



CalFresh Healthy Living Health Equity Assessment

Comprehensive Report

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Prepared For:
California Department of Social Services



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CalFresh Healthy Living Health Equity Assessment Executive Summary

Background

In response to the national emphasis on equity, this assessment focused on identifying and describing current practices and areas for improvement for incorporating racial and health equity practices in CalFresh Healthy Living programming, planning, and evaluation.

Methodology

This assessment included:

- A comprehensive literature review to identify best practices for incorporating racial or health equity strategies into health and nutrition programming.
- Spatial analysis using geographic data overlaying policy, systems, and environmental (PSE) intervention sites with Healthy Places Index, CalFresh Healthy Living eligibility, food access, and race and ethnicity data.
- Online surveys for State and Local Implementing Agency staff to better understand current practices and needs of State Implementing Agencies (SIAs) and Local Implementing Agencies (LIAs).
- Health equity roundtable discussions at the CalFresh Healthy Living Pre-Forum session in October 2022.
- Key informant interviews with local and state leaders with experience integrating racial equity into organizational practices and/or nutrition or public health programs reaching vulnerable populations.

Findings

Literature Review

The recommendations from the literature were summarized according to the Bread for the World Institute's six guiding principles for applying a racial equity lens to federal nutrition programs (**Table 1**).

Table 1. *Summary of Literature Review Findings*

Guiding Principles	Recommendations from Literature
Putting the needs of communities of color at the center	<ul style="list-style-type: none">• Utilize the Community Empowerment Model to engage the communities in need• Consider strengthening social support when implementing interventions aimed at increasing healthy behaviors, especially among Latino communities

Guiding Principles	Recommendations from Literature
Expanding inclusivity	<ul style="list-style-type: none"> • Continue offering SNAP-Ed to organizations serving diverse populations — i.e., community-based organizations (CBOs) — to increase fruit and vegetable consumption
Strengthening equity-centered approaches to make it easier for participants to access nutritional support	<ul style="list-style-type: none"> • Consider providing transportation vouchers or food delivery and clinical community linkages to those without transportation access to fresh produce • Increase variety, accessibility, and affordability of high-quality produce in low-resource communities • Expand the reach of information about food pantries and meal distributions sites
Increasing support for and accountability of program staff	<ul style="list-style-type: none"> • A digital health equity framework should be incorporated into health provider trainings to limit inequities in the virtual health landscape • Increase diversity in leaders and program staff to ensure they are representative of the community they serve
Creating mechanisms that enable recipients, particularly recipients of color, to equitably participate in designing, implementing, and evaluating programs	<ul style="list-style-type: none"> • Provide a mechanism for incorporating participatory research practices into interventions to obtain valuable feedback from the community • Increase coordination with CBOs and civil rights organizations focused on equity
Strengthening data collection and disaggregation	<ul style="list-style-type: none"> • Consider qualitative data to tell the story of the community beyond numbers • Employ a participatory approach to evaluation using an iterative process to engage stakeholders • Report and disaggregate the race and ethnicity of study participants to properly assess the impact of interventions on different groups

Healthy Equity Mapping

Overall, PSE activities are taking place in or near high-need areas; however, there are some gaps, particularly in the Central Valley, (Fresno, Kern, and Tulare counties) as well as San Bernadino and Riverside counties, where there are communities with few PSE sites and high CalFresh Healthy Living eligibility in addition to high proportions of Latino, Black, Indigenous, or other populations of color.

State and Local Implementing Agency Surveys

The California Department of Social Services (CDSS) sent emails to SIA and LIA staff inviting them to participate in an online survey. The LIA survey focused on direct services with the CalFresh Healthy Living population, while the SIA survey focused more on providing support to the LIAs. Both surveys included questions related to workplace culture. The surveys included both multiple-choice and open-ended questions (See Appendix I).

LIA Survey

Demographics

There were 110 LIA staff who completed an online survey, representing all four SIAs and 18% of all local staff. Almost all respondents indicated involvement in PSEs (88%), Indirect (87%) and Direct (86%) Education, and partnership and/or coalition building (80%), with 66% involved in evaluation activities and 42% involved in social marketing. Over half of the respondents (60%) were program coordinators, managers, or supervisors, 23% were health or nutrition educators (23%), with 10% as program specialists, and 3% as other administrative support. Twenty-nine percent of respondents identified as Hispanic or Latino, 44% identified as white and 10% identified as multiple races or ethnicities. Almost all respondents (96%) were fluent in English, with 56% fluent in English only and 40% fluent in English and other languages, most frequently (30%) in Spanish.

Direct Education

Of those who reported being involved in delivering Direct Education (n = 86), 97% indicated that they deliver Direct Education in English and 64% indicated they deliver Direct Education in Spanish. The most common ways that respondents reported culturally adapting Direct Education were the translation of lessons or materials into other languages (36%) and including culturally appropriate recipes (27%). While 36% reported that they use lessons in participants' primary language and 27% provide culturally appropriate recipes, respondents still indicated that to better serve their populations they need additional translated materials (23%) and more culturally appropriate recipes and resources (15%). Of the 82 respondents indicating that they conduct evaluation activities with Direct Education participants, 23% indicated that participants often or always have trouble answering questions due to cultural or language barriers.

Policy, Systems, and Environmental Change Activities

LIA staff respondents who indicated PSE involvement (n = 85) reported that racial and ethnic diversity is considered in PSE planning in the following ways: direct community input either through direct engagement, surveys, or feedback from participants or champions (26%); feedback from local partners (15%); using culturally appropriate materials (14%); and data or literature reviews (7%).

Workforce Readiness

Most respondents (83%) indicated that their organizations are providing racial equity and cultural competency training, over half (59%) said their organization has a mission statement that incorporates equity, and 52% reported an internal structure dedicated to promoting diversity. Only one-third (34%) of respondents indicated their organization has written procedures to increase recruitment, retention, and promotion of people of color; however, 42% of the staff did not know if those procedures were in place. Respondents indicated that the California Department of Social Services (CDSS) can help them better serve their populations through the provision of tailored resources and campaigns for specific groups (61%), additional translated materials and curriculum to reach more audiences (61%), specific training on equity (52%), tailored technical assistance (47%), and partnerships with healthy equity and racial justice organizations (42%).

SIA Survey

Demographics

There were 29 SIA staff who completed the online survey representing all four SIAs and 35% of all state-level staff. Seventy-six percent of respondents indicated being involved in coordination and support of LIAs and 62% involved in training. The majority of SIA respondents (59%) identified as white, 14% as Hispanic or Latino alone or Hispanic or Latino and white, 3% each as Black or African American, Asian, or Biracial. All respondents indicated fluency in English, with 24% fluent in English and one other language.

Translated Materials

All respondents reporting languages indicated materials were provided to LIAs in Spanish as well as the following additional languages: Chinese (68%), Hmong (41%), Russian (32%) and Vietnamese (32%).

Assessment and Consideration of Racial Equity

To better serve CalFresh Healthy Living populations, 62% of respondents felt that asset-based or strength-based approaches are needed, 62% stated that PSE guidance on tailoring activities for specific groups are needed, 59% indicated that additional translated materials and resources are needed, and 59% noted that new culturally tailored curricula to reach specific groups are needed. The top three challenges or barriers that respondents mentioned they face with gathering input directly from diverse CalFresh Healthy Living eligible populations to inform overall multi-level program planning and priorities were lack of funding for incentives (38%), lack of staff (31%), and language and/or cultural barriers (28%).

Organizational Readiness

Eighty-one percent of respondents indicated that their organizations are providing racial equity and cultural competency training, 76% have a mission statement, 57% have formal written policies that incorporate equity and 52% have an internal

structure dedicated to promoting diversity. Forty-eight percent of respondents indicated their organization has written procedures to increase recruitment, retention, and promotion of people of color, although many of the staff (43%) did not know if these procedures were in place.

Health Equity Roundtable Discussions

At a CalFresh Healthy Living Pre-Forum session on October 17, 2022, titled *Health Equity & Racial Justice in CalFresh Healthy Living: Why it Matters & How to Take Action*, Public Health Institute Center for Wellness and Nutrition staff gathered additional feedback from LIAs and SIAs on what challenges they faced in the field and what the state could do to support the expansion of racial and health equity work in CalFresh Healthy Living. The following points summarize those discussions:

- **Materials and Resources:** Participants felt that there was a strong need for translated and culturally tailored nutrition education materials to better serve the diverse populations in California.
- **Disconnect Between Management and Educators:** Attendees felt that there was a detachment between leadership and the front-line staff related to understanding how hard it was to implement nutrition education and PSEs.
- **Foundational Training in Cultural Sensitivity and Equity:** Attendees emphasized the need for training on different cultures, equity, and how to implement equitable practices throughout the CalFresh Healthy Living work.
- **Equity Framework and Equity Partnerships:** Attendees noted the need for an equity framework in CalFresh Healthy Living, but emphasized that there were several examples already being developed locally and that it should be LIA-informed.
- **Community Involvement:** Attendees mentioned the value of engaging the community in the program planning process and that there is more need for this.

Key Informant Interviews

A list of potential key informants across the state of California who had experience integrating racial equity into organizational practices and/or nutrition or public health programs was proposed by PHI CWN and approved by CDSS. The informants were contacted via email by PHI CWN staff and six agreed to participate. Findings were organized according to the overarching themes of challenges, facilitators, and recommendations. The themes and subthemes that emerged from the interviews are shown in **Table 2**.

Table 2. *Key Informant Interview Theme Breakdown*

Themes	Sub themes
Theme 1: Challenges facing organizations in addressing equity	Failing structural systems
	Program accessibility
	Lack of diversity
Theme 2: Facilitators and structures to support equity work	Internal organizational policies and practices
	Leadership buy-in
	Commitment to community engagement
	Equitable compensation practices
	Equity-centered evaluation
Theme 3: Recommendations and resources for conducting and evaluating health equity work	Address systemic oppression and build foundational knowledge
	Center community through partnerships and collaboration
	Define and measure equity
	Implement equitable funding and compensation practices

Limitations

State and local staff respondents to the surveys were not representative in terms of staff numbers and geographic location. Therefore, the results from the surveys cannot be generalized to all CalFresh Healthy Living staff, LIAs, or SIAs. There were only six key informants interviewed to provide expertise on racial and health equity practices, again not allowing these results to be generalized across all leaders integrating racial equity practices into nutrition programming. Despite these limitations, common themes were noted across the literature review, survey responses, roundtable discussions, key informant interviews, and mapping exercises.

Overarching Themes

In summary, across the literature review, survey responses, roundtable discussions, key informant interviews, and mapping exercises, several common themes in advancing racial and health equity arose:

- Organizational commitment and investment
- Community engagement and equitable compensation
- Acknowledging, dismantling, and rebuilding systems of oppression

- Inclusive evaluation practices

Overall Recommendations

The following are recommended for CalFresh Healthy Living to commit to improving and expanding racial and health equity throughout the program.

Organizational Capacity Building

- Invest in internal best practices and processes that promote equity
- Develop a series of foundational health equity training sessions for all CalFresh Healthy Living staff
- Establish a Statewide Justice, Equity, Diversity, and Inclusion (JEDI) Committee
- Advocate for systemic change at the federal, state, and local levels

Program and Resource Development

- Center community
- Ensure that community participation is fair and valued
- Expand language offerings and adaptations of educational materials and curricula
- Co-create/co-design culturally tailored campaigns and resources for diverse Californians

Evaluation Practices

- Recognize and acknowledge the implicit biases that influence evaluation practices and take a mixed methods and systems approach
- Report and disaggregate data by race/ethnicity to more accurately identify inequities, successes, and to better tailor program activities. Use multiple evaluation methods to assess several types of change and tell the community story
- Use a geographic information system as a tool to map data and prioritize programs in underserved areas and identify gaps in service
- Tell the story of community through participatory evaluation approaches
- Create a health equity framework with measurable indicators of progress and change

CalFresh Healthy Living Health Equity Assessment Comprehensive Report

Background

Racial equity is a national priority of the Biden Presidential Administration. On his first day in office, President Biden signed Executive Order 13985, *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (2021)*. The executive order recognized the impact of systemic racism and other disparities on the American people and set forth government-wide policy to address equity, including allocation of federal funds to advance fairness and opportunity. To meet the national push for more equitable practices, the United States Department of Agriculture's Food and Nutrition Services (USDA FNS) *Actions on Nutrition Security* report (USDA Food and Nutrition Service, 2022) included increasing equity as one of the four pillars for improving nutrition security among Americans, stating, "Disparities in diet-related diseases are rooted in long-standing historical inequities. To help tackle these systemic issues, USDA is advancing nutrition security in an equitable way that supports resilient, sustainable food systems for all." SNAP-Ed Plan Guidance states that SNAP-Ed agencies should adopt approaches to deliver evidence-based nutrition education and obesity prevention activities with an equity lens.

CalFresh Healthy Living has made equity a priority with its number one principle: *Address racial and health equity through the promotion and maintenance of an equitable program practice that is inclusive of those with lived experience in design, implementation, and evaluation.* The overarching goal of CalFresh Healthy Living is to reduce rates of obesity and racial/ethnic disparities in rates of obesity among Californians eligible for CalFresh Healthy Living. The following Goals and Objectives will be used to track progress on this goal:

Priority Goal 3 - Reduce racial/ethnic disparities in dietary quality and physical activity among Californians eligible for CalFresh Healthy Living.

Objective 3: By September 2026, to increase equitable representation in Direct Education, the proportion of Direct Education recipients will be at least 75% of the SNAP-Ed eligible race/ethnicity population proportion.

Objectives

This assessment focused on identifying and describing current practices and areas for improvement for incorporating racial and health equity practices in CalFresh Healthy Living programming, planning, and evaluation. For this evaluation, racial and

ethnic equity was defined as, “a process of eliminating racial and ethnic disparities and improving outcomes for everyone through structural and systemic improvements.” (Race Forward, N.D.). The objectives of this assessment were the following:

- Identify best practices for incorporating racial or health equity strategies into CalFresh Healthy Living programming
- Identify existing health equity frameworks that can be adapted for CalFresh Healthy Living programming and evaluation
- Use geographic data to identify high-need areas that are being well served or have gaps in CalFresh Healthy Living programming and services
- Gain perspectives from CalFresh Healthy Living State Implementing Agency (SIA) and Local Implementing Agency (LIA) staff on the following:
 - Current practices incorporating racial equity in CalFresh Healthy Living programming, planning, and evaluation
 - Gaps in services for racially and culturally diverse communities
 - Organizational needs to better incorporate racial equity in CalFresh Healthy Living programming, planning, and evaluation

Methods

Literature Review

A systematic literature review was performed based on the guiding principles from the Bread for the World Institute's recommendations for applying a racial equity lens to federal nutrition programs (Bread for the World Institute, 2019). Keyword searches were based on these six principles:

- Putting the needs of communities of color at the center
- Expanding inclusivity
- Strengthen equity-centered approaches to make it easier for participants to access nutritional support
- Increasing support for and accountability of program staff
- Creating mechanisms that enable recipients, particularly recipients of color, to equitably participate in designing, implementing, and evaluating programs
- Strengthening data collection and disaggregation

A PubMed search was conducted using unique and tailored search terms (e.g., including Medical Subject Headings (MeSH) terms) for racial/health equity in food assistance including the terms “population groups” or “health equity” or “social justice” and “food assistance” for the years 2012 through 2022. The relevant articles were reviewed and summarized based on the following categories: racial/ethnic differences, social determinants of health, and barriers. An additional targeted search was conducted to identify best practices in federal programming practices,

including health and racial equity goals for federal and nonprofit programs. Finally, a search of the grey literature was conducted to fill in any gaps.

Health Equity Mapping

A Geographic Information System (GIS) map of the State of California was developed displaying sites where CalFresh Healthy Living policy, systems, and environmental (PSE) interventions were implemented in 2021 to help identify geographic areas where there may be gaps in services for Latino, Black, Indigenous, or other people of color (BIPOC) CalFresh Healthy Living eligible populations. The addresses for the PSE sites with changes implemented in 2021 were obtained from the California Program Evaluation and Reporting System (PEARS) and converted to GIS files for mapping. Additional data layers related to food access, healthy communities, and race and ethnicity were incorporated into the map to help identify geographic areas of high need as shown in **Table 3**.

