



Massachusetts Department of Public Health

Promoting Optimal Early Childhood Nutrition Massachusetts WIC Program and the Nutrition Division's Breastfeeding Initiative

Rachel Colchamiro, MPH, RD, LDN, CLC

Director, Nutrition Division, BFHN



BFHN Aim Statement

Advance and sustain equity for Bureau of Family Health and Nutrition (BFHN) staff and the communities and families we serve by dismantling structural racism and co-creating healing centered policies, practices, and social norms.



Bureau of Family Health and Nutrition



Division of Pregnancy, Infancy, and Early Childhood (DPIE)

Promotes healthy, safe and nurturing environments for children, birthing people, and families by providing direct services, research, and policy development.



Early Intervention Division (EI)

Supports families and caregivers with infants and toddlers at risk of developmental delays to enhance their child's learning and development.



Division for Children & Youth with Special Health Needs (DCYSHN)

Promotes the health and well-being for children and youth with special health needs and collaborates with families and providers to address a range of medical, developmental, and behavioral conditions.



Nutrition Division

Helps ensure that all families have the healthy foods they need, and the knowledge, resources, and care necessary to live healthy lives.



Division for Surveillance, Research, and Promotion of Perinatal Health (DSRPPH)

Focuses on the surveillance, research, training, and health promotion of perinatal health to improve health outcomes for all pregnant people, children, and families.



Division of Maternal and Child Health Research and Analysis

Aims to enhance the health of infants, children, caregivers, and families by leveraging partnerships and data-driven insights to inform policies and decision-making.

First 1,000 Days

Evidence suggests that the nutrition quality from conception to a child's second birthday has a critical impact on proper brain development, healthy growth and immune system function for the entirety of the child's life, perhaps even impacting the next generation.

Eating patterns established in early childhood can positively impact intake patterns later in life.



Women, Infants, and Children Nutrition Program (WIC)

What is WIC?

- WIC is a nutrition program that provides healthy foods, nutrition education, breastfeeding support, and referrals to healthcare and other services, free of charge, to families that meet income guidelines

Who is eligible for WIC?

- Children under age 5
- Pregnant individuals
- Breastfeeding individuals up to 12 months postpartum
- Non-breastfeeding postpartum individuals up to 6 months postpartum
- WIC serves households up to 185% of the FPL; individuals with SNAP, TANF, and most types of MassHealth are automatically deemed income-eligible



WIC Program Highlights

WIC Staff & Programs



Approximately **500 dedicated staff**
at 31 local programs with
120 sites across the state

Infant Participation



Over 40% of infants born in
Massachusetts participate in the WIC
program during their first year of life

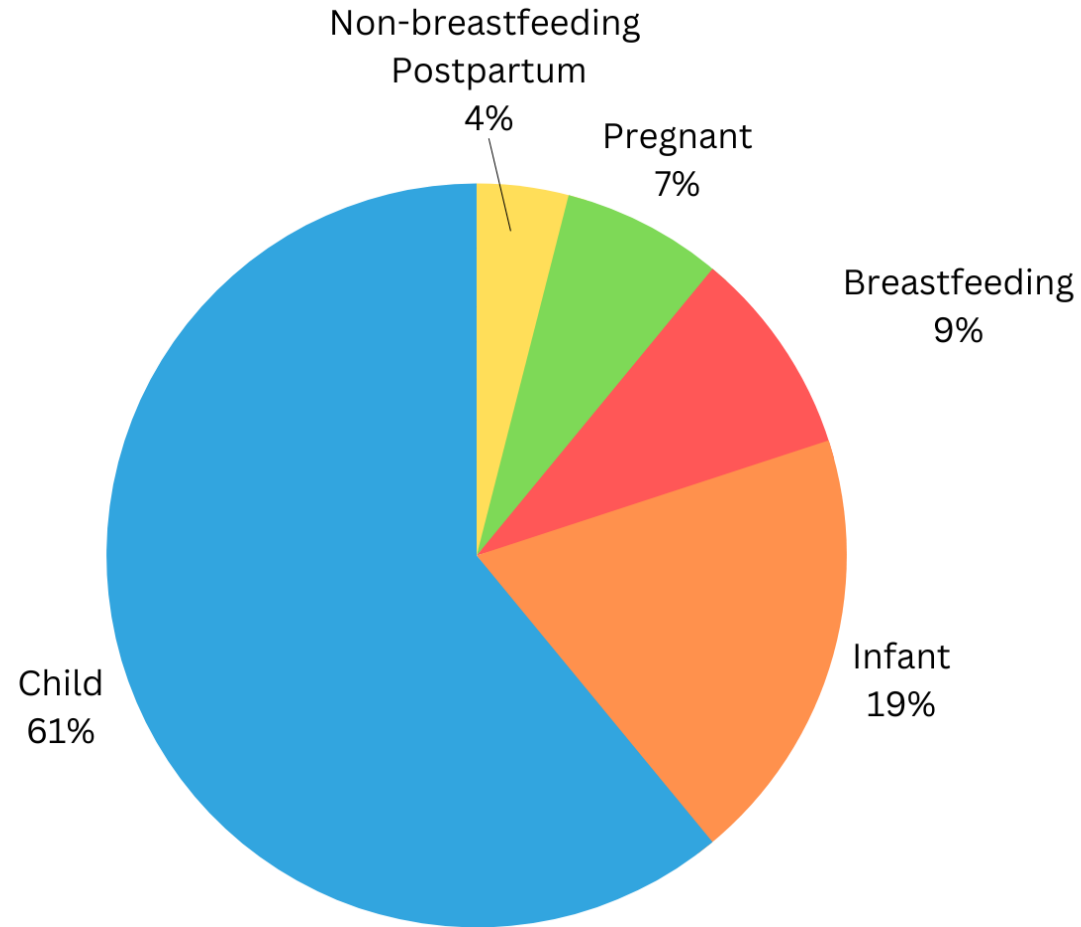
Monthly Reach Among All Participants



Currently serves about
127,000 individuals/month

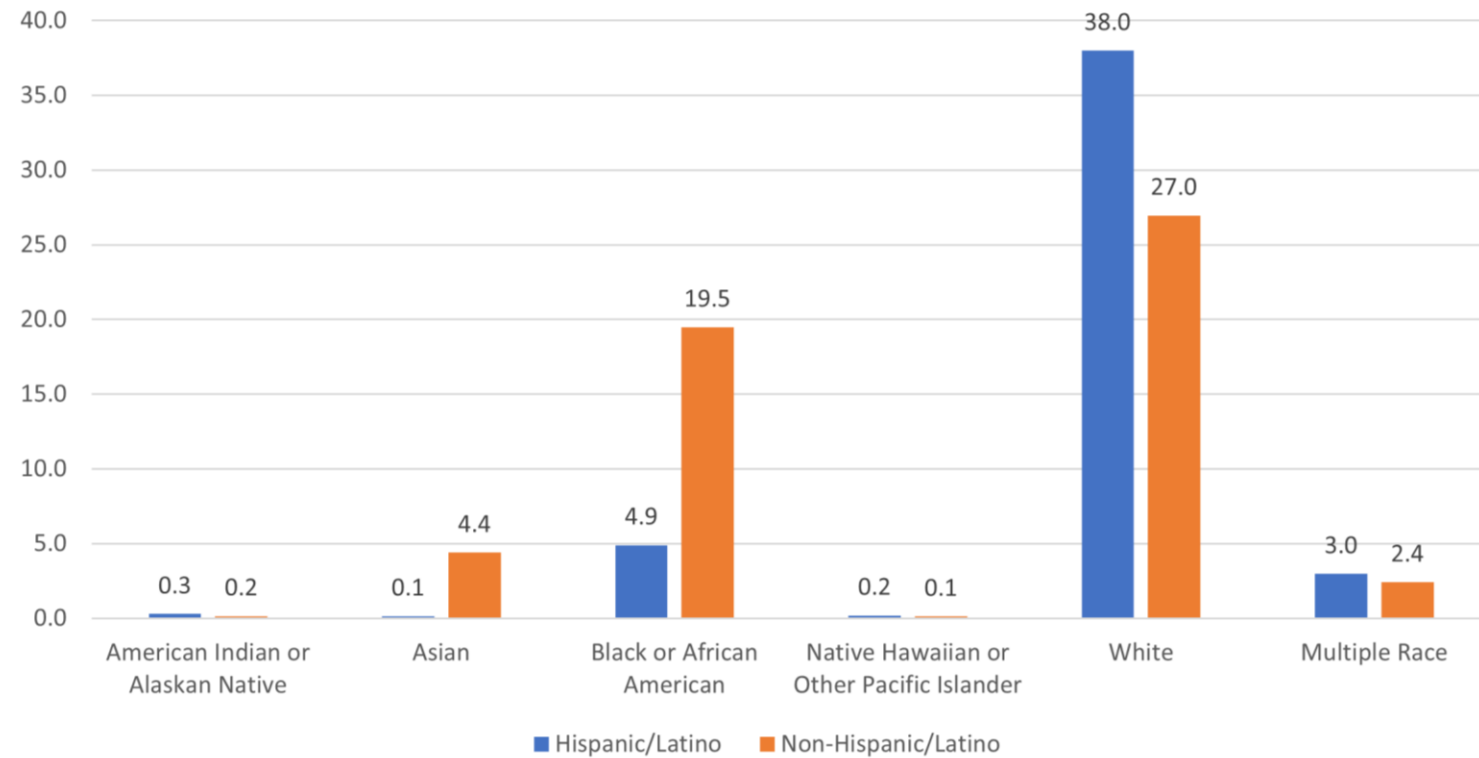
Who is using MA WIC Services?

Distribution of WIC Participants by Category — September 2023

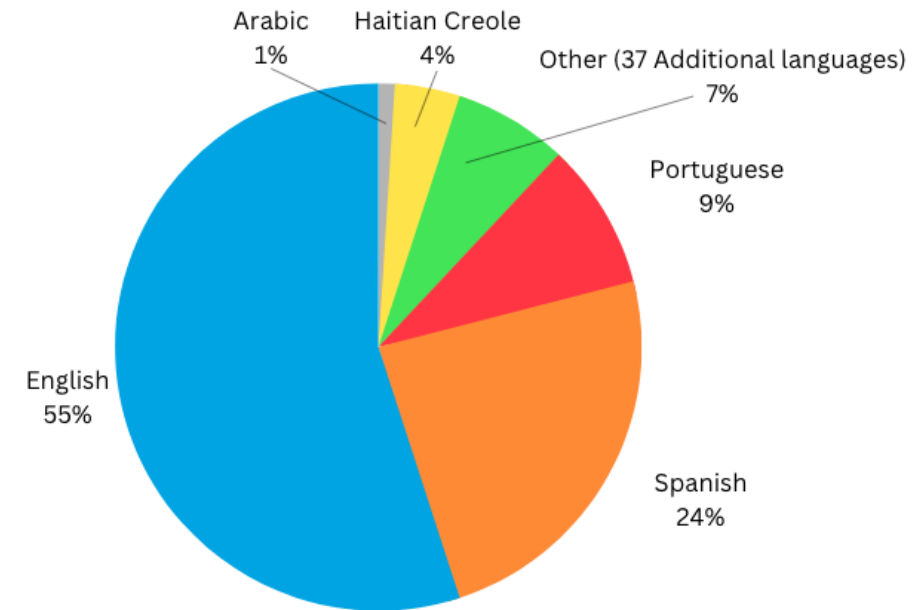


Who is using MA WIC Services?

Percentage of WIC Families by Report Race and Ethnicity
September 2023



Languages Spoken by WIC Households
September 2023



WIC Program Funding

- Massachusetts WIC is funded largely by USDA
 - WIC receives about 15% of its funding from the Commonwealth of Massachusetts
- Federal funds are specifically dedicated for either food costs or nutrition services administration (e.g., Staff, technology, program supports)
- WIC also receives breastfeeding peer counseling, infrastructure, and modernization funds
- Sufficient WIC funding has been a concern recently due to overall and food cost inflation, growing caseloads, and challenges with federal appropriations



WIC Program Services & Benefits

Certification Appointments

- Individuals receive a thorough health and nutrition assessment, tailored nutrition education, breastfeeding support, immunization assessment, and referrals to address any identified health or social needs
- Follow-up nutrition education appointments occur quarterly
- Recertifications are required annually or when a pregnant participant becomes postpartum

Food Benefits

- Participants receive a set of food items specifically targeted to meet their nutritional needs
- Participants receive these benefits electronically and are accessible through the WIC Card, which can be redeemed at more than 800 retailers across the state



WIC Program Foods



WIC Works!

