The City of Boulder Health Equity Fund

A THEORY OF CHANGE

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BACKGROUND

The Theory of Change describes the long-term strategic focus for the Health Equity Fund (HEF) that is aligned with the legislative intent of the Sugar Sweetened Beverage Product Distribution Tax (SSBPD Tax) ordinance, rooted in evidence-based research, and aimed at the city-wide advancement of health equity.

Sugar Sweetened Beverage Product Distribution Tax

In 2016, the city of Boulder voters passed ballot issue 2H authorizing the SSBPD Tax. The measure imposes an excise tax of two cents ($0.02) per fluid ounce on the distribution of sugar-sweetened beverages, such as soda, energy drinks and other sweetened beverages that contain at least five grams of caloric sweetener per twelve fluid ounces. Certain drinks, such as infant formula, milk products, alcoholic beverages and 100 percent natural fruit and/or 100 percent vegetable juice, are exempt.

Revenue collected from the SSBPD Tax, less the costs of collecting the tax and fund administration, is used for the HEF, a dedicated source that aims to reduce health disparities and improve health equity throughout the city. Boulder Revised Code Section 3-16-11 defines purposes for the tax revenue as health promotion, general wellness programs and chronic disease prevention.

Health Equity Fund Governance and Funding Allocation

Most funding from the HEF has been distributed to governmental and non-profit agencies through competitive requests for proposals. Each year, non-profit organizations, government agencies and institutions serving Boulder residents can request funding for programs that meet HEF criteria. Funding recommendations are made by the Health Equity Advisory Committee (HEAC), a nine-member committee appointed by the city manager.

Since the tax went into effect on July 1, 2017, the city has awarded funding to programs aimed at decreasing health disparities and increasing health equity in the city. HEF funded program priority areas include:

- Chronic disease prevention through physical fitness, food and water security, or health and wellness education;
- Physical, dental, or behavioral health services;
- Research or educational campaigns designed to identify, understand, and address health disparities;
- Systems integration or collaborative approaches that provide more coordinated, efficient, and effective health services; and
- Innovative programs to advance health equity.

The City has partnered with Health Management Associates to develop the Theory of Change for the HEF.

What is a Theory of Change?

One of the most difficult components of any evaluation is attribution or demonstrating cause and effect. Without an experimental design, it is often impossible to state, with certainty, that something (i.e., improved health) is caused by something else (i.e., HEF activities). In the absence of rigorous experimental design, the evaluation must document activities, measure both short-term and longer-term outcomes, and make some logical assertions that the activities undertaken might have been related to the outcomes. To do this, it is essential to develop a clear articulation of the Theory of Change logic behind HEF grantee activities.

A Theory of Change begins to answer a set of key questions:

- *Who* should benefit from the HEF?
- *What* benefits are to be achieved from the HEF?
- *When* will the city achieve them using the HEF?
- *How* will the city make this happen through the HEF?
- *Where* and under what circumstances will HEF work most effectively to achieve what the city and its residents desire?
- *Why* will the Theory of Change be reality?

There are six key components of a Theory of Change, as illustrated in Figure One:

Figure One. Six Components of a Theory of Change

- **Logic model**, to identify one or more causal HEF mechanisms by which change might come about for individuals, groups and/or communities.
- **Context**, to identify and allow for understanding the circumstances in which HEF is implemented and to what extent change in context might affect activities and results.
- **Unintended results**, to identify potential for positive and negative unintended results of HEF.
- **Assumptions**, which are clearly stated beliefs upon which the Theory of Change would be based, including both beliefs about the context in which HEF is implemented and beliefs regarding the cause-effect relationships shown in the logic model.
- **Community engagement,** to articulate how it is that the target communities, including grantees and those being served, become engaged in HEF.
- **Sustainability**, or the way in which results are expected to be sustained after HEF funding ends.

A valuable benefit of a Theory of Change is that it provides a framework for a "change story" – a coherent narrative about how the HEF is improving the health of the community, especially for populations experiencing disparities related to health equity issues. This can be useful for communicating important information about the HEF and its grantee projects to potential partners,

participants and policymakers, and for providing a consistent point of reference for those involved in implementing and managing HEF projects. For example, policy makers will be able to describe how the SSBPD Tax is being used strategically to reduce health costs in the city. Local agencies will be able to state how their programs fit into the goals of the HEF. Lastly, individual success stories will highlight the reduction of health inequities. Ultimately, everyone will be able to point to the same goals and articulate their roles clearly.

METHODOLOGY

HMA used several different methods of data collection and information gathering, including document review, key informant interviews, focus groups, and deep listening community sessions to ensure stakeholder engagement. This engagement helped to develop of a common understanding of how the HEF works and is intended to work, and to define desired community-level impact indicators of change. Specifically, between October 2018 and January 2019, HMA reviewed existing documentation that explains the development and purpose of the HEF, as well as existing research, evaluation, and other evidence from similar projects, programs, and policies related to municipal-based health equity initiatives in Colorado and around the United States. HMA conducted focus groups and key informant interviews with HEAC members and leaders in public health. HMA also facilitated a discussion concerning drivers of health inequity within the city as well as desired health equity impacts among HEF grantee organizations at the 2018 Health Equity Fund Summit. Lastly, HMA conducted focus groups among individuals served by HEF grantee organizations. Twenty people from the community participated across two focus groups.

This mixed method approach allowed the city to incorporate critical on-the-ground knowledge and expertise of community partners to inform the Theory of Change, including a logic model and future evaluation framework.

Developing a Theory of Change for Health Equity

Foundational to the Theory of Change is an understanding of the desired health equity outcome, or vision of health equity, answered in part by four key questions:

1. Is there a specific area of health disparity to eliminate?

Stakeholder input and a review of city and county-level data were taken into consideration when beginning to understand where areas of disparity in health and social determinants of health (SDOH) exist within Boulder. A few examples of existing health inequities in Boulder include:[1]

- Two times as many Hispanic residents of Boulder County experience obesity, compared to their White neighbors, 26.8 percent and 11.7 percent respectively;
- Nearly two times as many older (65 plus years of age) residents of Boulder County experience diabetes, compared to their younger neighbors, 4.8 percent and 10.8 percent respectively; and
- Three times as many Hispanic residents of Boulder County self-report poor or fair health compared to their White neighbors, 9.3 percent and 31.4 percent respectively.