Table 3. *Additional GIS Map Data Layers*

Data Layers	Data Source
Percentage of population who are eligible for CalFresh Healthy Living: household incomes at or below 185% of the Federal Poverty Level (FPL)	American Community Survey, 2020 (U.S. Census Bureau, 2020)
Low income and low food access tracts based on the 2019 Food Access Research Atlas data	Food Access Research Atlas, 2019 (Economic Research Service, N.D.)
Healthy Places Index (HPI) percentiles based on the HPI 3.0 score	Healthy Places Index 3.0, 2015-2019 (The Public Health Alliance, 2022)
Percentage of Latino or BIPOC	American Community Survey, 2020 (U.S. Census Bureau, 2020)

In addition to creating maps, spatial analysis was conducted using ArcGIS software to determine census tracts that may be most in need of SNAP-Ed interventions based on CalFresh Healthy Living eligibility, race and ethnicity, food access, and the Healthy Places Index (HPI). The proportion of census tracts with PSE sites that were considered high-need based on the health of the community, food access, CalFresh Healthy Living eligibility, and race and ethnic diversity were calculated. Additionally, the top site settings (e.g., schools, after-school programs, food stores, etc.) and their proportions located in high-need areas are reported. A publicly accessible ArcGIS *StoryMap* was created displaying multiple maps with different variables overlaid on the PSE sites and including text to describe the findings.

SIA and LIA Surveys

Based on the literature review and the guiding principles for incorporating racial and health equity in nutrition programming, data collection tools were developed by the Public Health Institute Center for Wellness and Nutrition (PHI CWN) incorporating feedback from CDSS and the Evaluation Working Group for the CalFresh Healthy Living SIAs. The LIA survey focused on direct services with the CalFresh Healthy Living population, while the SIA survey focused more on providing support to the LIAs. Both surveys included questions related to workplace culture. The surveys included both multiple-choice and open-ended questions and can be found in Appendix I.

The LIA survey was sent out to 361 email addresses from the CDSS LIA staff members' email group. There were 110 LIA staff that consented to and completed the LIA survey which is a 30% response rate from the original email list. However, CDSS indicated that as of October 2022 there were 614 local staff representing about 374 full-time equivalents, therefore LIA survey respondents reflect 18% of the total LIA staff. The SIA survey was sent out to 131 email addresses of SIA and other state-level staff members. As of October 2022, there were 84 state-level staff representing about 63 full-time equivalents. There were 29 SIA staff that consented to and completed the SIA survey representing 35% of all SIA staff.

Finalized surveys were programmed into an online platform (SurveyMonkey) and distributed to staff via email by CDSS. Data collection occurred between July and September 2022. The surveys included an informed consent statement before answering the first survey question. Participation in the survey was strictly voluntary; those who did not consent to participate were directed to the end of the survey.

Descriptive statistics for the categorical variables were calculated overall where the sample size was greater than five to maintain confidentiality. Responses from open-ended questions were reviewed and coded by common themes. Themes as well as relevant quotes without identifiers are reported. Survey results are reported in aggregate and no individual staff members are identified in the final report. Data cleaning and descriptive analyses were conducted using IBM SPSS Software for Windows.

Key Informant Interviews

A list of potential key informants across the state of California who had experience intentionally integrating racial equity into organizational practices and/or nutrition or public health programs reaching vulnerable populations was proposed by the PHI CWN and approved by CDSS. The informants were contacted via email by PHI CWN staff and six agreed to participate. Consent was attained from all participants before the interviews and participants agreed to be cited confidentially and to have their thoughts and experiences published in the final study report.

A structured interview guide was developed by PHI CWN and reviewed by CDSS (Appendix II). The interview guide focused on the informant's racial equity work, their recommendations on how to improve racial equity in nutrition programs like CalFresh Healthy Living, and best practices for incorporating racial equity practices into organizations and programs. The interviews were conducted by two PHI CWN team members, one acted as the moderator and the other as the notetaker. The interview recordings and transcripts were all saved and stored confidentially using study identification numbers on a password-protected internal drive. The interviews were coded using the qualitative software, Dedoose, and the codes were grouped into larger themes. Analysis was conducted using an inductive process to allow the unrestricted emergence of themes.

Findings

Literature Review

The results from the literature review are summarized according to Bread for the World Institute's guiding principles for applying a racial equity lens to federal nutrition programs described in the methods section.

Putting the Needs of Communities of Color at the Center

Historically, there are disparities in food insecurity by race and ethnicity. In 2021, the rate of food insecurity of white Californians eligible for CalFresh Healthy Living (185% of the Federal Poverty Level) was 32% compared to 42% for the Hispanic or Latino population and 46% for the Black or African American population (UCLA, 2021). Incorporating equity in nutrition programming by centering the needs of communities of color ensures all community members have equal access to nutrition and food security, regardless of socioeconomic status.

- Fowler and Giger (2017) in a review of existing literature found that despite receiving community-level resources — i.e., Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) — to support healthy nutrition, food insecurity persists among low-resource African American women. Both food insecurity and food deserts negatively affected emotional eating, emotional coping, coping strategies, and depressive symptoms in low-resource African American women. Beyond traditional SNAP-Ed intervention strategies, one way to address this issue suggested by the authors is to engage the community most impacted through the five core processes of the Community Empowerment Model: 1) community coalitions, 2) critical consciousness-raising, 3) exerting public pressure, 4) lobbying, advocacy, and mediation, and 5) reframing and reorienting health services.

- Hromi-Fiedler, Chapman, et al., (2016) found that social support from family and friends was a primary factor driving prenatal fruit and vegetable intake among Latina women residing in Connecticut. These findings suggest that interventions designed to increase fruit and vegetable intake among pregnant Latinas should consider elements that can strengthen social support. In the absence of familial support, strengthening available support systems could provide an environment that promotes healthy prenatal eating behaviors.

Expanding Inclusivity

Expanding inclusivity for health and nutrition programs increases access to food and services for individuals in need of healthy food options.

- Molitor, Sugerman, et al., (2015) examined SNAP-Ed interventions across California and found that people living in high-reach census tracts — i.e., census tracts containing a high number of residents (90%+) who were SNAP-Ed-eligible — reported eating more fruits and vegetables than communities with fewer SNAP-Ed-eligible members. The findings also support that offering SNAP-Ed to organizations serving diverse populations can help increase fruit and vegetable intake to low-income people throughout California.

Strengthening Equity-Centered Approaches to Make it Easier for Participants to Access Nutritional Support

Equity-centered approaches consider the barriers citizens face when trying to access nutritional support.

- Banks, Bell, et al. (2021) discussed the transportation barriers that exist for clients in urban communities in Ohio that are not near farmers or fresh produce. The researchers found that people who used their car when shopping for food had lower odds of food insecurity and more positive attitudes related to the ease of shopping for healthy foods. Providing transportation vouchers or food delivery and clinical community linkages to those without transportation access to fresh produce may help connect SNAP beneficiaries to healthy foods and nutrition resources.
- Gosliner, Brown, et al (2018) examined availability of fresh produce in low-income neighborhoods in California. They found that fresh produce tends to be more expensive in low-resource neighborhoods and convenience stores tend to have poorer-quality produce than larger stores. Additionally, those stores participating in WIC or SNAP tended to have better produce availability, variety, and quality than non-participating stores. Work that increases the variety, accessibility, and affordability of high-quality produce in low-income communities, particularly in smaller stores, is needed.

- McLoughlin, McCarthy, et al. (2020), guided by the *Getting to Equity* framework, conducted a case study on school meals in four large urban school districts in Chicago, Houston, Los Angeles, and New York City during the COVID-19 pandemic and identified potential strategies to increase equitable access to nutrition assistance programs, such as increasing healthy food options and promoting the consumption of a balanced diet. Additionally, districts used inclusive language and images, partnered with first responders and relief organizations to build community capacity, provided technical assistance to families, referred essential workers to childcare resources, and provided other wellness resources to meet people where they are and increase equitable access to nutrition assistance programs.

Increasing Support for and Accountability of Program Staff

Increasing workforce diversity and cultural competency can reduce some of the unconscious biases that can impact the successful implementation of programs.

- Crawford and Serhal (2020) examined digital health innovations that have been rapidly implemented to tackle health delivery challenges amplified by the COVID-19 pandemic. However, they found that poverty, lack of access to digital health, poor engagement with digital health for some communities, and barriers to digital health literacy were contributing to poor health outcomes in a digital world. A digital health equity framework should be incorporated into provider training. Furthermore, meaningful involvement by people from marginalized groups in positions of leadership and in codesigning at all stages of innovation and implementation is important to ensure the needs of the community are being met.
- Cooksey Stowers, Marfo, et al., (2020) identified multiple themes drawing linkages between structural characteristics (e.g., increased access to unhealthy food from donors, inadequate food supply, etc.) and social characteristics (e.g., stereotypes, lack of trust, lack of diverse representation among food bank system leaders, etc.) of the food banking system and inequities in the prevalence of obesity and food insecurity for food pantry clients. Improving how well organization leaders and staff are representative of the community they serve and using an equity-oriented obesity framework will help to address the underlying issues of access to economic and social resources.

Creating Mechanisms that Enable Recipients, Particularly Recipients of Color, to Equitably Participate in Designing, Implementing, and Evaluating Programs

Ongoing evaluations that allow program recipients to provide meaningful recommendations about how programs can best serve them are necessary to achieve equity in nutrition and health programs.

- Nelson and Zanti (2020) used participatory action research and public deliberation to co-create a framework of best practices for centering equity across the stages of an administrative data life cycle. Purposeful sampling was used to gather a 15-person workgroup, representing diverse perspectives across race, gender, geography, and profession to incorporate the expertise of those historically without power (e.g., research subjects) and those with power (e.g., the researchers) that resulted in the development of a toolkit with guidance on encouraged and discouraged data access and utilization for community-based and government agencies regularly reusing administrative data.
- The *Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government* stated that agencies must consult with historically underrepresented and underserved communities. Through this executive order, President Biden emphasized increasing coordination, communication, and engagement with community-based organizations and civil rights organizations (Exec. Order No. 13985, 2021).

Strengthening Data Collection and Disaggregation

To achieve equity in health and nutrition programs, it is essential to track outcomes for all community members regardless of race/ethnicity or income level.

- Krzyzanowski Guerra, Hanks, et al., (2021) used semi-structured interviews to identify facilitators and barriers to increasing access to food through food value chains in the rural Appalachia region of Ohio. Using qualitative methods, interviewers gained contextual insights into the implementation and perceived impacts of market-based and assistance-based local value chain models of healthy food access. Additionally, the researchers enhanced the credibility of the findings by establishing an ongoing collaborative partnership, developing a detailed codebook, using an iterative, group process for transcription, and member-checking findings with the community.
- Nelson and Zanti's (2020) framework describe using an equity lens to consider the biases and vulnerability in data collection and how they can be reduced. Data should be released using a multi-tiered approach to allow for clear delineation of practical and legal availability of data and reduce the misrepresentation of data in secondary research. Additionally, when analyzing, data should be disaggregated to show the experiences of each subgroup and identify disparities in outcomes. Because of the complexity of centering equity, data analysis should be an iterative process with participation from a variety of collaborators.
- Singleton, Kesse, et al., (2020) found that in Illinois non-Hispanic Black participants infrequently went to farmers markets and had lower odds of

consuming fruit compared to non-Hispanic White participants. Through this research, Singleton et al., (2020) concluded that reporting and disaggregating the race and ethnicity of study participants is important to properly assess the impact of interventions, such as farmers' market incentive programs to diverse low-resource communities.

Summary of Literature Review Findings

The results from the literature review are summarized in **Table 4**. This supports the need for incorporating guiding principles when centering equity in health and nutrition programming.

Table 4. *Summary of Literature Review Findings*

Guiding Principles	Recommendations from Literature
Putting the needs of communities of color at the center	<ul style="list-style-type: none"> • Utilize the Community Empowerment Model to engage the communities in need • Consider strengthening social support when implementing interventions aimed at increasing healthy behaviors, especially among Latino communities
Expanding inclusivity	<ul style="list-style-type: none"> • Continue offering SNAP-Ed to organizations serving diverse populations (i.e., CBOs) to increase fruit and vegetable consumption
Strengthening equity-centered approaches to make it easier for participants to access nutritional support	<ul style="list-style-type: none"> • Consider providing transportation vouchers or food delivery and clinical community linkages to those without transportation access to fresh produce • Increase variety, accessibility, and affordability of high-quality produce in low-resource communities • Expand the reach of information about food pantries and meal distributions sites
Increasing support for and accountability of program staff	<ul style="list-style-type: none"> • A digital health equity framework should be incorporated into health provider trainings to limit inequities in the virtual health landscape • Increase diversity in leaders and program staff to ensure they are representative of the community they serve
Creating mechanisms that enable recipients, particularly recipients of color, to equitably participate in designing, implementing, and evaluating programs	<ul style="list-style-type: none"> • Provide a mechanism for incorporating participatory research practices into interventions to obtain valuable feedback from the community • Increase coordination with CBOs and civil rights organizations focused on equity

Guiding Principles	Recommendations from Literature
Strengthening data collection and disaggregation	<ul style="list-style-type: none"> • Consider qualitative data to tell the story of the community beyond numbers • Employ a participatory approach to evaluation using an iterative process to engage stakeholders • Report and disaggregate the race and ethnicity of study participants to properly assess the impact of interventions on different groups

Framework for Equity Practices in Evaluation

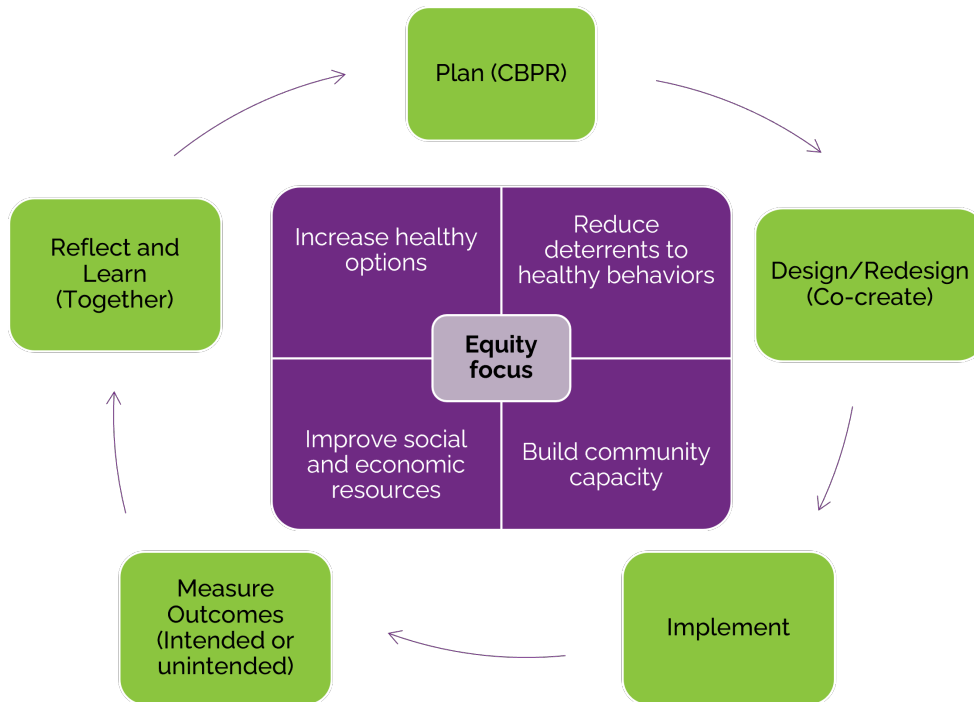
Several equity frameworks were reviewed in the literature review process. A combined framework was developed for initial consideration by combining the following two existing frameworks, one more evaluation-focused (W.K. Kellogg, 2021) and one more programmatic (Kumanyika, 2017):

- [Getting to Equity in Obesity Prevention Framework](#) (Kumanyika, 2017)
- [Practice Guide Series – Doing Evaluation in the Service of Racial Equity](#) (W.K. Kellogg Foundation, 2021)

The programmatic framework is an equity-oriented obesity prevention action framework, focusing on increasing healthy options, reducing deterrents to healthy behaviors, improving social and economic resources, and building community capacity. The evaluation framework focuses on planning an intervention, co-creating with multiple stakeholders, implementing, measuring outcomes, and reflecting and learning from outcomes together.

