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Health Equity: Moving from the Margins to the Center

By Anthony Iton, MD, JD, MPH, Senior Vice President for Healthy Communities, The California Endowment

In the many years I've spent connected to NACCHO's work, conversations about health equity have moved from the sidelines to become a central focus of many in local health departments (LHDs). Although we arrive at this commitment to health equity from different pathways, for many of us it becomes our life's work. My understanding of the fact that your zip code is more important than your genetic code came less from the training I received in medical school and more from the community I lived in while there.

Although I was born in the United States, I spent my childhood and adolescence in Canada, where I grew up as a young black man in a society with universal single-payer health insurance, universal children's dental care, high-quality K-12 schools, heavily subsidized post-secondary education, and high-quality neighborhood amenities such as parks, recreation facilities, grocery stores, and community centers. Canada invested in

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me, a black American child. When I saw the decayed and burnt-out buildings, garbage-strewn lots, neglected, rodent-infested schools, and hundreds and hundreds of unemployed adults in the East Baltimore area surrounding our medical school, I wondered what I would have become had this been my childhood environment. Would I have survived, much less thrived, if I had been constantly bombarded with the message that my life didn't matter? I can honestly say, I don't know for sure.

This experience, along with serving as the Alameda County Public Health Director in Oakland, CA, fomented my commitment to eliminating the underlying causes of health inequities. More and more LHDs are joining the fight. Social movements of our time—communities organizing after Hurricane Katrina, Occupy Wall Street, Black Lives Matter—have pushed public health further than we would have gone on our own, challenging us to think critically about our frameworks, the true meaning of equity, and the role of government in creating a society where everyone has the opportunity to be healthy. While there is hope for the future, getting there requires that LHDs urgently advance a health equity practice.

Recently, The California Endowment (TCE) supported the Advancing Health Equity Awards to lift up the hard work of California LHDs committed to eliminating health inequities (see page 14). Through deep discussions, a planning committee of leaders in the field helped define the key elements of health equity practice that became the criteria for the awards. While contexts and strategies will vary, there are aspects of a guiding framework that constitute essential components for seriously tackling health inequities. This article summarizes the five key principles of a health equity practice.

While there is hope for the future, getting there requires that LHDs urgently advance a health equity practice.

What is a Health Equity Practice?

Principle 1: LHDs must grapple with and confront racism. Racism, not race. What my professors in Baltimore were calling differences due to race were in fact differences due to racism. Calling them racial differences subtly implied that they were natural biological differences. During medical school, it became clear to me that the medical model had no answers for the virulent and starkly racialized poverty that clawed at the spirit of the patients I was treating. Because our country was built on profound and pathological racial exploitation, we must grapple with and address racism and its intersections with classism, sexism, heterosexism, and numerous other forms of oppression in all of our work. This is not an optional aspect of health equity practice—it is foundational to all that we do and must be woven throughout the other principles presented in this article.

Principle 2: LHDs must change the public narrative of health from exclusion to inclusion. We must retell the story of health with our own framework, rather than reinforcing the narratives that were created in the past and continuing to support systems of inequity. A dominant narrative in this country is that some people are deserving and others are not. Another dominant narrative is that some people take personal responsibility and others do not. These narratives are extremely prevalent in politics and are based on an ethos of exclusion. Welfare recipients are routinely held up for public disgrace, which is often racially tinged, and welfare offices rules and practices are designed to reinforce shame and denigrate the self-worth of those who receive benefits. However, homeowners who receive mortgage interest tax deductions, including on second homes and yachts, are not seen as recipients of government welfare. These narratives drive how we do our work. Many health interventions are designed to exhort people to make better choices or risk getting pushed further to the margins, all the while ignoring the broader structural injustices at play. The good news is that the narrative of exclusion has always had to compete with a different and equally enduring narrative of inclusion.

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The roots of our inclusion narrative are as old as the United States, and are embedded in the very ideas that led to its founding. Integrated strategies to move the dominant narrative from one of exclusion to one of inclusion and to ground the public health narrative in this broader narrative of inclusion are critical to a healthy equity practice.

Principle 3: LHDs must build strategic partnerships across sectors and communities to move policy and systems change and to shift the power dynamics behind health inequities. Health is political. Liquor stores, fast food establishments, payday lending, and dilapidated school buildings and parks are not natural. Local, regional, and state policies and institutional practices actively and passively facilitate the neglect of and disinvestment in some communities while investing in and privileging others. Past practices such as redlining, racially restrictive covenants, and racial zoning forced African-Americans into certain parts of town and actively stripped resources and amenities from black neighborhoods. Present day policies and the roll-back of important regulations on school funding, labor, affordable housing, and transportation serve to maintain racial and economic segregation, affecting numerous communities with low income levels and communities of color.

To improve community health, LHDs must focus on policy and systems changes across the social determinants of health and health inequity and examine institutional practices and procedures—within LHDs and across government—that impede the implementation of policies designed to change the odds for communities impacted by health inequities. As described in Principle 4, community power-building is essential to changing these systems. In addition, LHDs must move outside of the public health sector and develop relationships with neighborhood business districts, planning departments, schools, and all of the sectors and groups whose decisions we know impact community health. This does not mean that an LHD must endorse all actions of a partner, but it does mean becoming adept at mapping the power structures and then recognizing or creating opportunities to shift power toward those most impacted and strategically advance equity-focused policy, systems, and practice changes. Throughout this work, we must develop the narratives that reframe what public health is, what the role of LHDs are, and why investing in health equity benefits all of us.