An Agency for Healthcare Research and Quality meta-analysis published in 2022 found that WIC participation was associated with:



Improved birth outcomes



Lower infant mortality



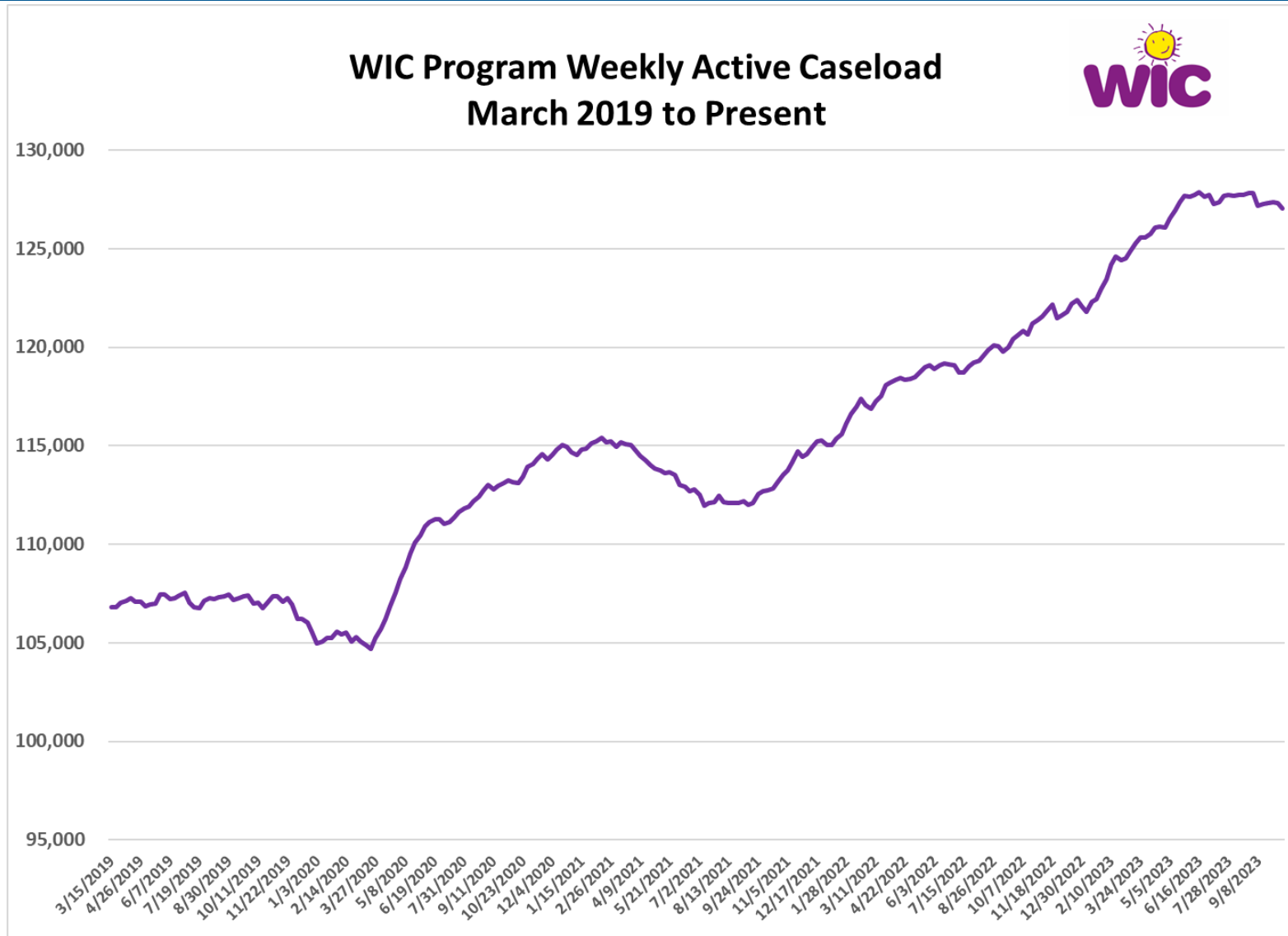
Better child
cognitive development



Healthier food choices and
improved diets for pregnant
women and children

Caulfield LE, Bennett WL, Gross SM, Hurley KM, Ogunwole SM, Venkataramani M, Lerman JL, Zhang A, Sharma R, Bass EB. Maternal and Child Outcomes Associated With the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Comparative Effectiveness Review No. 253. (Prepared by the Johns Hopkins University Evidence-based Practice Center under Contract No. 75Q80120D00003.) AHRQ Publication No. 22-EHC019. Rockville, MD: Agency for Healthcare Research and Quality; April 2022. DOI: <https://doi.org/10.23970/AHRQEPCER253>.

MA WIC Enrollment: Up >20% since the COVID-19 Pandemic



WIC Program Supports Local Economies

WIC participants spend more than **\$300,000 of WIC benefits** a day on healthy foods **at local WIC retailers**

- This includes an average of \$85,000 spent per day on fruits and vegetables, made possible by enhancements to the Cash Value Benefit for fruit and vegetables in recent years

WIC partners with the Department of Agricultural Resources to implement the **WIC Farmers' Market Nutrition Program**, providing **\$30 for participants** to use at markets and farm stands in the summer and fall



WIC Modernization — Technology Initiatives



Online pre-application



WICShopper app



Teletask texting platform



WICSmart online nutrition education



OnBase digital storage solution



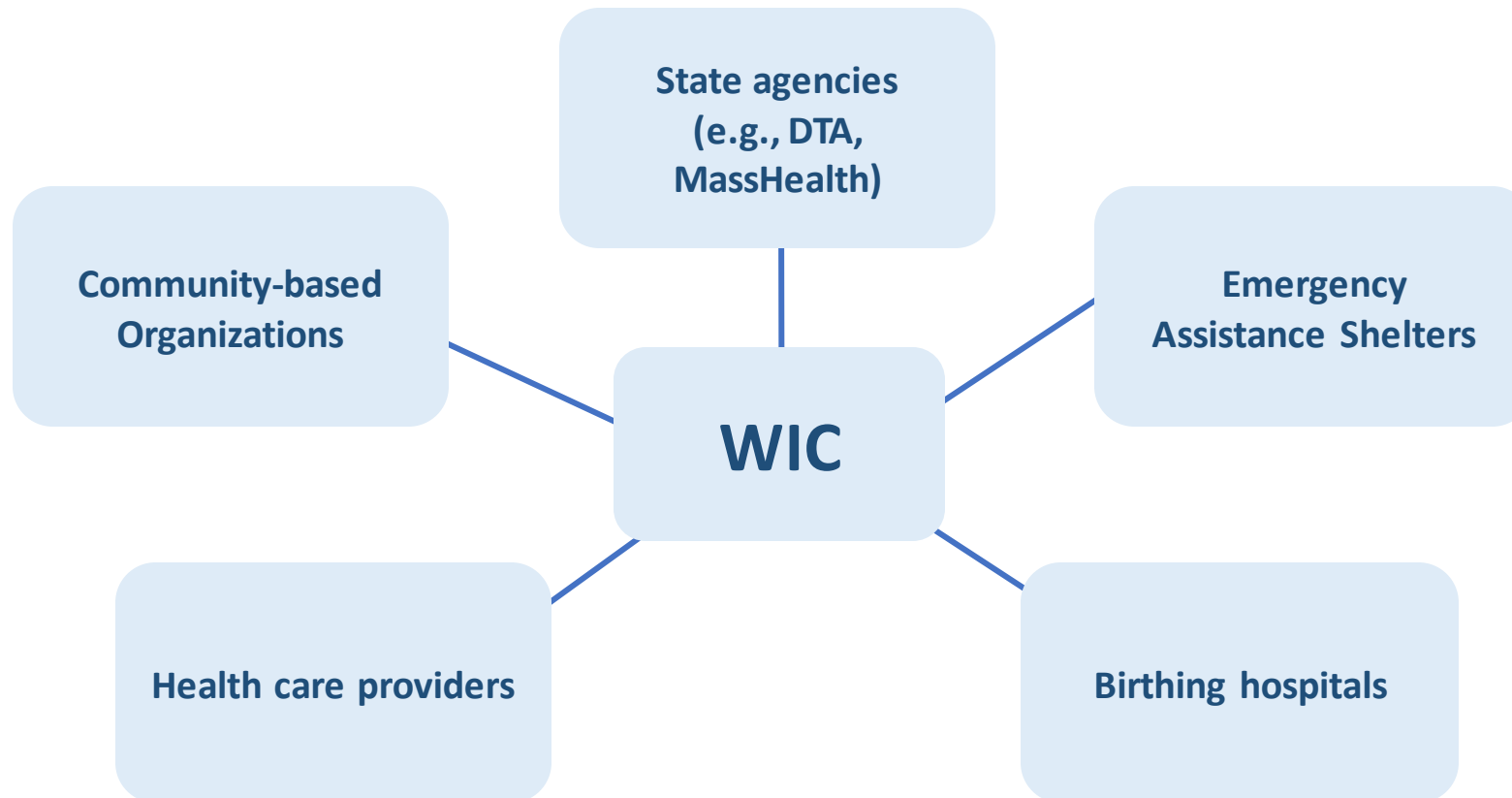
WIC Online Ordering Project
(in partnership with Washington WIC and Walmart)



e-Farmers Market Nutrition Program Feasibility Study

WIC Partnerships

WIC works closely with state and local organizations to identify and enroll eligible families as well as address larger health and food security issues across the Commonwealth.



Breastfeeding Promotion is a Key Public Health Intervention

Optimal source of nutrition for infants and helps to protect both babies and mothers from illnesses and poor health outcomes.

The short- and long-term medical and neurodevelopmental advantages of breastfeeding make breastfeeding, or the provision of human milk, a public health imperative. (American Academy of Pediatrics, 2022)



2023 CDC Breastfeeding Data



Region	Ever Breastfed	Breastfeeding at 6 months	Breastfeeding at 12 months	Exclusive breastfeeding at 3 months	Exclusive breastfeeding at 6 months
U.S. National 2023 (2020 Births)	83.1%	58.2%	37.6%	45.3%	25.4%
Massachusetts 2023 (2020 Births)	88.5%	63.9%	44.7%	43.9%	25%
Healthy People 2030 Target			54.1%		42.4%

Breastfeeding Outcomes by Race – US Births 2020

	Initiation	Any BF at 6 months	Exclusive BF through 6 months
American Indian/Alaska Native Non-Hispanic	80.1%	NA	NA
Asian/Pacific Islander Non-Hispanic	90.6%	73.7	29.1
Black Non-Hispanic	83.7%	49.1	20.4
Hispanic	82.1%	55.2	24.3
White Non-Hispanic	86.7%	61.3	27.6

Source: National Immunization Survey-Child, Centers for Disease Control and Prevention, Department of Health and Human Services, 2023

Breastfeeding Programming in the Bureau of Family Health and Nutrition

[Welcome Family](#)

- Universal one-time 90-minute Home Visit from experienced public health nurses-CLCs and IBCLCs
- Visit conducted up to 8 weeks postpartum (aiming for 2 weeks)
- Available in Boston, Fall River, Holyoke, Lowell, New Bedford, and Springfield

[Early Intervention Parenting Partnerships Program \(EIPP\)](#)

- Services by a multidisciplinary team of a maternal and child health nurse, clinical social worker, and community health worker up to 1 year postpartum.
- Participant must be enrolled by 3 months postpartum.
- Provides lactation support as part of their multidisciplinary team.

[MA Maternal, Infant and Early Childhood Home Visiting](#)

- Support in connecting to health care
- Information on child development and early learning
- Parenting support (for example, support with breastfeeding and care for your baby)
- Support in setting and achieving goals for your future
- Help finding employment and childcare
- Home visiting programs include CLCs and provide supports to families around infant feeding, accessing additional supports, and referrals to WIC.

