Health Equity Assessment of Healthy Start Sites
Healthy Start Performance Project

National Institute for Children's Health Quality (NICHQ)
Technical Assistance & Support Center (TASC)

August 2023

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1. Background

Amaka Consulting and Evaluation Services (ACES), LLC is a trusted minority and woman-owned consultancy firm with deep expertise in program planning and evaluation in public health. Since its inception in 2016, ACES has provided invaluable technical expertise in areas such as health disparities, maternal and child health, program evaluation, grant writing, and mixed methods research. With more than 30 years of combined experience, the composition of research and evaluation associates within ACES reflect the diversity of technical skills and content knowledge to meet clients' needs across many domains. ACES evaluation work is also rooted in our commitment to health equity, racial justice, and inclusion. ACES prides itself on maintaining a team of evaluation experts with diverse expertise and backgrounds. AMAKA's team members are people of color, immigrants, first-generation college students, and folks from low-income backgrounds.

ACES' ability to integrate a client-centric approach, public health experience and expertise positions ACES well to work collaboratively with the National Institute for Children's Health Quality's (NICHQ) Healthy Start TA and Support Center (TASC). NICHQ is a nonprofit organization aiming to improve the lives of children and families through innovative, community-based, equity-driven initiatives targeting parental and child health. One of NICHQ's largest initiatives is the Supporting Healthy Start Performance Project (SHSPP), a program aimed at technical assistance and capacity building for the Healthy Start (HS) program, a community-based federal program to eliminate perinatal and infant health disparities consisting of 101 grantees across 34 U.S. states, Puerto Rico, and Washington, D.C. The SHSPP is made possible through a cooperative agreement with the Maternal and Child Health Bureau Division of Healthy Start and Perinatal Services and the Health Resources and Services Administration.

Between February and July 2023, ACES worked closely with NICHQ SHSPP's team to design and implement an opt-in survey assessment of health equity work at HS sites from across the U.S. The phrase "***health equity work/activities***" used in the survey and for the purpose of this report means ***work addressing the root causes and systems-level factors influencing health disparities and inequity***. Examples of health equity activities can include community needs assessments; root cause analyses; work addressing social and structural determinants of health; collecting data that includes race, ethnicity, zip code, or other potential indicators useful to analyzing systemic oppression; and organizational and/or community-based advocacy activities for policies addressing health inequities. Moreover, the term "fiduciary" or "institution" refers to the organization, where the HS site and its respective funding mechanism reside.

The goal of the assessment was to explore existing health-equity-related activities across HS sites. Secondary aims were to assess attitudes towards and readiness for engagement in health equity work, as well as opportunities for health-equity-related technical assistance across sites. Assessing these goals through an opt-in survey instrument fell into three broad categories: Community Action Network, Health Equity Work, and Technical Assistance Needs. As listed below, each category's objectives were further explored in the survey:

I. Community Action Network

- Assess the activity level of each site's Community Action Network (CAN)
- Assess the intersection of the CAN with health equity work

II. Health Equity Work

- Assess staff's understanding of health equity work, particularly how it relates improving health outcomes for families
- Determine the type and stage of implementation of several health equity activities
- Assess staff's attitudes and self-efficacy towards engaging in health equity work
- Understand the success and challenges associated with health equity work thus far
- Understand the fiduciary and other organizational collaborations in place or in progress that are necessary to engaging in health equity work
- Learn each sites data collection priorities as it relates to health equity work

III. Technical Assistance & Funding Needs

- Determine technical assistance needs that sites have in order to best engage in health equity work
- Gauge priorities for additional unrestricted funding

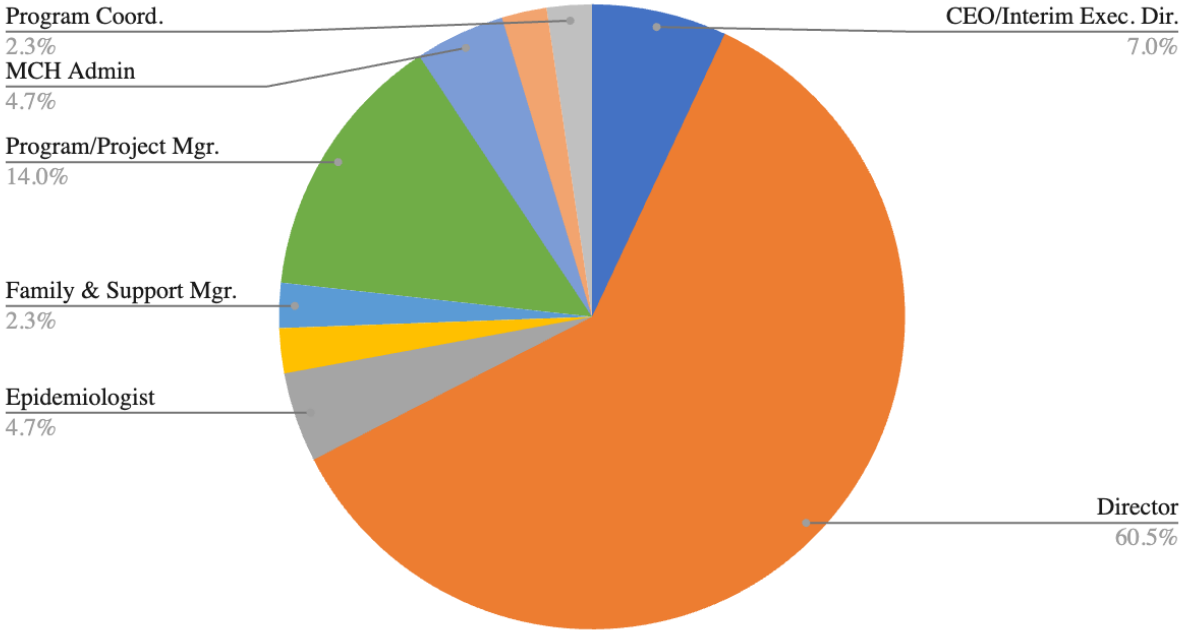
Please note that the findings in this report are based upon sites who choose to respond to the survey (*N*=36 unique sites across 44 responses, representing 35.6% of sites) and are not intended to be representative of all Healthy Start sites (*N*=101). Furthermore, the responses given by the staff member from sites that responded to the survey are not meant to be inclusive of all the perspectives of staff members at their site.

In addition, partial responses were included in these findings. Thus, the sample sizes listed in the below report will vary by how many people filled out a specific question as part of their response. **Appendix D** includes all questions asked on the survey, their answer choices, and the number of respondents for each question.

2. Demographics of Responding Sites

Forty-four (*N*=44) respondents, each representing their respective site, filled out the survey partially or completely. Of the staff members who provided a job title (*N*=43; 97.7% of total respondents), most (*n*=26; 60.5%) held a title at the level of Director, Program Director, or Project Director. Other commonly reported job titles included Program Manager (*n*=5; 11.6%), CEO/Interim Executive Director (*n*=3; 7.0%), and Maternal and Child Health (MCH) Administrator (*n*=2; 4.7%). The breakdown of job titles of survey respondents is shown below in **Figure 1**.

Figure 1. Job Title Breakdown of Survey Respondents (N=43).



Of the 44 total responses, 29 were completed in full (65.9%). Most of the completed responses (*n*=19; 65.5%) were completed by respondents at the level of Director, Program Director, or Project Director. Respondents at the level of Manager, including Program Manager and Support Manager, made up 13.8% of responses (*n*=4). Other job titles comprising the completed responses each had one response (3.4%) and included Maternal and Child Health Administrator, Program Coordinator, Interim Executive Director, Professor, and Epidemiologist. On the other hand, incomplete responses were also primarily filled out by Directors (*n*=7; 46.7%), while other job titles comprising the incomplete responses were Program/Project Manager (*n*=2; 13.3%), as well as Faculty Staff, CEO, Interim Executive Director, Epidemiologist, and Maternal and Child Health Administrator, each of which had one incomplete response (6.7%).

