Lessons Learned from Community Partners: Strengthening a Mini-Grants Process to Advance Health Equity

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ABSTRACT:

Background: The Be ActiveWV Grant Program aims to increase equitable access to physical activity throughout the state of West Virginia using mini-grants awarded to community-based organizations. Although health equity is a priority in this program, and questions have been added to the application to convey this focus, consideration for health equity is noticeably absent in mini-grant applications and evaluation reports. Thus, more research is needed to understand how to bolster the health equity initiatives in the Be ActiveWV Grant Program.

Objectives: The purpose of this paper is to overview lessons learned from community partners and to recommend specific strategies to enhance academic-community partnerships and the mini-grant process in service of health equity.

Methods: Online surveys and semi-structured interviews were conducted with 20 former mini-grant applicants. The lessons learned presented in this paper are a reflection of process notes, data analysis notes, thematic analysis, and conversations among WVU researchers.

Lessons Learned: The five lessons learned include (1) build capacity early; (2) facilitate connections; (3) collaborate with communities to develop and disseminate project-related resources; (4) support project promotion; and (5) interact with intention. Rationale is provided for each of the lessons presented, as well as suggestions for how researchers and practitioners might translate these lessons into actionable items.

KEYWORDS: Community-Based Participatory Research, Health Equity, Mini-Grants, Community health partnerships, Rural Health

Mini-grants (also referred to as micro-funding, capacity-building grants, seed grants, etc.) can be an effective, cost-efficient way to forge community-academic partnerships and empower communities to address their health challenges.[1,2] This particular strategy has been applied across disciplines to enhance health behaviors, health outcomes, and access to health resources, including physical activity (PA). Such efforts have been linked to a number of favorable outcomes, including: increased capacity to work with target populations, more visibility and opportunities for programming, expanded reach, and strengthened sustainability.[3-5] Because mini-grants are rooted in a community-based participatory approach, they also have the potential to advance health equity if implemented effectively.

The Be ActiveWV Grant Program is a community-based initiative implemented by the Center for ActiveWV (CAWV). This initiative is a partnership among WVU's College of Applied Human Sciences, the West Virginia Division of Health Promotion and Chronic Disease Prevention, the Bureau of Public Health (BPH), and community-based organizations throughout the state of West Virginia. Community partnerships are established through mini-grants, whereby applicant organizations are funded $1,000 to $5,000 and supported to carry out policy, system, or environment changes (PSE's) to improve access to physical activity in their local community. The partnership between WVU, Division of Health Promotion and Chronic Disease, and BPH is ongoing. Partnerships between the CAWV and funded projects last about a year; however, organizations are encouraged to reapply during the next grant cycle for funds to expand their previous project, or fund a new project. Previously funded partners (N=52) represent health and wellness organizations, local governments, park and recreation departments, health departments, schools, Cooperative Extension services, and more. To see the full list of funded

partners and projects, visit: https://activewv.org/our-work-in-communities/be-activewv-grant-program/.

The CAWV has made it a goal to enhance the health equity component of their mini-grant program and have included specific questions on the application to convey this focus (e.g., populations to be reached, strategies used to reach these populations). However, this focus is not always evident in community partners' applications or evaluation reports. Similar to findings from O'Hara Tompkins and colleagues[3], we have noticed an absence of attention to health equity in mini-grant applications. The reasons for this disconnect are unclear, though previous literature points to factors that contribute to this gap. Some have suggested that there is a lack of education or training in public health among grant recipients.[3] This factor is certainly worth consideration, as researchers posit that understanding root causes of inequities is needed to advance health equity.[6] Other researchers have suggested that the use of academic terminology is a barrier during mini-grant research due to misalignment with community needs.[7] And of course, the barriers and challenges frequently identified by mini-grant recipients, including lack of training, lack of capacity (e.g., time, staff, and funds), administration processes, and misalignment with the culture may pose practical challenges to advancing health equity.[8-11] Still, more research is needed to understand how to bolster the health equity focus of the Be ActiveWV Grant Program.

