston Alliance *for* Community Health

MAPP Report Appendix 2014

ABOUT COMMUNITY HEALTH ASSESSMENT AND PLANNING

What is a Community Health Assessment?

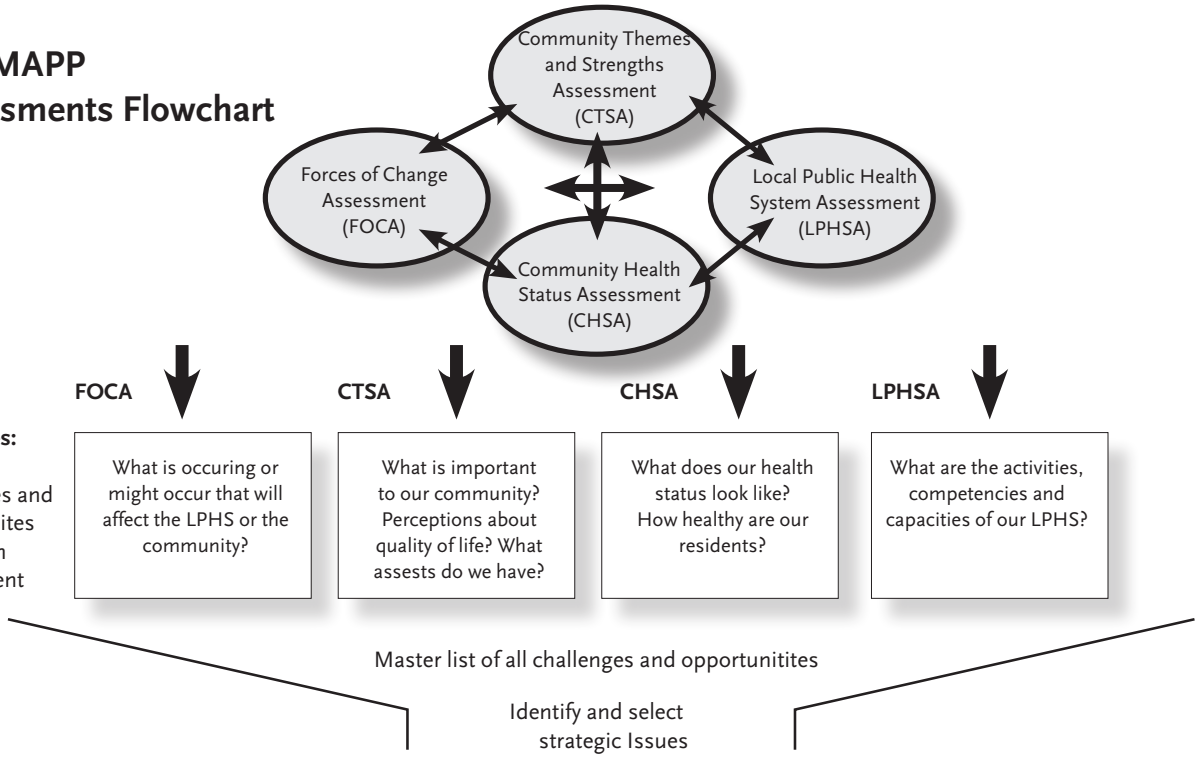
A Community Health Assessment, or CHA, is commonly defined as a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues. A variety of tools and processes may be used to conduct a community health assessment; the essential ingredients are community engagement and collaborative participation.

What is a Community Health Improvement Plan?

A Community Health Improvement Plan, or CHIP, is an action-oriented strategic plan outlining the priority health issues for a defined community and how these issues will be addressed, including strategies and measures, to ultimately improve the health of the community. CHIPs are created through a community-wide, collaborative planning process that engages partners and organizations to develop, support, and implement the plan. A CHIP is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.

Connecting the CHA to the CHIP

Four MAPP Assessments Flowchart



How to use a CHIP

A CHIP is designed to be a broad, strategic framework for community health, and should be a "living" document that will be modified and adjusted as conditions, resources, and external environmental factors change. It is developed and written in a way that engages multiple voices and multiple perspectives so that anyone can find a role and a place in the plan. A CHIP outlines ways for all community groups and sectors – private and nonprofit organizations, government agencies, academic institutions, community- and faith-based organizations, and citizens, among others – to become involved in a unified effort to improve the health and quality of life for all people who live, work, play, pray and learn in Boston.

We encourage you to review the strategic issues and goals, reflect on the strategies, and consider how you can join this call to action: individually, within your organizations, and collectively as a community.