Respondents reported working primarily in an urban (*n*=32; 74.4%) setting, followed by rural (*n*=12; 27.9%), with one respondent working in a border setting (*n*=1; 2.3%). The fiduciary for their Healthy Start site was a nonprofit organization in 20 cases (46.5%), a health department, board, or commission in 13 cases (30.2%), and an academic/university setting in 7 cases (16.3%). Ten respondents reported receiving the "*Action Plans for Infant Health Equity*" supplement (23.3%), and two had received the "*Catalyst for Infant Health Equity*" supplement (4.7%). The job titles, settings, fiduciaries, and supplemental funding sources for all respondents are shown in **Table 1**.

Table 1. Participant Characteristics.	***n***	**%**
Job Title (N=43)		
CEO / Executive	3	7.0
Director	26	60.5
Program / Project Manager	6	14.0
Epidemiologist	2	4.7
Maternal and Child Health Administrator	1	2.3
Program Coordinator	1	2.3
Faculty Staff	1	2.3
Professor	1	2.3
Family Preservation and Support Manager	1	2.3
Setting[*] (N=43)		
Urban	32	74.4
Rural	12	27.9
Border	1	2.3
Fiduciary[*] (N=42)		
Health Department, Board, or Commission	13	30.2
Academic / University	7	16.3
Non-profit Organization	20	46.5
Hospital / Healthcare	1	2.3
City Government	2	4.7
Other (FQHCs, community foundations)	3	7.0
Supplement Funding (N=42)		
Action Plans for Infant Health Equity	10	23.3
Catalyst for Infant Health Equity	2	4.7
Neither	33	76.7

[*]*Categories not mutually exclusive*

Participating Healthy Start sites ranged in years of operation from 4-50, with a median age of 22 years and an average age of 18.4 ± 11.2 years. A full list of sites who participated in the survey is shown in **Table 2**.

Table 2. List of Participating Sites.

Access Community Health Network	Institute for Population Health, Inc.
Centerstone of Indiana, Inc.	Laurens, County of
Centerstone of Tennessee, Inc.	Lucas, County of
Central Mississippi Civic Improvement Association, Inc.*	Maternity Care Coalition, Inc.
Children's Service Society of Wisconsin	Mercer University, Corporation of
Cleveland, City of	Metro Gov't. of Nashville & Davidson County
Cobb County Board of Health	Multnomah, County of*
Colorado Nonprofit Development Center*	Northern Manhattan Perinatal Partnership, Inc.
Connecticut Department of Public Health*	Nurture KC
Cook, County of	Philadelphia, City of*
Delta Health Alliance, Inc.	Project Concern International
Family Road (of Greater Baton Rouge)	Public Health Solutions
Five Rivers Health Centers	SHIELDS for Families
Florida Department of Health	Tougaloo College*
Genesee, County of	University of Houston System
Greater New Haven, Community Foundation for, Inc.	University of Illinois
Health and Hospital Corp of Marion County	University of North Carolina at Pembroke*
Indiana Rural Health Association	Visiting Nurse Services

**Site completed survey more than once*

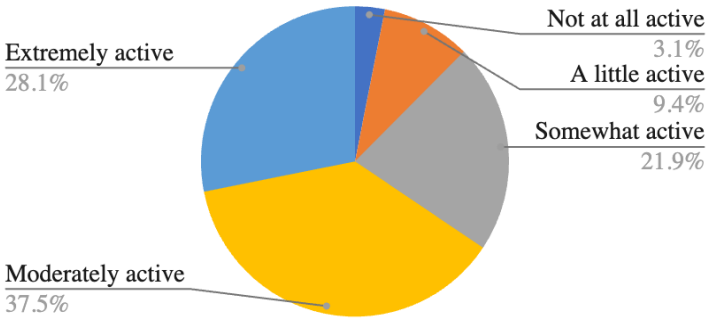
3. Results

The results reported in this section are grouped by the goals of the assessment, as laid out in the **Background** section of this report.

I. Community Action Networks: Intersection with Health Equity Work

Participants were asked to report on any multi-sectoral partnerships within their CAN, the overall activity level of their CAN, and the CAN's involvement with health equity activities. Every grantee who completed the question on partnerships within their CAN (*N*=31; 100%) reported that their CAN incorporated multi-sectoral partnerships. The activity level of the CAN varied (**Figure 1**), with the most common response being *Moderately Active* (*n*=12; 37.5%).

Figure 2. CAN Activity Level (N=32).



Participants were also asked to rank the CAN's involvement with a variety of health equity activities at their site, including root cause analyses, health equity trainings, environmental scans, community needs assessments, and more (see section *II. Health Equity Work*). On average, CAN members were involved in health equity activities 64.2% of the time, with involvement ranging from *Low* (30.5%) to *Medium* (46.0%) to *High* (23.5%); 79.3% of all activities were reported as being connected to the CAN. For the activities with high CAN engagement, respondents most often said that the CAN coordinator and program staff actively coordinated *Occasionally* or *Most of the Time*. Coordinating *All of the Time* was reported by 25.8% for activities related to social determinants of health (SDOH), and 4% of the time for changing internal policies. Involvement of the CAN by type of health equity activity is reported in **Table 3** below. *Note: Please refer to* ***Appendix D*** *for sample sizes for each question concerning CAN engagement with health equity activities.*

Table 3. CAN Involvement, Engagement, and Collaboration by Health Equity Activity Type.

Activity Type	Connected to CAN	Involves CAN Members	Level of CAN Engagement			Frequency of Collaboration Between CAN Leadership and Program Staff				
			High	Medium	Low	*Never*	*Rarely*	*Occasionally*	*Most of the time*	*All of the time*
	n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
Root cause analysis	26 (92.9)	23 (82.1)	2 (7.4)	17 (63.0)	8 (28.6)	1 (3.7)	3 (11.1)	10 (37.0)	10 (37.0)	3 (11.1)
Training around health equity	24 (80.0)	20 (66.7)	8 (28.6)	15 (53.6)	5 (17.9)	1 (3.2)	4 (12.9)	12 (38.7)	9 (29.0)	2 (6.5)
Activities related to SDOH	31 (100.0)	30 (93.8)	14 (43.8)	14 (43.8)	4 (12.5)	0 (0.0)	1 (3.2)	11 (35.5)	11 (35.5)	8 (25.8)
Community needs assessment	24 (75.0)	22 (66.7)	6 (20.0)	14 (46.7)	6 (33.3)	2 (6.5)	4 (12.9)	14 (45.2)	7 (22.6)	4 (12.9)
Environmental scan	20 (80.0)	17 (70.8)	6 (30.0)	5 (25.0)	9 (45.0)	1 (4.8)	2 (9.5)	10 (47.6)	5 (23.8)	3 (14.3)
Examining the structural determinants of health	29 (93.5)	22 (68.8)	7 (22.6)	16 (51.6)	8 (25.8)	0 (0.0)	5 (16.1)	12 (38.7)	11 (35.5)	3 (9.7)
Changing internal policies	14 (46.7)	8 (28.6)	4 (17.4)	9 (39.1)	10 (43.5)	6 (24.0)	5 (20.0)	6 (24.0)	7 (28.0)	1 (4.0)
Advocating for policies that affect the community	27 (87.1)	23 (74.2)	7 (25.9)	12 (44.4)	8 (29.6)	0 (0.0)	5 (17.9)	10 (35.7)	9 (32.1)	4 (14.3)
Collecting data by race/ ethnicity/zip code	20 (62.5)	15 (46.9)	4 (14.8)	12 (44.4)	11 (40.7)	4 (13.8)	3 (10.3)	8 (27.6)	10 (34.5)	4 (13.8)
Analyzing data collected	21 (75.0)	13 (43.3)	6 (23.1)	10 (38.5)	10 (38.5)	2 (6.9)	5 (17.2)	9 (31.0)	10 (34.5)	3 (10.3)

II. Health Equity Work

Longevity of and Attitudes Toward Health Equity Work

Thirty-four sites reported their site had been engaging in systems-level/root cause work for a median of ten years with a range of 2-40 years across responses, signaling a wide range of familiarity with and experience in doing this type of work. While some sites reported a gap between the start of their site and the beginning of their health equity work (range of 2-27 years), the majority of respondents (*n*=18; 54.5%) reported that their site had been engaging in health equity work since its inception.