Provided that community leaders are being tasked with assisting in and leading the implementation of PA interventions, we originally aimed to explore community partners' perceptions of health equity to better understand the absence of health equity initiatives in applications and evaluation reports. However, through the course of our conversations with participants and reflections, we came to learn how we, as academic partners, can take steps to strengthen our relationships with mini-grant recipients and in turn, our health equity initiatives.

Therefore, the purpose of this paper is to highlight the lessons learned during these research activities and recommend specific strategies to enhance academic-community partnerships and the mini-grant process in service of health equity.

Methods

Sampling and Recruitment

Purposive sampling was used to recruit participants. All former CAWV mini-grant applicants (from 2020 – 2023) over age 18 were eligible to participate in the survey (N=100). Participants were recruited from December 2022-February 2023 using a modified Dillman[12] survey recruitment method. Participants who completed the online survey were offered the opportunity to enter a raffle to win one of four $100 Amazon gift cards. Only survey respondents were eligible to participate in interviews and were invited to take part in a follow-up interview if they indicated interest in their survey response. Participants who completed an interview were guaranteed a $25 Amazon gift card via email.

[Insert Table 1]

Instrumentation

Online Survey: An online survey was developed by the CAWV and BPH staff for the purpose of this study. The survey was designed to collect demographic information and stimulate participants' thinking about health equity, their use of health equity strategies, and populations reached through their PA work. The health equity portion of the survey consisted of 20 Likert and checklist items modified from previously administered health equity questionnaires (e.g., Rich & Pascal, 2020).[13] Survey responses served as a foundation for discussion between participants and the researcher, and therefore survey responses were not part of data analysis for this paper.

Interview Script/Questions: A semi-structured interview guide was developed by the CAWV and BPH for the purpose of the study. Interview questions mirrored the topics included on the online survey. Participants answered questions about the following topics: 1) understanding of health equity and related concepts (e.g., familiarity with terms, groups that face health inequities, if/how their organization addresses health inequities); 2) perceptions/beliefs about health equity; and 3) barriers and benefits of promoting health equity in the community. Each participant's responses on the survey were referenced during the interview for clarification and deeper understanding.

Procedures

The IRB at West Virginia University approved this study. Participants received an initial request to participate in the study via email from the CAWV community coordinator containing a description of the study, a link to the survey, and an attached cover letter. Recipients were informed that they could participate in the survey alone or both the survey and follow-up interview. Individuals who completed the survey and indicated interest in participating in an interview were contacted 24-48 hours post survey completion to schedule an interview. The first author conducted semi-structured interviews via phone and Zoom. Each interview was audio recorded with permission from the participant. After each interview, the interviewer engaged in a written reflection of the process, interpersonal dynamics, and noteworthy observations, topics, and patterns. The interviews were transcribed verbatim to prepare for data analysis. Each participant received a copy of their interview transcript and were asked to retract any statements or make additions/clarifications within two weeks. No participant edited or retracted their interview transcript.

Data analysis:

The lessons presented in this paper are a reflection of process notes, data analysis notes, themes from our original thematic data analysis (conducted using steps set forth by Braun, Clarke, & Weate[14]), and conversations among WVU researchers—all of which were based on the process of conducting interviews and analyzing the interview data. The sample of interviewees (N = 20) is detailed in Table 1. The participants represent a variety of organizations across the state of West Virginia (detailed in Table 2). The original intent, to better understand community partners' perceptions about health equity, evolved into learning about the need for academic partner support for community led projects. This work is a starting point to facilitating strengthened partnerships and health equity initiatives in the mini-grant program.

[Insert Tables 2 & 3 here]

Lessons Learned

1. Start Building Capacity Early

Why is it needed to advance health equity? Early capacity building has been recommended by other researchers, as such efforts can support applicants in proposal development and increase visibility of mini-grant opportunities.[15] Additionally, our participants indicated that they, or others in the community, are unaware of the challenges that various groups face to getting physically active. They also noted that despite having attended health equity trainings or workshops, they are frequently left wondering how to translate these concepts to make them concrete, actionable items. We also found the need to assist community partners in moving beyond compliance with regulatory measures (e.g., Title IX, Americans with Disabilities Act, anti-discrimination laws), which often do not address the full scope of barriers to PA participation (e.g., Calder, Sole, & Mulligan, 2018; Rimmer et al., 2017; Krahn, Walker, &

Correa-De-Araujo, 2015)[16-18], to create environments that are accessible, welcoming, and inclusive to historically underserved populations.

