Data and Action

A Guide for Using Data to Support and Drive Action

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PREPARED FOR:
The Massachusetts Department of Public Health

PREPARED BY:
Public Health Institute of Western Massachusetts

PUBLIC HEALTH INSTITUTE
OF WESTERN MASSACHUSETTS
PARTNERS FOR HEALTH EQUITY

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About The Public Health Institute of Western Massachusetts

The Public Health Institute of Western Massachusetts (PHIWM), formerly Partners for a Healthier Community, is a 501(c)(3) non-profit organization based out of Springfield, MA whose mission is to build measurably healthier and more equitable communities through community engagement, collaborative partnerships, research and evaluation, and policy advocacy. PHIWM is committed to improving the public's health by fostering innovation, leveraging resources, and building partnerships across sectors, including government agencies, communities, the health care delivery system, media, and academia.

PHIWM's Health Equity Statement

A historic legacy of social, economic, and environmental inequities, such as racism and gender-based discrimination, are embedded in societal institutions and result in poor health. These unjust inequities affect communities differently with some bearing a greater burden of poorer health. These inequities can influence health more than individual choices or access to healthcare. PHIWM recognizes its responsibility to dismantle these injustices by promoting health through policies, practices, and organizational systems that benefit all. We encourage others to join in these efforts.

Public Health Institute of Western MA
1350 Main St Ste 1006, Springfield, MA 01103
PublicHealthWM.org

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Lead Authors:	Victoria Hill Kathleen Szegda
Other Contributors:	Natalia Putnam (Literature Review) Jessica Collins Lisa Ranghelli Keleigh Waldner
Reviewers:	Capacity Building for Racial Equity Community of Practice PHIWM Board of Directors- Data to Policy Action Committee
Interviewees:	Gail Gramarossa, Quaboag Hills Substance Use Alliance Malikah Jeffries, Gandara Center Brittney Rosario, Baystate Health Phoebe Walker, Franklin Regional Council of Governments

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“Data and Action” or “Data to Action” is the process of using information to inform decisions or strategies, implement interventions, or take other actions to positively impact the health and well-being of communities and address the root causes of health inequities.

Introduction

In today's data-driven world, we are constantly bombarded with data points from various sources. It's no wonder that "data to action" has become a buzzword as we embark on making sense of the data available to us. But what does it truly entail? This framework is designed to demystify the concept and empower those interested in using data to make positive changes in health and health equity.

The main objective of the Data and Action framework is to provide guidance to individuals and organizations looking to utilize the Massachusetts Department of Public Health's COVID-19 Community Impact Survey (CCIS) and Community Health Equity Survey data, along with other data sources, to inform and support ongoing or new actions aimed at improving health outcomes and addressing health disparities. This guide outlines key elements to consider throughout the process, offering specific steps and overarching considerations, complemented by real-life examples and best practices.

Who is this for?

- **Coalitions**
- **Community advocates**
- **Municipal health department staff**
- **Board of Health staff**
- **Other municipal government staff**
- **Community-based organization staff**
- **State agency staff**
- **Non-municipal program staff focused on housing, education, employment/workforce, safety, transportation, food, technology/digital divide, etc.**

From grassroots organizations to longstanding private or public institutions, all are invited to utilize this resource at any stage of their data-to-action endeavor, be it planning, implementation, or evaluation.

As you delve into the guide, you'll discover invaluable resources and guidance documents to help you navigate the process with confidence. So, let's embark on this data-driven journey together, transforming information into actionable insights to foster healthier communities and promote equitable health for all.

For more information about CCIS and CHES, visit Community Health Equity Initiative | Mass.gov

Defining Data and Action

"***Data and Action"*** or "Data to Action" is the process of using information to inform decisions or strategies, implement interventions, or take other actions to positively impact the health and well-being of communities and address the root causes of health inequities. The distinction between "and Action" and "to Action" comes from the belief that the road to action is not a linear process and may not always begin with having the data necessary to act. It is a continuous cycle where the process may involve repeating certain steps or stages to refine and improve the results over time. Each cycle builds on the previous one, making adjustments and modifications as necessary until the desired outcome is achieved.

To make lasting and meaningful change, **it is important to involve a variety of stakeholders** to ensure that we are collecting the right information, interpreting it correctly, and focusing on areas of action that have the greatest likelihood to make change. **Community members know their communities the best**, and by having their voice and those of other key stakeholders in the process of using data for action, we are going to have the greatest likelihood of seeing the sustainable change we want to see. Therefore, ***Data and Action*** is a **collaborative process that centers health equity to drive change.** We will define these values of health equity, community engagement and collaboration, as well as other core values later in the guide in the *"Core Values"* section.

What do we mean by "Data"?

Data are pieces of information. When you think about what counts as data, please consider:

- Data can be both quantitative and qualitative.
    - The COVID-19 Community Impact Survey(CCIS) and the Community Health Equity Survey provide important quantitative data to understand health and social needs of our community.
    - The CCIS administration was also paired with population specific focus groups, such as focus groups with indigenous people, that provided important qualitative data to add to the findings from the survey results.

Quantitative vs. Qualitative Data

- **Quantitative data are represented with numbers and can help with measuring what we are interested in.**
- **Qualitative data are represented by words and can help with providing important context to quantitative data through stories and lived experiences.**

- Data can come from internal sources, such as from your own coalition or organization, or from external sources. For example, if we would like to learn more about the community we serve:
    - Internally, we can use the demographic information (race, gender, language, etc.) we collect from a patient's chart at a health clinic or from the intake paperwork of residents we serve in a community program.
    - Externally, we can look to websites such as the U.S. Census Bureau data to learn more about our community's demographic makeup.
- Having "enough" data should not be a barrier to action. Working with the best information available is often where we need to start.
- Look at data critically and ask as many questions as possible to understand if it is trustworthy, reliable, and useful for your needs.

This guide will help provide some tools to get started.

What is Action?

According to Merriam Webster, action is "the accomplishment of a thing usually over a period of time, in stages, or with the possibility of repetition." Our definition adds that action can be taken either individually, by a single person, entity, or organization, or collectively with many people, entities, or organizations together.

Additionally, actions range in size and scope and do not need to be a large-scale intervention or policy change to be considered successful at addressing the root causes of health inequities. Remember, it may require repetitive action, action in several stages, or revising actions based on learnings.

With this definition in mind, please consider:

- Each step you take towards your goal should be celebrated as a completed action within itself. Explicitly acknowledging small actions or victories can help motivate a team to continue the work.
- No action step is too small.
- Change takes time, but each step along the way makes a difference.
- Your actions may evolve along the way as you work toward your desired outcome.

Examples of Action

- **Joining a coalition**
- **Advocating for a policy change (in your organization, in government, etc.)**
- **Collecting additional data**
- **Training to further understand root causes of health outcomes and inequities**
- **Applying for a grant or other funding**
- **And more!**

This guide will help you think about how to ensure that your action is keeping equity at the center and is sustainable.

Overview of Data and Action Framework

The Data and Action framework was developed through collaboration with a variety of stakeholders that were at different stages of using data for action, but that are all focused on achieving health equity. It is informed by the lessons we've learned from our own experiences doing this work, as well as through a literature review process (See references). The Data and Action framework illustrates the key steps and core values for going from data to action and how these components are interconnected. The framework process is dynamic—the values and steps are working together simultaneously and there is no set starting point. Though many people or collaboratives may start with defining the focus of their work, you can enter the Data and Action process wherever it makes the most sense for you and your partners. Additionally, you may consider a variety of data sources to help drive your work; however, this guide will focus on data from the COVID-19 Community Impact Survey (CCIS) or Community Health Equity Survey (CHES) data.

Throughout the framework guide, there are various call-out boxes. Refer to the **legend** below:

Learning from the Field ☆

To help further illustrate the Data and Action process, we will be highlighting stories from community partners engaging in Data and Action work across our region.

Health Equity Checkpoint 🔍

We will provide "Health Equity Checkpoints" that serve as reflection points for you and your partners to consider how equity is centered in the process.