[1] Data are provided by Boulder County Health Compass, available at http://www.bouldercountyhealthcompass.org/

A few examples of existing disparities in the SDOH in Boulder County include:

- Just under 20 percent of Hispanic families live below poverty in Boulder County, compared to 3.9 percent of White families; and
- The median household income for Hispanic families in Boulder County is $44,927, compared to $76,591 for White families.

2. At what scale will there be change?

Achieving health equity in Boulder requires change on the individual, community and system levels. Ayers presents a set of core elements that together make up the "Triple Aim of Health Equity".[2] The elements include: 1) expand the understanding of what creates health, 2) implement health in all policies with equity as the aim, and 3) strengthen community capacity to create their own healthy future. These elements suggest a need to build capacity of individuals, communities, and systems to act with health equity at the forefront as well as develop a greater understanding of the social and structural determinants of health.

Furthermore, Braverman et al. (2017) provides the following guiding principle: "Piecemeal approaches targeting one factor at a time are rarely successful in a sustained way. Approaches are needed that both increase opportunities and reduce obstacles. Successful approaches should address multiple factors, including improving socioeconomic resources and building community capacity to address obstacles to health equity" (p. 10).[3] This research suggests that HEF investments, including both funds directly given to grantees as well as the city's administration of the HEF and capacity building activities, should include multi-pronged activities targeting individuals, organizations, and community assets and barriers to health equity. Therefore, the Theory of Change for the HEF includes a diverse array of funded activities including education, advocacy, and engagement of healthy living and policies, activities to address SDOH, and activities to build the infrastructure or capacity of individuals, organizations, and community to act with equity at the forefront.

This research supports an assumption that the HEF can advance health equity through changing social norms, building capacity, and/or increasing opportunities to health equity. It is assumed that the HEF directly and indirectly drives these change mechanisms. The extent to which this occurs will be the focus of the HEF future evaluation efforts.

3. What will "health equity" look like?

Equity is about making sure people get fair access to opportunities to realize their health potential regardless of their life circumstances. Therefore, achieving health equity requires "improving access to the conditions and resources that strongly influence health".[4] Health equity should *look like* an overall improvement in access to and quality of the conditions and resources that bring about health. Conditions that bring about health include improved cultural competence and delivery of health and social services, greater integration and/or collaboration of services, and the inclusion of equity in

[2] Ayers, J. (2016, July). *Next Steps in Health Equity: Addressing Racial and Economic Inequality*. Presented at the Grantmakers in Health, Minnesota Department of Health.
[3] Braverman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. (2017). What Is Health Equity? And What Difference Does a definition Make? Princeton, NJ: Robert Wood Johnson Foundation.
[4] Ibid.

organizational and community decision-making. Advancement of health equity because of these improvements may present itself through an evaluation of the following:

- Outcomes by target population, such as low-income population, elderly and/or individuals with developmental disability;
- Outcomes by target health inequity, such as rates of obesity and/or diabetes; and
- A combination of health inequity with specific target population, such as elderly population and chronic disease management or Latinx/Hispanic population and rates of obesity.

4. When are the results expected to occur?

City staff, HMA and community stakeholders will develop an evaluation framework to track and measure health equity results defined in the HEF Theory of Change. This framework will include short-term (one to three year) and long-term (eight to ten year) outcomes.

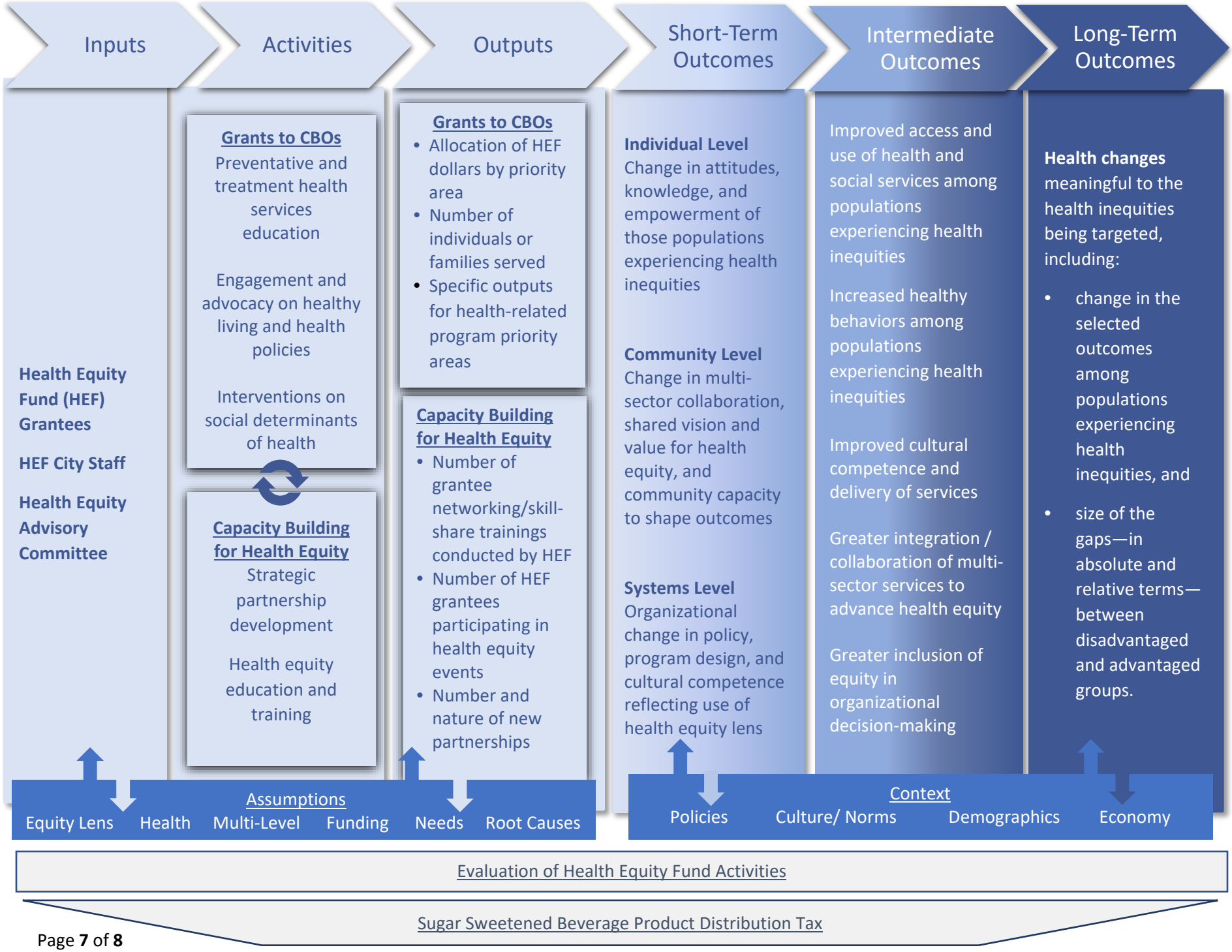
Based on this vision of health equity, the following Theory of Change has been developed.

