

Leveraging HOPE

A Community of Practice for
Identifying and Leveraging
Health Equity Indicators



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Dear Colleagues,

The COVID-19 pandemic revealed many challenges and opportunities for public health and healthcare systems. Among these are our capacity to identify and apply data and information about the social determinants of health and about the effects of structural racism, historic and contemporary. The disproportionate burden of exposure, disease and deaths borne by communities of color demands innovative action now.

This publication describes such an innovative approach to adapting an equity-centered health database, [Health Opportunity and Equity \(HOPE\) Initiative](#), for use by local community leaders. With generous support from the John D. and Catherine T. MacArthur Foundation, the National Collaborative for Health Equity (NCHE) facilitated a year-long community of practice for the purpose of learning from and with these communities about ways to adapt our national equity-centered data index to support local health equity and racial justice efforts.

NCHE has a long history of leveraging data to create authentic and compelling narratives about the lived experiences of communities of color. Our national network, Collaboratives for Health Equity (CHE), and in 2012 the related [Community Health Equity Reports](#), offered groundbreaking insights about the gaps in life expectancy based on residential segregation and denied opportunity for healthy living. While life expectancy is an established indicator of health outcomes, the conditions that predispose individuals to short and long life expectancies are nuanced and require examination. For example, air quality, specifically pollution levels and particulate matter, was documented to correlate with levels of COVID-19 cases in some urban areas. Coronavirus patients in areas that had high levels of air pollution before the pandemic were more likely to die from the infection than patients in cleaner parts of the country according to a [nationwide study](#) that offered the first clear link between long-term exposure to pollution and [COVID-19 death rates \(New York Times Article\)](#).



Launched in 2018 with funding from the Robert Wood Johnson Foundation, the interactive HOPE data initiative website was available before COVID as a resource to be used to raise expectations and drive actions that result in fewer health inequities. Using an opportunity framework rather than a deficit one, HOPE data identifies where residents of individual states and the country are doing well and where states can do more to help residents be healthier. In doing so, HOPE calculates three important factors that help state and federal leaders, advocates, and other stakeholders shape policies and practices:

- 1.** where the gaps in opportunity are among people of different races and ethnicities;
- 2.** what goals for achieving equity look like; and
- 3.** how far they need to move the dial to make these goals a reality.

The HOPE Initiative knows it is no accident that communities of color have been hit the hardest by the devastation of COVID-19. Across the country, these are the same groups facing steep systemic barriers to basic opportunities—from a livable income, affordable housing and food security, to access to neighborhoods that are safe and thriving. Left unchecked, disasters like the pandemic only make existing disparities worse.

The disproportionate burden of exposure, disease and deaths borne by communities of color demands innovative action now.

While the HOPE data tools are valuable resources for policymakers at the national, state, and county level of governance, NCHE has learned that policymakers need to work in collaboration with leaders of local communities who are experiencing the realities of inequity on a day-to-day basis. The Leveraging HOPE Community of Practice provided insights about how to use data more effectively to foster and support these needed collaborations. Some of our initial data-related insights are:

- 1.** In addition to using the readily available HOPE domain measures, Leveraging HOPE organizations were able to access substate data in four commonly used public datasets (see Table 4). Many organizations also utilized data collected locally (i.e., not part of a national survey) in their work.
- 2.** One promising solution to the challenge of data collection at substate geographies is a statical estimation of substate values from existing data. A good example of this is PLACES2, a collaboration between the CDC, Robert Wood Johnson Foundation, and the CDC Foundation, which provides community estimates of 29 health measures at multiple substate geographies (counties, census tracts and ZCTAs) across the United States. PLACES data are computed using the data from the Behavioral Risk Factor Surveillance System (BRFSS), which is typically only available at the state level.
- 3.** When the data is not broken down by population subgroups (e.g., race, ethnicity, poverty and education), direct computation of distance to goals is not possible. However, the approach used for area-based measures in the state-level HOPE Initiative can be an effective substitute. In the area-based approach, the distribution of subgroups in areas (e.g., tracts, ZCTAs) that did not meet the HOPE goal are used as a substitute for direct measurement of the distance to goal among subgroups. This results in a slight change in interpretation, but it still allows important comparisons among population subgroups. Instead of quantifying the number of persons not meeting a HOPE goal, the area-based distance to goal will identify the number of persons living in an area that do not meet the HOPE goal.

NCHE staff and consultants deeply appreciate the commitment and determination of the participating community leaders. We look forward to expanding these efforts and continuing to both learn and demonstrate how and why racial and ethnic data are critical tools for achieving health equity.

Sincerely,



A handwritten signature in black ink that reads "Gail C. Christopher". The signature is fluid and cursive.

Gail C. Christopher
Executive Director
National Collaborative for Health Equity

Introduction

The following report describes Leveraging HOPE by the National Collaborative for Health Equity, particularly its work in 2022 with a Community of Practice.

Part 1 of this report is a summary from the technical assistance provided by Virginia Commonwealth University's Center on Society and Health to organizations who made up the Community of Practice in order to assist them in selecting appropriate data and adapting the "distance to goal" concept to their local work.

Part 2 consists of key points from narratives prepared by the organizations that participated in the Community of Practice.



Leveraging HOPE: Promoting Health and Racial Equity in Local Communities

Abstract

Leveraging HOPE by the National Collaborative for Health Equity (NCHE) aimed to advance health equity following the challenges brought on by COVID-19 by highlighting the systemic barriers to having a fair or just opportunity to be healthy faced by people of color. The project, funded by the MacArthur Foundation in 2022, represents the next phase in the Health Opportunity and Equity (HOPE) Initiative, using the HOPE database and framing as a catalyst for increasing policy and practice changes in 10 local jurisdictions to promote health and racial equity in communities disproportionately harmed by the

effects of the COVID-19 pandemic. The goals were to develop a collaborative regional strategy that leverages state and local capabilities and to apply and update existing HOPE data resources to local priorities. In the process, we identified challenges related to data availability that necessitated modifications to the original HOPE methods when applying the standard HOPE Initiative approach at substate geographies. We discuss the data challenges faced by community equity initiatives and make recommendations for the availability, accessibility and scope of data that can inform local advocacy and policy work.

Health Equity

Every person living in the U.S., no matter what their background, where they are from, or where they live, should have equal opportunities for good health and well-being. We know from research that this is not what is currently happening in America, but it does not have to be that way. What drives health is more about the resources we have access to and the conditions in our neighborhoods, and less about medical care. Health behaviors like exercise and diet matter a lot, but our behaviors and even our ability to get quality health care depend on the opportunities and resources we can access. The good news is that we can create better opportunities for all Americans—especially for the most vulnerable among us—by advancing health equity.

“Health equity” means that everyone has a fair and just opportunity to be as healthy as possible. It requires working to reduce and eliminate the root causes, and the profound effects of poverty, discrimination and other perils to health and well-being. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants. Information, in the form of health equity data, is vital to the work of achieving better health and creating conditions that determine the opportunity to be healthy.





The Health Opportunity and Equity (HOPE) Initiative

The National Collaborative for Health Equity (NCHE) was founded in 2014 to promote health equity through action, leadership, inclusion and collaboration by developing leaders, harnessing data and catalyzing partnerships across different sectors that share responsibility for creating a more equitable and just society. In alignment with this mission, NCHE began the Robert Wood Johnson-funded HOPE Initiative in 2018 in collaboration with Texas Health Institute and Virginia Commonwealth University's Center on Society and Health (CSH). The HOPE Initiative provided an interactive data tool designed to help states and the country move beyond measuring disparities to spurring action toward health equity.

The HOPE Initiative uses an opportunity frame to shift the narrative from deficits and disparities to building opportunities for all.

The HOPE Initiative's approach stands out from other population health measures because:

- Equity has been its vision and focus from its inception.
- It uses an opportunity frame to shift the narrative from deficits and disparities to building opportunities for all.
- HOPE goals are aspirational reference points based on what leading states have achieved, which helps states see what's possible.
- Distance to Goal quantifies the number of people overall and by population subgroups (race and ethnicity, poverty and education) whose health or opportunity would need to improve to meet the HOPE Goal.
 - *For example, 2,044,691 Ohio adults would need to live in households with a livable income to meet the HOPE goal (88%). Black adults in Ohio face the greatest challenges in being able to own homes and earn a livable income. They are also least likely to live in opportunity-rich areas with low rates of poverty, homicide and robbery.*

The HOPE Initiative dataset's 24 state-level indicators measure items across five domains:

1 Health Outcomes capture the overall physical and mental health of a population across the life cycle. These indicators measure the presence or absence of health and wellness, as well as mortality.

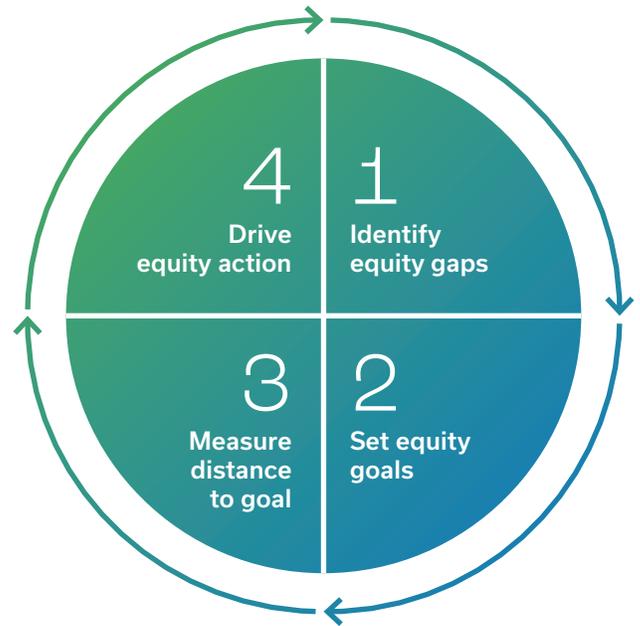
2 Social and Economic Factors reflect systemic circumstances that promote or constrain opportunities to enjoy good health. These indicators broadly measure financial, educational and occupational conditions influencing the standard of health people and households can achieve.

3 Community and Safety Factors include elements of one's social surroundings with implications for health, such as living in an environment without concentrated poverty or violence. Differences in social conditions between groups often reflect historical practices or policies that privilege certain groups of people over others.

4 Physical Environment reflects the health opportunities embedded in people's physical surroundings such as food security and housing quality. These indicators are meant to capture the physical conditions that either promote or discourage health and wellbeing in the places where people live, work, play and perform activities of daily living.

5 Access to Health Care indicators measure the extent to which people can engage with clinical services when needed. Accessible and affordable health care are essential to protect people's opportunities to maintain the highest possible standard of health across the lifespan.

HEALTH OPPORTUNITY AND EQUITY (HOPE) APPROACH



These measures demonstrate how well the 50 states and D.C. are providing equitable opportunities to thrive and achieve good health.

HOPE data can help drive equity action by:

- Showing where states are faring well, and where they are not, as a means of prioritizing investment,
- Illuminating where "bright spots" exist across states that are achieving both good outcomes and have narrowed inequities, and
- Encouraging folks to identify what policies, programs and conditions have enabled these states to close equity gaps.

Learn more about the HOPE Initiative at www.hopeinitiative.org.

Leveraging HOPE

The COVID-19 pandemic disparities in morbidity and mortality clarified the urgency for creating health equity by highlighting how many people of color face systemic barriers to having a fair or just opportunity to be healthy. Funded by the MacArthur Foundation, NCHE launched Leveraging HOPE, which sought to use the HOPE Initiative data and approach as a catalyst for increasing local policy and practice changes in 10 local jurisdictions that will promote health and racial equity in communities disproportionately harmed by the effects of the COVID-19 pandemic. The goals were to develop a collaborative regional strategy that leverages state and local capabilities along with federal dollars

that are being made available to health agencies and local organizations, and to apply and update existing HOPE data resources to meet local priorities.

Leveraging HOPE was led by NCHE, with key program staff Executive Director, Gail C. Christopher, D.N.; Deputy Director for Programs and Strategies, Luz E. Benitez Delgado; and Program Associate, Bethlihem Gebremedhin. The Center on Society and Health provided project support as a thought partner and technical consultant, with key staff Derek Chapman PhD, Diane Bishop, MPH and Emily Zimmerman, PhD, MPH.

Using Data to Address Equity at the Local Level

Leveraging HOPE worked with 10 organizations addressing equity at the state, county and local levels. These organizations represent on-the-ground efforts to inform, train, mobilize and equip communities to address challenges; including environmental justice, racial equity, education, health, housing, safety and many other critical issues. Their approaches inform local action through data, conversations, advocacy, youth engagement, leadership and policy action. A description of each partner's Leveraging HOPE work is provided in Table 1 and organizational reports are highlighted in Part 2 of this report (see p. 26).

Organizations participating in Leveraging HOPE included:

- Equity Matters (Baltimore, MD)
- Louisiana Center for Health Equity (Baton Rouge, LA)
- Partnership for the Public Good (Buffalo, NY)
- Collaborative for Health Equity Cook County (Chicago, IL)
- Center for Achieving Equity (Cleveland, OH)
- Health Equity Solutions (Hartford, Connecticut)
- One Love Global (Lansing, MI)
- LatinX Racial Equity (Oakland, CA)
- Neshoba Youth Coalition (Philadelphia, MS)
- Selma Center for Non-Violence, Truth and Reconciliation (Selma, AL)

These organizations used HOPE data and adapted the HOPE Initiative's approach to meet organizational objectives as well as addressing specific inequities highlighted or created by the COVID-19 pandemic. To achieve this, many organizations utilized the HOPE indicators and distance to goal measure (see Example 1 and Example 2).