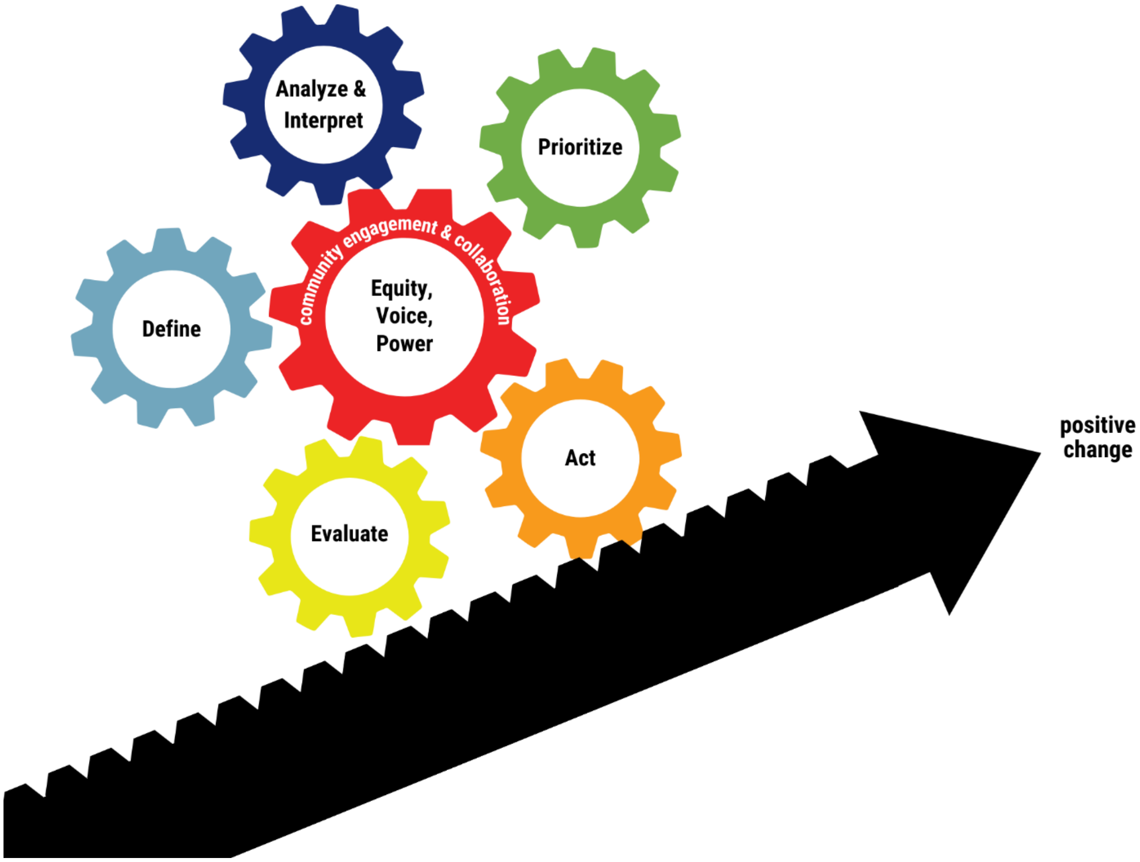
⚠ Process Reminder

As you navigate the framework, we encourage you to reflect on your journey to action. Although we have laid out the process in a linear direction, you may start at the point that is best for you.

Key Steps for Data and Action

The Data-and-Action process consists of 5 steps. These steps are:

- **Defining the focus**- What do we want to understand from the available data? What area do we want to focus on to improve health?
- **Analyzing and interpreting the data**-What do the data say?
- **Prioritization**-What area are we focusing on for action?
- **Taking Action**-What actions are we taking to make change?
- **Evaluation and Storytelling**-Did it work? What did we learn?



The graphic on the previous page aims to illustrate the steps and how they are related. At the center is "Equity, Voice, and Power", which are the core values that drive the process. Each step is a gear that can move independently but is related to the other steps. This is to illustrate, as noted before, that the process is iterative, so you may repeat each of the steps as needed. Additionally, you may start the process at any point as there is no set starting point. Ultimately, the gears work together to move the machine, in this case the process, forward towards a positive change.

Core Values

At the core of the Data and Action Framework are four values that are intended to ensure that the actions taken in our communities 1) honor the lived experiences of the communities we are serving, and 2) address the root causes of health inequities in our communities.

The core values of the Data and Action process are:

- **Centering Health Equity**
- **Community Engagement and Collaboration**
- **Sharing Power**
- **Lifting Community Voice**

> **"People with lived experience are those directly affected by social, health, public health, or other issues and by the strategies that aim to address those issues. This gives them insights that can inform and improve systems, research, policies, practices, and programs. When we say lived experience, we mean knowledge based on someone's perspective, personal identities, and history, beyond their professional or educational experience."**
>
> **-U.S. Department of Health and Human Services**

CORE VALUE

Centering Health Equity

> **Health Equity is "the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being."**
>
> **-World Health Organization**

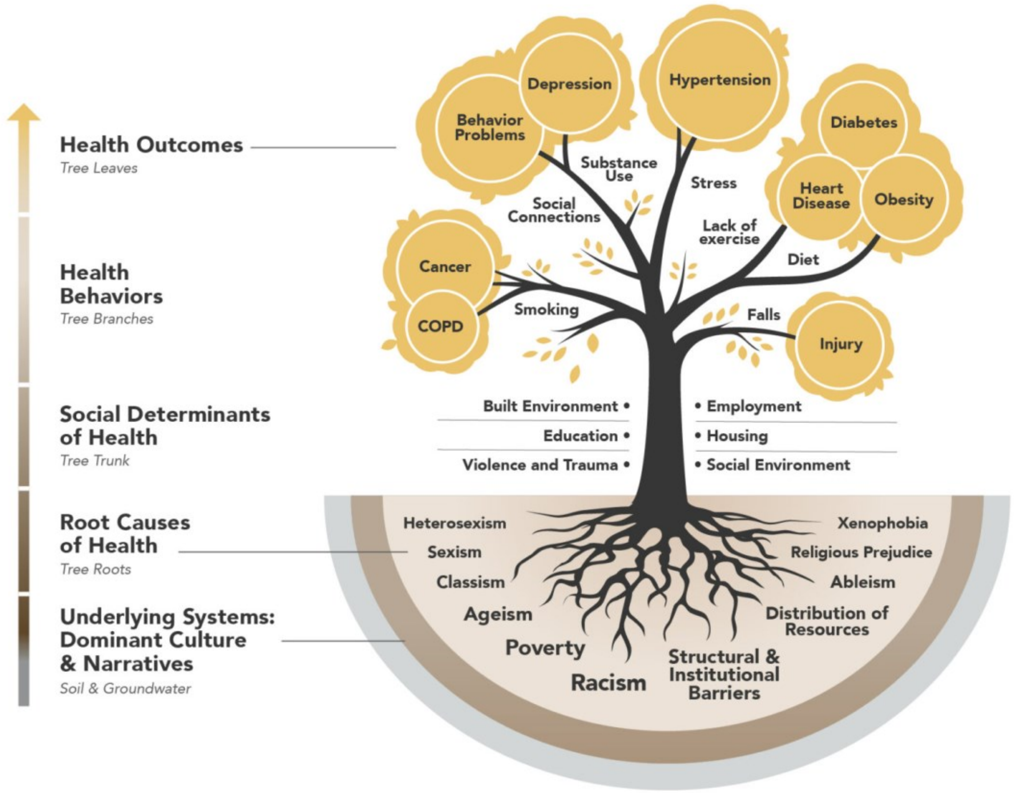
A foundational value for the Data and Action framework is centering health equity. Achieving health equity involves addressing barriers to health and promoting solutions that ensure everyone can achieve and maintain good health, regardless of their background. Racism plays a significant role in creating health disparities and barriers to health, such as through the unequal access to resources and opportunities. These inequities go beyond individual choices and are deeply rooted, both historically and presently, in both public and private institutions, systems, policies and practices. Therefore, **the practices and recommendations from our framework lead with addressing racism explicitly, but not at the exclusion of addressing other forms of oppression and inequities.**

The Health Equity Tree in Figure 1 illustrates the many different root causes of health inequities and how they relate to the health outcomes and behaviors we can see in our community. When engaging in the Data and Action process, we encourage you to reflect on the root causes of health inequities and underlying systems and structures that impact health. An intersectional approach recognizes that race in addition to other social identities like gender, class, and immigration status further complicate health disparities, creating unique challenges for different groups. By acknowledging the interconnectedness of these factors, the framework aims for solutions that consider how racism interacts with other forms of oppression to create health

> **"Intersectionality is simply a prism to see the interactive effects of various forms of discrimination and disempowerment. It looks at the way that racism, many times, interacts with patriarchy, heterosexism, classism, xenophobia — seeing that the overlapping vulnerabilities created by these systems actually create specific kinds of challenges."**
>
> **- Kimberlé Williams Crenshaw**

inequities. This may require some capacity building and additional information, so please refer to our equity resources in the Resources Tracking Spreadsheet in the appendix.