What might this look like? Early capacity building can take many forms, including assisting community partners in collecting community-level data via focus groups, key informant interviews, needs assessments, and objective environmental measures. In fact, it has been suggested that lack of community-level data may stand in the way of advancing health equity, as it prevents applicants from using strategies that are evidence-based, relevant, and culturally appropriate.[19] Thus, there may be potential for such data to increase applicants' awareness of community residents with low or no access to physical activity, as well as barriers to physical activity. However, we also understand that these activities may not always be feasible; therefore, in alignment with CBPR, any community data collected by academic partners should be reported back and stored on an open-access platform for community use. Engaging community partners in asset mapping, or documenting a community's tangible and intangible resources, is another capacity-building strategy that can empower communities and identify resources to facilitate implementation or overcome challenges. Asset mapping is a necessary alternative to a deficiency-oriented approach, as McKnight and Kretzmann[21] explain: "Communities have never been built upon their deficiencies. Building community has always depended upon mobilizing the capacities and assets of a people and a place" (p.17).[20-21] Strategies to enhance use of local and community resources have also been requested by community partners in previous studies and are cited as a way to strengthen partnerships.[22]

2. Facilitate Connections

Why is this needed to advance health equity? Our community partners noted that they struggle to reach residents and cultivate interest in physical activity engagement, as many residents' basic

needs are not being met. Community partners also emphasized a desire to connect with other organizations or individuals who understand the unique needs, challenges, and strengths of their community and environment to learn from each other and celebrate successes.

What might this look like? To facilitate connections, it would be beneficial to host events or workshops (both in-person and virtually) for multisector community partners to meet. These events may lead to formal or informal partnerships, and enhance the capacity of community partners to meet the needs of local residents. Online platforms and message boards (e.g., Facebook groups) may also be helpful for partners to seek support from each other in a timely manner, as well as develop sustainable, community-owned resources to assist with project development and implementation. Academic partners may also consider developing a community of learning and practice among mini-grant recipients and key stakeholders, which in other contexts, have been found to help fill the gaps in understanding health equity and aid in overcoming implementation issues like lack of resources and capacity.[23]

3. Collaborate with Communities to Develop and Disseminate Project-Related Resources

Why is this needed to advance health equity? Terms like "health equity" or "health disparities" can lead to resistance due to unfamiliarity or preconceived ideas about what these terms mean, which may appear to be in conflict with community values (e.g., Efird 2020; Efird 2021).[24-25] These findings are not dissimilar from Gabbert, O'Hara Tompkins, and Murphy[7], who speculate that use of academic language may pose challenges during various phases of mini-grants. However, we suggest that academic partners develop discretion regarding when to use these terms with the understanding that in the right context, exposure to these terms may assist community partners in developing grants or advocating for policy change. We also heard from our community partners that efforts to advance health equity should be disseminated through

existing community channels (e.g., community organizations' meetings, events, or platforms) to enhance reach and trust. In alignment with Kennedy-Rea, Mason, Hereford, & Whanger[26], our community partners expressed mistrust of outsiders and academic institutions, indicating a clear need to prioritize true community partnership and align grant objectives with community culture and values.

What might this look like? Genuine community-academic partnerships require transparency and collaboration during all stages of project/research.[27] Development of a community advisory board, hosting periodic meetings, or development of a semi-frequent newsletter to share updates and collect feedback can be a helpful place to start. We also believe that academic partners should develop support resources *with* community partners by requesting input on focus areas and delivery methods, as well as feedback on materials/ideas before they are put into action. A train-the-trainer model may be a promising way to deliver content and buffer against the expressed mistrust of outsiders and academic institutions; however, special consideration should be paid to who delivers content. Trainers should be locally-based to increase the likelihood that they can provide evidence-based practices that are feasible for their communities and aligned with their specific grant funding.[28] It is also worth considering the lived experiences of trainers; historically, many health care and public health professionals are individuals who have been unaffected by inequities, which can lead to a number of concerns including: lack of understanding of the complex issues surrounding inequities, discomfort or disinterest in examining power structures, unwillingness to accommodate the schedules of working community members, and lack of experience working with different groups to build trust.[29]

