SAMHSA Disparity Impact Statement
Training and Technical Assistance Example

Purpose

SAMHSA requires that its grant recipients prepare a Behavioral Health Disparity Impact Statement (DIS) as part of a data-driven, quality improvement approach to advance equity for all, and to identify racial, ethnic, sexual and gender minority populations at highest risk for experiencing behavioral health disparities as part of their grant projects. The purpose of the DIS is for recipients to identify, contextualize and address disparities[1] and to develop and implement a disparity reduction action plan with a quality improvement process to address and close the identified gap(s). The aim is to achieve behavioral health equity[2] for disparate populations and to improve systems addressing the needs of these populations. The DIS requirement aligns with expectations outlined in [Presidential Executive Order 13985: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government](#), which includes identifying the needs of underserved communities and developing policies to advance (health) equity within those communities.

Background

To address behavioral health disparities, it is important to understand the role that Social Determinants of Health (SDOH) [3] can have on the health of individuals and communities**.** SDOH are the conditions in the environment where people are born, live, work, play, worship, age and thrive that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH can be grouped into 5 domains: 1) Economic Stability; 2) Education Access and Quality; 3) Healthcare Access and Quality; 4) Neighborhood and Built Environment; and 5) Social and Community Context. The SDOH framework recognizes that cross-sectoral systems contribute to advancing equity through a lifespan perspective. Understanding the SDOH community context can help recipients identify the disparity (or problem), population of focus and inform the development of accurate measures to study and improve outcomes.

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[1] Healthy People 2030 defines a health disparity as a "particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; disability; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

[2] Behavioral health equity is the right to access high quality and affordable health care services and supports for all populations regardless of the individual's race, age, ethnicity, gender (including gender identity), disability, socioeconomic status, sexual orientation, or geographical location. Advancing behavioral health equity involves ensuring that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with quality services, this involves addressing social determinants of health, such as employment and housing stability, insurance status, proximity to services, and culturally responsive care – all of which have an impact on behavioral health outcomes.

[3] https://www.cdc.gov/socialdeterminants/index.htm

The purpose of this document is to support recipients in developing measures associated with DIS. All of SAMHSA's discretionary grants are required to report Government Performance and Results Act (GPRA)[4] data, which includes the National Outcome Measures (NOMS). Grant programs using the NOMS client-level outcomes tool uses data collected that includes demographics[5], ICD-10 diagnostic categories, substance use and abuse, mental health and physical health functioning and other variables. There are limitations to the categories regarding certain race, ethnicity, language, and disability. For some grant programs that are collecting Infrastructure, Prevention and Promotion (IPP) indicators, demographic data are collected, but are not housed within SAMHSA's Performance Accountability and Reliability System (SPARS).

Despite these limitations, the DIS can be used to identify and demonstrate the impact of SAMHSA's investments to reduce and eliminate inequities among underserved populations. By developing the DIS, recipients will identify the population experiencing the disparity, share more specific population data that will assist in determining if SAMHSA's grant investments are reducing disparities, use data to more precisely direct resources to improve the SDOH and CLAS (Culturally and Linguistically Appropriate Services) while moving towards outcomes that will reduce disparities among the population(s) noted.

For recipients serving distinct populations (i.e., tribes, etc.), disparities within these populations can be identified (e.g., age, gender identity, sexual orientation, disability).

As recipients collaborate within their respective organizations to complete this DIS, we hope that it will inspire and guide an approach to reducing and eliminating behavioral health disparities for the populations being served. In the following pages the modernized SAMHSA Behavioral Health Disparity Impact Statement is included as a worksheet to support completion by the recipient.

Resources, guidance, and training to support recipients in completing the DIS can be found here https://www.samhsa.gov/grants/grants-management/disparity-impact-statement; see also accompanying Appendices).

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[4] https://www.samhsa.gov/grants/gpra-measurement-tools
[5] https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=53

Disparity Impact Statement Worksheet
Training and Technical Assistance Example

Grantee Organization Name: Peer Support and Recovery Wellness Center
Grant ID: TI012345
Grant Program: National Consumer and Consumer Supporter Technical Assistance Centers
Project Director: Jane Smith
Grant Project Officer: Samantha H. Sutter

SECTION I. Identifying Behavioral Health Disparities

IDENTIFY and DESCRIBE THE SCOPE of the PROBLEM
What is the disparity/problem/gap you are seeking to address as it relates to the grant program? What are the data to support this (e.g. SAMHSA National Survey on Drug Use and Health (NSDUH), CDC and OMH Minority Health Social Vulnerability Index (SVI), CDC/ATSDR Social Vulnerability Index (SVI), CDC Behavioral Risk Factor Surveillance System, CDC Youth Risk Behavioral Surveillance System, AHRQ National Healthcare Quality and Disparities Report (NHQDR), U.S. Census Bureau Data, U.S. Census Bureau American Community Survey (ACS), Federal Register Annual Update of the HHS Poverty Guidelines, CMS Informational Bulletin on 2022 Federal Poverty Level Standards, other federal, state, or county level data. Note: You may frame the disparity(ies) by looking at the individual/client level, organizational level, and/or systemic level.