Figure 1. Health Tree Model: Understanding Root Causes of Health Behaviors and Outcomes



Source: The Health EquiTREE (2022), illustration by Health Resources in Action for the Massachusetts Community Health and Healthy Aging Funds. https://mahealthfunds.org/resources/Action

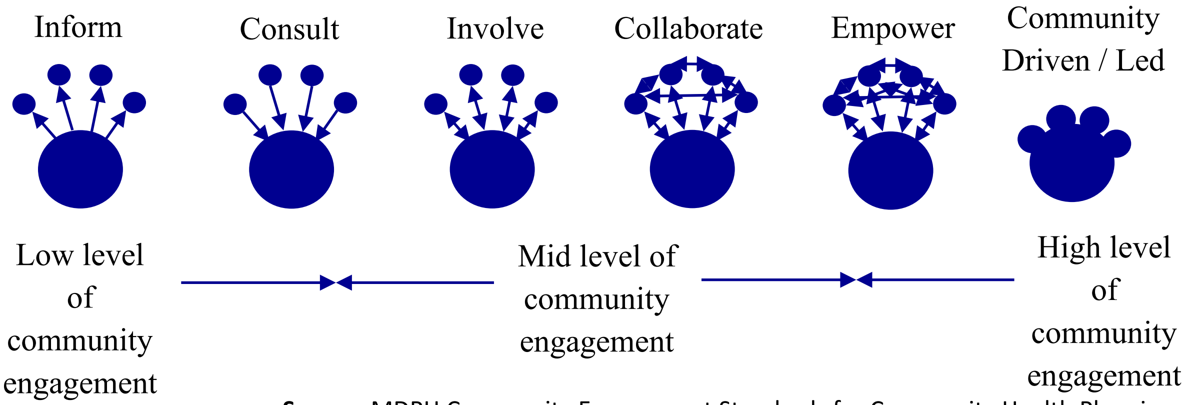
CORE VALUE

Community Engagement and Collaboration

To ensure that the Data and Action process meets the needs of the community it intends to serve, it is necessary to give careful thought about who is at the table. Having community partners at the table is essential because they can more closely understand or have themself experienced the health needs and inequities in their communities and can best help identify potential solutions. Through community engagement and collaboration, we can invite a diverse group of people to engage in the Data and Action process from residents to local officials, healthcare providers, and more. They also can help keep us accountable and build momentum for a given action. The ***Spectrum of Engagement*** is a helpful tool to assess what type of community engagement aligns with your action (Figure 2). Each action may have a different appropriate level of community engagement.

> **"Community engagement is the collaborative processes between organizations/institutions and communities impacted by their policies, programs, or practices to influence decisions and actions through the mutually beneficial and bidirectional exchange of resources, expertise, and information."**
>
> -Health Equity Solutions

Figure 2. Spectrum of Engagement



Source: MDPH Community Engagement Standards for Community Health Planning Guideline (Adapted from International Association for Public Participation, 2014)

We can also think about how we can collaborate with others who are working toward similar action. Collective action is a great way of sharing and maximizing resources, building power, and increasing the visibility of your action. Collective action, or collective impact, is "the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem at scale”(Community Tool Box). Consider the following:

- Are there any organizations, coalitions, or community organizing efforts that you can collaborate with?
- Are there opportunities to build relationships with these groups?
- Do you have shared values and/or mutual interests?

Deepening community engagement and collaboration makes it more likely that our process will lead to action and change, as it brings diverse perspectives, lived experiences, and valuable insights to the decision-making process. When community members are empowered to contribute meaningfully, they become invested stakeholders who can drive sustainable change.

It is essential to recognize that every organization's journey in community engagement is unique and multifaceted. While deeper engagement can lead to better outcomes, it's important not to become discouraged if you are at lower levels of engagement on the Spectrum of Engagement. Factors, such as available resources to provide accommodations (transportation, childcare, stipends, etc.), bureaucratic constraints, and power-sharing opportunities with the community, influence where an organization stands in the engagement process.

Ultimately, fostering a culture of continuous improvement and open dialogue between organizations and the community is key. By valuing and respecting the contributions of all community partners - regardless of the level of engagement - we can create a collaborative environment where the collective goal of improving public health remains at the forefront. Each step towards deeper community engagement represents progress in the journey of harnessing data for meaningful action and promoting health equity within our communities.

Who is at the table?

Throughout the data and action process, it is important to consider who is at the table and how they are involved. Consider the following:

HOW DO WE DEFINE COMMUNITY?

When convening our partners, it is important that there is a shared understanding of what we mean by community. Community Catalyst differentiates community between “grass tops" and “grassroots” (see definition below). Each type of community participant has its benefits and drawbacks in terms of the perspectives they provide, their lived experience, and the role they can serve at the table. Consider what perspectives you would like to prioritize having at the table and how you will support their participation in the data and action process.

Grassroots	Grass tops
“Grassroots” often refers to people “who do not have a formal or professional role in public life, and who are not in leadership of a local agency or organization” but “are most impacted by a problem”	“**Grass tops”** describe “residents or other community members who are recognized leaders in their neighborhoods or organizations due to their professional roles, public profiles, or positions of power. Grass tops leaders usually have access to, and can wield influence on, key decision-makers or segments of the grassroots community.” **(Curtis, 2018)**
Benefits	
• Contribute their lived experience and/or knowledge of their communities. • Add to our overall understanding of an issue (and related data) and potentially reveal other facets of it we may not have considered.	• Bring additional skills and capacity to the table. • Can be easier to convene because they may have more professional capacity to participate in the process. • May also have lived experience, live in the communities they work in, or close knowledge of the communities they work in
Considerations	
• Consider what resources you can provide so that they are accommodated, prepared to participate, and mutually benefit from the relationship. • Consider that each resident or grassroots partner is an individual and their experience does not speak to the experience of all members of their communitie**s.**	• They may not have the lived experience desired to inform the data and action process.

HOW DO WE IDENTIFY AND INVITE COMMUNITY PARTNERS TO THE TABLE?

You can **leverage existing relationships** using your network. Are there partners at the table that are already in relationship with your desired partners? Collaboration can help you get connected.

You can **do outreach in your desired communities,** whether it is to different demographic groups or different geographic areas in your region. To reach communities members of interest, consider where and how you would like to reach out to them. For example, you can create flyers, table at events, or attend community meetings. Ideally, you are **meeting people where they are at.**

HOW DO WE GET COMMUNITY PARTNERS TO THE TABLE?

- ✓ Value the expertise of community partners
    - Give credit to the contributions of community partners
    - Provide stipends for their time
- ✓ Reduce the barriers for participation through accommodations:
    - Flexible time of meeting
    - Accessible venue
    - Childcare
    - Transportation
    - Food
- ✓ Encourage participation through preparation and clear mutual expectations:
    - Set ground rules for working together
    - Co-create a vision for your collaboration so that you can identify ways to make the experience meaningful for everyone
    - Maintain timely and accessible communication about progress and key decision points
    - Provide capacity building training for community partners on relevant topics
    - Provide training on facilitation or community engagement to staff working with community partners
    - Provide racial and health equity training, such as cultural humility or anti-racism training, for all partners to develop a shared understanding of these foundational concepts to advance equity

Building relationships with community partners takes <u>time</u>. To be in relationships with community partners, you need to foster <u>trust</u> and develop a <u>mutually beneficial</u> relationship.

QUESTIONS TO CONSIDER:

- In what capacity are community partners involved?
- Who do they represent?
- What is their role?
- What skills are available?
- How do we build trust?
- How do we share power?
- Who is missing?

Building a Diverse Multi-Sector Table

When Baystate Health began convening people around digital equity, they built their table to include experts, community members, and other stakeholders that had a shared interest in addressing digital equity, including social workers, councils on aging, youth serving organizations, municipal departments, and technology.

Engaging community partners is beneficial at all stages of the data and action process. It allows for each step to be collaborative and informed by a diverse group of thought. However, it may be frustrating and injure the trust developed with community partners too early in the process if you are not ready to support their participation. It is important that community partners engaged in the process are prepared to participate and are accommodated. Therefore, it is important to invite partners into the process only when you are ready.

Health Equity Checkpoint

✓ Do the community partners at the table represent the communities that you want to serve or support though action?

Resources

- Work Together, County Health Rankings and Roadmaps
  - This resource provides insights, key activities, and tools to build partnerships that work together towards meaningful change.
- Building Inclusive Communities, The Community Toolbox
  - This guide includes readings, examples, and resources for how to build an inclusive community and why inclusive communities are important.
- Engaging Communities as Experts throughout the Assessment Process, Health Resources in Action
  - This post describes how to engage community at each phase of the assessment process and why community engagement is important at each phase.
- Transformational Community Engagement to Advance Health Equity (rwjf.org), Health Equity Solutions
  - This resource provides strategies and tactics for transformational community engagement.