The proposed combined framework takes concepts from both the Kumanyika and W.K. Kellogg frameworks, centering equity-oriented obesity prevention with the evaluation coexisting around the outside as shown in **Figure 1**.

Figure 1. *Combined Equity in Programming and Evaluation Framework*

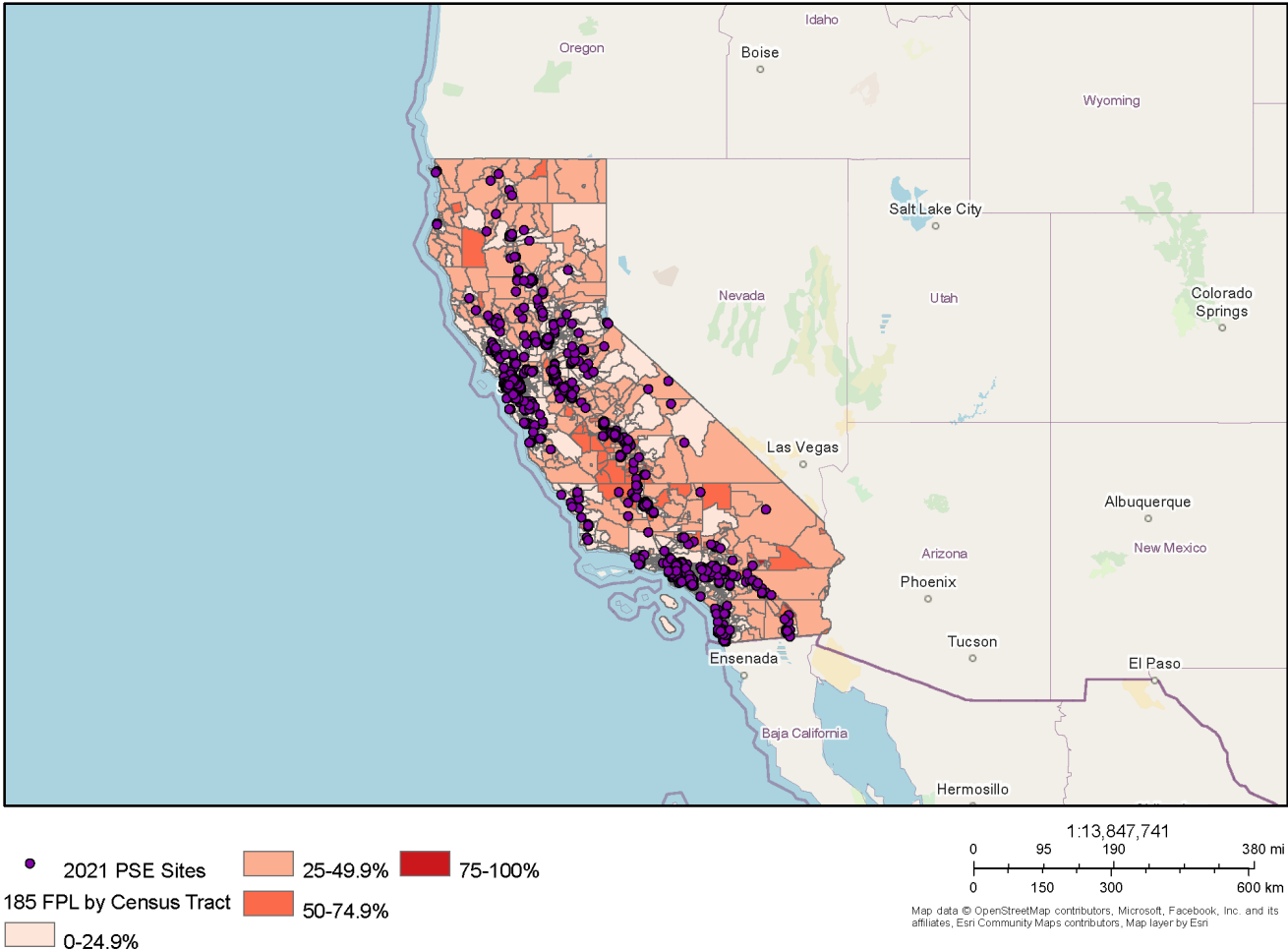


Healthy Equity Mapping

The Story Map was published publicly at the following link: <https://arcg.is/OXGbiP>. Screenshots of the Story Map are included in this report. However, for interactivity and best viewing, it is recommended to use the online version.

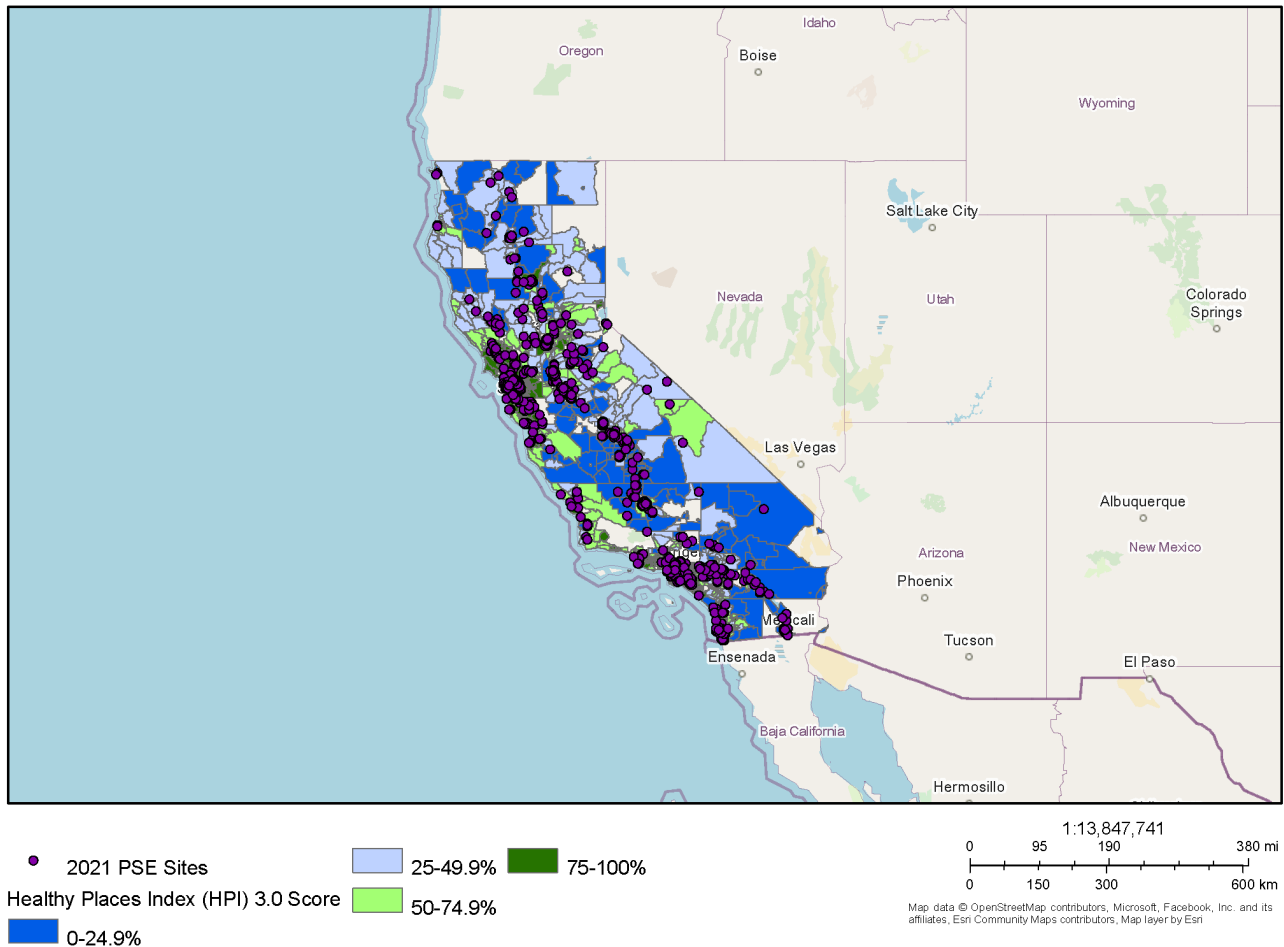
California has 9,218 census tracts, 11.6% of which, or 1,066, have more than 50% of the population eligible for CalFresh Healthy Living (household income less than 185% of the Federal Poverty Limit). Out of the 58 counties in California, none have more than 50% CalFresh Healthy Living-eligible, but 27 have more than 30% of the population eligible. Based on data entered into the Program Evaluation and Reporting System, there were 940 unique sites where 1,025 CalFresh Health Living-supported PSE activities took place in 2021 (**Figure 2**). Some sites had more than one PSE activity that occurred.

Figure 2. 2021 CalFresh Healthy Living PSE Sites by Percent SNAP-Ed Eligible



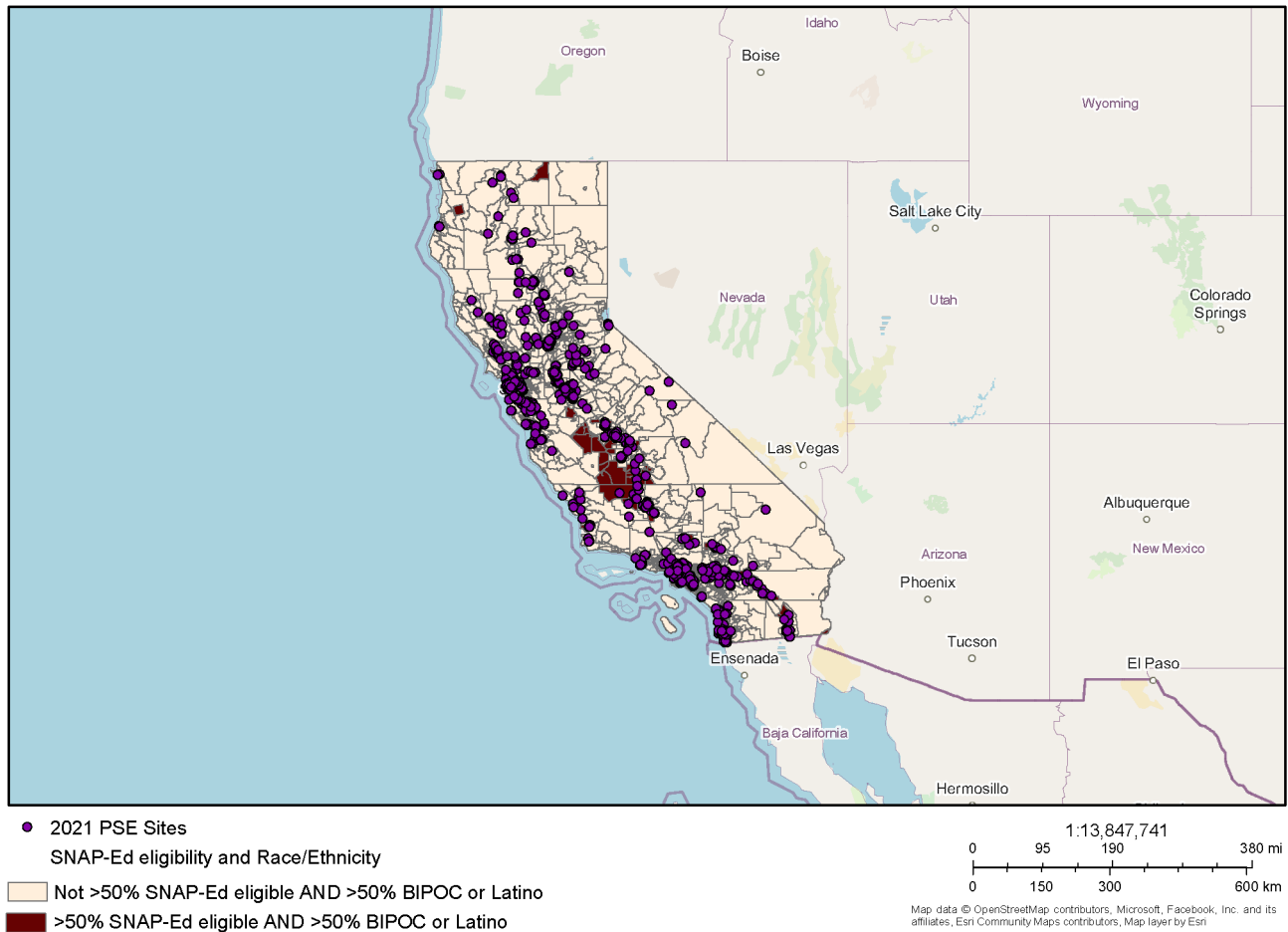
The California HPI (The Public Health Alliance of Southern California, 2022) is a tool to explore the community conditions that impact life expectancy. The HPI combines 25 community characteristics, such as access to healthcare, housing, education, and more, into a single indexed HPI score. The healthier a community, the higher the HPI score. In California, 42% (n=3,895) of the census tracts have been identified by the HPI as experiencing less healthy community conditions (i.e., HPI percentile less than or equal to 50%). As shown in **Figure 3**, almost 70% of PSE sites were located in areas where the HPI was less than 50%. However, there are 4 counties with HPI scores less than 50% and no PSE sites: Modoc, Mariposa, Lassen and Sierra.

Figure 3. 2021 CalFresh Healthy Living PSE Sites by Healthy Places Index



Examining by race/ethnicity, 10% (n=940) of California census tracts have more than 50% SNAP-Ed-eligibility, and more than 50% of the population identified as Latino or BIPOC, based on 2020 data from The American Community Survey. A majority of those are in Los Angeles and the Central Valley (including Fresno, Kern, San Bernadino, Riverside and Tulare Counties) as shown in red on the map. Of the 940 high-need census tracts (i.e., >50% SNAP-Ed eligible and >50% Latino, Black, Indigenous, or other people of color), 156 (16.6%) have PSE sites (**Figure 4**).

Figure 4. 2021 CalFresh Healthy Living PSE Sites by Areas of High Need (>50% SNAP-Ed eligible and >50% Latino, Black, Indigenous, or Other People of Color)

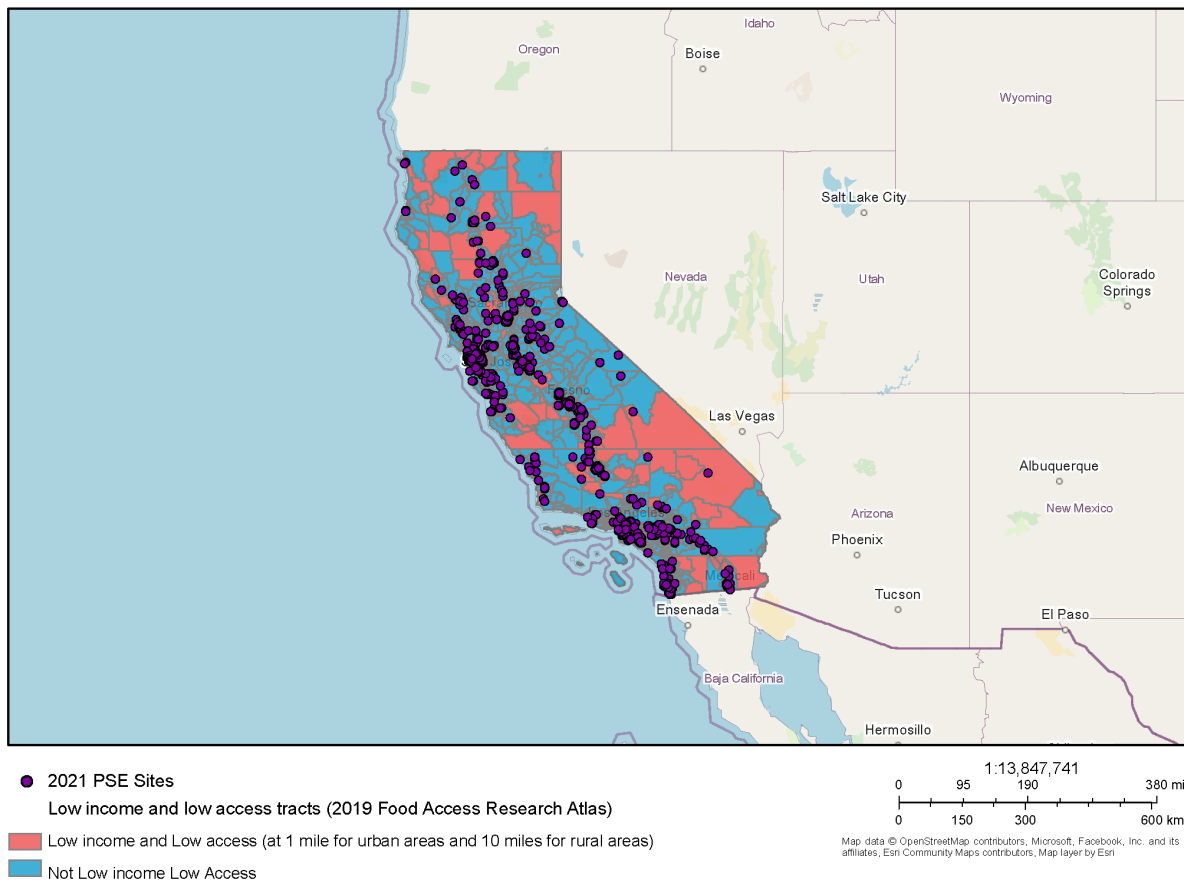


The United States Department of Agriculture Economic Research Service's Food Access Research Atlas (Economic Research Service, N.D.) does the following:

- Presents an overview of food access indicators for low-resource and other census tracts using different measures of supermarket accessibility.
- Provides food access data for populations within census tracts; and
- Offers census-tract-level data on food access that can be downloaded for community planning or research purposes.