Example 1

Health Equity Solutions (HES), Hartford, CT. Health Equity Solutions promotes policies, programs and practices that result in equitable health care access, delivery and outcomes for all people in Connecticut. To achieve these goals, HES organizes coalitions, engages in outreach and education (with community, policymakers and health care professionals) and advocates for policy changes. HES conducts listening sessions and workshops to learn about the health equity priorities of people across the state, vet policy solutions and build coalitions around priority issues. HES leveraged the HOPE opportunity database to provide framing for a series of conversations with community members about their health equity priorities. The data helped illustrate how health inequities impact the lives of people in Connecticut and how issues such as affordable housing impact health equity. Data were presented on premature death, livable income, poverty concentration and affordable housing metrics stratified by race and ethnicity to illustrate the wide-reaching consequences of systemic racism and their impact on health.

Example 2

Selma Center for Nonviolence, Truth and Reconciliation, Selma, AL.

The Selma Center for Nonviolence, Truth and Reconciliation was established to address violence and conflict by “bridging divides and building the Beloved Community.” This work requires educating communities about the factors impacting their health, supporting advocacy and partnering with leaders and decision-makers. Through Leveraging HOPE, the Selma Center focused on reaching the goal of low homicide rates, which is part of the HOPE domain of Community and Safety Factors. The Selma Center’s work recognizes the impact of community factors such as low income, limited access to education and residential segregation on individual outcomes; and the importance of community response (seeing positive aspects of the community, passing on local knowledge, supporting healing and growth and creating employment opportunities) while focusing on non-violence. Their work recognizes the power of pairing narrative and story to impact culture and culture change, and the importance of using data to tell a story and shift narratives.

Leveraging HOPE: Challenges and Lessons Learned

Applying HOPE to Substate Geographies

Three key aspects of the HOPE Initiative approach (equity centering, opportunity framing and setting aspirational goals) translated easily onto substate geographic levels (e.g., county, zip code, census tract). Some modifications to the original HOPE methods were needed to overcome challenges related to data availability, HOPE goal setting and computing distance to goals at substate geographies (see *Lessons Learned* sections below for more details).

DATA AVAILABILITY

Challenges. Of the 24 original HOPE Initiative measures, only half are readily available (e.g., regularly updated and publicly available without a restricted use license) and have data at the county, zip code tabulation area (ZCTA) and census tract levels (see Table 2). Table 3 lists the measures no substate data available (n=3), require a paid license (n=1), require a restricted use license (n=3), are computed and posted by an inter-university consortium that has not updated the data recently (n=4) or come in a raw data format that requires software to clean and compile (n=1). None of the datasets listed in Table 3 offer data at the census tract or ZCTA levels. When substate data are collected; data by race, ethnicity, educational attainment or poverty are typically suppressed due to privacy concerns. Many health outcomes relevant to the HOPE Initiative are derived from national survey data¹ collected by federal agencies. The primary geography of focus in these surveys is the state, with time and cost considerations

preventing the collection of sufficient data to allow substate reporting.

Lessons Learned. In Leveraging HOPE, we recognized the value of focusing the work on measures that were readily available and updated annually. Local organizations participating in Leveraging HOPE prioritized making the data actionable and did not want to spend months negotiating data sharing agreements or conducting complex data cleaning and processing. They wanted data that could be updated and measured over time to assess progress towards goals.

In addition to using the readily available HOPE measures listed in Table 2, Leveraging HOPE organizations were able to access substate data in four commonly used public datasets (see Table 4). Many organizations also utilized data collected locally (i.e., not part of a national survey) in their work.

One promising solution to the challenge of data collection at substate geographies is static estimation of substate values from existing data. A good example of this is PLACES², a collaboration between the CDC, Robert Wood Johnson Foundation, and the CDC Foundation, which provides community estimates of 29 health measures at multiple substate geographies (counties, census tracts and ZCTAs) across the United States. PLACES data are computed using the data from the Behavioral Risk Factor Surveillance System (BRFSS), which is typically only available at the state level.

1 e.g., Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment and Monitoring System (PRAMS), National Health Interview Survey (NHIS), National Survey of Children's Health (NSCH)

2 <https://www.cdc.gov/places/index.html>

HOPE GOAL SETTING

Challenges. Whenever possible³, the original HOPE Initiative goals were chosen based on the best outcomes achieved among population subgroups (race, ethnicity and education) in the top five states. However, due to their smaller numbers, especially when disaggregated into population subgroups, substate geographies often yield unstable rates (e.g., large confidence limits) and many suppressed values and data outliers (e.g., clusters of extremely large or small values). These data quality issues can be more pronounced in smaller geographies like census tracts that tend to be more homogeneous with respect to sociodemographic characteristics. Although aspirational goals are part the HOPE approach, setting them based on extreme values or unreliable data is discouraged.

Lessons Learned. Because of the challenges with data availability, data reliability and suppression described in the *Challenges* section above; setting HOPE goals at all substate geographies using overall county rates (i.e., not disaggregated by population subgroups) was our preferred method. In other words, a county-level goal was set as the average of the five best performing counties on a measure in a given state. This same goal served as tract and ZCTA-level goals in that state to ensure that the goal was aspirational but also based on sufficient data. When using measures that were part of the original HOPE Initiative, some participating organizations opted to use the state-level goal as their local HOPE goal.

COMPUTING DISTANCE TO GOALS

Challenges. Even when substate data are available by population subgroups, there may be insufficient data to directly compute distance to goals for all groups (e.g., race and ethnicity, poverty and education), especially for less common measures. For example, the overall U.S. infant mortality rate in 2019 was 10.6 deaths per 1,000 live births for non-Hispanic Black women.⁴ This means that to have 20 infant deaths in the numerator, often a threshold for data suppression, you would need to have at least 1,887 live births to non-Hispanic Black women. Because many neighborhoods are highly segregated, racial and ethnic minorities frequently do not have sufficient population counts to compute reliable rates. In 2019, one-third (n=1,034) of the 3,142 counties in the U.S. had a non-Hispanic White population of 90% or higher. Population proportions were <10% in three fourths of counties for both non-Latino/a Black and Latino/a groups. Asian (n=3,089), Native American or Alaska Native (n=3,020), and Native Hawaiian or Pacific Islander (n=3,140) populations were <10% in nearly all counties.

The total population size of counties varies widely in the U.S., ranging from 10 million in Los Angeles County, CA to 315 counties with total population less than 5,000. The impact of small numbers will vary accordingly. Census tracts, on the other hand, typically range from 1,200 and 8,000 persons with an optimal size of 4,000.⁵ The smaller population in census tracts; coupled with the residential segregation by race, ethnicity and income that is common across the U.S.; make the computation of reliable (and

3 Community and safety measures, access to primary and psychiatric care, liquor store density and food security were area-based measures that did not have breakdowns by population subgroup

4 Source: CDC; <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>

5 Source: U.S. Census Bureau; https://www.census.gov/programs-surveys/geography/about/glossary.html#par_textimage_13

unsuppressed) rates difficult outside of densely populated cities and for any population group that is not in the majority in a given tract.

Zip Code Tabulation Areas (ZCTAs) are the U.S. Census Bureau's approximations of U.S. Postal Service ZIP codes. ZCTAs have more variation in size than census tracts, but average 9,987 persons and have similar data challenges to tracts when computing rates by population subgroups. Using a geographic relationship file⁶; data at the ZCTA, census tract and county levels can be also aggregated into the much larger 435 U.S. Congressional Districts which have an average population of 763,000 persons.

Lessons Learned. The framing of health inequities as distance to goal is important, as it represents the opportunity component of the HOPE Initiative. In some cases, most commonly when working with county-level socioeconomic measures from the U.S. Census Bureau, distance to goals can be computed directly by population subgroups. Table 5 shows an example of distance to goal computations by race and ethnicity in Alameda County, California. The HOPE goal used was the average rate in the top five counties in California (79%). In this example, Latina/os had the lowest rate of post-secondary education as well as the largest distance to goal – 77,898 Latina/o adults in Alameda County would have to attain post-secondary education to meet the HOPE goal of 79%.

When the data aren't broken down by population subgroups (e.g., race, ethnicity, poverty and education), direct computation of distance to goals is not possible. However, the approach used for area-based measures in the state-level HOPE Initiative can be an effective

substitute. In the area-based approach, the distribution of subgroups in areas (e.g., tracts, ZCTAs) that did not meet the HOPE goal are used as a substitute for direct measurement of the distance to goal among subgroups. This results in a slight change in interpretation, but it still allows important comparisons among population subgroups. Instead of quantifying the number of persons not meeting a HOPE goal, the area-based distance to goal will identify the number of persons living *in an area* that do not meet the HOPE goal.

The area-based distance to goal method can be used with any measure. While substate data are often unavailable by population subgroups, we do know the characteristics of who lives in each of those substate areas. The U.S. Census Bureau's American Community Survey (ACS) provides data on population subgroups⁷ at the county, tract and ZCTA levels that can be used for distance to goal calculations. A simple example of an area-based approach to a distance to goal computation is shown in Table 6. In this example, census tracts in the East End neighborhood of Richmond, Virginia that failed to meet the HOPE goal (diabetes rate of 8% or less) had predominantly non-Hispanic Black residents, resulting in the largest distance to goal (n=11,389). This means that 11,389 non-Hispanic Black residents in the East End of Richmond, Virginia would need to live in a census tract with low diabetes rates to meet the HOPE goal. Advocates could use these data in many ways, including working with local food banks to address food insecurity, partnering with local health systems to increase access to screening and treatment for diabetes, connecting residents with their local YMCA or seeking policy changes that increase access to healthy food options and exercise opportunities.

6 Missouri Census Data Center: <https://mcdc.missouri.edu/applications/geocorr.html>

7 Commonly used data include race and ethnicity (ACS table DP05), foreign born population (ACS table B05002), English proficiency (ACS table S1602), poverty (ACS table S1701), and education (ACS table C15002).

Leveraging HOPE: Recommendations

As described in a recent Robert Wood Johnson Foundation report⁸, there is much work to be done to transform public health data systems to be centered on equity. One recommendation made in the report describes actions necessary to create a data system that shifts “the narrative to one that is just, positively oriented and equity-based (e.g., from deficit to strengths, from oppressive to restorative)”, which aligns with the HOPE approach. The creation of a system that calls for the collection of data to a more local, granular level, including the availability of both aggregated and disaggregated formats is ideal and aligns with the HOPE mission and goals as well as this report’s recommendations. However, the timeline for this to come to fruition would likely be long as it requires the buy-in, coordination and collaboration of many stakeholders across multiple sectors. Thus, an intermediate step is necessary to help address the need for data today that aligns with the HOPE approach and our recommendations.

We propose the following to address access barriers to local, disaggregated data:

1 Increase data accessibility. Local health equity work would benefit from more accessible existing data sources. Ideally, a “local HOPE” website would provide access to a set of pre-computed HOPE measures at common substate geographies. This would provide a more streamlined approach to accessing data where information is compiled and the methodologies and data caveats are clear. However, given the wide range of topics, geographic areas covered and data challenges in Leveraging HOPE, it may not be feasible to pre-compute all locally relevant topics and geographies. Instead, we recommend that existing data providers (including data sources shown in Table 2) make it easier to view and export data by population subgroups. Removing the need to work with raw data tables or to compute your own rates will greatly facilitate the ease and accuracy of HOPE goal and distance to goal calculations.

2 Collect and report more granular data. More data sources need to collect data by sociodemographic subgroups (e.g., race, ethnicity, income, education) and at substate geographies. Ideally, data would be geocoded at the census tract level based on place of residence so that measures could be aggregated to the ZCTA and county levels. When data collection at substate geographies is not possible, statistical estimation of those data can be an effective substitute.

⁸ Christopher, G. C., Zimmerman, E. B., Chandra, A., and Martin, L. T. (Eds.) (October 2021). Charting a Course for an Equity-Centered Data System: Recommendations from the National Commission to Transform Public Health Data Systems. <https://www.rwjf.org/en/library/research/2021/10/charting-a-course-for-an-equity-centered-data-system.html>

3 Review data suppression criteria in publicly available datasets. Data suppression is important to protect confidentiality. However, data privacy can be conflated with data reliability concerns, resulting in unnecessarily strict suppression criteria. Reliability of data can be addressed without suppression by providing confidence intervals—data suppression criteria should focus on privacy only. In cases where laws or agency policies require a certain degree of suppression, allowing users to request data aggregated by years, geography or subgroups would reduce the amount of suppressed data. Allowing users to create their own meaningful aggregations until suppression criteria are met (e.g., requesting a 3- or 5-year aggregate or aggregating data into congressional districts) will dramatically increase access to local HOPE measures.

4 Use the HOPE approach with existing data sources. This report identified HOPE Initiative indicators that are readily available by population subgroups at multiple local geographies (see Table 2). But as shown above, even when data disaggregated by population subgroups are not available, HOPE goals and distance to goals can be computed using an area-based method. And one does not need to be limited to the 24 measures on the state-level HOPE Initiative website. Table 4 lists four publicly available data sources that provide a wealth of measures at the substate level which could be used for local HOPE projects.



Conclusion

Throughout 2022, NCHE and VCU's Center on Society and Health met regularly with ten health equity and social justice organizations working at the local, county and state levels to address historic and pandemic-related systemic barriers to health. In these meetings, local organizations became familiar with the HOPE Initiative and approach and shared their work with the Leveraging HOPE cohort. The organizations received support and technical assistance for using HOPE and other data sources to pair data with the narratives needed to further their work. The organizations served as thought partners for how to apply data to community action.

This process confirmed the utility of the HOPE Initiative approach (equity centering, opportunity framing and setting aspirational goals) and how it is easily translated for smaller geographic areas. It also identified challenges related to data availability, HOPE goal setting and computing distance to goals that necessitated modifications to the original HOPE methods when applying the standard HOPE Initiative approach at substate geographies. We found that only half of the 24 original HOPE Initiative measures are readily available at the county, zip code tabulation area (ZCTA) and census tract levels. Furthermore, breakdowns by race, ethnicity, educational attainment and poverty are rarely available in publicly available datasets at the substate level or have suppressed data due to low counts, impeding the direct computation of the HOPE distance to goal measure. Local organizations participating in Leveraging HOPE prioritized making the data actionable and wanted data that could be updated and measured over time to assess progress towards

goals. In addition to the readily available HOPE measures, many organizations utilized local datasets in their work.

