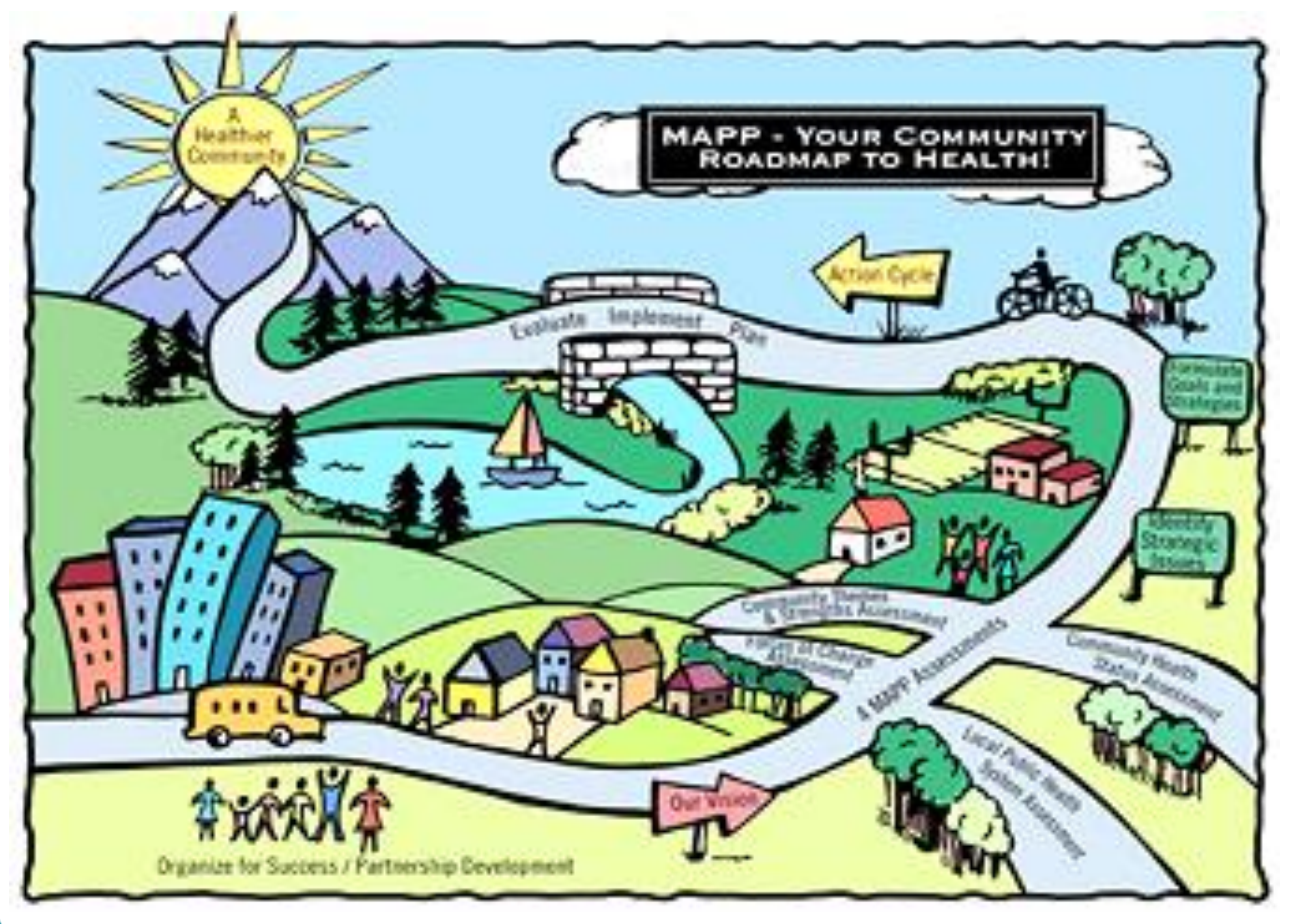



Healthy Start
Virtual Grantees' Meeting

# Introduction to NACCHO's Mobilizing for Action through Planning & Partnerships (MAPP) Training

Peter Holtgrave, MA, MPH
NACCHO

June 24, 2020

# Agenda

| | |
|---|---|
| Housekeeping | Colleen Bernard, NICHQ |
| Introductions | Sara Black, NACCHO |
| Introduction to the MAPP Training | Peter Holtgrave, NACCHO |
| Q&A | All |
| Closing | Colleen Bernard, NICHQ |

# Meeting Logistics

**Please note the following:**

- This session is being recorded, and will be archived for future viewing.

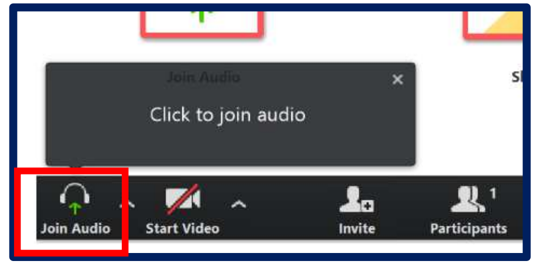
- All participants are muted upon entry. We ask that you remain muted to limit background noise.

- Members are encouraged to participate in the discussion by typing your comment/asking questions using the chat box.

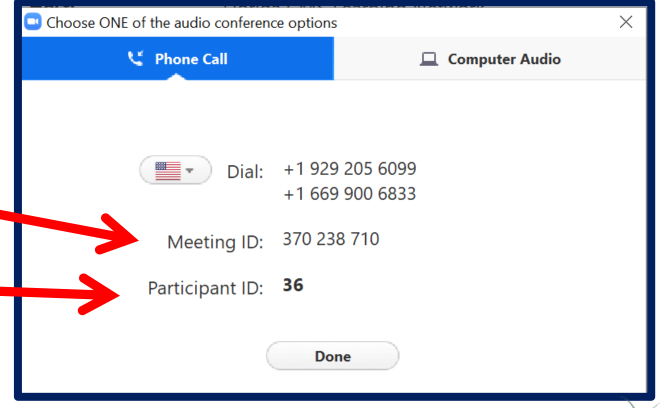
# Connecting to the Audio Conference

- Join Zoom Meeting by **clicking Zoom Meeting link** & launching the Zoom application

- An audio conference box will appear
  - If you do not see the box click the **'Join Audio' button**




- From the audio conference box: Select to **"Phone Call"** or **"Computer Audio"**
- If using the phone:
  - dial the number next to "Dial"
  - You will be prompted to enter the **"Meeting ID"**
  - Then you will be prompted to enter the **"Participant ID"**



# Ways to Participate: Chat

Zoom Participant ID: 49 Meeting ID: 617-788-369

Talking:

Meeting Topic: Healthy Start Webinar

Host: HS TA & Support Center

Invitation URL: https://zoom.us/j/617788369

Copy URL

Participant ID: 49

Share

Invite Others

Join Audio | Start Video | Invite | Participants | Share | Chat | Record | Leave Meeting

Zoom Group Chat

To: Everyone File

Type message here...

At the bottom of the Zoom window, you will see a 'Chat' button

After you click the 'Chat' button, a sidebar will appear where you can chat to all participants

Chat here to everyone!

# Need Help or Have a Question?

- Use the chat box to message a NICHQ staff member
- All staff have this picture as their Zoom thumbnail

# #HealthyStartStrong

- Spread the word about #HealthyStartStrong on social media
- Throughout the meeting, post about what you're learning/enjoying about the meeting
- Include the hashtag #HealthyStartStrong and be sure to tag @NICHQ

Peter A. Holtgrove, MA, MPH
National Association of County and City Health Officials (NACCHO)

# NACCHO's Mission

NACCHO is comprised of nearly **3,000 local health departments** across the United States. Our mission is to serve as a **leader**, **partner**, **catalyst**, and **voice** with local health departments.

*There's value in belonging*

Learn more by viewing a short video available on our website.

# NACCHO's Work

Advocacy

Partnerships

Funding

Training and education

Networking

Resources, tools, and technical assistance

# Today's Learning Objectives

- Describe the MAPP process.
- Understand how the MAPP framework can support the development and function of Healthy Start Community Action Networks (CANs) to improve maternal and child health.
- Describe how CANs and related partnerships can use MAPP to address health inequities in their communities.
- Understand where to find resources to aid CANs in strengthening partnerships, improve community engagement, collect and use data to inform and formulate goals and strategies, and advance health equity.

# Poll

# MAPP is:

**M**obilizing for

**A**ction through

**P**lanning and

**P**artnerships

A **Community-wide and driven strategic planning process** for improving public health.