DEVELOPMENT OF BOSTON'S COMMUNITY HEALTH IMPROVEMENT PLAN

Community Engagement (i.e. Organizing for Success and Partnership Development)

While community engagement and participation is an important part of every step of the assessment and planning process, the MAPP framework recommends that significant time and effort be spent at the beginning of the process to build a strong foundation and network of partners to participate along the way.

Visioning

One of the initial steps in the MAPP process is to create a vision- the ideal, healthiest community possible. This is where people put their passion and set the long-term goal for their health planning work. In November 2012, a group of 50+ community residents and stakeholders came together to develop a vision to guide our health planning work. The result of that meeting was the following vision for a healthy Boston: "We envision a Boston that is vibrant, just, and equitable, where all people who live, work, play, pray, and learn here have optimal health and well-being and enjoy a supportive environment and a sense of safety and belonging- regardless of who they are, what neighborhood they live in, or where they come from."

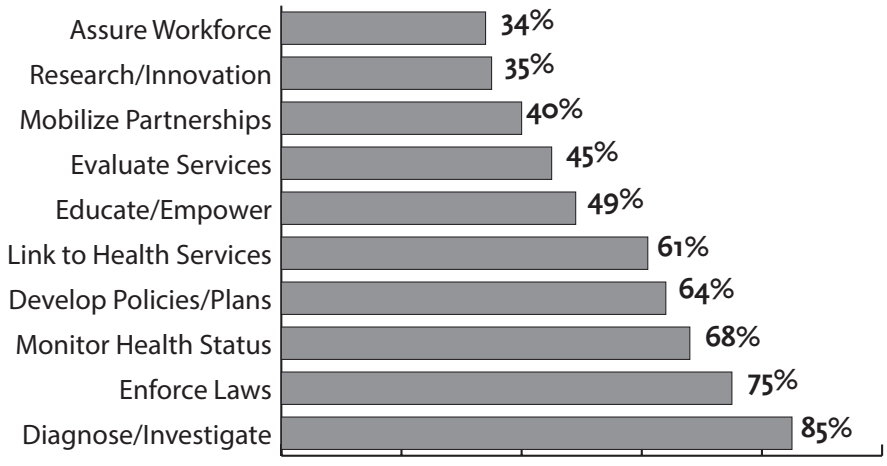
Assessment

Local Public Health System Assessment – On February 2nd, 2013, 118 local residents and public health leaders and dozens of volunteers came together to conduct the Local Public Health System Assessment. Using the National Public Health Performance Standards Program, the group determined the activities, capacities, and competencies of Boston's public health system related to the 10 essential public health services. The results of the Local Public Health System Assessment are presented below.

At a follow-up meeting on April 1st, a group of community stakeholders prioritized the following Essential Public Health Services (**bolded below**):

- Mobilize Community Partnerships to Identify and Solve Health Problems
- Inform, Educate, and Empower Individuals and Communities about Health
- Develop Policies and Plans that Support Individual and Community Health Efforts

Rank Ordered Performance Score of 10 Essential Public Health Services



Strengths and Weakness of Each Essential Public Health Service

1. **Assure a Competent Public and Personal Health Care Workforce- 34%**
    a. Strengths
        i. Strong emergency preparedness plans in place
        ii. Workforce standards, e.g. job descriptions
    b. Weaknesses
        i. Lack of collaborative leadership
        ii. Applying health equity/racial justice lens to professional development, e.g. training, hiring, practice, etc.

2. **Research for New Insights and Innovative Solutions to Health Problems- 35%**
    a. Strengths
        i. Large amounts of research dollars
        ii. Some community-based organizations propose and conduct their own studies
        iii. More research over the past year on health inequities
        iv. Strong partnership between LPHS and institutions of higher learning and/or research organizations
    b. Weaknesses
        i. Sectors not working together
            1. E.g. Community-based organizations often do not know about research projects and therefore cannot participate or give input as to what hypothesis should be tested
        ii. History – racial victimization and communities not benefitting from research; cultural disconnect between research institutions and communities
        iii. Challenge of moving best practice from literature to actual practice
        iv. Organizations don't have resources or the capacity to do annual reviews