When assessing buy-in for health equity work, all respondents chose *Agree* or *Strongly Agree* to statements expressing that their site should engage in health equity work; that they were willing and able to commit to a plan for health equity work; and that they understood the implications of this work for maternal and child health equity. Respondents were divided on their ability to communicate a case for health equity work, as well as their ability to articulate the results that

would be expected from engaging in this work. Responses to all of the value statements posed about health equity work are shown below in **Table 4**.

Table 4. Respondent Attitudes Towards Health Equity Work (*N*=37).	***n***	**%**
1. "All staff members at our HS agree that we should move towards health equity work addressing root causes and systems-level factors."		
Strongly Agree	25	67.6
Agree	12	32.4
2. "We are willing and able to commit to a plan to work towards root causes and systems-level work."		
Strongly Agree	28	75.7
Agree	9	24.3
3. "We understand the implication of root causes and systems-level work on maternal and child health equity."		
Strongly Agree	25	67.6
Agree	12	32.4
4. "We can articulate what measurable results are expected from engaging in health equity work."		
Strongly Agree	14	37.8
Agree	16	43.2
Neutral	4	10.8
Disagree	3	8.1
5. "We can communicate a clear, compelling case for focusing on root causes and systems-level work as it relates to our HS."		
Strongly Agree	22	59.5
Agree	13	35.1
Neutral	2	5.4

Of those reporting on their site's prioritization of and support for health equity work, 83.3% of respondents (*n*=30) agreed to some extent (either *Strongly Agree* or *Agree*) that their site had been prioritizing health equity work for a long time. In terms of institutional support, 91.7% of respondents (*n*=33) anticipated that their institution would collaborate with them to support ongoing health equity work, while 45.9% of respondents (*n*=17) agreed to a separate statement that their institution would pose challenges in this work.

Capacity for Health Equity Work

Participants were asked to rate their agreement to a set of statements regarding their site's capacity to engage in health equity work. In general, respondents endorsed a high level of capacity and readiness to engage in health equity work. A notable strength of the represented sites seemed to be leadership, with 100% of respondents to a related question (*N*=36) agreeing to some extent that their site had adequate leadership in place to engage in health equity work. Moreover, most respondents (83.8%; *n*=31) agreed that their site had sufficient representation of diverse local and community partners. Slightly more variation arose when respondents were asked whether their staff had the necessary skills to engage in this work, with 11.1% (*n*=4) sites disagreeing. Additionally, a few sites either responded *Neutral* or *Disagree* to questions about

being able to seek support from other Healthy Start sites (10.8%; *n*=4) and from NICHQ TASC (8.1%; *n*=3). Overall, however, responses were mostly positive and are shown below in **Table 5**.

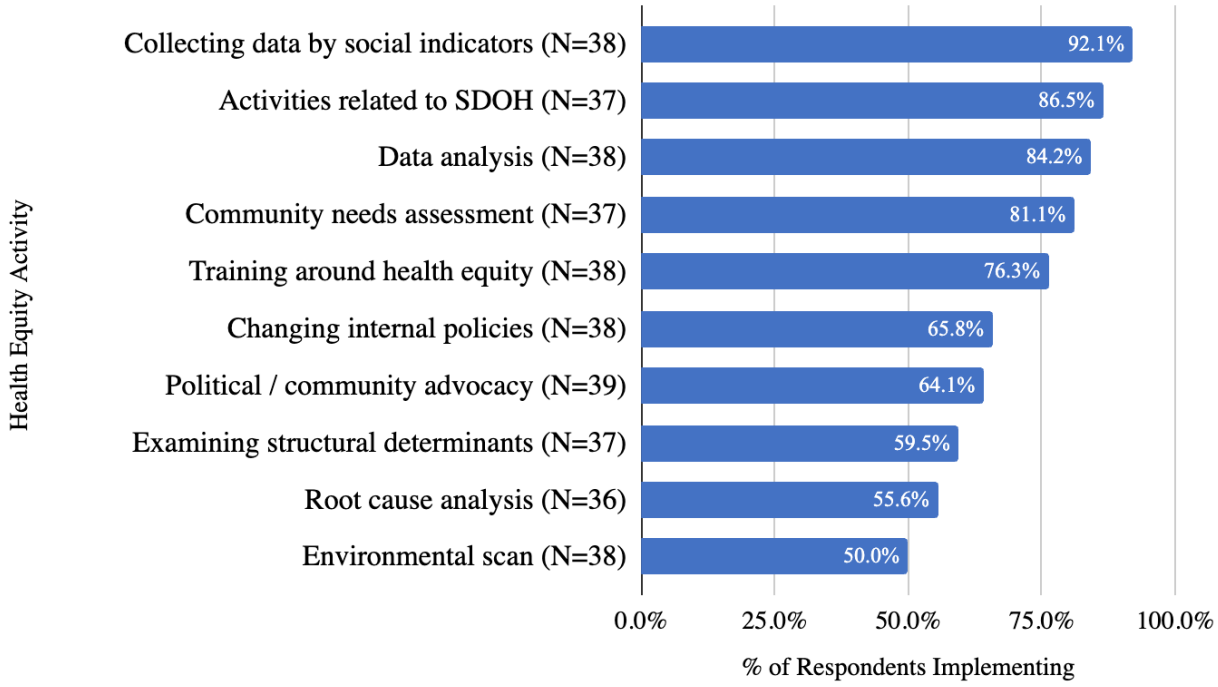
Table 5. Site Capacity for Health Equity Work.		***n***	**%**
1. "Overall, I believe we are well-positioned to make the shift towards root cause/systems-level work." (*N*=37)			
	Strongly Agree	16	43.2
	Agree	18	48.7
	Neutral	1	2.7
	Disagree	2	5.4
2. "Our staff has the necessary skills to do this work." (*N*=36)			
	Strongly Agree	13	36.1
	Agree	17	47.2
	Neutral	2	5.6
	Disagree	4	11.1
3. "We understand how to identify root causes." (*N*=37)			
	Strongly Agree	18	48.7
	Agree	13	35.1
	Neutral	5	13.5
	Disagree	1	2.7
4. "We have sufficient representation of diverse local and community partners to support this work." (*N*=37)			
	Strongly Agree	19	51.4
	Agree	14	37.8
	Neutral	4	10.8
5. "We can seek support from other HS sites who are also engaging in this work." (*N*=37)			
	Strongly Agree	21	56.8
	Agree	12	32.4
	Neutral	3	8.1
	Disagree	1	2.7
6. "We can seek support from the NICHQ TA and Support Center (TASC) who can help us engage in this work." (*N*=37)			
	Strongly Agree	24	64.9
	Agree	10	27.0
	Neutral	2	5.4
	Disagree	1	2.7
7. "We have adequate leadership in place to support this work." (*N*=36)			
	Strongly Agree	18	50.0
	Agree	18	50.0

Stage of Implementation for Health Equity Work Activities

Participants were asked to report the stage of implementation of each of a list of health equity activities (activities and answer choices listed in **Appendix D**, Page 35). The activities that were most commonly reported as in the process of being implemented (defined as either *Actively Using*, *Completed*, *Evaluating*, or *Applying Evaluation to Next Steps*) were Collecting Data by Race, Ethnicity, Zip Code, or Other Social Indicator (92.1%); Activities Related to Social Determinants of Health (86.5%); Community Needs Assessments (81.1%); and Training Around Health Equity (76.3%).

Less commonly implemented activities were Changing Internal Policies (65.8%); Advocating for Policies that Affect the Community (64.1%); Analyzing Data Collected (84.2%); Root Cause Analysis (55.6%); and Environmental Scan (50.0%). The proportions of respondents implementing each activity type are shown below in **Figure 3**.