[Massachusetts WIC Program](#)

Provides breastfeeding education and support before and after a baby is born, as well as assistance in accessing breast pumps

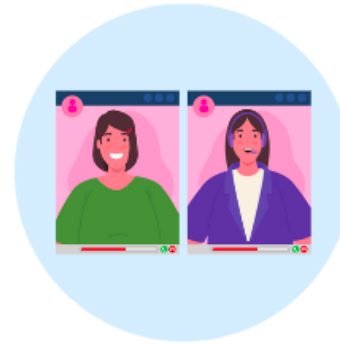
WIC Program Breastfeeding Services



Breastfeeding counseling and education



Breastfeeding Peer Counseling Program



Virtual prenatal and breastfeeding support groups



Breastfeeding materials in multiple languages



Partnership with birth hospitals



Assistance in returning to school or work



Assistance with accessing breast pumps



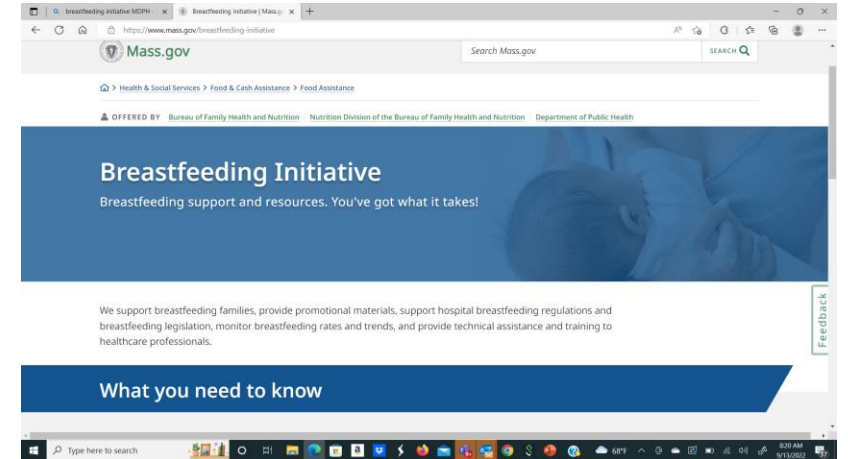
Enhanced food benefits for breastfeeding participants

MDPH Breastfeeding Initiative

The Breastfeeding Initiative supports breastfeeding families by:

- providing promotional materials and resources for families
- supporting hospital breastfeeding regulations and breastfeeding legislation
- monitoring breastfeeding rates and trends
- providing technical assistance and training to healthcare professionals

MDPH is wrapping up a breastfeeding needs assessment process and plans to move towards development of a statewide breastfeeding strategic plan this fiscal year.



Explore the website:

<https://www.mass.gov/breastfeeding-initiative>

[Breastfeeding Resources](#)

[Becoming Baby-Friendly: Practical Solutions Toolkit](#)

Prenatal Breastfeeding Education Video



- MDPH developed and released videos in winter 2023
- Educational videos provide families with information on the benefits of breastfeeding, tips to get breastfeeding off to a good start in the hospital and resources for postpartum support.
- Currently available in English and Spanish. Haitian Creole and Portuguese will soon be available.
- Located on website:
<https://www.mass.gov/breastfeeding-initiative>

Thank you for the opportunity to present this information today.

Please direct any questions to:

Rachel Colchamiro, MPH, RD, LDN, CLC

Director, Nutrition Division

Bureau of Family Health and Nutrition

Rachel.Colchamiro@mass.gov

Solving for Root Causes in the Division of Community Health Planning and Engagement

Kim Etingoff (*she/her*)

kim.etingoff@mass.gov

Massachusetts Department of Public Health

January 9, 2024

The Division of Community Health Planning and Engagement at DPH

Addresses root causes of chronic disease

Builds capacity of communities, municipal governments, and health systems

To change policies and practices that perpetuate inequities

Building community capacity...

improve physical and social conditions

more active partnerships across sectors

more dollars invested in communities in
ways that improve and support health

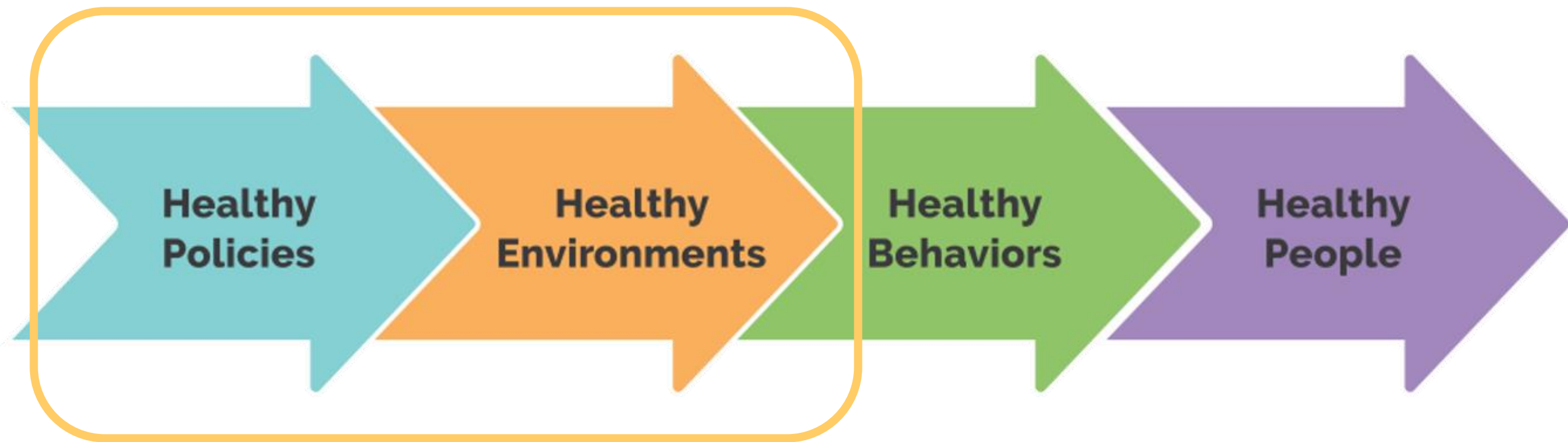
healthier, more resilient communities

Division Programs Building Local Capacity:

- Determination of Need's Community Health Initiative (Factor 6)
- MA Community Health and Healthy Aging Funds
- Medicare Rural Hospital Flexibility (Flex) Program
- Rural Vaccine Equity Initiative*
- State Office of Rural Health (MA Rural Community Health)
- Mass in Motion Municipal Wellness & Leadership Initiative*
- Root Cause Solutions Exchange*
- Healthy Communities Capacity Building

How We Think Change Happens

Healthy Community Theory of Change



This is where we work

MDPH Approach to SDOH

Social Determinants of Health are factors that contribute to health outcomes.

Racism both influences social determinants and is an independent factor in health outcomes.

Structural racism is racial bias across institutions and society over time. It is the cumulative and compounded effects of factors such as public policies and institutional practices that work in reinforcing ways to perpetuate racial inequity.

Why do we lead with race and racism?

- Research and experience shows that structural racism **shapes opportunities** for health and wellbeing
- Racial inequities and racism also exist in **communities that are mostly white**
- We help people build their ability to use **practices based in racial equity** principles
- We lead with race and racism **explicitly but not exclusively**: society and institutions marginalize other identities too

Mass in Motion Vision

DPH's **Mass in Motion** Municipal Wellness & Leadership Initiative is a **movement** to lower the risk of chronic disease by supporting equitable food access and **active living opportunities**.

2023 Mass in Motion Communities

Bay State Community Services

Quincy, Randolph, Milton, Weymouth

Boston

Roxbury, Dorchester

Fall River

Franklin County

Colrain, Deerfield, Erving, Gill, Greenfield, Leverett, Leyden, Montague, Orange, Sunderland, Whately

Heywood Hospital

Gardner, Winchendon

Holyoke

Lawrence

Revere

Chelsea

Springfield

Hampshire County

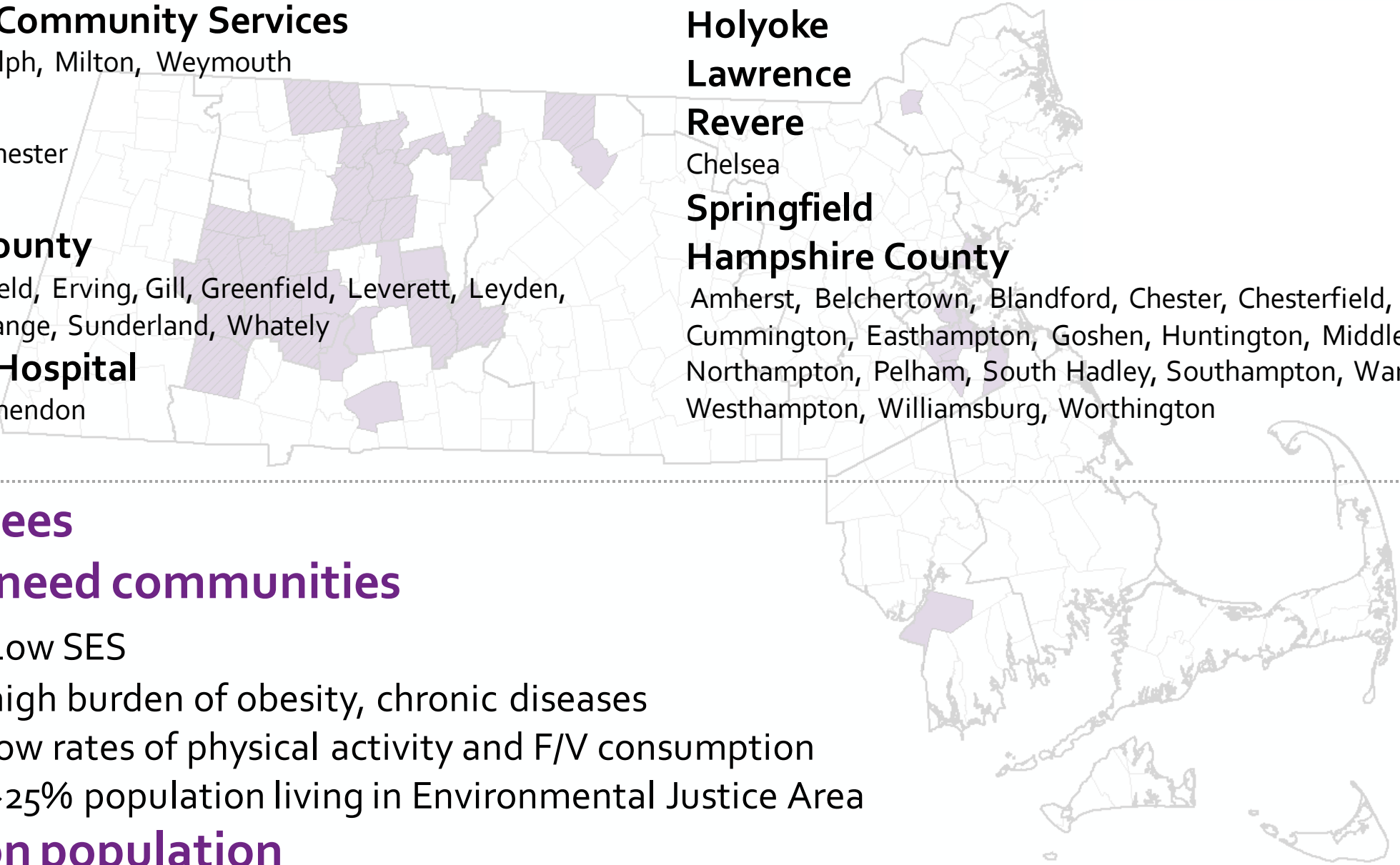
Amherst, Belchertown, Blandford, Chester, Chesterfield, Cummington, Easthampton, Goshen, Huntington, Middlefield, Northampton, Pelham, South Hadley, Southampton, Ware, Westhampton, Williamsburg, Worthington

10 grantees

43 high-need communities

- * Low SES
- * high burden of obesity, chronic diseases
- * low rates of physical activity and F/V consumption
- * ~25% population living in Environmental Justice Area

1+ million population



Impact of Mass in Motion (FY19-21)



749 Active Partners

More than 18 sectors represented:
academic, agriculture, community coalition, community service organization, elected/appointed officials, faith-based, healthcare/clinical, housing, industry/business, law enforcement, media, parks & recreation, planning, public health, residents, transitional services, transportation



> \$57 million leveraged

Examples:

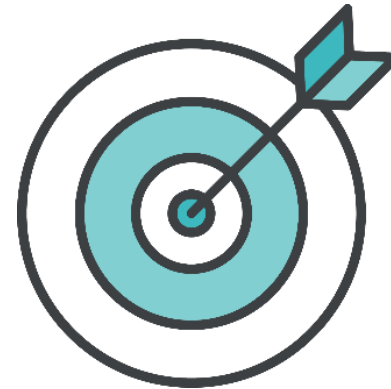
- MassDOT grants – Safe Routes to School, Complete Streets Funding
- MassWorks Infrastructure Program
- Federal Community Development Block Grant Funding



51 policies passed

Examples:

- Complete Streets policies
- Urban Agriculture ordinances
- Everett Food Plan
- Cape Ann annual walk audit added to Master Plan
- Springfield Open Gym program adopted by city



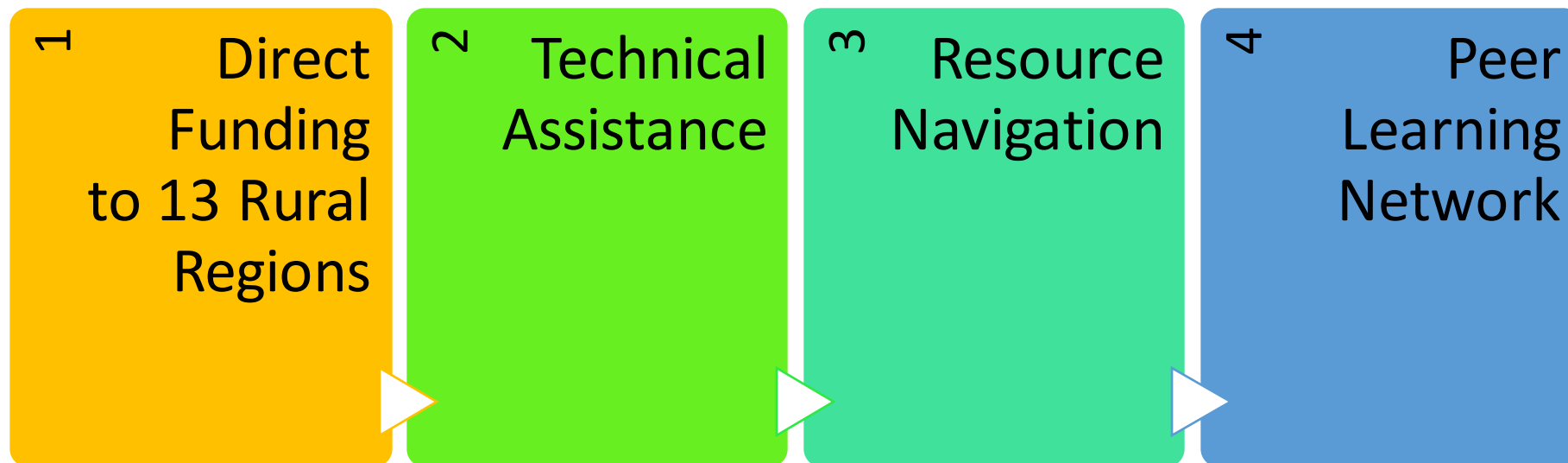
587 physical sites changed

Examples:

- Food Retail Sites
- Schools
- Intersections & Roads
- Sliver Parcels
- Bike Share stations

Vaccine Equity Initiative: Rural CBO Investments

This **three-year initiative** is supporting rural communities to both meet **immediate needs for COVID-19 mitigation** and implement long range strategies to ensure **resiliency** from the factors that created poor outcomes during the COVID-19 pandemic.

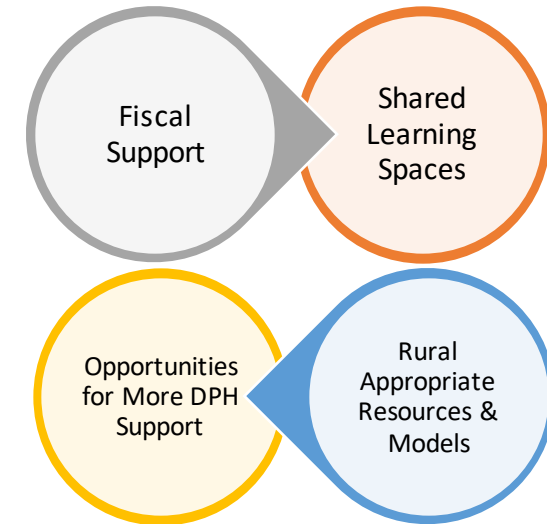
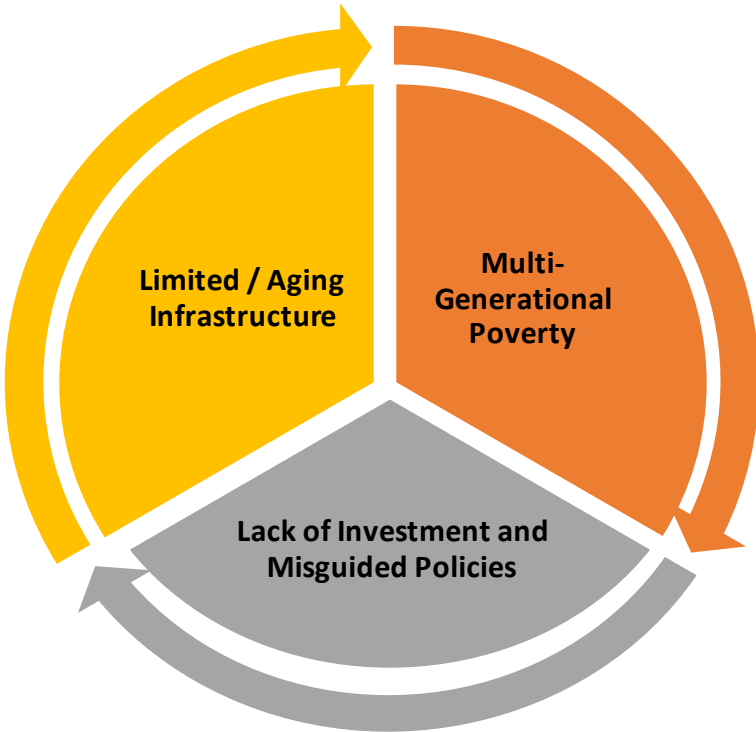


Building Capacity for Equity

We (DPH) Acknowledge Structural Barriers & Harms

Partner With Rural CBOs Who Are Authentically Engaging in Their Communities to

Work with a Vendor with Rural Expertise to Create



Rural communities have unique histories and experiences. Using equity focused frames allows us to understand their individual needs.

The Root Cause Solutions Exchange is...

a resource hub and network of people and communities building capacity to improve the conditions that play the biggest role in our health.

Root Cause

Addresses the reasons people experience poor health and health inequities

Solutions

Supports participants to take action with quality resources relevant to a MA context

Exchange

Participants contribute and learn from DPH and each other

Who we work with

- Municipal governments
- Regional structures
- Community-based organizations
- Resident groups

What we offer

- Website with resources like tools and trainings
- Coaches/liaisons to help identify and use resources
- Technical assistance on specific topics
- Networking opportunities
- Seed funding

Tools and topics

- Social Determinants of Health
- Policy, systems, and environmental change
- Racial equity and justice
- Community engagement
- Data to action
- Multi-sector collaboration

The Exchange partners for success

State Office of Rural Health Vaccine Equity Initiative

Staff time, vendor time, local partnerships



Root Cause Solutions Exchange

Staff time, funding, technical assistance

- Facilitated conversations with grantees (CBOs) about local issues
- CBOs voted on priorities
- 12 CBOs are receiving support on communicating about SDOH and how to improve local transit
- 6 CBOs received a \$20K grant to dig deeper and address root causes locally.

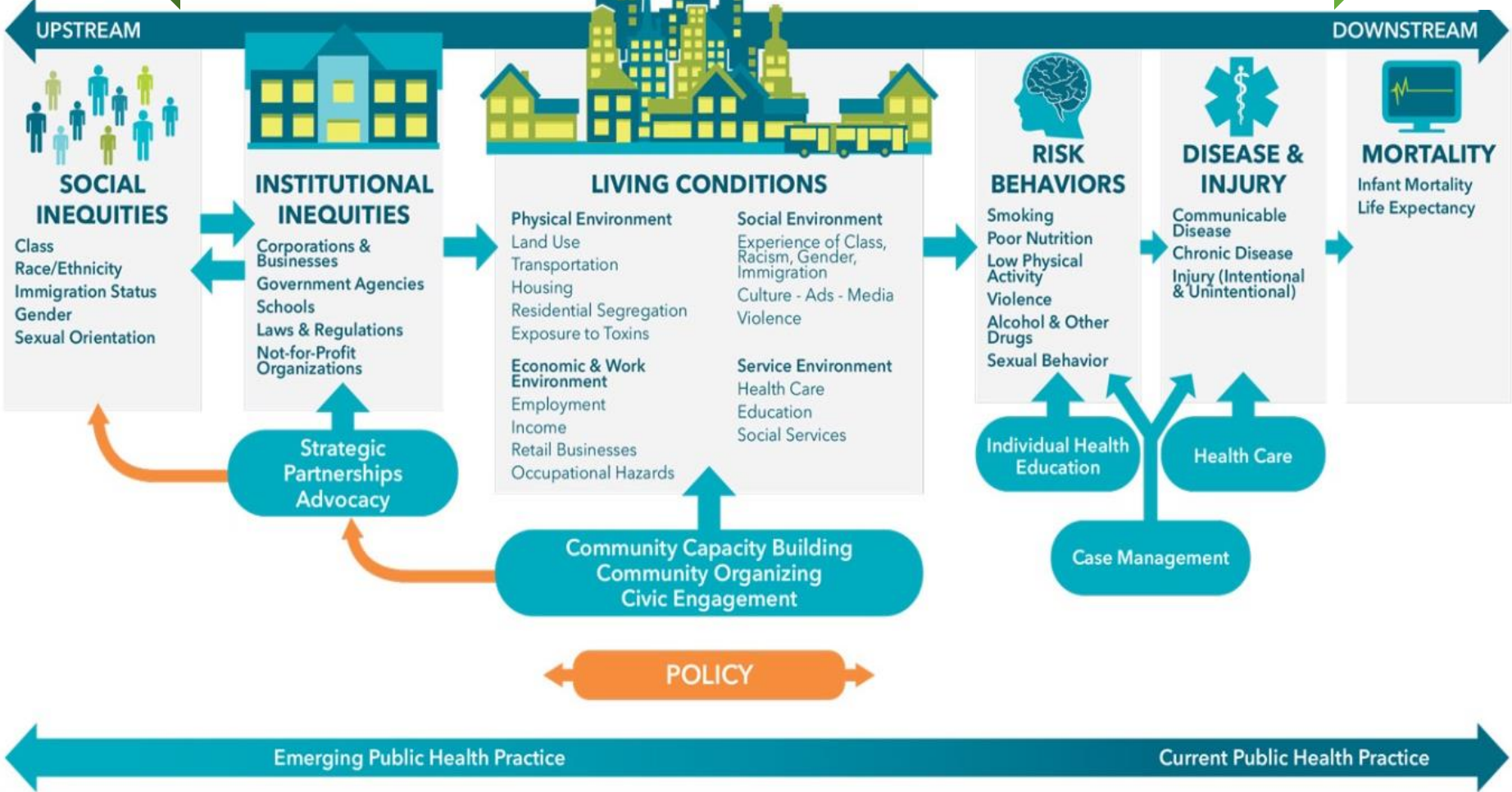
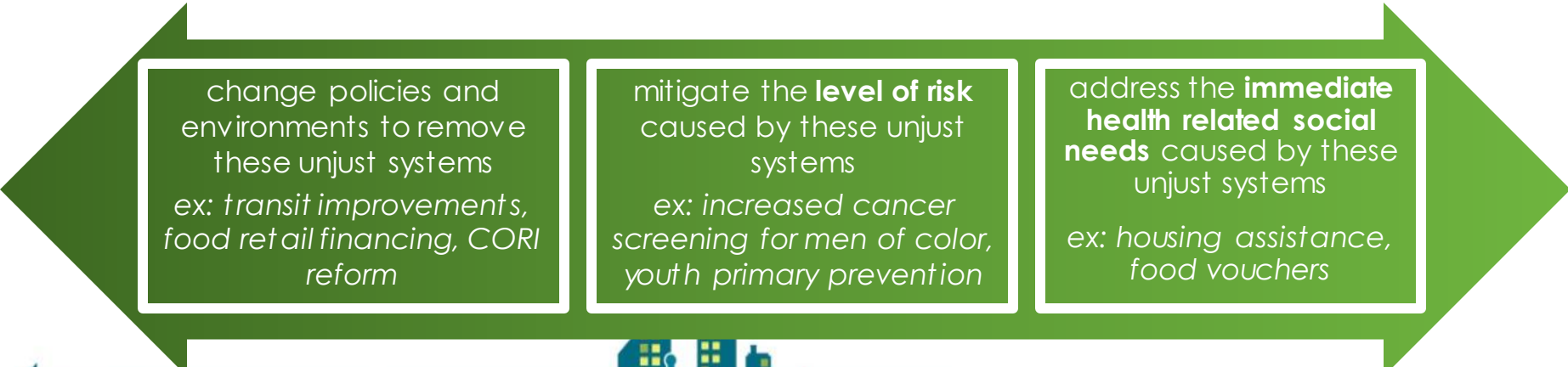
This led to some local projects...