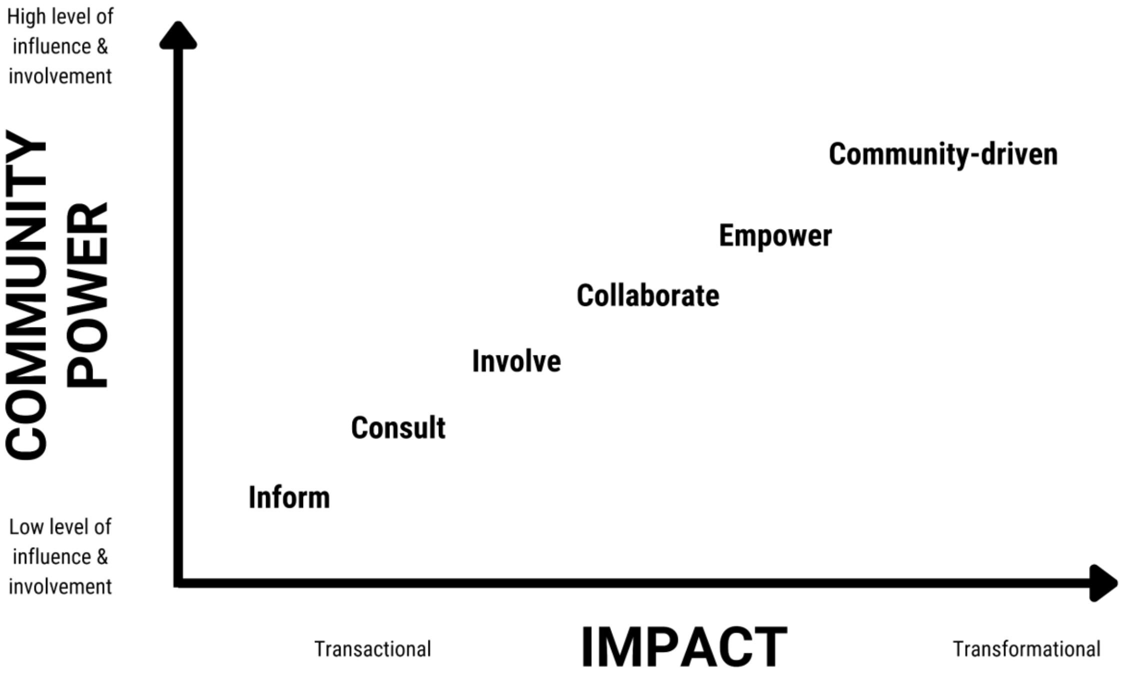
CORE VALUE

Sharing Power

Power is "A) The ability to name or define. (B) The ability to decide. (C) The ability to set the rule, standard, or policy. (D) The ability to change the rule, standard, or policy to serve your needs, wants, or desires. (E) The ability to influence decision makers to make choices in favor of your cause, issue, or concern."

When working with community partners in the Data and Action process, there will be many opportunities to consider how power is shared. Earlier, when looking at the Spectrum of Engagement, as we moved to the right on the spectrum, community is given more power to make decisions, drive, and lead the work. In Figure 3 below, this adapted community engagement model adds the concept of impact to the spectrum, which "describes the degree to which engagement results in change that centers the needs of those impacted by the program or policy" (Health Equity Solutions).

Figure 3. Meaningful Community Engagement



Source: Adapted from Health Equity Solutions (Transformational Community Engagement to Advance Health Equity (rwjf.org) and MDPH Spectrum of Engagement

Health Equity Solutions describes impact as a range: “from **non-existent** (in which there is no community engagement) to **transactional** (engagements centering the needs of the agency and often focused on a specific idea or product at a single point in time) to **transformational** (ongoing and bidirectional efforts that result in equity-focused change).” For more on ***Transformational Community Engagement***, see resources.

Power can be a difficult subject to broach, considering the history and legacy of racism, as well as other forms of oppression. The process of sharing power and discussing it with community partners can be an uncomfortable and difficult process, but we can strengthen partnerships through a commitment to being brave, embracing vulnerability, and creating safe spaces for communication. We are stronger when we do this work together.

To acknowledge the role of power:

- Be transparent about how you would like to be in relationship with your community partners, such as by setting up clear roles and mutual expectations
- Discuss how you would like to share power
- Name or acknowledge the role of power when discussing health inequities

Consider the decision-making processes that need to occur to go through the data and action process and how you will navigate making those decisions, who will decide, and how you will act on the contributions from community partners.

CORE VALUE

Lifting Up Community Voice

The concept of **“voice”** in the Data and Action process is related to both **power** and **community engagement**. Voice is about listening to the perspectives shared by partners at the table and lifting it up in the process to influence how we look at data, what actions we consider, and other decision making. It requires creating safe spaces, opportunities, and incentives to share. We differentiate this from community engagement because lifting up community voices can be a result of community engagement, but may not always occur depending on the process. By centering this as a core value, we hope that you consider how input from your community partners is shared and centered in the process.

Language is also an important consideration when lifting up community voice. Consider if there is opportunity for people with different language needs to participate and share their voice in the process. For more information, see Language Justice Tools in *Resources* below. Once your partners have shared their perspective and feedback, it is important to consider what happens with this information and how it contributes to your data and action process. Acknowledge and give credit to the contributions of community partners and how they impacted your collaborative action. For example, lift up how you may have changed course or shared power with your community partners to change how you approached your work/action. Consider how community voice shows up in each step of the process.

Stipends for Community

The Franklin Regional Council of Governments (FRCOG) offers residents a “Priority Perspective Stipend” to ensure community representation and voice in the process. Because residents represent a priority perspective, the FRCOG contracts with them for a year as advisors. They are compensated to engage in and provide critical feedback to various projects where their perspectives are necessary. They bring lived experience to the work and receive training. The advisors are recruited through referrals and activities in the community such as focus groups.

Resources

- **Language Justice Tools, Racial Equity Tools**
    - **This resource guide provides practices and tools for language justice, as well as research and analysis.**

Defining the Focus

What do we want to understand from the data?

This step involves identifying or defining what focus areas or issue(s) you are interested in better understanding based on the data available to you to support community health efforts. This guide focuses on data from the COVID-19 Community Impact Survey (CCIS) or Community Health Equity Initiative (CHEI) data. However, there may be other data sources you would like to consider. Collect all the data sources you will be considering to define the focus of your work and potential action. If there is not existing data, consider data collection as potential action.

The CCIS and CHEI survey have a wide variety of health and health-related topics to consider. Many people or collaborative groups may be working on an issue and decide that they want to look at data such as the CCIS or CHEI to help them determine what actions they should take. For example, a group may be working on mental health in their county and want to understand what population was most impacted early in the pandemic. Other collaborative groups, such as Community Health Improvement Plan (CHIP) groups, may have not decided the focus of their plans so they will want to develop a process to gather input from community partners and other stakeholders (see example). By actively involving community members, stakeholders, and diverse voices, we ensure that the

Defining the Focus of a CHIP

The Quaboag Valley CHIP group needed to understand what data could help with identifying the focus areas of their CHIP. Multiple data sources were considered such as local Community Health Needs assessments, youth health surveys, Age Friendly and Dementia Friendly Hospital reports as well as the COVID-19 Community Impact Survey (CCIS). The group collectively walked through the data to understand what information was available and being considered to identify community needs. CCIS data on substance use and mental health during the pandemic provided local data that generally was hard to find for the rural communities they serve. With this data, the CHIP explored the relationship between resident experience of poor mental health days and increase of substance use during the pandemic.

Process Reminder

Please consider where you are at in your Data and Action journey. This process may not be linear.

For example, if there is no data available to assist in defining your focus, consider getting started with taking action to collect data.

identified issue is grounded in the realities and needs of those it directly impacts.

Defining the issue requires generating questions to help you explore what you want to understand from the data and your research or assessment process. These are some questions to consider:

- Are there specific health conditions, outcomes, or other social factors that impact health that are of ongoing concern (See Figure 1)? Have new concerns arisen?
- Are there concerns or needs you are hearing directly from residents in your community or that you are seeing in your community?
- Are there specific populations or communities that are being impacted disproportionately?
    - Are they defined by geography, race/ethnicity, gender, or another demographic?
- What assets and resources exist that can be built on?
- What information from the data do you want to explore?
    - Who will analyze the data? How?