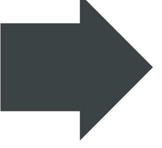
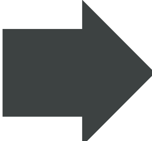
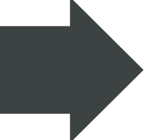
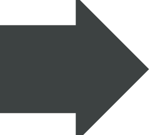
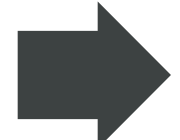
# MAPP as a Framework

Health Equity

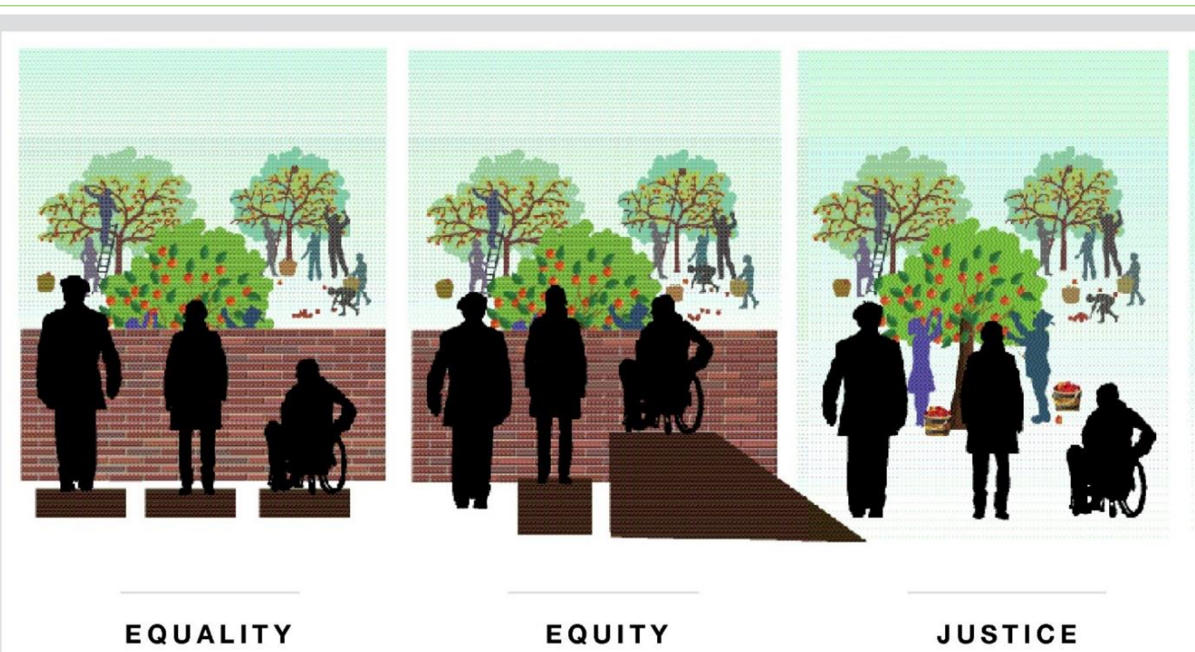
**<u>Six phase process:</u>**

- **Phase 1**: Organize for Success/Partnership Development
- **Phase 2**: Visioning
- **Phase 3**: Four Assessments
- **Phase 4**: Identify Strategic Issues
- **Phase 5**: Develop Goals and Strategies
- **Phase 6**: The Action Cycle

# The MAPP Approach

| | | |
|---|---|---|
| Operational planning |  | Strategic planning |
| Focus on the organization |  | Focus on the community and system |
| Needs assessment |  | Emphasis on assets and resources |
| Medically-oriented model |  | Broad definition of health |
| Organization knows all |  | Everyone knows something |

# The MAPP Approach




Source: National Council on Aging

- Honoring community voice
- Addressing social & structural determinants of health

# Roots Causes of Health Inequities

- Structural Racism
- Class Oppression
- Gender Inequity
- Heterosexism
- Ableism

http://www.rootsofhealthinequity.org/

ROOTS of HEALTH INEQUITY

ABOUT PROJECT | ABOUT COURSE | PREVIEW INTERACTIVES | HOW TO REGISTER | SITE CREDITS | LEARN MORE CONTACT

NACCHO presents
The Roots of Health Inequity
A Web-Based Course for the Public Health Workforce
LEARN MORE »

1 | 2 | 3 | 4 | 5 | 6

What's in this Online Learning Collaborative?
As part of the Roots of Health Inequity Learning Collaborative, participants will be able to:
• Explore social processes that produce health inequities in the distribution of disease and illness.
• Strategize more effective ways to act on the root causes of health inequity.
• Form relationships with other local health departments who are working to ensure health equity.

ENTER ROOTS COURSE SITE

About the Project
Social justice affects the way people live, their chance of illness, and their risk of premature death. Can public health influence the unequal structuring of life conditions? This course provides an online learning environment from which to explore the root causes of inequity in the distribution of disease, illness, and death

Who Can Sign Up for the Course?
Anyone interested in addressing the root causes of health inequity may take this course. Our material is written primarily for local public health department staff at all levels. There is no fee. Learn More »

# Benefits of MAPP

- Anticipates and manages change
- Creates a stronger infrastructure
- Builds stronger partnerships
- Builds leadership
- Aligns duplicative efforts to maximize efficiency
- Increases visibility
- Creates advocates
- Strengthens health equity efforts
- Creates a healthy community and better quality of life

# Phase 1: Organizing for Success

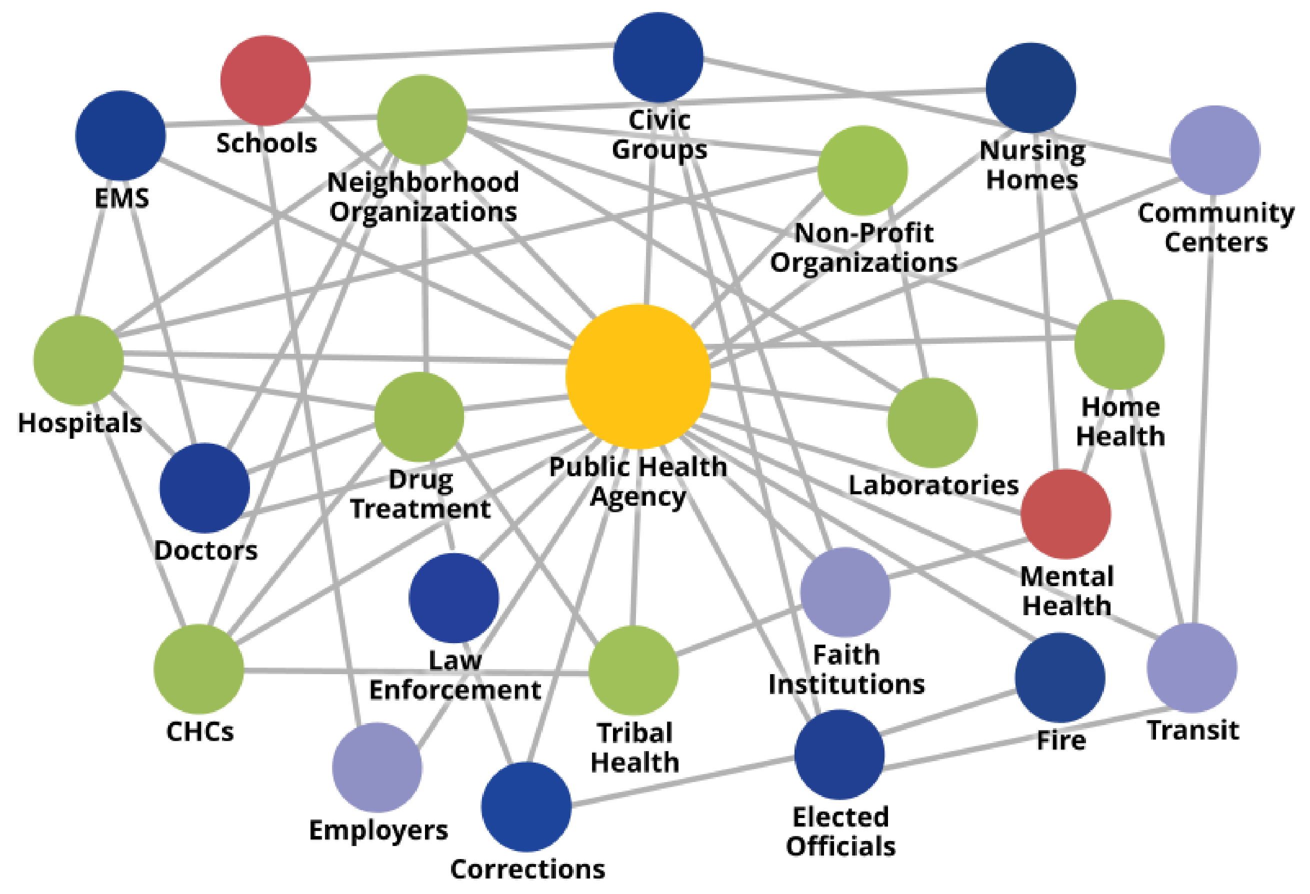
**Addresses:**

- Who should be included?
- Is the community ready?
- What are resource needs?
- How will we proceed?

# Let's Chat!

- What are some current challenges that you are experiencing with your CAN in terms of member/partner engagement?
- What are some solutions or successful practices that have helped your CAN function well as a group?