THEORY OF CHANGE

COMPONENT ONE: LOGIC MODEL

The logic model presents a picture of how the HEF works to advance and achieve health equity in the city. As the term suggests, the logic model depicts the logic behind the HEF and illustrates the inputs, activities, outputs, short-term outcomes, intermediate outcomes, and long-term outcomes. Flowing from left to right, it illustrates:

1. **Inputs**, or resources that the City has available to implement the HEF;
2. **Activities** that the HEF invests in to achieve desired outcomes;
3. **Outputs**, or the immediate and measurable products of HEF's investments and activities. These outputs are part of the process evaluation and help track the degree to which HEF grantees and the City are meeting their implementation goals;
4. **Short-term outcomes**, or the goals that the HEF will be working to achieve within any one granting cycle. Meeting these short-term outcomes leads to meeting the intermediate and long-term outcomes;
5. **Intermediate outcomes**, or the goals that the HEF will be working to achieve upon conclusion of a granting cycle and ideally, within one to three years of any one granting cycle. Meeting these intermediate outcomes leads to HEF getting closer to its set of long-term outcomes; and
6. **Long-term outcomes**, or the goals established by the HEF with input from its stakeholders that the HEF is working towards regarding reducing health inequities. They will be measured over the course of several years (eight to ten years) and include measurement of health changes meaningful to the health inequities being targeted by the HEF.


Inputs
Activities
Outputs
Short-Term Outcomes
Intermediate Outcomes
Long-Term Outcomes
Health Equity Fund (HEF) Grantees
HEF City Staff
Health Equity Advisory Committee
Grants to CBOs
Preventative and treatment health services education
Engagement and advocacy on healthy living and health policies
Interventions on social determinants of health
Capacity Building for Health Equity
Strategic partnership development
Health equity education and training
Grants to CBOs
Allocation of HEF dollars by priority area
Number of individuals or families served
Specific outputs for health-related program priority areas
Capacity Building for Health Equity
Number of grantee networking/skill-share trainings conducted by HEF
Number of HEF grantees participating in health equity events
Number and nature of new partnerships
Individual Level
Change in attitudes, knowledge, and empowerment of those populations experiencing health inequities
Community Level
Change in multi-sector collaboration, shared vision and value for health equity, and community capacity to shape outcomes
Systems Level
Organizational change in policy, program design, and cultural competence reflecting use of health equity lens
Improved access and use of health and social services among populations experiencing health inequities
Increased healthy behaviors among populations experiencing health inequities
Improved cultural competence and delivery of services
Greater integration / collaboration of multi-sector services to advance health equity
Greater inclusion of equity in organizational decision-making
Health changes meaningful to the health inequities being targeted, including:
change in the selected outcomes among populations experiencing health inequities, and
size of the gaps—in absolute and relative terms—between disadvantaged and advantaged groups.
Assumptions
Equity Lens
Health
Multi-Level
Funding
Needs
Root Causes
Context
Policies
Culture/ Norms
Demographics
Economy
Evaluation of Health Equity Fund Activities
Sugar Sweetened Beverage Product Distribution Tax

The following sections describe each element of the logic model, the relationship between elements, and how the logic model as a whole can help measure HEF results and impact.

Inputs

Inputs are the resources available to undertake the initiative and are needed for the Theory of Change to be successful. The evaluation will track the availability and use of these resources throughout the initiative. These resources and/or inputs include:

- City staff administering the HEF which contributes strategic guidance, leadership, and capacity building resources;
- Health Equity Advisory Committee (HEAC) composed of community representatives invested in advancing health equity in Boulder. The HEAC contributes advisory and technical support to the administration of the HEF[5]; and
- Non-profit organizations, government agencies, and institutions that serve the city's residents who receive HEF funding and meet the HEF eligibility criteria. HEF grantees implement the activities that advance health equity.

Activities

Activities describe the priority HEF tasks that will help achieve its goals, including:

- Allocate grants from the HEF to support the activities of Boulder's community-based organizations (CBOs); and
- Build capacity for healthy equity through activities that grow theoretical understanding of equity and build practical skills to apply this knowledge among HEF grantees and City staff.

The activities undertaken as part of the initiative will be measured as part of the evaluation.

Grants to CBOs

In many cases, the HEF funding decisions that directly fund CBO activities already align with best practices for health equity funding identified in the literature. However, some grantee proposals and funding decisions could be refined to improve outputs and health outcomes. Table One contains examples of activities that have been identified as best practice in the literature. Some of these align with current funding decisions, and others can serve as inspiration for future funding decisions.