4. Support Project Promotion

Why is this needed to advance health equity? Many of our community partners expressed discouragement over the lack of awareness around existing resources and programming, which often leads to a sequence of low participation and dissolution of these resources. It was also suggested that while many may be in favor of implementing strategies to reach historically underserved populations, there is resistance to tailoring initiatives to meet the needs of certain groups (e.g., LGBTQ+, individuals with obesity, or individuals with substance use disorders), which aligns with previous studies highlighting stigmatization among these groups.[30-31] We also believe that supporting project promotion will allow us to showcase how advancing health equity benefits the community at large and buffer resistance stemming from a scarcity mindset.

What might this look like? Providing marketing materials (e.g, flyers, signage) is a technical assistance strategy to support policy, system, and environment changes;[32] we recommend that academic partners take this a step further by guiding project promotion with suggestions for content, messaging, images, and potential outlets to help increase project reach. Messaging rooted in social drivers of health may increase awareness of the many factors beyond individual behavior that impact health. Inclusive imaging (e.g., representing individuals with different body sizes, skin tones, cultures) may also serve as a starting point for organizations that want to create an inclusive environment for historically underserved populations. Tailoring messages to each community may also make a larger impact, helping residents see how advancing health equity improves the lives of their neighbors and benefits their community as a whole. Extant documents, such as *A New Way to Talk About the Social Determinants of Health*[33] and *Framing Guidance: Equitable Physical Activity*[34] can assist in the development of these materials; however, academic partners should rely on community partners' expertise in developing messaging that appeals to the community's values, and prioritize content that elevates local

voices, stories, and successes. In particular, personal stories have been shown to contribute to destigmatization of historically oppressed and underserved populations.[35]

5. Interact with Intention

Why is this needed to advance health equity? From our interviews, we learned that our community partners are starting in different places when it comes to both their understanding of health equity, and willingness to work towards creating more equitable physical activity environments and programs. Our partners reminded us that everyone is shaped by their own experiences, making it difficult for some to understand inequities or disparities if they have not experienced them personally.

What might this look like? To open a dialogue about health equity, we need to remain open and curious, with a willingness to meet our community partners where they are. We believe that interactions (including trainings, workshops, etc.) should be conducted with a spirit of motivational interviewing, characterized by collaboration, humility, evocation, acceptance, and compassion.[36] To interact with intention also means that academic partners should create more opportunities to connect with community partners. Previous mini-grant programs used research events and mixers to strengthen connections between community and academic partners, though informal opportunities, like virtual drop-in hours, to build rapport, gather insights from community partners, and provide space for any questions or concerns may be equally beneficial.[37]

[Insert Table 4 here]

Conclusions

Through conversations with community partners and reflexivity during multiple stages of the research process, we were able to consider strategies that would enable us to better support our

community partners. Though many of these suggestions are not novel, we believe that framing them with respect to advancing health equity through our mini-grant program provides valuable insights. Still, we understand that these data were interpreted by academic partners, and based on our positionality, through a lens of privilege; thus, additional information is needed to understand how well these interpretations align with our community partners' experiences, as well as the specifics around how these strategies can be carried out to align with partners' needs and values. We have since reported back what we learned to our community partners using an infographic (Appendix A) distributed through email and are planning an upcoming social media campaign (Facebook, Instagram). Alongside the infographic, we provided a link to an anonymous survey in an attempt to clarify these remaining questions and help us plan for the development of support resources. We also believe that moving forward, it would be helpful to move beyond evaluation of mini-grant outcomes to assess the strength of our partnerships using objective and subjective methods. In line with Brush and colleagues (2020)[38], there are a number of indicators of partnership success, including characteristics of the partners (e.g., diverse, representative) and characteristics of the relationship (e.g., trust, respect, transparency), partnership characteristics (e.g., leadership, flexibility), processes (e.g., guidelines, structures, evaluations), resources (e.g., shared allocation of resources), capacity (increased capacity for research), and partnership outcomes (e.g., policy and system changes, community benefit).