Although multiple challenges regarding data availability, data reliability and suppression made the process of setting HOPE goals at all substate geographies less straightforward than state-level data, we identified various workarounds to help local organizations adopt the HOPE domains and approach. For example, when subgroup data were not available for distance to goal calculations by population subgroups, we found that the approach used for area-based measures in the state-level HOPE Initiative can be an effective substitute. In the area-based approach, the distribution of subgroups in areas (e.g., tracts, ZCTAs) that did not meet the HOPE goal are used as a substitute for direct measurement of the distance to goal among subgroups. This results in a slight change in interpretation, but it still allows important comparisons among population subgroups. So, instead of quantifying the number of persons not meeting a HOPE goal, the area-based distance to goal will identify the number of persons living in an area that does not meet the HOPE goal.

Leveraging HOPE provided a meaningful Community of Practice for 10 equity-focused organizations, supported by the National Collaborative for Health Equity and the VCU Center on Society and Health. Through this process we learned not only about how to apply the data to local health equity work, but also about the inspired and diverse approaches to this work at the community level.

TABLE 1

Leveraging HOPE Local Site Descriptions

Organization Focus	Focus Areas	Strategic Initiative	Levers of Change	Data Needs	Data Sources
Equity Matters (Baltimore, MD)	Serving: statewide <ul style="list-style-type: none"> Equity and networks Racial equity Social and economic Health outcomes Community safety and physical environment 	Contact: Michael Scott <ul style="list-style-type: none"> Equity Leverage Framework Tools for changing complex adaptive systems 	<ul style="list-style-type: none"> Raise awareness among various stakeholder populations through events with community organizations, government and elected officials and declare racism a public health crisis in central Maryland in multiple jurisdictions. 	<ul style="list-style-type: none"> Life expectancy A sensemaking database to have agile and community organizing and relevant actionable intelligence Housing 	<ul style="list-style-type: none"> Data that disrupts normal data narratives, and presumptions, and cultures (actual lived experience of community belonging and public safety) Disintermediation of experts
Louisiana Center for Health Equity (Baton Rouge, LA)	Serving: statewide <ul style="list-style-type: none"> Health Social and economic factors Community and safety Physical environment 	Serving: statewide <ul style="list-style-type: none"> LA40by2030 (improve state ranking) 	Contact: Alma Stewart Allen <ul style="list-style-type: none"> Youth initiatives Task force for legislative recommendations on student behavior, mental health, discipline and other policy recommendations 	<ul style="list-style-type: none"> Data broken down by demographics Indicators for children, youth, and adolescents (high school graduation rates, children in poverty, concentrated disadvantage, ACEs, teen suicide, child mortality, juvenile violence, and homicide). 	<ul style="list-style-type: none"> America's Health Rankings Healthy People 2030 HOPE data
Partnership for the Public Good (Buffalo, NY)	Serving: Buffalo, NY <ul style="list-style-type: none"> Water equity 	Serving: Buffalo, NY <ul style="list-style-type: none"> Using publicly owned land for public benefit, increasing spending for foster care alumni, and creating a language access plan for governmental action, improving water equity for Buffalo residents, increasing tenant protections and incentivizing affordable housing in the suburbs 	Contact: Sarah Wootton <ul style="list-style-type: none"> Report titled, "Just Recovery: policy solutions for long-term COVID response and a more equitable future" Report on water shutoffs 	<ul style="list-style-type: none"> Municipal-level data City comparison tool Transportation access Affordable housing units 	<ul style="list-style-type: none"> American Community Survey Water shutoff data
Building a more just, sustainable, and culturally vibrant Buffalo Niagara through action-oriented research, policy development, and citizen engagement, together with our network of 325 partner organizations.					

Organization Focus	Focus Areas	Strategic Initiative	Levers of Change	Data Needs	Data Sources
Collaborative for Health Equity (Cook County–Chicago, IL) Working to change the maldistribution of money, power and resources that produce health inequities and gross injustice by raising awareness, advancing policy, and building power among oppressed populations and focusing on the root causes of health inequities that are at the structural level of society.	<ul style="list-style-type: none"> Environmental justice Adult health status Air quality 	<ul style="list-style-type: none"> Building coalitions to continue to work on environmental justice and other ongoing issues Workshop training for community activists and organizers 	<ul style="list-style-type: none"> Targeting inside and outside groups and public health officials with advocacy Social media Youth ambassadors 	<ul style="list-style-type: none"> Air quality Health data (life expectancy at birth, and maternal mortality) State and census tract level data 	<ul style="list-style-type: none"> Chicago Dept of Public Health air quality data/health status index Qualitative data
Center for Achieving Equity (Cuyahoga County, OH) Ensuring health implications and equity considerations are in the forefront as policy makers and others make decisions that substantially impact the residents of Cuyahoga County and the neighborhoods in which County residents live.	<ul style="list-style-type: none"> Social and economic Health 	<ul style="list-style-type: none"> Achieving equity for African American Women in Cuyahoga County 	<ul style="list-style-type: none"> Community health indicator report Facilitated community discussions Shared data Strategic planning 	<ul style="list-style-type: none"> Housing affordability and quality (e.g., lead) Foreclosure Chronic unemployment, underemployment African American leadership opportunities Access to culturally appropriate mental health support Black/brown small business opening and/or closures Educational attainment and earnings by ethnicity Car loans or repossessions or loan interest rates Number unbanked COVID cases or deaths by ethnicity and geographic location County level data 	<ul style="list-style-type: none"> HOPE data Federal Reserve Bank of Cleveland Institute for Women's Policy Research (Status of Black Women in the United States) College NOW
Health Equity Solutions (HES) (Hartford, CT) Promoting policies, programs, and practices that result in equitable health care access, delivery, and outcomes for all people in Connecticut. To achieve these goals, we organize coalitions, engage in outreach and education (with community, policymakers, and health care professionals), and advocate for policy changes.	<ul style="list-style-type: none"> Health Economic 	<ul style="list-style-type: none"> Strategic plan for health equity Engage community members to inform the plan and implementation (community conversations) 	<ul style="list-style-type: none"> Policy advocacy Community engagement Shared policy platform 	<ul style="list-style-type: none"> Local data disaggregated by race and ethnicity More complete and quality data on health outcomes Transparency and data democracy Publication of interactive and de-identified datasets Indicators that can be stratified by race and ethnicity and town level 	<ul style="list-style-type: none"> State data HOPE data

Organization Focus	Focus Areas	Strategic Initiative	Levers of Change	Data Needs	Data Sources
One Love Global (Lansing MI) Investing in youth organizing and community leadership development to build the individual and collective power needed to transform policies and practices.	Serving: Detroit, Lansing Community and safety	Contact: Angela Austin Build an infrastructure for civic engagement, digital organizing and grassroots advocacy	Transform Michigan podcast on Michigan Business Network with a series on the HOPE Indicators Racial equity scorecard/community presentations Racial Equity Accountability Process Lansing People's Assembly	Police shootings and homicides of civilians Environmental toxins like lead and PFAS Water affordability Gentrification Hate crimes Civic engagement (e.g., voter turnout, diversity in elected offices) Internet access Age as a drop-down category Ability to layer indicators across domains County and city-level data Ability to target specific areas for comparisons with state-level or other communities	HOPE data Local data (police, prosecutor's office)
LatinX Racial Equity Project (Oakland, CA) Tackling structural racism embedded in our society's systems by training and developing a robust network of Latinx leaders to drive policy and systems changes that end health and racial disparities.	Serving: state, some national Health status Economic factors Housing	Contact: Claudio Leon Train the Trainers – leaders across different sectors Racial healing and multiracial alliance through a framework of cultural resilience and decolonization	Training – equity driven leadership	Health disparities and other outcomes by race Standardization (ethnicity vs. race) Undocumented population -LatinX specific data (e.g., indigenous, Afro-descendent, mixed race) Agricultural workers Post-Covid data in Hope database Data by county and race	American Community Survey HOPE data CA Healthy Places Index
Neshoba Youth Coalition (Philadelphia, MS) Improving educational, health and economic opportunities for children and families in Mississippi by advancing racial equity and healing, leadership development and authentic community engagement that leads to positive and sustainable social change that improves the lives of vulnerable children and families.	Serving: Philadelphia, MS Social and economic factors	Contact: Leroy Clemons Reduce teen pregnancy, high school dropout and child poverty, while offering high-quality educational opportunities and eliminating structural racism	Empowering youth and communities of color to better understand and address the social determinants of health associated with teen childbearing, and implementing community-level interventions	County-level data	HOPE data Kids Count
Selma Center for Nonviolence, Truth & Reconciliation (Selma, AL) Transforming and healing the root causes of physical, political, psychological, environmental, economic, and racial violence at personal, family, community and systemic levels.	Serving: Dallas County Community and safety Homicide rates	Contact: Drew Glover Restorative justice as a form of violence reduction Violence Intervention Program (VIP)	Street Outreach Team and Victim Service Manager Development of dashboard to track progress	County-level data Employment Education trends Housing Homicide	HOPE data Local data

TABLE 2**HOPE Initiative Indicators Publicly Available¹ at County, ZCTA, and Census Tract Geographies**

HOPE Domain	HOPE Indicator	State-Level Data Source	Notes	Source Website
Health Outcomes	Adult Health Status	BRFSS ⁴ PLACES Data		www.cdc.gov/places/help/explore-data-portal/index.html
Social and Economic Factors	Affordable Housing	ACS ² Table S2503		data.census.gov/cedsci
	Employment	ACS ² Table C23002	Data also available by race (ACS Tables C27001A-C27001I)	
	Livable Income	ACS ² Table S1701		
	Post-Secondary Education	ACS ² Table C15002	Data also available by race (ACS Tables C15002A - C15002I)	
	Youth in School or Working	ACS ² Table B23001		
Physical Environment	Food Security	USDA ⁵ Food Access Research Atlas		www.ers.usda.gov/data-products/food-access-research-atlas
	Home Ownership	ACS ² Table DP04		data.census.gov/cedsci
	Low Liquor Store Density	U.S. Census County Business Patterns		www.census.gov/programs-surveys/cbp/data/datasets.html
Access to Health Care	Access to Primary Care	HRSA ² Area Health Resource File		data.hrsa.gov/topics/health-workforce/ahrf
	Access to Psychiatric Care			
	Health Insurance Coverage	ACS ³ Table C27001		data.census.gov/cedsci

1 Data available at county, Zip Code Tabulation Area (ZCTA), and census tract levels for totals only except where noted

2 Health Resources and Services Administration

3 American Community Survey

4 Behavioral Risk Factor Surveillance System

5 U.S. Department of Agriculture

TABLE 3

HOPE Initiative Indicators That are Not Readily Available at Substate Geographies

HOPE Domain	HOPE Indicator	State-Level Data Source	Notes	Source Website
Health Outcomes	Child Health Status	NSCH ¹	State data by population subgroups requires restricted data request. Substate data not available.	www.cdc.gov/nchs/slait/nsch.htm
	Infant Mortality Low Birthweight Premature Mortality	NVSS ²	State and county data available via restricted data request. Local data could potentially be obtained through state or local health departments.	www.cdc.gov/nchs/nvss/nvss-restricted-data.htm
Access to Health Care	Affordable Health Care Dedicated Health Care Provider	BRFSS ³	Substate data not available.	www.cdc.gov/brfss/data_documentation/index.htm
Physical Environment	Housing Quality	ACS-PUMS ⁴	Counties, cities, and metropolitan areas with populations >100,000 people available via raw data download; need software (e.g., SAS, SPSS, R, etc.) to compile and analyze.	www.census.gov/programs-surveys/acs/microdata/access.html
Community and Safety Factors	Low Poverty Concentration	Neighborhood Change Database	County and tract data available. Data license must be purchased.	geolytics.com/products/normalized-data/neighborhood-change-database
	Low Homicide Low Physical Assault Low Sexual Assault Low Robbery	FBI Uniform Crime Reporting (UCR) Program	County totals available (most recent are 2016 data released in 2019). Raw data download; need software (e.g., SAS, SPSS, R, etc.) to compile and analyze. Online analysis tool has data covering 1994-2001 only.	www.icpsr.umich.edu/web/pages/NACJD/guides/ucr.html#desc_cl

1 CDC National Survey of Children’s Health

2 CDC National Vital Statistics Surveillance System

3 CDC Behavioral Risk Factor Surveillance System

4 American Community Survey (ACS) Public Use Microdata Sample (PUMS)

TABLE 4**Commonly Used Public Datasets with Substate Data**

Data Source	Substate Geography	Website
American Community Survey (ACS)	County, tract, ZCTA ¹	data.census.gov
CDC PLACES	County, tract, ZCTA ¹	www.cdc.gov/places/index.html
CDC WONDER	County	wonder.cdc.gov
RWJF County Health Rankings and Roadmaps	County	www.countyhealthrankings.org

1 ZCTA = Zip Code Tabulation Area

TABLE 5

Direct Distance to Goal Computation Example: Post-Secondary Education by Race and Ethnicity in Alameda County California, 2016-2020

Racial and Ethnic Group	Numerator (n)	Denominator (n)	Rate (%)	HOPE Goal (%) ³	HOPE Goal (n) ⁴	Distance to Goal (n) ⁵
American Indian and Alaska Native	4,123	7,750	53.2	79.0	6,123	2,000
Asian alone	290,690	379,903	76.5	79.0	300,123	9,433
Black or African American alone	85,599	124,338	68.8	79.0	98,227	12,628
Hispanic or Latino	98,059	222,731	44.0	79.0	175,957	77,898
Native Hawaiian and Other Pacific Islander	5,031	9,760	51.5	79.0	7,710	2,679
Two or more races	49,005	65,765	74.5	79.0	51,954	2,949
White alone, not Hispanic or Latino	337,140	404,915	83.3	79.0	319,883	-17,257 (exceeded goal)

1 Number of persons 25 years and older with some college education

2 Total number of persons 25 years and older

3 HOPE goal (%) was set at 79% (the average of the top 5 counties in California for this measure)

4 Target number of persons needed to reach goal percentage = Denominator (n) x HOPE goal (%) x 100

5 HOPE Goal (n) - Numerator (n)

TABLE 6

Area-Based Distance to Goal Computation Example: Diabetes Prevalence in Census Tracts in the East End of Richmond, VA, 2019

Tract	Diabetes (%)	Met HOPE goal? (8%)	Non-Hispanic White (n)	Asian (n)	Non-Hispanic Black (n)	Two or More Races (n)	Hispanic or Latino (n)
201	21.7	No	48	5	1,528	42	38
202	22.6	No	69	2	3,248	95	73
203	21.5	No	360	27	1,205	95	80
204	20.6	No	252	9	3,940	98	98
206	8.7	No	1,261	48	319	79	87
207	19.5	No	538	26	889	69	76
208	8.6	No	1,203	49	260	96	85
Distance to Goal			3,731	166	11,389	574	537

2

Reports on the Work of Individual Leveraging HOPE Communities

The HOPE Data Project has an interactive website with data compiled for all of the states as well as national data around health equity indicators. The data is organized around five health equity domains with 27 indicators across the five domains. The innovation of this project is that it focuses on what it will take to achieve health equity, rather than focusing on inequities. It addresses what we need to do to solve complex problems in order to achieve health equity. Through the distance to goal concept, it helps groups determine the distance they have to reach their goal.