Principle 4: LHDs must support communities in building their power to address the root causes of health inequities, including addressing historical and current trauma. Power matters. Changing systems, policies, and practices to improve health requires building social, political, and economic power in a critical mass of residents so that our democracy functions for all, not just for some. Systems that affect health, such as criminal justice, transportation, education, and housing, must be accountable to the communities most impacted by health inequities, including how they invest resources. Enormous barriers have been created precisely to prevent this fundamental engagement in the political process, oftentimes with explicit racial bias intended. Complex voter registration and voter ID laws, the disenfranchisement of the formerly incarcerated, arcane local government public participation processes, and the growing influence of money in politics are just some of the ways that the beneficiaries of the status quo protect their influence and privilege. These barriers have profound health and social consequences for low-income communities and communities of color and must be dismantled. Improving community health will require that LHDs develop ways to support communities in recognizing and building their own power and optimizing local democracy. It also requires a narrative that illustrates that power is inherent in people and communities, and that when communities fight for a more democratic, fair, and inclusive government, we all benefit.

In addition to structural barriers to full participation in our democratic system,

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low-income communities and communities of color carry the weight of centuries of exclusion and the denigration of human dignity. Policies that unintentionally contribute to racial and health inequities create wounds that must be healed. Spaces and services for culturally rooted, trauma-informed healing and other essential services are critical for building community power. Ensuring that communities have their basic needs met is a fundamental role that LHDs can play; however, the funding and infrastructure of LHDs often divorces this service role from the other long-term principles of building community power and addressing the roots of inequities. Both in narrative and in practice, it is imperative that services are conducted in a way that accounts for and addresses trauma and that these services are tied to a vision of equity.

Principle 5: Government, including LHDs, plays a central role in the movement for racial and health equity. Government must change. While achieving racial and health equity will require the work of many, government plays a key role, in particular LHDs. To begin, sustain, and grow this work of changing government, LHDs must seek to institutionalize this work in the policies, practices, and norms of the agency. This requires strong leadership, organizational commitment, staff development, and integration of a health equity framework and heath equity values into departmental policies, procedures, and, perhaps most importantly, within outside partnerships that will hold LHDs accountable for becoming health equity champions. We must also seek to uplift a narrative about how government has a unique and critical role in holding the social fabric of society together.

Conclusion

My pathway toward health equity continues through my position as Director of Healthy Communities for TCE's Building Healthy Communities (BHC) initiative, a billion dollar, 14-site, place-based health improvement effort targeting comprehensive local and statewide policy and systems change. BHC enlists the very residents that have been the targets of exclusion, stigma, and discrimination in remaking their environments through holding local, regional, and state systems accountable for creating healthy and equitable community environments. BHC supports communities in building their social, political, and economic power so they can engage more deeply in the policy and systems change needed to create healthy environments and achieve health equity.

LHD's are critical to realizing the vision behind BHC. The following articles highlight how LHDs are engaging in BHC, with the elements of a health equity practice threaded throughout each article. A greater number of examples help us understand how LHDs are grappling with integrating the above principles into their work and are striving to deeply engage with communities in the transformational work needed to shift power over the long term. There is hope in this moment. We cannot let the challenges, as enormous as they may be, block our view of the catalytic role LHDs can and must play in moving all of us toward hope and health. Together, and with our community and funding partners, we will make health equity practice the standard, not the exception, for every LHD across the country.

Dr. Iton would like to acknowledge Katherine Schaff and Alexandra Desautels for their support on this article.

Essential Elements of Health Equity Practice: Partnering to Support Power-Building

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The Alameda County (CA) Public Health Department's (ACPHD's) vision is that everyone, no matter who they are, where they live, how much money they make, or the color of their skin, can lead a healthy, fulfilling, and productive life. However, access to good schools, quality housing and transportation, jobs that pay a living wage, safe places to live and work, and a fair criminal justice system is differentially distributed based on the intersections of race, income/wealth, and place.[1]

An essential aspect of addressing these inequities is supporting power-building in low-income communities of color. The California Endowment describes people power as when:

> ...local residents understand their leadership and change making potential, lifting their voices in public forums, and exercising real power. In turn, local institutions and government agencies are being challenged to reorient the civic infrastructure to truly optimize democracy and incorporate genuine resident input in decision making beyond the minimal and often superficial methods typically used.[2]

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Focus on short-term change that supports a long-term strategy to build community power.

Building Power in Alameda County: Engaging in Development and City Planning

While ACPHD has many ongoing health equity initiatives, two that address land use and development decisions—issues that deeply impact social and health inequities—are helpful in examining local health departments' (LHDs') role in power-building.[3,4]

Healthy Development Guidelines—Residents, community based organizations (CBOs), developers, and government partners collaborated to create Healthy Development Guidelines (HDG), which will help ensure that the City of Oakland takes into account issues such as access to healthy food, affordable housing, clean air, safe places to play, and good jobs when making decisions about development. ACPHD played a key role in the process through Place Matters, a local policy initiative that includes health department staff and CBOs, and through East Oakland Building Healthy Communities (East Oakland BHC), an initiative directed by a steering committee of CBOs and residents that ACPHD has been involved with since its inception. Oakland's dense network of base-building CBOs* that build collective power to bring about structural change shaped ACPHD's involvement in the process.