Figure 3. Proportion of Respondents Implementing Each Activity Type.



The activity with the highest proportion of responses indicating completion (*Completed*, *Evaluating Use*, or *Applying Evaluation to Next Steps*) was Collecting Data by Race, Ethnicity, Zip Code, or Other Social Indicator, which was reported to be completed or further by 50.0% (*n*=19) of respondents. Other activities commonly reported at or beyond completion were Data Analysis (*n*=16; 42.1%) and Community Needs Assessment (*n*=14; 37.8%). Changing Internal Policies was the least likely to be reported as completed or further, with only 15.8% (*n*=6) respondents indicating its progress at or beyond completion.

Activities Related to Social Determinants of Health had the highest number of respondents reporting active use (*Actively Using*; *n*=22, 59.5%). Other activities with high reports of active

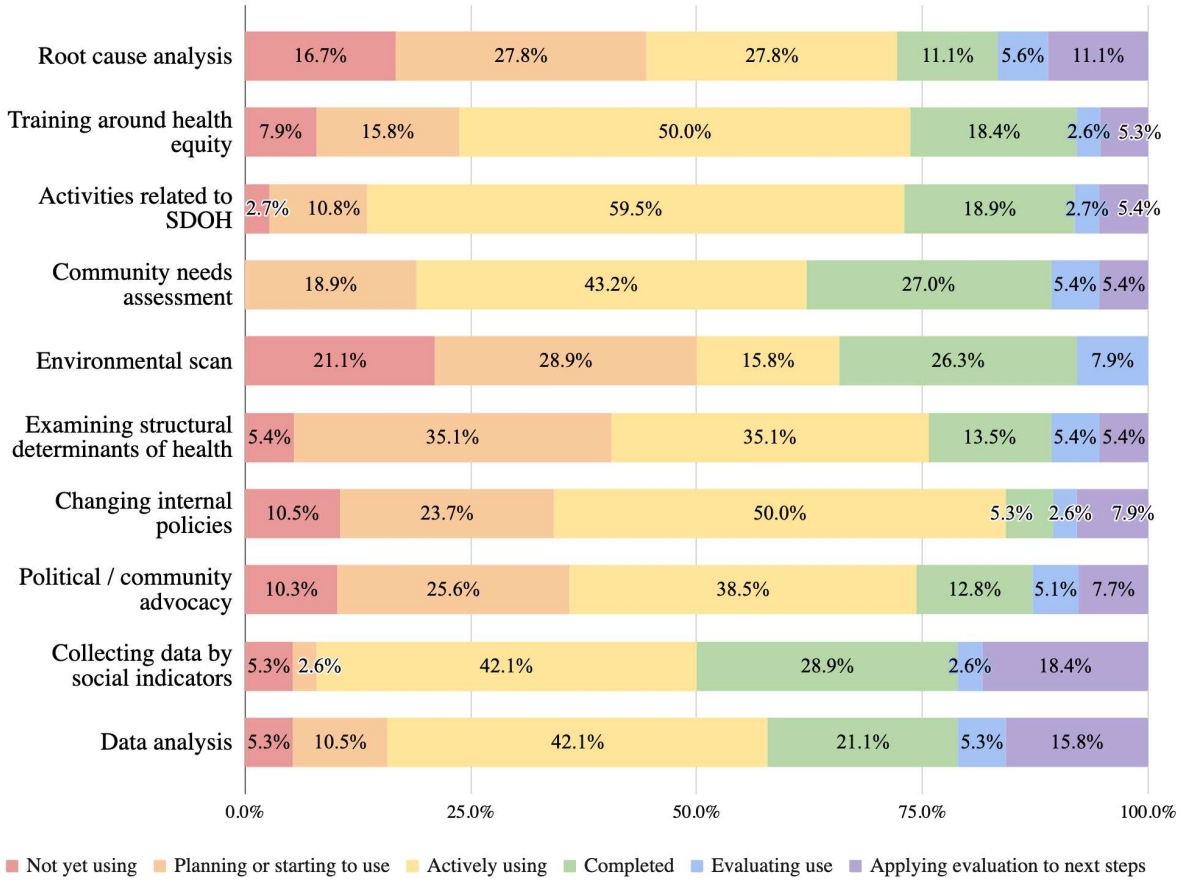
use were Training Around Health Equity (*n*=19; 50.0%) and Changing Internal Policies (*n*=19; 50.0%), while the activity being actively used by the fewest number of respondents was Environmental Scan (*n*=6; 15.8%).

In addition, Environmental Scan was the activity with the highest number of respondents reporting that they were *Not Yet Using* it at their site (*n*=8; 21.1%). However, Environmental Scan was one of the most commonly planned activities (*Planning or Starting to Use*), endorsed by 28.9% (*n*=11) of respondents, and another 26.3% of respondents (*n*=10) marked Environmental Scan as *Completed.*

Other commonly planned activities included Examining Structural Determinants of Health (*n*=13; 35.1%) and Root Cause Analysis (*n*=10; 27.8%). The activity with the fewest respondents reporting *Planning or Starting to Use* was Collecting Data by Race, Ethnicity, or Other Social Indicator (*n*=1; 2.3%); however, it should be noted that this is likely due to otherwise high implementation of this activity.

Besides Environmental Scan, the highest proportion of respondents reporting they were *Not Yet Using* an activity was related to Root Cause Analysis (*n*=6; 16.7%), while the lowest was for Community Needs Assessment, where 0.0% of respondents reported *Not Yet Using*. **Figure 4** below displays all of the activities by their stage of implementation.

Figure 4. Stage of Implementation by Health Equity Activity Type.



Types of People Involved in Health Equity Work

Healthy Start staff were all reported as likely to be involved in most types of health equity work and were indicated as collaborators in 82.4% of responses across all activities. Fiduciary staff were also frequently cited (65.8%), with highest involvement in Examining Structural Determinants of Health (n=25; 78.1%) and Analyzing Data Collected (n=25; 83.3%) and lowest involvement in Advocating for Policies that Affect the Community (n=17; 54.8%) and Root Cause Analysis (n=16; 57.1%).

Involvement of community members was also high (56.8%), with highest involvement in Root Cause Analysis (n=21; 75.0%) and Activities Related to Social Determinants of Health (n=24; 75.0%). Lowest involvement of community members across all activities was in Changing Internal Policies (n=9; 32.1%) and Analyzing Data Collected (n=10; 33.3%). Involvement of Healthy Start families varied the most, with 50.0% of respondents (n=16) reporting families' involvement with Activities Related to Social Determinants of Health; 39.4% reporting family involvement with Community Needs Assessment (n=13); and only 3-4% of respondents reporting their involvement with Changing Internal Policies (n=1; 3.6%); Collecting Data by

Race, Ethnicity, Zip Code, or Other Social Indicator (n=1; 3.1%); or Analyzing Data Collected (n=1; 3.3%). **Table 6** below shows the involvement of each of these collaborators by health equity activity.

Table 6. Collaborator Involvement in Health Equity Activities.