NCHE pulled together ten Leveraging HOPE communities to figure out how they might use the HOPE data and concepts underneath it to support local efforts to achieve health equity, including in response to COVID-19. NCHE

convened the communities once a month and they learned from each other about their priorities and approach to using the data in support of their work and progress. The main concept the communities worked with was the concept of distance to goal (the number of people overall and by population subgroups whose health or opportunity would need to improve to meet the HOPE Goal.)⁹ At these convenings, the Center for Society and Health at Virginia Commonwealth University offered technical assistance about how to find the data that would support the work they were doing and how to apply the distance to goal framework in their work.

Overall, the communities found the approach to using data – and in particular the distance to goal concept – extremely helpful. The

⁹ See Part 1, above, for more information about Distance to Goal and the overall project.

Louisiana Center for Health Equity (LCHE) (Baton Rouge, LA) described that distance to goal “can assist LCHE in developing policy recommendations that are supported by data. LCHE can, also, adapt this feature into our work by distinguishing the need within different communities and creating or adapting current programs to fit that need ... The distance to goal and correlational aspects to other states provides LCHE with tangible evidence to develop strategies and approaches for awareness campaigns, community engagement and policy advocacy.” Likewise, the Center for Achieving Equity (Cleveland, OH) describes that “the concept of distance to goal is a particularly advantageous element within the Leveraging HOPE approach.” The Neshoba Youth Coalition (Philadelphia, MS) said that, “in the fight for justice and equity, data is a critical tool. We will use the distance to goal concept to establish our performance benchmark indicators to chart our progress toward closing the health opportunity gap for the number of youths in school or working. We will also use the distance to goal concept to chart our continued progress in reducing teen pregnancy, low birthweight, premature and infant mortality, while also charting our efforts to increase access to affordable housing, food security, post-secondary educational opportunities, health insurance coverage and primary care. We will continue to document the facts and data collected from our work and translate that information for diverse audiences, apply it to real-world problems to find solutions and share it in accessible ways with policy makers, business and philanthropic leaders, advocates, practitioners and the youth and communities

most directly affected.” Partnership for the Public Good (Buffalo, NY) said that “this framing will help spur our local politicians into action as they will more easily be able to understand the progress that can be made.”

The main limitation the communities found was that the data in the HOPE Data Project is at a state and national level, while many communities needed more granular local, municipal and even neighborhood-level data to support their efforts. In Baltimore, they found that even county-level data wouldn’t be granular enough and that there are neighborhood-level differences in outcomes. In Hartford, CT, Health Equity Solutions described that, “Town-level data can be beneficial when working with municipal governments or state legislators who want to understand how a given issue impacts their constituents.” In Lansing, MI, One Love Global reported that, “County and city-level data would also be helpful. If we could target specific areas for comparison with state-level or other communities, that would further illustrate how separation exacerbates racial inequities.” Some were able to find reliable local data sources and used the Leveraging HOPE concepts to translate local data into distance to goal narratives that helped them define and communicate their work.

Many also described needing multiple domains and indicators to capture the complexity of working to achieve health equity. Communities suggested additional indicators (or even domains and supporting processes) that might be useful for the work going forward.

This appendix contains the reports about each of the communities' work in response to the following six questions:

1 Describe your organizational purpose related to advancing policy change, including any COVID equitable recovery responses.

2 Which policy area(s) did you decide to work with using the HOPE opportunity database?

3 What are your projected outcomes for the work you focused on for this project? Please specify outcomes for any specific population groups.

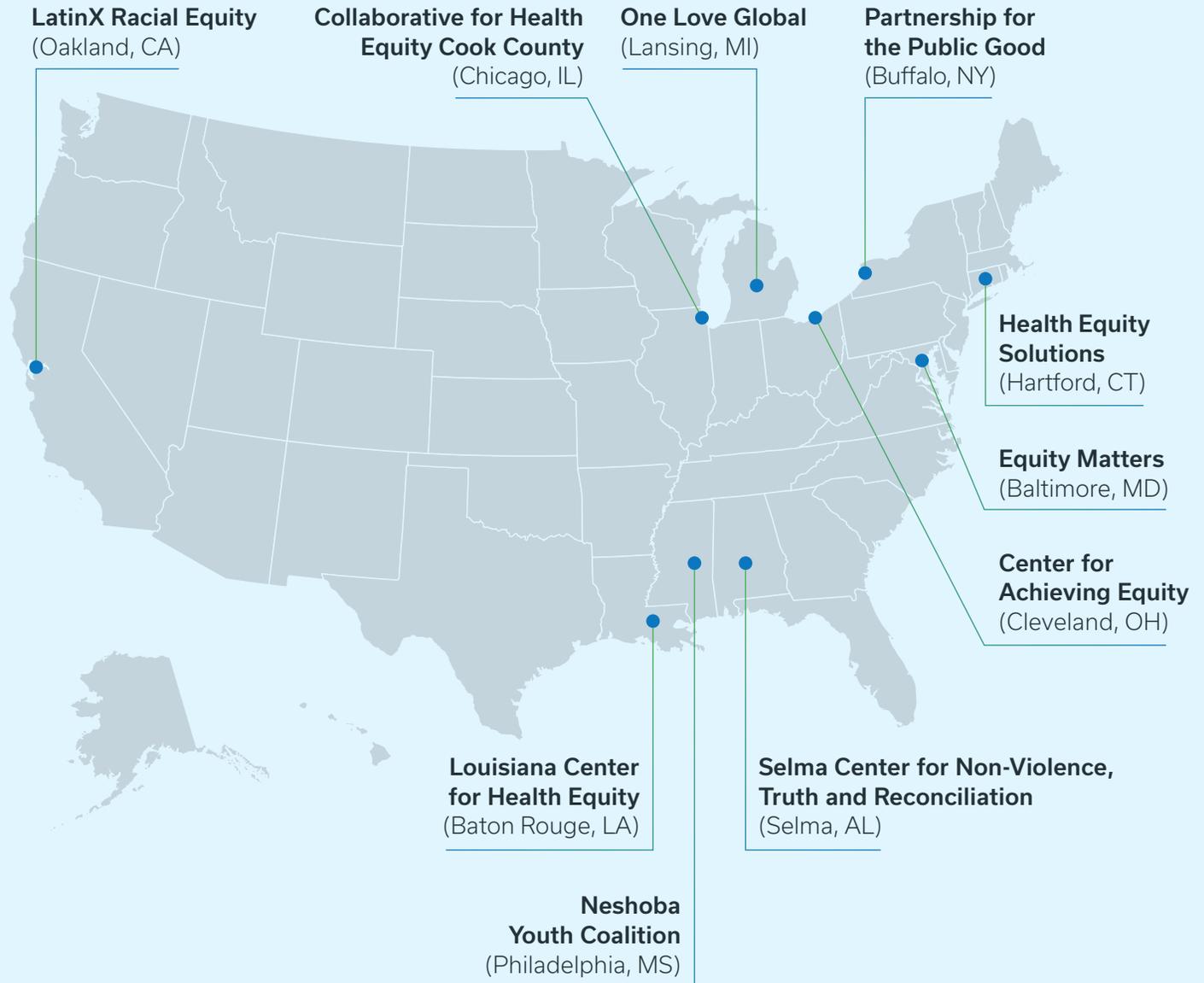
4 What HOPE domains and indicators were helpful and why?

5 What additional domains or indicators can be added that would be helpful and why?

6 Please describe how you will adapt the a concept in your local work.

More detail about the overall project and data available can be found in the main report, above.

Organizations Participating in Leveraging HOPE



Equity Matters (Baltimore, MD)

1 Describe your organizational purpose related to advancing policy change, including any COVID equitable recovery responses.

Equity Matters is a network of equity practice and equity practitioners. We apply network theory, systems thinking, complexity science and movement strategies to create equity in public policy. While some would say that the harmful effects of systems play out just as they were designed to, others (particularly those within the systems) presume that systems are designed to work for good and that people within those systems are at least trying to do good work. We work with movements and networks to combine systems thinking (realizing that systems always work to create homeostasis, so that interventions will have unintended consequences that bring them back to the status quo) with complexity science (using tools like the Cynefin Framework¹⁰ to ensure that strategies the community decides on are determined by understanding the complexity of the problem being addressed). We do this by working with movements to ensure that they have the predisposition of equity mindsets and tools which they combine with the appropriate choice of strategies to achieve the equity

outcomes they are seeking. Data and actionable intelligence can affect mindset, tools and strategy as we examine equity behavior. This allows us to produce community impacts and leadership that is bold and challenges identities and cultures from which policy and narratives flow (downstream).

2 Which policy area(s) did you decide to work with using the HOPE opportunity database?

We chose Social and Economic Factors and Health Outcomes. We have always thought that life expectancy and the co-morbidities and mortalities that underlie structural advantage and disadvantage are powerful organizing tools to highlight and mobilize around inequity.

Our community partners chose a broader set because the coalition is broad. Social and Economic Factors as well, in addition to Community and Safety, Physical Environment. We looked at those with an equity and social determinants lens who do health systems design and invited them into our circle work in case there was some longer-term alignment.

10 Snowden, D. J., and Boone, M. E. (2007). A Leader's Framework for Decision Making. *Harvard Business Review* (November). <https://hbr.org/2007/11/a-leaders-framework-for-decision-making>

When you look at the rankings across the country, it appears that Maryland is doing very well. We knew that in the aggregate this may be true, but that it is not true in local contexts. So, we needed to supplement the HOPE Data with some local and census tract data.

Howard County is one of the wealthiest counties in the country and is usually ranked first among all the counties in the state of Maryland. In 2021, Howard County was ranked as the eighth best county in the US in terms of health. It was ranked by *Money Magazine* in 2021 as one of the best places to live and as one of the best places to raise a family. Compared with Baltimore City and with Prince George's, Montgomery, and Rondo and Baltimore Counties, those who live in Howard County are doing pretty well. They have a high percentage of residents who have bachelor's degrees. The median household income is the highest in the state. And the annual unemployment rate is the lowest in the state. The assumption within Howard County was that everyone who lives here is doing okay. But this was not true for everyone who lives in the county.

Overall, Howard County has one of the highest life expectancies within the state of Maryland. But when we break the data down by race, we see that there are differences in terms of life expectancy between non-Hispanic white residents and non-Hispanic Black residents of Howard County. That difference is only second to Baltimore City, which is known to have some of the most significant issues within the state in terms of disparity and inequity in health outcomes. If we dig deeper into Howard County and look at the data by district, we see that there is a range of

differences in terms of life expectancy based on where you live. Looking within districts, you can see that the life expectancy is 82 years, but life expectancy varies depending on where you live within Howard County.

If we look at birth-related outcomes by race and ethnicity within the county, we see that there are racial differences in birth related. Non-Hispanic Blacks have higher rates of infant mortality and higher rates of low birth weight than non-Hispanic whites. Among the non-Hispanic Black and Hispanic populations within the county no prenatal care and you see 40% of non-Hispanic Blacks who give birth within the county have C-sections. C-sections increase the risk for having severe hemorrhage or post-delivery complications, which is one of the leading causes of maternal mortality.

In addition to the health data, we also looked at educational system data and indicators. In the Howard County public school system, 30% are non-Hispanic White, a quarter are non-Hispanic black, a quarter are Asian and about 12% are Hispanic. When you look at outcomes, you see discrepancies based on race. Non-Hispanic Black students are five times more likely to be suspended than non-Hispanic white students. Hispanic students are five times more likely to drop out. There are also disparities in kindergarten readiness.

If we looked only at state-level and county-level data, we would assume that Maryland and, in particular, Howard County is a great place to live and raise a family. That's not necessarily the case for everyone or for people who live in different districts within the county.

3 What are your projected outcomes for the work you focused on for this project? Please specify outcomes for any specific population groups.

Our long-term projected outcomes are a reduction in the distance to goal for all P.O.C. but for Black and Latinx people in particular. The time of the project however is too short to reasonably expect a shift in those outcomes in the short term. But through sharing data, awareness among various stakeholder groups, especially those most affected by these data, has been an achievable step.

4 What HOPE domains and indicators were helpful and why?

Life expectancy and distance to goal contextualize even in a relatively good outcome ecosystem, like Howard County, that those positive outcomes are not common to all and that they can be sharp and concentrated.

5 What additional domains or indicators can be added that would be helpful and why?

We don't have specific domains or indicators to suggest, but do feel it would be helpful to share processes that highlight complexity theory and sensemaking to ensure that real change is happening. Without that, we fear that there will be quick changes in one dimension but that the system will work to go back to the status quo. Having information about best practices to tackle complex problems (a sensemaking database) would be extremely helpful.