Preparing for Data Analysis

In the next section, we will discuss analyzing and interpreting the data. If there are data you will be using to define the focus of your work, consider what resources would be helpful to better understand the data. Please consider:

- Are there people on your team or in your organization that can help with analysis and interpretation of the data?
- For CCIS and CHES data, ask for data analysis and interpretation support from the MDPH Regional Data and Action Providers. [Link website page]
- Consult a statistician or epidemiologist.
- Partnering with organizations who have capacity to analyze and interpret data

Health Equity Checkpoint

- ✓ When generating questions that you would like to understand from the data:
    - Reflect on the fact the data may provide insufficient or missing information about communities that have been historically and systemically disenfranchised and oppressed. This does not negate that the need exists. Additional data collection may be necessary.
    - Consider who gets to decide what questions are being asked and what information is being included. Is there an opportunity to share power to decide?
- ✓ Are there people at the table that represent important perspectives to help with defining the focus and questions you would like to understand from the data? Or are there opportunities to get community voice to inform what you define as your focus area?

Resources

- **Defining and Analyzing the Problem, The Community Tool Box**
    - **This guide describes the process of determining the nature of the problem, clarifying the problem, deciding how to solve the problem, and analyzing the problem. Examples, tools, and a checklist for understanding are included in this resource.**
- **Analyzing Information About the Problem, Goals, and Factors Affecting Them, The Community Toolbox**
    - **This resource provides readings and resources for assessing community needs and resources to anchor change efforts.**
- **More than Numbers: A Guide Toward Diversity, Equity, and Inclusion (DEI) in Data Collection, Schusterman Family Philanthropies**
    - **This guide provides guidance for applying a diversity, equity, and inclusion lens to data collection processes.**
- **The Future for Community Use of Data to Advance Equity, The Urban Institute**
    - **This video walks through what is needed to democratize data and illuminates the need for sharing data to communities equitably.**

Analyzing and interpreting the data

What does the data say?

Once we know what we would like to understand from the data, we can work on analyzing and interpreting the data. This step helps us assess what we can say with the data available to us and identify where we may not have the data we need to answer our research questions generated in the **"Define the Focus"** step. Community partners can help with how we look at the data and create shared meaning.

Analyzing the data helps us to gather the information we need from the data and think critically about the data source and how the information was collected.

- Look for patterns, trends, and contextual factors such as who is represented by the data, who is missing, and when the data was collected, etc. that can inform what you can say with the data.
    - For example, the COVID-19 pandemic led to many changes in people's behaviors. Data collected during this time may be very different from previous years.
- Look at the data by race, ethnicity, gender, age, disability status, income, geography, education, or sexual orientation, among others, to reveal disparities that might be masked when looking at the overall data. This is called "Disaggregation".
- Look for what is going well in your focus area. When analyzing the data, there can be a tendency to focus on the negative. However,

For more on analyzing and interpreting data with a racial justice lens, please watch the introduction to the COVID-19 Community Impact Survey, in the resources.

For more on analyzing and interpreting your data, please see our Data Guide.

For CCIS and CHEI, if there are specific analyses you would like to get from the data or if you need help interpreting findings, please reach out to MDPH Data and Action Support.

Using Data to Identify Need

Our shift to remote work and school during the COVID-19 pandemic shed light on inequitable access to digital resources. Baystate Health decided to convene people in Western MA to address these gaps. This group became the Alliance for Digital Equity.

The COVID-19 Community Impact Survey (CCIS) was an invaluable source of information as it was one of the only data sources available that provided timely data on the impact of COVID-19 on digital access across the state.

When the Alliance looked at the data by geography (disaggregation), they noticed that residents of Berkshire County were experiencing some of the greatest digital inequities.

the data can also inform our understanding of what is going well, what resources or policies are being used to address the needs in our focus area, and the assets that exist.

Interpreting the data is creating meaning from the data and adding appropriate context once it has been analyzed. When we involve community into the process of interpreting the data, we can create **shared meaning** of the data that considers the broader context. Consider engaging with the communities affected by health inequities to gain a deeper understanding of their experiences and perceptions of the data. We can learn a lot by facilitating conversations with the communities we would like to serve or engage through action. This can be by partnering with community organizations, conducting focus groups, or asking for input through surveys to ensure community perspectives shape our interpretation of the data.

Process Reminder

Please consider where you are at in your Data and Action journey. This process may not be linear.

For example, you may need to build your capacity to analyze or interpret the data. As you build capacity or seek assistance, you may choose to move onto another step to continue your process.

Creating shared meaning of the data is a collaborative process of examining the data with community partners that considers different perspectives and lived experiences to come to shared understanding of what the data says or does not say. By including our community partners in the process of understanding what the data says and means, we can get a better sense of how to use the data for action. Through this process we can learn whether the data reflects the reality of those with lived experience and knowledge of what is going on in their community, or if it is necessary to get additional information to act. For an example of this collaborative process, see our case study on page 38.

Health Equity Checkpoint

When analyzing the data:

- ✓ Think critically about who is represented by the data and who is missing. It is important information as you interpret the findings and apply them for action. If the data is missing information about communities you are interested in, then you may need to identify or collect additional data (either qualitative or quantitative) to inform your action.
- ✓ Consider how power and bias can impact the types of questions we ask from the data. We can perpetuate negative stereotypes and reinforce harmful narratives with how we look at the data.
- ✓ Seek to understand the root causes of disparities in your data. See resources for root cause analysis tools.

When interpreting the data:

- ✓ Remind your audience upfront that the data, or numbers, represent people
- ✓ Consider how multiple dimensions of identity, such as race, gender, and socioeconomic status, intersect and influence health outcomes (Intersectionality). Intersectionality helps capture the unique experiences and challenges faced by individuals who belong to multiple marginalized groups.
- ✓ Be mindful of the language you use and narrative you are creating as you frame the data. How we interpret the data is heavily informed by our own worldview and bias can show up in the narrative we create with it. The American Medical Association's Guide to Language, Narrative, and Concepts, recommends the following:
  - ○ Focus attention on inequitable systems, hierarchies, social structure, power relations, and institutional practices to reveal the sources of inequalities and the mechanisms that sustain them.
  - ○ Avoid both blaming individuals for their condition or assuming that inequity can be resolved through programmatic fixes that ignore the social responsibility of corporations and government agencies.
  - ○ For example, when interpreting physical activity data, consider the role of

Resources

- ✓ **Advancing Health Equity: A Guide to Language, Narrative and Concepts, American Medical Association and Association of American Medical Colleges**
  - **This guide provides guidance on using language that promotes health equity, explores the power behind words and why narratives matter, and a glossary of key terms and concepts.**
- ✓ **Framing Data, The Frameworks Institute**
  - **This short video discusses how to talk about data and how to frame data equitably.**
- ✓ **The Storytelling Power of Numbers, The Frameworks Institute**
  - **This article provides five lessons for using quantitative data more effectively to advance social issues.**
- ✓ **Make Inequitable Systems the Villain, The CaseMade**
  - **This resource includes a video, list of skills, and examples of how to identify and addresses inequitable systems as the root causes of social issues in order to further understanding that societal structures and policies contribute to disparities.**
- ✓ **Understand and Identify Root Causes of Inequities: Worksheet, County Health Rankings and Roadmaps**
  - **This worksheet provides opportunity to practice how to identify root causes, why identifying root causes is important, and how to ask “Why’ to uncover root causes.**
- ✓ **Analyzing Root Causes of Problems: The "But Why?" Technique, The Community Tool Box**
  - **This resource explores how to identify the root cause of a problem using the “But Why?” technique.**
- ✓ **Five Whys Tool for Root Cause Analysis, The Centers for Medicare & Medicaid Services**
  - **This worksheet provides another opportunity to practice asking “Why?” to uncover the root cause of an issue.**
- ✓ **MA Health Funds Health EquiTREE Blank Tree Exercise**
  - **This is blank version of the Health Tree Model in Figure 1. Use this to map out the root causes of the health outcome you are working to understand.**
- ✓ **An Introduction to COVID-19 Community Impact Survey, Massachusetts Department of Public Health**
  - **This webinar provides an overview on how to frame CCIS data with a racial justice lens**
    - **Slides: CCIS Introduction Slides (mass.gov)**

Prioritization

What area are we focusing on for action?