Where	Partners	Topics	Result
East/West Franklin & North Quabbin	<ul style="list-style-type: none">• Regional Council of Governments• North Quabbin Community Coalition	<ul style="list-style-type: none">• Lack of access to affordable housing that impedes wealth for people of color and rural low-income people.	Non-profit affordable housing development orgs set up a new system to turn vacant properties into quality, healthy, affordable homes for first-time and first-generation homebuyers.
Quaboag Valley	<ul style="list-style-type: none">• CBOs• Municipal partners	<ul style="list-style-type: none">• Issues of food insecurity and lack of access to healthy food.	Food Policy Council for the region, bringing together food producers, food consumers, and food distributors, and explore and implement solutions

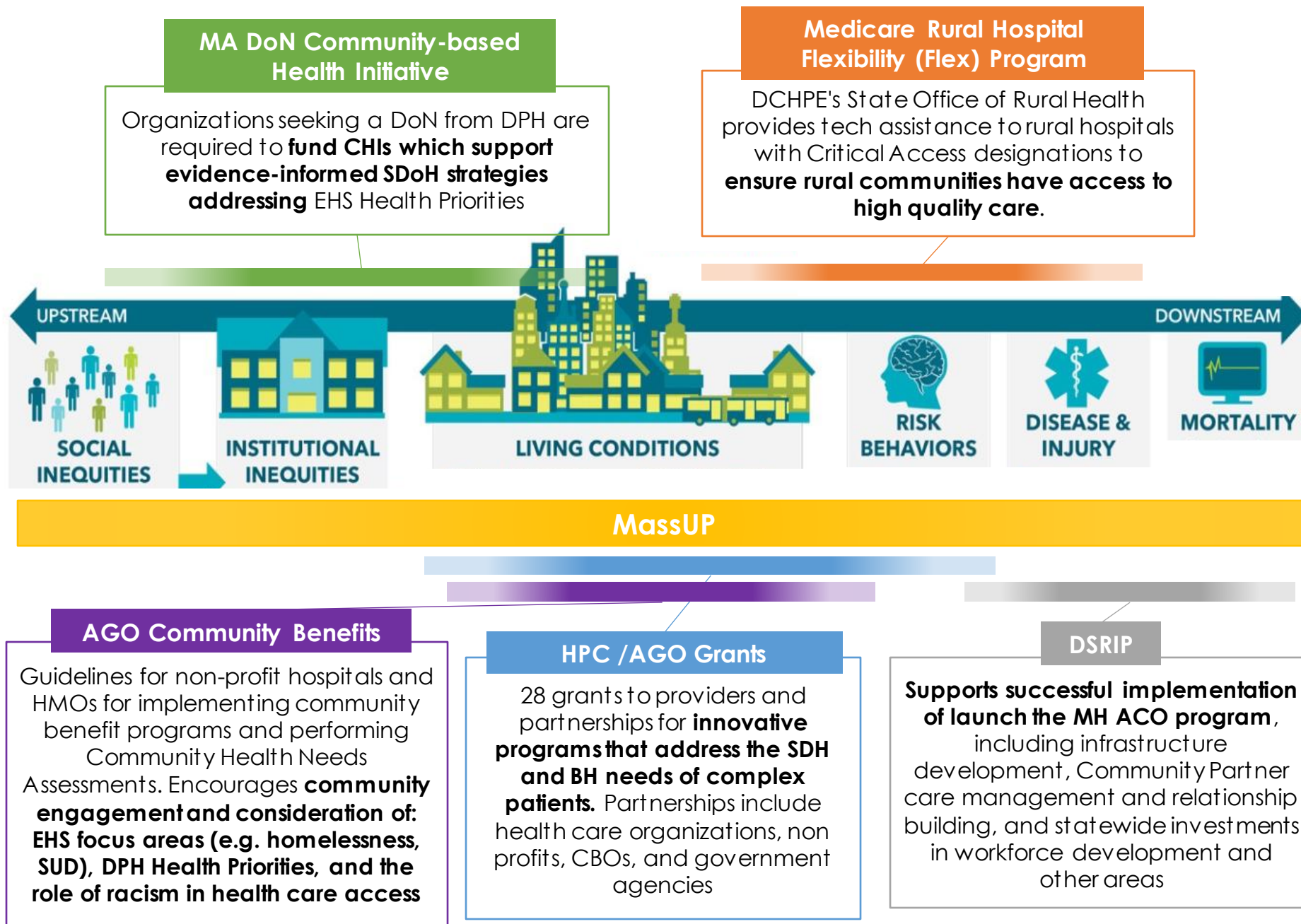
Using Policy to Shift How Healthcare Systems Address Social Determinants of Health

Lessons from Massachusetts

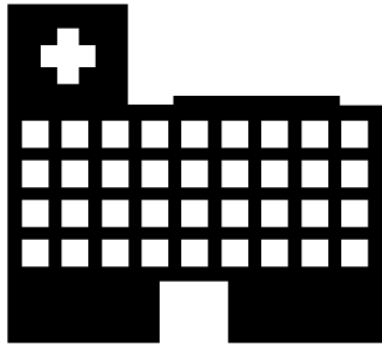
Katie Teague, MSW (*she/her*)
Massachusetts Department of Public Health
January 9, 2024



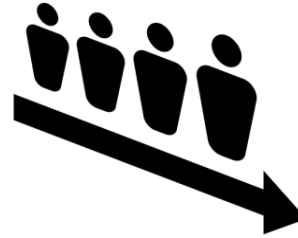
Where do our sister agencies intervene on the spectrum?



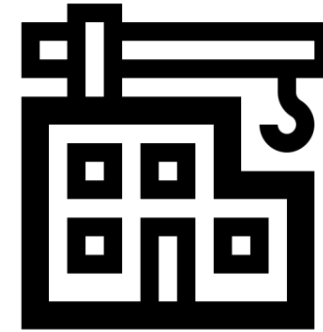
MA Determination of Need, Community Health Initiative



Hospital
Health Care System
Health Care Facility



Need to Expand /
Improve Health Care
Facilities



Determination of
Need Project

Local CHI Investments

Statewide CHI Investments
(CHHAF)



5%

Community Health
Initiative
Funding

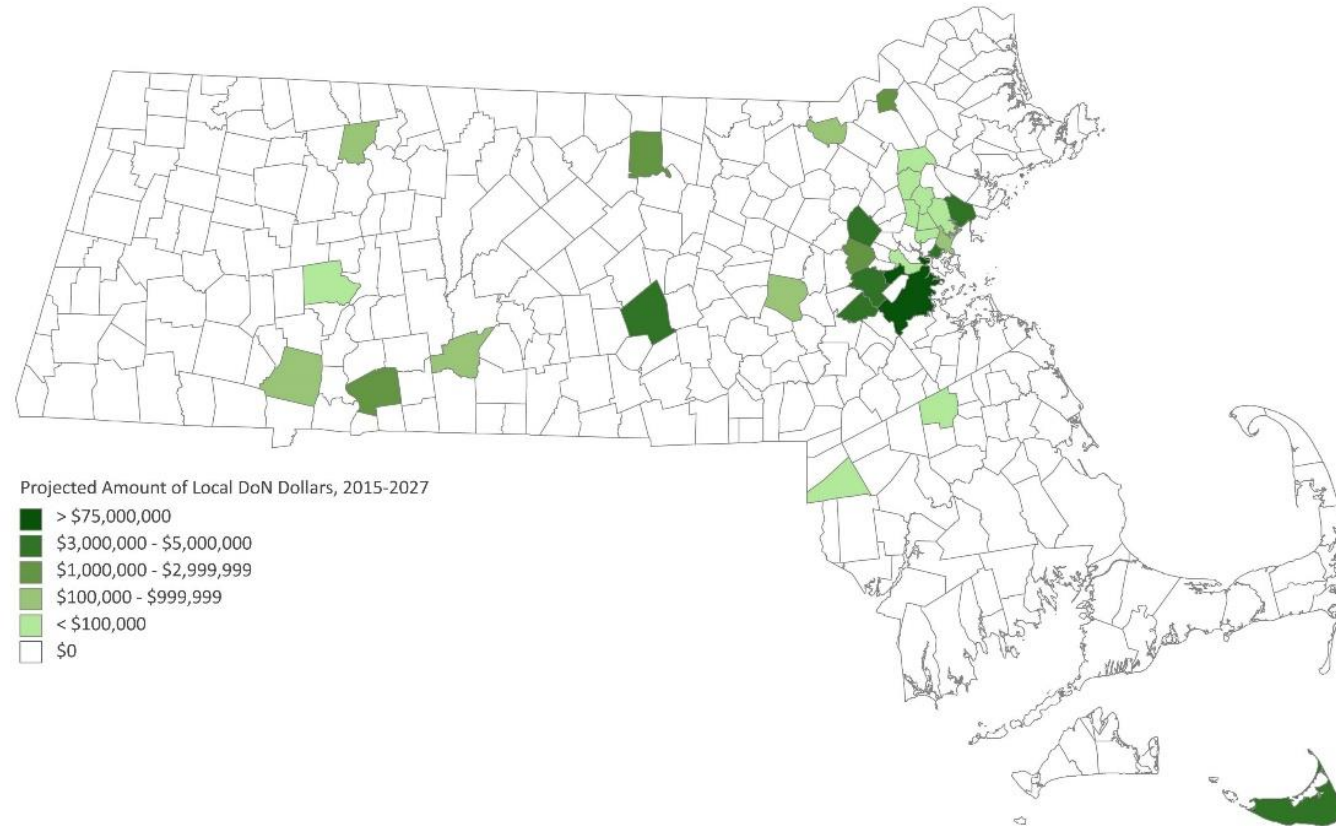
\$\$\$

Project's
Maximum Capital
Expenditure



Overview of Determination of Need (DoN)

- The Determination of Need (DoN) program is the result of healthcare institutions and long-term care facilities who identify a need to expand or improve their services to support the individuals they are serving.
- **Projected** amount of local DoN dollars for 2015-2027 are displayed below



Standards for our Community Health Initiative: Community Engagement



Community Health Improvement Planning (CHIP):

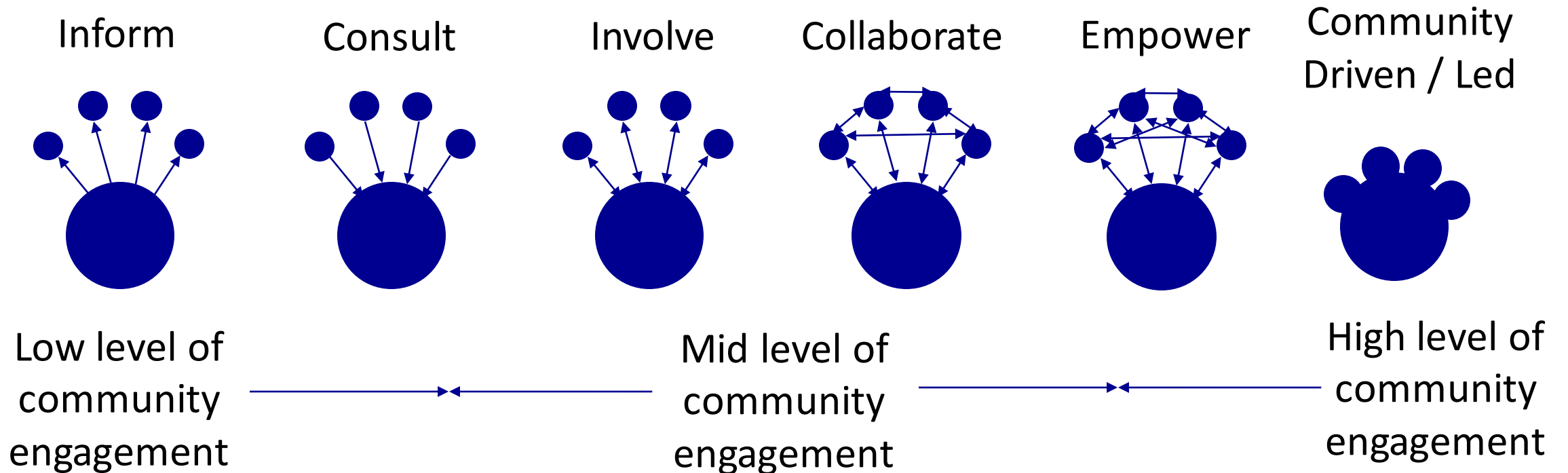
- Continuous process of community engagement
- At different points in the process different types of community engagement may be necessary

DoN CHI planning process:

- Episodic and fitting into overarching CHIP



Community Engagement Spectrum





Source: Massachusetts State Health Assessment, 2017

Our successes!