6 Please describe how you will adapt the distance to goal concept in your local work.

The distance to goal concept helps movements set a pace and goals to their organizing and strategy, but does so with agility. Typically, the data we generate in emergence is agile and suited toward decision making around action. These data are guideposts. The actions on the ground in organizing can be iterated as intentional organizing probes within the context of target goals. This aligns with Equity Matters' practice of applied complexity science. Distance to goal gives a drumbeat and a target beacon to a larger network for potential decentralized autonomous effects. In Movement Terms, it potentiates virality.

Louisiana Center for Health Equity (Baton Rouge, LA)

1 Describe your organizational purpose related to advancing policy change, including any COVID equitable recovery responses.

Founded in 2010, the Louisiana Center for Health Equity (LCHE) is a tax-exempt non-partisan nonprofit organization dedicated to advancing health equity to improve the overall health and well-being of all Louisianans. The organization works to eliminate health and healthcare disparities attributable to structural, institutional, or social disadvantages.

LCHE promotes research, projects and policy advocacy capable of meaningful policy change to the state of public health in our communities; and galvanizes health care industry stakeholders, professionals, policymakers and community advocates to improve health outcomes in our state.

As an example, at LCHE's 2022 Health Summit earlier this year, the Opening Plenary session was "Framing an Equitable Recovery through Policy and Practice", which was followed by a session on "Leveraging Funding Opportunities to Advance Equity and Economic Mobility." COVID was a priority focus with objectives including 1) being more aware of the impact of trauma on the overall wellness of school age

children and how the current COVID pandemic has exacerbated children's mental health concerns, such as depression, anxiety and self-injury and 2) learning more about policies and initiatives that can be implemented to address any inequities in access to behavioral health services for youth. During this summit, experts in various fields gathered to discuss the response to COVID, its impacts on the citizens of Louisiana as well as the nation and the opportunity for transformational investments.

Following the Summit, the Louisiana Legislature passed [House Resolution \(HR 173\)](#) creating the Student Behavior, Mental Health and Discipline Task Force to study improving certain policies related to student behavior and discipline. The task force will study:

- the ability to provide trauma-informed care in K-12 schools,
- the feasibility of mandating mental health counselors in schools in a similar fashion that physical health nurses are,
- the feasibility of prohibiting corporal punishment,
- the feasibility of abolishing zero-tolerance policies, and
- the definition of "willful disobedience" as it relates to school discipline.

- The HR 173 Task Force was convened on July 18, 2022 and will submit its final report to the House of Representatives no later than January 17, 2023. This work is consistent with LCHE's mission, goals and approach related to advancing policy change.

2 Which policy area(s) did you decide to work with using the HOPE opportunity database?

For the Leveraging HOPE Initiative, LCHE focused on children, youth and adolescents. Education, poverty and behavioral health have been identified as policy areas and are key performance indicators that align with LCHE's LA40by2030. The goal of LA40by2030 is to improve Louisiana's national health ranking to 40th by the year 2030. Our bold vision is to improve health outcomes and the quality of life for Louisiana's children and families over this decade. LCHE's strategies for accomplishing LA40by2030 throughout the state are policy changes, community engagement, collaboration, innovation and evidence-based approaches. The LA40by2030 Blueprint seeks to address a broader agenda including the following strategic policy areas:

- Set a state minimum wage higher than the federal minimum wage, a livable wage;
- Implement trauma-informed approaches and services for Adverse Childhood Experiences (ACEs);

- Establish a state-run entity to coordinate a systematic approach to women's health, such as an Office on Women's Health; and
- Prioritize and adopt targeted America's Health Rankings' health measures¹¹ as policy.

3 What are your projected outcomes for the work you focused on for this project? Please specify outcomes for any specific population groups.

In alignment with the LA40by2030, LCHE has advocated for policy changes to address the childhood mental health crisis in Louisiana. LCHE is combining local, regional and national data as well as HOPE data in support of its LA40by2030 initiative to create data-driven decisions that can be piloted throughout the nine regions of Louisiana. With the LA40by2030 initiative, the health of Louisianians will improve, especially with the focus on areas that historically have not received adequate attention. LCHE's focus on children, youth and adolescents can help improve the overall health outcomes for generations to come.

The projected outcomes are to increase the rate for high school graduation from 78.1 percent to 86.4 percent, reduce the rate of children in poverty from 26.2 percent to 18.3 percent and increase access to mental health providers from 264.6 per 100,000 to the national average of 247.4 per 100,000. This data is from 2019, which is the LA40by2030 baseline year.

11 America's Health Rankings. (2019). Louisiana Summary 2019. <https://www.americashealthrankings.org/explore/annual/measure/Overall/state/LA?edition-year=2019>

America's Health Rankings. (2020). Louisiana Summary 2020. https://www.americashealthrankings.org/explore/annual/measure/Overall_a/state/LA?edition-year=2020

4 What HOPE domains and indicators were helpful and why?

LCHE reviewed Leveraging HOPE domain and indicators to determine which data points correlate to children, youth and adolescents and selected the domains of social and economic factors, physical environment and community and safety factors. LCHE selected HOPE indicators livable income, employment, post-secondary education, youth in school or working, low poverty concentration and food security because they were the most related to LA40by2030 policy areas and key performance indicators (KPIs). These HOPE indicators were compared with our LA40by2030 KPIs from America's Health Rankings and Healthy People 2030 to identify correlations in data elements and/or consistencies across platforms. Each of the data elements were examined by defining the indicator, i.e., how the data point is measured and the value depicted on the platform. After each health measure was clearly defined and examined, we analyzed and compared the data points to determine if they were comparable across the three data platforms based on how the data was reported. We analyzed and compared the data to determine if they included same or similar health measures (See Attachment 1). Through this analysis and comparison, the only data element that is consistent across platforms is infant mortality. For each LA40by2030 KPI, the related indicators (or health measures) selected are shown below.

- Education - high school graduation rates, post-secondary education and youth in school or working
- Children in poverty - poverty level, poverty concentration and child poverty

- Food insecurity - food security and food insecurity
- Concentrated disadvantage - employment status and livable income
- Adverse Childhood Experiences (ACEs)

5 What additional domains or indicators can be added that would be helpful and why?

In comparing the data, LCHE discovered gaps between the data platforms in relation to children. Most of the HOPE data elements displayed were in relation to adults. This has created an opportunity for LCHE and the HOPE initiative to create a dialog around data collection identification and indicators for children, youth and adolescents. Indicators that could be added include high school graduation rates, children in poverty, concentrated disadvantage, ACEs, teen suicide, child mortality, juvenile violence and homicide. Children are a population with limited focus in the HOPE data. Including data on children could increase the application and usefulness of this platform. By providing the racial demographics for this population, it could be beneficial to a health equity approach and policy initiatives and advocacy.

6 Please describe how you will adapt the distance to goal concept in your local work.

One of the unique performance measures of the HOPE data is the "distance to goal" feature. The distance to goal feature provides the number of people that will be impacted if the HOPE goal is reached. The feature also provides a line graph of the racial inequities of

a state under a particular indicator along with that race's distance to the goal. This can assist LCHE in developing policy recommendations that are supported by data. LCHE can, also, adapt this feature into our work by distinguishing the need within different communities and creating or adapting current programs to fit that need, such as, developing a program centered around decreasing child poverty among Blacks. The distance to goal and correlational aspects to other states provides LCHE with tangible evidence to develop strategies and approaches for awareness campaigns, community engagement and policy advocacy.

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Comparison of LA40by2030 Blueprint, Leveraging HOPE and Healthy People 2030 Data

Key Indicator	Health Measure	Value: AHR 2019 (LA) Baseline	Value: AHR 2021 (LA)	Value: AHR 2030 (LA) Target	Status: Healthy People 2030 (National)	2030 Target: Healthy People 2030 (National)	NCHE Leveraging HOPE (LA): Rate	NCHE Leveraging HOPE (LA): HOPE Goal	NCHE Leveraging HOPE (LA): Distance to Goal
Education	High school Graduation	78.1%	80.1%	86.4%	85.8% (2018-2019)	90.7%			
	Post-Secondary Education						50% of adults	83% of adults	1,014,764 more Louisiana adults
	Youth in School or Working				11.2% (2017)	10.1%	83% of young people	100% of young people	101,013 more young people
Children in Poverty	Poverty	19%	19.0%		11.8% (2018)	8.0%	64% of people	100% of people	1,677,300 more people
	Children in Poverty	26.2%	27.0%	18.3%					
Food Insecurity	Food Insecurity	17.3%	14.8%						
	Food Security				0.59% (2018)	0.00%	77% of people	97% of people	917,791 more people
Concentrated Disadvantage	Concentrated Disadvantage	34.6%	40.2%						
	Livable Income				77.9% (2017)	85.1%	55% of adults	88% of adults	1,013,393 more adults
	Unemployment /Employment	5.6%	5.6%		70.6% (2018)	75%	93% of people	99% of people	122,402 more people
Adverse Childhood Experiences	Adverse Childhood Experiences	25.2%	19.5%		There is one objective related to this measure, but no explicit goal				

NOTE: Un/employment means that America's Health Rankings ranked Louisiana unemployment rate, while Healthy People and Leveraging HOPE presented the employment rate.

Partnership for the Public Good (Buffalo, NY)

1 Describe your organizational purpose related to advancing policy change, including any COVID equitable recovery responses.

PPG is a community-based think tank that builds a more just, sustainable and culturally vibrant Buffalo Niagara through action-oriented research, policy development and citizen engagement. We have over 300 partner groups, mainly in the Buffalo region. Each year, we ask our partners to propose policy goals that they would like to work on in the coming year. We help them refine those policy goals and then we help them develop their pitch for those goals. After that, we bring our partners together to vote on their top policy priorities for the year. The top ten voted on policy priorities become our community agenda for the year.

This year, our community agenda includes issues like using publicly-owned land for public benefit, increasing spending for foster care alumni and creating a language access plan for governmental departments. COVID response related items include improving water equity for Buffalo residents, increasing tenant protections and incentivizing affordable housing in the suburbs. Throughout the year, we help partners with campaign strategy, organizing and assisting with elected official meetings and providing relevant local research.

We are also working on a report that will be published soon titled, "Just Recovery: policy solutions for long-term COVID response and a more equitable future." This report outlines policy recommendations at the city, county and state level for a number of issue areas, including housing, childcare, food and public safety.

2 Which policy area(s) did you decide to work with using the HOPE opportunity database?

We decided to focus on our water equity work for the HOPE Initiative network. Access to water is essential to sustain life. In 2019, Buffalo Water shut off water to over 2,500 occupied residential properties. Over 30,000 Buffalo Water customers remain in arrears on their water bills. Establishing policies to guarantee affordable water will relieve low-income customers of the distress associated with unpaid water bills and enable them to plan for their family's needs.

In a July 2021 announcement, the Mayor and the Buffalo Water Board announced that they intended to forgive the debt owed by Buffalo Water customers and permanently end water shutoffs. While those are laudable promises, much work remains to achieve them and create permanent affordability programs for low-income water customers.

This plan proposes that the Water Board announce written policies addressing the following issues:

- eliminating all water shutoffs in the future for nonpayment of bills by low-income customers;
- devising and disseminating a notice to go out to all customers with each bill notifying them of the criteria governing how low-income customers may qualify for reduced, affordable rates;
- adopting written policies and a timeline governing how low-income customers can become eligible to have their water debt forgiven; and
- adopt written policies detailing income levels and percentage caps on how much residents should be paying for water and sewer services.

3 What are your projected outcomes for the work you focused on for this project? Please specify outcomes for any specific population groups.

Buffalo Water has the authority to make policy changes around water shutoffs, water rates and programs for low-income customers. According to the City's plan for its American Rescue Plan funding, \$13 million will be allocated to forgive the debt owed by water customers. The Water Board should enact its own policy eliminating water shutoffs and establishing water rates for low-income customers based on what they can afford.

To clarify an existing confusion, the Common Council and Mayor, in partnership with Buffalo Water, must resolve the inconsistencies between the City's July 2021 plan to use American Rescue Plan funding to forgive water debt, the Mayor's July 2021 press conference announcing an end to shutoffs and resolutions enacted by the Buffalo Water Board and Buffalo Sewer Board in August 2021 leaving water shuts off as a future option.

4 What HOPE domains and indicators were helpful and why?

We found the asset-based framing of the HOPE database to be useful. As non-profit advocates, when writing proposals to funders or discussing community issues with elected officials, we often frame our policy change needs in a negative light. While this helps us convey the severity of the issue to decision makers and funders, doing this on a regular basis can cast low-income communities and communities of color as deficient and can further stigmatize those communities. By using the distance to goal measurement concept, we can instead focus on the progress we stand to make as a region.

We're focused largely on municipal-level policy and data. Especially in New York State, it's pertinent that we use local data because state-level data is heavily influenced by New York City's data. For that reason, we weren't able to use specific HOPE domain and indicator data. However, we greatly appreciated being a part of the network and hearing from other groups across the nation.

5 What additional domains or indicators can be added that would be helpful and why?

Adding municipal-level data to its platform would be exceptionally helpful to our work. PPG's mission is to focus on local policy change. We work at the city, county and occasionally the state level. We find that we can have the most impact within our local networks at the municipal level. For this reason, we are usually looking for municipal level data. We're generally able to find the data we need through American Community Survey data. However, having that data available already through the HOPE Initiative would save us time and it would likely spur us to think about our given policy areas through new data perspectives as well.

As for specific indicators and domains, a measure of transportation access could be useful. Access to transportation is woven into nearly every aspect of a person's life—where they can go to work, get fresh food, attend medical appointments, etc. Improving transportation access in our region is critical to many of our partners.

It would also be interesting to see an indicator outlining the number of affordable housing units needed in a region compared to how many affordable housing units exist currently. We had researchers [investigate this](#) for our region and the results were astounding¹². It gave us a sense of the scale of the affordable housing crisis in our region.

6 Please describe how you will adapt the distance to goal concept in your local work.

In our work with partners, we will encourage them to frame their policy plans as a distance to goal measurement in meetings with elected officials, the public and the media. Our hope is that this framing will help spur our local politicians into action as they will more easily be able to understand the progress that can be made.