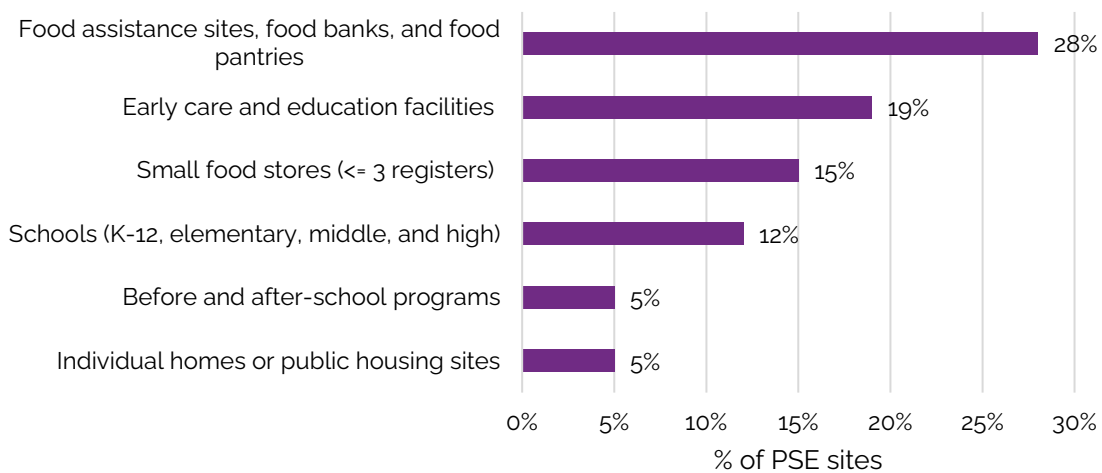
In California, 6.7% (n=536) of the census tracts have been identified as low-resource and low-access (LILA) to food retailers (more than 1 mile in urban areas, more than 10 miles in rural areas) based on 2019 data from the Food Access Research Atlas. Only 11.3% of the 2021 CalFresh Healthy Living PSE sites are in LILA census tracts. The majority of the LILA areas are wilderness or mountains; however Merced and Palmdale, both with a population of greater than 50,000, are in LILA areas and have few PSE sites nearby (**Figure 5**).

Figure 5. 2021 CalFresh Healthy Living PSE Sites by Low Income, Low Access to Food Retailers (More Than 1 Mile in Urban Areas, More Than 10 Miles in Rural Areas) Census Tracts



Of the 1,025 PSE activities in 2021, 202 (19.7%) were in high-need census tracts (i.e., >50% SNAP-Ed-eligible and >50% Latino, Black, Indigenous, or other people of color). Cities located in high-need areas that have populations of greater than 50,000 and have limited neighboring PSE sites include Merced, Palmdale, Fontana, Pomona, Alhambra, and Huntington Park. The most frequent site setting located in high-need areas where PSE activities took place in 2021 were food assistance sites (28%), early care and education facilities (19%), and small food stores (15%) (**Figure 6**).

Figure 6. *Percentage of 2021 CalFresh Healthy Living PSE Sites in High Need Areas. (>50% SNAP-Ed Eligible and >50% Latino, Black, Indigenous, or Other People of Color) by Site Setting*



Overall, PSE activities are taking place in or near high-need areas. However, there are some gaps, particularly in the Central Valley and including the counties of Fresno, Kern, San Bernadino, Riverside, and Tulare, where there are communities with high SNAP-Ed-eligibility and have high proportions of Latino, Black, Indigenous, or other populations of color, without many PSE sites.

Local Implementing Agency Survey

Respondent Demographics

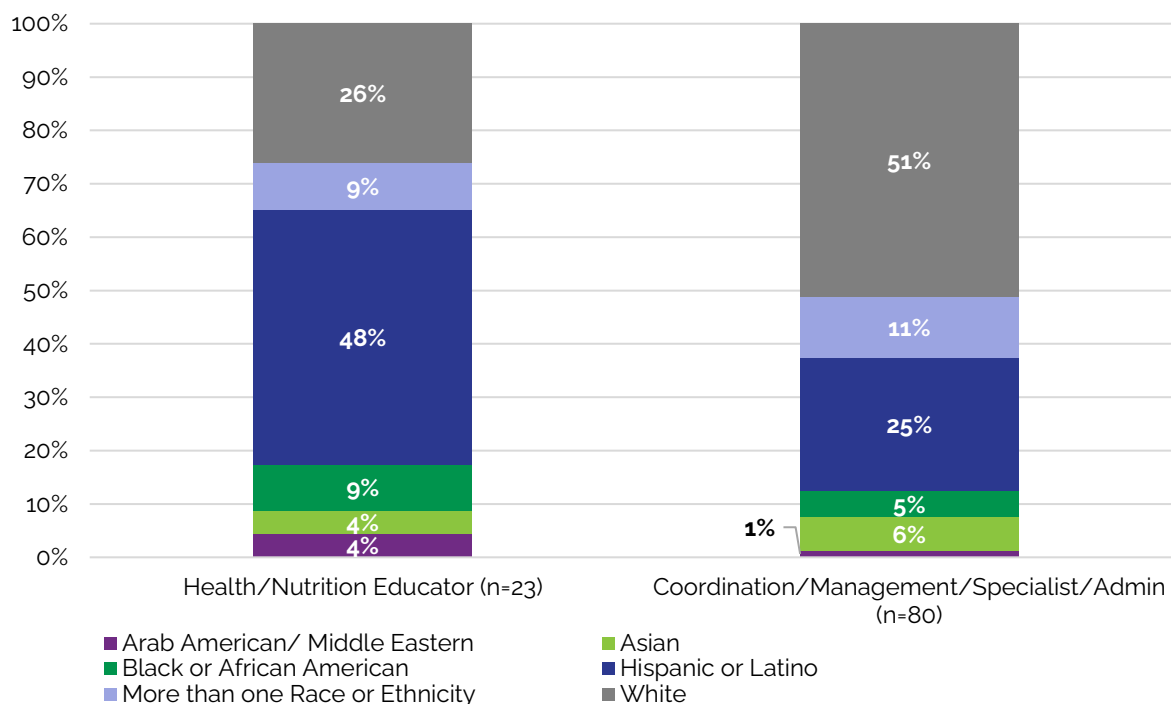
There were 110 LIA staff who consented to and completed the LIA survey, which was disseminated in July 2022 via SurveyMonkey. The survey respondents reflect 18% of the total LIA staff and are not a representative sample of CalFresh Healthy Living or the local agency staff overall. There were survey respondents representing LIAs overseen by all four SIAs, with 58% representing California Department of Public Health (CDPH), 17% representing the California Department of Aging (CDA), 16% representing CalFresh Healthy Living, University of California (CFHL, UC), and 6% representing Catholic Charities of California, Inc. (CCC).

Most respondents were involved in multiple aspects of working with CalFresh Healthy Living participants and partners. Almost all respondents indicated involvement in PSEs (88%), Indirect (87%) and Direct (86%) Education, and partnership and/or coalition building (80%) with 66% involved in evaluation activities and 42% involved in social marketing. Over half of the respondents (60%) were program coordinators, managers, or supervisors, about one-quarter were health or nutrition educators (23%), with 10% as program specialists, and 3% as other administrative support. Fifty-one percent have been in their position for five years or more with only 15% working in their current position for a year or less.

Twenty-nine percent of respondents identified as Hispanic or Latino, 44% identified as white, and 10% identified as multiple races or ethnicities, including four people who identified as both Hispanic or Latino and white. Almost all respondents (96%) were fluent in English, with 56% only fluent in English and 40% fluent in English and other languages, most frequently (30%) in Spanish.

When examining the role of the LIA staff respondents by their race/ethnicity (**Figure 7**), the health and nutrition educators who work most closely with the community had more representation from the Hispanic or Latino and Black or African American communities than those in more management or administrative roles.

Figure 7. Race and Ethnicity of LIA Respondents by Role (n = 103)*



*7 Respondents either did not provide their role or their race or ethnicity.

Almost all (95%) respondents indicated that some percentage of the population they serve have a primary language other than English, with 59% indicating that at least

25% of the people they serve have a primary language other than English. Forty percent of LIA survey respondents overall were fluent in a language other than English. However, among community and health educators, those working most closely with the community, 64% are fluent in a language other than English.

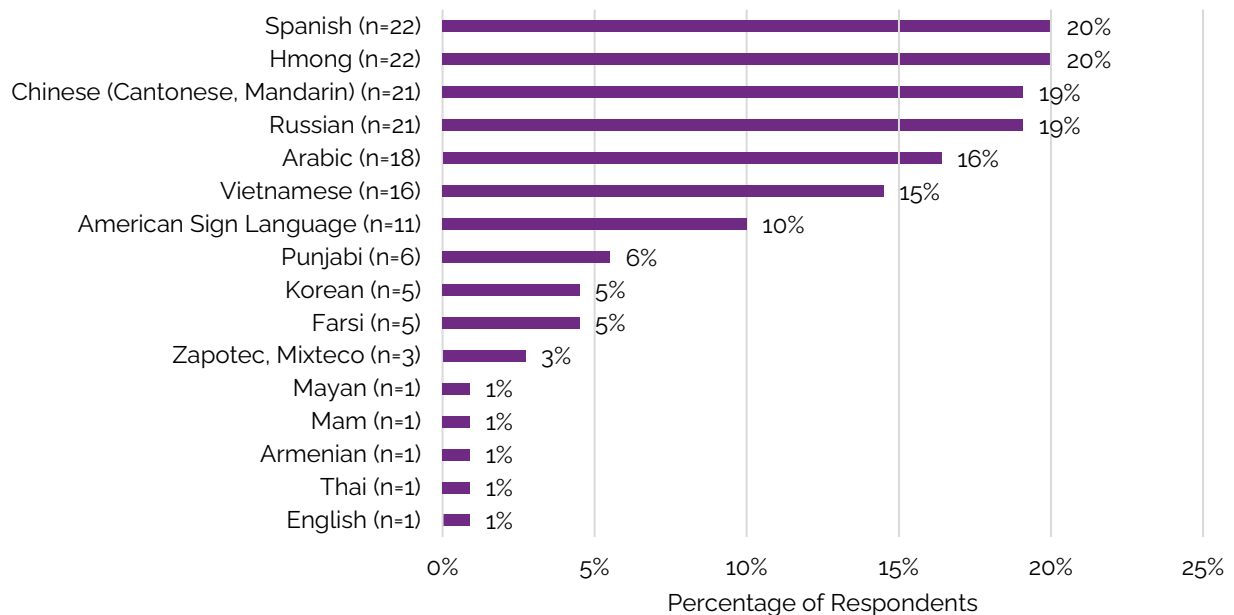
CalFresh Healthy Living Population Demographics

Survey respondents were asked to select the three predominant racial and ethnic populations served by their organization. Eighty-eight percent of respondents indicated that they serve the Hispanic or Latino population, 74% indicated that they serve the white population, 42% indicated that they serve the Black or African American population, 21% indicated that they serve the Asian population, and 3% indicated that they serve the Native Hawaiian or Pacific Islander population.

Translated Materials

Where English is not the primary language, 96% of LIA respondents reported providing translated materials for at least some of the primary languages of their participants. However, they did report that they have trouble finding materials in several languages, with Spanish, Hmong, Chinese, Russian, Arabic, and Vietnamese the most commonly mentioned as hard to find (**Figure 8**).

Figure 8. Languages in Which Respondents Have Trouble Finding CalFresh Healthy Living Materials (n = 110)*



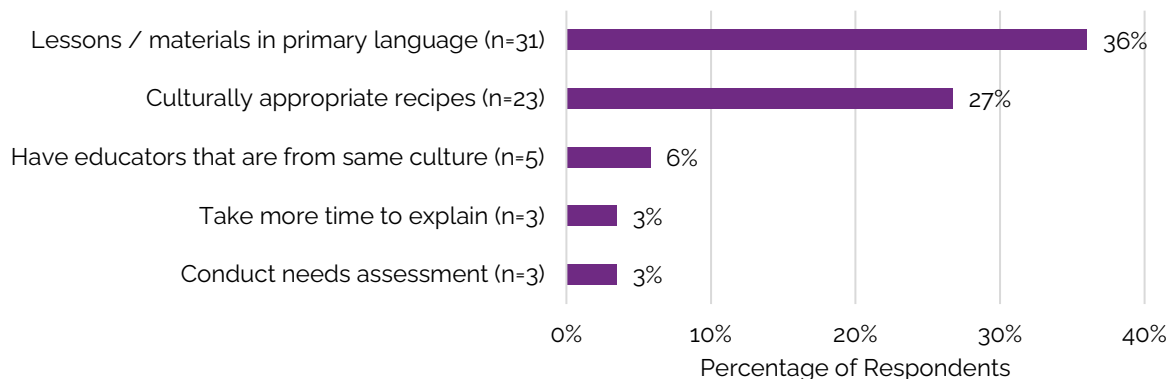
*Respondents could select multiple options.

Direct Education

Of those who reported being involved in delivering Direct Education (n=86), 97% indicated that they deliver Direct Education in English and 64% indicated they deliver Direct Education in Spanish, with other languages reported infrequently. As shown in **Figure 9**, the most common ways mentioned that Direct Education is culturally adapted are the translation of lessons or materials into other languages and including culturally appropriate recipes. One respondent said:

"Staff utilizes approved curriculum materials when delivering each intervention and communicates with older adults in ways that are language and culturally appropriate. Staff keeps to an appropriate literacy level and provides materials and instruction in language that can be easily understood by participants."

Figure 9. Ways in Which Respondents Culturally Adapt Direct Education (n = 86)



While about one-third each reported that in Direct Education they use lessons in participants' primary language (36%) and provide culturally appropriate recipes (27%), respondents still indicated most often that to better serve their populations, they need additional translated material (23%) and more culturally appropriate recipes and resources (15%). One respondent explained:

"I think we need more resources/trainings that would prepare us to work with populations with different cultural backgrounds than our own. For instance, when I started working with African American population, I had to work with our health equity officer to get a better

understanding of their trauma, dietary preferences, and history with food to better adapt the curriculum."

Evaluation Activities

There were 82 LIA staff respondents (75%) who indicated they conduct evaluation activities with Direct Education participants. When these staff were asked how often CalFresh Healthy Living Direct Education participants have trouble answering evaluation questions due to cultural or language barriers, 23% of respondents indicated often or always, 40% reported sometimes, and 37% reported participants never or rarely have trouble. Respondents further explained that participants most often have issues with answering due to language or wording used in the surveys (n=14), completing dietary or activity records (n=6), and demographic questions, including race and ethnicity (n=5).