3. **Mobilize Community Partnerships to Identify and Solve Health Problems- 40%**
    a. Strengths
        i. Lots of citywide and neighborhood level activity – outreach, surveys, goal setting, engagement, i.e. Yearly Neighborhood Health Status report, Health of Boston is neighborhood specific; hospitals and CHCs conduct community-based assessment
        ii. Flu response
        iii. Messaging penetrating throughout city
        iv. Cross-sector alliances

b. Weaknesses

i. Residents not accessing information

ii. Language and literacy barriers

iii. Haphazard mechanism in city to identify and engage constituents

iv. Activity siloed by topic and/or neighborhood – challenge crossing lines

v. Few large scale efforts

vi. Funding/resources; consistency; sustainability

4. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services- 45%

a. Strengths

i. Provision of health services

ii. Collective achievement has led to high rates of insured residents

iii. LPHS recognizes that disparities are real, that they relate to determinants other than economic status, and they are ready to help correct these disparities

b. Weaknesses

i. Lack of assessment of community satisfaction

ii. Redundancies

iii. Lots of gaps for how information is used and disseminated

iv. Lack of system-wide partnerships or system-wide evaluations

5. Inform, Educate, and Empower Individuals and Communities about Health- 49%

a. Strengths

i. Information going out and consistency in messaging, e.g. flu response

ii. Emergency preparedness – trainings, evaluation, data

iii. City council/policy makers

b. Weaknesses

i. Information not reaching citizens – barriers to engaging and communicating, i.e. distrust, literacy, language, cultural

ii. Resources available but segmented

iii. Turf issues

iv. Difficult to evaluate health messaging

6. **Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable- 61%**

    a. Strengths

        i. Identifying gaps

        ii. Rich array of organizations and perspectives

        iii. High visibility of healthy food and healthy activity promotion at the city level

        iv. Agency capability to conduct assessments

        v. Many avenues for disseminating and receiving info

    b. Weaknesses

        i. Racial, financial barriers

        ii. Many redundancies and shortage of services: social services not widely offered (disability), mental health and substance use not fully identified in community health systems

        iii. System is a maze – not everyone can navigate

7. **Develop Policies and Plans that Support Individual and Community Health Efforts- 64%**

    a. Strengths

        i. Strong level of youth engagement

        ii. Flu mobilization and emergency response

        iii. Good relationships/communication between city and state

        iv. Robust Boston Public Health Commission, organizational structure, and coordination with stakeholders, significant involvement in health equity issues

        v. Increased knowledge about laws and regulations

        vi. Public meetings and hearings that allow for greater citizen representation

        vii. Huge effort to coordinate and support coalitions

        viii. Cross-sector support from BACH

        ix. Strategic, multiyear plan is reviewed annually

    b. Weaknesses

        i. No community health improvement process or plan

        ii. Policies that lead to unfair distribution of resources

            1. Programs driven by funding, not by need – i.e. lacking resources for harm reduction, losing direct service workers

        iii. Need more coordination between larger hospitals and community health centers, provide more resources

        iv. Lack of outreach to and representation of Asian and Pacific Islander residents

8. Monitor Health Status to Identify Community Health Problems – 68%

a. Strengths

i. Amount and organizations collecting/reporting, e.g. The Indicators Project, Health of Boston

ii. Use of registries, e.g. Boston Police Department, healthcare

b. Weaknesses

i. Combining neighborhoods, i.e. defining neighborhoods differently

ii. Data collected by many organizations – not shared, no "community health profile," overlaps/gaps

iii. Limited communication with residents, i.e. do not address multiple languages in the community in data collection and sharing

iv. Need more effective enforcement of regulations and protocols

9. Enforce Laws and Regulations that Protect Health and Ensure Safety – 75%

a. Strengths

i. Widespread knowledge about laws and regulations

ii. Systematic approach, e.g. tobacco

iii. Many initiatives to promote health and safety, i.e. inspections of nail salons

iv. Most individual organizations have an emergency response plan

v. Flu response – lots of coordination

b. Weaknesses

i. No regular review

ii. Emergency response plans often aren't shared or known

iii. Public health system needs to understand that non-health laws (social justice issues) also impact equity

iv. Uneven enforcement of existing regulations (tobacco advertising, store window signage)