Health element—Ashland-Cherryland residents, CBOs, the Alameda County Planning Department, and ACPHD came together to create a health element in their General Plan, which was approved in 2015. The General Plan serves as the "constitution" of a community and guides all local government land use decisions and policies. Strong health elements can powerfully orient government actions for decades, provide opportunities to engage residents in identifying priorities, and promote health equity. Ashland-Cherryland is a small, unincorporated area of the county that has a smaller network of CBOs.

Build on existing community-based work—These initiatives would not have moved forward without strong partnerships with base-building CBOs that invest in building resident capacity and leadership and have ongoing campaigns to improve community conditions. The Health for Oakland's People and Environment Collaborative (HOPE Collaborative) proposed the HDG to the East Oakland BHC Land Use Workgroup as a way to bring diverse organizations together, bringing community voice and participation into the planning process while addressing the link between development and health. In Ashland-Cherryland, Congregations Organizing for Renewal (COR) was not initially focused on creating a health element; however, they had already built relationships, credibility, and resident leadership in the community.

Focus on short-term change that supports a long-term strategy to build community power—While each initiative had a specific policy aim, they shared a goal of investing in and supporting CBOs to achieve lasting transformational change. The long-term goals of increasing transparency, accountability, and community engagement in planning decisions informed the approach they used to create policy. In the HDG work, "Not only were residents engaged in the process, but residents were co-producers, themselves acting as policy-makers, creating a policy document instead of the traditional role of providing feedback."[5] In Ashland-Cherryland, ACPHD was able to provide funding to support COR's engagement in the process, which also included resident involvement in creating policy. Prioritizing a community-driven process helped create opportunities for residents to meaningfully sit at policy tables in these initiatives and beyond.

Base-building organizations may not be typical CBO partners for LHDs and the explicit focus on building resident power may create discomfort and raise challenging questions for LHDs. However, these questions provide an opportunity for LHDs to grow and build their own capacity. Furthermore, base-building groups help democratize the political process and create more transparent government, which is

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essential in moving towards health equity.

Inclusive planning teams help move complex processes—Supporting and maintaining community engagement and power-building took time and planning. While each initiative engaged a broad range of residents and community groups, they each had a smaller project management team that included staff from ACPHD, other government agencies, such as the Oakland Planning Department, and base-building CBOs. The CBOs were critical in guiding how the project management teams approached their work and in creating strategies to build community power. Developing trust and clarifying decision-making processes in the project management teams was essential.

Stronger together—In partnering with base-building CBOs, clarifying roles and leveraging the strengths of each organization is important. ACPHD brings expertise around data, facilitation, and policy and has played a bridge role between CBOs, residents, and other government agencies or elected officials.[5] CBOs have contributed their political strategy and savvy, their deep understanding of the issues and potential solutions, their ability to mobilize residents, and their ability to use of a strong social justice framework. In Ashland-Cherryland, the political process slowed, stalling for almost a year. COR mobilized residents to attend public hearings, which greatly contributed to moving the health element forward. CBOs can also help hold LHDs accountable to residents.

Assessing the capacity of the organizations involved is an important step in defining roles and setting policy goals. If CBOs lack the organizational stability or capacity to engage in new work, LHDs can consider ways to support CBOs in the process. Additionally, ACPHD spent years building their own capacity by exploring and addressing land use policy before taking on these larger and more challenging initiatives.

Challenges

Maintaining momentum—Staffing changes and policy timelines made maintaining engagement and momentum challenging. Additionally, policy work may require engaging in technical discussions that are not easily accessible to everyone. Each iteration of the HDG became more technical and included complicated city codes and regulatory limitations.[5] Breaking the work into two groups—a Technical Advisory Group (TAG) and Resident Engagement Group—allowed the work to move forward while keeping a focus on building community power and having an effective tool. The project management team ensured coordination between groups and that the TAG included CBOs.

Lack of clarity—Even with project management teams, at times each initiative faced a lack of clarity. As this was completely new work for everyone involved, as one CBO staff member described, the "build it as we go" mentality left people feeling uneasy and unsure of next steps.[5] There are no easy solutions to addressing the lack of clarity; however, organizational commitment to support this work, invest staff time and resources, and uphold community power-building was an essential foundation, rooted in trust.

Conclusion

ACPHD's work on health equity started years ago with many small steps. It took time to develop the capacity to get involved in policy change and even longer to take a lead role in supporting a process to create policies through the HDG and health element. Engaging in increasingly complex work has created opportunities for CBOs, residents, and ACPHD staff to identify how an LHD can be effective in supporting community power-building, which continues to evolve. ACPHD's organizational commitment to prioritizing policy work that supports community power-building has allowed the health department to expand its work and to move closer to achieving health equity in Alameda County.

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**For more information on base- or movement-building, visit Movement Strategy Center at http://bit.ly/1TEF5zD.*

Reflections on the Use of Health Impact Assessment and Policy Analysis to Guide Public Policy Decisions in Los Angeles County

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To augment its ability to engage the community and generate meaningful policy recommendations, the Los Angeles County Department of Public Health (DPH) has invested in building its capacity to conduct health impact assessments (HIAs) and policy analysis. HIA is defined by the National Research Council as "a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed [non-health sector] policy, plan, program or project on the health of a population and the distribution of the effects within the population."[1]

A recent HIA on a proposal to provide free public transportation passes to students in Los Angeles County helped facilitate dialogue among a large number of organizations both within and outside the health sector, including the Los Angeles County Metropolitan Transportation Authority (MTA), school districts, law enforcement and legal system partners, and youth-serving organizations.[2, 3]

The assessment estimated the costs and benefits of the program and described its potential impacts on a range of social and health outcomes including school attendance, contact with juvenile justice system, funds for schools, and healthier communities (see Table 1). Supported in part by the Pew Charitable Trusts and The California Endowment, the HIA provided stakeholders with a framework and a comprehensive set of user-friendly data that were considered as the partners discussed this broad-reaching policy proposal.