PSE Activities

According to the LIA staff respondents who indicated PSE involvement (n=85), the ways in which racial and ethnic diversity is considered in PSE planning were direct community input either through direct engagement, surveys, or feedback from participants or champions (26%), feedback from local partners (15%), using culturally appropriate materials (14%), and data or literature reviews (7%). One respondent said:

"We have members from the community help lead the efforts we are working on. We work with a variety of CBOs that serve our selected population and learn about the needs of the community, as well as vocalize what gaps in services exist and who the vulnerable and most at-risk groups are. From there, we come up with strategies to reach these groups such as working with housing institutions, community centers, and schools."

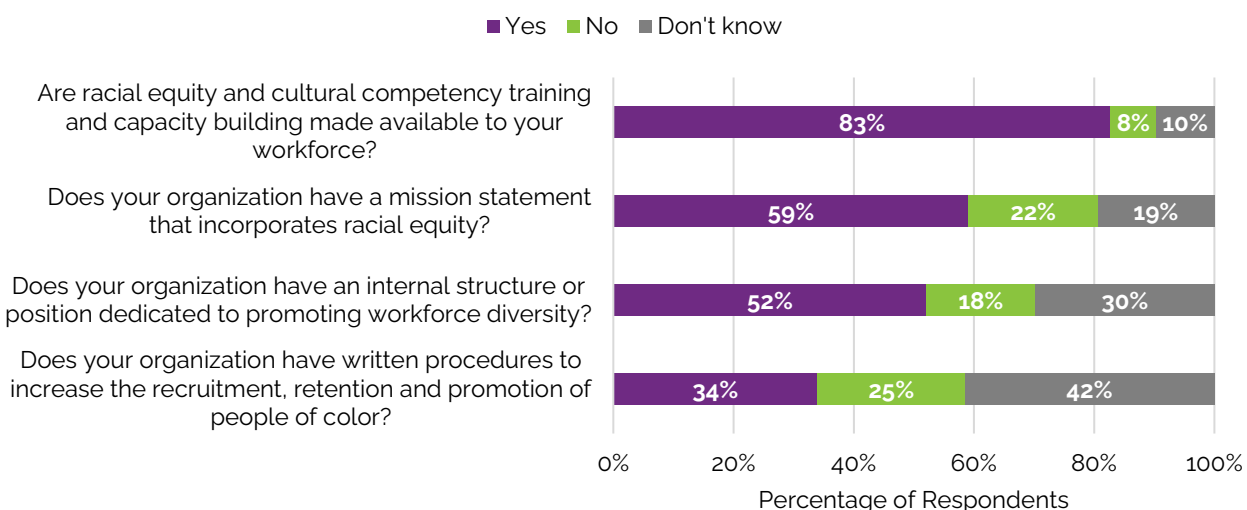
The most frequently mentioned ways in which community feedback is collected is through community-based organization partners, surveys, and meetings or listening sessions. One respondent described:

"We always implement a community engagement process with any of our PSEs - whether that is with youth or adults. I don't think you can do PSE work without strong community engagement".

Workforce Readiness

The LIA staff survey also included questions about workplace readiness to incorporate racial and ethnic diversity and increase the cultural competency of the staff, adapted from the Coalition for Communities of Color and All Hands Raised Tool for Organizational Self-Assessment Related to Racial Equity (Coalition for Communities of Color, 2014). As shown in **Figure 10**, most respondents (83%) indicated that their organizations are providing racial equity and cultural competency training, and over half said their organization has a mission statement that incorporates equity (59%) and an internal structure dedicated to promoting diversity (52%). Only one-third (34%) of respondents indicated their organization has written procedures to increase recruitment, retention, and promotion of people of color. However, 42% of the staff did not know if those procedures were in place.

Figure 10. *Workforce Readiness to Incorporate Racial and Ethnic Diversity and Increase Cultural Competency of the Staff (n=110)*



Finally, the LIA staff were asked about how CDSS can help them better serve their populations. As shown in **Table 5**, the most frequently selected ways were the provision of tailored resources and campaigns for specific groups (61%) and additional translated materials and curricula to reach more audiences (61%).

Table 5. *Ways That CDSS Can Help the LIAs Better Serve Their Populations (n=110)*

Ways that CDSS can help the LIAs	Number of Respondents (%)
Tailored resources and campaigns for specific groups	67 (61%)
Additional translated materials and curriculum to reach more audiences	67 (61%)
Specific trainings on equity, racism, cultural humility, etc.	57 (52%)

Ways that CDSS can help the LIAs	Number of Respondents (%)
Tailored technical assistance to help you reach specific groups	52 (47%)
Partnerships with health equity and racial justice organizations	46 (42%)

State Implementing Agency Survey

Respondent Demographics

There were 29 SIA staff who consented to and completed the survey, which was disseminated in August 2022 via SurveyMonkey. This represents 35% of all SIA staff. It is important to recognize that these results are not representative of CalFresh Healthy Living or the SIAs overall. Representatives from all four SIAs completed the survey, with 45% from CFHL, UC; 35% from CDPH; 10% from CCC; and 10% from CDA.

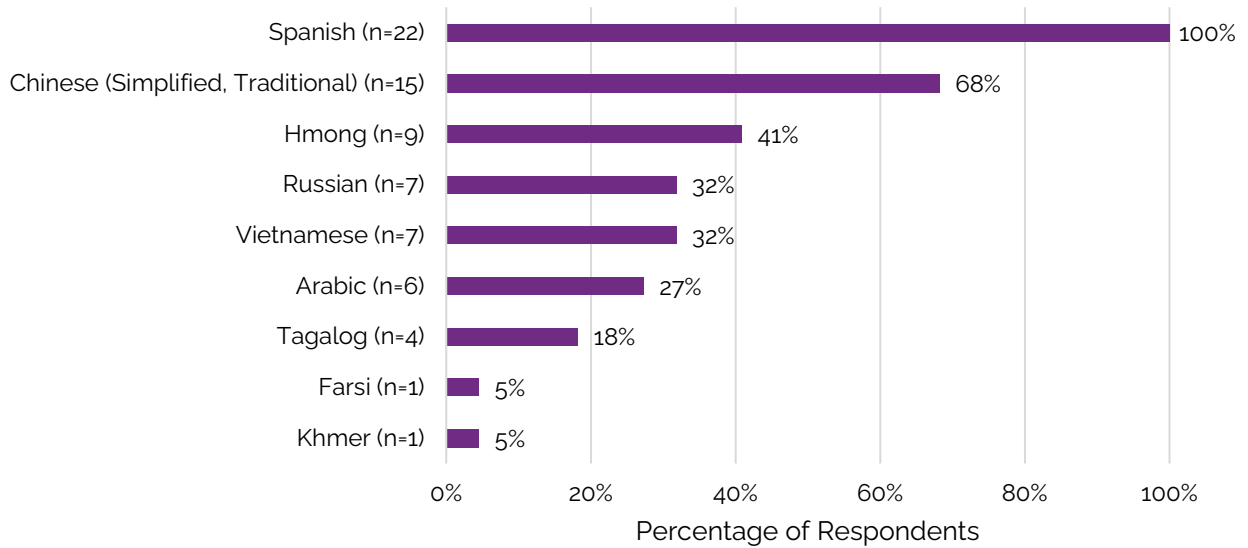
Most SIA respondents indicated involvement in several different program areas with three-quarters involved in the coordination and support of LIAs (76%), over half involved in training (62%), and 48% involved in each of the following areas: evaluation/PEARS, multi-level/PSE intervention models and tools and the Integrated Work Plan. Three quarters (76%) of the SIA staff respondents have been in their position five years or more and only 7% have been in their position for a year or less.

The majority of SIA respondents (59%) identified as white; 14% as Hispanic or Latino alone or Hispanic or Latino and white; and 3% each as Black or African American, Asian, or Biracial. All respondents indicated fluency in English, with 24% fluent in English and one other language (Spanish, Chinese, American Sign Language).

Resources

All SIAs provide translated materials to their LIAs in at least one language other than English, either pre-translated materials or materials that were translated by the SIA. As shown in **Figure 11**, all respondents reporting languages indicated materials were provided in Spanish, with respondents indicating other languages as well, such as Chinese (68%), Hmong (41%), Russian (32%) and Vietnamese (32%).

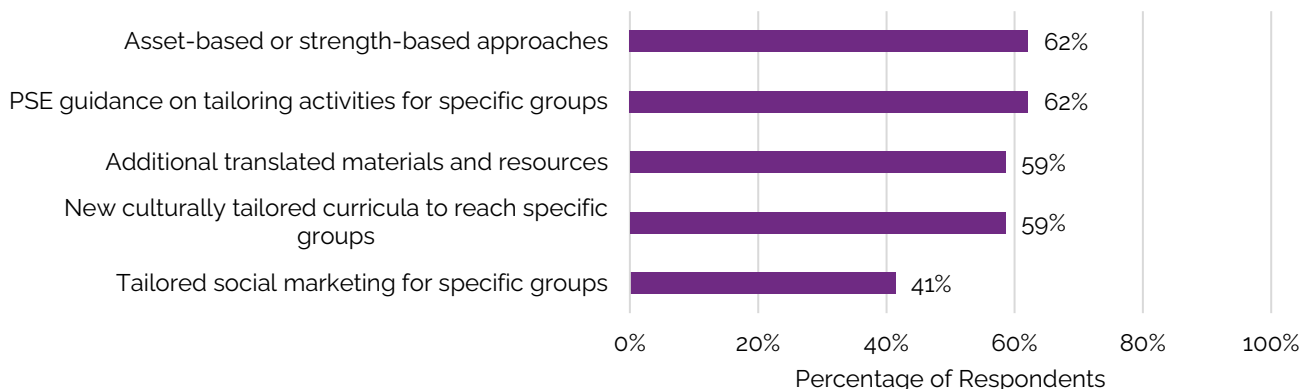
Figure 11. Languages in Which SIAs Provided Translated Educational Materials to Their LIAs (n = 22)*



*Seven respondents indicated they did not know if translated materials were provided. Respondents could select multiple responses.

As shown in **Figure 12**, more than half of respondents feel that asset-based or strength-based approaches (62%), PSE guidance on tailoring activities for specific groups (62%), additional translated materials and resources (59%), and new culturally tailored curricula to reach specific groups (59%) are needed to better serve CalFresh Healthy Living populations. Specific populations for which respondents see a need for more support by CDSS or CalFresh Healthy Living in accessing culturally adapted resources or translations include African Americans, Pacific Islanders, Tribal or Native Americans, Mexican Americans, Hispanic, Latino, first- and second-generation immigrants, and older adults.

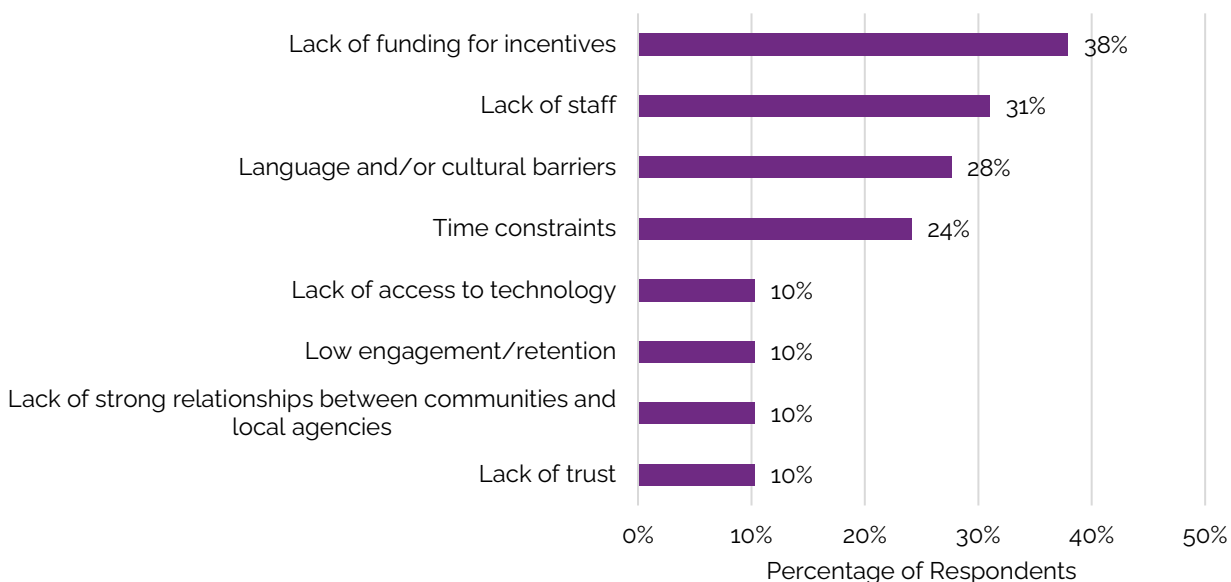
Figure 12. *Health Equity-Related Resources Needed to Better Serve CalFresh Healthy Living Eligible Populations (n = 29)**



**Respondents could select multiple responses*

The top three challenges or barriers respondents mentioned they face with gathering input directly from diverse CalFresh Healthy Living eligible populations to inform overall multi-level program planning and priorities were lack of funding for incentives (38%), lack of staff (31%), and language and/or cultural barriers (28%) (**Figure 13**).

Figure 13. *Top Challenges or Barriers Organizations Face with Gathering Input Directly from Diverse CalFresh Healthy Living Eligible Populations to Inform Overall Multi-Level Program Planning and Priorities (n = 29) **

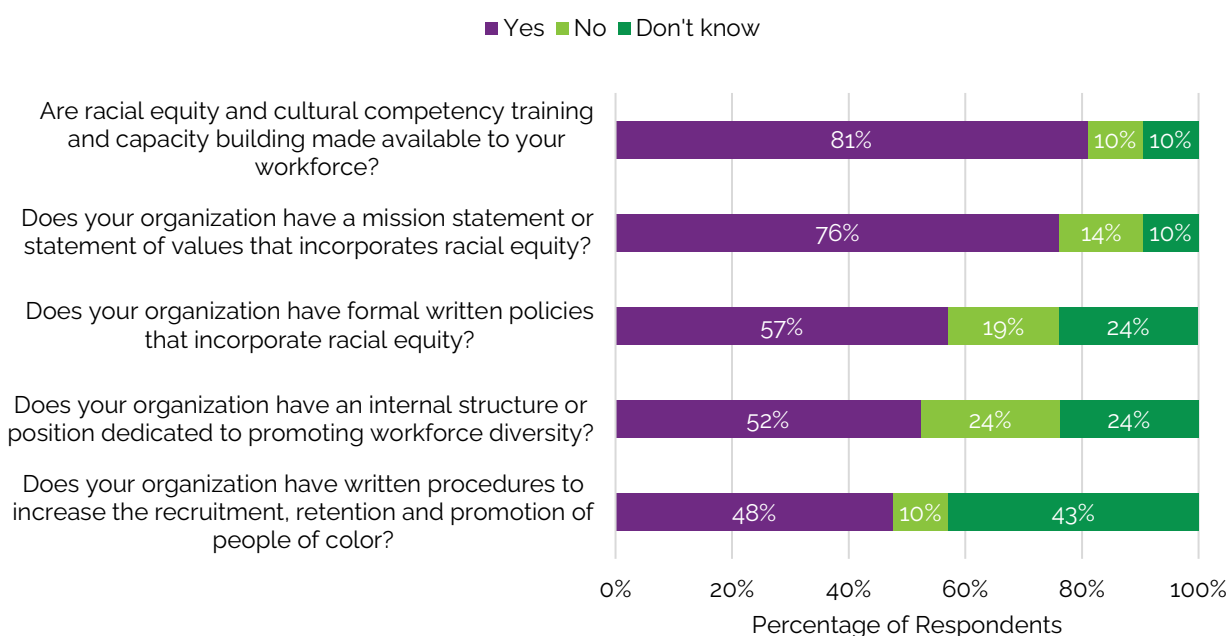


**Respondents could select multiple responses*

Organizational Readiness

Finally, the survey included questions about organizational readiness to incorporate racial and ethnic diversity and increase the cultural competency of the staff. As shown in **Figure 14**, 81% of respondents indicated that their organizations are providing racial equity and cultural competency training, 76% indicated their organization has a mission statement, 57% reported their organization has formal written policies that incorporate equity, and 52% indicated their organization has an internal structure dedicated to promoting diversity. Forty-eight percent of respondents indicated their organization has written procedures to increase recruitment, retention, and promotion of people of color, although 43% of the staff did not know if procedures were in place.