# Local Public Health System



Source: CDC, https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html

# Reminders: Why Should a Partnership be Created?

- Increase opportunities to learn and adopt new skills
- Secure access to resources
- Share financial risks and costs
- Gain input from more or different members of the community
- Aligning efforts for maximum impact
- Exchange information
- To tackle challenges in your community
- Leverage resources

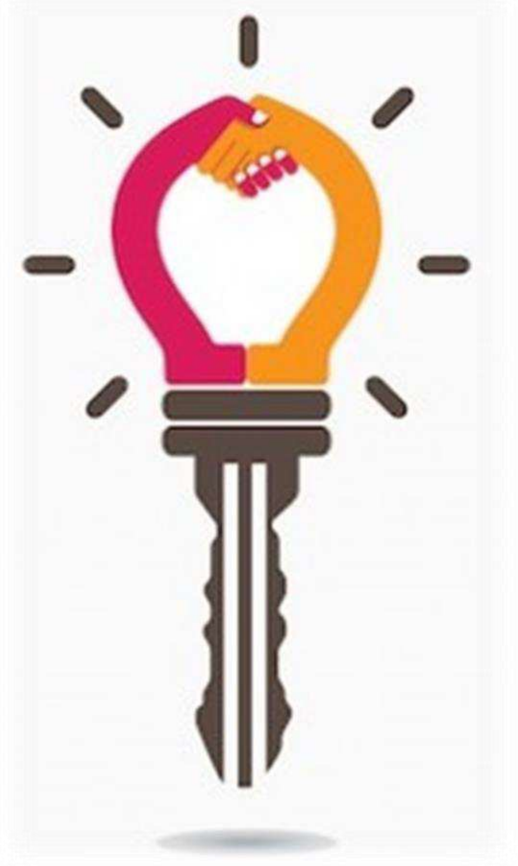
# Keys for Strong Partnerships

Be Inclusive and Build Trust

Have Purposeful Meetings

Communicate Frequently & in a language all understand

Understand Mutual Benefit

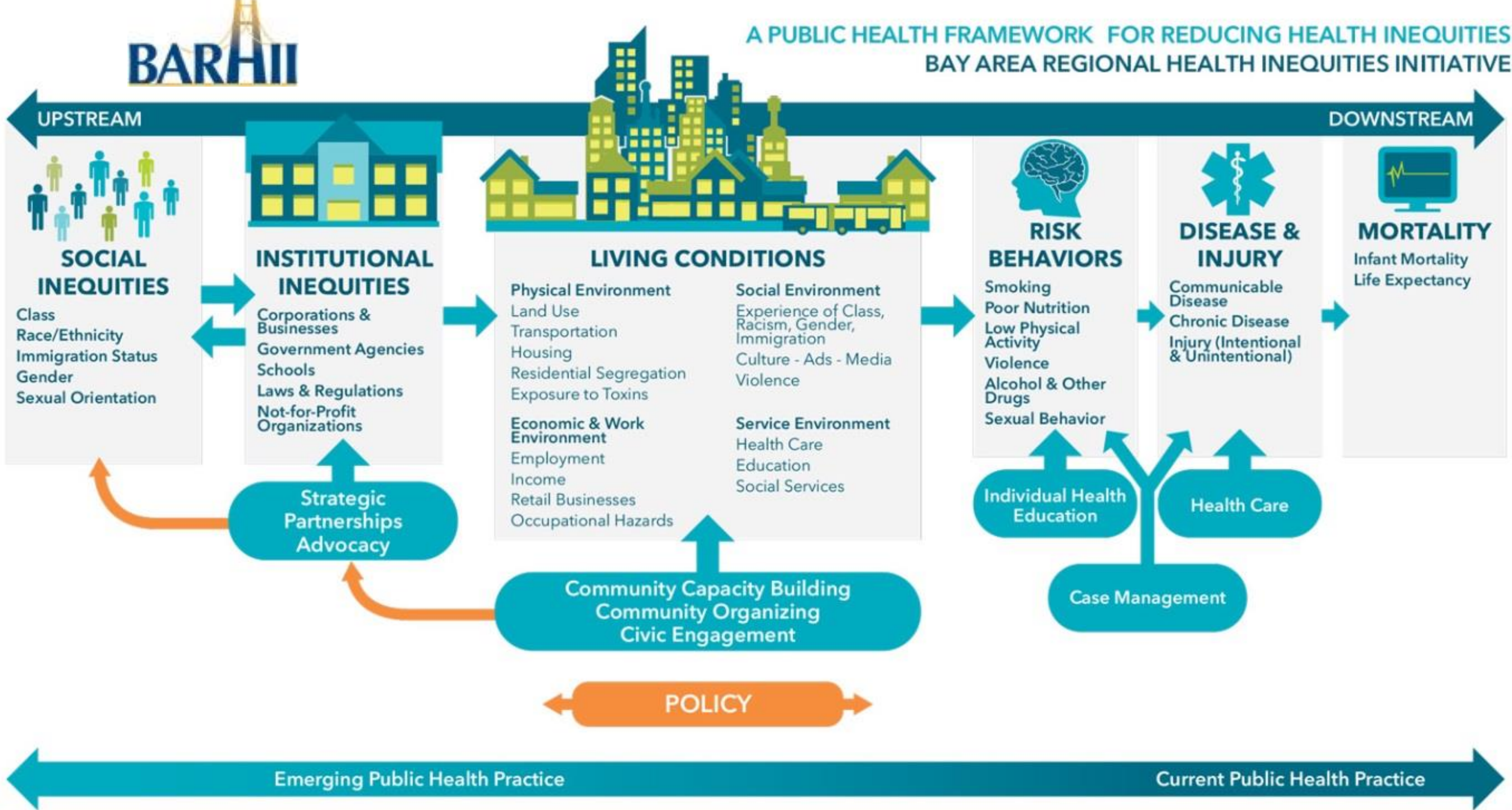


Define Roles & Responsibilities

Celebrate & Recognize Contributions

Identify Shared Goals & Vision

Share Progress Frequently

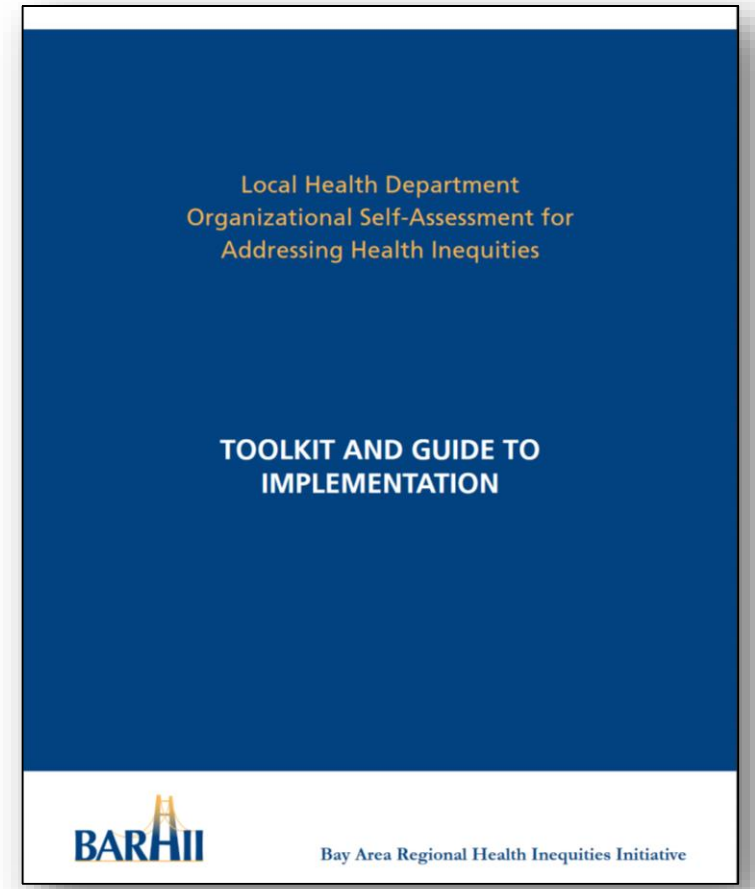



Source: BARHII, http://barhii.org/framework/

# BARHII Organizational Self-Assessment Toolkit

1. Staff Survey
2. Collaborating Partner Survey

Source: http://barhii.org/resources/barhii-toolkit/

