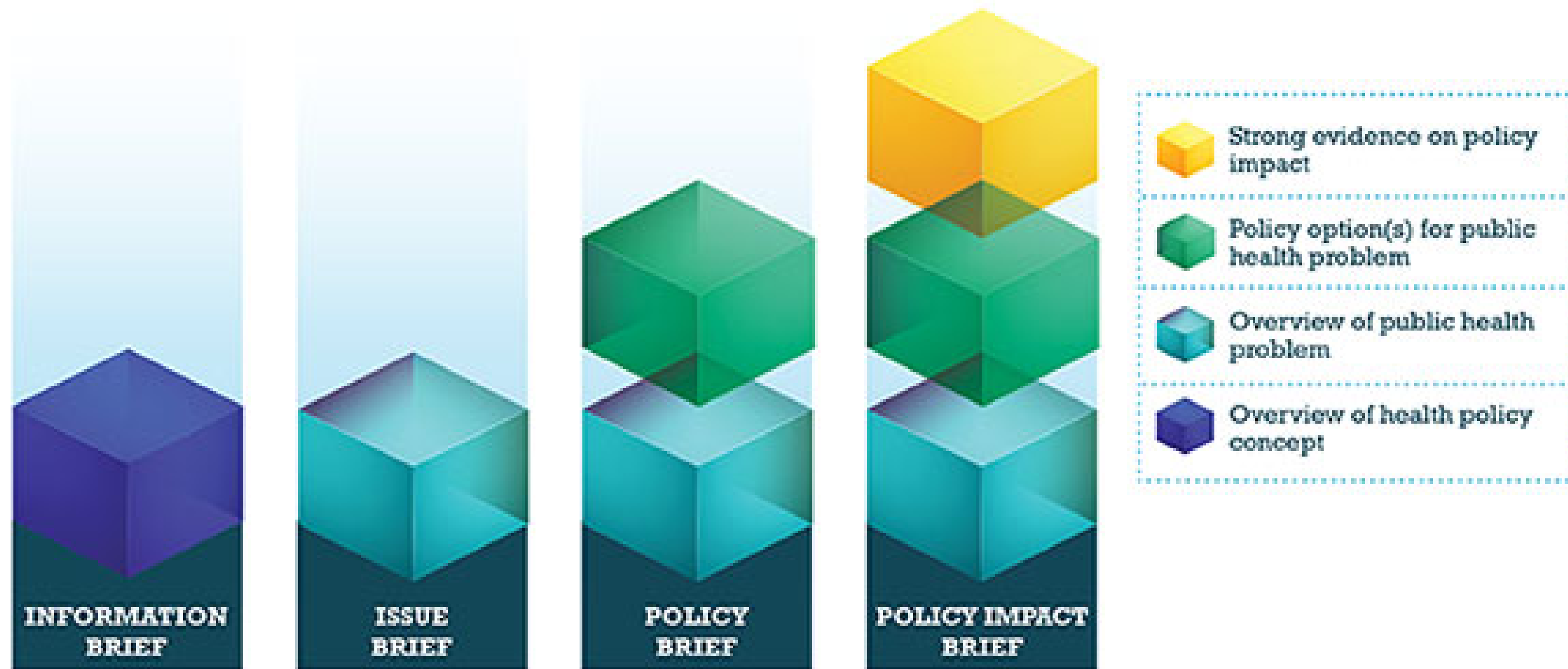


DATA PROJECT & WORKSHOP

*Making a 1-Page for a
Stakeholder/Partner
Audience*



The **F**our Types of Briefing Documents



<https://www.cdc.gov/policy/polaris/training/writing-briefs/index.html>

STEPS FOR WRITING BRIEFS

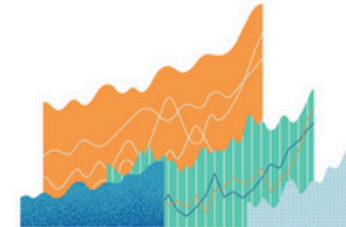
When you're ready to start developing your brief, consider the following steps.