DPH has since applied similar approaches with good effects to assist other county departments and regional agencies prioritize policies and inform program development and evaluation. DPH's experience with HIA and policy analysis underscores the importance of developing a comprehensive policy assessment strategy (or model) that aligns with health system transformation brought about by the Patient Protection and Affordable Care Act and supports national momentum to address the social determinants of health.

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TABLE 1: Potential impact of the proposed free student transit passes program on a range of social and health outcomes in Los Angeles County, 2013[2,3]

Outcome (Indicator)	Highlights of indicator estimates
School attendance	Increase in classroom attendance. **Context:** For every 1% decrease in unexcused absences in Los Angeles Unified School District, students would receive 29,000 more instructional hours per year.
Contact with juvenile justice system	Decrease contact. **Context:** The Los Angeles County Sheriff's Department issued 9,966 citations to youth for fare evasion in 2012. These citations can result in heavy fines or court appearances. A first-time court appearance during high school quadruples a student's odds of dropping out of school.
Available funds for schools	Increase school district funding for student attendance. **Context:** For every 1% decrease in unexcused absences in Los Angeles Unified School District, schools could receive an additional $125,000 each year.
Healthier communities	Increase in healthier families and environments. **Context:** Free transit passes could save families, especially those who are low-income, $2.5 million per year on student transit passes. If 13,000 more students used public transportation, CO_2 emissions could be reduced by 20.35 metric tons daily.

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Revitalizing Communities: Partnerships to Create Active, Safe Places in Merced County, California

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Located in the heart of California's San Joaquin Valley, the nation's most productive agricultural region, Merced County is home to a multi-million dollar agricultural industry. However, nearly 50% of the county's residents are Medi-Cal beneficiaries and 34% of children under the age of 18 years live in poverty[1,2] Merced County consistently ranks among the bottom third of California's 58 counties for mortality indicators related to chronic health conditions.[3] More than one in three adults are obese.[2]

Resource inequities persist across many of the county's rural towns and within its urban neighborhoods. Populations living in rural unincorporated communities are frequently low income with limited seasonal employment opportunities. Many residents speak English as a second language or are non-English speaking. Nearly 52% of the Merced County's population speaks a language other than English at home, primarily Spanish (35.3%), Hmong (3.2%), and Punjabi (1.0%).[4,5]

Rural populations face many barriers, including a lack of awareness of the political and decision-making processes affecting their communities. Rural areas share limited resources such as sheriff deputies, animal control officers, and parks and recreation department staff; such limitations impact crime rates, the perception of general safety, and the availability of recreational opportunities.

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Furthermore, transportation barriers exist due to a lack of investment in the roads, sidewalks, and overall infrastructure of many unincorporated communities. Transportation to and from these areas into the urban center is also limited because there are minimal public transit options, creating a sense of isolation. Most of the county's rural unincorporated communities have Municipal Advisory Councils that serve as advisory liaisons to the elected members of the county Board of Supervisors. However, the meetings, held in the evenings and conducted in English, are not well attended by the residents.

Even within the incorporated city centers, such as the City of Merced, the under-resourced neighborhoods are primarily in communities of color with low-paying jobs. These communities have traditionally not been well-served by the political structure due to systems such as at-large elections that allow elected officials to represent areas where they do not live, resulting in disproportionate representation of affluent, white communities and an imbalance of power.

Merced County has limited access to recreational facilities and healthy foods, along with a high percentage of fast food restaurants. Merced is ranked 48th in California in the category of Health Factors, which includes access to exercise opportunities.[2] Sixty-eight percent of Merced County's population is reported to have adequate access to locations for physical activity, compared to a rate of 93% for California and 92% for the Top U.S. Performers.[2] In the Merced County Department of Public Health's (MCDPH's) 2013 Health Equity Community Survey, residents identified nutrition/exercise and poverty as the top two social, economic, and cultural factors impacting health.[6] Only 57% of Merced County residents have adequate opportunities for exercise; in a majority of county communities, less than 60% of the residents live within one mile of a park.[7]

Home to one of 14 Building Healthy Communities (BHC) sites supported by The California Endowment, Merced County's rich partnerships among residents, community-based organizations, and local agencies have worked together to develop active and safe places for low-income residents to gather and play. Closing the resource gaps and building the political will to make this happen was not easy; however, a consistent collaborative approach involving cross-sector partners and resident engagement has resulted in a level of trust necessary to support cooperative planning that, in turn, has resulted in tangible, relevant outcomes for these marginalized communities.

Rural populations face many barriers, including a lack of awareness of the political and decision-making processes affecting their communities.