Figure 14. *Organizational Readiness to Incorporate Racial and Ethnic Diversity and Increase Cultural Competency of the Staff (n = 29)*



To better serve CalFresh Healthy Living populations, respondents would like to see additional state-level training, professional development, or continuing education opportunities regarding racial or ethnic diversity and engagement promoted by CalFresh Healthy Living.

"I would like to see programming focused on food literacy. SNAP-Ed focuses on nutrition, PA, and PSE to support these endeavors, but little efforts are given in meeting people where they are at. You cannot prioritize healthy eating when you don't have a house. You cannot prioritize healthy eating when your SNAP dollars don't cover your food until the end of the month. You cannot prioritize exercise when you

work multiple jobs to make ends meet. Food literacy acknowledges that there are MULTIPLE barriers to engaging in healthy eating behaviors. I would like to see our staff have training in this area so we can be authentic and really understand what our participants are up against. This would require us to overhaul our resources and focus on equity, which is out of reach. The State Offices alone cannot complete this work. We need experts from the relevant communities to help develop content for our trainings and be available for resource and curriculum development as needed."

One respondent suggested how CalFresh Healthy Living can better incorporate a racial equity lens with CalFresh Healthy Living programs and services statewide.

"CDSS has approached this with short-term funding and plans. In order to authentically do this work, it will take YEARS. I would love to see CDSS make a 5-year plan and be more realistic about taking the time to engage these communities with respect. Already, CDSS is dishing out funding to SIAs to engage Tribal groups when we have a documented LACK of appropriate curriculum, training, and resources for them. The likelihood that we will irreparably damage relationships with these communities through hasty, uninformed action is high. Please take a minute and accept that this is a long game. It should be funded and framed as such. This is not a trend. This is the way it always should have been. It will take time to do it the right way, and there is nothing wrong with that. Let's take our time, PAY our communities for their contributions and expertise, and make the next step for CFHL a better one."

Health Equity Roundtable Discussions

At the CalFresh Healthy Living Pre-Forum on October 17, 2022, during the session titled *Health Equity & Racial Justice in CalFresh Healthy Living: Why it Matters & How to Take Action*, Public Health Institute Center for Wellness and Nutrition staff gathered additional feedback from attendees on what challenges they faced in the field and what the state could do to support the expansion of racial and health equity work in CalFresh Healthy Living. Below is a summary of the themes that emerged from the roundtable discussions. Written quotes are included to emphasize participants' feedback. Participants were asked, *"What recommendations do you have to better support Health Equity strategies in CalFresh Healthy Living Programs at the local level?"* The following themes emerged:

- **Materials and Resources:** Participants felt that there was a strong need for translated and culturally tailored nutrition education materials to better serve the diverse populations in California. *“Translated materials should be available on demand for all needed languages.”* Someone else also noted the need for *“Less money on materials that are not effective. More money on appropriate translations focused on interpretation. Key messages need to be culturally relevant to the population we serve.”* Another participant shared, *“Rethink your drink is still pending proper Spanish translations, and we struggle to share the messaging that is appropriate to their culture.”* In addition to the overwhelming need for translation and cultural adaptations, some attendees noted the need for an equity-based curriculum, *“curriculum list for equity-based education/approved list for all ages k-12 and adults, seniors, etc.”* It was also noted how the strict delivery of curriculum does not allow for equity adaptations and more flexibility is needed: *“Curriculum fidelity can make direct education sessions a bit difficult.”*
- **Disconnect between Management and Educators:** Many attendees felt that there was a detachment between leadership and the front-line staff related to understanding how hard it was to implement nutrition education and PSEs: *“Management does not really know what's going on. To do the on the groundwork.”* There were also concerns related to valuing the process and input received by the community: *“We need to have directors, assistant directors, and deputy directors on board with us in this process so that they understand what the needs are and hear our input on the needs we hear after building rapport with the community.”* Attendees also wanted a viable feedback loop with the state, so their issues could be heard and addressed. We need a *“more streamlined or clear process of getting feedback loop from state to local and doesn't get lost.”*
- **Foundational Training in Cultural Sensitivity and Equity:** Several attendees emphasized the need for training on different cultures, equity, and how to implement equitable practices throughout the CalFresh Healthy Living work. Some felt there was a need to define equity in action, *“Equity is the way we do business. State it and then translate what this means.”* *“We need additional training on other cultures that we may not be familiar with...”* *“Training that addresses diversity and values and how those values relate to practice.”*
- **Equity Framework and Equity Partnerships:** Several attendees noted the need for an equity framework in CalFresh Healthy Living but emphasized that there were several examples already being developed locally and that it should be LIA-informed. *“Ask LIAs what their county health and racial equity framework is. Many have one in progress or in place.”* Many attendees also stated the need for expanded partnerships with different sectors, notably Social Determinants of Health (SDOH) and housing, which came up in several discussions. There is a *“Need to identify key partners addressing SDOH activities and find where we fit.”*
- **Community Involvement:** Several attendees mentioned the value of engaging the community in the program planning process and there is more need for this. *“We learn to include communities in our discussion to know what they need, and this takes a lot of work, and we need to interpret our work to the community and those in charge to change how things are done.”* Others noted the need to

incentivize or compensate community members for their time and expertise. Someone noted, *“A compensation policy for community members.”* Several people also recalled an Integrated Work Plan pilot related to job/employment and were very interested in implementing this strategy. Some asked for it, *“A small pilot on job and employment. Can we get this going so we can hire people? What’s become of this?”*

Several attendees also noted, *“Stop the dependent use of acronyms!”* based on the nature of how CalFresh Healthy Living uses an excessive number of acronyms in their program without defining the core terms. Attendees said how confusing it was to participants and even partners. A few also noted the need to develop a diverse workforce and compensate them fairly, *“pay isn’t enough”* and *“not high enough value for educators.”* Additionally, one participant at the training noted, *“Please make this health equity and racial justice session mandatory to all participants next year!”* This emphasized the need for foundational training for all CalFresh Healthy Living staff, with some attendees noting their management and leadership should have attended to better understand and apply equity in their work.

Key Informant Interviews

Key Informant Interviewees

The interviewees included 2 men and 4 women who worked primarily in nonprofit or university settings. Interviewees’ experience ranged from 14 to 20 years in health and nutrition, and all were in leadership positions (i.e., chief executive officer or director-level) at their organizations. Findings were organized according to the overarching themes of challenges, facilitators, and recommendations. The themes and subthemes that emerged from the interviews are shown in **Table 6**.

Table 6. *Key Informant Interviews Theme Breakdown*

Themes	Sub themes
Theme 1: Challenges facing organizations in addressing equity	Failing structural systems
	Program accessibility
	Lack of diversity
Theme 2: Facilitators and structures to support equity work	Internal organizational policies and practices
	Leadership buy-in
	Commitment to community engagement
	Equitable compensation practices
	Equity-centered evaluation

Themes	Sub themes
Theme 3: Recommendations and resources for conducting and evaluating health equity work	Address systemic oppression and build foundational knowledge
	Center community through partnerships and collaboration
	Define and measure equity
	Equitable funding and compensation practices

Theme 1: Challenges Facing Organizations in Addressing Equity

Failing Structural Systems

A challenge identified in the key informant interviews was the **inattention to systemic oppression** within programs that further marginalizes communities. Additionally, current policies and complexities within federal programming propagate **exclusivity** through disqualification practices. Things like immigration status and disability or mobility issues can bar vulnerable populations from accessing federal nutrition programs. The necessity and flexibility for more immediate responses to ever-changing situations that impact marginalized communities are needed. Without this, it limits equity work by overgeneralizing needs in specific communities.

The complexities involved in implementing SNAP-Ed programs, such as excessive **administrative work** and **reporting** requirements, can deter community-based organizations from implementing CalFresh Healthy Living programs in their communities.

Strict funding restrictions were also mentioned as a barrier, where budgets are not supportive of community engagement efforts through restrictions for staff time or restrictions in community compensation. As previously mentioned, changes to federal rules around equitable compensation of staff would be helpful, but also allowing more flexible use of funds for community engagement would improve equity.

"In addition, not having budget allocation to provide funds to foster community engagement activities and participation or restriction on staff time can create obstacles to community engagement efforts."

-P6, university.

Barriers to Food and Program Accessibility

Lack of food access in marginalized communities, due to geographic location, cultural needs, or other factors can contribute to **limited food choices** and unequal health outcomes making it difficult to maximize limited budgets on healthy food purchases. Additionally, the difficulty of navigating nutrition programs, including CalFresh Healthy Living can be attributed to difficulty understanding program guidance, according to some informants.

"...it's really difficult for a community-based organization or a tribe to really understand the (SNAP-Ed) guidance and like it's not written for community-based practitioners. It's, you know, it's written for state bureaucrats..."

-P1, nonprofit organization.

Lack of Community Representation

The overarching **lack of representation** of the communities being served taints all levels of the program, from leadership to program implementation, and as a result generates low community impact. The overall lack of representation, particularly in leadership, can bar the ability to generate equitable programs by a lack of understanding of lived experiences of diverse populations.

"There's not a lot of diversity in the room, so I think in a lot of ways, like for nutrition education, thinking about how to create more diversity is really important among the professionals. I think a lot of that too is the salaries are really low, so that's a challenge."

-P1, nonprofit organization

Additionally, the **lack of community input** into program design and **cultural diversity** within the dietary guidelines hinders program sustainability and does not reflect the diversity in California communities.

"I think a lot of the curricula and recipes are not designed for racial equity...Because there's not enough diversity in the field of being a nutritionist or public health, you know it's, and I say this as a white person, like a lot of the recipes and are designed by white people and so I think in a way, the response has been like oh we'll create a

program and then we'll just hire a translator and like that's the solution and it's like no...how do we engage the community to create the program, create the recipes. I think that's really important."

-P1, nonprofit organization.

Theme 2: Facilitators and Structures to Support Equity Work

Internal Organization Policies and Practices

Key informants highlighted that **internal organizational work** is needed to effectively conduct health and racial equity work in the community. The following key elements were emphasized to create a culture of inclusion and readiness to implement racial and health equity strategies: establishing internal policies, setting specific equity goals to track, supportive leadership, and acquiring or dedicating funds specifically for equity work.

Internal policies varied from the formation of JEDI committees to the creation of organizational goals and equity statements, and investment in capacity building to support an organizational-wide foundation of knowledge and understanding of racial and health equity. It is also key to have an organization that reflects the diversity of the community.

Leadership Buy-in

To begin the process of dismantling structural oppression, the incorporation of racial and health equity practices must be facilitated by **positive leadership buy-in** and the willingness of leadership to actively participate in racial and health equity work.

"I think that it really has to come from leadership and the requiring of foundational knowledge...is going to be very important because, like I said, we didn't get a lot of momentum until our leadership got on board and participated and it's not just a one-time thing."

-P4, university.

Establishing a **common foundational knowledge and open dialogue** through organization-wide training and conversations about racial and health equity was also mentioned as a crucial component. Gaining consciousness of inequitable systemic structures is key to understanding the root causes of nutrition insecurity and how it relates to racial and health equity as a practice.

"Us realizing that as an organization, if we really are talking about trying to address root causes of poverty and food insecurity and hunger, that we need to address issues like structural systematic racism and other forms of structural oppression and that we needed to do that, looking at ourselves how we operate as an organization."

-P3, nonprofit organization

Commitment to Community Engagement

A key component that informants shared about their organizational process to advance racial and health equity work was a commitment to **community engagement**, involving them in the process of active participation as well as co-designing programs.

"We try to bring folks to the table as early in the process, not just to provide input but to co-design with us the initiatives and then also to make sure that they're a big part of the implementation, you know where appropriate then also when doing evaluations..."

-P2, nonprofit organization

Informants explained the importance of **community capacity building** through skill building and leadership development, including engaging the community in problem identification and solutions to create equitable nutrition and health programs. It is also important to incorporate the voices of frontline staff when looking at racial and health equity work to enhance the visualization of community needs.

"One of the key principles that we are trying to carry forward in our work is that we should not assume what equitable and inclusive looks like. We need to ask other people what does equitable inclusive look like to you and ...what would that mean for you and what is your current experience and what we would need to change in order for it to feel like you were being respected..."

-P3, nonprofit organization

Partnerships have also been essential when implementing racial and health equity work. Key informants shared the various relationships that have helped them advance equity, including community partnerships as well as collaboration with organizations with shared racial and health equity values. Engaging community-based organizations as partners, who are already trusted in the community, helps

build trust and invites communities into the process early on to co-create programming.

Equitable Compensation Practices

Actively **hiring and compensating community partners** to reflect communities where programming is being planned or implemented was mentioned to address diversity and community voice in food spaces. This included the creation of funding opportunities and support for people of color interested in participating in food spaces like farmers' markets or local food vending to increase inclusiveness and representation in these spaces as well as hiring at the community level to increase inclusivity within the organization. Additionally, creating policies where community expertise for participation in the storytelling of their lived experiences is justly compensated is a best practice to facilitate equity.

"I think another way that we've looked at equity has definitely been at who we're hiring, how we're employing people, and you know the really perfect example is with COVID that intentionally we sought to hire promoters that were living in the communities that we were targeting so it meant rural communities. It meant people who weren't necessarily English speaking. It meant hiring immigrants that we could hire, right – really reflecting the population in our workforce. I think that's another way that we've tried to incorporate equity..."

-P5, nonprofit organization

Equity-Centered Evaluation

Having equity at the forefront of evaluation to prioritize marginalized communities and creating plans to better tell the story of communities in a way that is inclusive and community-oriented is key. Process evaluation can be utilized as a measurement of success and for centering health equity in strategic plans and logic models. Qualitative evaluation and storytelling were also mentioned as a way of **centering community voices**.

"...looking at storytelling through an equity lens, data driven decision making, so working with our research and eval team to pull data with that lens on, really looking at where our disparities are within our communities and our clients that we serve so that we can plan our program better."

-P4, university.

Theme 3: Key Informant Recommendations for Addressing and Incorporating Racial Equity in CalFresh Healthy Living

Address Systemic Oppression and Build Foundational Knowledge

There is a need to **address and advocate to change systemic oppression** to support racial and health equity within CalFresh Healthy Living and beyond.

Offering **educational opportunities** to learn about structural systems in place that lead to inequities and providing space within CalFresh Healthy Living-funded programs and organizations to gain understanding within staff is important for addressing equity. Educating and creating consciousness of larger systems in place, food system structures, and finding the opportunity to close these gaps is important to advance equity.

Many informants' recommendations included the need for intentionally **diversifying staff**, including leadership, to reflect the communities in which the programs serve.

"I also think that as organizations are hiring for staff, they should think about building a team that represents the communities that they're working with and also, again like I mentioned, like really listening from the frontline staff and hearing their ideas and knowledge."

-P1, nonprofit organization.

Working to reduce and **streamline administrative work** for participating organizations to the extent possible within the federal guidelines was also recommended to encourage more organizations to participate. Allow for the time needed to do this work and recognize it is a **long-term process** that takes time and investment from organizations, partners, and communities.

Center Community Through Partnerships and Collaboration

It is recommended that CalFresh Healthy Living invest in community-centered programming to help advance racial and health equity work within the program. It is important to **consider the community's definition of success** and incorporate those goals through the co-designing of programs.

"By exploring the communities that you want to work with and look for community leaders and local partners that share the same health/racial equity vision and value. Form a team to set goals and activities."

-P6, university.

Building strong and lasting **partnerships with local organizations** to address health and racial disparities in communities is strongly recommended with the inclusion of community voices throughout the process.

Include community when creating and designing recipes, not only translating into other languages, but also the need for the community to help in the creation of **culturally appropriate recipes**. Viewing health and nutrition through an equity lens when making food recommendations within programming was recommended by many informants, with one informant stating,

"I think there's a lot that we have to do to help ensure traditional diets. Like there's a lot of really important components about traditional diets that we need to help preserve."

-P5, nonprofit organization.

Uncomplicated external collaboration was also recommended by many informants, which included facilitating strong partnerships, community co-design, and collaboration with non-federally funded organizations.

"Looking for ways to have federal nutrition programs collaborate successfully would be helpful. A discussion at the state level to explore how to coordinate/integrate and remove obstacles so both programs can work together in an efficient manner may be necessary."

-P6, university.