1

IDENTIFY YOUR KEY AUDIENCE

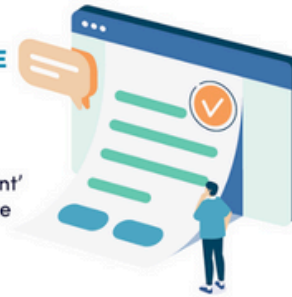
Potential audiences may be those who inform policy at the federal, state, or local level; federal, state, local, or nongovernmental decision makers; or other stakeholders.



3

DETERMINE YOUR PURPOSE AND MAKE SURE YOUR MATERIAL CONTAINS ONE OBVIOUS MAIN MESSAGE

Lead with your 'bottom line up front' (BLUF) which captures the purpose and main message.



2

CONDUCT AUDIENCE RESEARCH

In order to translate the evidence in a way that is easy to understand, get to know your audience. Don't guess or assume. Review data or, when possible, gather new data through formative research.

4

DEVELOP CONTENT FOR THE TYPE OF BRIEF YOU WANT TO CREATE

- Define and explain terms that may be unfamiliar to your audience. Avoid using jargon or technical terms unless absolutely necessary.
- Organize information into chunks with headings.
 - » A "chunk" is the amount of words or numbers people can hold in their short-term memory and group with other words or numbers. A chunk should be only one idea that people can connect to other, related ideas.
 - » Use headings to organize and label chunks.
- Use bulleted or numbered lists to break up text in the body of the material and make information easier to scan and read. Lists with more than seven items should be broken into sub-lists.
- Review the [CDC Clear Communication Index](https://www.cdc.gov/policy/polaris/training/writing-briefs/) for other tips on communicating clearly with your intended audiences.



5

INCLUDE AT LEAST ONE VISUAL AID THAT CONVEYS OR SUPPORTS THE MAIN MESSAGE

Photographs, graphs, and infographics are visual aids. Simple, well-designed visual aids help people easily and quickly grasp information. Make sure words and visual aids convey the same message and reinforce each other.



7

FORMAT YOUR BRIEF

Finally, your brief should be concise, compelling, and visually appealing to your audience.



6

INCLUDE CONSIDERATIONS FOR THE KEY AUDIENCE

Be clear about what the evidence might mean (as it relates to the issue at hand) but also what it might not mean (if relevant), and frame the evidence in a way that is accurate and easy for the audience to understand.



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

For more info: <https://www.cdc.gov/policy/polaris/training/writing-briefs/>

CS03017-A

- Notice the emphasis is centered around the audience, knowing them, formatting the brief so it's appropriate for them...
- Keep step 8 in mind (tell your story) when constructing the 1-pager (brief)

<https://www.cdc.gov/policy/polaris/training/writing-briefs/index.html>

HUNGER IN NH

December 2020

WHAT IS FOOD INSECURITY?

Lack of regular access to enough nutritious food to lead a healthy life.

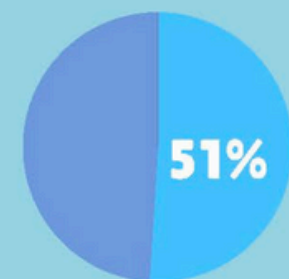
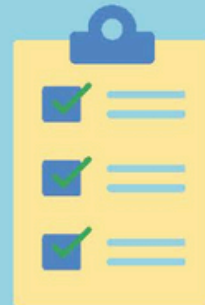
Food insecurity is one way we *measure* and *assess* **hunger**.



THERE ARE MANY FACTORS THAT CONTRIBUTE TO FOOD INSECURITY:

Low wages and high cost of living are major drivers of poverty and thus hunger in NH.

Those plagued by food insecurity often suffer from unaffordable housing, lack of health insurance, social isolation, and chronic health problems. These factors contribute to poor health outcomes and limit opportunities.