The population we are seeking to address includes adults with serious mental illness (SMI) and/or substance use disorders (SUD) from underserved and underrepresented populations. This includes African American, American Indian/Alaska Native, Hispanic/Latino, Asian American, Native Hawaiian, and Other Pacific Islander communities, individuals who identify as two or more races, and LGBTQIA+ populations. In 2020, there were an estimated 14.2 (5.6%) million adults aged 18 or older with SMI. The prevalence of SMI was highest among adults reporting two or more races (9.9%). American Indian/Alaskan Native (6.6%), Black or African American (4.7%), Hispanic or Latino (4.5%), and AA/NHOPI (3.3%) (NIH, 2020). Top reported reasons for not using mental health services among underserved populations include cost or insurance, stigma, and structural needs (SAMHSA, 2021).

We intend to address disparities among diverse adults with SMI and SUD in their ability to access employment opportunities by offering trainings that incorporate culturally appropriate practices. Trainings will include Mental Health 101 and Substance Use 101 series which cover topics such as behavior management, conflict resolution, crisis management, suicide prevention, job interviewing skills, resume writing, and entrepreneurship to address training needs for adults with SMI and SUD.

The grant additionally seeks to address lack of diversity among practitioners and the peer workforce who serve those with SMI and SUD by providing training opportunities for diverse behavioral health providers. We intend to partner with the National Latino Behavioral Health

Association, National Latinx Psychological Association, National Association of Black Psychologist, National Association of Black Counselors, and National Asian American Pacific Islander Mental Health Association and others.

Additionally, we want to address the stigma of mental health and substance use associated with racially, ethnically, gender, etc. by developing training to effectively reduce and stop stigma among diverse populations.

We have created an approach to provide training, technical assistance, and resources for adults with SMI and SUD and the behavioral health workforce who provide them behavioral health services. We intend to provide opportunities to support the 1) current peer workforce; 2) future peer workforce; 3) consumers (with SMI); and 4) mental health and substance use service providers. To address disparities with the workforce we intend to provide training, technical assistance, and best practices on successful recruitment and sustainability of a diverse behavioral health and peer and recovery specialist workforce.

Potential Data Sources

 Sources:

HRSA analysis of the ACS PUMS, 2008-2010, 2017 SAMHSA Uniform Reporting System (URS) Output Tables.

DISPARATE POPULATION(S) OF FOCUS
Identify the focus population(s) experiencing disparate access, use, and outcomes and that experience adverse SDOH with impact to behavioral health in your geographic/catchment area.

Identify data source(s) that you are using to inform the DIS for the grant program. *Grant recipients must select sound and reliable source(s) of programmatic, county, state, or national indicators the program deems best suited to the needs of this grant. Recipients may consider the same data sources listed above (e.g., ACS, NHQDR, SVI, NSDUH).* The data referenced within the DIS should be in alignment with the data provided in your application.

*Note: For client level data, CMS SDOH Z-codes are available and can be used to collect data on disparities. It is recommended to use SDOH Z-codes more broadly and beyond the billing environment to support data collection on available determinants. For more information on SDOH Z-codes and how they are being used to narrow health disparities, please see https://www.cms.gov/files/document/zcodesinfographic.pdf; https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf; *and* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6207437/pdf/18-095.pdf.

Demographic Profile
Complete a table that includes the disparity (the gap or difference) at the individual/client, organizational, or systemic level as it relates to the grant data collection requirements: NOMs, IPP, or both related to access, use and outcomes. *For examples, including the use of a table, please see Appendix A.*