Define and Measure Equity

Some informants stated the need for the creation and addition of **health and racial equity indicators** to track progress in CalFresh Healthy Living. The need to set equitable goals was also recommended, including adding a section within PEARS to track and create a foundational objective within equitable programming.

"Create systems at the statewide level so that anybody with CalFresh Healthy Living funding has the foundational knowledge, and we're all kind of working from the same definition with some kind of clear and tangible goals, and I don't know if that means when we do our PEARS reporting that there's a section that that we answer how is this addressing racial equity in this community."

-P4, university.

Many informants affirmed the need for **process evaluation** to evaluate community capacity building, community leadership, established community opportunities, infrastructure built, and an overall positive change in participant confidence. Qualitative evaluation can be valuable in telling the story of the community.

Equitable Funding and Compensation Practices

Informants recommended **equitable funding practices** as an important factor for advancing racial and equity work. Funding within organizations includes compensation practices for community expertise as well as a funding structure that is fair and inclusive for community-based organizations and BIPOC-led organizations.

Funding for **fair compensation of community members' time** was expressed as crucial during interviews to move forward with equity work as well as funding for community expertise, which was also spoken about in many interviews. Monetary compensation should be provided not only one time, but community members should be fairly compensated for their time, value, and expertise.

The **creation of incentives and funding to welcome BIPOC communities** into food programming was a recommendation mentioned by many informants. The inclusion of BIPOC community members into programming was described throughout the interviews with one informant recommending the need for incentives for communities of color to join the space. It was also mentioned that it is important to include farmers and farmworkers in the CalFresh Healthy Living decision-making process since they are at the foundation of food systems and should have a space at the table when creating racial and health equity-centered programs and evaluation practices.

Closing Comments

Overall, many informants were very enthusiastic about CalFresh Healthy Living working to identify needs and support changes around racial and health equity. Some mentioned that CalFresh Healthy Living has already pioneered many positive programs and efforts to address racial and health equity.

"I actually think that California has done a really good job of integrating racial equity and social justice into the work...California has really kind of led the way when it comes to working with the local health departments and community partners and school... that's always been a big part of the CalFresh Healthy Living Program especially since with CalFresh we're largely serving marginalized populations and people who are Latinx, Black, Asian American native Hawaiian..."

-P1, nonprofit organization.

Limitations

State and local staff respondents to the surveys constituted 18% of the LIA staff members and 35% of SIA staff, thereby not providing a representative sample. The results from the surveys cannot be generalized to all CalFresh Healthy Living staff members; however, the findings do provide a snapshot of current practices and needs based on those who responded to the surveys. While all SIAs were represented in the survey responses, the geographic location of the local staff respondents is not known. Therefore, it also may not be a geographically representative sample. There were only six key informants interviewed to provide expertise on racial and health equity practices, again not allowing these results to be generalized across all leaders who are integrating racial equity practices into nutrition programming. Despite these limitations, common themes were noted across the literature review, survey responses, roundtable discussions, key informant interviews, and mapping exercises.

Summary of Findings

Overarching Themes

In summary, across the literature review, survey responses, roundtable discussions, key informant interviews, and mapping exercises, several common themes arose.

1. **Organizational Commitment and Investment: There** is a need for supportive internal organizational processes, practices, and policies to truly engage in racial and health equity work. This includes a commitment and investment in capacity building, hiring and promoting diverse leaders and staff, and engaging in authentic conversations about race and health equity. Additionally, foundational training and honest discussions about inequitable systems and structures are needed to understand how to implement equity throughout the work. Health equity leaders shared that this process requires a

long-term commitment and resource investment to sincerely advance equitable policies and practices throughout an organization or program.

2. **Community Engagement and Equitable Compensation:** Both the literature and key informants strongly recommended centering the community during all aspects of the program and evaluation process as a crucial step to move toward more equitable policies and practices. The lack of compensation or incentives for community residents' time and expertise remains a strong barrier to being inclusive and equitable. All aspects of the study recognized the need for culturally tailored and linguistically appropriate resources for diverse populations to improve outcomes and connections, with a strong recommendation to co-create these resources with communities.
3. **Acknowledging, Dismantling, and Rebuilding Systems of Oppression:** The need to recognize and dismantle systemic barriers to implementing racial and health equity work is critical. Ensuring an understanding of historical context about why inequities exist and how to talk about these issues is needed. Some LIAs shared that they are looking at systemic issues and forging partnerships to address systemic oppression.
4. **Inclusive Evaluation Practices:** There is a need to examine implicit biases in research and evaluation and ensure a more inclusive process is used. This may include a method where community members participate as partners in the process, a commitment to collect different types of metrics, such as process measures related to skills and leadership, or the addition of qualitative approaches to better tell the community's story.

Overall Recommendations

Based on the comprehensive review of all components of this assessment, the following are recommended for CalFresh Healthy Living to commit to improve and expand racial and health equity throughout the program:

Organizational Capacity Building

1. Invest in developing and/or identifying **internal best practices and processes that promote equity**. The survey results show that not all organizations have a mission statement and policies related to promoting equity, and there are staff, particularly at the LIA level, who do not know if their organizations have these policies. Focus on developing equity-focused policies and procedures and ensure that staff are aware of equity practices. A competent, diverse workforce that understands how systems impact health outcomes and can connect them to CalFresh Healthy Living implementation is critical to keep equity as a core focus in the work. W.K. Kellogg Foundation has created the [Expanding Equity Inclusion & Belonging Guidebook](#).
2. Develop a series of **foundational health equity trainings** for all CalFresh Healthy Living staff delivered by internal and external experts with lived

experience. Fifty-two percent of LIA respondents indicated wanting CDSS to provide trainings on equity, racism, and cultural humility. Roundtable attendees and key informants also stressed the importance of equity education opportunities. The needs may vary by organization; however, this may include learning sessions on historical and systemic racism within food systems; positionality and how that effects how programs are delivered in communities; how to include community voices for storytelling about CalFresh Healthy Living programs.

3. **Establish a Statewide Justice, Equity, Diversity, and Inclusion committee** with representatives from SIAs, LIAs and CalFresh Healthy Living populations to work together to integrate best practices for JEDI into organizational and program values, policies, and programs. Committee members can work as thought partners to foster open and transparent conversations to promote equity and identify project areas that need to be changed to be more equitable. Based on findings from the equity assessment, examples of project areas to address can be cultural adaptations of curricula and creating a feedback loop from staff to management to better understand what happens in the communities, mentioned by roundtable attendees.
4. **Advocate for systemic change at the federal, state, and local level,** recognizing that some of these processes are hindered by structural and oppressive systems that need to change, including rules in the Supplemental Nutrition Assistance Program Education guidance, policy, and regulations. Connect with advocacy organizations/groups to encourage them to advocate on their behalf and potentially provide more flexible funding opportunities to help with fair and equitable compensation. Include community voices as testimonials and authentic evidence of needed resources and support.

Program and Resource Development

5. **Center Community.** Engage community members with lived experience throughout all aspects of the CalFresh Healthy Living programming, including design, planning, implementation, and evaluation process. Examples of ways to center community in programming include participatory action research as an approach to identifying gaps, issues, and solutions that matter to community members; community advisory committees to provide feedback through community-level leadership; participatory evaluation approaches to authentically examine if programs are effective for communities; and community-led pilot testing of products and projects. [The Community Engagement Toolkit](#), developed by PHI CWN, gives practical tools and strategies to build community engagement into programs from start to finish and to share power with the community. The [W.K. Kellogg Foundation's Doing Evaluation in Service of Racial Equity – Deepen Community Engagement](#) promotes responsible, responsive, and genuine engagement of communities

in the evaluation process and as an outcome of the evaluation. Using community-centered approaches and co-creating programs and evaluation models is crucial to racial equity and community success.

6. **Ensure that community participation is fair and valued.** For community participation as described above and in other recommendations to be an equitable practice, community members should be fairly compensated for their time, value, and expertise. FNS funding is restrictive; however, partnering with other organizations or finding ways to create staff positions for community members are ways that more flexible funding can be obtained. Additionally, honest conversations and full transparency about power and limits to community engagement in CalFresh Healthy Living are needed to build trust in communities. These conversations can lead to positive and powerful policy changes.
7. **Expand language offerings and adaptations of educational materials and curricula.** While CalFresh Healthy Living provides translations in many languages, as survey results revealed, more translations are desired. It is recommended that CalFresh Healthy Living matches the primary translated languages for CalFresh Food materials. When reviewing all resources based on cultural relevancy, consider translation into the following languages when feasible: Spanish, Chinese, Hmong, Russian, and Vietnamese. CalFresh Healthy Living should also discuss with LIAs whether other emerging language translations such as Arabic, as seen in the LIA survey responses, are needed. Additionally, it is recommended that the California Department of Social Services collects and coordinates existing translated materials that have been already created by LIAs and creates an online library of all translated resources. This would include support to ensure the LIA-developed resources meet branding guidelines and other required criteria.
8. **Co-create/co-design culturally tailored campaigns and resources for diverse Californians.** Engage CalFresh Healthy Living populations in the development of new resources using a co-design approach. Co-design centers and involves users and beneficiaries to help create conditions for success. Although co-design implementation can vary depending on the product and population, they generally follow five principles to ensure authenticity:

Co-design is:

- Inclusive - trusting relationships are built to include people with different lived experiences.
- Respectful - there is active listening with humility about the needs and priorities of stakeholders.
- Participative – there is a commitment to learning and continuous improvement.

- Iterative/Adaptive – willingness to adapt strategy and/or evaluation as more understanding develops and contexts evolve.
- Outcomes focused – there is a focus on achieving change and improving results or having a positive impact.

These principles can be applied to various practices and approaches to the creative and educational development of resources, materials, and campaigns.

Evaluation Practices

9. Recognize and acknowledge the **implicit biases** that influence evaluation practices and invest in **mixed methods** and **systems approaches** to collecting and examining data. Common implicit biases in social sector evaluation include the following:
 - Attribution bias where assets of a group of people (e.g., Black and Brown families) are undervalued and there is an imbalance and/or overvalue on deficits.
 - Confirmation bias where there is tendency to look for or favor data (qualitative and quantitative) that confirms or validates beliefs that we already hold.
 - Conformity bias can occur in group settings (e.g., small project teams, evaluation groups) where views are influenced by views of others in the group, or groupthink.
10. Report and **disaggregate data by race/ethnicity** to more accurately identify inequities, successes, and to better tailor program activities. It is also crucial to understand that it may not be enough to just report disaggregated data. Disaggregated data should use an asset-based framework that clearly identifies strengths of population groups and communities versus a deficit-based lens that may unintentionally shine a negative light on people of color.
11. Use a **geographic information system as a tool to map data relevant to CalFresh Healthy Living** to more effectively prioritize programs in **underserved areas** and **identify gaps in service**, as well as see where programs are successfully saturated. As data in this report demonstrate, there are opportunities to expand the impact of CalFresh Healthy Living programs and resources and reach underserved communities identified in the mapping. Mapping over time can continue to identify and increase the capacity of programming, as well as use GIS data as indicators of change and progress. Additionally, GIS data does not always tell the whole story of CalFresh Healthy Living communities. As described earlier, GIS data may intentionally (or inaccurately) be emphasizing deficits. This may be an opportunity to print out community maps and invite members of the community and LIAs to

participate in **Community Asset Mapping** to add assets and context to the maps, as well as to recommend solutions. This can be particularly effective in rural communities.

12. **Tell the story of community** strengths and change using mixed methods as described in this section. Stories can provide context, texture, voice, case studies, and be more accessible and engaging to multiple audiences from funders to decision-makers, and most importantly to the community itself. In addition to what has already been described, **participatory evaluation approaches** such as photovoice and “best change” interviews can also be effective. Results may include less emphasis on individual behavior changes and more emphasis on community change.
13. **Measurable and relevant indicators of progress and change** will be an essential component of any **health equity framework** that is developed and adopted to hold CalFresh Healthy Living and partners accountable for its commitment and service to equity goals. Indicators can be numerous as described above and throughout this report, including but not limited to disaggregated data, GIS mapping data, levels and types of participation in CalFresh Healthy Living programs, changes in how leadership is reflective of communities, quality of adapted and translated materials, and community feedback. [*Why Am I Always Being Researched*](#) is an example of and provides a framework for ensuring indicators and other evaluation components are implemented in service of equity and without burden to communities of color.

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Appendix I: LIA and SIA Survey Tools

Local Implementing Agency Survey

On behalf of the California Department of Social Services (CDSS) CalFresh Healthy Living (CFHL) program, the Public Health Institute Center for Wellness and Nutrition (PHI CWN) would like to invite you to take the following survey. The purpose of this survey is to help to improve health equity in California through the delivery of CalFresh Healthy Living services and programs by identifying gaps and promising practices across the state. The findings from this evaluation will be used to create a report highlighting racial equity work that is happening and including recommendations for improving racial and health equity in CFHL programs. This survey is intended for Local Implementing Agency staff who support the implementation of the CFHL program. We define racial and ethnic equity as, "a process of eliminating racial and ethnic disparities and improving outcomes for everyone through structural and systemic improvements." The survey should take about 20 minutes to complete.

Your responses are voluntary and will be kept confidential. You may skip any questions you do not wish to answer. Responses will not be identified by an individual or your organization. All responses will be compiled together at the state and SIA levels and analyzed as a group. If you have any questions or concerns, please contact Lizania Romero at the Center for Wellness and Nutrition (Lizania.romero@wellness.phi.org; 916.265.4042 ext. 133).

Do you agree to participate in the following survey?

- a. Yes
- b. No (if selected, skip to end of the survey)

Demographics

1. Which State Implementing Agency funds your LIA?
 - a. California Department of Public Health (CDPH)
 - b. CalFresh Healthy Living, University of California (CFHL, UC)
 - c. Catholic Charities of California, Inc. (CCC)
 - d. California Department of Aging (CDA)
2. Please select all the areas in which you directly work with CalFresh Healthy Living participants and/or partners. **(Please select all that apply)**
 - a. Direct Education
 - b. Policy, systems, environmental changes (PSEs)
 - c. Social marketing
 - d. Indirect education
 - e. Partnerships and/or coalition building
 - f. Evaluation
 - g. Other, describe: _____

3. What is your job title? (you may use general terms) *[Open ended]*
4. How long have you worked for CalFresh Healthy Living (SNAP-Ed)?
 - a. Less than 1 year
 - b. 1-2 years
 - c. 3-4 years
 - d. 5-6 years
 - e. More than 6 years

We are interested in assessing the diversity of CalFresh Healthy Living implementers responding to this survey through the following questions.

5. Please select the race/ethnicity that best describes you. **(Please select all that apply)**
 - a. American Indian or Alaska Native
 - b. Asian
 - c. Black or African American
 - d. Hispanic or Latino
 - e. Native Hawaiian or Other Pacific Islander
 - f. White
 - g. Other, please describe: _____
 - h. Prefer not to answer
6. What languages are you fluent in (e.g., comfortable reading and speaking)? **(Please select all that apply)**
 - a. English
 - b. American Sign Language
 - c. Chinese (Cantonese, Mandarin)
 - d. Hmong
 - e. Spanish
 - f. Tagalog
 - g. Vietnamese
 - h. Arabic
 - i. Russian
 - j. Other, please list: _____
 - k. Prefer not to answer

The following questions ask about your role as a CFHL implementer. Please answer based on your own personal work experience.

7. Please select **up to three** predominant groups you serve by race/ethnicity (Please estimate if this information is not readily available.)
 - a. American Indian or Alaska Native
 - b. Asian
 - c. Black or African American

- d. Hispanic or Latino
 - e. Native Hawaiian or Other Pacific Islander
 - f. White
 - g. Other, please describe: _____
8. What percentage of the participants or partners that you serve speak a language other than English as their primary language? (Please estimate if this information is not readily available.)
- a. None
 - b. 1-25%
 - c. 26-50%
 - d. 51-75%
 - e. 76-100%
9. Do you regularly provide documents in CalFresh Healthy Living participants' native language if English is not their primary language?
- a. Yes, for all languages of participants
 - b. Yes, for some languages of participants
 - c. No
 - d. Do not know
10. In what languages have you had difficulty finding CalFresh Healthy Living materials? **(Please select all that apply)**
- a. English
 - b. American Sign Language
 - c. Chinese (Cantonese, Mandarin)
 - d. Hmong
 - e. Spanish
 - f. Tagalog
 - g. Vietnamese
 - h. Arabic
 - i. Russian
 - j. Other, please list: _____
 - k. None

Direct Education

11. Are you involved in delivering Direct Education?
- a. Yes
 - b. No [SKIP to Q16]
12. Which age groups do you provide nutrition education to? **(Please select all that apply)**
- a. 0-5 years
 - b. 6-11 years

- c. 12-17 years
- d. 18-59 years
- e. 60+ years

13. In what languages do you provide Direct Education instruction? **(Please select all that apply)**

- a. English
- b. American Sign Language
- c. Chinese (Cantonese, Mandarin)
- d. Hmong
- e. Spanish
- f. Tagalog
- g. Vietnamese
- h. Arabic
- i. Russian
- j. Other, please list: _____

14. Briefly describe ways in which you culturally adapt your teaching or resources for Direct Education. *[Open ended]*

15. Please describe any additional cultural adaptations that you feel are needed for Direct Education curricula or resources. *[Open ended]*

Evaluation

16. Do you conduct any evaluation-related activities with CalFresh Healthy Living participants (i.e., administer pre/post surveys)?