WHO ARE EXPERIENCING FOOD INSECURITY EARN TOO MUCH TO QUALIFY FOR SNAP AND OTHER FEDERAL NUTRITION INCENTIVE PROGRAMS

PARTICIPATION IN NUTRITION PROGRAMS IS GOOD FOR NH ECONOMY & PROSPERITY:

Every federal dollar spent by federal nutrition programs generates **\$1.50 in local economic activity.**

(ex., SNAP (Food Stamps), WIC, National School Lunch and Breakfast programs, and Pandemic-EBT)



FOOD INSECURITY IS A REAL PROBLEM IN NH

1 in 6

NH households are food insecure today



2x the rate at the beginning of 2020

3 in 4 food insecure households have children

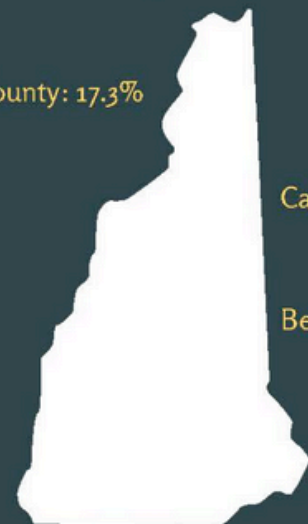


Top 3 counties in NH for food insecurity:

Coos County: 17.3%

Carroll County: 14.6%

Belknap County: 13.8%



*<https://www.feedingamericaaction.org/the-impact-of-coronavirus-on-food-insecurity/>



PREVENTING VIOLENCE: Roles for Local Public Health Agencies

EXECUTIVE SUMMARY • OCTOBER 2011

BACKGROUND

Violence is a leading cause of death and disability in the US¹. While there has been a growing recognition of the unique skills and solutions the public health community can offer to prevent violence², the role of public health is often overlooked and many times public health practitioners themselves do not know the appropriate roles they should assume to contribute to solutions.

In April 2010, the Safe States Alliance, with funding from the CDC, convened a roundtable of twenty-four violence prevention experts and stakeholders to address this issue. Recommendations resulting from these discussions are offered as a resource for public health departments in identifying specific roles for their organizations in a full report on the Safe States website. This is a summary of recommended roles for local public health agencies.

THE PUBLIC HEALTH APPROACH

The Public Health Approach to Violence Prevention is a four-step process designed to guide practitioners through program planning, evaluation, and dissemination (Figure 1)³.

The first step in the public health approach is to clearly define the problem by collecting and analyzing epidemiological data. The second step is to identify the factors that protect

Figure 1. Public Health Approach to Violence Prevention



people or put them at a higher risk for experiencing or perpetrating violence. The third step is to select and adapt a preexisting

intervention or develop and test new prevention strategies to appropriately address the issue. The final step is to broadly disseminate the intervention strategies and evaluation results to facilitate adoption in other communities.

OVERARCHING ROLES

Public health leaders at national, state, and local levels must continuously demonstrate an interest in and commitment to the multi-disciplinary approach needed to prevent violence. Throughout the roundtable meeting four overarching goals

were identified that must be addressed at all levels of public health in order to successfully prevent violence:

1. Institutionalize visible, high-level leadership that prioritizes violence prevention;
2. Prioritize a balanced approach that includes the primary prevention of violence;
3. Focus on disparities and the role of social determinants, including racism and poverty; and
4. Re-frame the issue of violence as a community-level problem that involves all of us, and not simply "them."

RECOMMENDATIONS FOR LOCAL PUBLIC HEALTH AGENCIES

- 1 Build coalitions and partnerships;
- 2 Conduct needs assessments and strategic planning;
- 3 Identify and support effective policy approaches to violence prevention;
- 4 Seek sustainable financial resources;
- 5 Implement evidence-based policies, programs and practices to prevent violence;
- 6 Enhancing public awareness;
- 7 Conduct surveillance;
- 8 Build public health practitioner capacity and skills to prevent violence; and
- 9 Support the medical community to assess and respond to violence

Local health departments (LHDs) are critical access points for the assurance of community health. LHDs protect and improve community well-being by preventing disease, illness, and injury, as well as impacting social, economic, and environmental factors fundamental to excellent health. LHDs have a critical role in facilitating, promoting, and supporting community-level violence prevention efforts.