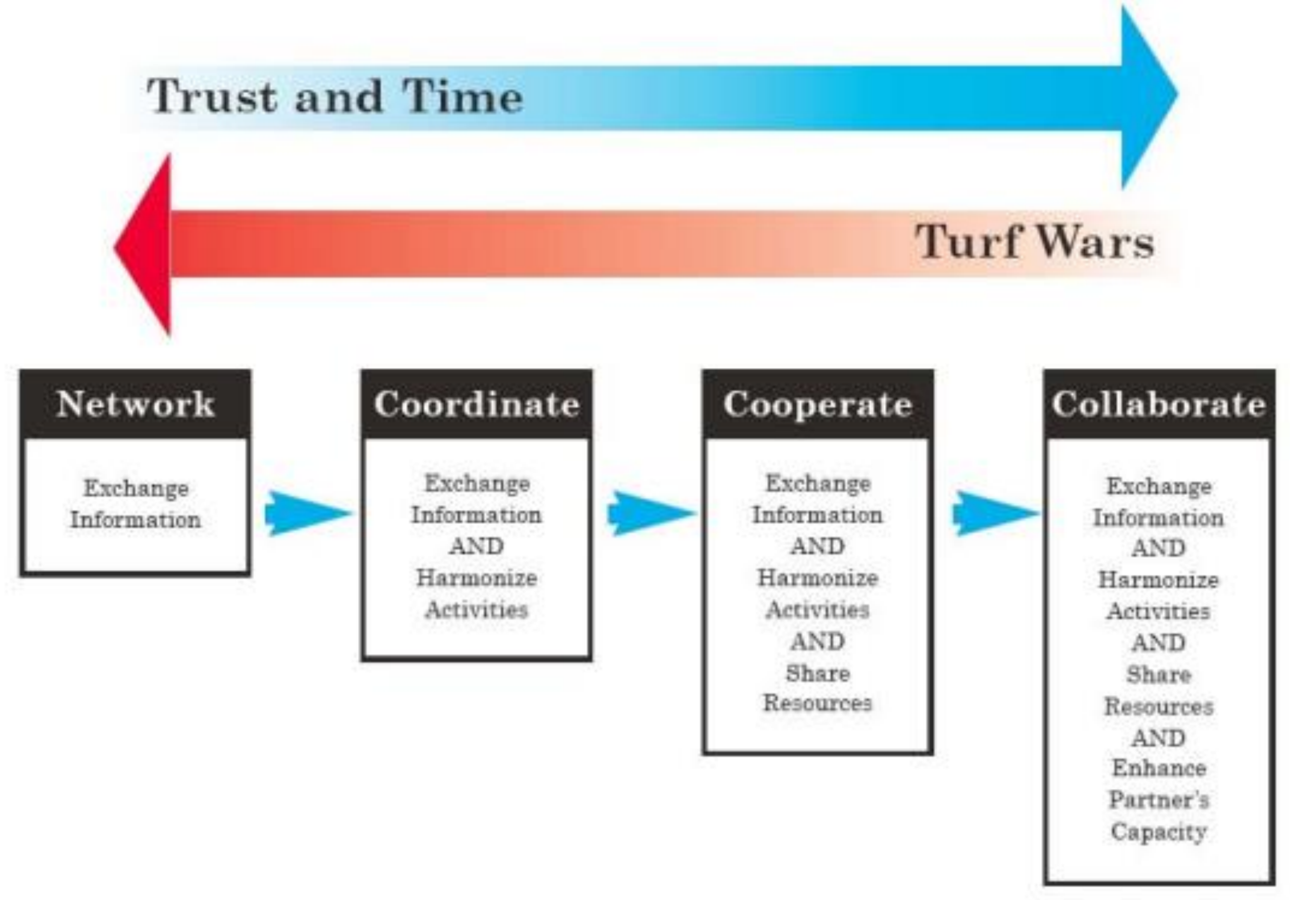


# Matrix of Workforce Competencies and Organizational Characteristics

| Organizational Characteristics | Workforce Competencies |
|---|---|
| • Institutional commitment to addressing health inequities<br>• Structure that supports true community partnerships<br>• Supporting staff<br>• Transparent and inclusive communication<br>• Creative use of categorical funds<br>• Community-accessible data and planning | • Personal attributes such as passion, self-reflection and listening skills<br>• Understanding of the social, environmental, and structural determinants of health<br>• Knowledge of affected community<br>• Leadership, collaboration, and community organizing skills<br>• Cultural competence and humility |

Source: http://barhii.org/resources/barhii-toolkit/

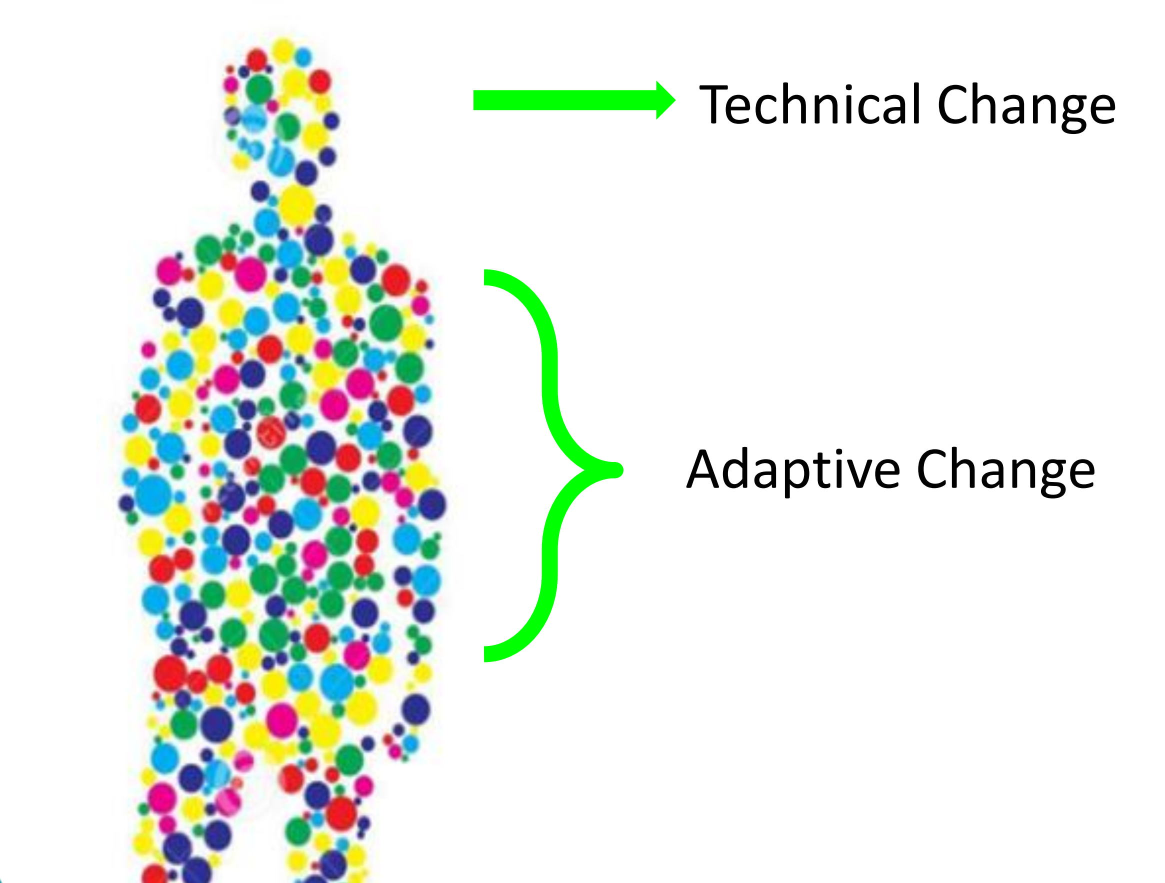
# Partnership Spectrum

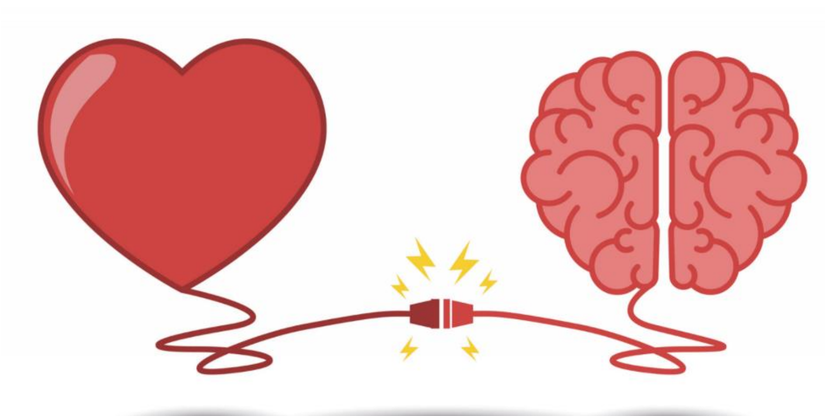


# What is Adaptive Leadership?

A practical leadership **framework** that helps individuals and organizations **adapt and thrive** in **challenging environments**.