	FY1	FY2	FY3	FY4	FY5	TOTAL
Number to be trained/served/ reached	6,036	7,206	9,206	13,306	21,206	56,960
By Race/Ethnicity						
African American *(12.7%)*	767	915	1,169	1,677	2,693	7,221
American Indian/Alaska Native *(0.9%)*	54	65	83	119	191	512
Asian *(5.6%)*	338	404	516	740	1,188	3,186
White (non-Hispanic) *(72.2%)*	4,358	5,203	6,647	9,535	15,311	41,054
Hispanic or Latino *(18.3%)*	1,105	1,319	1,685	2,417	3,881	10,407
Native Hawaiian/Other Pacific Islander *(0.2%)*	12	14	18	26	42	112
Other *(5%)*	302	360	460	660	1,060	2,842
Two or more Races *(3.4%)*	205	245	313	449	721	1,933
By Gender						
Female *(51.3%)*	3,096	3,697	4,273	6,775	10,879	28,720
Male *(48.7%)*	2,940	3,509	4,483	6,431	10,327	27,690
Transgender *(0.39%)*	24	28	36	52	83	223
By Sexual Orientation/Identity Status						
Lesbian *(1.4%)*	85	101	129	185	297	797
Gay *(1.9%)*	115	137	175	251	403	1,081

The numbers in the chart below reflect the proposed number of individuals to be reached during the entire grant period and all identified subpopulations in the grant service area. The disparate populations are identified in the narrative below.

SECTION II. Addressing Disparities Using the Funding Opportunity

SOCIAL DETERMINANTS OF HEALTH[6]
Identify one or more SDOH domain(s) that your organization will work to address and improve for the identified population(s) of focus using the Notice of Award (NOA). Include a brief explanation about how your organization will address the specific domain(s) to support the reduction or elimination of disparities for the identified population.

Social Determinant of Health Domains
(Visit Healthy People 2030 for more information on the five (5) domains.)
1. Education and Quality
2. Economic Stability
3. Health Care Access and Quality
4. Neighborhood and Built Environment
5. Social and Community Context

Education and Quality- According to **health.gov**, "People with higher levels of education are more likely to be healthier and live longer. Children from low-income families, children with disabilities, and children who routinely experience forms of social discrimination — like bullying — are more likely to struggle with math and reading. They're also less likely to graduate from high school or go to college. This means they're less likely to get safe, high-paying jobs and more likely to have health problems like heart disease, diabetes, and depression."[1]. Peer Recovery's plan is to address the SDOH of Education and Quality through TA (technical assistance) on a national level and focusing on the Northeast region.

We will partner with state and local government, the business sector, Certified Community Behavioral Health Clinics (CCBHCs), other SAMHSA consumer TA centers, higher education institutions (minority serving institutions), community college networks, U.S. Small Business Association, U.S. Chamber of Commerce, and U.S. Department of Labor to support a national focus on employment for adults living with SMI and SUD. We will share evidence-based (and evidence-supported) practices that support development of culturally appropriate educational programs and trainings that will enable employers to hire and retain recovery support and peer specialists.

Training and technical assistance will be provided to support leadership development for those with SMI and SUD to emphasize the critical role of family engagement in behavioral health and recovery. Training and technical assistance will address stigma that is experienced by persons with mental and substance use disorders and that may present a disparity in their ability to obtain and retain employment.

 Sources:
https://health.gov/healthypeople/objectives-and-data/browse-objectives/education-access-and-quality

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[6] https://www.ruralhealthinfo.org/toolkits/sdoh

Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care [7]

Using the Behavioral Health Implementation Guide, identify one or more of the CLAS standards (listed below) that your organization plans to meet, expand, or improve through this grant opportunity. Include an explanation on any activities, policies, and procedures that your organization will undertake to ensure adherence.

(Review the [Behavioral Health Implementation Guide](#) for full explanations of the overarching themes and 15 CLAS Standards with behavioral health related samples, strategies, and examples.)

Principal Standard
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs

Governance, Leadership and Workforce
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support culturally and linguistically diverse governance, leadership, and workforce responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance
5. Offer language assistance to individuals who have limited English proficiency (LEP) and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

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14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all partners, constituents, and the general public.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency (LEP) and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

We plan to address the CLAS theme communication and language assistance with a focus on standards 5 and 8 to improve upon communication and language assistance through this grant. Peer Recovery staff will have access to interpreters and offer multiple language translated materials for non-English speaking clients, those who speak English, may be limited English proficient or, prefer materials in their primary language. We will ensure that materials and signage are culturally and linguistically appropriate.

SECTION III. Developing a Disparity Reduction Quality Improvement Plan

This final section of the DIS is to help you develop and implement a disparity reducing quality improvement plan as part of your DIS to address under-served population differences based on the (GPRA) data for access, use and outcomes of activities.

For example:

- Access: number of individuals served, number of outreach contacts, number of screenings, number of referrals.

- Use: number of screenings, number of referrals, retention rate, number of trainings.