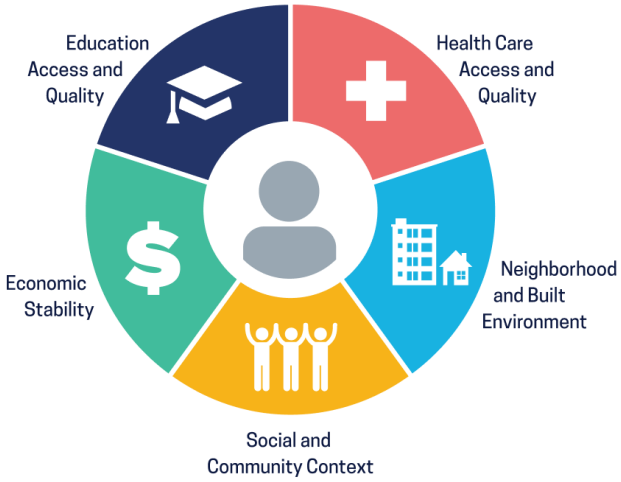
	N	%
1. Root cause analysis (n=28)		
Healthy Start (HS) program staff	24	85.7%
CAN members	23	82.1%
Families served by Healthy Start (HS)	5	17.9%
Institutional staff	16	57.1%
Community partners	21	75.0%
Other	1	3.6%
2. Training around health equity (n=30)		
HS program staff	30	100.0%
CAN members	20	66.7%
Families served by HS	7	23.3%
Institutional staff	23	76.7%
Community partners	18	60.0%
3. Activities related to SDOH (n=32)		
HS program staff	30	93.8%
CAN members	30	93.8%
Families served by HS	16	50.0%
Institutional staff	23	71.9%
Community partners	24	75.0%
Other	1	3.1%
4. Community needs assessment (n=33)		
HS program staff	27	81.8%
CAN members	22	66.7%
Families served by HS	13	39.4%
Institutional staff	24	72.7%
Community partners	21	63.6%
5. Environmental scan (n=24)		
HS program staff	13	54.2%
CAN members	17	70.8%
Families served by HS	5	20.8%
Institutional staff	17	70.8%
Community partners	12	50.0%
6. Examining the structural determinants of health (n=32)		
HS program staff	26	81.3%
CAN members	22	68.8%
Families served by HS	2	6.3%
Institutional staff	25	78.1%

	Community partners	19	59.4%
7. Changing internal policies (n=28)			
	HS program staff	22	78.6%
	CAN members	8	28.6%
	Families served by HS	1	3.6%
	Institutional staff	21	75.0%
	Community partners	9	32.1%
8. Advocating for policies that affect the community (n=31)			
	HS program staff	22	71.0%
	CAN members	23	74.2%
	Families served by HS	11	35.5%
	Institutional staff	17	54.8%
	Community partners	22	71.0%
9. Collecting data by race/ethnicity/zip code (n=32)			
	HS program staff	31	96.9%
	CAN members	15	46.9%
	Families served by HS	1	3.1%
	Institutional staff	23	71.9%
	Community partners	14	43.8%
	Other	1	3.1%
10. Analyzing data collected (n=30)			
	HS program staff	22	73.3%
	CAN members	13	43.3%
	Families served by HS	1	3.3%
	Institutional staff	25	83.3%
	Community partners	10	33.3%
	Other	2	6.7%

Grantee Priorities in Health Equity Work

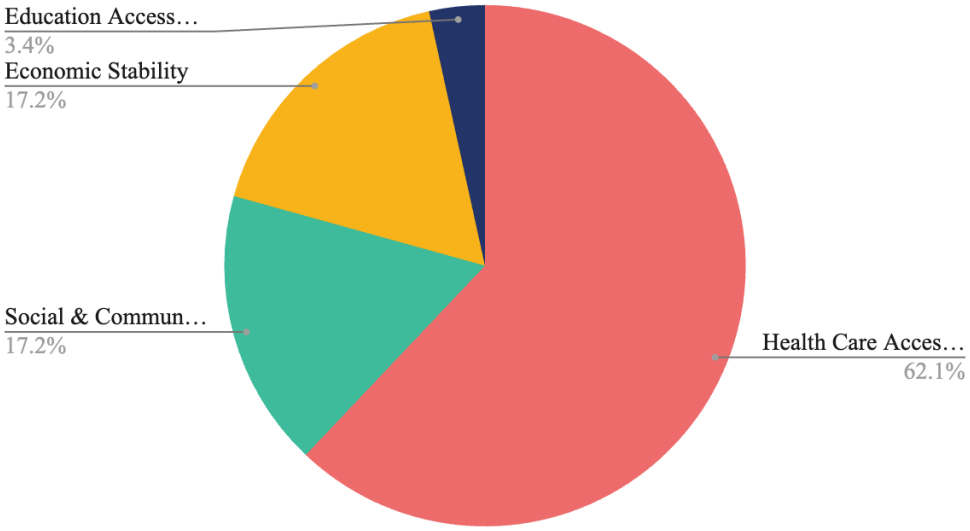
Participants were asked to identify which of the five Healthy People (HP) 2030 domains their site's work most closely aligned with over the last year. Created by the U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, the HP 2030 domains represent data-driven objectives to address social determinants of health with the eventual goal of eliminating health disparities and preventing premature death. The five HP 2030 domains are shown in **Figure 5** below.

Figure 5. Healthy People 2030 Domains Addressing Social Determinants of Health.



Of the 29 respondents indicating which domain their site prioritized over the last year, 18 respondents (62.1%) selected Health Care Access and Quality. Other responses were Social and Community Context (n=5; 17.2%); Economic Stability (n=5; 17.2%); and Education Access and Quality (n=1; 3.4%). No respondents (0%) selected Neighborhood and Built Environment as their site's top priority. When asked how they went about choosing this domain as their priority, most sites reported that they were responding to the needs of their community (n=16; 55.2%), while others reported alignment with their site's mission and/or Health Resources and Service Administration requirements (n=5; 17.2%) and 2 sites (6.9%) reported that their chosen domain is the one that most closely aligned with their CAN. The frequency of each Healthy People 2030 Domain reported as a priority by HS sites is shown below in **Figure 6**.

Figure 6. HP 2030 Domains Prioritized by HS Sites (N=29).



Challenges & Barriers in Doing Health Equity Work

Respondents were asked to share stories related to health equity and list examples of challenges and barriers they face in doing health equity work. **Some reflected on very common stories or situations they see in their work:**

"How common is a story of a woman facing eviction due to the inability to pay rent. How common is a story of a woman who has no car to go to work everyday…"

"Racism in healthcare---many stories of experiences....there need to be more policies and procedures to ensure this does not happen."

Others shared stories that describe the persistent challenges existing at multiple intersectional levels:

"We encountered a participant who lived an hour away from her prenatal care provider. She had to drive herself to the hospital while actively in labor, was stopped by the police and held while he gave her a citation. She barely made it to the hospital to deliver. This story was featured in an article in Mississippi Today."

"We had a client whose baby died. She didn't receive an explanation as to why. She never received or got to see the baby. She didn't receive a death certificate until a year later, and it didn't have a cause of death. Many of the hospital staff as well as her physician could not give her any answers. She contacted the police and [agency staff]. The [agency staff person] that was working her case expeditiously was transferred to another office, and no one could tell her the details of the investigation. She was treated unfairly. When she became pregnant again, she had her baby at home with the help of her spouse and mother. She still refused to go to the hospital because of the way she was treated previously. Her case manager was very persuasive in getting her to go see someone she trusted. Mom and baby are doing well, but because of the way she was treated previously could have caused her situation to be worse. Mom and baby could have died."

"We worked with a family that had no income and came from a background of generational poverty. Their newborn was premature and spent three weeks in NICU while the family (lives rurally over an hour away) had no transportation to travel except through our program services. Once the baby was ready to go home, it required specialized formula, but the hospital only provided enough for two feedings. They can't get an appointment with WIC for two weeks, and there are no other known resources available."

(Additional stories can be found in **Appendix A**.

Furthermore, respondents were asked to reflect on barriers and challenges that arise in their self-efficacy to do this work. When asked to what extent they agreed with statements like "we can articulate measurable results" and "we understand how to identify root cause/systems-level

work" 18.9% and 16.2%, respectively, responded *Neutral* or *Disagree*. When asked whether their site had sufficient representation of diverse and local partners, 10.8% responded *Neutral*.

In terms of barriers related to the institution or fiduciary that their site was housed within, 8.3% felt *Neutral* when asked to assess whether their fiduciary would work with them, and 70.2% anticipated that their fiduciary would pose challenges. Several other challenges or barriers came up, which are grouped in **Table 7** below. Direct quote are italicized:

Table 7. Trends in Responses to Barriers & Challenges in Doing Health Equity Work.