We also find that our local elected officials are motivated when they understand how Buffalo compares to other Rust Belt cities. We may employ the distance to goal concept to draw comparisons between our city and similar cities.

12 Weaver, R., and Knight, J. C. (2021). *Engaging the Future of Housing in the Buffalo-Niagara Region: A Preliminary Exploration of Challenges that Lie Ahead*. Buffalo, NY: <https://ppgbuffalo.org/buffalo-commons/library/resource/engaging-the-future-of-housing-in-the-buffalo-niagara-region-a-preliminary-exploration-of-challenges-that-lie-ahead/>

Collaborative for Health Equity Cook County (Chicago, IL)

1 Describe your organizational purpose related to advancing policy change, including any COVID equitable recovery responses.

The Collaborative for Health Equity Cook County (CHE Cook County) is committed to policy change that focuses on the root causes of health inequities at the social structural level. Since February, 2021, CHE Cook County has worked in solidarity with community residents on the Southeast Side of Chicago to promote environmental justice in order to stop a proposed move of a metal shredding recycling operation from Lincoln Park to the Southeast Side. The organizing, known as “#StopGeneralIron” was focused on stopping the City of Chicago and the Chicago Department of Public Health (CCDPH) from issuing a final permit to the owners to begin operation. This fight against environmental racism has implications for inequities in Covid-19 morbidity and mortality. One research

study found that inequities in Covid-19 morbidity and mortality were related to higher neighborhood social vulnerability index. The researchers noted that “factors [that] may also affect the severity of disease and the case-fatality rates, [include] access to and quality of health care, co-occurring social factors (for example, stressors) and environmental factors (for example, air pollution).”¹³ Despite Chicago’s shocking, worst-in-the-nation 30.1-year life expectancy gap across neighborhoods¹⁴ and its public commitment to equity in neighborhood environments, including a focus on “communities disproportionately burdened by air pollution”¹⁵ to reduce the life expectancy gap, residents advocating for cleaner air and better health found themselves facing the opposition of Chicago’s Mayor Lori Lightfoot and the Chicago Department of Public Health, led by Commissioner Allison Arwady, MD, MPH.

13 Bilal, U., Tabb, L. P., Barber, S., and Diez Roux, A. V. (2021). Spatial Inequities in COVID-19 Testing, Positivity, Confirmed Cases and Mortality in 3 U.S. Cities: An Ecological Study. *Annals of Internal Medicine*, 174(7), 936–944. <https://doi.org/10.7326/M20-3936> p7.

14 Gourevitch, M. N. (2019). Large Life Expectancy Gaps in U.S. Cities Linked to Racial and Ethnic Segregation by Neighborhood. NYU Langone News. Retrieved August 23, 2022, from <https://nyulangone.org/news/large-life-expectancy-gaps-us-cities-linked-racial-ethnic-segregation-neighborhood>

15 Chicago Department of Public Health. (2020). *Healthy Chicago 2025*. City of Chicago. https://www.chicago.gov/content/dam/city/depts/cdph/statistics_and_reports/HC2025_917_FINAL.pdf p20.

2 Which policy area(s) did you decide to work with using the HOPE opportunity database?

We did not use the HOPE database for the #StopGeneralIron effort. That policy struggle over permitting for the polluter to move from a neighborhood in the 1st decile for air quality and health to one that is already overburdened with pollution and in the 9th decile for air quality and health¹⁶ involved using local level data, both qualitative and quantitative. However, CHE Cook County leaders plan to use HOPE data as part of a training for community activists and organizers to increase their awareness that public health and population health data, including HOPE data for Illinois, are powerful tools in a fight against structural racism. In addition, HOPE data can be useful to support legislation at the State level aimed at taking into account the cumulative impact of pollution when making permitting decisions for locating polluters.

3 What are your projected outcomes for the work you focused on for this project? Please specify outcomes for any specific population groups.

The training CHE Cook County envisions is aimed at organizations already building people-power for racial justice and health equity in metro Chicago. Those organizations include:

- 7th District Health Task Force (Cook County Commissioner Alma Anaya)
- Alliance for the Southeast (Amalia NietoGomez)
- Centro de Trabajadores Unidos

- Cook County Department of Public Health
- ENLACE Chicago
- Little Village Environmental Justice Organization
- Metropolitan Tenants Organization (John Bartlett)
- People for Community Recovery (Cheryl Johnson)
- SOUL in Chicago (Tanya Watkins)
- Southeast Environmental Task Force (Olga Bautista)
- Southeast Youth Alliance (Oscar Sanchez)
- Other Chicago-area advocacy and racial and health-justice organizations (including in the issue-areas of housing, income, health, occupational safety, environment, education, immigration)

These organizations work primarily with Black and Latinx communities, immigrant communities, working and low-income people, renters, youth and populations disproportionately affected by Chicago's and Cook County's historically high levels of racial segregation.

CHE Cook County intends to produce outcomes from the health equity data workshop that may include those listed below:

Workshop participants will be able to:

- Describe the racial justice and equity values of public health;
- Identify HOPE data that may be useful for a given organizing campaign;
- Explain key population health indicators including life expectancy, infant mortality and maternal mortality;
- Name trustworthy sources of data;

16 City of Chicago. (2020). Air Quality and Health Report. City of Chicago. https://www.chicago.gov/content/dam/city/depts/cdph/statistics_and_reports/Air_Quality_Health_doc_FINALv4.pdf

- Compare and contrast the individual behavior and lifestyle explanations of health and inequities with structural and social explanations;
- Identify strategies to build a relationship with a public health department or public health non-profit organization; and
- Describe the role and responsibilities of a governmental public health department and how it might be supportive of a racial justice-social justice policy change campaign.

4 What HOPE domains and indicators were helpful and why?

The work of CHE Cook County over the Spring and Summer of 2022 has been focused on the #StopGeneralIron solidarity campaign. Because this policy fight against environmental racism involved data at the City level, the HOPE domains and indicators were not used. This work included:

- maintaining the CHECookCounty.org website;
- convening two Committees: the Fight Environmental Racism Committee and the Spatial Social Polarization Tool Committee;
- Planning a visit to the Southeast Side neighborhood at the invitation of Olga Bautistia, Executive Director of the Southeast Environmental Task Force. This visit was cancelled because of high rate of Covid community transmission;

- Organizing a panel on August 26th for the DePaul University Health Equity and Social Justice Annual Conference. The panel members included Beria Hampton of People for Community Recovery, Oscar Sanchez of Southeast Environmental Task Force and Jim Bloyd of CHE Cook County. HOPE Domains and indicators will be useful for the workshop/training on data and racial justice organizing¹⁷.

5 What additional domains or indicators can be added that would be helpful and why?

We would suggest adding a life expectancy at birth indicator to the health outcome domain. The City of Chicago recently announced in a press release and not in a detailed epidemiological report, that "As of 2020, the gap in life expectancy between Black and white Chicagoans was ten years, up from 8.8 years in 2017. For the first time in decades, life expectancy for Black residents of Chicago fell below 70 years¹⁸."

Chicago Latinx residents saw more than a 3-year drop in life expectancy between 2019 and 2020, the steepest decline for any group and have lost a total of 7 years of life expectancy since 2012. Asian/Pacific Islander life expectancy showed a 2-year drop from 2019 to 2020, while white Chicagoans' life expectancy declined by one year.

17 The panel was videotaped and is available at <https://youtu.be/ksThuHBkrm0>. The slides for the presentation are available at https://5dd873fa-79ee-41a2-90f9-3c9e504d4026.usfiles.com/ugd/5dd873_8a5a539c63eb408985d48ee0d687e3a1.pdf

18 Mayor's Press Office, City of Chicago. (2022, April 25). *Life Expectancy in Chicago declined during the pandemic's first year with the biggest drops among Black and Latinx Chicagoans*. https://www.chicago.gov/content/city/en/depts/cdph/provdrs/health_data_and_reports/news/2022/april/life-expectancy-in-chicago-declined-during-the-pandemic-s-first.html

We would also suggest adding an indicator for maternal mortality. The fascist threat in the United States¹⁹ and its impact on women's health and reproductive justice suggests that indicators that would reveal how racial inequities in maternal mortality can be reduced and morbidity and mortality related to loss of reproductive rights and bodily autonomy among the States would be useful for the HOPE database.

6 Please describe how you will adapt the distance to goal concept in your local work.

The concept of distance to goal will be a useful concept for the training/workshop because it will highlight those areas where Illinois falls short and can identify potential policies from states that have better health performance that may be explored for adoption in Illinois.

However, the distance to goal needle on the dashboard doesn't reveal larger goal gaps when comparing indicators by race and ethnicity groups across states. People in the Chicago area may be surprised to learn that while 47% of Blacks in Illinois live in low-poverty concentration areas, that is similar to Indiana and Wisconsin, at 46% and 43%, respectively. In contrast, 64% of Blacks live in low-poverty concentration neighborhoods in California. Illinois has a larger distance to goal of Blacks living in low-poverty concentration areas than California. But since the dashboard needle describes percentage of all people, California (75%) has a larger distance to goal than Illinois (80%).

In addition, Chicago's focus on environmental pollution created the opportunity for the use of a local data tool. The Chicago Health Department's Air Quality + Health Index is in some sense a competing measure with HOPE in that it already takes into account race and other social determinants in its scoring. However, they do provide the individual data components at the block group level (e.g., a scaled pollution burden score) that could be extracted and used with the HOPE approach by:

- Using a positive frame e.g., talking about folks living in areas with good air quality (low pollution burden score)
- Setting a HOPE goal. Since this measure appears to only be available for the City of Chicago, state or county averages cannot be considered. In this case the goal may need to be statistically defined (e.g., the top decile of the air quality score)
- Comparing the demographics (e.g., race and ethnicity, income, poverty, education, etc.) of folks who live in areas with poor vs. good air quality scores.
- Computing the distance to goal for each of the demographic groups above (i.e., the citywide total and number of persons in each demographic group that would need to live in a block group that had good air quality to achieve the HOPE goal)

19 Morabia, A. (2022). Reproductive Rights and Fascist Threat. *American Journal of Public Health*, 112(9), 1229-1229. <https://doi.org/10.2105/AJPH.2022.307001>

Center for Achieving Equity (Cleveland, OH)

1 Describe your organizational purpose related to advancing policy change, including any COVID equitable recovery responses.

The Center for Achieving Equity (CAE) ensures health implications and equity considerations are in the forefront as policy makers and others make decisions that substantially impact the residents of Cuyahoga County and the neighborhoods in which County residents live. We leverage the organizational capacity and leadership of experts across multiple domains, including qualitative researchers; environmental, health and economic policy experts; city planning and parks and recreation staff. We establish that “health and equity in all policies” is embedded in work throughout every sector, by building the capacity of policy-makers, organizational leaders and community members to use an overarching health equity lens when developing policies. Ensuring community leadership among those who experience the impact of policy and systems decisions is a core value of our organization. We build the capacity of leaders to apply an equity lens to policy, planning and systems change work.

2 Which policy area(s) did you decide to work with using the HOPE opportunity database?

The policy areas we are working on are health outcomes and social and economic factors.

3 What are your projected outcomes for the work you focused on for this project? Please specify outcomes for any specific population groups.

We plan to produce a social and economic outcomes report that will enable community leaders in public and private organizations to measure movement on economic inclusion within the region. The indicators will be used to measure long-term impact within the BIPOC community.

We are working to create a collective impact initiative that leverages the strategic priorities of multiple organizations within the region, including but not limited to:

- the NAACP
- the Federal Reserve of Cleveland
- City of Cleveland, including a newly formed commission to look at the intersecting issues preventing African American women to thrive
- Environmental Health Watch

Discussions are ongoing to expand the organizations we work with. Note that our focus on African American women, in particular, is supported by a CityLab publication²⁰ describing how poorly African American women are faring within the city.

4 What HOPE domains and indicators were helpful and why?

The concept of distance to goal is a particularly advantageous element within the Leveraging HOPE approach. Updating this information on an annual basis will be extremely helpful in our effort. We found that the area of focus displaying social and economic factors was helpful to our work. We utilized the statewide indicators of affordable housing, home ownership, employment, livable income, post secondary education, and youth in school or working.

The Center for Achieving Equity was interested in how disparities among the statewide indicators in combination with the impacts of COVID contributed to the increased need of mental health support within the African American community in Cuyahoga County. The indicators helped to frame discussions around culturally appropriate mental health care services and provided data regarding contributing factors that directly impacted our community's mental health.

5 What additional domains or indicators can be added that would be helpful and why?

We are researching which additional indicators will be helpful to us and are in the process of researching additional data sources to help us develop a compelling narrative as we move forward with this process. Indicators under consideration:

- Chronically unemployed or under-employed
- Black/Brown small business openings and/or closures
- Educational attainment and earnings by ethnicity
- Home foreclosures by ethnicity and location
- Access to culturally appropriate mental health services
- Car loans or repossessions or loan interest rates
- Number unbanked
- COVID cases or deaths by ethnicity and geographic location

6 Please describe how you will adapt the distance to goal concept in your local work

We theorize that there are additional indicators that will help us understand better how we are closing the gap related to distance to goal. CAE plans to adapt the distance to goal concept by highlighting the progress needed to achieve the HOPE Goal related to health outcomes and social and economic factors. We plan, for example, to author a new community health indicator report, facilitate further community discussions, and network/coordinate strategic planning across our county. We are continuing conversations and intend to seek grant funding for this purpose.

20 Mock, B. (2020). What 'Livability' Looks Like for Black Women. *Bloomberg*, (January 9). <https://www.bloomberg.com/news/articles/2020-01-09/the-best-and-worst-cities-for-black-women>

Health Equity Solutions (Hartford, Connecticut)

1 Describe your organizational purpose related to advancing policy change, including any COVID equitable recovery responses.