[5] To learn more about the HEAC and its purpose, visit https://bouldercolorado.gov/human-services/health-equity-advisory-committee

Table One. Best Practice Examples of Activities for Advancing Health Equity

Preventative and Treatment Health Services	Education, Engagement, and Advocacy	Interventions on SDOH
• Implement school-based dental programs (Culler et al. 2017); • Facilitate community health worker training (Brach and Fraserirector, 2000); • Increase availability of clinical interpreter services (Brach and Fraserirector, 2000); and • Increase risk factor screening (Record et al. 2015).	• Conduct health-coach home visits (Ahn et al. 2017); • Conduct registered dietitian visits (Ahn et al. 2017); • Place point-of-decision prompts on public signage to boost physical activity. (Martin et al. 2015); • Foster patient-physician-health coach collaboration (Record et al. 2015); and • Increase access to recreational facilities (Franckle et al. 2015).	• Establish a full-service food retailer in a neighborhood (Abeykoon et al. 2017); • Provide medically tailored meals to individuals living with chronic illness (Cohn and Waters 2013); • Improve energy efficient housing (e.g. warming) (Thomson et al. 2008); and • Rehouse residents into safer, more stable housing units (Thomson et al. 2008).

Capacity Building for Health Equity

Capacity building activities may include training on health equity, anti-bias training, learning collaboratives, and networking events. Building a solid infrastructure for health equity requires a focus on strategies that grow theoretical understanding of equity, oppression, and power, and impart practical skills to apply this knowledge.[6] The sample of activities listed in the logic model under "Capacity Building for Health Equity", and further described in Table Two, aim to reaffirm current decisions and propose ideas about the types of programs the HEF might support in the future.

Table Two. Best Practice Examples of How to Build Capacity for Health Equity

Strategic Partnership Development	Health Equity Education and Training
• Target recruitment of diverse leadership on public committees (Health Equity and Community Voice report, 2018); • Cultivate diverse leadership via workshops and coaching in a leadership institute (Bergstrom et al. 2012); • Host "meet and greets" with local groups to introduce cross-sector interactions (Bergstrom et al. 2012); • Facilitate regular walking tours with elected officials, community leaders, and stakeholders (Bergstrom et al. 2012); • Foster integration of hospital/clinical leadership and community leaders to address chronic disease prevention (Record et al. 2015; Pierce et al. 2017); and • Fund community coalition-driven interventions (Anderson et al. 2015).	• Facilitate peer-led group health education (Anderson et al. 2015); • Conduct Implicit bias training programs (Devine et al. 2012); • Shared-decision making training programs (Durand et al. 2014); • Sponsor community conversations (Health Equity and Community Voice report, 2018); and • Dedicate time and space for anti-racism training & dialogue (Health Equity and Community Voice report, 2018).

[6]Health Equity Guide, available at https://healthequityguide.org/strategic-practices/build-organizational-capacity/

Outputs

Outputs are the immediate and measurable products of the HEF investments. Outputs should be meaningful to the city and the HEF stakeholders. The process of developing the evaluation framework will further refine these outputs. Ultimately, the final outputs will reflect current data availability, data collected by the HEF grantees, and stakeholder input.

Grants to CBOs

Measuring the designated outputs will determine whether the HEF investments are implemented as planned. Examples of outputs include:

- Allocation of HEF dollars by priority area; and
- Number of unique individuals or families served.

For each HEF program priority area, specific outputs will help determine whether the HEF investments are being successfully implemented. For each priority area, specific outputs will be partly defined by what HEF grantees currently collect as well as what measures are identified during the development of the HEF evaluation framework. Examples of outputs include:

- Amount of food distributed;
- Types of physical fitness activities; and
- Number of educational sessions or topics discussed or presented.

Capacity Building for Health Equity

Outputs will also be defined in the evaluation framework that will measure the extent to which capacity building supports the advancement of health equity in the city. Examples of outputs include:

- Number of HEF grantee networking or skill-share trainings conducted by HEF;
- Number of new partnerships facilitated among HEF grantees and/or with other community stakeholders that specifically seek to improve the access and delivery of services to those identified as populations experiencing health inequities;
- Number of HEF grantees (and grantee staff) participating in community convenings and/or trainings on health equity;
- Number and nature of new collaborative partnerships among HEF grantees and between grantees and at-risk community members;
- Number of grantee agencies that increased diversity and meaningful inclusion among board and service staff; and
- Number of community members who respond to a community survey who rank the city as inclusive and welcoming.

Short-Term Outcomes

Short-term outcomes are positive effects of HEF activities that can be observed or experienced within approximately one year. Specifically, short-term outcomes refer to changes in knowledge, attitudes, or empowerment and may include reports of behaviors that grantee organizations, staff, and service recipients intend to change or are motivated to change. Meeting short-term outcomes leads to meeting intermediate and long-term outcomes. The logic model considers three levels at which the HEF generates beneficial outcomes: individual, community, and systems.

Individual Level: The HEF evaluation framework will include a description of individual-level indicators to understand changes in capacity, attitudes, knowledge, and empowerment experienced by individuals receiving services from HEF grantees. Evidence suggests that the types of HEF activities described in the logic model can lead to improved health knowledge, attitudes, and empowerment as well as overall health. Additionally, past and current grantee report similar kinds of outcomes among their service recipients. Such indicators include:

- Decrease in food insecurity (Palar et al. 2017);
- Increased consumption of fruits and vegetables (Palar et al. 2017; Hector et al. 2017; Abeykoon et al. 2017);
- Improved medication adherence (Palar et al. 2017; Ma et al. 2008).
- Increase in use of preventative health services (e.g. vaccinations, risk screening, dental sealants etc.) (Knopf et al. 2016; Culler et al. 2017);
- Improved self-reported mental health (Thomson et al. 2008; Gibson et al. 2011; Martin et al. 2015);
- Reduced incidence of delayed or postponed medical care (Ma et al. 2008);
- Fewer emergency department visits hospitalizations (Ma et al. 2008; Record et al. 2015; Martin et al. 2015);
- Increased physical activity (Peirce et al. 2017; Kahn et al. 2002);
- Reduced blood glucose levels for individuals with diabetes (Cohn and Waters, 2013);
- Improvement in aerobic capacity (Kahn et al. 2012);
- Increased self-efficacy to engage in health promoting behavior (Pierce et al. 2017); and
- Reduced risky behaviors, such as smoking and binge drinking (Record et al. 2015; Palar et al. 2017).