As we progress in the **"Data and Action"** process, we use the insights we have gathered from the data to brainstorm and begin prioritizing and planning for the actions we wish to undertake. The possibilities for action range from small, incremental changes to long-term, sustainable transformations. Central to the prioritization and planning process is the contribution of community voice, as it provides essential perspectives that inform the types of actions considered. Community partners can help co-create solutions, strengthening our planning for making change. It is important to think about 1) efforts underway in the community that can be leveraged and built on, and 2) the feasibility and effectiveness of each proposed action, mindful of potential challenges and possibilities for success.

Thinking about actions for sustainable change:

The types of actions we consider can have an impact at different levels. Referring to the health equity tree in Figure 1, we hope

Gathering More Data

The existing data may ultimately not tell you what area to focus on, so you may need to focus your efforts on identifying actions that will help you get the information you need to act, such as engaging in data collection, inviting more people into the group, etc.

Referring to our earlier example of the Quaboag Valley CHIP, the CCIS data helped during their assessment to highlight the unmet mental health and substance use disorder needs in their region and the types of barriers present in access to care. However, the CCIS survey was only able to reach a small portion of these communities which made it difficult while analyzing and interpreting the data and to make the case for mental health and substance use as priority needs without additional information. To overcome this barrier, the CHIP group was able to leverage ongoing vaccine clinics in the community to collect additional data from community members via a survey to understand what the community felt were the most pressing health needs. Ultimately, the survey helped the CHIP coalition to narrow to the four top needs, which were mental health, transportation, access to care, and housing.

Process Reminder

Please consider where you are at in your Data and Action journey. This process may not be linear.

You may need additional data to help with how your resources and networks are prioritized for action. Additional data may help you answer important questions.

that the actions taken to address the needs of our community work towards addressing the social determinants of health (see glossary) and root causes of health inequities such as racism, sexism, and ableism. We hope that these actions can begin to change the conditions of our communities that are shaped by structural racism and other systems of oppression. However, it may be necessary to take action at other levels, such as, health behaviors, represented in the tree branches, due to the resources and capacity available.

We can work towards actions that address the root causes of health inequities by prioritizing actions focused on policy, systems and environmental (PSE) change. According to Community Commons, *"Policy, system, and environmental (PSE) change strategies are approaches to behavior and culture change that aim to create lasting improvements in individual and community health and well-being…* ***Actions focused on changing conditions through PSE are more effective than traditional programs alone because they create more supportive environments, reach more people, and lead to more impactful, sustainable change****".* For more resources on PSE, see the resources at the end of this section.

Lastly, at this stage consider how you will decide on an action. The Interaction Institute for Social Change details the various options for decision-making that range from an individual(s) being the decider to getting full consensus from the group to decide (Table 1). Referring back to the Spectrum of Engagement in Figure 2, there are different levels at which community partners are engaged which relates to what extent community partners get to decide. Both concepts ask us to consider how power is shared with members at the table and how community voices contribute to the process. Ultimately, when prioritizing and planning for action, the type of decision-making process used will be dependent on many factors, but it is very important to be transparent about what decision-making process will be used to foster trust with community partners.

Table 1. Types of Decision-Making Processes

Level of Ownership And Involvement (Power sharing)

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Decision-making Process	Description
Delegate with constraints	Leader defines the decision that needs to be made in the form of a question or questions, clarifies the constraints on the decision (e.g., budget, timeframe, quality requirements), and delegates the decision to others. The leader does not alter the decision as long as it follows the constraints. A fallback option should be identified in the event the group cannot make the decisions within the constraints.
Consensus	A consensus decision is one that every member of the team is willing to support and help implement. All key stakeholders have had an opportunity to give their opinion and to understand the implications of various options. All members, including the leader, have the same formal power to support or block proposals. The group should agree on a fallback option for making a decision if consensus cannot be reached. The fallback might be to a super-majority, to the leader, to a person with relevant expertise or skills, or to a subset of leaders (e.g., BIPOC leaders). If consensus on the criteria is not reached, the fallback option is invoked. If the fallback is to the leader or other individual or group, they will make the final decision, taking the group's discussion into account.
Gather Input from Group and Decide	Leader asks the group members to share their ideas. The leader makes a decision after hearing from the group
Gather Input from Individuals and Decide	Leader asks selected individuals for input (ideas, suggestions, information). The leader makes a decision after gathering input from the individuals.
Decide and Announce	Leader makes a decision with little or no input then announces the decision to those who will be affected by or must carry out the decision.

Source: Adapted from [Interaction Institute for Social Change]

Recommendations:

- When in doubt, start small. Sustainable, systemic change takes time. Consider what resources are available and the actions you need to take to get to your desired goal. Each action towards the goal should be celebrated and gets you closer to what you are trying to achieve.
    - Take inventory of the resources available: Funding, Relationships, Capacity, etc.
- Consider the existing actions that are happening and explore opportunities to build upon them, fostering a cohesive and integrated approach.
- Develop a process for prioritization and selection of an action.
    - Allow space for big, open sky thinking. What actions would you consider if there were no limitations?
    - When you are ready to narrow your possibilities for action, think about what feedback or information you will consider and the strategies you will use to do so.
    - When you are ready to decide on your action, consider what decision-making process will be and who will be involved. Be transparent about why you are deciding on this action.
- Explore Policy, System, and Environmental (PSE) changes that can create lasting improvements and promote health equity on a larger scale. *See resources.*

Health Equity Checkpoint

- Identify the historical, social, economic, and systemic factors/drivers that contribute to racial inequities and other forms of inequities. To center equity, we must recognize the historical injustices, social determinants, economic disparities, and systemic barriers that have shaped the current health landscape. Understanding these complex drivers is fundamental for developing tailored and evidence-based interventions that address root causes of health inequities.
- Get community input in the strategy prioritization and planning process, being mindful to intentionally engage the communities most impacted.
- Be transparent about the decision-making process and who the deciders are. There is an opportunity to share power with community in how your narrow an decide on an action.
- When applying for funding, include best practices to advance health equity as appropriate (e.g., communicating back with community participants, providing stipends or incentives to community partners, recommending disaggregation of data, suggestions for making research more action oriented)
- Identify community assets and where power lies in the community.

Questions to consider:

- Based on the data we've examined, what actions will help us address what we've learned about our issue(s) of interest?
    - To what extent do they address the root causes or underlying structures and systems of the issue?
- How can we use the data to narrow the focus of our action(s)?
    - Are there specific communities of interest that are most impacted by the issue?
    - What conditions/barriers are contributing to the inequities?
    - Are there existing efforts that can be added to?
- What resources are available?
- Where can we have the most impact with available resources?
- What support do we need?
    - Do we need more people at the table?
    - How do we decide our focus?

Resources

- Focus on What’s Important, County Health Rankings and Roadmaps
    - This resource provides guidance on how to understand the most pressing community health issues and develop targeted interventions or policies to address them effectively.
- An Introduction to Policy, Systems, and Environmental (PSE) Change, Community Commons
    - The guide explains the concept of PSE change, which involves implementing strategies and interventions that address social and public health issues by influencing policies, systems, and environments.
- Using Community Sectors to Reach Targets and Agents of Change, The Community Tool Box
    - This guide defines community sectors and describes how to use community sectors to reach different community members.
- Anchor and Credential Solutions Not Problems, The CaseMade
    - This resource provides a video, list of skills, and examples of how to anchor conversations in solutions, not problems, in order to build trust and encourage greater support for social change.
- Discovering Community Power, Asset-Based Community Development Institute
    - This guide explores how to strengthen an organization by connecting with and investing in community assets.

Taking Action

Once you have come to agreement on **what** the desired action is with your partners and **why** you chose this particular action, think about **how** you are going to achieve your action and **who** will be involved. Then, it is finally time to take your action. Remember, action is not only about getting to your desired destination and results, but also about the journey. When we focus too heavily on the results of the action, we may lose sight of how we maintain relationships and communication with community partners in the process. For our actions to be sustainable and continuously improving, we need to continue to foster trust and collaboration with our community partners.

Recommendations:

- Maintain the engagement of your community partners that helped you along the way and/or invite new community partners to the table.
- Create an Action Plan: Within your action plan, effective delegation of tasks is a valuable tool for ensuring efficiency and productivity. Identifying clear roles and responsibilities empowers each member to contribute meaningfully to the collective effort.
- Start to think about Evaluation: The relationship between evaluation and action is intertwined, as the evaluation process provides real-time feedback and insights that inform our actions. As we implement the action plan, measuring progress becomes

Data to Action in Real Life

There are many great people and organizations doing Data to Action work across our region. We have included an example in our Case Study. See some additional examples below:

- **Conducting a Health Impact Assessment to recommend policy change for Older Adults with criminal records**
- **Using qualitative and quantitative data about opioid overdoses to generate an Anti-Stigma Campaign: 413 Cares Break the Stigma Campaign**

Process Reminder

Please consider where you are at in your Data and Action journey. This process may not be linear.