Health Equity Solutions' mission is to promote policies, programs and practices that result in equitable health care access, delivery and outcomes for all people in Connecticut. Our vision is for every Connecticut resident to attain optimal health regardless of race, ethnicity, or socioeconomic status.

To achieve these goals, we organize coalitions, engage in outreach and education (with community, policymakers and health care professionals) and advocate for policy changes. Over the past two years, for example, we have helped to advance state legislation to declare racism a public health crisis, define the doula profession, strengthen hospital community benefit requirements, recognize an annual health equity week and standardize how the state collects race, ethnicity and language data.

Starting in 2020, Health Equity Solutions (HES) worked with dozens of municipalities interested in declaring racism a public health crisis and taking steps to address racism at the local level. HES also serves on several state workgroups and councils to embed health equity in public health, Medicaid and health insurance exchange policies and address barriers to health beyond formal

health systems. Finally, we engaged in advocacy, door-to-door education and outreach related to COVID vaccinations and provided trainings and webinars to various stakeholders. Since the first days of the pandemic lockdown in 2020, HES has advocated for equity in Connecticut's COVID response. We successfully advocated for the release of race and ethnicity data related to COVID-19 cases and deaths, for trusted messengers to provide COVID information and support transitions from Medicaid to the new, free coverage on the state's health insurance exchange and for embedding equity in planning for the recovery period and beyond. HES also created and provided weekly summaries of a community assessment survey for the first nine months of the pandemic to inform our Executive Director's participation in the Governor's emergency response workgroups. This information and updates on the evolving COVID situation were shared with our partners in a weekly newsletter for the first year of the pandemic. In 2020 HES created a series of short, medium and long-term policy goals to reinforce what we had learned and the steps for embedding equity in the COVID response efforts. HES also wrote numerous letters to the Governor and the Commissioners of Public Health and Social Services and organized coalitions, webinars and social media to gather information from and share information with our networks.

Recently, HES released a [cross-sector guide](#) to state policies to advance health equity, which was created in collaboration with community members and dozens of grassroots and advocacy organizations. To date, over 50 organizations have signed on in support of these goals. This work aimed to ensure the steps towards dismantling racism and barriers to health were clear to policymakers, candidates and voters and to bring advocates together around shared policy priorities. In other words, we are bringing all stakeholders together to take action.

HES works to ensure all our advocacy is community-informed at minimum and community-led whenever feasible. To this end, we conduct annual listening sessions to learn about the health equity priorities of people across the state. We also hold workshops to ensure we have recorded these priorities accurately and that the policy solutions we pursue in response to these priorities truly meet the needs of Connecticut's residents. Finally, we also engage in health equity and advocacy training and build coalitions around priority issues. For example, over the last year, we have been working with a coalition of community health workers to define their needs and wants related to Medicaid reimbursement. We will support the coalition in advocacy to achieve their goals in the year ahead.

2 Which policy area(s) did you decide to work with using the HOPE opportunity database?

Health Equity Solutions leveraged the HOPE opportunity database to provide framing for a series of conversations with community members about their health equity priorities. These conversations were held in partnership with

local grassroots organizations. The data helped illustrate how health inequities impact the lives of people in Connecticut and how issues such as affordable housing impact health equity. The data was provided at the start of these events, along with our definition of health equity to ensure a shared understanding of racial inequities in health. We included in our presentation the premature death, livable income, poverty concentration and affordable housing metrics stratified by race and ethnicity to illustrate the wide-reaching consequences of systemic racism and their impact on health.

3 What are your projected outcomes for the work you focused on for this project? Please specify outcomes for any specific population groups.

The goal of these community conversations is twofold. First, output from these conversations is compiled and guides the formation of HES' policy agenda for the year ahead. Second, these conversations help us engage Connecticut residents in thinking about health policy and advocating for their priorities. We ask how people want to be involved and follow up with future opportunities to learn more, help define and detail policy solutions and take action.

4 What HOPE domains and indicators were helpful and why?

Several HOPE domains were considered as there were many relevant options. The most helpful were those we were able to disaggregate by race and ethnicity because Connecticut has high overall ratings on most metrics and experiences deep disparities by

race and ethnicity. Given our focus on equity, with a “Race Forward” definition of equity, it was helpful to compare metrics among nearby states that were stratified by race and ethnicity and to see how inequities in Connecticut compared to those in other states in the region.

5 What additional domains or indicators can be added that would be helpful and why?

The indicators and domains seemed relevant and HES did not identify gaps in topics or metrics. Additional indicators that can be stratified by race and ethnicity at the town level would be helpful. Given the state’s small size, lack of county governments and many small towns (169 towns with a population of just 3 million), this can be difficult. Multi-year data sets sometimes allow for data to be stratified at the local level and would serve our purposes. Town level data can be beneficial when working

with municipal governments or state legislators who want to understand how a given issue impacts their constituents. Our grassroots partners often look for this data. A [one-time equity report](#) by DataHaven at the town level has been vital. A more ongoing, regularly produced data source that can be stratified by town AND race/ethnicity would be helpful.

6 Please describe how you will adapt the distance to goal concept in your local work.

HES appreciates this effort at asset-framing. HES never shares disparities data without context because these data are so easily misconstrued and so often used to blame people for their population’s experience of racism. We will continue to use this concept in our messaging with stakeholders, policymakers and local advocacy groups to reinforce that there are concrete, attainable goals for achieving health equity.

One Love Global (Lansing, MI)

1 Describe your organizational purpose related to advancing policy change, including any COVID equitable responses.

One Love Global (OLG) is a 501c3 nonprofit organization working to transform communities so Black children experience justice, peace, healing, opportunity and abundance. OLG invests in youth organizing and community leadership development to build the individual and collective power needed to transform policies and practices.

Our work over the past four and a half years has centered the needs and priorities of communities disproportionately affected by the pandemic while supporting non-BIPOC community members to be effective allies. We have worked with youth and adult allies to transition our programming so that it is engaging and interactive in a virtual space, thereby expanding our reach throughout Michigan. We also launched the centrally located One Love Global Center for Truth, Racial Healing and Transformation (TRHT) as a physical space in Lansing to serve the state of Michigan in our 4600 square foot space. The space is ideal for socially distanced gatherings.

The pandemic overlapped with our theory of action to bring directly impacted people together with allies to co-create a collective community vision of what racially equitable policy and practice looks like. This took place after an intentional period of orientation, onboarding and relationship-building within each sector. One Love Global and TRHT partners launched the Lansing People's Assembly in May of 2020 as a dedicated space for innovation, community co-governance and transformation across TRHT framework areas. Significant outcomes of our TRHT work include:

- We developed a partnership with Ingham County Prosecutor, which led to substantive changes in prosecutor policies, increased data transparency and the formation of a Michigan People's Assembly.
- Resolutions declaring racism a public health emergency were passed by the City of Lansing, the Ingham County Board of Commissioners and the Governor of the State of Michigan as a direct result of our collaboration with public health professionals to host a series of webinars and press conferences on the impact of the pandemic on Black communities (coinciding with a global uprising in support of racial equity).

- Ongoing community healing circles, including with nurses, students and teachers, have been increasingly in demand given the stress of the pandemic.
- Peace and Prosperity Youth Action Movement members (ages 12-25) prioritized healing, youth-led circles and mutual aid as pandemic interventions.
- We created a social entrepreneurship pathway for Lansing youth in partnership with Lansing Area Economic Partnership.
- We created a COVID media map.
- We launched a Lansing Racial Equity Scorecard

2 Which policy area(s) did you decide to work with using the HOPE Opportunity Database?

One Love Global chose Community and Safety as our area of focus to frame our policy work in economy, law and education. The domains are intersecting so our approach is to start with low poverty concentration as a primary influencer of other domains and indicators, particularly within the domain of community and safety.

3 What are your projected outcomes for the work you focused on for this project? Please specify outcomes for any specific population groups.

Incorporating HOPE database indicators on the social determinants of health has strengthened our capacity to advocate for the policy and systems transformation needed to meet our communities' need for healing,

with meaningful and measurable action. We launched the [Transform Michigan](#) podcast on Michigan Business Network with a series on the HOPE indicators. Guests and conversations to expand the narrative behind the data included Elon Geffrard, Program Director for Birth Detroit; Dominique Stepp, Director of Communications for One Love Global; Jordan Scrimger, Policy Specialist for One Love Global and Tashmica Torok, Founding Co-Director for The Firecracker Foundation. We will continue to use HOPE data to identify guests and ground future conversations with transformers and healers across Michigan.

HOPE data has been shared with One Love Global staff and our data team will be integrating HOPE indicators into our racial equity scorecard. We plan to expand the scorecard to include other communities in Michigan where Black youth and families are most impacted. Presentations of HOPE data have been provided to Greater Lansing UN Association, Lansing School District Board and the East Lansing Health Equity Committee. We will be leveraging the HOPE data in our Racial Equity Accountability Process to support communities that declared racism a public health crisis.

Our backbone support work has inspired us to build an infrastructure for civic engagement, digital organizing and grassroots advocacy that can put HOPE data in the hands of our people in urban, suburban and rural communities as we continue building on a base of over 40,000 supporters in Michigan. We will continue to leverage HOPE data in local, state and national assemblies that bring people together in co-governance for policy and systems transformation.

4 What HOPE domains and indicators were helpful and why?

All of the domains and indicators are helpful because together they tell a story about structural racism that a single domain or indicator cannot. For the Transform Michigan podcast, the data was helpful in educating the Michigan business community on racial inequities in the impact of COVID, infant mortality, low birth-weight and child health status.

The data on sexual assault was particularly poignant, as our community has been working to disrupt the narratives of police and prosecutors that carceral punishment is the justice sought by survivors, when we know from lived experience that prisons only harden perpetrators who are often themselves survivors. We learned from our conversation with Tashmica Torok, the co-founder of The Firecracker Foundation, that sexual assaults often occur within families and trusted relationships and that the criminalization of perpetrators often means a family is torn apart permanently because prisons do not heal survivors or perpetrators. Michigan is further from goal in the sexual assault indicator than for any of the other indicators, which should make this a topline for intervention across the state.

5 What additional domains or indicators can be added that would be helpful and why?

- Low rates of police shootings and homicides of civilians
- Low rates of environmental toxins like lead and PFAS
- High rates of water affordability
- Low rates of gentrification
- Low rates of hate crime
- Either add Civic Engagement as a new domain or add indicators to Community and Safety

- High rate of voter turnout
- High rate of diversity in elected offices
- High rate of hi-speed WIFI access (may be a better fit with Social and Economic)
- Add: By Age as a drop-down menu option to view data

It would be extremely helpful to have the ability to layer indicators across domains so we can see how racial inequities pile up and create devastating impact on communities. County and city-level data would also be helpful. If we could target specific areas for comparisons with state-level or other communities, that would further illustrate how separation exacerbates racial inequities.

6 Please describe how you will adapt the distance to goal concept in your local work.

We will adapt the distance to goal concept in our racial equity accountability process with our results-based accountability scorecard. The scorecard tracks progress to goal, the story behind the data and recommendations to turn the curve. Our convening work will allow us to use the distance to goal concept to set short, intermediate and long-term objectives to reach 100% across domains. The HOPE data will be used to update data and policy recommendations for our My Brother's Keeper/Girls Equity Network so that communities may renew commitments on how we will make progress on the distance to goal. Our ultimate goal is that MBK GEN legislation would be passed as part of a Michigan BREATHE Act that divests from harmful policies. MI BREATHE Act is the civil and human rights legislation of our time. New legislation will reallocate resources for community-based and community-driven solutions to move us closer to the goal as an entire state through racially equitable investment. HOPE data will be used for teach-ins, community education and advocacy.

LatinX Racial Equity (Oakland, CA)

1 Describe your organizational purpose related to advancing policy change, including any COVID equitable recovery responses.

Our organization works to uplift Black and Indigenous Latinx people by ending their marginalization rooted in racism and internalized oppression. We advance policy shifts by training grassroots activists, government workers and policy makers to shift their narratives and the focus of their work away from a one size fits all approach to Latinx communities and towards understanding the differentiated impact of racism. Because of the over representation of Latinx workers in “essential/low paying jobs” and the patterns of Latinx people delaying accessing care due to not having health insurance, Latinx people had the highest morbidity rates in the US from COVID 19. The last two years have been challenging for most people in our country, but for front-line workers and the non-profit organizations that support them, the last two years have been brutal. Our trainings have provided a respite and a place where leaders can problem solve and develop solutions. Using HOPE and California Healthcare Foundation data, leaders were able to practice building a case for shifting policy to provide greater access to primary care for all Californians - including the undocumented.

2 Which policy area(s) did you decide to work with using the HOPE opportunity database?

Access to Primary Care and Affordable Health Care

3 What are your projected outcomes for the work you focused on for this project? Please specify outcomes for any specific population groups.

- On average 100 leaders/year trained with our tools, who then work with anywhere from 20-50 people in their communities. Overall, they reached about 2,000-5,000 people with our tools. One third of the people who attended our trainings work at the local and state government level and are responsible for drafting legislation. We have not been able to track policy shift outcomes as a result of our work. We have not had the resources to invest in data and learning.
- We concretely introduce data exercises as part of the policy planning and change section of our curriculum. This allows them to have more compelling narratives to achieve equity goals for their communities. By supporting leaders to have tools focused on equity values so they can impact change in their demographic regions.

4 What HOPE domains and indicators were helpful and why?

Access to care, which is related to health outcomes.

5 What additional domains or indicators can be added that would be helpful and why?

Immigration status. Not having legal documentation to work in the US keeps undocumented immigrants in jobs that do not offer health insurance and is a barrier to accessing healthcare. Understanding how immigration legal status impacts health is important for the population we work with.

Neshoba Youth Coalition (Philadelphia, MS)

1 Describe your organizational purpose related to advancing policy change, including any COVID equitable recovery responses.

The Neshoba Youth Coalition (NYC) was founded in October of 2010. The Youth Coalition was formed in response to the local school district's high teen pregnancy rate in 2009. In 2009, Neshoba County had the 9th highest teen pregnancy rate in Mississippi, a State with the highest teen pregnancy rate in the Nation. The idea was to develop a program that would target the most at-risk youth in the district and empower those students with the knowledge and skills to make intelligent and informed decisions through a focus on local history, education, teen pregnancy, school dropouts and race relations.