Promoting Physical Activity in Rural Winton through Cross-Sectoral Partnerships

This story begins in Winton, a rural unincorporated community in Merced County with a population, largely Hispanic and low income, of fewer than 11,000 residents. Inadequate infrastructure and high crime rates discourage residents from engaging in physical activity, contributing to high rates of obesity among both children and adults. The most recent California Physical Fitness Test found over 54% of fifth-graders in the Winton School District need improvement or are at high risk due to their weight (body composition).[8]

Using policy, system, and environmental change strategies, MCDPH supported partnerships intended to build healthier communities in rural Merced County. MCDPH began working with the Winton School District, the Merced Bicycle Coalition, Lifeline Community Development Corporation, and Cultiva La Salud to promote safe routes to

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school and active transportation.[9] MCDPH first met with local partners that were rooted in and trusted by the community. Local partners emphasized the importance of engaging residents in the process, giving residents an opportunity to voice their concerns and to have a part in the decision-making process. One of the first suggestions was to develop a survey in English and Spanish and to distribute the surveys to parents through the Winton School District, a respected and trusted community institution. Sixty-six percent of the surveys distributed were returned and the results identified crime, unsafe intersections, and speed of drivers as top reasons parents do not allow children to walk or bike to school. Survey results also demonstrated that less than one percent of students arrived to school by bike and less than 25% walked to school.[10]

Merced partners engaged the Local Government Commission (LGC), a non-profit organization that provides technical assistance to create healthy, walkable, and resource-efficient communities. LGC organized two walk and bicycle workshops involving parents, local elected officials, representatives from county Planning and Public Works Departments, school district personnel, and community-based organizations to identify needs and priorities and garner ideas on ways to improve the design of the primary streets leading to the schools.

Each workshop consisted of an overview of optimal community design to promote active transportation and a field assessment that allowed participants to walk the streets to see challenges and safety issues first-hand and envision re-design options. Participants then used large aerial maps to note areas of concern and document improvement recommendations. Participants' feedback was incorporated into the Winton Community Plan, a document used by the county Planning Department to seek funding to make the suggested improvements. The Winton School District school board voted unanimously to pass a Safe Routes to School policy for the district.

Six months later, MCDPH and the county Public Works Department collaborated on a California Department of Transportation Active Transportation Program (ATP) grant, and they incorporated the results of the Winton parent survey and walkability assessment process into the proposal. The involvement of a local elected official and the Public Works Department in the assessment process meant that the Winton community was top of mind when the ATP grant opportunity became available. In addition to the structural improvement plans, Winton's ATP grant application was strengthened by a non-infrastructure component: continuing resident engagement. Winton received an ATP infrastructure and non-infrastructure award that today is bringing about many of the suggested improvements made by the parents, including the construction of curbs, gutters, sidewalks, and bike lanes leading to the schools. These infrastructure changes will improve connectivity for residents and make it safer and easier for students to walk and bike to school. MCDPH is responsible for implementation of the non-infrastructure portion of the grant by engaging parents and students in bicycle and pedestrian safety measures and training teachers on strategies to integrate bicycle and pedestrian education into the classroom.

Replicating the Revitalization Model

The story does not end here. Going forward, MCDPH, community partners, technical experts, and county agencies all have the capacity to work together to support infrastructure improvements and recognize the value of that collaboration. Winton's efforts are being successfully replicated in Merced's BHC neighborhoods of Franklin-Beachwood and South Merced. MCDPH, BHC community partners, technical assistance experts, and local agencies are using this model of resident engagement to revitalize areas around schools to improve safety, walkability, and bikeability and to

Revitalizing safe active places is one key element to achieving health equity within low-income, resource-poor communities and neighborhoods.

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open school grounds for community resident use after hours and on weekends.

Revitalizing safe active places is one key element to achieving health equity within low-income, resource-poor communities and neighborhoods. Working across multiple community sectors is a key element to building understanding and commitment to community improvements. Planning and implementation processes that put community at the center of driving change are critical to securing resources for infrastructure improvements and sustaining long-term efforts to advancing health equity, and have made Winton a healthier and safer place to live, work, and play. MCDPH is committed to continuing multi-sector partnerships that include resident engagement in community revitalization projects.

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The Advancing Health Equity Awards: Replicable Examples from Local Health Departments

By William Jahmal Miller, MHA, Deputy Director, Office of Health Equity, California Department of Public Health

President John Quincy Adams once said, "If your actions inspire others to dream more, learn more, do more and become more, you are a leader." With this prophetic statement, President Adams recognized that true leadership comes by way of example. That very same notion led to origin of the Advancing Health Equity Awards, which recognize and support innovative local public health department work that strives to achieve health equity. In California's first State Office of Health Equity, our mission is to promote equitable social, economic, and environmental conditions to achieve optimal health, mental health, and well-being for all Californians.

Far too often, the realities of where we live, work, and play become the ultimate drivers of our health. People living a few miles apart can have a difference of up to 20 years in life expectancy based on access to quality education, good jobs, a fair criminal justice system, clean and safe places to play and work, quality housing, and affordable transportation. Communities marginalized by low income and communities of color are more likely to face barriers to accessing these necessary determinants of health. In order to advance health equity on a broad scale, we must first do so by small examples. We recognize that no matter how effective a statewide Office of Health Equity might be, health happens at the community level. Local health department leaders and staff, embedded in the communities they serve, are solving our state's greatest health challenges. We must celebrate the leadership role they play in showing us through example that health equity is achievable.

The beauty of the Advancing Health Equity Awards is that the program was developed to recognize the leadership of our local health departments, showcasing initiatives that go beyond the traditional scope of public health and help inspire further progress toward health equity. Our steering committee, comprising local health directors and other statewide health equity leaders, developed the criteria for these awards and worked collaboratively to select the winners. Four public health departments stood out in particular, due to their exceptional work reducing health inequities. These departments include Alameda County Public Health Department, Shasta County Health and Human Services Agency Public Health Branch, Sonoma County Department of Health Services, and the Los Angeles County Department of Public Health. Alameda's award came with a grant of $100,000, while the latter three counties' grants were awarded $25,000 each, all for efforts to further progress toward health equity. Beyond the awardees, there are many examples and case studies of leaders in this work. In all, 13 health departments across the state demonstrated their ability to go beyond the traditional scope of public health.