Trends	**Barrier & Challenges**
Creating a shared definition or understanding of health equity	*"Health equity must be defined as it is perceived by the individual and the community [otherwise, activities do not focus on root causes]"*
	No organizational understanding of health equity and its importance
	"Denial or disbelief that there are health equity issues and institutional racism."
Serving Diverse & Immigrant Populations	Need for translation services
	Changing demographics
	"There are still language barriers despite having Spanish-speaking coordinators on staff."
	"Access to accurate information is sometimes challenging. Some traditions, practices or beliefs can be a challenge for making progress in the work."
Systems Challenges	Insurance eligibility
	The political environment in which to advocate for systems-level change
	Low quality of services in the community
	"Not enough people of color to support families [...] in hospitals, physicians offices, dental clinics, etc."

	Strict funding guidelines
	"The not-for-profit rush to seek the same dollars."
Buy-in & Engagement	Getting Healthy Start participants to participate in educational programs
	Getting buy-in from complex sectors (housing, childcare)
	"Having a positive relationship with our state public health department."
	Obtaining support from leadership
	"Big entities (hospitals and govt.) don't listen to community-based organizations."
	Lack of buy-in from program staff to engage in the work
Capacity & Sustainability	Getting progress to "stick" long term
	Staff not having capacity to engage in CAN work
	Staff retention, high turnover
	"We understand that many of our clinicians are overworked because of the overwhelming amounts of patients they see. However, there has not been significant change in best practices with their offices."
	"Health equity needs a champion that is supported by funding."
	"There are not many choices for healthcare options in our area. Many of the clinicians are not willing to take health equity training and apply it to their practice."
	"We'd have to reduce direct services to participants to allocate more resources to systems-level equity activities."
Changing the Narrative	Using strategic storytelling to change narrative about "who" is deserving of support and care

	Lack of complete information or statistics
The Process and Nature of Change	Implementation takes time in order to see change
	"One is always fighting a system that has been in place for a very long time. People find change [to be] difficult."
	"The large structure and system are very bureaucratic and [it is] difficult to change the status quo."
Building Accountability & Action	*"Engaging stakeholders [...] and helping community members to see their role in impacting change as well as holding members accountable for their commitments to action."*
	"The number of institutions that have health equity statements in their organizational description but who lack actual political will to implement what is equitable for residents."
	"Moving away from awareness-type activities to changing systems and policies."
	"It's surprising [that] more of the decision makers at the macro level aren't involved at the community level to hear from community members, such as through the CAN."
	Lack of direction/instruction about how to make changes

Successes in Health Equity Work

Despite the numerous barriers and challenges, respondents shared successes in overcoming these influences for families. Some shared stories of success:

"We have a former client who gave birth while being incarcerated who, after being in our program, made huge changes. She has received her doula and CLC certifications and now wrote a bill that has been submitted to the legislature and passed in our state that will allow incarcerated pregnant women to have doula support while they are incarcerated."

"The number of people who have experienced health inequities and have never told their stories are now speaking up and realizing the experience had an impact on them."

"Mom enrolled in the Healthy Start program at 23 weeks pregnant in her second trimester of pregnancy. [...] Healthy Start's RN conducted a routine visit, which included a routine blood pressure check and noticed that mom's blood pressure was high. The RN made a medical decision and encouraged mom to go to the hospital. Later, mom delivered at 32 weeks because she had high blood pressure and the baby weighed in at 4 lbs. 5 oz. Mom instantly breastfed after delivery. Dad is involved and supportive of Mom and baby. The baby is now 14 months and participates with the Healthy Start program. The baby is now healthy and meeting all milestones."

Respondents also named examples of successes or "wins" at the family-, site-, or systems-level. A list of additional stories and examples can be found in **Appendix B.**

Table 8. Illustrative Examples of Success in Doing Health Equity Work.

Maternal & Infant Health Improvements	Social Determinants of Health & Systems-Level Change	Notable Partnerships	Site Efforts or CAN Offerings
Blood pressure screening in home during pregnancy	Transportation vouchers	Partnerships with American Heart Association and Kresege Foundation	Training CAN in root cause analysis
"*Many of our clients have learned how to advocate for themselves and their families. We have seen better outcomes in their overall health because of it*."	Translation services	Developed a coalition of stakeholders to better understand issues preventing families from accomplishing their breastfeeding goals and advocate for services in feeding	1.5-day strategic planning retreat with CAN
PPOR analysis to learn what period of risk contributes to excess infant deaths among Black families	"Food as Medicine"	Safe Sleep certification with metro area birthing hospitals	"Performance in Equity" days with staff
Expanding availability of same-day long-acting reversible contraceptives (LARCs)	$3.5 million funding to pilot a guaranteed income initiative for birthing people in zip codes with high infant mortality rates ($1,800/month for 18 months they can choose how to use)	Addressing gaps in hospital labor and delivery care	HR receptivity to implementing and promoting trainings
		Education with providers on perinatal mood disorders	

Local or State Policies Needed

Respondents had several policies or systems-level changes they believed needed to be enacted in order to reach the vision of health equity for all. A sample list below is included here, and more responses can be found in **Appendix C**.

- Transportation
- Housing
- Childcare
- Immigration support (increase access to care)
- Medicaid expansion
- Postpartum care
- Inclusionary zoning
- Universal healthcare
- Mandatory training for clinicians in health equity, like implicit bias
- Breastfeeding policies (e.g., The PUMP Act)
- Coordinated intake and referral units
- Doula care reimbursement
- Postpartum Medicaid coverage
- Autonomy in maternity care choices (home birth vs. hospital, midwife vs. OB) that are all covered by insurance

Data Indicators

Respondents were asked an open-ended question regarding what they feel are the most important data indicators to assess whether their health equity-related activities are making an impact. **Table 9** below is a compilation of the trends found in their responses.

Table 9. Trends in Responses for Data Indicators Assessing Health Equity Activities.

Overall
● Family demographics ● Comparisons with non-enrolled individuals in the service area ● Analysis by zip code and racial groups ● Community input ● Surveys of partners
Site & Program
● # of referrals over time ● # of trainings offered to staff ● # of staff who attended trainings ● # of policies to incentivize staff attendance at trainings

- Hours of education and counseling provided by case managers
- Rate of program retention
- # of family members attending events
- # of mandated implicit bias trainings
- Participant satisfaction survey

Policy Change

- Policies and practices influenced as a result of CAN
- Changes in community/population-level data
- Policies in institutions/programs where families are receiving services

Social Determinants of Health:

- # assisted with housing
- # assisted with childcare
- Education level obtained (longitudinal)
- Earnings and income (longitudinal)
- Healthcare coverage
- Job security
- Transportation resources

Health Education

- # of blood pressure cuffs given
- Knowledge of health equity
- Safe sleep
- Health literacy levels

Health Outcomes

- # of people with preeclampsia
- Infant lifespan (longitudinal)
- Infant Mortality Rate
- Maternal Mortality Rate
- Low birth weight - Very Low birth weight
- Preterm Birth
- Postpartum visit uptake
- Medical Home
- Breastfeeding rate
- Partner involvement
- Mental Health
- Domestic Partner Violence

- Reproductive/Family planning

III. Technical Assistance & Funding Needs

In terms of seeking assistance for ongoing health equity work, 89.2% of respondents indicated they felt they could seek support from other Healthy Start sites, and 91.9% responded that they could seek support from the NICHQ's TASC.

Of all respondents, 16.7% chose *Neutral* or *Disagree* when asked if their staff had the necessary skills to engage in health equity work. However, there was no clear type of training or technical assistance that was chosen as likely to be particularly helpful, with 40-50% choosing webinars, 1:1 assistance, scholarships, and training/workshops. Healthy Start frontline staff (74%) and CAN members (71%) were most often indicated as the audiences likely to benefit from these offerings.

Respondents had several ideas of what additional funding could be used towards, each shown in **Table 10** below.

Table 10. Ideas for Additional Unrestricted Funding Use.