For example, before taking action, it may be necessary to expand your community partnerships or evaluate your past actions before initiating your desired action.

vital, allowing us to track outcomes, identify successes, and address challenges. *Refer to Evaluation for more on measuring progress.*

- Please see *Prioritization* step for additional guidance on how to plan for taking action. As you take action, please consider:
    - How is your action addressing the root causes of health inequities?
    - How your action supports policy, systems, and environmental change?
    - How can you build off of actions that have already been taken in the community?
    - What assets or barriers exist in your community?
    - Which people can help you towards your goals and what skills sets would be helpful to have on your team?

Questions to consider:

- What are the intended outcomes of your action?
- What may be the unintended consequences?
- What are the short-term and long-term goals?
- What is the timeline?
- How do we make the case for change?
- How do we motivate people to get involved?
- Who has the power to help push the action forward? Who has the power to interfere with action?

Health Equity Checkpoint

- ✓ Adjust the scope of your action as necessary with sustainability and equity in mind. Slow down the process if needed.
- ✓ Set up a process to collect and address community feedback continuously throughout, so that you can make improvement to your actions and maintain or improve trust with your community partners.
- ✓ In addition to getting feedback from community, share what you are doing with your community. Provide updates on the progress of your action, any outcomes or results of your action, and/or how community feedback was used.

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Resources

- Foster Collective Ownership, The CaseMade
    - This resource describes how to foster a sense of collective responsibility among stakeholders and community members in order to address social issues effectively.
- Implementing Effective Interventions, The Community Tool Box
    - This article provides information and resources for how to prioritize and implement intervention strategies based on what has been learned through research and experience in community contexts.
- Framing and Messaging for Racial Equity
    - This resource list provides examples and guides for the how we communicate and frame racial equity information.
- SMARTIE Goals Worksheet, the Management Center
    - SMARTIE stands for Strategic, Measurable, Ambitious, Realistic, Time-bound, Inclusive, and Equitable. This worksheet will help with the development of tangible and actionable goals that center equity and inclusion.
- Database for Best Practices, The Community Toolbox
    - Explore best practices for promoting community health and development.

Evaluation and Storytelling

Did it work? What did we learn?

Evaluation helps us understand the impact of our collective efforts and informs future actions. It is necessary to think of evaluation as a step that happens before action occurs, so that we can figure out how we will measure progress, foster learning through the process, engage in reflection, and make improvements. An ongoing evaluation process ensures that our actions remain dynamic and adaptable, responding to changing circumstances and emerging data.

Questions to consider:

- What went well? For whom?
- What could have been done better?
- What were the barriers?
- What was the role of community partners in the action process?

Hampden Community Health Improvement Plan Evaluation

In their 2021 evaluation cycle, the Hampden CHIP engaged in an evaluation process focused on storytelling by lifting up the journey of the coalition and their four community teams. This was made possible by the funder which established an evaluation process that was simply an interview to understand the success and challenges over the course of the funding year as they worked through their proposed action plans. Coalition facilitators developed a discussion guide with key questions to collect quantitative outcomes, overall feedback, lessons learned, and areas for future action. A written summary was then compiled from these facilitated discussions to help guide conversation with the funder. This process helped reduce barriers for participation in the evaluation process with community partners.

- What are the perceptions of our community partners on the action? To what extent did our community view this as a helpful action?
- Did your action help you get closer to addressing the root causes related to your focus area? How?

Process Reminder

Please consider where you are at in your Data and Action journey. This process may not be linear.

For example, one you have evaluated your work, you may go back to “Taking action” to modify your methods in your action plan.

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STORYTELLING AND COMMUNITY ENGAGEMENT

As you evaluate your actions, you will be gathering both quantitative and qualitative data that can help you measure your progress toward your goals. You can weave these data together to tell the story of your journey towards action. Consider who has contributed to the process, what you have learned, where there are opportunities for growth, and other key metrics that align with the narrative you would like to share. Through this practice of storytelling, you can engage and communicate back with your community partners and broader communities to foster trust and transparency. Often times, we may engage our community partners in our processes and actions as we work toward our goals but fail to communicate what happened with their input. This can be detrimental to your ongoing relationship. Storytelling and thoughtful outreach to close the community engagement loop as we conclude our actions, can be an important tool for fostering strong community partnerships.

Recommendations:

- Create an Evaluation Plan: Developing a comprehensive evaluation plan is critical for guiding the evaluation process. The plan outlines the objectives, data collection methods, how we will measure outcomes and progress, and timelines, ensuring that the evaluation is systematic and well-organized. See Resources for guidance.
    - Measuring Progress and Outcomes: Your evaluation plan will help you think about what data, both quantitative and qualitative, you collect to measure your progress towards your objectives. Quantitative data provides measurable metrics, while qualitative data offers valuable insights into the experiences and perspectives of those affected by the actions.
    - Continuous Improvement: While engaged in your action, use the data you are collecting in real time to improve your process or approach for action. The insights from what you learn can help with adapting and refining your strategies as you progress.

- Revisit Your Data: Regularly revisit the initial data and goals set forth at the beginning of the process. Assess where you are now compared to your starting point and identify any changes or progress made. Capturing the milestones achieved is essential for celebrating successes and motivating ongoing efforts.
- Communicate with Collaborative Partners: Sharing the successes and challenges of the action process with collaborative partners fosters transparency and open communication. It allows for collective reflection and learning, fostering a spirit of collaboration and shared responsibility.

Through thoughtful evaluation, we gain valuable insights into the effectiveness of our actions and pave the way for continual improvement.

Health Equity Checkpoint

✓ As you modify your strategies or actions with continuous evaluation, consider the decision-making process for incorporating feedback from community partners.

Resources

- Documenting Progress and Using Feedback, The Community Tool Box
    - This page describes the importance of documenting progress and using feedback to create more successful and impactful interventions.
- Making Outcomes Matter, The Community Tool Box
    - This resource emphasizes the critical role of outcomes in successful change processes and offers guidance on how to make outcomes matter in planning and evaluating interventions.
- Evaluate Actions, County Health Rankings and Roadmaps
    - This tool provides resources for preparing to evaluate an intervention, determining appropriate measures of success, sharing evaluation results, and how to make effective changes.
- Share your Roadmap and Metrics for Success, The CaseMade
    - This resource describes the importance of establishing and sharing metrics of success throughout the entire intervention.
- Addressing Health Equity in Evaluation Efforts, Center for Disease Control and Prevention
    - This guide describes how to evaluate an intervention with a health-equity lens. This document also includes reflection questions.

Pulling It All Together- A Case Study

The Alliance for Digital Equity is a coalition of partners working on addressing inequities in digital access across Western MA. It came about during the COVID-19 pandemic when there was a pivot to remote work and school for many people across the region. The shift quickly unveiled digital access issues for many from access to internet to technology.

Getting Started
Baystate Health took on the role of convening people across Western MA to address these digital access gaps. This group became the Alliance for Digital Equity.

Defining the Focus
The Alliance completed its own 3-county survey which was an important part of the assessment process because it was one of the only data sources available that provided timely data on the impact of the COVID-19 pandemic on digital access across the state.

Centering Health Equity
Locality-based data (GIS) and other qualitative methods (key interviews and focus groups) complemented municipal and county census data to identify marginalized communities with inequitable digital access: rural communities, BIPOC, disability, older adults, low-income people.

Community Engagement
The primary role of Baystate was to be a convener. They built their table to include experts, community members and other stakeholders that had a shared interest in addressing digital equity. The members included social workers, councils on aging, youth-serving organizations, municipal departments, and people from the technology sector.

Taking Action
The Alliance completed an assessment and community action framework to drive action to improve digital access in Western MA. The assessment work was designed to be accessible to a wide range of people by making the data visible in the PowerPoint style of data presentation It was light on words with emphasis on data visualization. The assessment led to the coalition building a case for addressing digital inequity. It took approximately 2 years of conducting the assessment and convening to be able to advocate for funding.

Conclusion

Thank you for using our data and action framework as you consider what action you will be taking in your community. We want to acknowledge that data is not just a collection of numbers and statistics; it represents the lived experiences of people in our communities. Using data for action helps us reveal insights about what is going on in our communities and can help us focus our efforts strategically so that we can maximize the impact. However, we acknowledge that there must be continued effort to improve the data that is available about our communities and how it is collected so that the actions we take based on the data are equitable and represent the lived experience of those we serve.