# Technical vs Adaptive Work

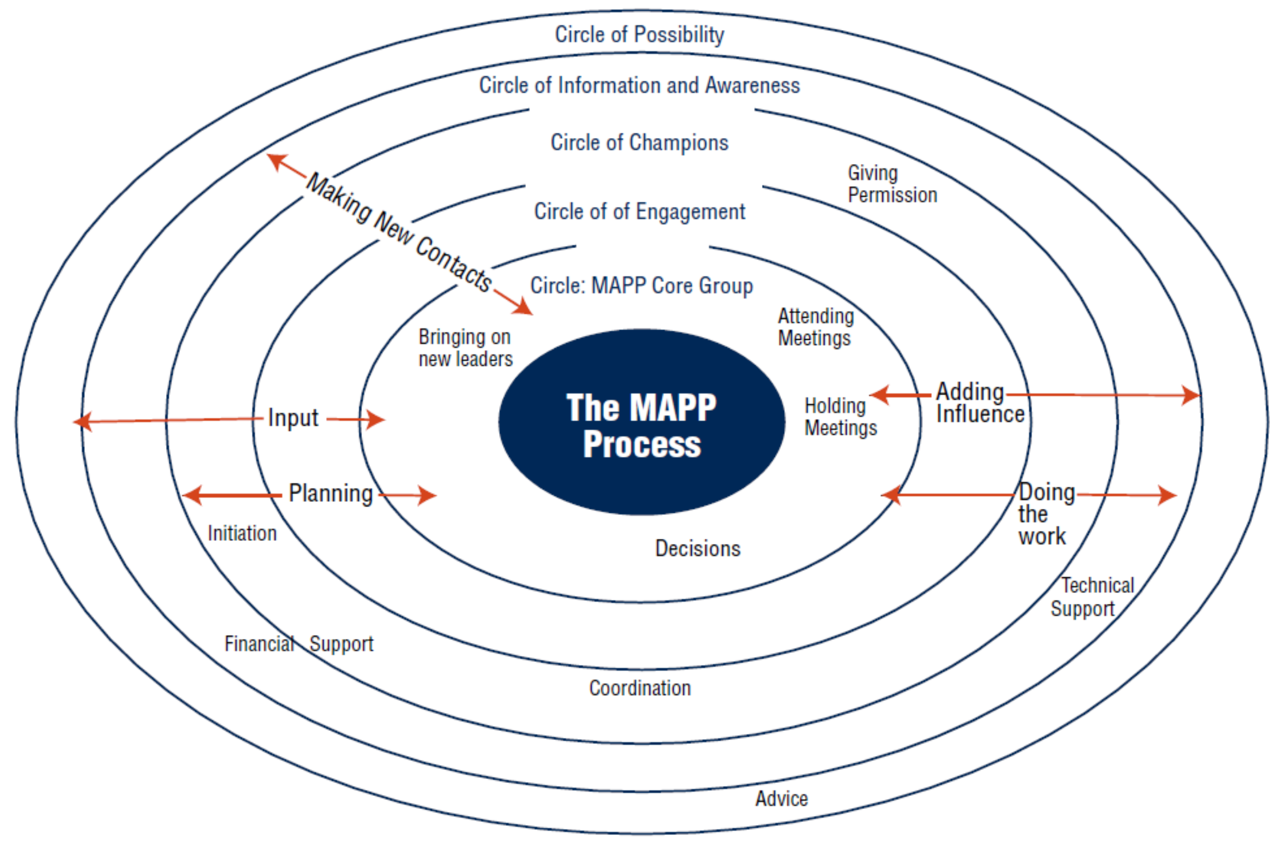


# Managing the Process

- **MAPP Core Group** – regularly support and lead the process
- **MAPP Steering Committee** – a group representative of the LPHS, provides guidance and direction
- **Sub-Committee** – designated to oversee and complete certain aspects of the MAPP process
- **Community** – broad community participation should be considered in every phase

# Circles of Involvement




Adapted from "Creating a Framework of Support and Involvement" originally created by The Canadian Institute of Cultural Affairs.

# Phase 2: Visioning

## Addresses:

- What does health look like for all in the future?
- What are the living conditions for the whole community?
- How do community members, organizations, and/or institutions interact differently with one another?

# Formulate a Vision Statement

An aspirational description of what one would like to achieve or accomplish in the longer-term future that is:

- Clear
- Memorable
- Inspirational
- Motivating
- Aspirational
- Inclusive
- Promotes health equity

# Vision Statement Examples

*"We envision a safe, equitable New Orleans whose culture, institutions, and environment support health for all."*
*~ New Orleans, LA*

*"The local public health system is accessible, affordable, collaborative, holistic, inclusive, and works to achieve a culture of health through collective impact. The community is active, empowered, diverse, knowledgeable, and lives in an environment that is sustainable, and supports an optimal quality of life for all."*
*~ Linn County, IA vision statement*

# Phase 3: MAPP Assessments

## Together they:

- Provide insight on **gaps** between current circumstances and vision.
- Serve as the **source of information** from which strategic issues, strategies, and goals are built.

# MAPP Assessments

- **Community Health Status Assessment:** provides quantitative information on community health status and conditions
- **Community Themes and Strengths:** identifies assets in community and issues important to community members
- **Local Public Health System Assessment:** measures how well different public health system partners work together to provide the 10 Essential Services
- **Forces of Change:** identifies forces that may affect a community and associated opportunities and threats

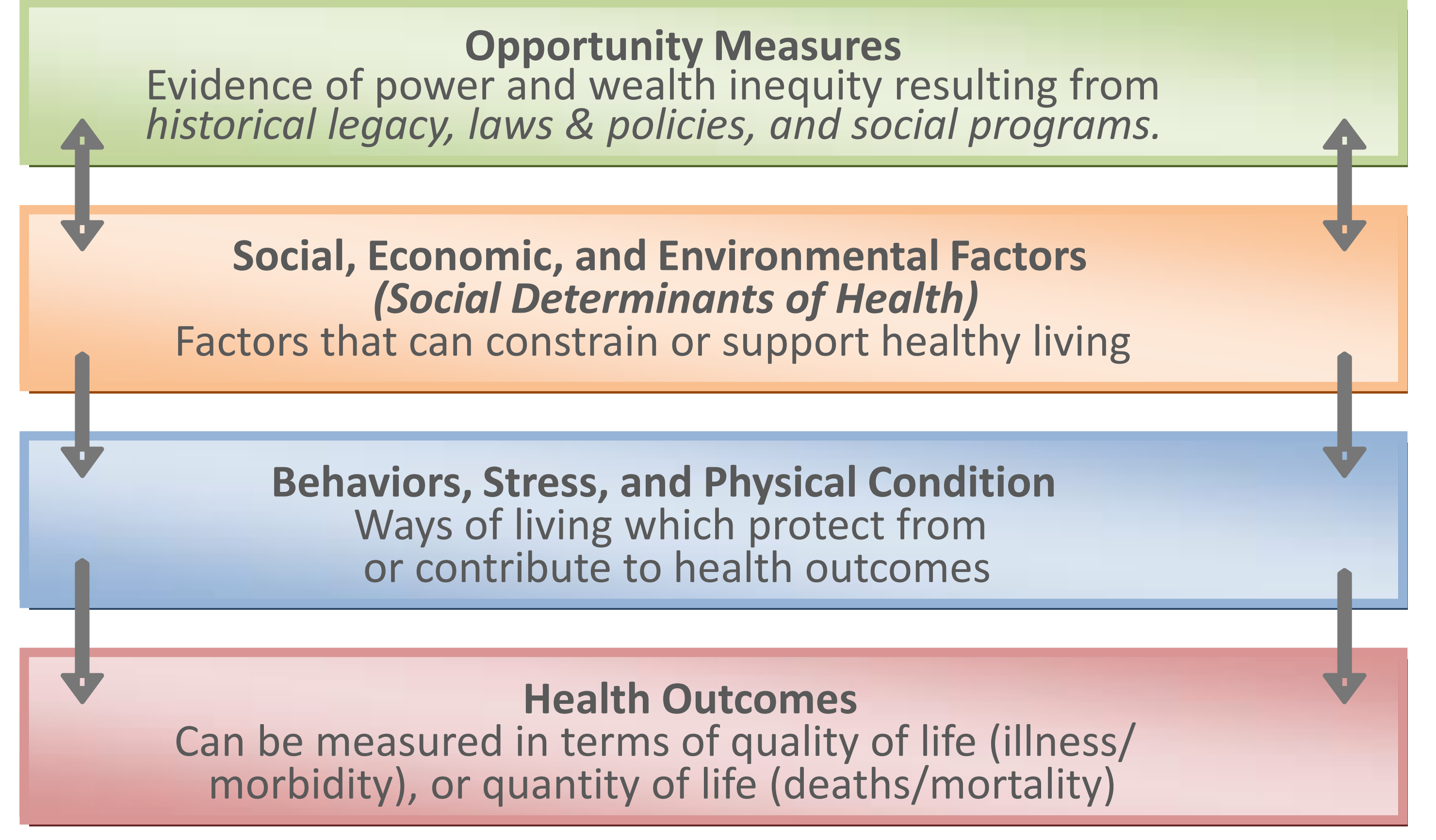
# Categories of Data

- Demographic characteristics
- Socioeconomic characteristics
- Health resource availability
- Quality of life
- Behavioral risk factors
- Environmental health indicators
- Social and mental health
- Maternal and child health
- Death, illness and injury
- Infectious disease

# Social, Economic, Political Indicators

- Level of investment and disinvestment by neighborhood
- Foreclosure rates
- % households below poverty
- Unemployment rates
- Civic engagement
- High school graduation rate
- Income and wealth inequality
- Political participation by race, income, gender
- Allocation of city/county budget by neighborhood

# Healthy!Capital Counties, MI Indicator



# Measuring Health Inequities

**Traditional approach to public health data analysis might include initial questions such as:**

- What is the overall infant mortality rate in the jurisdiction?
- How has this rate been changing over time?
- What behaviors contribute to or reduce the risk of infant mortality?
- What population groups in the jurisdiction have higher rates of infant mortality than others?

**Using Health Equity Data Analysis:**

- What living and working conditions contribute to the risk of infant mortality?
- How are the living and working conditions of the community with a higher diabetes rate different from those communities with lower infant mortality rates?
- What structures, policies and systems contribute to the differences in living and working conditions?