We are hopeful that these lessons learned from our rural WV communities offer insights for other practitioners to build upon and strengthen their work in physical activity promotion. By listening to the perspectives of our partners, we have been able to sustain and expand our efforts in dozens of communities throughout the state which are aimed at empowering community organizations to create their own changes. Still, there is much work to be done to ensure

academic-community partnerships are helpful and productive as we aim to advance health equity.

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Table 1. Interview Participant Demographics.

Demographic Characteristics	**% (N = 20)**
Age	
25-44	45%
45-54	20%
55-64	20%
65+	15%
Gender	
Female	85%
Male	15%
Race	
White	85%
African American / Black	10%
Multiple Races	5%
Ethnicity	
Non-Hispanic	100%
Education	
Technical / Associate's Degree	5%
Some College	15%
Bachelor's Degree	35%
Graduate Degree	45%
Sexual Orientation	
Not LGBTQ+	100%
Documented Disability	
Yes	5%
No	95%
Requirements met for financial assistance? (e.g. WIC, SNAP)	
No	100%

Table 2: Overview of Interviewees' Organizations and Project Proposals.

Interviewees were either part of, or partnered with, the organizations described. Some interviewees' organizations applied for funding multiple years. Asterisks are used to indicate funded projects.

#	Organization Description	Project Proposal Focus and Description	Geographic Focus
1	Non-profit focused on social and economic change for youth and communities	**Y3 (2022)**	City
		Systems – Develop walking and/or bicycling club	
2	Local chapter of national sports team organization for youth and adults with disabilities	**Y3 (2022)***	City
		Systems – Provide home exercise equipment and protective gear for sports team for youth and adults with disabilities	
3	Local corporation providing free or affordable prescriptions, comprehensive health, and preventative care	**Y4 (2023)***	City
		Systems – Develop walking group program connecting patients with community health workers. Provide fitness club membership, monthly lectures by healthcare professionals, and monthly delivery of organic, WV grown produce.	
4	Local non-profit providing fun fitness activities in communities to curb adult and childhood obesity by	**Y2 (2021)**	City
		Systems – Host 12-week virtual competition for school-aged children to learn more about physical activity and increase movement. Competing schools to win $250 of physical activity equipment and a visit from a mobile gym.	
		Y3 (2022)	State

		Systems – Host 12-week program to engage kids in 5-minute workouts, seniors to participate in virtual chair yoga. Encourage families to increase activity via statewide challenge.	
5	Community collaborative created to encourage and support healthy behavior change	**Y1 (2020)***	County
		Environment – Improve and map trails at 2 locations, including a handicap accessible trail	
		Y2 (2021)*	City
		Environment – Improve trail with benches and signage	
		Y3 (2022)	County
		Systems – Develop outdoor walking groups by training volunteers in Walk with Ease and walking group leadership	
6	Non-profit that develops and manages multi-county trail system	**Y1 (2020)***	Multiple counties
		Environment – Construct paved connector between neighborhood / community park and rail trail	
		Y2 (2021)*	County
		Environment – Restore 5-mile section of trail from damage caused by grass encroachment and wash-outs	
		Y3 (2022)*	County
		Environment – Improve parking and drainage at trailheads	
		Y4 (2023)*	City
		Environment – Design and construct .5 mile connector trail	
7	Community organization established by local residents to identify and address complex environmental changes	**Y3 (2022)***	Town
		Environment – Install wayfinding and educational signs along a 2-mile trail	
8	Local organization promoting youth outdoor recreation and experiential learning opportunities	**Y3 (2022)***	County
		Systems – Create "Adventure Library" to provide bikes, helmets and instruction to schools throughout county; Provide professional development on integrating physical activity during the school day and incorporating parents/families in physical education.	
9		**Y2 (2021)***	County