This is difficult work, yet success is happening all across California. Local health departments are partnering with their communities to address housing conditions, the root causes of poverty, educational attainment, and community safety to ensure everyone has the opportunity to be healthy, no matter where they live, the color of their skin, or their income. No quick fix exists for achieving equity. Time will be truest measure of our success; however, the Advancing Health Equity Awards will help share our first success stories as shining examples that they can be replicated across California and the country.

To learn more about the awards, the selection process, and the award winners, visit http://www.bmsg.org/resources/publications/health-equity-case-studies-california.

Advancing Health Equity through Regional Collaboration

By Tracy Delaney PhD, RD, Executive Director, Public Health Alliance of Southern California; Melissa Jones, MPA, Executive Director, Bay Area Regional Health Inequities Initiative; and Van Do-Reynoso, MPH, Public Health Director, Madera County, California

California is the most populous state in the nation, with marked diversity in demography, geography, and economy. These factors result in striking disparities in health outcomes and life expectancy rooted in the social determinants of health (SDOH). To address these significant structural issues, it is necessary to work with non-health sectors to ensure their decisions advance health equity. This type of work is long-term and difficult, often without dedicated funding streams for staff efforts. To help meet these challenges, many local health department (LHDs) are utilizing regional public health department collaboratives to advance public health practice and improve population health and equity. Three such collaboratives include the Bay Area Regional Health Inequities Initiative (BARHII), the Public Health Alliance of Southern California (PHASoCal), and the San Joaquin Valley Public Health Consortium (SJVPHC).

Overview of Regional Collaboratives (RCs)

BARHII was the first collaborative to organize. The first of the three collaboratives, BARHII was founded by the leadership of LHDs and now includes 11 LHDs from the Bay Area covering a population of 7.8 million residents. The goal is to eliminate health disparities by transforming public health practice and increasing the capacity of LHDs to create community-wide conditions that promote health. Over its 14 years, BARHII has gone through different phases. Originally, the focus was executive leadership engagement and strategies to impact health inequities through organizational change. A second phase focused on practice development for mid-level managers and staff, which resulted in creation of many practical tools for health departments. The current focus is to serve as a regional voice and advocate, supporting public health practice transformations that impact health inequity and the social determinants of health. Current working groups include the following: a) built environment, b) data, c) internal capacity, d) policy, and e) structural racism/social determinants of health. Visit http://barhii.org/ for more information.

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Advancing Health Equity through Regional Collaboration

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PHASoCal is a collaborative of nine LHDs whose members collectively have statutory responsibility for the public health of 60% of the state's population. PHASoCal targets chronic disease prevention and equity through upstream, multi-sector policy, systems, and environmental change. PHASoCal's vision is that all Southern California communities are healthy, vibrant, and sustainable places to live, work, and play. Leadership comprises public health directors, public health officers, and chronic disease directors. Priority initiatives currently address transportation, food systems, and data in action and include staff-level participation as well as active participation from other sectors. All organizational activities have an overarching lens of equity and climate change. Visit http://www.PHASoCal.org/ for more information.

SJVPHC consists of eight LHDs with a combined population of nearly four million people. The consortium covers over 24,000 square miles in the central San Joaquin Valley, one of the largest rural and agricultural areas in the nation. It is also culturally diverse, with more than 70 ethnicities and 105 languages spoken. Leadership comprises public health directors, deputy and assistant directors, public health officers, and associate members from regional academic institutions and other organizations. SJVPHC's mission is to provide leadership for a regional health agenda that addresses the social determinants of health in the San Joaquin Valley. Convened monthly, the Consortium engages in strategic planning, training, action-oriented policy development, and research to improve the quality and responsiveness of public health programs in the Central California region. Visit https://www.fresnostate.edu/chhs/sjvphc/ for more information.

Why a Regional Approach?

A regional public health approach has been an effective strategy for the following reasons:

- **Addresses cross-jurisdictional health issues.** Some of the most serious public health concerns cross county lines and require new, coordinated approaches for effective targeting. These include a range of issues such as greenhouse gas emissions, air quality, transportation networks, regional food systems, cross-county employment destinations and housing fit, migrant populations, high poverty rates, and high rates of chronic disease.
- **Facilitates exchange of ideas and capacity building.** RCs provide a sharing forum that elevates best practices and expands the boundaries of public health practice across a region. Working together on data-driven key messages result in more effective and stronger, consistent communication, which is particularly helpful when working with other sectors.
- **Amplifies policy impact.** By collectively advancing policy through the combined representation of regional geographies, LHDs effectively mobilize and elevate a strong regional public health voice.
- **Unifies key messaging.** Working together to hone in on key messages supports stronger, consistent communication, which is helpful when working with other sectors. Key messaging is effective when it is data-driven and apolitical.
- **Provides opportunity for high-level regional strategic planning.** RCs have been highly successful in creating a safe forum for honest peer-to-peer discussions about barriers and potential solutions facing LHDs. They provide the needed place and dedicated time to jointly reflect and act on regional strategic planning activities. These joint efforts can help address the root causes of disparities in an apolitical environment.
- **Leverages resources.** RCs serve as "staff extenders" for LHDs. Smaller, under-resourced LHDs gain benefits such as access to services, products, and even specialized staff. All LHDs gain benefits by having collaborative staff take the initial lead on developing time-consuming policy recommendations and public comment letters that would otherwise drain their staff time. With RCs, LHDs can more effectively use their time to review and vet materials, thus supporting them to weigh-in on crucial policy, systems, and environmental issues. Due to high workloads across LHDs, these deeper, impactful, and time-consuming activities would likely not be possible without the RCs.