Safe States Alliance
2200 Century Parkway • Suite 700 • Atlanta, GA 30345 • (770) 690-9000 • www.safestates.org

National Center for HEALTHY HOUSING

Environmental Health Fact Sheet: Health Department Strategies for Implementing Health in All Policies to Reduce and Prevent Lead Exposure

Introduction

State and local health departments (HDs) face complex public health challenges due largely to decisions made outside of the health sector. Factors such as socioeconomic policies, land use and transportation decisions, and the quality of education shape access to resources and opportunities that affect quality of life and health outcomes. Problems such as health inequities, which are unfair and avoidable differences in health status within and between localities; healthcare costs; environmental exposures; and climate change are complicated, interrelated issues lacking simple solutions. In the cases of lead exposure, both the sources of lead exposure within a community and the impacts of lead exposure are multisectoral. For instance, lead may be found in paint, soil, water, food, and other consumer products (all regulated and managed by different entities) and impacts the housing, healthcare, education, criminal justice, and other sectors. Evidence-based solutions exist, but often require collaboration among stakeholders within a community.¹ One way HDs can begin to address such problems is by collaborating with partners from “non-health” sectors through a Health in All Policies (HiAP) approach that infuses health considerations into policy, planning, and program decisions. The National Association of County and City Health Officials (NACCHO) and the National Center for Healthy Housing

(NCHH) have produced this fact sheet to provide an overview of strategies that can help HDs implement HiAP to reduce and prevent lead exposure through state and local strategies.

About Health in All Policies

NACCHO defines HiAP as a change in the systems that determine how decisions are made and implemented by local, state, and federal governments to ensure that policy decisions have neutral or beneficial impacts on health determinants. HiAP emphasizes collaboration across sectors and breaking down “silos” to achieve common health goals. HiAP is an innovative approach to changing how policies, plans, and programs are created and implemented by ensuring that health and equity are considered prior to adoption and implementation. Because HDs possess the legal authority, responsibility, and mission to protect and promote the public’s health, they are natural leaders to implement HiAP at the state and local level by acting as facilitators to convene partners and stakeholders — such as public officials, planning or transportation departments, community-based organizations, local businesses, developers, and advocates — to address the policy and structural factors affecting health within communities. HiAP often fits within HDs’ ongoing efforts to improve population health through policy, systems, and environmental change strategies.

7 STRATEGIES for Implementing Health in All Policies

HiAP is a change in the systems that determine how decisions are made and implemented by local, state, and federal governments to ensure that policy decisions have neutral or beneficial impacts on health determinants.



Be Well: Cultivating Resilience to Address Health and Well-Being



What Is “Burnout”?

Burnout is defined as loss of enthusiasm for work, feelings of cynicism and low sense of personal accomplishment.

Who Is Affected?



1 out of 2 physicians (54%)
are experiencing burnout



compared to **1 in 3 (29%) professionals**
in the general population.⁴

What Contributes to Burnout?*



Workload. Excessive, the wrong kind, or emotionally draining work.



Control. Insufficient control over resources needed or insufficient authority to pursue work more effectively.



Reward. Lack of appropriate rewards (financial, social, or intrinsic).



Community. Lack of connection with others in the workplace.



Fairness. Lack of perceived fairness and mutual respect.



Values. Mismatch between personal values and leadership/organizational values or organizational values and actual practice.

The rapid pace of change in health care, from system redesign to new payment models to increased data reporting and electronic interoperability, has clinician attention divided among many competing priorities. All the while, the health care workforce itself is shifting and changing to reflect the growing diversity of the nation as well as needs and preferences of our communities. Clinician stress is associated with lower patient satisfaction, patient safety issues, overuse of resources and increased costs of care. Clinicians at the front lines of care, including primary, emergency and critical care, are especially vulnerable.