Based upon the Minnesota Department of Health, "HEDA: Conducting a Health Equity Data Analysis" http://www.health.state.mn.us/divs/chs/genstats/heda/healthequitydataguideV2.0-final.pdf

# Social Determinants Data Sources

| Domain | Indicator | Data Source |
|---|---|---|
| Economic | Housing Cost Burden | • American Community Survey (ACS), U.S. Dept of Housing and Urban Development |
| Economic | Living wage | • MIT Poverty in America Living Wage Calculator, ACS |
| Service | Violent crime rate | • Uniform Crime Reports |
| Social | English language learners | • ACS |
| Social | Voter turnout rates | • U.S. Census Bureau |
| Physical | Access to public transportation | • U.S. Census Bureau, local/regional transportation planning authorities |
| Physical | Food Access | • ACS, USDA |

2. Applying SDOH Indicator Data for Advancing Health Equity - BARHII (2015). Retrieved April 23, 2018, from http://barhii.org/resources/sdoh-indicator-guide/introduction/

# Example Data Sources

- NACCHO National Profile of Local Health Departments (nacchoprofilestudy.org)
- NACCHO Forces of Change (nacchoprofilestudy.org/forces-of-change/)
- Health Indicators Warehouse (healthindicators.gov)
- Healthy People 2020 (healthypeople.gov)
- Youth Risk Behavioral Surveillance System (cdc.gov/yrbs)
- Behavioral Risk Factor Surveillance System (cdc.gov/brfss/)
- Community Commons (communitycommons.org)
- County Health Rankings (countyhealthrankings.org)
- NACo County Explorer (explorer.naco.org)
- National Equity Atlas (nationalequityatlas.org)
- Data USA (datausa.io)

National Equity Atlas

# Community Engagement

- Focus groups
- Surveys
- Brainwriting exercise
- Windshield surveys
- Photovoice
- Town hall meetings
- Informal discussions with community
- Wordle
- Asset Mapping
- Vox Pops
- Street Stall
- Web-based Engagement

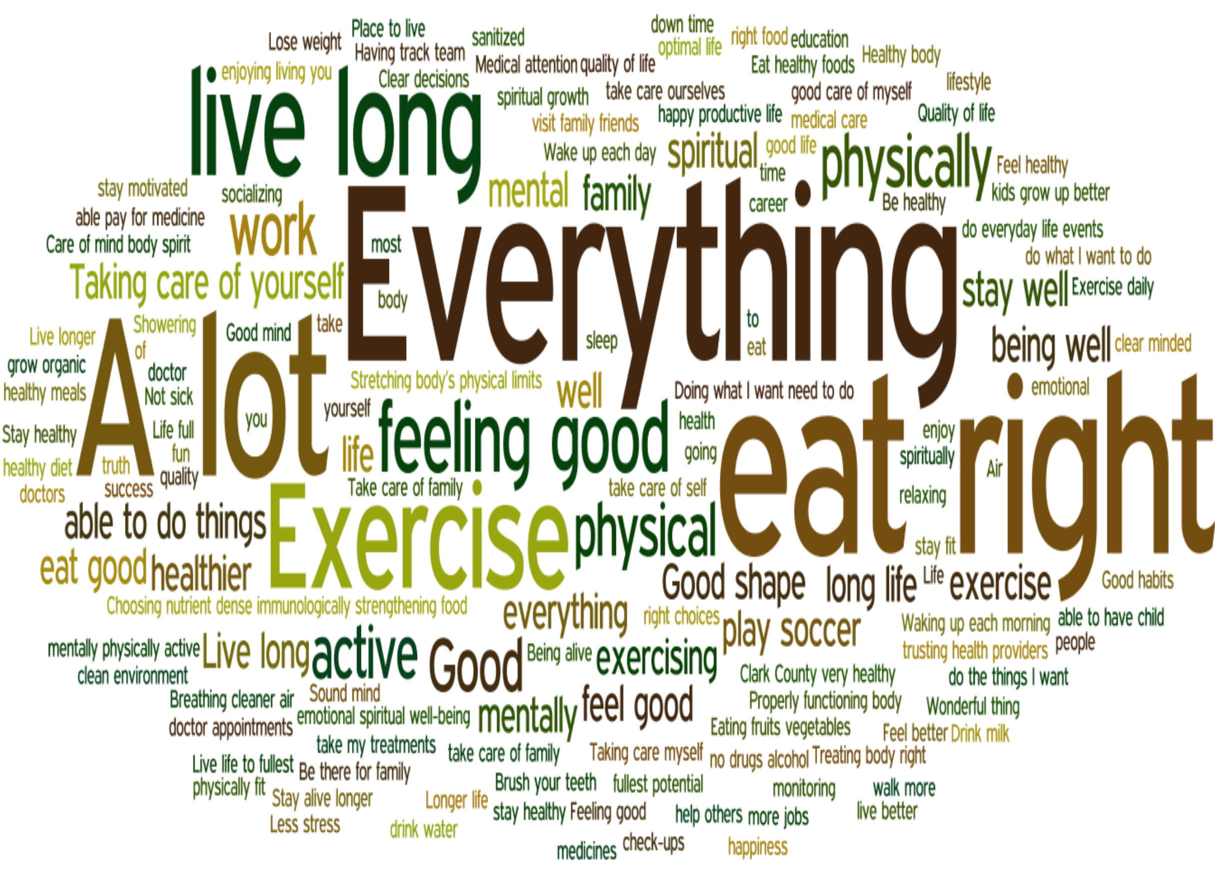
**Tip:** Have community members participate on planning committees

# Kansas City Health Department: Qualitative Data

## Quality of Life and Community Themes and Strengths Assessment

- What services or programs do you feel improve the quality of life in your community?
- What policies do you feel improve the quality of life in your community?
- Identify your top 3 concerns or needs in your community
- Identify 3 attributes about the community in which you live that you would replicate for the city as a whole

# "What Does Health Mean To You?"



# Strengths and Assets of Pierce County that support Healthy Communities

Arts and Humanities
Higher Education Network
Access to Local Food
Service Clubs
access to nature · natural assets
Coalitions & Collaborations
Health Care Systems & networks
Volunteer Base
Good Roads
open minds & complementary care
Farmers Markets
patient navigators
Faith Communities

These Pierce County features were generated by local leaders and community members

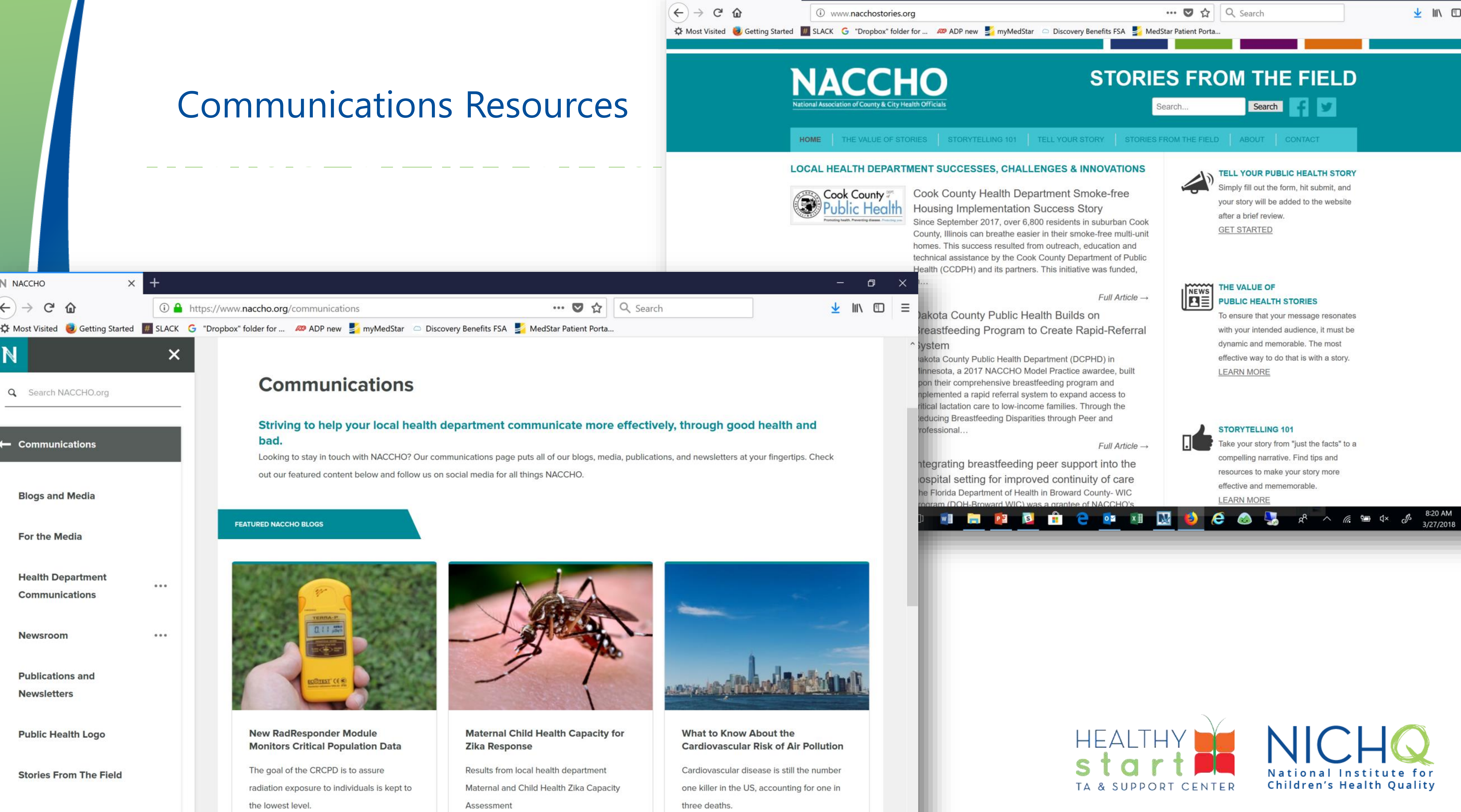
Tacoma-Pierce County Health Department
MultiCare
Franciscan Health System