10. Diagnose and Investigate Health Problems and Health Hazards in the Community – 85%

a. Strengths

i. Citywide emergency preparedness and response (i.e. Shots fire program – sensors around city that recognize fire arm shooting), risk communication, emergency preparedness, and response

ii. Excellence in flu response

iii. Coordinated effort with agencies, i.e. EMS existing in BPHC creates great link

iv. Laboratories

v. Interconnectedness of health centers

vi. Providers – mandated to ask demographic questions, trainings

vii. Grants to community organizations to improve emergency preparedness

b. Weaknesses

i. State lab situation

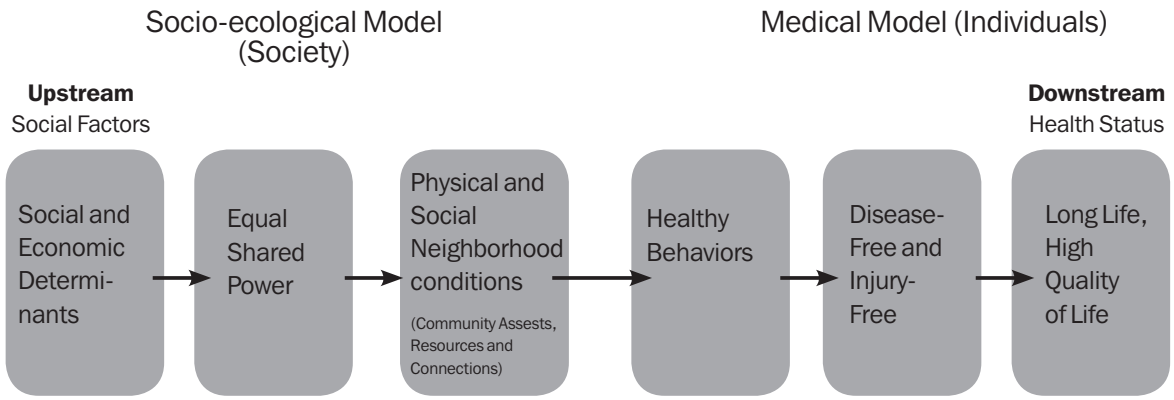
ii. Communication with community

iii. Many providers still use paper – not current standard/best practice, late submission of data and currently no consequence, questionable quality of data - no standard collection system around ethnicity, cultural values, etc.

iv. Serious issues around resources

Community Health Status Assessment

On April 5th, 2013, BACH convened a group of data experts to review and prioritize citywide data for the Community Health Status Assessment. Eight BACH members and affiliates met to reexamine the list of indicators that had been previously collected, based on national resources, such as Healthy People 2020 and the National Prevention Strategy. These indicators were aligned with BACH's data framework, seen below. Data sources included the 2010 US Census, American Community Survey, Boston Police Department Neighborhood Survey, Behavioral Risk Factor Surveillance Survey, and Vital Statistics. Using health equity and social determinants of health lenses, the group came up with the following key findings. Much of this data was compiled from the Health of Boston report, an annual resource developed by the Boston Public Health Commission. These data can be accessed at the following link: http://www.bphc.org/healthdata/health-of-boston-report/Pages/Health-of-Boston-Report.aspx



Social, Economic, and Environmental Determinants

Income, Poverty, Employment

- The median annual household income in 2010 for Latino households was $23,243 compared with $61,636 for White households, $35,564 for Black households, and $37,889 for Asian households.
- In 2010, 60% of female-headed households with children under age 5 had income below the poverty level compared with 18% for all family households in Boston. This is an increase from 2000 when 45.6% of female-headed householders with children under age 5 had income below the poverty level compared to 15.3% of all family households.
- Black male residents had an unemployment rate of 32%, almost four times the rate of 9% for White male residents in 2010. In 2000, Black male residents had an unemployment rate of 7.8%, while White male residents had an unemployment rate of 4.2%.
- More than 3 in 10 people employed in Boston are in the industries of *educational services and health care and social assistance.*

Housing

- 54% of households in Boston were non-family households in which no one in the household was related by marriage, blood, or adoption.
- 66% of occupied housing units in Boston were renter-occupied, while 34% were owner-occupied in 2010, compared to 68% renter-occupied and 32% owner-occupied in 2000.
- More than 7,600 homeless individuals were counted in Boston in 2011; 33% of these individuals were children. This is an increase from a homeless population of 5821 in 2000, of which 22% were children.

Transportation

- Only 33% of Boston's employed residents took public transportation to work in 2010, with 29.0% of White residents, 38.0% of Black residents, 36.0% of Asian residents, and 39.1% of Hispanic residents utilizing public transportation to get to work.

Education

- For the 2010-2011 school year, 53% of White youth in Boston attended public schools, compared to 71% of Black youth, 88% of Asian youth, and 91% of Latino youth. This is consistent with both the 2009-2010 and 2011-2012 school years.
- In 2010, Boston Public Schools had a 4-year graduation rate of 63%, an increase over the 59% in 2006.
- The percentage of Boston residents with less than a high school diploma or GED was significantly higher among Latino adults (32%), Asian adults (24%), and Black adults (20%) compared with White adults (7%). This indicates increased educational attainment compared to 2000 when 42.7% of Latino adults, 35.7% of Asian adults, 26.9% of Black adults, and 13.8% of White adults had less than a high school diploma or GED.