Community Level: The HEF evaluation framework will include a description of community-level indicators to understand the extent to which the HEF (indirectly or directly) generates community change. Community-level change necessary for the advancement of health equity includes:

- Multi-sector collaboration to intentionally further health equity, as potentially measured by the number of new multi-sector collaborations among HEF grantees;
- Shared vision of and value placed on health equity, which will be measured by the extent to which grantees articulate a shared vision and value placed on health equity as the HEF and thus the vision is shared across all HEF grantees; and
- Community capacity to shape outcomes, as potentially measured by the number of new funding sources to sustain work and/or enhance work beyond HEF funding. This will also be measured by the extent to which there is an increase in awareness of the health inequities that exist in

Boulder and what drives those inequities. Another measure will be the degree to which there is an increase in knowledge of the ways to reduce obstacles and barriers to health inequity through the application of the health equity lens. This increased awareness and knowledge will be an outcome of the health equity trainings and education.

Systems Level: System level factors encompass organizational changes to policies, laws, and power structures within the city government and HEF grantee organizations. The HEF evaluation framework will employ a health equity lens to system-level indicators to measure changes within the city's and grantees' internal and external program and policy design, implementation, and cultural competence. Organizational and program policies and procedures that reflect a health equity lens are more likely to advance overall health equity and achieve desired outcomes. The listed examples of outcomes represent indirect links between health equity-related activities of the HEF and health. These outcomes indicate progress towards health equity resulting from reduced systemic barriers. These include:

- Increased self-reports of trust and shared norms (Anderson et al. 2015);
- Reduced implicit racial bias (Devine et al. 2012);
- Increased intentions to conduct interpersonal interactions without prejudice (Devine et al. 2012);
- Increased planning/hosting ongoing anti-racism training (Washtenaw County, 2019; Lane County, 2016);
- Increased intentions to hold regular health equity dialogue (Washtenaw County, 2019; Lane County, 2016); and
- Increased diversity within leadership structure, including among boards.

Intermediate Outcomes

Intermediate outcomes are positive effects resulting from one- to three-year HEF activities, e.g. after three consecutive years of program funding. Meeting these intermediate outcomes brings the HEF closer to achieving the long-term outcomes. An evaluation of intermediate outcomes will assess actions taken at the individual, community, and systems levels as a result HEF funding. Intermediate outcomes measure the extent to which the change in knowledge, capacity, attitudes and empowerment resulting from short-term HEF activities led to longer-lasting changes toward health equity. Intermediate outcomes include:

- Improved access and use of health and social services, including access to quality health services. Improved access and use will be measured by self-reported changes in access and use of services by service recipients and if data are available, changes in service utilization rates among HEF grantees and other service providers in the city;
- Increased healthy behaviors (such as exercise, fruit and vegetable consumption, quitting smoking). The change in these behaviors will be measured by self-reported changes in health behaviors (e.g. self-reported increase in fruit and vegetable consumption; self-report physical activity);
- Improved cultural competence and delivery of services (such as interpreters in clinics, materials in English and Spanish). The change in delivery of services will be measured by extent to which policies and procedures have changed among HEF grantees and the city as well as self-reported experience;

- Greater integration and/or collaboration of services (such as use of health navigators/Promotores, health screening events in schools and worksites, multi-organizational planning). Greater integration of services will be measured by the number of collaborations and the extent to which they are cross-sector and deliver services to those experiencing health inequities and in particular, those who are not typically identified as experiencing health inequities. Additionally, greater integration and collaboration will be measured by the extent to which information and data are shared to accurately assess who is being served and identify strategies to connect with those not traditional identified as experiencing health inequities; and
- Greater inclusion of equity in organizational decision-making (such as including people of color on staff and boards of organizations or involving the community in decision making). Greater inclusion of equity in decision-making will be measured by the extent to which policies and procedures have changed among HEF grantees and the city and the extent to which the equity lens has been applied to the administration and delivery of HEF activities.

Long-Term Outcomes

Long-term outcomes are the positive effects of HEF activities that can be measured in eight- to ten years or longer. These outcomes include health improvements or systems-level SDOH changes. The HEF evaluation framework will include a description of the long-term outcomes and will consider whether alignment with HealthyPeople 2020 and 2030 goals is meaningful to the city.[7] There are two types of potential outcome measures for long-term change.

One type is the change in selected outcomes among populations experiencing health inequities, with example indicators of change include:

- Percentage reduction in child and adult obesity rates among people of color and low-income community members;
- Percentage reduction in older adults experiencing diabetes and high blood pressure;
- Number of low-income and Latinx households with access to clean water;
- Percentage increase in consumption fruits, vegetables and other healthy foods among children; and
- Percentage reduction in food insecurity among low-income individuals and families.

The second type of change is an assessment of the size of gaps—in absolute and relative terms—between disadvantaged and advantaged groups. For example, an indicator of change might be percent reduction in the gap between White and Hispanic adults who are obese.

[7] HealthyPeople has established evidence-based national health objectives with clear targets that allow us to monitor progress, motivate action, and guide efforts to improve health across the country. It establishes 10-year goals and targets at the national level. For more information, visit https://www.cdc.gov/nchs/healthy_people/hp2020.htm

Assumptions

Equity Lens | Health | Multi-Level | Funding | Community Needs | Root Causes

Assumptions are the clearly stated beliefs upon which the Theory of Change is based, including beliefs about the context in which the HEF is implemented. The evaluation framework will include measurements to understand the extent to which these assumptions remain true. The assumptions are described in more detail below in component four of the Theory of Change.

Context

Policies | Culture/ Norms | Demographics | Economy

The context acknowledges the socio-economic or political circumstances or conditions in which the HEF is implemented. To some extent, any change in these factors may affect the activities and outcomes of the HEF, and vice versa. Context is described in more detail below in component two of the Theory of Change.