Innovative and new SDoH strategies and collaborations (Boston)

- Investing in new Affordable Housing development and healthy retail through a social impact fund
- Empowering the community through an Innovative Housing Stability Fund
- All Boston Hospitals (13) collaborating on one Community Health Needs Assessment and Community Health Improvement Plan!
 - DPH SDoH framing is a key component



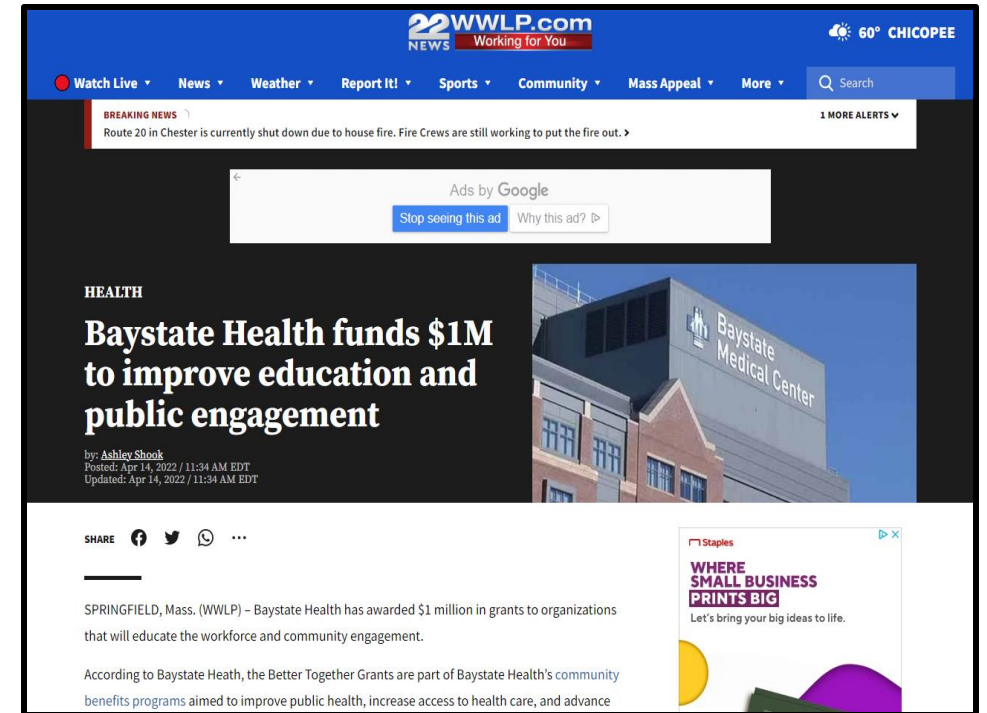
Bartlett Station (Roxbury)

Affordable Housing + Healthy Retail Development

Our successes!

Innovative RFP process building community capacity (Pioneer Valley)

- Broke up application process for CHI funds into (1) feedback period, (2) LOI and (3) review
- Offered 2 cohorts of grant writing courses for local CBOs
- Held feedback panels and office hours with public health professionals to pitch and strengthen applications



Baystate Health

Education + Social Environment

New funding streams established to distribute DoN CHI funds more equitably across Massachusetts—CHHAF are born!



— **Massachusetts** —
**COMMUNITY HEALTH AND
HEALTHY AGING FUNDS**



Two Funds and Three Funding Opportunities

Advisory Committee

Statewide CHI Fund

Healthy Aging Fund

Policy, Systems, &
Environmental
Change Approaches

CHIP Processes

Healthy Aging
Domains





Focus, Strategies, and Outcomes of CHHAF

Focus: Populations that experience inequities and are historically underserved in geographic areas of Massachusetts that have not benefited from DoN CHI funds.

Strategies: Multi-year investments and capacity building

- Policy, systems, and environmental change approaches
- Community health improvement planning processes
- Evaluation process for improved community health initiatives



Outcomes

- Disruption of structural and institutional racism and other forms of oppression
- Improved population health outcomes
- Improved cross-sector/community-centered collaboration



Statewide CHHA Fund Investment Process

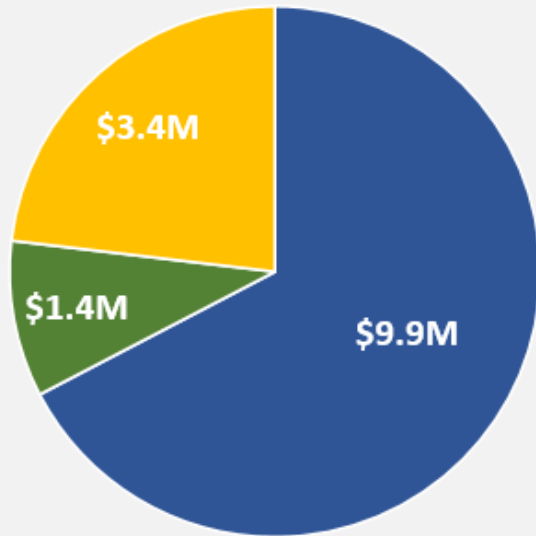




CHHAF distributed every two years starting in 2020

2020 Inaugural Awardees Overview

\$14.7M available for first funding cycle



■ PSE ■ Healthy Aging ■ CHIP



WHO RECEIVES FUNDING

32

Awardees

+

>35

Community Partners

in

163

Cities and Towns



DISTRIBUTION OF FUNDS

\$1.7M

goes to community members and to ensure authentic community engagement

\$4.3M

goes to Massachusetts-based partners

\$8.2M

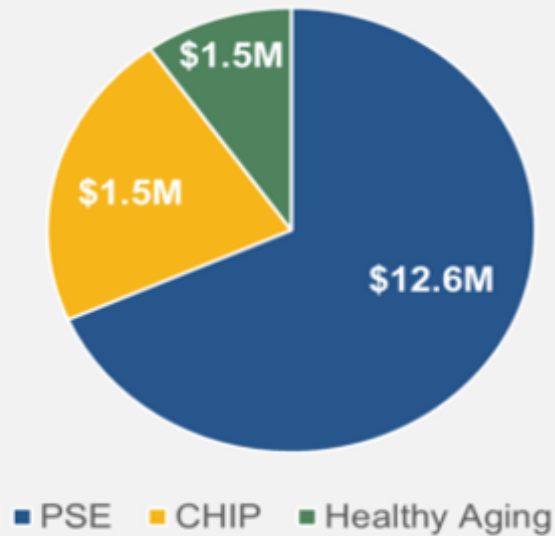
goes to primary awardees



CHHAF for Cohort 2 went out in 2022!

2022 Cycle 2 Awardees Overview

\$15.6M available for second funding cycle



WHO RECEIVES FUNDING

24 + >35 in 183
Awardees Community Partners Cities and Towns

DISTRIBUTION OF FUNDS

\$1.7M goes to community members and to ensure authentic community engagement

\$2.1M goes to Massachusetts-based partners

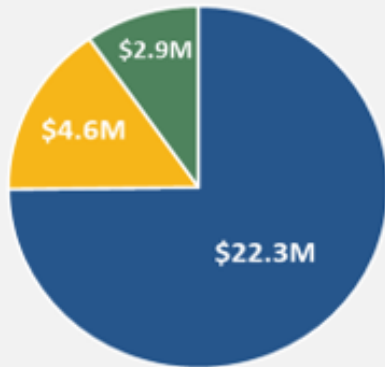
\$11.7M goes to primary awardees



In just 4 years...

2020 & 2022 Awardees Overview

\$30.3M available for first funding cycle



■ PSE ■ CHIP ■ Healthy Aging



WHO RECEIVES FUNDING

56

Awardees

+

>70

Community Partners

reaching

298

Cities and Towns



DISTRIBUTION OF FUNDS

\$3.4M

goes to community members and to ensure authentic community engagement

\$6.4M

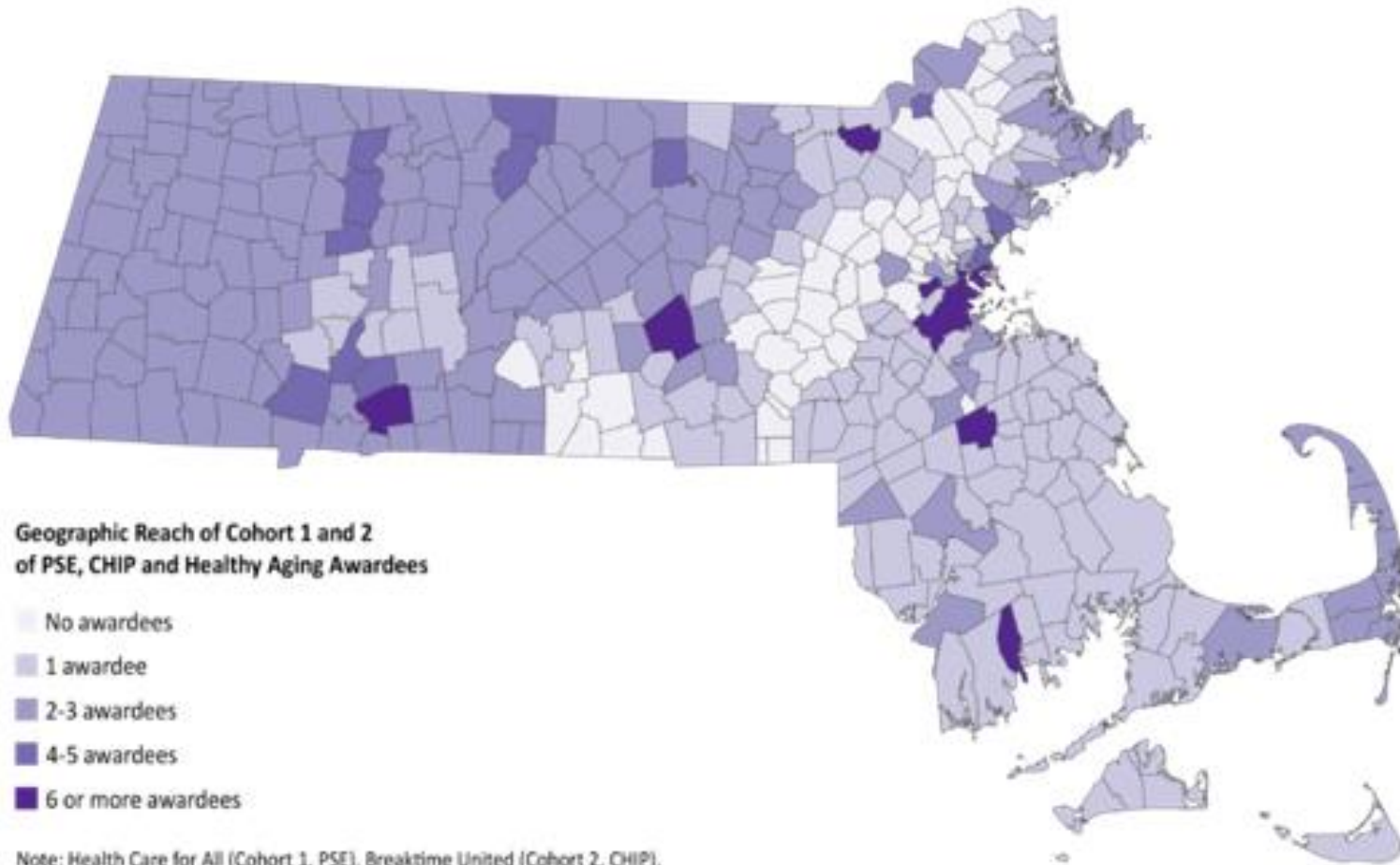
goes to Massachusetts-based partners

\$19.9M

goes to primary awardees



Key Success Themes from CHHAF Cohort 1



Note: Health Care for All (Cohort 1, PSE), Breaktime United (Cohort 2, CHIP), Housing Navigator Massachusetts and Massachusetts Law Reform Institute (Cohort 2, PSE) have statewide coverage but are not included in the map.