Language

- In 2010, 35% of Boston residents (ages 5 and older) reported speaking a language other than English at home. This is an increase from 2000, when 33% of residents spoke a language at home other than English.

Physical and Social Environment

- Boston has approximately 8.3 acres of green space per resident as of 2009
- Bostonians' trust in their neighbors decreased from 81% in 2007 to 75% in 2010.

Equal Shared Power

- 75.1% of Boston's voting age population is registered to vote. 65.9% of these residents voted in the 2008 elections and 62.1% voted in the 2012 elections.

Health Behaviors and Outcomes

- The adolescent birth rate for Boston female residents ages 15-17 decreased 9% from 2005 to 2010 and the overall percentage of preterm births among all Boston resident births decreased from 11% in 2005 to a preliminary 9% in 2010.
- The 5 year rolling average infant death rate for Black infants declined 11% from the period 2001-2005 to 2006-2010, based on preliminary data, compared to a decline of 8% for Boston overall.
  - Infant mortality in White babies may be increasing
- Boston's heart disease hospitalization rate decreased 10% from 2005 to 2011, and the heart disease death rate decreased 16% from 2005 to 2010 based on preliminary death data for 2010.
- From 2001 to 2011, the percentage of Boston public high school students who reported smoking cigarettes decreased. Similarly, the percentage of Boston adult residents who reported smoking cigarettes decreased from 2001 to 2010.
- From 2001 to 2011, the percentage of Boston public high school students who reported persistent sadness (feeling sad, blue, or depressed every day for two weeks straight during the past year) decreased
- From 2001 to 2011, the percentage of public high school students getting regular physical activity during the past week and the percentage reporting excessive alcohol consumption (binge drinking) during the past month remained statistically similar.
- From 2007 to 2011, the percentage of public high school students who reported drinking one or more sodas per day and the percentage considered obese remained statistically similar.
- From 2001 to 2010, the percentage of Boston adult residents considered obese increased.
- The percentage of Boston adults who reported getting regular physical activity, having asthma, having diabetes, and having persistent sadness (being sad, blue or depressed 15 or more days during the past month) remained statistically similar from 2001 to 2010 having diabetes, and having persistent sadness (being sad, blue or depressed 15 or more days during the past month) remained statistically similar from 2001 to 2010.
  - Asthma visits to the ER have decreased, despite the prevalence of asthma remaining the same
- Compared to residents of color, Boston's White residents had higher rates of:
  - Suicide
  - Substance Abuse

- Compared to Boston's White residents, Black and Latino residents had higher rates of:
  - Births to adolescent females
  - Low birth weight births
  - Infant deaths
  - Asthma emergency department visits among children less than 5 years old
  - Heart disease hospitalizations
  - Cerebrovascular disease (including stroke)-related hospitalizations
  - Diabetes hospitalizations
  - Nonfatal gunshot and stabbing injuries resulting in emergency department visits
  - Homicide
  - Adult obesity (based on self-reported height and weight)
  - Adults who self-reported having persistent sadness (feeling sad, blue or depressed 15 or more of the past 30 days)
- Compared to Boston's adult residents whose income was greater than $25,000, adult residents with income of less than $25,000 had higher rates of:
  - Smoking
  - Asthma
  - Diabetes
  - High blood pressure
  - Obesity
  - Depression
- Compared to Boston's adult residents whose income was less than $25,000, adult residents with incomes of more than $25,000 had higher rates of:
  - Heavy drinking
  - Physical activity
  - Fruit and vegetable consumption
  - Mammograms within the past year

Community Themes and Strengths Assessment

On April 22, 2013, BACH hosted an assessment retreat to conduct the citywide Community Themes and Strengths Assessment. Nearly 40 people from BACH's Steering Committee, Health Planning and Improvement Committee and BACH affiliates convened to identify community themes, strengths, and quality of life across the city and in subsets of neighborhoods. The data used in this analysis were drawn from quality of life surveys conducted by BACH-affiliated neighborhood coalitions and focus groups in 5 additional neighborhoods. The group considered which issues were "high impact" and how to address issues with a systems approach. Using a structured group process, retreat participants developed the following key findings.