- Outcomes: number of completed referrals, number of people trained, number and percentage of individuals who have demonstrated improvement in knowledge/attitudes/beliefs, number of programs/organizations/communities that implemented specific behavioral health practices or evidence-based activities.

Include activities as they relate to both the grant requirements and your application. Also mention the identified gaps, disparate/population(s) of focus, and subpopulations listed above. Be prepared to provide at a minimum, an annual update on the disparity reducing quality improvement plan (what worked, what did not work, and what modifications were made) as part of the programmatic progress reports per the NOFO. The DIS should be viewed as a living document.

IMPLEMENTATION OF ACTIVITY

Based on the responses above, identify specifically how you will address these disparities and the populations' needs with the required activities from the NOFO and within your application (using the SMART goals). Using the SMART goals, your application should be aligned with the DIS. Be sure to answer the following: What can your grant program activities do to address the disparity/ies? Address access, use, and outcomes (see Appendix C). How will you implement these activities? Who will be responsible to do so? How will you include client/peer/family/friends' voices in your program activities?

Please describe the activities that you will implement.

> **Goal 1**: Increase training opportunities for racial, ethnic, and gender minority adults with SMI and SUD by providing training and supports to increase employability.
> - Objective 1: Provide trainings to adults with SMI and SUD on condition management, medication adherence, and workplace communication quarterly to support successful employment.
> - Objective 2: Provide trainings to employers on effectively working with persons who have SMI and SUD quarterly to support employment retention.
>
> **Goal 2**: Increase knowledge and training opportunities for behavioral health providers and peer and recovery support specialists on cultural competency.
> - Objective 1: Provide cultural competency trainings for staff and peer and recovery support specialists and providers across all 5 grant years, with at least 2 trainings per year.
> - Objective 2: Provide cultural competency trainings for employers across all 5 grant years, with at least 2 trainings per year.

INTENDED OUTCOMES AND IMPACT

How will these activities improve the problem or close the disparity? How will you identify and outreach to the identified population(s) of focus in your catchment area?
(Intended outcomes and impact should be directly related to your goals and objectives.)

> Adults in the training program with SMI/SUD will have increased access to employment opportunities and be more likely to successfully retain employment. We expect this effort will impact underserved adults with SMI/SUD by improving their professional skills and economic stability.
>
> The trainings will increase cultural competence of the employer(s), those in the behavioral health workforce (including peer and recovery support specialists), and family members who support adults with SMI/SUD. We expect this effort to increase culturally competent employer, social, and community support for persons with SMI/SUD.
>
> We will work with state behavioral health agencies, community service boards, courts, and mental health providers to identify and recruit ideal participants, families, and employers into the training program. We will also recruit clients from our other programs who would be well suited for this training program.

CLIENT/PEER/PARTNER INVOLVEMENT

How will you include client/peer and family voices and other relevant partners in your program's activities based on the identified population of focus?

Peer Recovery Wellness will engage clients, peer, and family voices in the training program curriculum development, through client experience surveys to improve participant trainings, by applying principles outlined in the SAMHSA Supported Employment Evidence-Based Practices (EBP) kit, and other evidence-based resources. These efforts will ensure that the client, peer, and family voices are included in the planning and implementation of this training program.

We will ensure that peers from diverse populations (African American, American Indian/Alaska Native, Hispanic/Latino, Asian American, Native Hawaiian, and Other Pacific Islander communities, individuals who identify as two or more races, and LGBTQIA+) serve on the training teams to support implementation.

GPRA data will be used to monitor and manage program outcomes by race, ethnicity and urban/rural geographic classifications. Programmatic adjustments will be made as indicated to address identified issues, including behavioral health disparities, across program domains.

TIMELINE

When will you implement these activities? How often will they be reviewed and adjusted? (Recipient should follow NOFO specific NOMs data collection timelines with DIS reporting updates.)

Activities will be implemented throughout the five-year grant project period. We expect quarterly trainings to be offered each grant year with participants, employers, and family members to support persons with SMI/SUD.   The cultural competency trainings will be offered bi-annually to staff, employers, and peer recovery support specialists. Pre- and Post- training surveys will be offered for each training that is implemented. Training surveys will be reviewed and analyzed throughout the project period to improve activities with the population of focus.

Ongoing GPRA data will be collected and entered per the SPARS guidance. For additional information on training timelines, please refer to the implementation of activity section. Our evaluator will review and report on the data analyses and outcomes to the project director weekly and meet with the team to discuss gaps and solutions bi-monthly.

MEASUREMENT/ EVALUATION

How will you measure your process, progress, and outcomes to show you were able to improve disparities (i.e., reduce or close the gap) within the identified population(s) of focus? How will you measure incremental progress achieved under this award?