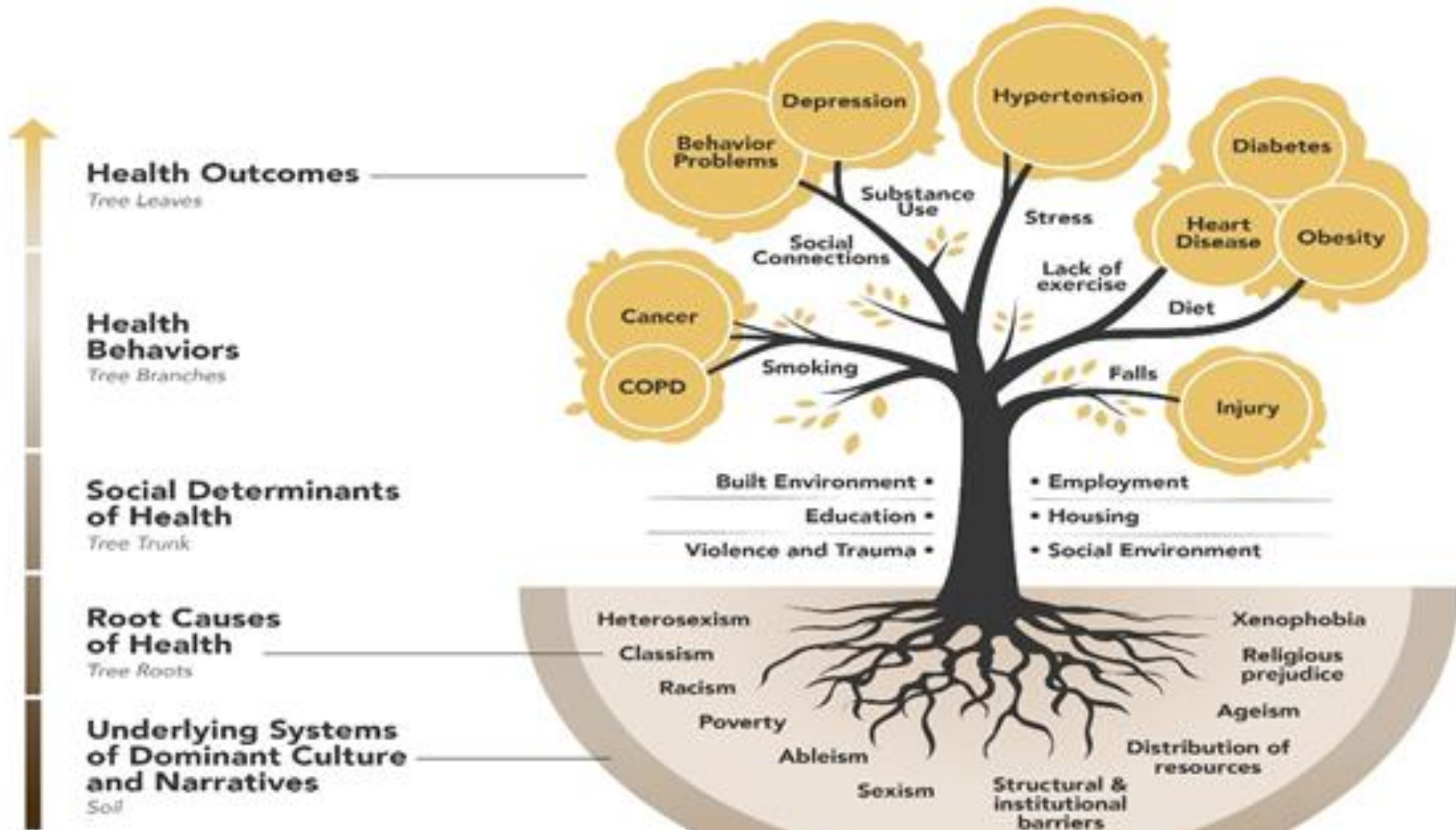


CHHAF Preliminary Accomplishments

- Amidst the changes and challenges in recent years, awardees persisted in their plans to affect PSE change, disrupt structural racism, and further age-friendly communities
 - Increased opportunities for immigrant farmers
 - Youth-led hiring process
 - Community engagement → professional advancement
 - Enhanced tools to incorporate racial equity in Age-Friendly community process
- Awardees pivoted to adapt to COVID and their communities' most pressing needs:
 - Vaccination listen & learn session for PoC
 - Advocacy for vaccine rollout in affordable housing
 - Ensuring accessibility to vaccine information and administration for blind and visually impaired
- Success despite COVID-19
 - Accelerated progress in walkable communities
 - Increased participation in community meetings

Success Themes for Local + Statewide CHHAF

- **Disrupting Racism and Advancing Equity**
- **Community Engagement**
- **Age Friendly Community Improvements**



Thank you!

Katelyn.teague@mass.gov



Massachusetts Department of Public Health

**Child and Youth Violence
Prevention Unit (CYVPU)**

Public Health Approach

Positive and negative structural and social factors impact a child's lifelong health, some more than others. They can help explain a child's exposure to toxic stress and opportunities for healthy development.

Positive Childhood Experiences (PCE's)

Things that support a child's lifelong health, such as:

- Trusted adults
- Community engagement
- Civic engagement
- Friendships
- Acceptance
- Recreational activities
- Greenspace
- Economic opportunities

+



-

Adverse Childhood Experiences (ACE's)

Forms of oppression / discrimination that increase toxic stress and ACE-associated risk-taking that hurt a child's lifelong health, such as:

- Racism
- Classism
- Ablism
- Disenfranchisement
- Disinvestment in communities
- Intergenerational trauma
- Homophobia
- Transphobia
- Sexism

Public Health Approach

When factors that increase toxic stress are present, conditions are created that increase exposure to adverse childhood experiences, such as increased exposure to the justice or child welfare system or increased exposure to harm due to oppression based on identity.

Positive Childhood Experiences (PCE's)

Things that support a child's lifelong health, such as:

- Trusted adults
- Community engagement
- Civic engagement
- Friendships
- Acceptance
- Recreational activities
- Greenspace
- Economic opportunities

+



-

Adverse Childhood Experiences (ACE's)

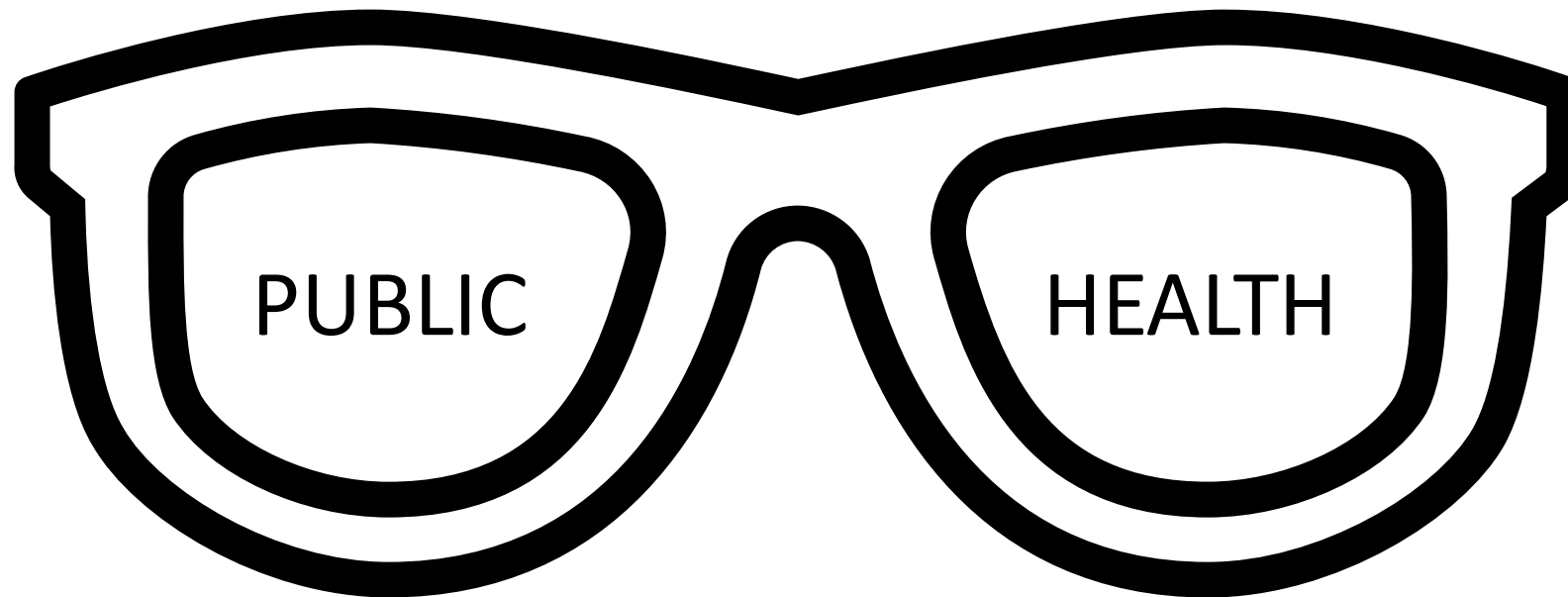
Forms of oppression / discrimination that increase toxic stress and ACE-associated risk-taking that hurt a child's lifelong health, such as:

- Racism
- Classism
- Ablism
- Disenfranchisement
- Disinvestment in communities
- Intergenerational trauma
- Homophobia
- Transphobia
- Sexism

The Public Health Approach

- **Health Disparities:** These are preventable variations in health experienced by populations facing social, economic, geographical, or environmental disadvantages.
- **Health Inequities:** These are specific variations resulting from unfair systems, policies, and practices that restrict access to resources essential for optimal health.

The Public Health Approach (Lens) to Violence Prevention.



Child and Youth Violence Prevention Unit (CYVPU)

- Our Program provides funding to community-based initiatives across the state working to prevent youth violence by increasing access to fundamental positive youth experiences and reducing adverse childhood experiences for youth and young adults.
- Our focus consists of educating and implementing interventions that prevent and/or address the overlapping root causes of all forms of violence (risk factors) and promoting factors that increase the resilience (protective factors) of youth, 10-24 years old.

Child and Youth Violence Prevention Unit (CYVPU)

- Healing, Equity, and Leadership (HEAL) Grant for Youth
 - Primary Violence Prevention (PVP)
 - Safe Spaces for LGBTQIA+ youth
 - Opportunity Youth
 - Bullying Prevention
- ***Gun Violence Prevention (GVP)***

Gun Violence Prevention

- Gun Violence Prevention (GVP) seeks to engage communities in planning and developing interventions in communities that experience gun violence.
- GVP program works with grantees in 15 communities across the Commonwealth to help youth avoid violent conflict and injury among youth ages 17 through 24.

Gun Violence Prevention

Purpose

- GVP Program grantees work directly with individuals affected by gun violence by delivering evidence-based prevention, intervention, treatment, and recovery services in six core domains.

Gun Violence Prevention

Award (FY19-FY23) : \$ 46,174,243

FY23 Award \$ 8,020,840

We have spent (\$4,224,000) on Gun Violence Prevention Program support, training, communication support, and evaluator services in FY23.

We are also in the midst of releasing the FY24 report, in which we have invested even more funds to support these organizations.


Gun Violence Prevention Challenges

Challenges


- **Ripple effects:** Firearm homicide and suicide can have a ripple effect in communities—reaching beyond the people immediately impacted by the deaths and affecting friends, families, and coworkers.
- **High risk for death:** Firearms can lead to deadly injuries and are often used in homicides and suicides.
- **Growing racial and ethnic gaps:** The COVID-19 pandemic may have worsened existing social and economic stressors that increase the risk for firearm homicide and suicide, particularly among racial/ethnic minority communities.
- **Poverty effects:** Counties with higher poverty rates had higher firearm homicide rates. People living in these areas experienced higher increases than those living in counties with the lowest poverty rates. Higher county poverty levels were also associated with higher firearm suicide rates.
- **Multiple stressors:** Multiple factors, including social, economic, and physical conditions in communities, contribute to firearm homicide and suicide risk, as well as racial and ethnic inequities.
- **Preventive actions urgently needed:** The increases in firearm deaths and widening disparities have heightened the need for comprehensive preventive actions. Programs, policies, and practices can have immediate and lasting benefits.

Gun Violence Prevention

Homicide
is the **leading cause of death**
for non-Hispanic Black or
African American youth.