Our data and action framework embodies a set of core values that lie at the heart of our collective journey towards positive change:

- Equity serves as our compass, guiding us to address inequities and create just opportunities for all.
- Power is shared, empowering each member of the community to contribute and shape the path ahead.
- Embracing community engagement, we actively listen to diverse voices, recognizing that every perspective is vital for building healthier, inclusive communities.

As we work through the process of using data for action, we remain mindful that this process is not linear, but rather iterative, allowing us to adapt and grow with new insights. By using data to inform our work, engaging our communities, sharing power, and centering the voice of our community partners, we will move forward in our efforts to create equitable, healthy communities. Let us embark on this path together, knowing that our shared commitment will pave the way for a brighter, more sustainable future.

Stories from our partners

Brittney Rosario, Baystate Health

The Alliance for Digital Equity is a coalition of partners working on addressing inequities in digital access across Western MA. It came about during the COVID-19 pandemic when there was a pivot to remote work and school for many people across the region. The shift quickly unveiled digital access issues for many from access to internet to technology.

- **Getting Started:** Baystate Health took on the role of convening people across Western MA to address these digital access gaps. This group became the Alliance for Digital Equity.
- **Data:** The Alliance completed its own 3-county survey which was an important part of the assessment process because it was one of the only data sources available that provided timely data on the impact of the COVID-19 pandemic on digital access across the state.
- **Equity:** Locality-based data (GIS) and other qualitative methods (key interviews and focus groups) buttressed municipal and county census data to identify marginalized communities with inequitable digital access: rural communities, BIPOC, disability, older adults, low-income people.

“Action is convening, is bringing people together”

- **Community Engagement:** The primary role of Baystate was to be a convener. They built their table to include experts, community members and other stakeholders that had a shared interest in addressing digital equity. The member included social workers, councils on aging, youth serving organizations, municipal departments, technology
- **Action:** The Alliance completed an assessment and community action framework to drive action to improve digital access in Western MA. The assessment work was designed to be accessible to a wide range of people by making the data visible in the PowerPoint style of data presentation It was light on words with emphasis on data visualization. The assessment led to the coalition building a case for addressing digital inequity. It took approximately 2 years of conducting the assessment and convening to be able to advocate for funding.

“During the action, you still need more data. It doesn’t end--it is part of the work”

- **Voice:** In terms of voice, the Alliance's work groups were designed around the notion of "asking people first" - those most impacted by digital inequality should be at the table and designs should be locality- and population-based.

Gail Gramarossa, Quaboag Hills Substance Use Alliance:

- **Getting Started:** The ***Quaboag Hills Substance Use Alliance*** is a part of the Quaboag Hills Community Health Improvement Plan coalition. The coalition needed additional data and community input to help identify and prioritize the community needs to be addressed through their CHIP.
- **Data:** Multiple data sources were considered: local Community Health Needs assessments, youth health surveys, Age Friendly and Dementia Friendly Hospital reports as well as the COVID-19 Community Impact Survey (CCIS). CCIS data on substance use and mental health during the pandemic provided local data that generally was hard to find for the rural communities they serve. The coalition looked at data on resident experience of poor mental health days and increase of substance use. The group collectively walked through the data to understand all the data sources and how to access them
    - **Success:** The CCIS data helped the Alliance during their assessment to highlight the unmet mental health and substance use disorder needs in their region and the types of barriers present in access to care.
    - **Challenge:** The CCIS survey was only able to reach a small sample size of these communities which made it difficult while evaluating and analyzing the data.
- **Equity:** All of the data that was analyzed helped to develop the narrative of the unmet needs in the rural communities of the Quaboag Hills region and highlighted the COVID-19 impacts.
- **Community Engagement and Action:** The Alliance was able to leverage ongoing vaccine clinics to meet community members where they were at with a survey to understand what the community felt were the most pressing health needs. Ultimately, the survey helped the CHIP coalition to narrow to the four top needs, which were mental health, transportation, access to care, and housing
- **Voice:** Community voice was incorporated through the survey process where community members were able to share qualitative feedback with the CHIP coalition.

Malikah Jeffries, Gandara Center

The STOP Access Coalition is citywide coalition serving Springfield, Massachusetts with the goal of addressing community level change to prevent and reduce underage drinking, and use of marijuana and tobacco/nicotine under the age of twenty-one years, focusing primarily on middle and high school age youth.

- **Data:** The coalition is required to collect data to inform their work of substance use prevention. The coalition collects data using the Prevention Needs Assessment Survey. This survey initiative collects data on risk and protective factors related to youth substance youth. Ultimately, funders decide what needs to be collected and reported, but the coalition has flexibility in how they engage community and conduct the survey process.
- **Community Engagement:** The coalition engages convenes youth in their coalition who inform their work.
  - Other: When trying to reach grassroots audiences:
    - "If the practice[action] isn't working, we throw it out instead of modifying our theory." This is to say that methods matter- you may need to refine the way you do your work to get your action to give the results you desire.
      - This process may require going back to the drawing board, getting feedback, and rethinking how you approach your action
      - Shift your vocabulary and use culturally appropriate analogies or metaphors to help paint the picture of your purpose
    - Sometimes in order to understand how to engage your target audience, you have to put yourself in their shoes. How would I receive this information as a young person? How do you know that you are talking about the same thing?
- **Action:** The coalition utilized the data to inform local policy makes by presenting findings to the subcommittee on mental health in the Springfield City Council.
- **Other:** The data collection efforts unveiled the rising needs around mental health and how it has worsened with COVID-19. The STOP Access coalition usually focuses on substance use but with this need arising from the data, they are taking action to break the silo between mental health and substance use

Phoebe Walker, Franklin Regional Council of Governments

- **Community Engagement:**
    - FRCOG has developed an intentional process for including community representation and voice in the process:
        - Priority Perspective Stipends: Residents that represent a "Priority Perspective" are employed as advisors to FRCOG. They are contracted for a year and are provided orientation. Residents are compensated to be engaged in various processes where their perspectives are necessary, and they provide critical feedback. They bring lived experience to the work. These people are recruited via referrals and activities such as focus groups. For example, a focus group was conducted with people in recovery looking for housing- they use this opportunity to recruit advisors. They have to balance finding people in a stable enough place to participate
        - Peer ambassador program: Contract with various organizations Peer ambassador program(parents) -family center, brick house, recover project (human service org) -- they identify leaders in their client pool. They contract with agency to stipend them
        - They table and go to events
        - Their agency supports them. Contract with agency is to support the administration
        - Best practice: FRCOG when they first set out to get more community engagement. This initially look like the traditional convening process for creating and advisory committee. However, they quickly realized that the rigid structure of meetings didn't feel right. They moved away from the committee structure to thinking about the individual and how they can invest in them while learning from their experience. The FRCOG provides their advisors with learning opportunities throughout their reengagement. Ultimately, the FRCOG is learning important information for their work while helping their advisors reach their goals. This requires more work to provide individual support, but it is better for all.

- **Prioritize and Plan:** The FRCOG conducts "Pitch Parties" with the community to help identify legislative priorities. All residents are invited to propose a bill for consideration as priority. They have 3 minutes to make their pitch on what it was and why it was important". The group then shifts to voting via a google form that captures the votes.

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Glossary

Data Collection: “Data Collection is the process of gathering data, typically in the context of a research project or for ongoing surveillance and tracking. This involves measuring information on variables of interest in a pre-established, systematic way that enables researchers to address research questions, test hypotheses, and evaluate outcomes. There are many methods of data collection including manual and automated, and the methods typically depend on the intended outcomes to be measured and analyzed. Data can be collected through forms or survey instruments; qualitative interviews or focus groups; extractions from EHR data; measurements from sensors, scales, and other lab or clinical equipment; video or audio recordings; review of corpuses of text.”

Intersectionality: “simply a prism to see the interactive effects of various forms of discrimination and disempowerment. It looks at the way that racism, many times, interacts with patriarchy, heterosexism, classism, xenophobia — seeing that the overlapping vulnerabilities created by these systems actually create specific kinds of challenges” (Racial Equity Tools)

Disaggregation: "To disaggregate data is to break down combined summary (or aggregated) data into smaller units of data... In order to be able to disaggregate data, you must have access to the variables or pieces of data that you want to disaggregate by.” (We all Count)

Social Determinants of Health: The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political system (World Health Organization)

Community engagement: Collaborative processes between organizations/institutions and communities impacted by their policies, programs, or practices to influence decisions and actions through the mutually beneficial and bidirectional exchange of resources, expertise, and information.

For additional race and health equity terminology, visit PHIWM Race and Health Equity Glossary