Thirteen years later, the teen pregnancy rate for the at-risk group is the lowest in the County and the County has seen a 40% drop in overall teen pregnancy. Since 2009, more than 700 at-risk youth have participated in the NYC Leadership Program. None of those students have been lost to violent crime or have committed a violent crime. Before the on-set of Covid-19, NYC students, in partnership with the USDA Summer Feeding Program, were providing more than 14,000 meals per summer to at-risk youth in the community. NYC student leaders have mentored more than 2,000 at-risk kindergarten to sixth grade youth in math, reading,

reading comprehension and vocabulary skill building during the summer months.

NYC has partnered extensively with local organizations, businesses and governmental leaders to promote the health and safety of our community. In December of 2021, we partnered with four local African American churches, Neshoba General Hospital and the Montgomery Institute to provide a Covid-19 Information and Lunch. The events were designed for individuals to come during their lunch hour and receive a meal, information about Covid-19, or get their Covid-19 vaccination or booster shot. The turnout was high, with more than 100 people attending the hour-long events. We also partner with our local community action agency to pick up and distribute monthly food boxes to the elderly. We work closely with our local elected officials to help keep families abreast of programs, decisions and opportunities that directly or indirectly affect the community. The city, county, school board and economic development leaders seek input from the NYC organization and its stakeholders before major decisions are made. The Neshoba Youth Coalition (NYC)'s mission of seeking to reduce teen pregnancy, high school dropout and child poverty, while offering high-quality educational opportunities and eliminating structural racism, is essential for breaking the cycles of health inequity that create and perpetuate

enormous health disparities across lifetimes and generations of youth and communities of color in Mississippi.

Ranking in the bottom five states for health-care access and socioeconomic measures, Mississippi experiences some of the worst health outcomes in the nation. The state has some of the highest rates of teen births, premature mortality, infant mortality and low birth weight in the country. Preterm birth, (delivery before 37 weeks of pregnancy), is the leading cause of infant death in Mississippi. The state ranks among the bottom for health care access measures, with low rates of health insurance coverage, affordable care and access to primary and psychiatric care.

The Black population in Mississippi experiences the highest rates of infant mortality and low birth weight in the state. They also face challenges in accessing quality housing and are more likely to live in areas with high poverty concentrations, crime and food insecurity.

Addressing social determinants of health is not only important for improving overall health, but also for reducing health disparities that are often rooted in social and economic disadvantages. The COVID-19 pandemic and its disproportionate impact among racial and ethnic minority populations is a stark example of these enduring health disparities.

By empowering youth and communities of color to better understand and address the social determinants of health associated with teen childbearing and by implementing NYC's community-level interventions, NYC seeks to eliminate disparities caused by teen pregnancy, high school dropout, poverty, structural racism and lack of high-quality educational

opportunities. This will help to achieve health equity, reduce the economic costs of teen childbearing and improve the life opportunities and health outcomes of young people and communities of color.

Systemic and structural racism have cemented inequities into America's foundation and the repercussions play out cruelly during periods of both crisis and calm. They influence the opportunities available to us to practice healthy behaviors, enhancing or limiting our ability to live healthy lives. Because these conditions in which we are born, live, learn, work, play, worship and age have such a profound impact on health, they also contribute to high teen birth rates.

2 Which policy area(s) did you decide to work with using the HOPE opportunity database?

We chose to focus on the HOPE Initiative Policy area found in the social determinant of health domain, Social and Economic Factors, where Mississippi ranks #47, under the indicator, youth in school or working. In Mississippi, only 83% of our youth are in school or working. This is the policy area that will significantly impact health equity in Mississippi. By increasing the percentage of youth in school or working, Mississippi communities will be better positioned to move beyond just measuring disparities, using data as a tool to spur policy makers, health agencies and local community organizations into action toward health equity.

Education is often referred to as the great equalizer: it can open the door to jobs, resources and skills that help a person not only survive, but thrive. Lack of access to education is a major predictor of passing poverty from

one generation to the next and receiving an education is one of the top ways to achieve financial stability. Keeping youth in school or employed helps to remedy many of the other issues that can keep youth, families and even whole communities vulnerable to the cycle of poverty. Education is a basic human right for all and, when tailored to the unique needs of marginalized communities, can be used as a lever against some of the systemic barriers that keep certain groups of people furthest behind. At its core, a quality education supports a child's developing social, emotional, cognitive and communication skills. They also gain knowledge and skills to earn higher incomes and build successful lives.

Promoting education, economically stable families and strong communities is a smart investment that yields benefits beyond health: a stronger economy, more productive workers, reduced crime and less demand for social services. These are goals that we can all get behind.

3 What are your projected outcomes for the work you focused on for this project? Please specify outcomes for any specific population groups.

Breaking the cycle of health inequity starts by intervening as early as possible in a child's life. Early Intervention can interrupt the cycle linking young children's experiences of social and health disadvantage with social and health disadvantage throughout their lives. Children disadvantaged by poverty are less likely to experience the benefits of positive health-promoting conditions, such as high-quality early care and education; safe streets and green spaces for physical activity; healthy foods; and role models who engage in healthy behaviors.

We believe that seeking to keep youth in school or working provides youth and communities with the tools to break the cycle of health inequities by:

- Providing youth with skills that increase employment opportunities and income.
- Assisting and supporting local leaders and jurisdictions in applying the HOPE Data as an advocacy tool to local change-makers, health agencies and local organizations, for equity policies and practices as part of recovery from Covid-19.
- Interrupting and replacing false, stereotypical narratives with more authentic engagements which are designed to facilitate understanding, new perspectives, compassion, empathy and changing of hearts and minds that lead to policy and system change that foster a new community narrative where people vote for and elect leaders who are representative of their beliefs and political will.
- Getting Leveraging HOPE Data resources into the hands of local change-makers to encourage long-term investments in education and programs to provide job training opportunities for youth, including in high-demand STEM career pathways and a wide array of supportive services to reengage youth.

4 What HOPE domains and indicators were helpful and why?

All of the HOPE domains and indicators were helpful. Health equity means that everyone has a fair and just opportunity to be as healthy as possible. Health inequities are produced by inequities in the resources and opportunities available to different groups of people based on race/ethnicity, income, education, gender

and other characteristics tied to a history of being marginalized or excluded. When we began to reframe the health disparities conversation in the context of health equity and opportunity and focus on the interconnected relationships between the five social determinants of health domains and the twenty-four indicators of health inequity, we were able to identify several drivers and upstream determinants, as well as promising solutions for communities to close health opportunity gaps. When we began to examine the five domains and the twenty-four indicators, we were surprised to find that the Neshoba Youth Coalition's Programs directly impact all five (5) of the social domains and seventeen (17) of the twenty-four (24) social indicators of health equity. Because of the HOPE data associated with the Social Determinants of Health framework, we are better able to develop a set of broadly accessible measures to chart our progress in how we are performing locally on closing the health opportunity gaps, as well as, provide us with the data to show local policy makers and health officials the relationships and opportunities available to address and close the health opportunity gaps when we work together.

5 What additional domains or indicators can be added that would be helpful and why?

I do not feel that any additional domains or indicators are needed. I believe that there is more than enough data to help identify and address the opportunities for communities seeking to improve their health opportunity gaps.

6 Please describe how you will adapt the distance to goal concept in your local work.

In the fight for justice and equity, data is a critical tool. We will use the distance to goal concept to establish our performance benchmark indicators to chart our progress toward closing the health opportunity gap for the number of youths in school or working. We will also use the distance to goal concept to chart our continued progress in reducing teen pregnancy, low birthweight, premature and infant mortality, while also charting our efforts to increase access to affordable housing, food security, post-secondary educational opportunities, health insurance coverage and primary care. We will also continue to document the facts and data collected from our work and translate that information for diverse audiences, apply it to real-world problems to find solutions and share it in accessible ways with policymakers at every level, as well as with business and philanthropic leaders, advocates, practitioners and the youth and communities most directly affected. Distance to goal data, along with compelling community stories, will be used to capture the experiences of youth and communities at the heart of our work to continue to deepen youth and community relationships and trust that reveal the depth of social and economic problems, the impact of policy changes and the solutions that are making a difference in closing the health opportunity gaps.

Selma Center for Non-Violence, Truth and Reconciliation (Selma, AL)

1 Describe your organizational purpose related to advancing policy change, including any COVID equitable recovery responses.

Violence is a public health issue. Fifty years after Bloody Sunday, the Selma Center for Nonviolence, Truth and Reconciliation (SCNTR) was established to address the violence and conflicts that still plague Selma and the nation. In 2014, our county was the poorest county in the state. In 2016, Selma was the 8th most dangerous place per capita in the country. Broken relationships have led to broken economies which lead to broken communities, all in need of healing. The founders of the SCNTR include historic change-makers like Dr. Bernard Lafayette, a comrade of Dr. Martin Luther King Jr. and a primary architect of Selma 1.0 (the Voting Rights Movement). Together they created the organization to help take the next step in accomplishing the next leg of the journey, "Selma 2.0: Finishing the Unfinished Business of Bridging Divides and Building the Beloved Community."

The SCNTR envisions the Beloved Community as a world where there is a spirit of cooperation, where people's similarities and differences are celebrated and where policies in government and community institutions, as well as the culture they create, support fairness, equity, harmony, compassion and love.

Our "Theory of Change" asserts that transformation of an individual and community occurs when we have consistent, ongoing awareness and action on personal, cultural and institutional levels that focus on people's material conditions; and co-created environments that raise consciousness and are conducive for positive shifts in people's hearts and minds. Our programming and projects reflect these values and perspectives. We therefore work to educate communities about the factors impacting their health outcomes, provide support and training about how to advocate for the community and then partner with leaders and decision-makers so that they are helping to lead the change from within.

The need for a more direct approach to the work became apparent during the pandemic. As violence rose across the country, Selma was no different. In fact, due to the contributing factors of racism and poverty, violence was much more apparent in Selma and Dallas County. This sudden halt to business as usual for the SCNTR, which up until now had been predominantly community organizing and training, called the SCNTR into the work of providing direct service. As a part of this shift, the SCNTR took on a lead role in coordinating critical food distribution to some of the most vulnerable members of the community. Through this work, the SCNTR impacted thousands of individuals by providing access to reliable, quality foods. The SCNTR supported aspects of COVID 19 testing and education around the community.

2 Which policy area(s) did you decide to work with using the HOPE opportunity database?

Using the HOPE database, the SCNTR decided to focus on reaching the HOPE goal associated with low-homicide rates.

3 What are your projected outcomes for the work you focused on for this project? Please specify outcomes for any specific population groups.

The core outcome for the work associated with this project is the reduction of violence and homicides in Selma and Dallas County, AL. Restorative justice as a form of violence reduction is one of the strategies at the forefront of the SCNTR's work. As Selma is a place for high rates of youth and student violence, addressing the rates of fighting as well as

court referrals from R.B. Hudson Middle School was made a priority leading up to the COVID-19 Pandemic. At the height of the program the school reported a 90% reduction in student altercations and court referrals. When the pandemic hit and schools shut down, the program was suspended, causing a correlated increase in violence and office visits. The SCNTR is currently reinstating the program in schools, courts and the community with the anticipation to once again achieve the reductions previously mentioned and see even further reduction in youth and student violence between the ages of 12 and 18 years old.

Other, less quantifiable areas being focused on by the SCNTR are a part of the Violence Intervention Program (VIP). The VIP was a primary area of focus in the presentation developed by the SCNTR as a part of this project. A point that was made in conversation, as well as in the presentation, is the difficulty that was encountered when attempting to quantify and calculate violence prevention. The work being done by our Street Outreach Team and Victim Service Manager is actively reducing occurrences of retaliatory violence, but without a solid way to track the effects, it is hard to quantify. One indicator that shows we are making an impact is the reality that since we have had boots on the ground and in the community, there has only been one non-domestic violence related murder. This was during a summer period that was expected to exceed last year's murders. As the work continues, we anticipate an increase of engagement with and a decrease in the violence associated with the Black community (the predominant community we work with). Since the clients we work with are predominantly local youth and other young folks, we estimate we will see a reduction in violence within that age demographic as well.

4 What HOPE domains and indicators were helpful and why?

The most helpful domain was the Community and Safety Factors. The confluence of the different domains helped to provide a more robust and holistic perspective of what is going on in the state as a whole. For example, looking at Alabama's domain score associated with the Community and Safety Factors alone gives a one-dimensional point of view. When you start to compare that to the other domains it appears that things are rather consistent, with Alabama falling between 44 and 56 in the summary score. However, when looking at the Health Outcomes domain and Alabama only getting a 22 and looking at the summary of the bottom 5 performing states (which Alabama is number 2) it illustrates how other data may be misleading out of context.

As for the indicator that was the most helpful, that was easily the Low Homicide indicator as it so closely correlated to our core focus for the project. It was eye-opening to see the disparities between races when it came to living in a county with low homicide, but it was even more interesting to see that no group in Alabama lived in anything above 51%. Also, the ability to compare with other states and to see the disparities in each area gave a lot of context to the issues facing Alabama, but also to the trends of the locations with the lowest scores.

5 What additional domains or indicators can be added that would be helpful and why?

In looking at the available data presented by the initiative, there was an observation made about the severe lack of county-level data that was available for analysis. Especially in a rural area such as Dallas County, AL, access to data to compare to national or even regional averages was lacking. Areas of data that were discussed that would strengthen the data set included: employment rate, education trends, housing statistics and homicide statistics.

6 Please describe how you will adapt the distance to goal concept in your local work.

By using the concepts of "distance to goal" the SCNTR can adapt the concept to our end goals for our programs on a micro level. By working around the goal broadly for the general population and specifically by race and ethnicity, we can also look at data associated with socioeconomic status. We are in the process of developing a dashboard to track our work and impact. This model will greatly assist us in that process.