Physicians with less control over their work environment and chaotic schedules and pace are more likely to report symptoms of burnout and it’s no wonder; primary drivers of burnout include regulatory and paperwork burden, deterioration of clinical autonomy, inefficient EHR design/interoperability and professional liability concerns.

Burnout is directly tied to job satisfaction and stress. In 2016, the *Physicians Foundation* surveyed 17,236 physicians and found long-term patient relationships, intellectual stimulation, interactions with colleagues, and social and community impact among the factors physicians value most in job satisfaction.

One study linked the areas of work-life balance with the dimensions of burnout for nurses; this in turn predicted nurse turnover. The study concluded that the impact of workload on exhaustion, which over time increases cynicism, indicates intervention to sustain manageable workloads and workplace health is necessary. It is imperative to recognize and acknowledge nurses’ contributions in ways they find meaningful.

Implications

Burnout has a substantial effect on health care quality and safety. In cross-sectional studies of more than 7,100 US surgeons, major medical errors reported were strongly related to the surgeon’s degree of burnout.¹ Other studies found that mean burnout levels among hospital nurses were an independent predictor of health care-associated infections.² As emotional exhaustion levels of physicians and nurses working in intensive care units increased, so did patient mortality ratios.³ Additionally, a study on hospital nurses found a correlation between longer shifts, higher levels of

BLEEDING FOR EQUITY

THE REALITIES OF PERIOD POVERTY
AT THE UNIVERSITY OF HAWAII



PERIOD POVERTY AFFECTS NEARLY HALF OF UNIVERSITY OF HAWAII MENSTRUATORS

43%

MENSTRUATING STUDENTS



in the UH system experienced period poverty in the past year, three times the national average*

One in five students experienced period poverty on a **monthly** basis, twice the national average*

Native Hawaiians experienced the highest prevalence with **51% experiencing** period poverty in the past year

"[Access to free period products] could only impact our community for the better. Not only will women feel safe, comfortable and looked after by the school, but they will also never have to worry about a period holding them back from achieving their academics. Being in college, our main priorities are to obtain an education, not stressing over our periods."

KEY INSIGHTS AMONG STUDENTS EXPERIENCING PERIOD POVERTY

Period poverty is the limited or inadequate access to menstrual products or menstrual health education as a result of financial constraints, negative socio-cultural stigmas associated with menstruation, or inadequate access to period-friendly bathroom facilities and running water.

Students experiencing period poverty face challenges with basic needs, mental health, school, and work. For those dealing with housing and/or food insecurity, period poverty is an added burden on mental health. These students were nearly two times more likely to report depressive symptoms compared to students with housing and/or food insecurity who did not experience period poverty.

Addressing period poverty and menstrual inequity is essential for meeting basic needs and promoting overall well-being and student success.



81% OF STUDENTS experienced academic disruptions



31% OF STUDENTS experienced depressive symptoms

2.5x

FOOD INSECURITY
Students experiencing period poverty were 2.5 times more likely to face food insecurity than those without.

1.4x

HOUSING INSECURITY
Students experiencing period poverty were 1.4 times more likely to face housing insecurity than those without.

"Tuition in Hawaii today isn't affordable, and it was helpful to have extra as needed. If not people would use napkins like how I did. Coming from a poor family. Always using jackets to hide the stains."

In 2023, Ma'i Movement Hawaii, in collaboration with George Mason University, surveyed University of Hawaii students about their lived experiences regarding accessibility of menstrual products and its impacts. For more information, please contact Nikki-Ann Yee (nikki@maimovement.org) or Dr. Jhumka Gupta (jgupta4@gmu.edu).

10 CAMPUSES
3 EDUCATION CENTERS

462
PARTICIPANTS

71%
AGED 18-25

Eligibility Criteria

- Student in University of Hawaii system
- Menstruated in the past year

*Cardoso LF, Scolese AM, Hamidaddin A, Gupta J. Period poverty and mental health implications among college-aged women in the United States. *BMC Women's Health*. 2021 Jan 6;21(1):14.