Across All Neighborhoods:

Themes:

- Behavioral health concerns
- Language/cultural issues
- Health food access/affordability
- Education/job readiness
- Economy – need to strengthen, more opportunities, address poverty, affordability
- Public safety
- Community cohesion/coordination
- Quality/diverse housing stock
- Education and schools in neighborhoods – school assignment

Strengths:

- Active civic engagement
- Community engagement
- Partnerships
- High rate of satisfaction w/quality of life – people know each other
- Diversity is embraced/values
- Many high quality hospitals and community health centers
- Institutions of higher education
- Research funds

Subsets of neighborhoods:

Themes-

- Increasing green space (Hyde Park, Mattapan, South Boston, Dorchester)
- Transportation (Roxbury, Dorchester, Hyde Park, Mattapan)
- Need to engage newcomers and people of color in community leadership (East Boston, Roslindale, Roxbury, Hyde Park, Charlestown)
- Trash (Mattapan, Chinatown)
- Jobs
- Youth Development (Charlestown, Codman, Jamaica Plain, Roslindale)
- Brownfield cleanup (Hyde Park, East Boston, Dorchester)
- Access to quality care

High Impact Issues of Note:

- Violence and crime
- Gentrification (SB, So End, Charlestown)
- Lack of community cohesion (Allston/Brighton, Mission Hill, Fenway)
- Substance Abuse (Charlestown, South Boston, South End, Codman Square)
- Poverty and Racism (all neighborhoods) – need equity in jobs and employment
- Housing – affordable, accessible, stable
- Educational quality and access (East Boston, Jamaica Plain, South Boston)
- Access to transportation (Hyde Park, Mattapan, Franklin Field, Jamaica Plain, Roslindale)
- Obesity/diabetes (Codman Square, East Boston, Mission Hill, Jamaica Plain)
- Immigration and immigrants (Charlestown, East Boston)

Correlations/Systems Approach[1]:

- Mental health – substance abuse- public safety
- Youth development – jobs
- Obesity/diabetes – fresh food- exercise- public safety
- Open space – public safety
- Education – neighborhood school – community cohesion
- Behavioral health (substance abuse, mental health) – access to care – economy
- Early education and care
- Violence – individual and community trauma – mental health – public safety

Forces of Change Assessment

In addition to engaging in the Community Themes and Strengths Assessment, the April 22nd retreat participants conducted the citywide Forces of Change Assessment. Participants engaged in structured conversations to determine the forces that affect the context in which Boston's local public health system operates. The group came up with the following overarching forces.

- **Inequitable public transportation system**
  - o Fairmont Indigo Line
    - Creation of 5 new stations on commuter rail line increases access to Downtown and jobs for Dorchester and Roxbury residents but has infrequent trains

1 A systems approach is the process of understanding how things (individuals, organizations, communities) influence one another within a whole. Systems thinking has been defined as an approach to problem solving, by viewing "problems" as parts of an overall system, rather than reacting to specific part, outcomes or events and potentially contributing to further development of unintended consequences. A systems approach claims that the only way to fully understand why a problem or element occurs and persists is to understand the parts in relation to the whole.

- Transportation for seniors and people with disabilities
  - Not all busses are accessible and "The Ride" is underfunded and difficult to use
- MBTA budget process and rising cost of public transportation
  - City of Boston has minimal input on MBTA budget; fares keep increasing

■ **Community engagement**

- MAPP process
  - Multi-stakeholder involvement in many neighborhoods and cross-sector involvement of many organizations
- Community-based best practices
  - There are many successful and evidence-based programs in Boston
- Lack of community capacity to engage residents
  - It is very difficult to engage residents due to time and money when there is not a perceived crisis
  - Student population is transient, not as cohesive with neighborhood

■ **How prevention money gets spent**

- Affordable Care Act
  - There is significant funding for multi-sector "community transformation" in the ACA and payment reform incentivizes providers to engage in prevention
- Prevention Trust
  - Massachusetts has a 5 year, $15 million per year funded trust that cannot be "raided" by the legislature in lean times.
- Shift to wellness and disease management
- Providers and employers are moving in this direction
- Primary care providers
  - Increasing understanding of social determinants of health and need to link primary care and prevention
- MA Dept of Public Health Determination of Need process
  - Requirement that 5% of the capital outlay for clinical space and equipment must be directed to community health and prevention
- IRS requirement of non-profit hospitals to conduct community health assessments
  - Hospitals are required to engage the community in their assessment process, which gives more opportunities for neighborhood coalitions to connect to hospital prevention and community benefits programs