Evaluation of Health Equity Initiatives and Activities

In 2019, the HEF evaluation framework will contain plans to identify key indicators of change, highlight data collection needs, and present protocols and tools to assess the extent to which the Theory of Change occurs. Specifically, the evaluation will define the outputs, short-term, intermediate, and long-term outcomes measures that grantees and other stakeholders of the HEF (e.g. the city, HEAC) will find meaningful and on which they will report. The framework will include technical assistance to HEF grantees to strengthen their evaluation skills. Ultimately, the evaluation framework will consider the three levels of impact – individual, community, and systems – to assess improved access to healthy foods, reduced food insecurity, increased physical activity, and reduced health disparities caused by systemic inequity.

Sugar Sweetened Beverage Product Distribution Tax

The Sugar Sweetened Beverage Product Distribution Tax is the source for HEF investments and administrative activities. The tax legislative intent defines the health equity purpose for HEF investments. Any changes in the tax legislative intent would necessarily result in modification to the HEF Theory of Change.

COMPONENT TWO: CONTEXT

Context describes the circumstances in which the HEF is being implemented. A change in circumstances or context has the potential to effect activities and outcomes of the HEF, and vice versa. The components of context explored in this section include population demographics, culture and norms, policies and other initiatives, and economic factors. Each of these components has an individual, as well as interrelated, effect on health equity in the community.

Population Demographics

The American Community Survey provides 2015 five-year estimates regarding the city of Boulder metropolitan statistics. Among a number of demographics variables described in Table Three, the city is largely made up of individuals of White race and ethnicity at 81.5 percent of the city population, followed by individuals of Hispanic or Latino origin at approximately nine percent. Households below poverty level make up five percent of the city population, with just about four percent of households using Supplemental Nutrition Assistance Program (SNAP) benefit. Approximately, 13 percent of households are limited English, Spanish-speaking.

Table Three. Demographics for the City of Boulder

Demographic Variable	Percent of City Population
Number of individuals over age 60	14.9
Individuals living with a disability	6.7
Black/African American	1
White	81.5
Hispanic or Latino origin	9.2
Households using SNAP	3.9
Households below poverty level	5.1
Limited English, Spanish-speaking households	13

Culture and Norms

Boulder is typically described using words like active, open minded, and affluent among those community members who participated in stakeholder engagement activities for the development of the Theory of Change. Focus group participants described Boulder as happy, green, beautiful, and mostly clean. These qualities can be leveraged to positively influence health equity. During the 2018 HEF Summit, participants discussed existing efforts to advance health equity in Boulder. Their responses included: the health care community agency initiatives; education and school district programs; the collaborative spirit of community; food programs; regional affordable housing plan and rapid rehousing programs; early childhood programs; in-home services; a supportive law enforcement; and minority community resources.

Stakeholders also identified potential challenges to furthering health equity in the city. It was identified that the level of support for and acknowledgement of health equity may be a barrier to advancing health equity. There was a notion of a “façade of support” among some Boulder residents. Participants

stated, “People (i.e. the community) likes the idea of equity, but not everyone is willing to actually do the work”, and “…people are not open to affordable housing. Participation and willingness to act for common good, such as housing, is lacking in this area.” One participant also stated that Boulder is a prideful community and at times pride “leads to [an] inability to see and acknowledge gaps in the community”. There was a sense among the community that individuals do not recognize gaps in health equity and therefore, do not acknowledge that anything needs to be done to address those gaps. These, and other cultural norms and beliefs must be considered and addressed when preparing for the next iteration of the HEF work.

Another finding from the discussions at the 2018 HEF Summit and focus groups was that a top driver of health inequity in Boulder is “othering” (i.e., to view or treat a person or group of people as intrinsically different from oneself). In the discussions, othering was described as: language barriers, not feeling a part of the community, people of color not feeling welcome, lack of cultural competence and bilingual staff at some local agencies, little integration of Latinx and other populations, education gap between wealthy and non-wealthy, extreme viewpoints of health and physical activity not inclusive or relatable to minority populations, physical activities not accessible due to cost and also not culturally relevant/approachable. Another way to describe this is systemic racism, which is defined as the policies and practices entrenched in established institutions, which result in the exclusion or promotion of designated groups. It differs from overt discrimination in that no individual intent is necessary. Systemic racism is not unique to the city. It is prevalent all over the United States and world.

Policies and Initiatives Impacting Health Equity

In the city, there are many policies and initiatives in place that impact health equity both directly or indirectly as well as both positively or negatively. There are opportunities for advancing health equity across many sectors, including transportation, housing, childcare, wage and income, and land use sectors. Moreover, cross-sector collaboration is critical to the success of heath equity. Of note among efforts intentionally confronting health inequity are the Race Equity Initiative[8], the Human Services Strategy, and the Homelessness Strategy[9]. The Race Equity Initiative is a partnership between the city and the Government Alliance on Race and Equity (GARE) that is intentionally focused on race and the development of a framework for equity that can be applied to other marginalized groups. The Human Services Strategy is an effort to identify the City’s human services goals and priorities; clarify the City’s role in providing human services; identify new or expanded community partnerships to leverage and coordinate resources and services to the community; and align City investments in human service with priorities and goals as a funder, services provider and community partner. The Homelessness Strategy is a city-wide effort to create a plan to address homelessness in coordination with other regional homelessness efforts.