	County Parks and Recreation organization	***Environment*** – Build two loops of a "Pump Track"—loops will link together with a bicycle playground for beginners within the first loop	
10	Community organization that provides training, support, and resources for gardening	**Y3 (2022)*** ***Environment*** – Complete and upgrade a local trail with wayfinding, informational signage, and plants and trees to connect downtown area to community gardens	Two counties
11	Title I public middle school	**Y4 (2023)*** ***Systems*** – Purchase new adaptive bikes, adult-size bikes, new parts to repair current bikes. Purchase hand tools and materials to improve trail conditions at local park. ***Environment*** – Install fix-it-station in centrally-located park	City
12	Organization that provides year-round sports, education, and recreation programs for individuals with disabilities	**Y2 (2021)** ***Systems*** – Develop a 6-month program that uses goal-setting, social support, and activity tracking to increase activity among individuals with disabilities.	Two counties
13	Local government	**Y3 (2022)** ***Environment*** – Construct educational signage around a trail for science-related educational learning ***Systems*** – Work with a local school to implement activity during the school day	County
14	Local (municipal) government	**Y2 (2021)*** ***Environment*** – Create a walking tour map of downtown that highlights local history and directs walkers to local art installations.	Town
15	Community non-profit promoting cultural enrichment and learning through natural environments	**Y4 (2023)*** ***Environment*** – Improve trail by adding pedestrian bridge, signage with maps, improve drainage, and create boardwalks over wet areas	County
16	Youth development organization focused on enhancing life skills in youth	**Y2 (2021*)** ***Environment*** – Create "Active Pathways" for youth to be active in various outdoor locations across the county. ***Systems*** – Train physical educators and facility managers on implementation of the Active Pathways.	County
17		**Y4 (2023)***	County

	State-wide organization providing nutrition education and obesity prevention outreach to low-resource children and adults	***Environment*** – Place interpretive signs throughout local trail systems. Signs will feature West Virginia native character and a coordinating physical activity. QR codes will link to information about the featured character and exercise information.	
18	Local site of state-wide medical Center	**Y4 (2023)***	County
		Environment – Implement exercise program by installing placards with QR codes along local trails. QR codes recommend daily workouts for trail users. Workouts will be adapted for (1) general public, (2) older adults, (3) women, (4) children, and (5) individuals with disabilities.	

Table 3. Demographic and Health Data from Proposed Project Counties.

Demographic and Health Data from Proposed Project Counties												
County	Jefferson	Pocahontas	Fayette	Monongalia	Berkeley	Cabell	Hampshire	Harrison	Hardy	Pendleton	Wayne	Kanawha
Population estimates, July 1, 2024, (V2024)[a]	61,264	7,653	38,600	108,697	136,287	91,489	23,793	64,472	14,335	5,944	37,589	173,906
Age												
Persons < 5 years[a]	4.70%	4.40%	4.80%	4.50%	6.00%	5.10%	5.00%	5.30%	4.80%	4.70%	5.00%	4.90%
Persons < 18 years[a]	20.50%	17.80%	20.50 %	16.10%	23.00%	19.80%	17.90%	21.10%	19.40 %	18.60%	20.10 %	19.70%
Persons 65 years and over [a]	18.00%	28.30%	23.50 %	14.00%	15.50%	20.10%	24.80%	20.90%	24.00 %	30.00%	23.00 %	22.60%
Sex												
Female[a]	50.10%	48.50%	49.40 %	48.30%	50.10%	51.20%	48.50%	50.60%	48.80 %	49.20%	50.90 %	51.60%
Race and Ethnicity												
White[a]	87.80%	95.90%	93.30 %	89.70%	85.90%	90.80%	96.50%	95.10%	93.50 %	94.90%	97.20 %	88.40%
Black[a]	6.40%	1.80%	4.00%	3.80%	8.50%	4.90%	1.40%	2.00%	3.60%	2.50%	0.80%	7.40%
American Indian and Alaska Native[a]	0.50%	0.30%	0.30%	0.20%	0.40%	0.20%	0.30%	0.20%	0.20%	0.30%	0.30%	0.20%
Asian[a]	1.90%	0.20%	0.30%	3.60%	1.40%	1.30%	0.40%	0.80%	0.90%	0.40%	0.40%	1.10%
Native Hawaiian and Other Pacific Islander[a]	0.10%	0.00%	N/A	0.10%	0.10%	N/A	0.10%	N/A	0.10%	0.10%	N/A	N/A
Two or More Races[a]	3.30%	1.70%	2.00%	2.60%	3.70%	2.80%	1.40%	1.90%	1.70%	1.80%	1.30%	2.80%