- a. Yes
- b. No [SKIP to Q19]

17. How often do participants need or ask for help when answering evaluation questions for Direct Education courses due to language barriers or cultural differences?

- a. Never [SKIP to 19]
- b. Rarely [SKIP to 19]
- c. Sometimes
- d. Often
- e. Always

18. *If participant answers Sometimes, Often or Always to Q17* Please describe the types of questions participants find challenging and provide the tool name, if possible, specifically among different racial/ethnic groups. *[Open ended]*

19. How often do you collect input from participants that helps you select future curricula or nutrition education topics for Direct Education classes?
- At every Direct Education session/series
 - Quarterly
 - Twice a year
 - Once a year
 - Once every other year
 - Once every 3 to 5 years
 - Never

Community Engagement and Policy, Systems and Environmental (PSE) Changes

20. Are you involved in planning and/or implementing Policy, Systems and Environmental (PSE) interventions? (Planning PSEs would include conducting needs assessments, engaging with the community, meetings with partners, etc.)
- Yes
 - No [SKIP to Q25]
21. How often is racial/ethnic diversity and inclusion considered in PSE planning and/or needs assessment?
- Never
 - Rarely
 - Sometimes
 - Often
 - Always
22. How often is input from CalFresh Healthy Living populations from diverse racial/ethnic groups (such as through a community engagement process) included in PSE planning and prioritization process?
- Never [SKIP to Q24]
 - Rarely [SKIP to Q24]
 - Sometimes
 - Often
 - Always
23. *If participant answers Sometimes, Often or Always to Q22* How do you typically gather input from the CFHL populations you serve to prioritize PSEs?
- Community or site surveys
 - Focus groups
 - Community meetings/listening sessions
 - Community Based Organization partners
 - Formal community engagement such as participatory action research (Community Based Participatory Research (CBPR), Youth-led Participatory Action Research (YPAR))

f. Other please specify:

24. Briefly describe ways that you consider racial/ethnic diversity and inclusion in your PSE planning and/or needs assessment (i.e. how feedback from diverse racial/ethnic groups informs planning, key partnerships to meet needs of racial/ethnic groups, etc.) *[Open ended]*

Workforce

The following questions ask about what your organization is currently doing to increase the racial/ethnic diversity and cultural competency of the staff:

	Yes	No	Don't know
25. Does your organization have a mission statement that incorporates racial equity?			
26. Does your organization have written procedures to increase the recruitment, retention and promotion of people of color?			
27. Does your organization have an internal structure or position dedicated to promoting workforce diversity?			
28. Are racial equity and cultural competency training and capacity building made available to your workforce?			

Wrap up questions

29. How can CDSS help you to better serve various racial/ethnic groups through CalFresh Healthy Living interventions?

- a. Specific trainings on equity, racism, cultural humility, etc.
- b. Tailored technical assistance to help you reach specific groups
- c. Partnerships with health equity and racial justice organizations
- d. Tailored resources and campaigns for specific groups
- e. Additional translated materials and curriculum to reach more audiences
- f. Other please specify:

30. Are there any other ways that you promote racial/ethnic diversity and inclusion in your CalFresh Healthy Living work that you would like to share? *[Open ended]*

31. Is there anything else you would like to share related to how CalFresh Healthy Living can better incorporate a racial equity lens in multi-level interventions? *[Open-ended]*

Thank you for taking the time to complete this survey! The information gathered from this survey will be used to create recommendations to address racial equity in CalFresh Health Living (SNAP-Ed).

State Implementing Agency Survey

On behalf of the California Department of Social Services (CDSS) CalFresh Healthy Living (CFHL) program, the Public Health Institute Center for Wellness and Nutrition (PHI CWN) would like to invite you to take the following survey. The purpose of this survey is to help to improve health equity in California through the delivery of CalFresh Healthy Living services and programs by identifying gaps and promising practices across the state.

This survey is intended for State Implementing Agency (SIA) staff who support the implementation of the CalFresh Healthy Living program. We define racial equity as, "a process of eliminating racial disparities and improving outcomes for everyone through structural and systemic improvements." The survey should take about 30 minutes to complete.

Your responses are voluntary and will be kept confidential. You may skip any questions you do not wish to answer. All responses will be compiled together and analyzed as a group.

If you have any questions or concerns, please contact Lizania Romero at the Center for Wellness and Nutrition (Lizania.romero@wellness.phi.org; 916.265.4042 ext. 133).

Do you agree to participate in the following survey?

- a. Yes
- b. No (if selected, skip to end of survey)

Demographics

1. Please identify the SIA where you work? *[dropdown list]*
2. Please select the program areas in which you work on CalFresh Healthy Living. **(Please select all that apply)**
 - a. Integrated Work Plan
 - b. Fiscal/Accounting
 - c. Training
 - d. Site selection approval
 - e. Curriculum selection, adaptation, and/or development
 - f. Evaluation/PEARS
 - g. Multi-level/PSE intervention models and tools (PSE priorities)
 - h. Long-term strategic organizational planning/leadership
 - i. State Nutrition Action Council (SNAC)
 - j. Coordination and support of LIAs
 - k. Other, please describe:

3. How long have you worked on CalFresh Healthy Living (SNAP-Ed) funded projects?
 - a. Less than 1 year
 - b. 1-2 years
 - c. 3-4 years
 - d. 5-6 years
 - e. More than 6 years

We are interested in assessing the diversity of CalFresh Healthy Living SIA staff through the following questions.

4. Please select the race/ethnicity that best describes you. **(Please select all that apply)**
 - a. American Indian or Alaska Native
 - b. Asian
 - c. Black or African American
 - d. Hispanic or Latino
 - e. Native Hawaiian or Other Pacific Islander
 - f. White
 - g. Other, please describe: _____
 - h. Prefer not to answer

5. In which languages are you fluent? (e.g., comfortable reading and speaking)? **(Please select all that apply)**
 - a. English
 - b. American Sign Language
 - c. Chinese (Cantonese, Mandarin)
 - d. Hmong
 - e. Spanish
 - f. Tagalog
 - g. Vietnamese
 - h. Arabic
 - i. Russian
 - j. Other, please list: _____
 - k. Prefer not to answer

Program Needs and Readiness

The following questions ask about your role overseeing and/or supporting local CalFresh Healthy Living programs and services. Please answer based on your own personal work experience.

6. In which of the following languages has your organization provided translated educational materials to your LIAs? This may include pre-translated materials or materials that your organization translated. **(Please select all that apply)**
 - a. Chinese (Simplified, Traditional)

- b. Hmong
 - c. Spanish
 - d. Tagalog
 - e. Vietnamese
 - f. Arabic
 - g. Russian
 - h. No languages other than English
 - i. Other, please list: _____
 - j. Don't know
7. How often does your organization assess health education materials for racial bias?
- a. Never
 - b. Rarely
 - c. Sometimes
 - d. Often
 - e. Always
 - f. Don't know
8. How often does your organization intentionally review health education materials to ensure that materials reflect the CalFresh Healthy Living-eligible population's diversity?
- a. Never
 - b. Rarely
 - c. Sometimes
 - d. Often
 - e. Always
 - f. Don't know
9. What health equity related resources are needed to better serve CalFresh Healthy Living-eligible populations? **(Please select all that apply)**
- a. Additional translated materials and resources
 - b. New culturally tailored curricula to reach specific groups
 - c. Tailored social marketing for specific groups
 - d. PSE guidance on tailoring activities for specific groups
 - e. Asset-based or strength-based approaches
 - f. Other, please specify:
 - g. This is not applicable to my work
10. Please list specific populations for which you see a need for more support by CDSS or CalFresh Healthy Living in accessing culturally adapted resources or translations. *[Open ended]*
11. Please briefly describe any successful cultural adaptations or modifications to curricula or broader resources that your organization has developed (beyond

translation) that could be helpful if adopted by other CalFresh Healthy Living funded agencies. *[Open ended]*

12. How often has your organization intentionally considered racial/ethnic diversity and inclusion in providing oversight to your LIAs? This could be in multi-level program planning, review of IWPs, or other types of support.
 - a. Never (SKIP to Q14)
 - b. Rarely
 - c. Sometimes
 - d. Often
 - e. Always
 - f. Don't know (SKIP to Q14)

13. Please briefly describe how your organization intentionally considers racial and ethnic diversity and inclusion when providing oversight to the LIAs.

14. How often does your organization seek engagement from CalFresh Healthy Living-eligible populations with diverse racial/ethnic identities for their input in overall multi-level program planning (e.g., from focus groups, listening sessions, key informant interviews, review of direct education surveys, community advisory boards)?
 - a. Never [SKIP to Q16]
 - b. Rarely [SKIP to Q16]
 - c. Sometimes
 - d. Often
 - e. Always
 - f. Don't know

15. *If participant answers Sometimes, Often or Always to Q14* Please briefly describe the successful engagement strategies your organization has used to gather input from CalFresh Healthy Living-eligible individuals to inform overall multi-level program planning and priorities, such as from focus groups, listening sessions, key informant interviews, review of direct education surveys, community advisory groups, etc. What factors lead to their success? *[Open ended]*

16. What are the top three challenges or barriers your organization faces with gathering input directly from diverse CalFresh Healthy Living-eligible populations to inform overall multi-level program planning and priorities?
(Please select three)
 - a. Lack of trust
 - b. Time constraints
 - c. Lack of staff
 - d. Language and/or cultural barriers
 - e. Lack of access to technology
 - f. Low engagement/retention

- g. Lack of funding for incentives
- h. Lack of strong relationships between communities and local agencies
- i. Other, please specify:

17. Please list or describe any key partnerships at the state level that have helped your organization better meet the needs of CalFresh Healthy Living- eligible populations from diverse racial/ethnic groups. What factors lead to their success?

Organizational Readiness

The following questions ask about what your organization is currently doing to increase the racial/ethnic diversity and cultural competency of the staff:

	Yes	No	Don't know
18. Does your organization have a mission statement or statement of values that incorporates racial equity?			
19. Does your organization have formal written policies that incorporate racial equity?			
20. Does your organization have written procedures to increase the recruitment, retention and promotion of people of color?			
21. Does your organization have an internal structure or position dedicated to promoting workforce diversity?			
22. Are racial equity and cultural competency training and capacity building made available to your workforce?			

Wrap up Questions

23. What additional state-level training, professional development, or continuing education opportunities regarding racial or ethnic diversity and engagement would you like to see promoted by CalFresh Healthy Living? Are there any training topics that you feel would address the social, environmental, and structural determinates of the racial and ethnic inequities we see in our communities? *[Open ended]*

24. What additional partnerships with health equity and racial justice organizations may help CalFresh Healthy Living programs better meet the needs of the diverse CalFresh Healthy Living-eligible population? *[Open ended]*

25. Is there anything else you would like to share related to how CalFresh Healthy Living can better incorporate a racial equity lens with CalFresh Healthy Living programs and services statewide? *[Open ended]*

Thank you for taking the time to complete this survey! The information gathered from this survey will be used to create recommendations to address racial equity in CalFresh Health Living (SNAP-Ed).

Appendix II: Key Informant Interview Guide

Date:

Moderator:

Interviewee Name:

Interviewee Affiliation

Start Time:

End Time:

Good morning/afternoon. Thank you for agreeing to meet with us, my name is (moderator name). On behalf of the California Department of Social Services (CDSS), the Public Health Institute Center for Wellness and Nutrition is working to assess the need and readiness of CalFresh Healthy Living programs to address racial and health equity.

CalFresh Healthy Living is the California's Supplemental Nutrition Assistance Program–Education (SNAP–Ed) program administered by the CDSS through funding from the United States Department of Agriculture's Food and Nutrition Service. It is an evidence-based program that supports Californians who live at or below 185% of the Federal Poverty Line in achieving healthy behaviors through nutrition and physical activity education, community changes, and social marketing. One component of this project includes interviewing racial equity program leaders like yourself.

We will ask you questions about your racial equity work. Your answers will be used to develop recommendations to help CalFresh Healthy Living further address health inequities in their programming and expand promising practices that reduce disparities that disproportionately impact program participants. Your participation in this interview is voluntary, and you can decline to participate, or withdraw consent at any time, with no consequences. The interview will take approximately 45 minutes. All interview notes, transcripts, and recordings will be stored on a secure electronic server that is only accessible to CDSS and the Center for Wellness and Nutrition research team.

Do you have any questions about the information discussed so far? Do you agree to participate in the interview? (Yes/No)

May I now begin recording the interview?

Part 1: Sharing About Racial Equity Work

To begin, I will ask a series of questions related to specific projects in which you have been involved. We are interested in learning more about the interventions, programs, or evaluation methods you have instituted/implemented within your organization to address racial equity.

1. Can you tell us a little about your professional background?
 - Probe: What has been your experience with food and nutrition programs, social service or public health programs serving vulnerable populations?
2. Please tell us about how you have intentionally included racial equity in your current or past work.
 - Probe: Walk me through the process of how you developed the intervention, program, or framework.
 - Probe: What were the goals of this work?
 - Probe: How did you build support within your organization to conduct this work?
 - Probe: How were the needs and preferences of individuals served by your organization incorporated in the development and implementation of this work?
 - Probe: how did you measure progress and evaluate success including in racial equity in your program?
3. What outcomes or lessons have you learned from this work?

Part 2: Best Practices Recommendations

Now I will ask a few questions to learn about your recommendations or beliefs on how we could improve racial equity in nutrition programs like CalFresh Healthy Living and best practices that you follow in your racial equity work.

4. When you look at the current situation of addressing racial equity in federal nutrition programs like CalFresh Healthy Living (this could be at the national, state, or local level), what do you see as the biggest successes and opportunities?
 - Probe: What is working well and why do you think it is working?
5. What do you see as the biggest challenges or obstacles in addressing racial equity in federal nutrition programs like CalFresh Healthy Living?
 - Probe: At the local, state, or national level?
 - Probe: What changes are needed to better address racial equity?
6. How might an organization that wants to start addressing racial equity more intentionally in their programs and interventions get started?
 - Probe: What are some recommendations that you may give to those just starting out in the field of racial equity?

7. How are you tracking progress in reaching your health equity goals?
 - Probe: Do you set SMART objectives for health equity? If so, what are these?

8. Do you use, or are you aware of, any conceptual frameworks or models to guide racial equity evaluation work? If yes, please describe.
 - Probe: You mentioned _____ is a framework/model that you use to guide your work. Could you tell me more about that?

Part 3: Wrap Up

Is there anything else you would like to share about your experience and recommendations to expand racial justice in food and nutrition programs?

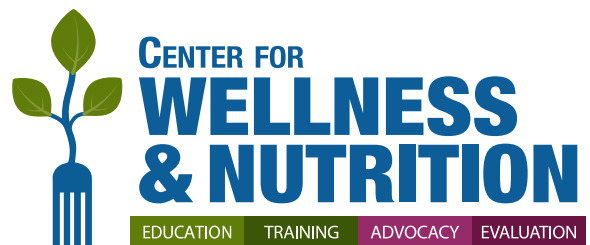
Do you have recommendations for any other people/contacts we could talk with who have included a racial equity focus within their food or nutrition work to which we should talk?

Thank you so much for your input. We sincerely appreciate your time today.



For more information, please contact:

The Public Health Institute's Center for Wellness and Nutrition
info@wellness.phi.org



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