Physical Barriers

The conversations with HEF grantees and those they serve provided insight into the experience of community members committed to improving health and health equity, as well as the lived experiences of community members themselves. Findings from these discussions show that lack of access to quality

[8] To learn more about Race Equity Initiative, visit https://bouldercolorado.gov/pages/racial-equity-project-3
[9] To learn more about Homelessness Strategy, visit https://bouldercolorado.gov/homelessness/homelessness-strategy

health services, housing issues including cost and policies (such as an inability to access services due to living just outside city boundaries), lack of clean drinking water, cost and accessibility of healthy food, and transportation are among the physical barriers to health equity in the community. The Robert Wood Johnson Foundation County Health Rankings presents three indicators that provide data on the potential physical barriers faced by city residents who experience health inequity and support what was heard in the community focus group discussions.[10] These include:

- Food Environment Index: [11] 8.2
  - The food environment index combines two measures of food access: the percentage of the population that is low-income and has low access to a grocery store, and the percentage of the population that did not have access to a reliable source of food during the past year (food insecurity). A ranking of 8.2 in Boulder is better than the United States and similar to Colorado. The index ranges from zero (worst) to 10 (best) and equally weights the two measures.
- Social and Economic Factors Ranking:[12] 14
  - While Boulder's ranking of 14 falls within the best quartile of counties across the United States, this ranking has worsened since 2014, from when it had a higher ranking of three. The ranking is based on a summary composite score calculated from the following measures: high school graduation, some college, unemployment, children in poverty, income inequality, children in single-parent households, social associations, violent crime rate, and injury death.
- Physical environment ranking:[13] 53
  - A ranking of 53 is low compared to other Colorado counties and is in the worst quartile (high ranking is one and two) overall. The ranking is based on a summary composite score calculated from the following measures: daily fine particulate matter, drinking water violations, severe housing problems, driving alone to work, and long commute while driving alone

[10] County Health Rankings and Roadmaps, available at http://www.countyhealthrankings.org/explore-health-rankings

[11] A lack of access to healthy foods is often a significant barrier to healthy eating habits. Low-income and underserved areas often have limited numbers of stores that sell healthy foods. People living farther away from grocery stores are less likely to access healthy food options on a regular basis and thus more likely to consume foods which are readily available at convenience stores and fast food outlets. Food insecurity, defined as limited availability or uncertain ability to access nutritionally adequate foods, is associated with chronic health problems including diabetes, heart disease, high blood pressure, hyperlipidemia, obesity, and mental health issues including major depression.

[12] Social and economic factors strongly influence the health of the individual and community. Studies repeatedly show a strong correlation between socioeconomic status and health outcomes. Understanding how a community compares to surrounding areas in terms of key social indicators such as educational attainment and crimes rates as well as understanding the comparative economic status of a community is necessary to determine the types of community health programs needed.

[13] The physical environment includes all of the parts of where we live and work (e.g., homes, buildings, streets, and parks). The environment influences a person's level of physical activity and ability to have healthy lifestyle behaviors. For example, inaccessible or nonexistent sidewalks or walking paths increase sedentary habits. These habits contribute to obesity, cardiovascular disease, and diabetes. Other factors that contribute to healthy lifestyle behaviors are access to grocery stores and farmer's markets, recreation facilities, and the presence of a clean and safe physical environment.

COMPONENT THREE: UNINTENDED RESULTS

This Theory of Change component considers the potential unanticipated positive or negative results of the HEF investments. Unanticipated results may also be considered "indirect" in that the HEF may not directly impact an outcome but through its work, it indirectly brings about desired outcomes. For example, the HEF is limited to influencing those organizations receiving HEF dollars. However, through capacity building efforts such as health equity education and training, evaluation, and facilitating strategic multi-sector partnership among those grantees, the HEF has potential to indirectly impact the community at large through the work of those they fund and other stakeholders.

The following are examples of intended HEF results, as described in the logic model:

- Improved access and use of health and social services (such as mobile health screenings, transit to doctor's appointments, Meals on Wheels deliveries) by those populations within the city who experience health inequities. This includes access to quality health services. Members of focus groups expressed that they know where to go for services but have very limited choice in places they can go for services that are both affordable and of high quality;
- Increased healthy behaviors (such as exercise, fruit and vegetable consumption, quitting smoking) among those experiencing health inequities;
- Improved cultural competence and delivery of services (such as interpreters in clinics, educational materials in English and Spanish) by those providing services to those experiencing health inequities;
- Greater integration and/or collaboration of services (such as use of health navigators/Promotores, health screening events in schools and worksites, multi-organizational planning) to address the complexity of a person experiencing health inequities in how and whether they benefit from services provided in part due to HEF investments. Collaboration of services will also help to ensure that all individuals experiencing health inequities will be identified and served, rather than those that are frequently outreached and currently known; and
- Greater inclusion of equity in organizational decision-making (such as including people of color on staff and boards of organizations or involving the community in decision making) to begin to address the systemic barriers to health equity, such as organizational and city policies, laws, and power structures.

One example of an unintended positive result of the HEF is that HEF grantee organizations leverage new funding opportunities because of increased capacity to apply the health equity lens to their work. Many philanthropic organizations are prioritizing equity, including health equity, in their funding initiatives.[14] Organizations that have the capacity to show they are intentionally working toward greater equity in communities and understand what that means will attract these new dollars.

The potential unintended negative results of the HEF might be that grantees unable to meet the terms of their HEF contracts, such as expectations for evaluation activities, risk being ineligible for future funding. The Theory of Change outlines a focus on capacity building, including evaluation, among HEF

[14] Funders' Support of Health Equity. Health Affairs, Vol 37 (3). Available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0088

grantees to manage this unintended result. A second unintended negative result that will be important to monitor is if grantees lacking inclusivity and equity within their organizations, they may not achieve their program outcomes or lose credibility among the population they serve. To manage this potential challenge, the city may provide equity training and education to grantees and community partners.

COMPONENT FOUR: ASSUMPTIONS

Assumptions are the clearly stated beliefs upon which the Theory of Change is based, including beliefs about the context in which the HEF is implemented, and regarding the cause-effect relationships shown in the logic model. The following assumptions underlay the HEF's Theory of Change.

Assumption One: Application of the Equity Lens

The Theory of Change assumes that the HEF implements activities with a health equity lens. Consistent application of a health-equity lens will bring about the following kinds of community changes which may directly or indirectly result in positive impacts of HEF investments:

- Greater community awareness of and action that will advance health equity;
- Strengthened community resources and capacity in health promotion and disease prevention that are responsive to the needs of the community;
- Greater community organizing and actions that address SDOH;
- Greater individual empowerment, as demonstrated by an individual's capacity to make choices and transform those choices into desired actions and outcomes; and
- Greater community empowerment to create an environment in which individuals can (and chose to) seize new opportunities, including the ability to develop new or strengthen existing skills, abilities, processes, and resources regarding health equity.