Hiring	Training & Internal Investments	Serving Diverse Populations	Social Determinants of Health
Hiring a Health Equity Champion or Health Equity Specialist to take ownership of the strategy for the work, oversee implementation, and assess the impact through data	Training on how to effectively engage consumers	Funds specific to immigrant populations	Equitable housing options for enrolled participants
Policy and system staff specialist to help members and partners draft suggested policies	Resources that could help us collect the necessary data	More or better interpretation services	Community awareness and action-based conferences
	Incentives for engagement	CLAS trainings	Rural access to care

	Marketing strategies to advance the work we are doing		
	Direct services, like doula services, mental health services, grief counseling, in-home postpartum care and lactation consultants (sustaining breastfeeding goals to six months or beyond)		
	Training to ensure baseline understanding of health equity and skills to improve it		
	Funding to train the trainer		
	Funds towards an evaluation firm		

4. Conclusion & Next Steps

This report comprises a snapshot of current success and challenges for doing health equity work among Healthy Start sites. HS site representatives reflected on health equity work to date, with many sites reporting that this type of systems-level work has been part of their goals since inception. Site representatives also reflected on CAN involvement in health equity work, as well as their site's capacity, readiness, and technical assistance opportunities for furthering (for sites in the early stages) or deepening (for sites into later stages) their level of engagement in health equity work at the time of assessment.

Overall, the vast majority of sites were supportive of health equity work, reporting high willingness to engage in this work as well as high levels of understanding of its implications on maternal and child health equity. In addition, respondents agreed that their site had both adequate leadership and representation from diverse community partners to engage in this work.

A few respondents disagreed that their site had the necessary skills to engage in health equity work. Some sites also expressed a lack of confidence in their site's ability to articulate why health equity work is needed and what measurable results can come from it. These findings potentially signal an opportunity for improvement of HS site communication strategies. Relatedly, some open-ended survey responses spoke of the desire to utilize marketing strategies to advance health equity work. Thus, to address the need for better communication skills around health equity, future training could focus on presentation and delivery of topics related to health equity.

In addition, sites provided insight on the stage of implementation of various health equity-related activities. Notably, none of the listed activities had an implementation rate (defined as the percent of respondents reporting either *Actively Using*, *Completed*, *Evaluating Use, or Applying Evaluation to Next Steps*) below 50.0%, suggesting overall high engagement in health equity activities. Certain activities reported higher rates of use than others. For example, while the vast majority of respondents reported collecting data by social indicators, much fewer respondents reported using environmental scans and root cause analyses, suggesting that training on these less commonly-implemented activities could facilitate HS sites' engagement in health equity work in the future.

Findings from this report will be used by both ACES and NICHQ TASC to further the assessment and application of these results to next steps. ACES will consider these results and incorporate them into a five-year assessment of HS sites and relevant technical assistance. The five-year assessment, to be drafted in late summer/early fall 2023, will further explore health equity activities at all HS sites (n=101). NICHQ TASC staff will use these results to better inform technical assistance efforts, particularly for health equity training and workshops to be offered to all HS staff in late summer/early fall 2023.

5. Appendices

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Appendix A

Additional stories related to health equity work:

Many of our mothers are in the $0-$16,000 annual income bracket and have very little quality mentoring. Our case managers often provide a lifeline during a potentially lonely period of time (postpartum/maternity leave).

As a result of our telehealth hypertensive project, because the mom was provided with education and the tools to measure her blood pressure regularly, she was able to identify early warning signs of preeclampsia. Her quick response and identification enabled us to refer her to the hospital timely for care to reduce her early labor.

A father was connected to a full time employment opportunity after losing his job due to COVID. Now he is providing medical insurance as well as more substantial income to his family.

A client who had a high-risk pregnancy and the hospital not considering her care or support (i.e., delivering in another city without support) and having a C-section and not supporting her with her baby in the ICU. We had to step in to advocate.

Appendix B

Additional examples of successes in doing health equity work

We have a client who has been homeless for years. Her case manager signed her up with another local agency who connected her to a program where she is being given permanent housing (currently in different motels) to not only address her homelessness but to meet a requirement with DCFS to support her reunification with her child. As a result, her DCFS case is projected to be closed in August and [she] is now able to focus on health and herself through therapy. She had been living in a park with her child and is due to complete the Healthy Start program soon.

Nasavia has an 8-month-old and has been in Healthy Start since August of 2022. She completed her Phlebotomy Technician training through MCC in February 2023, though she still has to complete her clinical hours. Nasavia is now enrolled in school for nursing and will begin in August 2023. Nasavia is also signed up to become a DONA-certified doula through a grant from Health Forward foundation given to Nurture KC. This will increase the number of doulas in the community but also help with financial stability for her family.

"Big funders have been responsive and receptive to our 'ask.' Using the results from a history of the 'work" makes it easier to proceed with others. Success makes way for more success. This is not really unexpected, but encouraging, for sure."

"Finding white leaders who are willing to embrace the work we are doing and push or elevate the need for change in their system"

Maternal & Infant Health Improvements	Social Determinants of Health & Systems-Level Change	Notable Partnerships	Internal Efforts or CAN Offerings
Telehealth offering for hypertensive pregnant people	Advocating for state reimbursement of doulas and community health workers	Development of a Centralized Intake System	Prioritizing health equity in interviewing and hiring process
Reinstatement of fetal infant mortality review (FIMR) and finding a sustainable funding source for it	"Observing agencies advocating for health equity. Many people are aware of health equity and are working toward change."	Cribs for Kids Hospital Safe Sleep Certification program	PHAB Accreditation

	Uber Business account for transportation to medical and social service appointments		Staff being trained in Health Equity as Train the Trainers
	Advocating for more hospitals in maternity care desserts		CLAS training
	Baby on Board transportation access for all pregnant people and families		
	Establishment of a paid parental leave policy on the city level		
	Providing lactation education scholarships to people of color		
	Changing policy so everyone receiving Medicaid is eligible for a blood pressure cuff prenatally		

Appendix C

The following table describes further suggestions from respondents on necessary policies to enact:

Additional Policies Suggested by Respondents that are Necessary Needed to Enact a Health Equity Vision
Paid family leave
Guaranteed income policies
Increasing public breastfeeding spaces
Investments in nonprofit organizations
Holding hospitals accountable to equitable outcomes
More mental health resources
Data transparency and accessibility
Investment in inclusive services
Taking a health equity lens to existing policies
Rent-controlled housing
Family-friendly community and business investments
Ensuring supportive services for all birth people, including those privately insured

Appendix D

Health Equity Survey Instrument Questions, Answer Choices, and # of Respondents per Question.

Question	Answer Choices	N (% reporting)
Name of person filling out assessment (First Last)	[open text]	44 (100.0)
Title of person filling out assessment	[open text]	43 (97.7)
Which Healthy Start site are you from?	[drop-down list of grantees]	43 (97.7)
Healthy Start (HS) site setting (select all that apply)	· Urban · Rural · Tribal · Border	43 (97.7)
Who is the fiduciary for your HS grant? (select all that apply)	· Health department, board, or commission · Academic / university setting · Non-profit organization · Hospital / healthcare system · City government	42 (95.5)
How long has your HS site been in existence (in years)?	[open text]	40 (90.9)
Did your HS project receive funding from any of the following?	· Healthy Start Initiative: Eliminating Disparities in Perinatal Health Supplement: Action Plans for Infant Health Equity · Catalyst for Infant Health Equity · None of the above	42 (95.5)
How long has your site been engaging in systems-level/root causes work (in years)?	[open text]	34 (77.3)