Highlights of Success

Data Driven Tools and Products—Highlights of tools developed to advance SDOH practice include the following:

- Development of a Health Disadvantage Index, based on the SDOH, that can be used to identify and prioritize census tracks across the state for public and private investments and programming (PHASoCal.org/ca-hdi).
- Creation of a comprehensive SDOH indicators guide to assist LHDs and other sectors in accessing and monitoring root causes of health and disparities (barhii.org/resources/sdoh-indicator-guide/).
- Implementation of a Healthy Communities Indicators Project resulting in data-sharing across different sectors for regional transportation planning (PHASoCal.org/data/healthy-communities-indicator-project/).

Policy Advancement—RCs have been very active on the policy front. This has been particularly noteworthy in the

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built environment, transportation, and climate change, where California's ambitious greenhouse gas (GHG) reduction policies and programming provide impactful opportunities to optimize health co-benefits. This includes advocacy on the distribution of Cap and Trade funds so they target health disadvantaged communities. Policy work with regional Metropolitan Planning Organization Sustainable Communities Strategies have led to stricter GHG reduction targets; increased investments for walking, biking, and public transit; attention to job/housing fit; first and last mile connectivity; and inclusion of specific health goals. Development of policy briefs has also supported advocacy focusing on housing affordability and health, as well as pediatric, adolescent, and adult health.

Organizational Change—Advancing health equity through RC's helps establish a "new norm" around healthy equity best practices. The regional dynamic that is creating is especially important for catalyzing adoption of health equity policies and actions among LHDs that were not working on healthy equity. RC's have led to significant LHD organizational changes. Highlights include the following: the launch of health equity policy units in several LHDs, the hiring of new built environment specialist positions to advance community level health, the development of a nationally renowned Organizational Self-Assessment Toolkit for addressing Health Inequities (http://barhii.org/resources/barhii-toolkit/), and the creation of a Health Policy Leadership Program.

Recognition of RCs as Influential Entities—Since the RCs have been active, new cross-jurisdictional interactions and collaborations have occurred among LHDs. These new collaborations spur additional joint regional actions, outside of the work of the RC, serving to further amplify and strengthen the public health voice. In addition, as the work of the RCs has advanced, they are now recognized and sought out by a range of other entities for their policy issues and for key collaborations. These include state entities, regional planning agencies, local municipalities, and community-based organizations.

Challenges

The key challenges RCs are confronting as they continue to develop their practice include the following:

- **Varying political contexts.** Even within RCs, there is still a range of political environments. Success requires that a range of options exist so that each LHD can participate based on their local environments. Introducing key language within each LHD's Legislative Agenda is a strategy to gradually advance health-equity focused policy work that crosses sectors.
- **Fast-paced environments.** The window of opportunity on key, cross-sector policy and systems changes is usually short. Vetting time-sensitive letters and other advocacy activities through multiple LHDs has been a challenge. It is important to deepen understanding of key issues in advance of time-sensitive vetting processes.
- **Succession planning.** LHD turnover of key RC leaders requires thoughtful succession planning and comprehensive orientation of new members.
- **Building political capital.** There is a need to engage power players in other fields beyond public health to tackle huge social issues and growing inequities. This network-building beyond public health departments is time consuming and difficult to navigate politically.
- **Unstable funding.** RC staff positions are primarily funded by foundations. To ensure RC sustainability, development of a range of funding portfolios is needed.

Conclusion

In a time of growing health inequities and categorical revenue streams, RC's create an opportunity for LHDs to pool talent and experience, share innovative best practices, and mobilize a collective public health voice to advance policy action. RCs provide a forum for honest, data-informed conversations about impactful actions to promote health for the region, distinct from the politics of any local jurisdiction. Regional action can expand boundaries and help transform the field of public health to address the root causes of disparities and advance health equity.

Governing for Racial Equity: A Local Health Department's Journey

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Governing for Racial Equity: A Systems Change Approach to Achieve Health Equity

Achieving health equity in local communities takes innovative practices. It requires out-of-the box thinking, courageous leadership, and the implementation of a wide range of strategies to eradicate inequities and address their root causes. Monterey County Health Department (MCHD) in California is engaging with key community partners to uplift Governing for Racial Equity (GRE), a promising new strategy being used to advance health equity.

Communities across the nation are referencing GRE as a potential solution to reduce or eliminate inequities. Racial equity—the condition that would be achieved if one's racial identity no longer predicted how one fares—includes work to address root causes, not just their manifestation.[1] At its core, it includes efforts to eliminate policies and practices that contribute to disproportionate outcomes for low-income communities of color. All over the country, efforts to eliminate health inequities are deployed daily; however, these attempts seldom contribute significantly to the narrowing of these inequities in communities that suffer from the poorest health outcomes. The concept of GRE brings hope to these communities. It challenges current practices and shifts power so that those in decision-making roles must examine the impact of their policies.

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The work of partners in Monterey County contributed to MCHD using GRE. In Salinas, the largest city within Monterey County, The California Endowment's 10-year Building Healthy Communities (BHC) initiative began working across systems in 2010 to change the way policies and practices were impacting community residents.[2] Salinas is a semi-rural community with significant health and socioeconomic inequities; 75% of its population is Latino and 21% lives in poverty.[3] In addition to economic inequities, the community has one of the highest youth homicide rates in the state, propelling a long list of other stressors.