Hispanic or Latin[a]	8.00%	1.70%	1.40%	3.20%	6.70%	1.80%	1.80%	2.30%	4.50%	1.10%	1.00%	1.60%
White, not Hispanic or Latino[a]	80.80%	94.40%	92.20 %	87.00%	80.30%	89.30%	95.00%	93.00%	89.90 %	94.20%	96.40 %	87.00%
Education												
High school graduate or higher, % of persons age 25 years+, 2019-2023[a]	90.00%	83.80%	86.10 %	94.00%	90.60%	90.00%	88.70%	88.80%	86.60 %	87.20%	85.30 %	90.70%
Bachelor's degree or higher, % of persons age 25 years+, 2019-2023[a]	33.70%	15.80%	16.10 %	47.90%	24.30%	32.40%	16.30%	25.90%	15.70 %	20.50%	17.70 %	29.30%
Health Information												
Disability, age < 65 years, 2019-2023[a]	9.30%	15.10%	15.80 %	9.40%	10.70%	14.40%	18.80%	11.60%	12.70 %	11.80%	18.50 %	14.90%
Adult obesity[b]	35%	44%	39%	37%	40%	42%	42%	40%	43%	39%	46%	40%
Adult diabetes prevalence[b]	12%	14%	14%	12%	12%	13%	13%	13%	14%	13%	14%	13%
Income and Poverty												
Median household income (2023 dollars), 2019-2023[a]	$95,523	$41,200	$52,672	$62,704	$77,329	$52,828	$60,299	$58,326	$49,302	$61,738	$55,539	$58,887
Persons in poverty [a]	9.00%	19.20%	16.70 %	18.30%	11.30%	19.80%	14.20%	14.40%	13.80 %	13.90%	18.20 %	15.60%
Physical Activity												

Adults reporting no leisure-time physical activity[b]	23%	36%	35%	24%	26%	32%	30%	29%	33%	30%	32%	29%
Population with adequate access to locations for PA[b]	35%	95%	61%	76%	56%	81%	33%	76%	67%	87%	44%	71%

[a] U.S. Census Bureau, "Quick Facts", https://www.census.gov/quickfacts/, accessed April 15, 2025.

[b] University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2025. www.countyhealthrankings.org, accessed April 15, 2025.

Table 4. Overview of Key Themes and Applications.

Key Theme / Lesson	Support for Importance	Recommendations to Improve Partnerships
Build Capacity Early	● Limited awareness of: ○ Challenges to getting active ○ How to translate health equity knowledge into practice ○ How to move beyond regulatory measures	● Assist in collecting community level data ● Report back and make available any community-level data that has been collected ● Provide evidence-based strategies ● Engage in collaborative asset mapping
Facilitate Connections	● Difficult to prioritize physical activity when basic needs not met ● Need to connect with others who understand unique local context	● Host local events and workshops for cross-sector partners and stakeholders ● Create message boards for timely support and problem-solving ● Develop communities of learning and practice to deepen health equity knowledge
Collaborate with Communities to Develop and Disseminate Project-Related Resources	● Terminology or wording leads to resistance ● Mistrust of outsiders ● Limited reach	● Establish a community advisory board ● Distribute newsletters to share project / research updates ● Collect feedback ● Co-develop support resources with community and use existing channels for distribution ● Implement a train-the-trainer model with locally-based trainers
Support Project Promotion	● Limited awareness of existing resources ● Resistance due to stigmatization and a scarcity mindset (i.e., more for them means less for me)	● Provide promotional materials and guidance on content development, messaging, and imagery ● Frame messaging around the social drivers of health ● Use inclusive imaging ● Tailor materials to each community's values ● Elevate local voices, stories, and successes
Interact with Intention	● Wide spectrum of partners' awareness and willingness to implement strategies to advance health equity	● Use motivational interviewing strategies during interactions ● Host research events and informal opportunities to build relationships and provide space for sharing questions and concerns

Appendix A. Infographic Used to Report Findings to Community Partners.