Each day,
more than **800** youth



are treated in emergency
departments for **physical
assault-related injuries.**

**Estimated Cost
of Youth Violence**

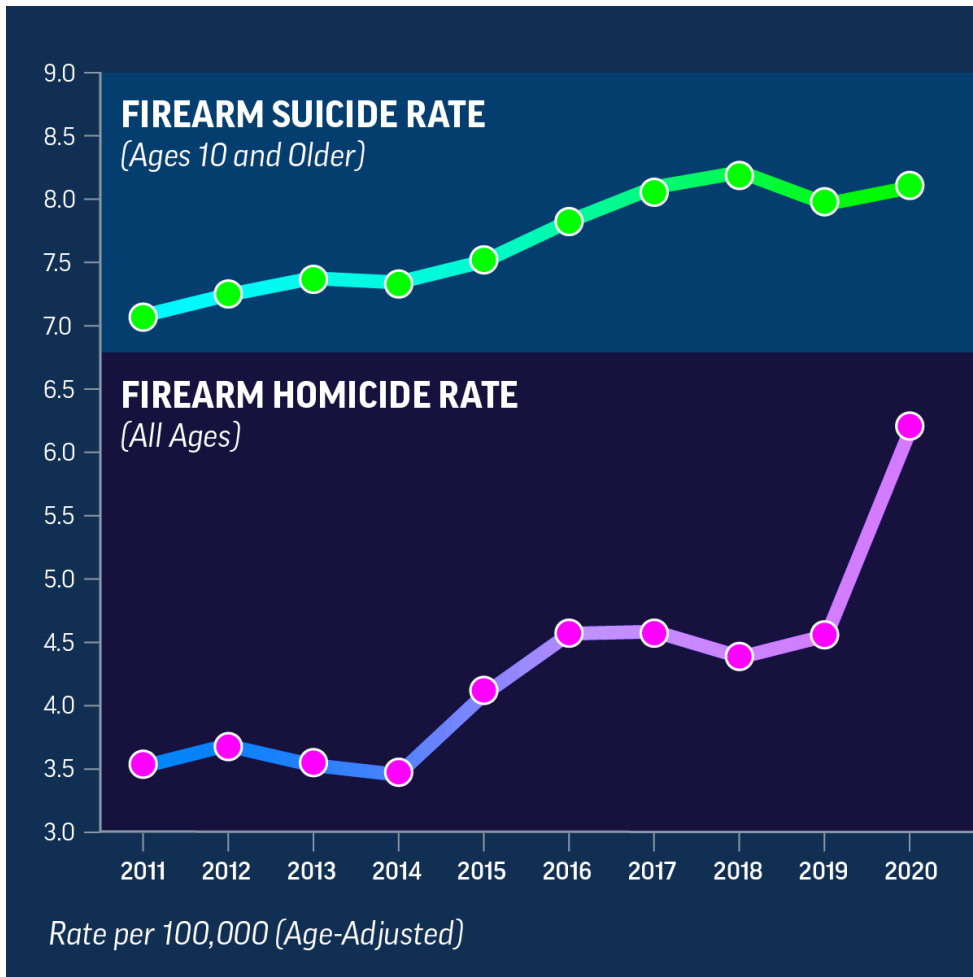


Nearly
\$122 Billion
annually*

*Medical, lost work, and quality and value of life costs associated with youth homicides and nonfatal assault-related injuries

Data and Information from CDC

Gun Violence Prevention



From 2019 to 2020, the firearm homicide rate increased about 35%, while the firearm suicide rate remained high.

Data and Information from CDC

Gun Violence Prevention

Policies to Enhance Economic and Household Stability



Housing assistance



Childcare subsidies



Tax credits
Livable wages

Physical and Social Characteristics of Communities



Clean vacant lots



Plant grass and trees in high-risk areas

Efforts to Protect Those at Greatest Risk



Promote safe firearm storage



Street outreach

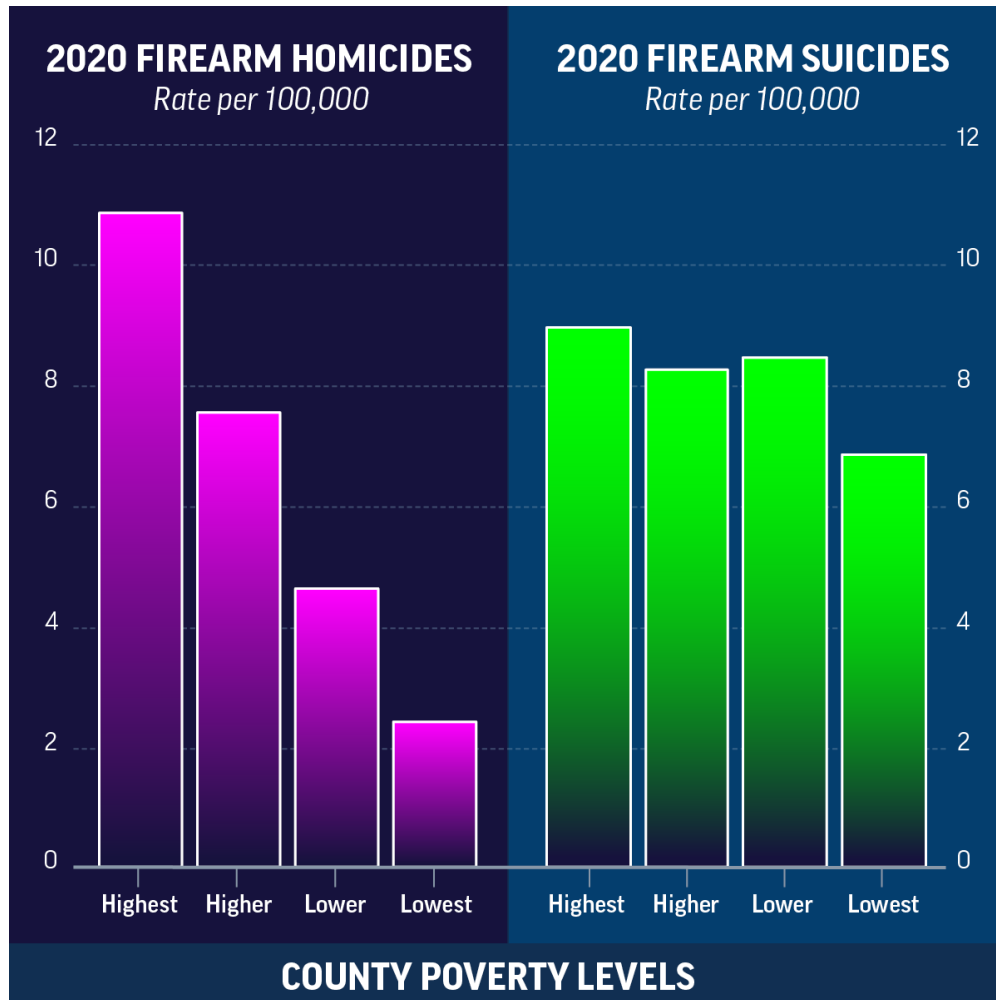


Hospital-based prevention programs

Strategies are needed to address physical, social, economic, and structural conditions known to increase firearm homicide and suicide risks.

Data and Information from CDC

Gun Violence Prevention



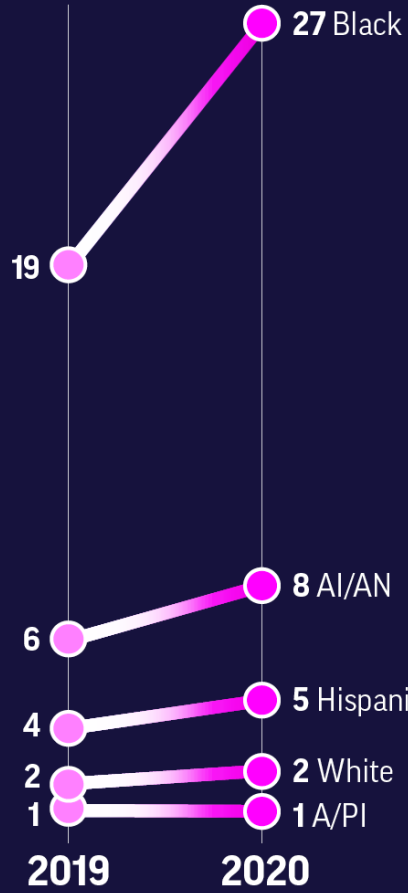
In 2020, counties with the highest poverty level had firearm homicide rates 4.5 times as high and firearm suicide rates 1.3 times as high as counties with the lowest poverty level.

Data and Information from CDC

Gun Violence Prevention

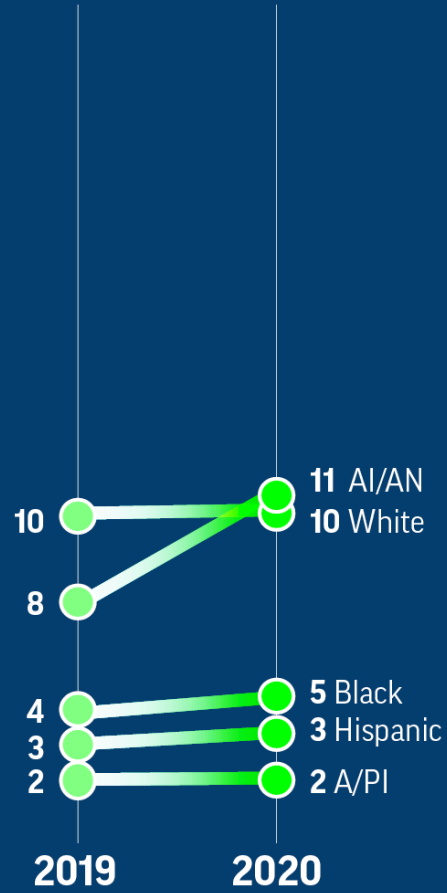
FIREARM HOMICIDES

Rate per 100,000



FIREARM SUICIDES

Rate per 100,000



AI/AN = American Indian/Alaska Native A/PI = Asian/Pacific Islander

The firearm homicide rate increased most for Black people, and the suicide rate increased most for American Indian/Alaska Native people.

Data and Information from CDC

How big is the problem?

- Youth violence can have serious and lasting effects on young people's physical, mental, and social health. It can harm development and contribute to impaired decision-making, learning challenges, decreased connections to peers and adults, and trouble coping with stress.
- Youth violence is linked to negative health and well-being outcomes and disproportionately impacts communities of color. Violence increases the risk for behavioral and mental health difficulties. These can include future violence perpetration and victimization, smoking, substance use, obesity, high-risk sexual behavior, depression, academic difficulties, school dropout, and suicide.
- Violence increases health care costs, decreases property value, negatively impacts school attendance, and decreases access to community support services. Addressing the short- and long-term consequences of violence strains community resources and limits the resources that states and communities can use to address other needs.

How big is the problem?

- In Massachusetts, firearms are the cause of death in 77% of homicides among 15-24 year-olds
- Thirty-nine percent of all firearm homicide victims are between 15 and 24 years old.

(Massachusetts Violent Death Reporting System, MA Department of Public Health, 2013-2017)

How big is the problem?

- Youth of color are particularly likely to be victims of gun violence. Black male youth are 32 times more likely to be hospitalized due to firearm assault than their white male peers,⁹ and far more likely to witness gun violence against friends, family, and neighbors.

(Massachusetts Inpatient Hospital Discharge Database, Massachusetts Outpatient Emergency Department Discharge Database, and Massachusetts Outpatient Observation Stays Database, Center for Health Information and Analysis (CHIA), 2014)

How big is the problem?

- Black male youth are 32 times more likely to be hospitalized due to firearm assault than white male peers.¹
- Hispanic male youth are 8 times more likely to be hospitalized due to firearm assault than white male peers.¹

Massachusetts Inpatient Hospital Discharge Database, Massachusetts Outpatient Emergency Department Discharge Database, and Massachusetts Outpatient Observation Stays Database, Center for Health Information and Analysis (CHIA), 2014

How can we prevent youth violence?



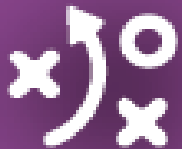
Promote family environments that support healthy development

- Early childhood home visitation
- Parenting skill and family relationship programs



Provide quality education early in life

- Preschool enrichment with family engagement



Strengthen youth's skills

- Universal school-based programs

How can we prevent youth violence?



Connect youth to caring adults and activities

- Mentoring programs
- After-school programs



Create protective community environments

- Modify the physical and social environment
- Reduce exposure to community-level risks
- Street outreach and community norm change



Intervene to lessen harms and prevent future risk

- Treatment to lessen the harms of violence exposures
- Treatment to prevent problem behavior and further involvement in violence
- Hospital-community partnerships