# Triangulating Data

Secondary data

GIS maps

Pictures


Communications Resources
NACCHO
National Association of County & City Health Officials
STORIES FROM THE FIELD
HOME
THE VALUE OF STORIES
STORYTELLING 101
TELL YOUR STORY
STORIES FROM THE FIELD
ABOUT
CONTACT
LOCAL HEALTH DEPARTMENT SUCCESSES, CHALLENGES & INNOVATIONS
Cook County Health Department Smoke-free Housing Implementation Success Story
Since September 2017, over 6,800 residents in suburban Cook County, Illinois can breathe easier in their smoke-free multi-unit homes. This success resulted from outreach, education and technical assistance by the Cook County Department of Public Health (CCDPH) and its partners. This initiative was funded,
Full Article →
TELL YOUR PUBLIC HEALTH STORY
Simply fill out the form, hit submit, and your story will be added to the website after a brief review.
GET STARTED
THE VALUE OF PUBLIC HEALTH STORIES
To ensure that your message resonates with your intended audience, it must be dynamic and memorable. The most effective way to do that is with a story.
LEARN MORE
STORYTELLING 101
Take your story from "just the facts" to a compelling narrative. Find tips and resources to make your story more effective and mememorable.
LEARN MORE
Communications
Striving to help your local health department communicate more effectively, through good health and bad.
Looking to stay in touch with NACCHO? Our communications page puts all of our blogs, media, publications, and newsletters at your fingertips. Check out our featured content below and follow us on social media for all things NACCHO.
Communications
Blogs and Media
For the Media
Health Department Communications
Newsroom
Publications and Newsletters
Public Health Logo
Stories From The Field
FEATURED NACCHO BLOGS
New RadResponder Module Monitors Critical Population Data
The goal of the CRCPD is to assure radiation exposure to individuals is kept to the lowest level.
Maternal Child Health Capacity for Zika Response
Results from local health department Maternal and Child Health Zika Capacity Assessment
What to Know About the Cardiovascular Risk of Air Pollution
Cardiovascular disease is still the number one killer in the US, accounting for one in three deaths.
HEALTHY start
TA & SUPPORT CENTER
NICHQ
National Institute for Children's Health Quality

# Phase 4: Identify Strategic Issues

Fundamental **policy choices** or **critical challenges** that must be addressed for a community to achieve its **vision**.

**FCA:** What is occurring that will affect the LPHS or community?

**CTSA:** What is important in our community? Perceptions about quality of life? What assets do we have?

**CHSA:** What does our health status look like? How healthy are our residents?

**LPHSA:** What are the activities, competencies, and capacities of our LPHS?

**Challenges, opportunities, and trends across assessments**

**Strategic Issues**

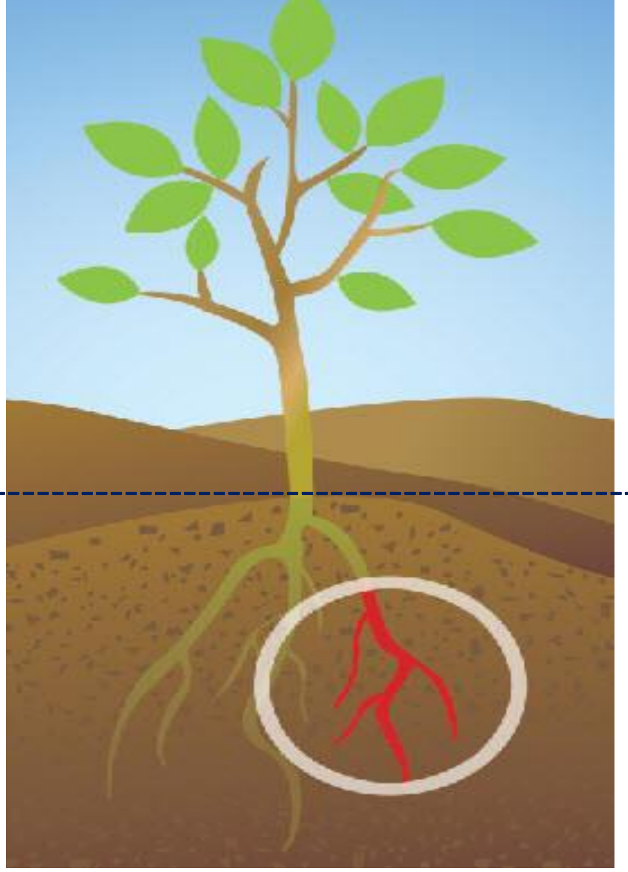
# Root Cause Analysis

Symptoms of the problem or
“The Weed” (obvious)

Mass incarceration
Obesity
Risky behaviors
Poor mental health
Violence
Morbidity/Mortality
Poor housing conditions

Underlying causes or “The Root”
(not obvious)

Policies
Education system
Legal system
Built environment
Economic opportunity
Discriminatory lending



# Root Cause Analysis: The 5 Whys

| Critical Challenge | Low income population disproportionately impacted by poorer MCH outcomes | |
|---|---|---|
| | **Proximal Causes** | **Assessment** |
| **Why?** | More risk factors (smoking, hypertension, etc.) | CHSA |
| **Why?** | Increasing no show rates at clinical appointments; high stress | LPHSA, CTSA |
| **Why?** | Limited access to care (e.g. no transportation, too far from work/home); Poor living conditions | LPHSA, CTSA |
| **Why?** | Leaving urban homes for more rural areas | CTSA |
| **Why?** | Decreasing affordable housing in urban hub | FOCA |
| **Root Cause:** | Elected officials cutting funding for programs like Section 8 housing and rent control | |

# Kansas City Health Department: Strategic Issues

Strategic Issue 1:

- How do we improve health through improvements to our **education system?**

Strategic Issue 2:

- How do we improve health through the mitigation of **violent crime?**

Strategic Issue 3:

- How do we improve health through improvements in **economic opportunity?**

Strategic Issue 4:

- How do we improve health through increased **utilization of mental health care and preventative services?**

Strategic Issue 5:

- How do we improve health through improvements to our **built environment?**

# Prioritization Criteria

- **Impact** – which strategic issue has the greatest potential for impact?
- **Urgency** – what risks are associated with not addressing this problem?
- **Alignment** – does the strategic issue align with the Essential Services and public health principles?
- **Acceptability** – will stakeholders and the community accept the strategic issue?
- **Feasibility** – do resources and expertise exist to address this issue?
- **Community focus** – is this important to the community?

# Prioritization Techniques

| Process | Level of Input | When to use |
|---|---|---|
| Prioritization Matrix | Intermediate | Need objectivity, lots of criteria |
| Strategy Grid | Intermediate | 2 primary criteria, simple process |
| Multi-Voting | High | Lots of options, eliminates bias, consensus building |
| "2 cents" | High | Need simplicity, engage a large group, anonymity |
| Facilitated Conversation | Low | Small number of decision makers, high expertise, nuanced decision |

*NACCHO's Guide to Prioritization Techniques: qiroadmap.org/resources*

# Phase 5: Formulate Goals and Strategies

# What are Goals and Strategies?

**Goal:** Broad, long-term outcome which sets the direction for addressing strategic issues

**Strategy:** A broad method to bring about achievement of a goal

Why are we here? → Vision

What are we going to do? → Strategic Issue → Goal

How are we going to do it? → Strategy

# Kansas City Health Department Strategic Issues & Goals

| Strategic Issues | Goals |
|---|---|
| How can we improve health through improvements to our education system? | All Kansas City 3rd graders should be able to read at grade level |
| How can we improve health by mitigating violent crime? | Reduce the incidence of violent crime and address racial disparities in incarceration. |
| How can we improve health through increased economic opportunity? | Decrease the income and wealth gap between zip codes |
| How can we improve health through improvements in our built environment? | Increase the proportion of neighborhoods that are safe, clean, well-maintained and consistently improved |

# The Health Equity Frame

| Remedial actions | Addressing root causes |
|---|---|
| Track health outcomes by county | Track underlying conditions that lead to health outcomes |
| Treat poor health outcomes (e.g. obesity) | Tackle underlying conditions that lead to poor health outcomes (reallocate resources for parks in low income communities) |
| Increase homeless shelters | Oppose discriminatory housing practices; Support subsidies for low-income housing |
| Toxic chemical screenings | Advocate to limit the production of toxic chemicals |