BHC's initial concentrated efforts included intensive investment in healing and community capacity building that developed relationships and trust among city leaders, community residents, and partners such as MCHD. Through these newfound relationships, collaborative community projects developed and their implementation led to a shift in power that highlighted new ways of working together. In 2014, the community experienced an additional set of stressors, when four officer-involved shootings occurred within a four-month span. These incidents called for immediate action. Partners united to develop solutions to address community outrage.

BHC partners, including MCHD, called for community healing and dialogues, and began conducting community healing circles led by a culturally relevant expert to address the community's recent and historical traumas, while engaging the community in discussions around root causes and inequities. The process set the groundwork for racial equity conversations and underscored the need for local systems change. City system leaders responded well to the healing efforts. They too recognized that change was necessary and became a partner willing to work more intentionally with the community and look internally to identify areas needing improvement.

The partnership led to the innovative approach of GRE. In late 2014, the City of Salinas and BHC partners underwent a week-long training for 50 city staff and 50 community members about the importance of racial equity and healing in communities. What differentiated this training from others was that it married the two concepts. It acknowledged the importance and power of racial equity and healing to transform communities by addressing community trauma, cultivating empathy, and authentically empowering residents.

Laying the Groundwork: Developing Capacity to Advance Health Equity

GRE efforts were aligned with MCHD's vision. MCHD had already built the capacity to champion an equity-oriented approach by working across sectors and in partnership with the community. MCHD had incorporated a Health in All Policies (HiAP) framework into the 2011–2015 Department Strategic Plan and the 2014–2018 Community Health Improvement Plan. This strategic work included funding key staff positons to serve as leaders to implement health equity practices both internally, within the department, and externally with community. Internal efforts included the development and implementation in 2013 of a Health Equity Scholars Academy for staff. MCHD researched and adapted promising practice curricula to create a five-module, four-hour-per-month training for staff to embed a thorough understanding within the workforce of equity and the social determinants of health. Evaluations show that 98% of participants have increased their knowledge of cultural humility, the effects of racism on health, social determinants, and health inequities.

Staff capacity building prepared MCHD to effectively establish strong partnerships with the community grounded in a commitment to HiAP and equity. Initial external work included supporting several health equity trainings for community partners and county leaders in 2011 and 2012, inviting keynote speakers who would resonate with particular groups.

Even when government leaders support the advancement of equity, it takes strong community partners to drive a GRE approach. It is critical that residents understand, participate in, and advocate for the implementation of more equitable practices. MCHD and its partners in philanthropy also invested in community capacity building. MCHD developed and began providing a civic engagement curriculum for community members in 2014. The curriculum aims to engage graduates in civic governance and encourage them to become

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advocates of intentional community engagement to further the advancement of equitable practices. To date, several cohorts have graduated and continue to develop and implement community improvement strategies.

Building on the early trainings, MCHD also developed a HiAP Council in the City of Salinas in 2012 that worked on advancing equitable strategies and ultimately supported the successful movement toward GRE. For example, partnerships that developed through the MCHD HiAP Council and community partner's influenced the Economic Development Element (EDE) proposed in 2013 for the City of Salinas's General Plan. With its BHC partners, MCHD was able to support authentic community engagement in the development of the EDE; through the city's willingness to embrace the effort, equitable policies and an entire "Quality of Life" section were incorporated into the EDE.

Advancing GRE in Monterey County

As GRE work in Salinas advanced in spring of 2015 and MCHD engaged in transformational work alongside its partners, interest in GRE among county leaders grew. An opportunity to turn interest into action arose when MCHD staff secured grant support to send 20 staff from MCHD, the County Administrator Officer's (CAO) Office, elected officials, and representatives from several cities in the county to attend the Governing for Racial Equity Network Conference in Seattle in June 2015.

Attendance at the conference offered opportunities to learn about what others across the country were doing around GRE. It provided a platform for county participants to better understand how to implement such practices and their potential for community impact. Similarly, it provided a space to talk openly about issues of race and the disproportionate outcomes communities of color face. It commenced a dialogue that did not formerly exist among the county and city attendees.

Catalyzed by the conference, county leaders began their own exploration of what equitable practices could look like in their work. To gain a deeper understanding of the potential impact of GRE, MCHD and the CAO's Office, with support from BHC, co-sponsored a half-day training in early 2016 for 60 staff from 27 county departments, including County Supervisors, led by the Compadres Network and Race Forward. At the end of the training, County Supervisors provided directives to key staff to develop recommendations on how to embed GRE principles into local practices.

Conclusion

While Monterey County is just embarking on GRE, seeds that were planted early with HiAP are contributing to broader systemic change around equity. MCHD continues to play a critical role in building internal capacity to access opportunities and align with and learn from the work taking place within the City of Salinas. Embedding these important practices will require additional capacity building and identifying internal system champions across county departments who are willing to implement and monitor such practices within their departments to ensure more equitable results. This effort will take time. Transformative change will require continued practice of system leadership, embracing a GRE framework, focusing on the solutions through data and measurement, and continuous communication and engagement.

Despite the challenges ahead, MCHD's growth trajectory from HiAP to GRE to advance health equity generates hope that government systems and community partners will effectively rise to the challenge. Doing so will lead to the eradication of social and economic inequality, enabling all Monterey County residents to reach their highest potential.

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