Figure Two. Applying the Equity Lens

Investigate: Understand who is being served and their needs.

Act: Design and implement programs/policies with health equity in mind.

Connect: Identify strategic partnerships for delivery/implementation of programs/ policies; Connect with those most impacted.

Sustain: Identify strategies to sustain the impact of HEF investments.

Assumption Two: Health

Investments made by the HEF in social services and public health result in better health outcome.[15]

Assumption Three: Multi-Level

Investments made by the HEF work in one of three ways to advance health equity at the individual, community, and systems level: 1) change social norms, 2) develop capacity for health equity work, and 3) increase opportunities and/or removing barriers to health equity for those experience health inequities.

[15] Bradley, E. H., M. Canavan, E. Rogan, K. Talbert-Slagle, C. Ndumele, L. Taylor, and L. A. Curry. 2016. Variation in health outcomes: The role of spending on social services, public health, and health care, 2000–09. Health Affairs 35(5):760–768

Assumption Four: Funding

The HEF can fund programs over a period of time as opposed to one-time funding. Long-term funding streams supports consistent service and program delivery as well as evaluation to measure intermediate and long-term impact of the HEF.

Assumption Five: Community Needs

The HEF funds programs that address immediate needs of individuals and families experiencing health inequities as defined by community stakeholder engagement.

Assumption Six: Root Cause

The HEF funds programs that seek to solve root causes of health inequities.

COMPONENT FIVE: COMMUNITY ENGAGEMENT

The Theory of Change defines community engagement as "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest or similar situations to address issues affecting the well-being of those people." It "involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as a catalyst for changing policies, programs and practices."[16]

Community engagement considers how people experiencing health inequities become engaged in the HEF and/or any of the projects, programs or policies that may impact them. Considerations for community engagement include the following:

- Each community, even within the city context, is unique. Communities have different disparities, different needs, and different desires. They are unique in their values, resources, and sources of power. They are experts on their own lived experience. The imperative of community input, voice, power, and control in addressing health disparities cannot be overstated;
- Community-based solutions cannot act in isolation. Policies to address structural inequities are vitally important and set the context in which community-based solutions can or cannot function;
- The HEF can impact community engagement at the grantee level by supporting and building the capacity of grantees to engage with the communities they serve to better understand their cultural norms, desires, and needs; and
- Community engagement is directly linked to sustainability as many funders emphasize community-defined programs and interventions.

During the focus groups, participants were asked if local service providers and organizations outreach them to provide input on program design or service delivery. The overwhelming answer was, "no." It is important that space is made for community members to contribute to the systems-level discussions regarding community-based solutions if these solutions are expected to be used and sustained. Some

[16] Principles of Community Engagement, CDC/ATSDR Committee on Community Engagement, Retrieved May 2, 2011

best practices that currently guide HEF's decision-making and support for community engagement include:

- Conduct a thorough assessment of community needs and resources, gathering and analyzing quantitative data (surveys, vital statistics, national data to compare with local) and qualitative data (from focus groups, interviews, observation);
- Address the community system, not just the individual. The burden should not solely be on the individual to make a change but rather the community and the systems it works within must be willing make changes to help reduce barriers and obstacles facing individuals when making choices about their health and wellness;
- Ensure initiative is culturally appropriate by including community members in the discussions of program design and implementation;
- Use coalitions/advisory groups effectively from the beginning to the end of the initiative; and
- Ensure representation by including people of color and members of the community on organizational boards and staff.

The HEF evaluation framework will seek to establish greater capacity among HEF grantees to engage the communities they serve at all levels of the decision-making process by providing technical assistance and other resources.

COMPONENT SIX: SUSTAINABILITY

Sustainability takes into consideration how HEF outcomes will be sustained beyond HEF funding for a long-lasting impact. Sustainability will be measured by the extent to which key elements are in place at the individual, community, and systems levels to sustain those outcomes. Specifically, sustainability of HEF investments is measured by both the City's and past and current grantees' capacities to implement their work with a health equity lens and report that impact in a meaningful way to stakeholders. One tangible outcome of the HEF will be grantees capacity to advance health equity in the work they do beyond HEF support. Additionally, this new capacity may also lead to increased attractiveness of these grantees to other funders of health equity.

There are best practices to consider when thinking about building capacity for and sustaining health equity work. These best practices are a priority for the HEF and are factored into its Theory of Change. These best practices include:

- Building the capacity of community-led organizations to design programs and services from a community-defined and led approach through community engagement;
- Educating grantees about cultural competence and how to design and deliver services with cultural competence to improve access and quality of those services;
- Articulating and funding strategies that aim to address race-related stressors and racism in tandem with reducing health disparities;
- Educating grantees on health equity and how to integrate equity into their own internal policies and practices (e.g. equitable hiring practices; equity and inclusion (not just diversity) in leadership);
- Funding programs and interventions that consider SDOH, such as food and housing inequities, that are root causes of health inequities in the city; and

- Recognizing the numerous other efforts in the community working to advance health equity (knowingly or unknowingly).

Lastly, evaluation is a critical component of effective programming and sustainability. Evaluation allows for improvement in program design and implementation, as well as demonstration of program impact. It is crucial to increase the capacity of grantee organizations to evaluate their programming to demonstrate not only their individual impact but also the collective impact of the HEF. It is important to note that health equity work can be especially challenging to evaluate as it requires constant monitoring, and many disparities will take many years to impact. Development of short- and intermediate-term, measurable goals is key to demonstrating effectiveness of health equity programming and will be a focus of the HEF evaluation framework.[17]

[17] Robert Wood Johnson Foundation 2017, "What is Health Equity? And What Difference Does a Definition Make?", Retrieved September 24, 2018.

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