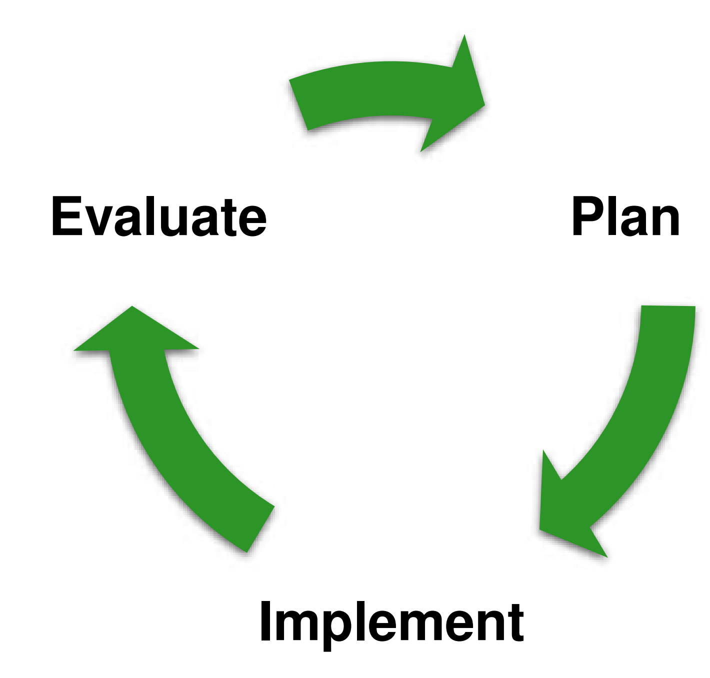
# Community Health Improvement Matrix

**Goal: Reduce Adverse Childhood Events (ACEs)**

| PREVENTION LEVEL | Individual | Interpersonal | Organizational | Community | Public Policy |
|---|---|---|---|---|---|
| Contextual/ Primary | Triple P Parenting program | Nurse-family partnership | Smoke-free housing | Neighborhood safety | Paid parental leave |
| Secondary | Screening for SA services during pregnancy | Strengthening Families Program | Provider communities of practice & prevention network | Employment opportunities | Living wages |
| Tertiary | Opiate withdrawal programs | Child-parent psychotherapy | Compassionate schools framework | Evaluation project | Homelessness Housing planning |

**INTERVENTION LEVEL**

# Phase 6: Action Cycle



# Develop SMART Objectives

| SMART | Objectives: measurable short to intermediate outcome statements directly tied to achieving broader goals and implementing strategies. |
|---|---|
| Specific | **Who** is the target audience?<br>**What** will be accomplished? |
| Measurable | Is this quantifiable?<br>How can success be **measured**?<br>**How much** change is expected? |
| Achievable | Can we **succeed** in the proposed time frame?<br>Do we have **enough resources** and support to achieve this? |
| Relevant | Will it **impact the goal**?<br>Is it within the **scope** of our vision and strategic priorities? |
| Time bound | **By when** should this objective be reasonably achieved? |

# Develop SMART Objectives

| | |
|---|---|
| **Strategic Issue** | **Policy question or critical challenge to be answered**<br>• *How can we create more equitable housing conditions?* |
| **Goal** | **Broad direction for resolving strategic issue**<br>• *Reduce barriers to access affordable housing* |
| **Strategy** | **General methods to achieve goals**<br>• *Develop partnerships with the housing sector*<br>• *Explore mechanisms for increasing affordable housing availability*<br>• *Advocate for policies that increase investment in affordable housing* |
| **Objective** | **Measurable Objective**<br>• ***By September 2022, increase the number of partnerships by 20% to support the construction and rehabilitation of deeply affordable housing.*** |

**Priority** Improve Staff Retention
**Strategy** Create a more effective staff review, promotion and compensation system
**Goal 1** Develop and implement a performance-improvement focused employee performance review system
**Objective 1 A:** *By December 2013, all employees will have received an annual performance review that focuses on performance against work-plan objectives.*

| Programs Activities Interventions | Person/Group Responsible | Time-line | Process Measure | Outcome Measure |
|---|---|---|---|---|
| Develop FY2013 annual goals, objectives and performance measures for each employee based on departmental goals and strategic plan | Staff, managers Division Directors | April 2012 – June, 2012 | 1. Program goals and objectives reviewed with each employee<br>2. Drafts of employee goals, objectives and performance measures that achieve program objectives<br>3. Division Directors approval of employee performance plans | 1. Employees use performance plan to guide their work |
| Results of 2013 employee goals and objectives reviewed for annual employee performance reviews. | Staff, managers Division Directors | June, 2013 | 1. Measures for all employee goals and objectives with targets compared to results<br>2. Final performance reviews. | 1. Employee annual performance increases linked to achievement of strategic plan goals and objectives. |

# Making the Connections

## Strategic Issue

- Improve health through improvements in economic opportunity

## Goal

- Decrease the income and wealth gap between zip codes

## Objective

- Increase access to living wage jobs through both supply-side (vocational training) and demand side (e.g. raising minimum wage) policies

## Activities

- Develop advocacy materials
- Meet with policy makers
- Recruit grassroots volunteers

# Planning Resources

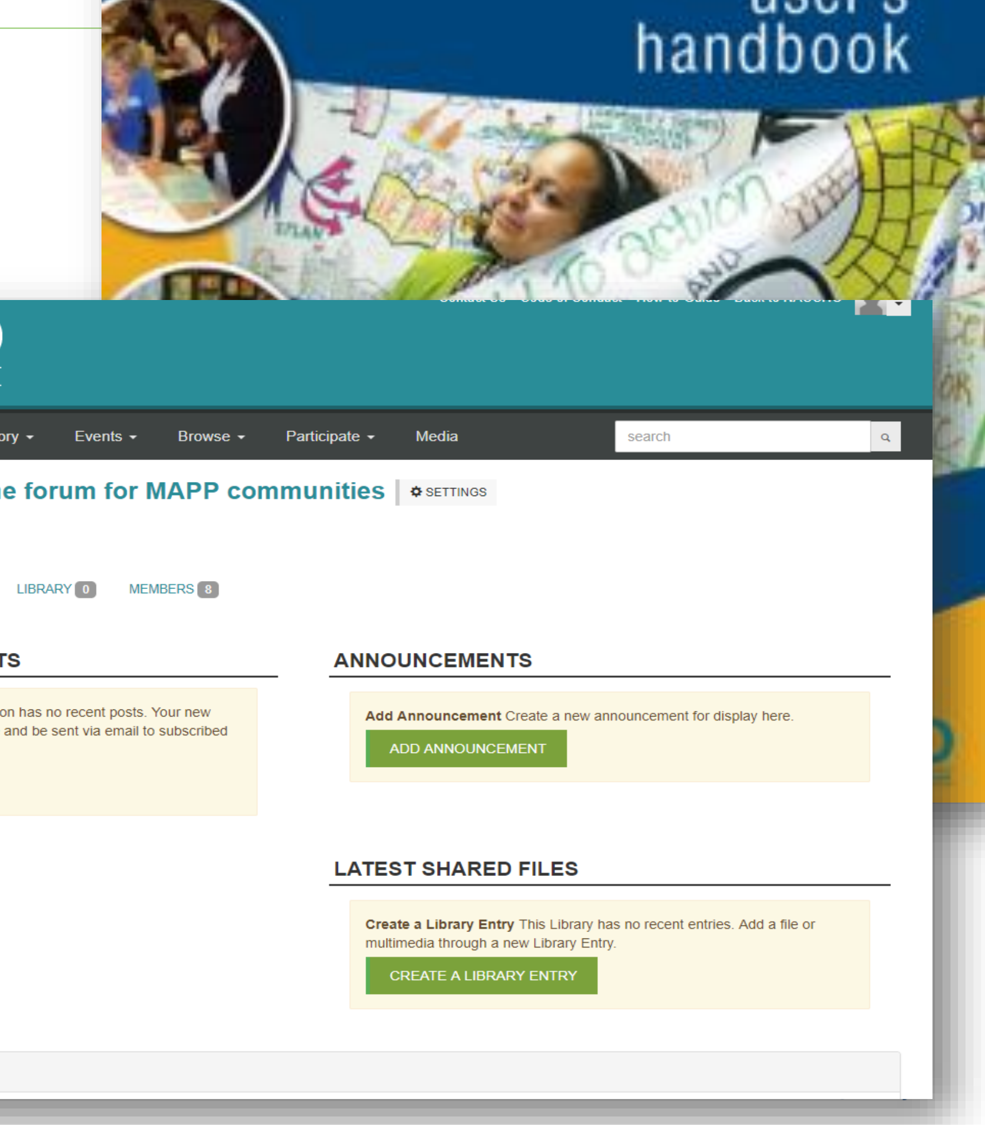
- **Community Balanced Score Card**
  http://www.rtmteam.net
- **UNC Management Academy Business Planning**
  http://www.maph.unc.edu
- **Evidence-based practices:**
  - The Community Guide
  - Healthy People 2020
  - National Prevention Strategy

  http://ebprevention.org
- **National Registry of Evidence-Based Programs and Practices**
  http://nrepp.samhsa.gov/

NACCHO
National Association of County & City Health Officials
RESOURCE CENTER
For Evidence-Based Prevention and C

# MAPP Resources

- MAPP Website (www.naccho.org/mapp)
- MAPP Network
- MAPP Handbook
- P.I. Compass Newsletter (subscribe at www.naccho.org/pi)
- mapp@naccho.org



# Suggested Next Steps

- Check-out MAPP and related resources
- Connect with local "MAPP Communities" and peers to expand your 'circles of influence'
- Engage your local health department and hospital systems to help leverage data and align priorities
    - Become familiar with Community Health (Needs) Assessments and Improvement Plans (CH[N]A-CHIP)
    - Better yet, participate in those efforts!
- Reach-out to NACCHO: we're here to help!

# Discussion

- What resonates with you?
- Any ‘a-ha!’ moments?
- What are 1-2 take-aways?
- What questions do you have or wisdom to share?

# Questions?

# Closing

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# Up Next

Federal Activities Complementary to Healthy Start Efforts

Beginning at 4:30 p.m. EST