■ **Consideration of the entire life spectrum**

- Focus on early childhood and family
  - Increased call for increasing early childhood education and health care funding
- Increasing senior population
  - Presents major challenges for chronic disease managemen, as well as socio-economic issues associated with aging
- Dynamic flux of community demographics
  - Ethnic and racial diversity in some neighborhoods presents opportunities and challenges for increased inclusion in decision making and community cohesion

- **Policy drivers**
  - City planning – licensing, zoning
  - State lab scandal
    - Decreased public confidence in public health and large numbers of incarcerated people with substance abuse and violent backgrounds released into the community suddenly
  - Affordable housing and homelessness policies; rising housing demand squeezing out middle income population
    - Subsidized "affordable" housing and greater gentrification in many neighborhoods
  - Medical marijuana regulations and implementation
    - Unknown impact, particularly on youth
  - Place-based strategies create funding inequity
    - Double-edged sword – Some neighborhoods in need improve while others get left out
  - Institutional barriers in public benefits
    - System is difficult to navigate and results in people not getting benefits for which they are entitled
- **Violence and trauma**
  - Effects of trauma, violence, natural disasters
    - Homicide, suicide, and the effects of substance abuse and untreated mental illness means some neighborhoods are traumatized on the community level
  - National Rifle Association
    - Their increased radical opposition to gun control results in increased accidental and purposeful gun deaths and injuries
  - Emergency response system
    - Flu response and marathon bombing response shows an effective system in Boston that includes public health and public safety.
- **Political changes**
  - Mayoral and city council election
    - We have had a mayor who is highly committed to public health. Many unknowns about the future. Existing relationships may not be able to continue and energy and time will need to be invested in building new personal and institutional relationships.
  - Federal sequestration
- **Boston Public Schools**
  - Relationships with neighborhoods
    - Since many children do not attend school in their neighborhood, it is difficult for community groups and schools to partner effectively.
  - School assignment plans
    - Unclear how the new plan will change relationships and affect health
- **Higher education accessibility**
  - Employment trends
    - Many of the available and new jobs require high skills and education
  - Rising cost of college
    - Increases wealth gap and potential for success
  - Access for local youth

- Communication across all ages
  - Social media fragmented by age
    - Need to develop different modes of communication with different age groups
    - Digital divide in communities – So much communication happens digitally and poorer communities have less access

IDENTIFYING STRATEGIC ISSUES

After collecting the data from the four MAPP assessments, on September 12th, 2013, BACH and its partners held a community meeting to review the data and identify strategic issues. Four stations were set up around the meeting room. Each station had posters showing the data for one of the four assessments, as well as food to engage participants. Each station also had two volunteers from BACH's Health Planning and Improvement Committee who were very familiar with the process and the results of each assessment. To start the meeting, participants rotated around the room to review data from the four assessments and ask questions of Health Planning and Improvement Committee members.

Following this process, the Health Planning and Improvement Committee presented three draft strategic issues for participants to react to and build on. These draft strategic issues represented a synthesis of the four assessments and considered national priorities such as the strategic directions outlined in the National Prevention Strategy. These issues were developed in the form of questions that the local public health system must address for Boston to achieve its vision.

The small groups developed a list of 22 strategic issues to be refined and prioritized by the large group.

Then, the planning team and participants established the following criteria for prioritization of the strategic issues:

- Addressing the issue will move us towards health equity
- Political will exists to support change
- Community need (based on assessment data)
- Feasibility
- Resources available or likely
- Can define measurable outcomes
- Community interest and motivation for the issue

After the brainstorming, the large group discussed each strategic issue and used the above criteria to take a vote. Each participant was given three dots, which could be placed next to one or more strategic issues that were written on flip charts around the room. In the end, the group decided on five strategic issues, the wording of which was refined in the Health Planning and Improvement Committee. These five issues are

- How can we achieve racial and ethnic health equity?
- How can we improve coordination and integration of healthcare and community-based prevention activities/services?
- How can we build and increase resilience in communities impacted by trauma?
- How can we improve health outcomes by focusing on education, employment, and transportation policies and practices?
- How can we increase the number of immigrants, people of color, and other underrepresented residents in meaningful leadership roles and decision-making processes?

Subsequently, BACH and its partners engaged a group of champions, or individuals who have significant work or lived experience with the strategic issues (two champions per issue) to lead the next phases of the MAPP process.

FORMULATING GOALS AND STRATEGIES

Once priorities, i.e. strategic issues, had been determined, BACH hosted a community meeting on November 16, 2013 to develop goals and strategies for each strategic issue. Participants self-selected into five groups, one for each strategic issue. Two facilitators guided each small group through the process of defining and deciding on one to two goals and three to five strategies per strategic issue.