Header	Statement	Answer Choices	N (% reporting)
Please rate the following statements when thinking about your site and its understanding of health equity work.	All staff members at our HS agree that we should move towards health equity work addressing root causes and systems-level factors	· *Strongly agree* · *Somewhat agree* · *Neither agree nor disagree* · *Somewhat disagree* · *Strongly disagree*	37 (84.1)
	We can communicate a clear, compelling case for focusing on root causes and systems-level work as it relates to our HS		37 (84.1)
	We are willing and able to commit to a plan to work		37 (84.1)

	towards root causes and systems-level work		
	We can articulate what measurable results are expected from engaging in health equity work		37 (84.1)
	We understand the implication of root causes and systems-level work on maternal and child health equity		37 (84.1)
Please rate the following statements when thinking about your site and its work related to root cause and systems-level work.	Our site has been prioritizing root cause and systems-level work for a long time	· *Strongly agree* · *Somewhat agree* · *Neither agree nor disagree* · *Somewhat disagree* · *Strongly disagree*	36 (81.8)
	We anticipate that our institution will collaborate with us to help our site reach our goals in doing this work		36 (81.8)
	We anticipate that our institution will pose challenges in reaching our goals in doing this work		37 (84.1)
Please rate the following statements when thinking about your site and its readiness to engage in systems-level work and work addressing root causes.	Overall, I believe we are well-positioned to make the shift towards root cause/systems-level work	· *Strongly agree* · *Somewhat agree* · *Neither agree nor disagree* · *Somewhat disagree* · *Strongly disagree*	37 (84.1)
	Our staff has the necessary skills to do this work		36 (81.8)
	We understand how to identify root causes		37 (84.1)
	We have sufficient representation of diverse local and community partners to support this work		37 (84.1)
	We can seek support from other HS sites who are also engaging in this work		37 (84.1)
	We can seek support from the NICHQ TA and Support Center (TASC) who can help us engage in this work		37 (84.1)
	We have adequate leadership in place to support this work		36 (81.8)
Question		**Answer Choices**	**N (% reporting)**

How does your current staff need to change, adapt, or grow in order to adequately engage in root causes / systems-level work?		[open text]	29 (65.9)

Header	Activity	Answer Choices	N (% reporting)
For your site, please rate the stage of implementation of the following health equity systems-level activities. If your site is implementing health equity systems-level activities that are not mentioned here, you may list them at the bottom under "Other."	Root cause analysis	· *Not yet using* · *Planning or starting to use* · *Actively using* · *Completed* · *Evaluating use of activity* · *Applying evaluation results to next steps*	36 (81.8)
	Training around health equity		38 (86.4)
	Activities related to social determinants of health		37 (84.1)
	Community needs assessment		37 (84.1)
	Environmental scan		38 (86.4)
	Examining the structural determinants of health		37 (84.1)
	Changing internal policies		38 (86.4)
	Advocating for policies that affect the community		39 (88.6)
	Collecting data by race/ethnicity/zip code/other social indicator		38 (86.4)
	Analyzing data collected		38 (86.4)
	Other		2 (4.5)
Which groups would you say are actively collaborating on this activity? Check all that apply.	Root cause analysis	· HS program staff · CAN members · Families served by HS · Institutional staff · Community partners · Other	28 (63.6)
	Training around health equity		30 (68.2)
	Activities related to social determinants of health		32 (72.7)
	Community needs assessment		33 (75.0)
	Environmental scan		24 (54.5)
	Examining the structural determinants of health		32 (72.7)
	Changing internal policies		28 (63.6)
	Advocating for policies that affect the community		31 (70.5)
	Collecting data by race/ethnicity/zip code/other social indicator		32 (72.7)
	Analyzing data collected		30 (68.2)

	Other		1 (2.3)

Question	Answer Choices	N (% reporting)
What other groups have been involved in your equity work?	[open text]	2 (4.5)
How active is your CAN currently?	· *Not at all active* · *A little active* · *Somewhat active* · *Moderately active* · *Extremely active*	32 (72.7)
Are there multi-sectoral collaborations in your CAN?	· Yes · No	31 (70.5)

Question	Activity	Answer Choices	N (% reporting)
Please explain how the CAN has been involved in equity and/or health equity activities your site is either engaging in, considering, or has completed in the last 12 months.			
Is this connected to the CAN?	Root cause analysis	· Yes · No	28 (63.6)
	Training around health equity		30 (68.2)
	Activities related to social determinants of health		31 (70.5)
	Community needs assessment		32 (72.7)
	Environmental scan		25 (56.8)
	Examining the structural determinants of health		31 (70.5)
	Changing internal policies		30 (68.2)
	Advocating for policies that affect the community		31 (70.5)
	Collecting data by race/ethnicity/zip code/other social indicator		32 (72.7)
	Analyzing data collected		28 (63.6)
	Other		1 (2.3)
What is the level of engagement of the CAN?	Root cause analysis	· High · Medium · Low	27 (61.4)
	Training around health equity		28 (63.6)
	Activities related to social determinants of health		32 (72.7)

	Community needs assessment		30 (68.2)
	Environmental scan		20 (45.5)
	Examining the structural determinants of health		31 (70.5)
	Changing internal policies		23 (52.3)
	Advocating for policies that affect the community		27 (61.4)
	Collecting data by race/ethnicity/zip code/other social indicator		27 (61.4)
	Analyzing data collected		26 (59.1)
	Other		1 (2.3)
How often do you feel the CAN program staff are actively collaborating on this activity?	Root cause analysis	· *Never* · *Rarely* · *Occasionally* · *Most of the time* · *All the time*	27 (61.4)
	Training around health equity		28 (63.6)
	Activities related to social determinants of health		31 (70.5)
	Community needs assessment		31 (70.5)
	Environmental scan		21 (47.7)
	Examining the structural determinants of health		31 (70.5)
	Changing internal policies		25 (56.8)
	Advocating for policies that affect the community		28 (63.6)
	Collecting data by race/ethnicity/zip code/other social indicator		29 (65.9)
	Analyzing data collected		29 (65.9)
	Other		1 (2.3)

Question	**Answer Choices**	**N (% reporting)**
To what extent is health equity/root causes/systems-level work a focus of collaborations with your CAN?	· *Not at all* · *Very little* · *Somewhat* · *To a great extent*	35 (79.5)
What do you feel are the most important data elements for your site to collect in order to assess whether your actions are making an impact?	[open text]	27 (61.4)

What are some successes in the health equity work you have engaged in?	[open text]	27 (61.4)
What are some challenges you have encountered in the health equity work you have engaged in?	[open text]	29 (65.9)
What has been unexpected about the health equity work you have engaged in?	[open text]	23 (52.3)
What would be your priority for funding given to support this work?	[open text]	27 (61.4)
What local or state policies should be prioritized in order to better support this work?	[open text]	25 (56.8)
Is there a story of a client within the last year that you believe is a good example of what should be considered when doing health equity work?	[open text]	23 (52.3)
If the value of doing this work is not shared across your site and/or institution/fiduciary, what do you see as the barriers to achieving that?	[open text]	9 (20.5)
In your view, which of the following Healthy People 2030 domains has your site primarily been focusing on for the last month?	· Economic Stability (includes goals targeting employment, housing costs, food insecurity, and work-related injuries) · Education Access and Quality (includes goals targeting high school graduation rates, early education and intervention programs, and math and reading skills) · Health Care Access and Quality (includes goals targeting preventive health screenings, substance use treatment, health insurance, and sexual and reproductive health care) · Neighborhood and Built Environment (include goals targeting environmental health risks, housing quality, injury prevention, and transportation) · Social and Community Context (includes goals targeting social support at home, work, and in the community)	29 (65.9)
How did you go about choosing that HP 2030 domain as your primary focus?	[open text]	25 (56.8)

Moving forward, what types of training and technical assistance would be helpful to support your HS site's social and structural health equity work? (select all that apply)	· Topical webinars for all grantees · Small cross-project learning opportunities (e.g., cohort, networking cafe, community of practice) · Training / workshops for one or a few HS projects · 1:1 technical assistance · Conference or training scholarship for individual HS staff · Other	29 (65.9)
What topics would you like to see covered in future training and technical assistance to support your site's social and structural health equity work?	[open text]	22 (50.0)
Which audience(s) do you think would most benefit from training and technical assistance on social and structural health equity? (select all that apply)	· HS site leadership · HS frontline staff · CAN members · HS consumers · Other · Other · Other	29 (65.9)