**IT'S TIME TO
TAKE ACTION**

MAKE PERIOD PRODUCTS FREE
ACROSS THE UNIVERSITY SYSTEM

98% OF RESPONDENTS SAY YES

[MAIMOVEMENT.ORG](https://maimovement.org)
[@MAIMOVEMENTHAWAII](https://twitter.com/MAIMOVEMENTHAWAII)

- Bring a draft of your topic
 - What is the problem/opportunity?
 - Who are your partners?
 - What do you want them to know?
- Think about how DATA can “tell your story” of the problem and solution
 - What kind of data might be compelling?
- Take a look at the Hawai'i Health Data Warehouse website:
 - <https://hhdw.org/>

ACTIVITY

Humanizing Data



WRITING AS AN ADVOCACY & STORYTELLING TOOL





*“With great power
comes great
responsibility”*

- Popularized by Spider-Man in Marvel Comics

PAIR SHARE

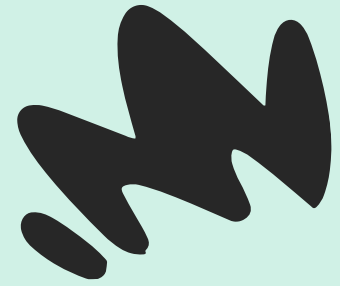
What power do we hold as
writers & knowledge producers
in the public health field?

STORYTELLING WITH DATA

(DON'T LET DATA SPEAK FOR ITSELF)

- Not everyone “speaks data.”
- Statistics without explanation are waiting to be misinterpreted.
- Data on its own can create more questions (especially with complex issues like racial disparities in health).
- People are more than data points.





DIS-EMPOWERING VS. EMPOWERING LANGUAGE

DIS-EMPOWERING

- Focuses on a group's deficits
- Blames victims of their circumstances
- Overlooks systemic structures & oppressive contexts (racism, sexism, ableism, colonialism, transphobia, etc.)
- Highlights past failures
- Focuses on problems
- Relies on external & "expert" knowledge
- Needs to find what's missing

EMPOWERING

- Focuses on a group's strengths
- Contextualizes circumstances
- Is critical of systemic structures & oppressive contexts (racism, sexism, ableism, colonialism, transphobia, etc.)
- Highlights past successes
- Focuses on solutions
- Relies on internal & community knowledge
- Builds on existing strengths

WORDS HAVE POWER

- “Mainland” vs. “continent”
- “Pre-contact” vs. “pre-Western contact”
- “Outer island” vs. “Neighbor island”
- “Hawaiian” vs. “people from Hawai‘i” vs “Hawai‘i residents”



BE SPECIFIC & INCLUSIVE

- “AAPI” vs spelling out the specific group
- “BIPOC” vs spelling out the specific group
- “Homeless” vs “houseless” vs “unhoused”
- “Slaves” vs “enslaved”
- “Pregnant woman” vs “pregnant person”
- “Fetus” vs “unborn child” or “baby”





HUMANIZING DATA

“One of the ways to think of the racial gap in health is to think of how many black people die prematurely every year who wouldn’t die if there were no racial differences in health. The answer to that from a carefully done [2001] scientific study is 96,800 black people die prematurely every year. Divide it by 365 [days], that’s 265 people dying prematurely every day. Imagine a jumbo jet — with 265 passengers and crew — crashing at Reagan Washington Airport today, and the same thing happening tomorrow and every day next week and every day next month. That’s what we’re talking about when we say there are racial disparities in health.”

~ Dr. David Williams (Norman Professor of Public Health and Professor of African and African American Studies at Harvard University)

In groups of 3-ish, discuss:

1. How does the speaker “humanize” the data? (Give examples)
2. Would the data alone have been just as effective? (Why or why not?)
3. What do you think is the goal of “humanizing” the data in this example?