The meeting format allowed for rapid strategic planning process in which each small group had the opportunity to develop goals and strategies, as well as give feedback on those developed by each of the other groups. A summary of the strategic issues, goals, and strategies can be found in the table below.

Summary of Strategic Issues, Goals, and Strategies

Strategic Issue	Goal	Strategies
1. How can we achieve racial and ethnic health equity?	Public and private institutions will adapt, implement, and enforce comprehensive system-wide policies and practices that achieve racial equity and justice.	• Develop a context and shared language where race is primary • Identify and build on locally developed models of effective community engagement, organizing, and accountability • Develop an equitable and collaborative infrastructure that will include community residents, organizations, private and public institutions that develop policies and practices
2. How can we improve coordination and integration of healthcare and community-based prevention activities and services?	Improve population health by better integration of the health care delivery system with community-based prevention activities.	• Demonstrate the return on investment (financial and quality of life) and advocate for equitable funding mechanisms including insurance reimbursement, hospital community benefits, and philanthropic initiatives for prevention and wellness activities • Advocate for a robust, accessible shared data platform for Boston that medical providers, public health practitioners, community-based organizations, and residents can use to identify issues and track improvements in health, including social determinants of health • Develop a system of mutual accountability and transparency that represents multi-sector commitments to improve coordination and integration of efforts to achieve health equity

Summary of Strategic Issues, Goals, and Strategies *(continued)*

Strategic Issue	Goal	Strategies
3. How can we build and increase resilience in communities impacted by trauma?	Nurture the natural and existing strengths and resilience of the Boston community to ensure that all residents, regardless of background, have the skills to prevent traumatic events when possible and are prepared to cope with traumas and chronic stressors on any scale.	• Inventory all current trauma prevention and response resources to identify gaps in the continuum of care • Develop and connect a range of community resilience strategies and build on the existing capacity of communities by increasing access to training and educational resources • Educate community residents and human service providers about what resources are available and when and how to access them.
4. How can we improve health outcomes by focusing on education, employment, and transportation policies and practices?	Enhance and build collaborations that consider health in all policies and practices to ensure optimal quality of life within and across all neighborhoods	• Develop and communicate a shared language about health in all policies and practices and its importance to decision-makers and community members • Develop new and more inclusive ways for getting meaningful participation of community members in decisions that impact health • Establish a coordinating body that will support communication and implementation of health in all policies and practices work
5. How can we increase the number of immigrants, people of color, and other under-represented residents in leadership roles and decision-making processes?	Increase the number of immigrants, people of color, and other underrepresented residents in meaningful and effective leadership roles and decision-making processes	• Identify existing Boston-based decision-making bodies that influence the core equity areas[2] and assess for leadership of immigrants, people of color, and other underrepresented groups • Examine institutional and structural policies and practices that hinder immigrants, people of color, and other underrepresented groups from serving in leadership roles and decision-making processes • Build on existing capacity to develop and support immigrants, people of color, and other underrepresented groups for sustained leadership roles through training, mentoring, and organizational/institutional change

[2] *Decision-making bodies are prioritized by those that influence core equity areas of education, transportation, public planning, land use, housing, health, and jobs, e.g. civic associations, neighborhood councils, school-parent councils, planning boards, advisory boards, etc.*

Action Cycle

Once the goals and strategies were drafted, BACH and the strategic issue champions brainstormed and recruited individuals to be part of action planning groups. Each group comprised between 10 and 20 participants. Between January and May 2014, the five action planning groups each met 2-3 times to refine and flesh out the goals and strategies, and continue into the action cycle.

During these months, corresponding actions were developed for each strategy. The groups also considered who might implement the actions and within what time frame – short term (1 year), medium term (1-3 years), or long term (3-5+ years).

Given the breadth and overlap of several of the strategic issues, the five action planning groups came together on May 19th, 2014, to examine the entire set of proposed actions across the five strategic issues. While there was not much duplication of proposed actions, it was useful for each group to hear what others were planning.

At this meeting, participants also brainstormed a list of stakeholders from whom feedback would need to be sought regarding the action plan. A process and feedback tool were developed, and BACH members reached out to stakeholders to get their feedback on whether any clarifications or revisions were needed regarding the proposed actions, if they could see a way for their organization to be involved in implementing any of the actions, and if they had suggestions of other individuals or organizations who should also be involved.

Based on this feedback, the final community health improvement plan and action plan have been developed. Please refer back to the full MAPP report for additional details.

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