You should link measurement[8] and evaluation to goals and objectives submitted in your application and as noted earlier in the DIS. Please refer to Appendix D for additional resources.

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[8] Measurement of Health Disparities, Health Inequities, and Social Determinants of Health to Support the

We will identify assigned staff from diverse cultures, racial/ethnic, and LGBTQIA+ populations to serve as part of the data collection and analysis process, to obtain defined outcomes in meeting the grant project program measures, as well as national data for future reporting. The analysis of these data will allow the program to determine if our efforts have a broad reaching impact or if we are isolated to specific populations, geographic areas, or cultures. In case there are variations or shortcomings that reflect the identified populations, there will be a partner meeting to identify potential causes, possible responses, and necessary adjustments to adjust the trainings in those identified areas.

This may include connecting with minority-serving institutions, Certified Community Behavioral Health Clinics, and/or state and local government to ensure program outcomes extend to the diverse training participants from the populations of focus.

Performance Assessment: Peer Recovery will measure outcomes and impacts of the project to determine how well the TA Center is meeting its goals. Results will be reviewed and discussed internally at quarterly Quality Improvement and Performance Assessment meetings. Evaluation and impact reports on the TA Center progress will be provided to SAMHSA as required. We will implement the following data collection methods to successfully assess performance.

Event Description: On a monthly basis, information about the event primary audience from the GPRA Event Description Form will be compared to the participant demographics to identify gaps or areas of improvement needed in communication and marketing to increase participation of diverse audiences. Additionally, event formats, topics and dates will be analyzed against post-event forms to improve effectiveness of events.

Pre – training survey: Peer Recovery's Pre-training survey will be conducted on paper forms if the intervention is in person, or online, via Qualtrics, if the training is virtual. Pre-tests will be administered prior to the beginning of the training. This survey will measure and assess the participant's baseline knowledge on the training topics. Pre-test surveys will be analyzed and immediately shared with the training leads to prepare for implementation. This pre-training survey will support the organizations measurement of participant behavior changes, and agency organizational changes that occur as a result of the trainings.

Participant Satisfaction Survey: The GPRA-Post Event Form survey will be administered at the end of each training. Participants will have opportunities to complete the survey through a web-based survey tool or paper survey tool to all training and technical assistance participants. Through the web-based survey tool participants will have the ability to choose up to 10 different language options to complete the participant satisfaction survey. We will also provide support through a language access service to participants who need additional support. This tool will capture the demographics of participants and participant satisfaction with the event. Analysis of results will be shared with project leads within the month after the survey is closed. Results, lessons learned, and implementation strategies will be discussed at staff meetings with project leads, and evaluators and shared with the community via our website.

Advancement of Health Equity. Journal of Public Health Management and Practice. 2016.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5845853/

Post – training surveys: In addition to the GPRA Follow-up Form at 60-days post event, Peer Recovery's Post- training survey will be conducted 12 months after the training was completed over the phone or online as per participant expressed preferences for follow-up. This survey will measure the outcomes of participant behavior changes, participant knowledge improvement, and agency organizational changes implemented. Post-training surveys will be analyzed within the month of their execution, and results will be shared and discussed immediately with intervention leads, and yearly at the Performance Assessment project lead meetings.

Key Partner Interviews. Interviews will be conducted with a random selection of training participants regarding the impact of the training and technical assistance activities. These interviews will identify strengths to build upon and provide feedback on how to improve the work of the center. Peer specialists will share impact stories anonymously to promote the training activities, inform partners about the training and technical assistance opportunity, and build morale. Interviews will be conducted by the grant project director who has extensive experience conducting interviews such as the SAMHSA System of Care Key Partner and Key Partner Interviews. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

SUSTAINABILITY

What changes will your organization make to enable sustainability and continue the process to improve disparities? (e.g., policies, financing, budget, training, systems, environmental changes) What external systems exist that can support sustainability efforts? (e.g., Local organizations adopting service priorities to support progress made under this award, partnerships with other community organizations, etc.)

- Develop a post implementation product (best practices guide/training) scale up to support other entities with implementing similar trainings
- Develop implementation framework that would support replication of 'intervention/trainings' – guide practice (Support pre-implementation/planning efforts.; workforce/peers who would be implementing; fidelity)
- Use data to support impact that the organization
- Document
- Create a database for people/organizations to access trainings on-demand
- Have financial team review budget and engage community partners (philanthropy) (Support dialogue about how to leverage additional funding opportunities
- Examine how we finance the assessment of the population and impact post- funding (explore partnerships with university and/or philanthropic organization